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Kia Taupunga te Ngākau Māori

**Anchoring Māori Health Workforce
Potential**

Annemarie Gillies

Ngāti Kahungunu, Ngāti Awa, Te Whānau-a-Apanui, Te Arawa

2006

Kia Taupunga te Ngākau Māori

**Anchoring Māori Health Workforce
Potential**

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HE POROPOROĀKĪ

E rere nei ko ngā roimata i āku mata, e tētere nei i āku kamo, e tātaka ana i taku kauwae.
Pā mai ana ko te matangi ki taku kiri, auwhi ana ko te ngākau e rite nei ki te āhao e whakakoi
nei i tāku manawa.

Auē, te mamae e papatu nei!

Nei ra taku reo karanga e rere, ki āku poutoko manawa, ki āku Manu Aute o te pō, o te
Awatea e rērere tonu mai i te poho o Ranginui, whirinaki ana i ōna parirau.
Tū mai ra Pukeko, tu mai ra Hokopu ki runga o Putauaki, karawhiua o mata ki Mataatua,
tētere rawa i te awa o Rangitaiki, pātata atu ki roto o Poroporo, karawhiua atu ki Wairaka. Rere
atu ra ki te tau o to ate e tū mai ana i te maunga o Whanganui— ā— Tara, karawhiua ana ngā
mata ki Taupunga whare, ki te marae ātea a Tumatauenga, karawhiu atu ki
Te Motu— o— Kura, kia tiketike te titiro, tārewa noa te mamae i ngā mokopuna kua waiho noa.

Nei ra te haehae i tāku Manawa.

Auē tāku tangi i a koutou e āku manu tioriori, e ngā reikura o tāku manawa.

Anō ko te mārama kua ngaro, kua ara anō.

Mai i te hiku o te ika, rērere tonu taku rākau ki rō o Waikato awa, ki te manu tioriori,
te rau Pōhutukawa o Tainui waka, nei tana rite ki te kererū i te rangi.

Rere tonu atu ki Te Arawa

Heke iho ki te puku o te whenua, Taupo – nui – a – Tia, tētere rawa i ngā tapuwae a
Tongariro, Ngauruhoe, Ruapehu, ki te awa o Whanganui tae atu ra ki te pane o te motu,
whakawhiti atu taku rākau i te moana o Raukawa, ko Te Waipounamu e tau ra!

Koutou nā, rere ra i te pō, ki a Hine – nui – te – pō, okioki ra i te Awhireinga. Taukiri e!

HE MIHI

‘E koeko te tūi, e ketekete te kākā, e kūkū te kereru’

‘Ehara taku toa i te toa takitahi engari he toa takitini’

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Ki tēnā, ki tēnā

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ABSTRACT

In New Zealand Māori are under-represented in the workforce across multiple sectors. This thesis explores this incongruity with regard to Māori health. A Māori perspective and philosophical foundation formed the basis of the methodological approach, utilising a case study research design to inform the study. This provided the opportunity to explore Māori health workforce development initiatives and their potential to contribute to improvements and gains in Māori health.

It was important that this work take into account social and economic factors and their impact on health, as well as the varying political climates of market oriented reform and a fiscal policy focus, because it has not only challenged Māori health development but also provided opportunities for increased Māori involvement and participation in health and New Zealand society. Therefore the thesis, while focused on health takes cognisance of and, coincides with the capacity and capability building efforts that have been a feature of overall Māori development, progress and advancement.

In the context of this thesis Māori health workers are seen as leaders within their whānau, hapū, iwi, and Māori communities. Consequently a potential workforce that is strong and powerful can lead to anticipated gains in Māori health alongside other Māori movements for advancement. The potential cannot be under-estimated.

This thesis argues that there are critical success factors, specific determinants, influencing Māori health workforce potential, and that these success factors have wider application. Therefore, as this thesis suggests Māori workforce development, especially in relationship to the health workforce, is dependent on effective Māori leadership, the application of Māori values to workplace practices, levels of resourcing that are compatible with training and development, critical mass, and targeted policies and programmes.

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THESIS DESIGN

The thesis is organised around ten chapters. Divided into various sections the chapters begin and end with an introduction and appropriate closing remarks, conclusions, reviews or summaries. There is no chapter dedicated solely to a review of the literature instead, each is imbued with its own strand of literature, at the same time though there is a fusion with other chapters.

Chapter 1 introduces and sets an historical backdrop and provides appropriate context and rationale for an exploration and understanding of Māori involvement and participation in health development and advancement. The chapter raises the impact of colonisation on Māori health and discusses strategies used to advance a Māori health workforce at the turn of the twentieth century. The key players, events, legislation and policies that had some influence on Māori health workforce development are discussed. The chapter supports the notion that there are distinct Māori approaches to Māori health workforce development and identifies a number of strategies that are not incompatible with broader goals for Māori development and advancement.

Chapter 2 outlines and presents a range of theoretical perspectives and methodological approaches that were explored to inform the assumptions, considerations and methods, and the processes utilised during this research programme.

Chapter 3 is concerned with contemporary Māori development and provides an overview of the position of Māori people in New Zealand with a particular focus on the period 1984-2004. It features Māori participation and involvement in a variety of initiatives across sectors, and in services provision. The chapter also presents data and information in relation to social and economic indicators which have served to impact on Māori adaptation, development, and progress. It also highlights distinct Māori developmental and advancement frameworks, concepts, tools and structures that have guided and led Māori initiative.

Chapter 4 reviews health workforce development generally, giving consideration to the contours that have shaped workforce development such as economic and labour market theories – demand and supply models used to determine inventories of ‘stock’ (people), stock

inflows and outflows, elasticity and inelasticity of stocks, and determining the value of stock piles. How organisations might use, train, up-skill and or educate their stocks, the influence of state policies on stock piles, and trends in stock management are discussed. Workforce development priorities and strategies, and leadership roles in health workforce developments are established.

Chapter 5 presents and examines Māori workforce responses to the impacts of urban migration, economic and social reform, and market conditions. It tracks the emergence and development of Māori workforce development and participation health services provision. The chapter identifies Māori capacity and assesses capabilities in health services provision, presents pertinent legislation in relation to increased Māori involvement in health, and the assurance of future Māori participation in health sector initiatives that include a Māori perspective.

Chapter 6 through to 8 provide details of the four case studies that contribute the data source for this research: Part I of chapter 6 presents Vision 2020 an accelerated Māori health professional workforce development initiative that intends to produce 500 Māori medical practitioners and 500 allied health professional by 2020. Part II presents environmental and health protection services, an exploration of an occupational vocation and potential destination choice for Māori. Chapter 7 contains the views and perceptions of Tīpu Ora (a Māori health provider) organisation on workforce development in a Māori community and tribal context focused. Chapter 8 describes and presents Te Rau Puawai, a mental health workforce development initiative designed to facilitate access and enhance the academic qualifications of Māori community health workers.

Chapter 9 brings the perceptions and views of the participants from the four case studies together in an analysis that draws from previous chapters. The chapter reveals new knowledge and tools that will have practical application in Māori health workforce development initiatives and relevance to Māori health development and advancement generally.

Chapter 10 draws the thesis to a close. The chapter points to the contribution the study makes in the ongoing development of new knowledge, relevant methodologies and research tools and methods, and stresses six key contributions to advancing wider understandings of Māori health and Māori health workforce potential.

Chapter 1

INTRODUCTION

Tika tonu atu ki a koe e tama
(E) *biki nei koe i aku whakaaro, pākia!*
He biki aba tō biki?
He biki roa tō biki, i ā ha ha!
E tama te uaua nā
E tama te māro
Inā hoki rā
Te tobe o te uaua nā
E tau nei
Ana kss aue, kss aue, kss aue
*Hi!*¹

‘Tika tonu atu ki a koe e tama’, is from the title of a haka written around 1891 at a time in New Zealand history when Māori demise was predicted. This prediction was based on a population decline from approximately 170,000 in 1840 to 42,000 in 1896 (Durie, 1994; Lange, 1999). Performed informally around the areas of Hawke’s Bay and Wairarapa in the tribal region of Ngāti Kahungunu, the aim of this particular haka was to encourage Māori to stay strong, rally together, not lose heart, nor give up, rather prepare for the struggle to survive. And, over the following decades, survival of Māori as a people was a paramount goal. The haka did not necessarily reverse the population decline but it has endured for over a century. At the same time, the Māori population increased to approximately 576,000 by 2001, and is expected to exceed 800,000 by 2051 (Statistics New Zealand, 2005)². *Tika tonu* is still performed around the country and its message remains relevant, because although their survival is no longer threatened, Māori are still marginalised within New Zealand society, and continue to experience disparities in health, education, income, justice, and social and economic activity. The words of this haka, then, are appropriate to open the first chapter in this thesis. Not only does the haka tell of enduring struggle and hardship from one century to another but it does so in a culturally affirming way. This haka is performed on many

¹ This Ngāti Kahungunu haka was composed in the early 1890s and performed on visits to marae in the areas of Wairarapa, Pahiatua, Central Hawke’s Bay, Heretaunga, Ahuriri, Te Wairoa, and Mahia. It was performed for the first time publicly by Ngāti Kahungunu at the opening of a meeting house in Rotorua in 1901. The opening was attended by the Duke of Cornwall. Later, in 1920 at another opening of a meeting house, it was performed again, this time in memory of the Duke of Cornwall who had recently died.

² <http://www2.stats.govt.nz/domino/pasfull/pasfull.nsf/> retrieved 14/07/2005

occasions: at graduations, birthdays, weddings, sports games, and various occasions to celebrate Māori achievement. It is also performed as a salute to people who have passed on; the haka encourages Māori to excel; it is a haka of encouragement but also a challenge to stand firm, and to contribute in new and innovative ways to modern society. In this sense it has relevance to ongoing Māori development.

Māori development requires a Māori workforce. This has not always been accepted, and in the past there was often an assumption that others could work on behalf of Māori. Māori reject that proposition (Hui Taumata, 1984, 2005). A Māori workforce, whether in health, education, agriculture, business or science is critical for positive Māori development. Māori and non-Māori disparities in all socio-economic areas are paralleled by disparities in the workforce (Durie, 1996a, 1996b). This thesis provides a conceptual framework that has practical application for the ongoing development of a competent Māori health workforce and, at the same time, given Māori worldviews, is applicable and relevant to other sectors. In this respect, the thesis contributes to the major goals of Māori development: to be Māori and healthy, to be Māori and culturally secure, to be Māori and educated, to be Māori and politically astute, to be Māori and economically sound, to be Māori and socially included, to be Māori in two worlds.

Colonisation

While there is evidence that some trade with Europeans (whalers, sealers and missionaries) took place before the signing of the Treaty of Waitangi in February 1840, the repercussions of the Treaty quickly reversed this interaction because it paved the way for colonisation on a much grander scale. Māori experiences of colonisation, such as depopulation through epidemics of infectious disease, cultural and political oppression, land alienation and war, are similar to those experienced by other Indigenous peoples around the world (Walker, 1990; Smith, 1999; Voyle & Simmons, 1999). There are, however, differences in the manner in which colonisation took place for indigenous peoples. In the New Zealand context, for instance, the settlers were prevented from using the same acquisition of land strategies they had used in Australia, and did not resort to the formation of 'killing posses', largely because Māori already had a reputation of fierce, war-faring abilities (Belich, 1986 as cited in Thurnheer, 1999, p 5; Thurnheer, 1999). Further, because of their earlier experiences with whalers and missionaries, Māori were already competent traders with their own technological

skills supporting a thriving but small agricultural and fishing economy. In many ways Māori welcomed the opportunities, in terms of trade, that the settlers brought. The British, it seemed, had happened upon a people who were ready to trade, engage, and yet retain their own independence. It had not always been like that in other colonisation missions. Further, in 1835, Britain had acknowledged the Declaration of Independence and the sovereignty of the Confederation of the United Tribes of New Zealand. Because of Britain's doubtful reputation in relation to its brutal colonising strategies, Europe watched developments in New Zealand with great interest (Orange, 1987). British strategy to acquire land for settlement would need to be different; more attuned to aboriginal rights and title, and less inclined to assume British superiority. Nonetheless, whatever strategy was used and under whatever pretext, the aim of colonisation was the acquisition of lands to ease the burgeoning population of Britain and to generate wealth for British settlers. The Treaty of Waitangi became the means to the end, enabling a settler government to be established, and providing the vehicle by which land acquisition could take place in a seemingly 'just' manner. The variety of modes used to acquire land and its impact on Māori is discussed more fully in a later chapter, the intention here is to acknowledge similarities with other indigenous experiences. In a contemporary context, similarities of the current situations of Māori and other indigenous peoples are also evident in almost all socio-economic areas. The impact of colonisation on indigenous peoples today is probably best reflected in the following passage, from a Native Hawaiian explaining the situation of the majority of their people:

I am often told by Haole [white people] 'to stop moaning, you [Hawaiian people] live in paradise [Hawaii], you should be thankful that you live in such a beautiful place, a paradise'. I replied once and said. If this is paradise why are we [Native Hawaiian] the sickest people in the world, the most uneducated people in the world, have high unemployment, low incomes, don't own our lands and live in conditions of poverty, yes all this and more in paradise... They look at me as if I am a raving lunatic, complete incomprehension of what I am saying.³

The implication is that indigenous disadvantage is, at least in part, linked to the colonising experience. Colonisation not only led to the alienation of resources, but also to the undermining of dignity and self-respect (Walker, 1990; Smith, 1999). Māori workforce development will not necessarily remedy all aspects of disadvantage, but it will go some way to restoring a sense of control and responsibility and providing a pathway for effective and efficient service delivery.

³ Pers. comm. Native Hawaiian academic, Manu Ka'iama, 28 June 2004.

Background to Māori health workforce development

The intention of this research is to investigate the policies and environment under which Māori health workforce development can be progressed. While Māori socio-economic disadvantage forms a large part of the discourse on Māori health, there is also a need to document and celebrate Māori achievement. In this thesis there is a focus on Māori people and their successes. In particular, initiatives and best practice models in Māori health development are discussed as they demonstrate opportunities for growing Māori capacities, and encouraging and nurturing Māori participation as groups and individuals in improving their own health. In some respects, however, initiatives in the late 20th and early 21st centuries may not be considered new because Māori health workforce development has a longer history. It stems from the early 1800s when Samuel Marsden first suggested the training of Māori in medicine and surgery (Lange, 1999). But a trained Māori doctor did not eventuate until the late 1800s with the graduation in 1899 of Dr Maui Pomare (MacLean, 1932; Newell, 1954; Durie, 1994; Dow, 1999; Lange, 1999; Durie, 2003b) followed by Te Rangi Hiroa, Dr Peter Buck in 1904 and Dr Tutere Wirepa in 1908 (Dow, 1999; Lange, 1999; Durie, 2003b).

Many of the Māori initiatives of the early 20th century have been attributed to the efforts of the Te Aute College Students Association (TACSA), which in 1898 became known as the Young Māori Party (YMP). Members of the YMP were mostly students who had attended the College in the 1880s and 1890s, and included Apirana Ngata, Maui Pomare, Peter Buck, Tutere Wirepa, Hamiora Hei, Timutimu Tawhai, Reweti Kohere and others (Lange, 1999). Using the manual *Health for the Māori* written in 1884 by James Pope, Inspector of Native Schools, these young men began as students, a crusade to 'save the Māori race'. During their holidays they would engage on walking tours to promote the gospel of health (Dow, 1999; Lange, 1999). From these efforts the YMP identified problems and started the process of planning strategies to work through these problems and providing a leadership role in Māori affairs (Lange, 1999). Members of the YMP never faltered in their belief that the Māori population would survive, although there were times when despair overtook their beliefs. The YMP also played a major role in Māori health workforce development. Pomare, Buck and Wirepa, regularly attended the annual TACSA conferences. In the late 1890s a proposal was prepared for the Government by the TACSA for the training of Māori girls to become nurses. The proposal asked that the training be supported by the Government and the prospective

nurses chosen from Hukarere, St Josephs Māori Girls College and later Queen Victoria College for Māori Girls (Lange, 1999; Durie, 2003b).

Alongside the initiatives to train Māori doctors and nurses, Sir Apirana Ngata and Sir James Carroll, concerned for the health, well-being and survival of the Māori, were involved in activities designed to increase Māori participation in other societal endeavours. Among other initiatives Ngata actively promoted Māori land development schemes and Carroll strongly supported the establishment of Māori councils (Lange, 1999). Both Ngata and Carroll acknowledged the links between Māori autonomy, control and ownership, and improved Māori socio-economic status. A recurring theme in all the proposed initiatives was that Māori advancement would require Māori participation, and Māori leadership would be integral to success, together with active Government support.

In terms of settler support, Dow (1999) claims that much more was actually done for Māori health development during the period 1840–1900 than has previously been acknowledged. He refers, in this instance, to the work of the missionaries and the more civilised ideas and concepts of medicine and health they advocated and applied in their dealings with the natives. Missionary tending of the natives was gradually phased out after 1840 and Māori were expected to go to settler appointees.

Before the arrival of the first missionaries, Māori health relied on Māori concepts and understandings such as tapu and noa (Buck, 1910; Te Rangihiroa, 1949; Newell, 1954) and their impact on Māori social order. For example, Newell (1954) described ‘tapu’ as a ‘social policeman’ and no one was exempt from its rules not even the highest born chief who was always highly tapu (p. 10). Pākehā misunderstandings of tapu and noa as being solely ‘native superstition’ and ‘most unhealthy’ dominated prevailing Western thinking. However, according to Newell (1954, p. 11-12), if that were true then, given “the high state of tapu of a chief, one could safely assume that a chief would be extremely ill and unhealthy.” But, he asserts, this did not appear to be the case. There were no increased rates of illness with increased responsibility to observe tapu. The Pākehā notion of tapu being ‘most unhealthy’ was unfounded. Newell concludes, however, that there was a link between the tapu status of a chief, their level and access to resources could be equated with social class. Therefore, because they were well resourced, their ability to call on these resources to alleviate the breaking of tapu was accepted. In comparison, at the other end of the social scale, people

who had fewer or no resources were more likely to bear the burden of ill health. Consequently, Newell (1954) identified tapu as a linking factor to physical, social and economic well-being (pp. 11–12). In support of these notions, Wilkinson (1997) also linked ill health to the rich or poor status of a population, suggesting that those populations who do not have access to social and economic resources are more likely to experience ill health.

Te Rangihiroa (1949) suggests a pragmatic perspective of tapu as an injury prevention measure highlighting risky situations and dangerous locations (pp. 358–359). Durie (1994, pp. 8-12; 1998b, pp. 7-11; 2003b, pp. 80-81) takes a similar view: tapu and noa, its regulations and controls, provided a philosophical basis for a public health system focused on illness prevention, risk awareness, safety, health promotion, and healthy practices. He maintains that approximately 1000 years ago when Māori first came to these islands, survival was the major challenge. Tapu and noa, and rahui became a ‘code of conduct’ that served:

to guide social interaction and behaviour and synergised the needs of human inhabitants with an often harsh environment... Māori learned about their environment at least enough to know what was safe, noa, what was risky, tapu, and what should be avoided at all costs, rahui... Adaptation to the cold, to the dense bush, to ocean swells, to tough fern roots, to mountain peaks, took its toll on human life. Survival of future generations required adherence to safe practices that were relatively risk free. From that perspective the application of tapu was about safeguarding life and managing environmental resources in a sustainable way. (Durie, 2003b, p. 3)

For Māori, the practical connotations of tapu and noa, and the focus on survival and adaptation to the environment remain as relevant today as it was then. This practical application, though, is relatively ignored or overlooked by Western researchers; tapu and noa remain spiritual, superstitious or mystical.

Tohunga played a major role in Māori society in pre-European times, especially in relation to tapu and noa. In this respect their role was one of guidance and leadership. They applied tapu and noa in a practical sense. For example, they identified environments that were risky and unsafe and prevented access through tapu, or protected scarce resources from depletion. In this sense they regulated and managed resources required for safe living (Buck, 1910; Te Rangihiroa, 1949; Newell, 1954).

Whare wananga provided levels of learning for tohunga. Tohunga were scholars, politicians, philosophers and theologians who were well regarded because of their skills and knowledge.

Further it was because of their knowledge that tohunga maintained influential positions within Māori society. The highest level of learning involved ritual and tribal lore, the next level applied to historical and genealogical matters, and the last involved human interventions including healing (Buck, 1910; Te Rangihiroa, 1949; Newell, 1954).

The introduction by missionaries in the early 1800s of Western ideas and concepts of medicine and health had an eroding effect on tapu and noa and modified the concepts and understandings of health and social order in Māori society. Missionaries demonstrated that there was value in Pākehā medicine and used healing through medicine as a way of 'impressing' their potential native converts (Sargison, 2001). Provision of Western health services for Māori from as early as 1820 was undertaken by a number of missionary organisations and a small number of surgeons and doctors, albeit in an ad hoc and indiscriminate manner (Dow, 1999). A genuine partnership seemed to exist between Māori and the missionaries in relation to the provision of health services. Missionaries seemed keen to provide health services to Māori and Māori were equally keen to avail themselves of the services offered. Dow (1999) states that even though, 'most missionaries had very limited medical knowledge, Māori would still attend the mission stations for treatment of various ailments' (p. 18). By 1846, however, the goodwill between Māori and Pākehā that had been the essence of the Treaty of Waitangi had become strained by racial tension. Seemingly, concern for the health of the Māori population had been the original impetus through which Pākehā (mainly missionaries) encouraged and initiated British intervention (Orange, 1986; Dow, 1999). The Treaty of Waitangi proposed obligations for the Crown in relation to protecting the rights and interests of the Māori population; by 1846 it had become clear to Māori that Crown obligations were not being met and health care for Māori was not being adequately provided nor funded.

The Treaty of Waitangi in 1840 had effectively placed New Zealand and its inhabitants under the control and protection of Britain. In 1846 it was announced that Governor George Grey intended to make sweeping changes that would reform the colony. These reforms included resources to establish schools, hospitals and other institutions for natives. In particular, the reforms proposed that resident magistrates would oversee expenditure on Māori health. However, fiscal limitations meant Grey was unable to fulfil his intentions to any great degree, and Māori health remained precariously positioned. In 1850 Grey attempted to introduce Civil List payments for 'native purposes', but this was defeated by 'settler' opposition. In 1852

the New Zealand Constitution Act provided for provincial and central Governments and established an amount of £7,000 per annum for Māori purposes in the Civil List budget to be administered by the Governor. This amount of £7,000 was intended to cover the cost of medical care, pensions and rations for the indigent. The amount allocated to the Māori purposes budget remained unchanged for over a century but over the years became the subject of vigorous debate, conflict and allegations of misappropriation (Lange, 1972; Dow, 1999; Lange, 1999). Identifying expenditure for Māori purposes in the government presentation of expenditure accounts was fraught with difficulties. Some years there were no entries, no expenditure was listed, and there was usually no breakdown given in the government accounts for medical expenditure. However, Dow (1999) located evidence of payments for hospitals, medicines and subsidised medical officers, albeit sporadically, during the late 1850s and 1860s (pp. 17–19). Subsidised medical treatment for Māori eventually lessened the burden on the missionaries, so that by the late 1850s missionary medical services were almost non-existent. The work of the missionaries had initiated a partial acceptance by Māori of Western medical treatment. According to Dow (1999), Māori also showed a willingness to utilise hospitals from the early 1840s (p. 28). But Newall (1954) points out that this willingness later waned and suspicion of hospitals as tapu, a ‘place where people died’ began to prevail in the ensuing decades (p. 87). European attitudes and official apathy in relation to funding of Māori health in the later decades of the 19th century and the decades following the turn of the century can also be blamed for Māori unwillingness to avail themselves of Pākehā hospital care services (Newall, 1954; Dow, 1999; Lange, 1999). The objective of the TACSA was always for Māori to provide services for Māori and even to establish and provide hospital services. However, government support was always required to achieve this end, and it never came (Lange, 1999).

Māori doctors

In 1900, the Department of Public Health was established under the Public Health Act 1900, and in 1901 the recently qualified Dr Maui Pomare was appointed Māori medical officer to the Department of Public Health. His duties as Māori medical officer were wide ranging but in the main they were to: visit natives in their villages; inquire and investigate their general health; inquire and investigate condition of, for example, water supply; inform and educate on issues of sanitation and hygiene; and inquire and inform on any social aspects that may affect native welfare. In order to carry out his duties, Pomare enlisted the help of local Māori councils which had been set up under the Māori Councils Act 1900 and appointed Māori sanitary

inspectors who would report conditions in their villages to him and he could appropriately advise. His decision to utilise local leadership and expertise was a shrewd one and gained wide community support for the health reforms he was proposing. Later, he advocated for more Māori nurses to work alongside Māori sanitary inspectors thus reinforcing the links between Māori health advancement and Māori community development and acknowledging that for Māori health to advance there needed to be an alignment of clinical skills with community knowledge. Knowledge of the language and culture were seen as ‘essential ingredients’ in the fight to improve Māori health (McKegg, 1991). On one hand, Pomare recognised Māori health advancement as reliant on Māori community involvement, but more important in relation to this thesis, he recognised as vital to Māori health and Māori development, the need to increase the numbers of Māori health advocates both at clinical and professional levels, and at the community level. His own appointment as Māori medical officer was based on the fact that as a Māori and a doctor he would be able to accomplish more. Dr J Malcolm Mason, chief health officer who appointed Pomare to the position, recognised that Māori improvements in health would be more likely to eventuate if Māori took a leading role (Durie, 2003b).

By 1909 Pomare had entered politics as an independent member of Parliament for Western Māori. In 1923 as a member of the Reform Party he was appointed Minister of Health. Pomare’s work while the Minister of Health focused on the poor conditions of mental hospitals and led to the establishment of psychiatric clinics in general hospitals. Durie (2003b) notes these provisions as being revolutionary. However, in 1925 he was relieved of the health portfolio as a result of pressure on Prime Minister Gordon Coates that:

As the minister representing native peoples it was considered improper for him [Pomare] to handle a major portfolio such as health. (Durie, 2003b, p. 43)

Dr Peter Buck, Te Rangihiroa, graduated from Otago University Medical School in 1904 and accepted the Government-appointed position of Assistant Native Health Officer working alongside Pomare. Later in 1919, when he was appointed Director of Māori Hygiene, Buck placed importance on establishing and maintaining good relationships with Māori communities and their leaders (Lange, 1999). He often recounted that as both he and Pomare were Māori, and their knowledge of language and custom meant they were accepted as part of the Māori communities they worked in. This, he would reiterate to politicians, was the main reason for employing Māori staff, especially after it was decided that the position vacated by

Pomare in 1909 would not be filled. Buck, through his own application for reappointment in 1919, identified certain qualifications. A Native Health Officer should:

have expert knowledge of Māori language, manners and customs. Am personally acquainted with the leading men and chiefs of the various Māori tribes throughout New Zealand and have visited almost every Māori settlement. Prestige and influence amongst the older and younger generation of Māoris recognised by them as a personal thing outside of official position.⁴ (as cited in Lange, 1999, p. 164)

Buck placed great importance on explaining health reforms in terms that made sense and were reflective of cultural experience. Frequently, his method was to justify a new idea by relating it to a traditional custom. For example, in explaining the benefits to Māori of the hygienic practice of the latrine he used a story of a Māori ancestor, Rupe, to show that the privy was not a ‘startling foreign innovation but an attempt to restore an ancient health measure which had been forgotten’ (Sorrenson, 1986). Like Pomare, Buck did not believe in a policy of imposed reform. Reform needed to be a cooperative venture between the health department and the Māori people. Buck believed that until the health of the people had progressed to Pākehā levels it should continue to be cared for under a special Māori system (Lange, 1999, p. 166). Buck, like Pomare, also had a role in the selection and instruction of Native Sanitary Inspectors and in advising and encouraging Māori Councils.

Tutere Wirepa, the third Māori doctor, graduated from the University of Otago Medical School in 1908. He had attended Te Aute College and the University of Otago with Buck. After graduating from Otago Wirepa was appointed to Gisborne hospital, although he never took up the position because the board, on realising he was Māori, cancelled the appointment (Lange, 1999; Durie, 2003b). Wirepa turned to general practice, the distasteful experience with the Gisborne hospital board effectively stifling a promising hospital-based medical career (Lange, 1999). He remained an active member of the TACSA supporting the work of Pomare and Buck through his writing on Māori community health matters which were published in *Te Pipiharauroa* – a newsletter and current affairs periodical for Māori. *Te Pipiharauroa* became the avenue for publication of much of the work of the TACSA, including the publication of the annual conference papers and Apirana Ngata’s Travelling Secretary Reports (Lange, 1999, p. 95).

⁴ When he applied for the position Director Māori Hygiene Buck included these requirements in his application and noted that they should also be applicable to those applying for positions as Native Health Officers.

While the TASCAs intention from 1897 onwards was to provide scholarships to train Māori doctors, it appears that Peter Buck and Tutere Wirepa were the only recipients – the scholarships were not continued. However, the University of Otago continued to reserve two positions for Māori medical students and even now has a policy that recognises the importance of having a medical workforce that approximates the population make up of New Zealand society. In the University of Otago Regulations for the degrees of Bachelor of Medicine and Bachelor of Surgery, MB ChB it states:

Regulation 1 Admission to the Programme (g) To gain entry through further categories a candidate:

- (i) must have achieved a minimum academic standard to be determined by the Medical Admissions Committee from year to year in the course of study on which the application for admission is based; and
- (ii) may be considered under one of the following sub categories:
 - (a) Māori or other Polynesian descent.
 - (b) Health related professional experience and satisfying special criteria.
 - (c) Mature entry for graduates who do not fulfil the requirements of regulation 1(f).
 - (d) Rural origins satisfying special criteria (see regulation 1 (h) and note).
 - (e) Health professional experience in mental health and satisfying special criteria (see note). (University of Otago, 2005, p. 316)

However, for whatever reason, the system failed to produce another Māori doctor until Edward Pohau Ellison, also an old boy of Te Aute College and a member of the Young Māori Party, graduated in 1919.

Māori nurses

In 1899, Emma Mitchell of Pakipaki, Hawke's Bay, and followed by Sara Burch and Eva Wirepa of Waima and Te Kaha respectively gained nursing certificates (1 year training) as a result of a Māori initiated proposal put forward at the first Te Aute Association conference in 1897. The proposal was championed by Hamiora Hei of Opotiki, whose sister Akenehi Hei became the first Māori registered nurse qualifying with both general and midwifery nursing in 1908. In the same year, Heni Pokino Whangapirita of Whareponga became a registered nurse (MacLean, 1932; McKegg, 1991; McKillop, 1998; Lange, 1999; Sargison, 2001). In 1911, Maud Mataira of Nuhaka qualified, followed by Ellen Taare in 1913, Ngapori Naera in 1914, Rena Te Au in 1914, and Ngaro Ngapo in 1915 (Lange, 1999). Of the first three to gain nursing certificates, Eva Wirepa (sister to Dr Tutere Wirepa) worked in Pahiatua hospital and later became a member of the Native Health Nursing Scheme (NHNS), later replaced by the

Māori Nursing Scheme (MNS). After only 2 years of exemplary work among her people, Akenehi Hei died in 1910, having contracted typhoid fever while nursing her brother and his family. She published accounts of her experiences and understanding of the concepts on which Māori health concepts were based, warning that:

great discretion must be used not to offend the patient's beliefs, and at the same time uphold one's own mission... such customs (ancestral), having kept the Māori race in vigorous health for many generations, deserve consideration... a greater knowledge of the native mind will inspire a greater and thereby a deeper sympathy for the Māori people. (as cited in McKegg, 1991 p. 82)

Hei's warnings came at a time when some of the TACSA proposals were under scrutiny and discussions had already taken place for the establishment of the Native Health Nursing Scheme – where Pākehā nurses (because there were more of them) would be trained to work in Māori communities. Hei pointed out, from her understanding and experiences, that Māori would not easily welcome strangers into their lives: 'Who cares to have a stranger poking around his back door, condemning the hundred and one things which sanitarians know are detrimental to public health?' (as cited in McKegg, 1991 p. 82).

Had it been well supported, the Māori Nursing Scheme might have been hugely successful. However, in reality the original scheme with its intention to train Māori to work in Māori communities was doomed to fail because support at Government level had not been guaranteed. The obstacles and barriers prospective Māori nurses faced from hospital boards and Pākehā nurses during their training have been described as 'insurmountable' and 'blatantly racist' and it is not surprising that very few Māori women trained and even fewer qualified (Goodfellow, 1991; McKegg, 1991; McKillop, 1998; Sargison, 2001). Those women who did qualify were well placed among their Pākehā counterparts in their final examinations but Pākehā authorities had concerns about their 'application and reliability' (McKillop, 1998).

Comments such as those made by Government representatives and hospital boards generally reflected the prevailing ideology of Pākehā society towards Māori. While outwardly there seemed a genuine concern for the devastating poverty and the spread of introduced infectious disease following colonisation it is evident that fear of the infectious diseases spreading to the Pākehā population was the real motivation behind the concern (McKillop, 1998); Māori, it

seemed, were a 'health hazard' (McKegg, 1991). McKillop (1998) quotes Hester MacLean⁵ "The insanitary conditions under which the natives live in close proximity, and their frequent epidemics, are likely to be a serious menace to the growing European population, unless something really practical is done to remedy the state of affairs" (pp. 95–96).

Institutional racism was clearly evident in the health system of the time (Goodfellow, 1991; McKegg, 1991; Holdaway, 1993; McKillop, 1998; Lange, 1999; Sargison, 2001). The prevailing Western view that Māori were a health hazard, under-resourcing, lack of support from hospital boards and administrative chaos led to the demise of the Māori Health Nursing Scheme, which from its outset had been a Māori initiated and led development (McKillop, 1998). Evidently there was value in the idea of the TASCAs Māori Nursing Scheme because it was appropriated, renamed and re-established albeit for a predominantly Pākehā workforce. Proponents of the original scheme maintained that more could have been accomplished to improve Māori health, in both schemes, if the nurses could have been Māori. Their intimate knowledge of the language and customs of their people gave them an edge over the most highly trained Pākehā nurse. Later, reports mentioning the difficulties encountered by those Pākehā nurses who lacked understanding of Māori custom and who also appeared unwilling to appreciate different points of view and ways of dealing with illness and childbirth, were made to the Chief Health Officer, Valentine. Clearly the qualities most admired in Māoridom were seldom recognised in the European world, and progress was laboured (McKillop, 1998).

Māori health commissioners and sanitary inspectors

By 1900, Māori leaders like Tamahau Mahupuku and Henare Parata of Ngāti Kahungunu were already involved in Māori health development in the Wairarapa region, and their involvement became even more intense in early 1900, when the possibility of the plague was raised. News of the plague in other parts of the world in the late 1890s was disseminated to Māori leaders who were keen to take action within their own communities. Mahupuku and Parata were officially appointed Native Sanitary Commissioners in early 1900. Parata as health inspector, continued work he had already been doing for some time with Mahupuku in Wairarapa. With the official appointments, Parata's duties included inspections of Māori villages in the

⁵ Hester MacLean was Assistant Inspector of Hospitals and Deputy Registrar of Nurses and Midwives in New Zealand from 1906-1923. She was also editor of *Kai Tiaki The Journal of the Nurses of New Zealand*, a quarterly journal first published in 1908.

Wellington and other districts as requested by the Government. Later, two more chiefs were appointed commissioners – Takarangi Metekingi of Wanganui and Eruera Te Kahu of Rangitikei. The plague scare had initiated a Māori response to Māori health development and heralded the emergence of a Māori capacity to provide health advice and health measures to combat modern health risks. The plague scare was also the reason for the Public Health Act 1900. Government fears that an outbreak of the plague would be disastrous for New Zealand fully supported the Māori sanitation campaign, including the appointments of Native Sanitary Commissioners, an initiative suggested by Māori (Lange, 1999).

Following the work of Parata, and with the intention of working alongside the Māori councils, Native Sanitary Inspectors representing different iwi groups were appointed. The first of these was John Chase of Taihape who had Wanganui and Taupo iwi connections, followed by Elsdon Best, a Pākehā ethnographer whose research was based in Urewera. In 1904, Riapo Puhipi, Rameka Waikerepuru and Waaka Te Huia were appointed for the Northland areas; Raureti Mokonuiarangi for Bay of Plenty; Te Wharehotu for Maniapoto; Eruera Te Kahu for Kurahaupo; Hori Pukehika for Wanganui; and Taiawhio Te Tau for Rongokako. Ihaia Hutana for Tamatea and Haimona Patete for Arapaoa were appointed in 1906; and in 1908 Horomona Paipa for Horouta, Taurau Toi for Hokianga, and Raimona Heretaunga for Arawa (replacing Mokonuiarangi). All but one of the Native Sanitary inspectors was Māori, and leaders within their own iwi. The fact that they were Māori attests to the effectiveness of the contribution they made to Māori health development because while Best remained in the position for 6 years he ‘eventually admitted defeat, complaining bitterly of Tuhoe incorrigibility’ (Lange, 1999).⁶ Notable at this time was the development of a Māori health workforce that took account of cultural and socio-economic aspects of health and recognised that improvements in health required leadership that came from within Māori communities.

By 1901, when Pomare was appointed Māori medical officer, the decline in Māori population had started to reverse. Pomare’s appointment and his working with Māori communities certainly accelerated the reversal that had already begun. Once it seemed that Māori survival was assured, the emphasis the Department of Public Health had placed on Māori to participate in Māori health improvements appeared to lessen. Māori nurses, for example, were no longer encouraged by the Department to work within their own villages; instead, Pākehā

⁶ Lange, in *May the People Live* (1999), provides more detail of the lives of these men, see pp. 205–216.

district nurses were thought to be more professional and unbiased in their approach to Māori health issues and better suited to work in Māori communities. Eventually, even the Māori community leaders who were often also the sanitary inspectors ceased to be recognised as key players in the health sector (MacLean, 1932; Durie, 1994; 2003b; Lange, 1999).

A major piece of legislation that was to have an impact on Māori society and future Māori development was the Tohunga Suppression Act 1907. The purpose of the Act was twofold: first, to dislodge the influence of Tohunga, specifically those tohunga who “pretended to possess supernatural powers in the treatment or cure of any disease, or in the foretelling of future events.” Thus the Act endeavoured to oppose Māori protest movements led by prophets such as Rua Kenana and Te Whiti. Second, the Act ensured that health care for Māori was to be based on Western concepts and methods. While no specific mention was made in the Act about traditional healers, it was clear that Māori understandings and approaches to health care had no place in the system (Dow, 1999, p, 129). Durie (1994, 1998b, 2001c) comments that, “traditional healers, their knowledge, understandings, methods and methodologies were driven underground. By outlawing traditional healers the Act also opposed Māori methodologies and the legitimacy of Māori knowledge in respect of healing, the environment, the arts and the links between the spiritual and the secular-te kauae runga and te kauae raro” (Durie, 2003, p. 51). In this sense the Act had an erosive effect on the organisation of Māori knowledge and understanding. But while methodologies have vacillated, some skills of the tohunga have endured.⁷

The first Māori health workforce development initiatives, though successful from a Māori perspective, had been effectively halted through lack of funding, government apathy and administrative chaos (McKillop, 1998), and Māori were fated to become passive receivers of Western-based health services rather than providers of services. They had become marginalised from determining their own health advancement. Nonetheless, even with erosive legislative instruments, health gains were made.

⁷ for more detail see Durie, 1994, pp. 45–46; 1998b, pp. 45–46; 2001c, pp. 51–52

Māori contributions to health

The pioneering Māori health workforce, represented by early Māori doctors, the Māori Sanitary Inspectors, and early Māori nurses, opened paths for later Māori participation in health. While participation as professionals was to continue, and escalate, participation also took many other forms. For instance, in the Waikato, Te Puea Herangi was noted not only for her leadership qualities but her staunch advocacy for health. For her, Māori cultural perspectives of health and Western treatment in health care were not entirely incompatible.

Land confiscations in a number of tribal regions such as Taranaki, Whakatohea and Waikato from the 1850s to 1895 had a more devastating affect on the health of Māori people in those areas than in other areas (King, 1977). Without land there was no economic base to sustain the people, they were poor, living in insanitary conditions, and many were isolated and homeless. Conditions such as these were a breeding ground for diseases Māori had not experienced before. In Waikato, for instance, health in Māori communities at the turn of the 19th century had deteriorated to such an extent that Māori people were living a miserable existence of inveterate typhoid epidemics combined with bouts of influenza, measles, and whooping cough (King, 1977, p. 33). Some of this deterioration in Waikato has been attributed to the partial collapse of social organisation and leadership as a result of land confiscations and the refusal of Waikato to establish Māori councils and sanitary inspectors under the Māori Councils Act 1900. At that time “there were few doctors that would attend Māori patients, no hospitals to admit them and no preventative health measures. The nearest hospitals were in Auckland and Hamilton but they rarely took Māoris and did not want to” (King, 1977, p. 33). Although Māori deaths were not notifiable it is believed that both typhoid and tuberculosis took a heavier toll in Waikato than other districts. Further, Māori were blamed for any outbreaks of these diseases in the Pākehā population (King, 1977, p. 33).

While an outbreak of smallpox, brought by a missionary of the Church of Jesus Christ of the Latter Day Saints in 1913, had the potential to be more serious it was, however, managed and contained (McLean, 1964). Even so, King (1977, p. 71) maintains that Northland, Auckland, Waikato, Thames and Bay of Plenty were hit hard by the outbreak. During the smallpox outbreak in Waikato, Māori communities were without medical facilities and medical supplies, and were under quarantine, nothing was allowed in or out of these communities. One community infected by smallpox was Te Paina the home of Te Puea Herangi, chief advisor to

King Te Rata Mahuta, and a member of the kahui ariki o te kingitanga. In order to help nurse her people in Te Paina, Te Paea had rows of makeshift, open-air shelters built with nikau palms near the river. Her understandings of health meant she had everything on hand – fresh air, clean water and healthy food from the river – to nurse her people back to health. No one died of smallpox in Te Paina, but according to King (1977, p. 73) other communities were not as fortunate.

From the smallpox outbreak and later experiences during the 1918 influenza epidemic it became clear to Te Paea that Pākehā-introduced diseases could be cured by Pākehā medical treatment. Te Paea concluded that every Māori community in Waikato should have a hospital (King, 1977, p. 73). However, Māori aversion to attend impersonal, unfamiliar, hostile Pākehā hospital environments and the reluctance of the hospitals to take Māori patients made medical treatment for Māori difficult (King, 1977, p. 72). In Te Paea's view, however, a hospital for each Māori settlement was necessary for Māori health improvement. The meeting house, Mahinarangi, opened in 1929 at Turangawaewae, was originally intended to be a hospital:

Māori patients could stay there, Māori nurses could take care of them, and their families remain close. It, she said, would be an application of European medical care in a reassuringly Māori environment. Māori rules of tapu would be observed, for they were not incompatible with Pākehā practices. Such things as washing the head in the same utensil as the rest of the body is abhorrent to Māori, neither will Māori women permit the washing of male and female clothing together. (King, 1977, p. 127)

This attempt for a hospital, as with later attempts, was thwarted by 'officials' focused on public health regulations.

The Waikato stance of non-participation and anti-conscription during World War I further isolated the region in terms of government support for essential services. For example, Māori councils and sanitary inspectors were not established, schools were not built nor were they wanted, only a few doctors would work in the Waikato, and Māori still refused to attend Pākehā health institutions. The health and displacement of Waikato Māori during the War remained in a dire state so that by the end of the War Waikato was ill-prepared for the influenza epidemic that immediately followed (King, 1977).

The influenza epidemic affected 720,000,000 people world-wide (King, 1977, p. 98). In New Zealand, Māori deaths from influenza were reported at a rate four-and-a-half times greater

than Pākehā. However, Rice (1988) ascertains that these rates are grossly under-estimated and it is more likely that the Māori death rate was more than seven times greater than for Pākehā (Rice, 1988, p102). Māori had far less immunity from the disease, and while many Pākehā believed this to be caused by ‘congenital physical weakness or inherited racial characteristics’, Rice (1988) provides a simpler ecological explanation (p. 104). He asserts that until the War Māori lived in isolated rural communities never experiencing the “normal bouts of colds and respiratory ailments within the predominantly European population. Constant exposure to such minor infections seems to give town-dwellers better general immunity to new infections” (p. 105). Further, only a few Māori settlements had piped water supplies or appropriate sanitary and waste disposal systems. Māori settlements had inadequate housing, inappropriate clothing, and a lack of food supplies, placing Māori communities at risk, and making them more susceptible to disease and the spread of disease (King, 1977, p. 98; Rice, 1988, p. 105). While many observers at the time commented on the ‘filthy’ conditions, and the ‘hovels’ for houses, other observers recalled visiting settlements and commenting that while ‘food supplies were low in most houses, they were beautifully clean’. Rice (1988) explains that the differing observations most likely reflected the extent of the infection. Those settlements lightly affected with influenza still had able-bodied people to care for the sick and keep the settlement clean, in other communities there were barely the people to nurse the sick let alone clean the settlements (pp. 105–106). King (1977) adds that Māori communities had little or no supplies that could be used to prevent or alleviate the infection such as “liquid soda chlorinate gargles, face masks, prophylactic vaccination and good nourishing food” (p. 99).

A devastating factor of influenza was its attack on the core of Māoridom, among young adults in the high-fertility age-groups. The infection was most potent among adults between the ages of 18 and 44 – the parents, primary wage earners and often, active leaders – with the heaviest adult mortality suffered by the 25–29 age-group. Relatively devoid of an adult Māori population, a greater burden was placed on adolescence and middle age (King, 1977, p. 99; Rice, 1988, pp. 122–124). The magnitude of the Māori death rates attributed to the 1918 influenza epidemic has never been accurately determined and is possibly even higher than Rice (1988, p. 102) has estimated. Buck (as cited in King, 1977) supported these notions and stated later that the “influenza in three months caused more casualties to the Māoris than the campaigns in Gallipoli, France and Belgium” (p. 99), and that he saw it as “the severest setback the race has received since the fighting days of Hongi Hika” (as cited in Rice 1988, p. 102).

Waikato was hit hard by the influenza epidemic and Te Puea once again set about building makeshift hospitals and, although sick herself, nursed her people in her settlement. Māori settlements were placed in quarantine, and were required to deal with the infection as best they could, on their own in many cases. In most settlements no one knew what to do or how to help, and often those that did know were too sick to care for others.⁸ With ‘bans’ on Māori travel, and settlements placed in quarantine, Te Puea was unable to travel to other settlements to provide necessary assistance. After the epidemic, however, she visited ‘all the settlements between Mangatawhiri and the Waikato Heads’ and collected the orphaned children and old people without kin to care for them and took them back to live in her settlement (King, 1977; Rice, 1988, p. 109). Her dream in 1913 of establishing a hospital for Māori in a Māori environment, became even stronger. She remained fearful through the following decades, of a repetition of the smallpox and influenza epidemics that might again catch her people unprepared. She became informed about and encouraged vaccination and other preventative medicines; all that was missing was a place to ensure treatment was readily and permanently available (King, 1977).

In the 1920s Turangawaewae became the favourable location for the hospital to be situated. Te Puea’s ideas for the hospital were that the ‘shape of the building was that of a conventional meeting house’. Te Puea believed a Māori hospital would not be acceptable to patients unless it presented a familiar and comforting appearance’ (King, 1977). To cater for the nursing requirements, modifications would need to be made to the traditional design and these included the addition of windows (for fresh air and sunlight), and no poles to block a central aisle (King, 1977, p. 141). Te Puea began raising funds specifically for the building of the hospital. By this time, as a result of her tours around North Island with Te Pou o Mangatawhiri (TPM) Māori concert party, she had become aware of the situation of Māori generally. As far as Te Puea was concerned the tours were the most effective way of raising money for different projects; and the hospital would be a huge project (King, 1977, p, 117). Her awareness of the general situation of the Māori population had broadened her outlook: she was no longer just focused on Māori in Waikato and on the King Movement, she had now developed a real concern for all Māori. Her concern was noted in King (1977) by her intention to build a hospital that would not only be for Waikato Māori but for ‘any Māoris

⁸ Rice (1988) provides some personal accounts of individuals who survived the epidemic; see pp. 109–111.

who might be afflicted' (as cited in King, 1977, p. 127). The 'concert party' went on tour during the 1920s to raise funds for the meeting house/hospital. During one tour she met Apirana Ngāta, who supported the cause for her fundraising and was instrumental in accessing resources both financial and human to assist with its building (King, 1977, p. 133). It was Ngata who suggested the name for the meeting house/hospital at Turangawaewae. He pointed out that East Coast and Waikato whakapapa are linked through a common ancestor, Mahinarangi, from whom she herself was descended (King, 1977, p. 136).

Te Puea, mindful of her own youthful experiences with alcohol, as well as the experiences of others, had forbidden alcohol within the bounds of Turangawaewae from the time of its establishment. Her intention was that Turangawaewae would be the home of the King Movement and be an example of high moral, cultural and health standards (King, 1977, p. 142). While she welcomed all religious denominations at Turangawaewae, she was especially supportive of the Mormon faith as their stance on alcohol and tobacco was most favourable to her. The meeting house/hospital, Mahinarangi, was opened in March 1929. By the end of 1929, however, 'authorities' had intervened, and Te Puea was refused a license to operate Mahinarangi, as a hospital (King, 1977, p. 145). Māori aversion to Pākehā institutions persisted, and those who required hospital attention failed to receive it. Hospitals too were still reluctant to have Māori patients. According to King (1977), "the alternative to first class hospital facilities had to be no facilities." This was a blow to Te Puea, who had her heart set on a hospital that would provide care and treatment for Māori people (p. 145).

Later, during the 1930s and into the years of World War II, Te Puea worked tirelessly, making significant progress in lifting the standards of Māori health throughout the Waikato (King, 1977, p. 220). The Medical Officer of Health in Hamilton, Dr HB Turbott is noted for two significant schemes that he, along with Te Puea, implemented in the Waikato. The first scheme was to improve the sanitation and water supplies in Māori settlements to reduce the high Māori mortality rates through typhoid; rates that were 35 times greater for Māori in the Waikato than Pākehā. To achieve this reduction, water tanks and privies were delivered to Māori households in the four Waikato counties. Two years later the typhoid mortality rates had dropped to that of the Pākehā rate. The second scheme, in 1940, was to reduce the rate of tuberculosis infection and mortality. A house-to-house survey was undertaken to ascertain the source and prevalence of the disease and isolate active cases for hospital treatment (King,

1977, p. 220). Māori were resistant – they still “regarded hospitals as a place you went to when you were dying” (King, 1977, p. 221). Another barrier was racism: Māori were not welcomed as guests in city hotels so there was nowhere for a family to stay when visiting a patient. Te Puea joined with the Hamilton Rotary Club in building a hostel in Frankton for the families of hospital patients. A shelter was also built at Turangawaewae so that infectious cases could be treated away from their families but remain close to a Māori environment. Māori attendance for treatment increased and a few years later there seemed to be no more secondary cases. In 1943, in an effort to consolidate the scheme, Te Puea persuaded Māori from outside Turangawaewae to seek medical treatment (King, 1977, p. 221). A clinic was established at Turangawaewae where people could be treated in a Māori environment, and where consultations took place in Mahinarangi. Dr Rachel Monk initially attended the clinic one afternoon a week, but within a short time this had changed to twice a week. This scheme was a modification of Te Puea’s original plan to use Mahinarangi as a hospital. As she had hoped, people came from Tuakau in the north to Te Kuiti in the south (King, 1977, p. 221). Maira Moke, Sister Irene Hobbs, and Heeni Wharemaru assisted Dr Monk with administration, interpreting and nursing care. The clinic was later moved to Turangawaewae House (former parliament house of the King movement) and Te Puea made plans and raised money to turn the house into a hospital. Again, as in 1929, the proposal was defeated by Public Health regulations (King, 1977, p. 222). By 1945, Te Puea achieved her long-term goal of lifting the standard of Māori health in the Waikato, but the hospital never materialised. However, from her efforts, knowledge and experience it is clear that Te Puea was convinced that good health for Māori depended on clean environments, cultural affirmation, Māori participation in health-service provision, and self-governance. To this end she never succumbed to the Government’s assimilation policies (Durie, 2003b, p. 5).

From about 1850, Māori prophetic leaders of significance emerged and gained influence, mainly throughout the North Island. Raureti (1954) describes these as “the Māori prophetic movements which achieved influence did so because of the remarkable personal qualities of their founders, the times in which they appeared and their wider appeal to the mind and talents of the Māori people” (p. 1). Most notable of these were The Kingitanga Movement in Waikato, and the prophecies of Tawhiao, Te Ua Haumene and the Hauhau Movement, Te Kooti Rikirangi and the Ringatu Movement, and later Tahupotiki Wiremu Ratana and the Ratana Movement.

There were three reasons for the emergence of the Hau Hau movement. First, were Māori feelings of betrayal by missionary church leaders accompanying the Government in military campaigns against Māori. Second and third were the campaigns at Rangiriri and Rangiaowhia respectively, where women were among the majority of those shot and killed (Henderson, 1972, p. 5). Government violence towards Māori precipitated a 'violent response' from Māori in the murder of the missionary Carl Volkner on March 2 1865 just as the Hau Hau movement sought converts and support (Binney, p. 38). The murder and resulting skirmishes between Hau Hau supporters and Government-assisted tribes on the East Coast ended in 1866 with many Hau Hau men, women and children imprisoned on Wharekauri/Rekohu (both names are used for the Chatham Islands).

Binney (1995) clearly states that even though Te Kooti Rikirangi had fought against the Hau Hau he was "unjustly imprisoned" with the Hau Hau rebels in the Chatham Islands in 1866. Te Kooti Arikirangi Te Turuki was born around 1832 at Te Pa-o-Kahu, a large settlement of Ngati Maru. His birth had been predicted in 1766 by his grandfather, Toiroa, a known matakite (seer): his vision saw the arrival of a boy 'Arikirangi', whose birth would coincide with the arrival of strangers who would bring with them another God (missionaries). The prophecy further described times of trouble and hardship, and connected these to the child 'Arikirangi'. In 1866 Te Kooti was exiled and imprisoned in the Chatham Islands and Binney (1995) suggests that perhaps this was "the beginning of the dark years of trouble and conflict that Toiroa had foreseen exactly 100 years earlier" (Binney, 1995, pp. 11–29). It was while he was imprisoned in the Chatham Islands that Te Kooti began to have visions of his own that eventually culminated in the founding of a new faith, the Ringatu or the Upraised Hand, as it is known today. Binney (1995) maintains it is the 'oldest of the surviving, indigenous, scripturally based religions in Aotearoa'. There are three main branches to the church, each with its own constitution and name: Te Haahi o Te Kooti Rikirangi takes its name from its founder; Te Wairua Tapu (the Holy Spirit) was the original name given to the faith; and Te Haahi Ringatu, the Upraised Hand. Binney (1995, p. 11) claims the first of the branches to be registered, in 1929, was Te Haahi Ringatu (Binney, 1995, p. 11); although Henderson (1972) claims the Ringatu church was in fact not constituted until much later, in 1938 (p. 6).

Henderson (1972) also notes that Te Kooti's vision of Ringatu (the Upraised Hand) was a new, more sober worship of Jehovah. His visions became more pronounced and regular

while he was imprisoned at Wharekauri in 1866. Apart from prophecies, he made inroads into health reform/care, and is noted for teaching his people the rules of hygiene to help them survive (Henderson, 1972, p. 6). Most importantly, however, he is better known for his focus on Māori land retention and Māori autonomy (Binney, 1995).

Some have claimed that the emergence of Ratana was not unexpected. Henderson (1972), for example, describes important prophecies made by Aperahama Taonui (a Ngapuhi prophet) in 1863 and Te Kooti Rikirangi in 1893. Aperahama's prophecy told of "the coming of a man carrying two books: the bible and the Tiriti of Waitangi" and Te Kooti spoke of the "advent of a child in six years...if not then...he would arise from the west in 26 years time and will unite the people." Te Kooti also often referred to a star that would "herald the rising of the next great leader who would set upright the capsized canoe of the Māori." Twenty-six years later, in November 1918, at the same time as influenza was wreaking havoc on Māoridom, Tahupotiki Wiremu Ratana experienced a series of spiritual episodes described as visions, and the Ratana Movement began (Raureti, 1954). Beginning first as a faith-healing cult it spread nationwide before extending beyond New Zealand to Europe, Asia and the United States (Raureti, 1954, p. 1).

As with other movements before it, such as the Hau Hau, Ringatu, Te Whiti, Tohu, and the King Movement, the Ratana Movement arose from protest against the "encroachment and growing dominance of Pākehā power... and a distrust of European ideas and methods" stemming from the "land confiscations of the 1860's"(Raureti, 1954, pp. 2-3).

The emergence of the Ratana movement in 1918 was at a time when Māori were economically and socially impoverished. Battered by the land wars of the 1860s, the confiscations that resulted, disease, poverty and despondency, the threats of the plague in 1900, smallpox outbreaks in 1913, and anti-conscription in Waikato, Māori were ready for the emergence of a leader. By 1920, Ratana's influence and mana as a faith healer had spread and Māori were "flocking to him, bent on the alleviation of their troubles and cures of their ills and sicknesses" (Raureti, 1954, p. 6). He encouraged people to come and stay, and the Ratana farm became Ratana Pa, and living became that of a traditional communal pattern. Ratana utilised his family lands to provide cropping facilities for their sustenance (Raureti, 1954).

While other movements had been confined to regions, e.g., the King Movement in Waikato; Hau Hau, Te Whiti and Tohu largely in Taranaki; and the Ringatu movement in the East Coast, Bay of Plenty and also Taranaki, the Ratana movement crossed boundaries and spread throughout New Zealand. Ratana travelled both islands of New Zealand healing the sick and infirm. In 1924 he undertook a world tour and the following year a tour of the United States. Later, in 1925, the Ratana Movement was formally proclaimed a church. The Ratana Movement and Church knew no territorial or tribal bounds. People were prepared to give up family, friends and tribal affiliations, and Ratana Pa became a detribalised unit of people. Tribal differences and affiliations were submerged by religious and spiritual considerations, and any division was based solely on regional or territorial basis, e.g., there are four regions, Tai Tokerau, Tairāwhiti, Waipounamu, and Taihauāuru. Ratana's faith-healing drew from both Māori traditional healing and biblical practices. He focused on the spiritual side of man not the material and physical, he was therefore never 'anti-medical' in his attitude. He allowed Health Department Officers and District Health Nurses to work among the people at Ratana Pa, offered no resistance nor opposition to medical authority in the matter of sickness, and would refer patients for medical attention when he knew it was required (Raureti, 1954, pp. 6–20).

During the early 1920s Ratana was approached by other Māori leaders, mainly from the King Movement in Waikato, to help them right the wrongs of the past because for them it was “not the ills of the body but the ills of the land” that ailed Māori. Ratana replied, “Kei te pai! Whakakotahi ki te Atua i te tuatahi – ana tatou ki te whakakotahi ki te whenua” (First unite in the Lord; then we will unite in the land). Through his son, Tokoura Hami, Ratana entered politics in 1922 as an independent candidate (Raureti, 1954, pp. 30–31). Ratana made a prophecy that he would one day control Ngā Hau e Whā (the four winds) and his influence would be felt throughout the length and breadth of New Zealand. As his interest in politics became stronger, Ratana's healing abilities became weaker – to a point where he no longer practiced healing. Twenty years later his prediction came true and in 1946–1949 the four Ratana members held the four Māori parliamentary seats and held the balance of power in Government (Raureti, 1954, p. 28). Since then, Ratana as a political Movement has lost momentum, but the Church and memory of its leader and his work has endured into the third millennium.

The Department of Health supported three major health initiatives from 1900, aimed to reduce maternity and infant mortality and assist the District Health Nursing Scheme. The first initiative was engaging Native Schools in health prevention and medical care working alongside district health nurses. The second initiative, was enlisting the Plunket Society, founded by Dr Fredric Truby King in 1907, to promote the health of New Zealand women and children. This clearly highlighted the need for the separate but parallel development advocated and previously recommended by Buck in 1906. The prevailing attitudes and the reluctance of the Plunket Society to include Māori are expressed in the following quote taken from a New Zealand Medical Journal editorial, which supported the work of the Society on the basis that it was essential to the “permanence of what we believe to be the finest race that the world has ever produced - we mean the the Anglo-Saxon race” (as cited in Dow, 1999, p. 200). Even in later adaptation’s of Truby King’s writings, doubts were expressed about the effectiveness of both Plunket staff, and the organisation, to deliver health services to Māori. Despite these misgivings by officials, claims were made by the Health Department in 1930 that Māori mothers were accepting Plunket health advice (Dow, 1999, p. 200–201). The third initiative, an agency recruited by the Department of Health to promote health, was the Māori Women’s Institutes. The New Zealand Women’s Institute was established in 1921, and by 1936 there were almost 900 branches around the country. The key focus of the Institutes was home-making, co-operation and citizenship. Māori women were encouraged to join existing branches, and eventually the first Māori Women’s Institute was founded in May 1929 (Te Awapuni) at Kohupatiki, Hastings. This movement looked promising and by 1937 there were about 40 branches in Northland alone. Later in 1937 there was a clash between the Institute’s Dominion organiser and the Medical Officer’s of Health over the future direction of the Institute. Harold Turbott claimed that the Institute had “failed to capture the Māori imagination;” he favoured and predicted a brighter future for the newly established Women’s Health League, which had been formed on tribal lines (Dow, 1999, p. 202). Dow (1999) maintains that the Women’s Health League was supported by Te Arawa tribal leaders, and that departmental officers regarded the League more favourably than they did the Institutes. While many Māori Women’s Institute branches survived to the 1950s, they later transferred their allegiance to the Māori Women’s Welfare League, formed in 1951 (p. 203).

Meanwhile, the Women’s Health League, according to Meha (1995), was essentially formed in 1931 during the Depression years (1928 through the 1930s), by Māori women in Te Arawa, who were concerned about the health of Te Arawa people, especially the children. They

discussed the establishment of a Māori health organisation to assist in the promotion of health for Māori in Rotorua “i te tau 1931 pea...i taua wā i huihui mai ngā wahine i raro i te rakau ngaio i te marae o Te Tāheke i te taha hauāuru o te moana o Te Rotoiti. Arā, ka puta mai ngā whakaaro me ngā hiahia kia tīmatahia he rōpu hei āwhina i te hauora o te iwi Māori i Rotorua.” They identified a number of barriers that prevented them from actioning their thinking, the major one being that of Te Arawa kawa “he nui ngā tauārai e pā ana ki ngā wahine, i taua wā anō, ā, ko te mea nui ko te kawa o Te Arawa” (Meha, 1995, pp. 4–5). It was also at this time that Robina Cameron, a District Health Nurse, was posted by the Department of Health to work with the Rotorua Māori community. Many of the Māori women of Te Arawa assisted her with her work in the community. Through this working relationship with Nurse Cameron and their earlier thoughts of establishing an organisation to meet the health needs of Māori in their area they enlisted and encouraged Nurse Cameron to set up The Women’s Health League, an organisation to which they could align themselves, with the support of their own tribal leaders. Dow (1999) credits the establishment along tribal lines of the Māori Health League to the women of Te Arawa (p. 202). Nurse Cameron provided a mechanism for Te Arawa women to realise their own goals of promoting health and healthy practices for Māori in Rotorua. The ‘unswerving loyalty’ to Nurse Cameron mentioned by Durie (1994, p. 48) reflects a sense of gratitude that is understandable, given the times (depression years), the state of housing and sanitary conditions, high maternity and infant mortality rates, high rates of tuberculosis and periodic outbreaks of other infectious diseases, and, most importantly, prevailing Pākehā attitudes preventing Māori access to appropriate care such as the Plunket Society.

Māori access to health care was often dependent on the good will or whims of a few Pākehā who knew and had some understanding of how the situation of Māori might be improved. Nurse Robina Cameron was one such person. Te Arawa women set up women’s committees on each marae, “Ka mahi tahi ngā komiti wahine me ngā komiti marae, e mahi tahi tonu nei” (Meha, 1995, p. 11.). The aims of these committees were to provide explanation and understanding of hygiene in the home and marae areas, teach mothers in the care of children, food nutrition values, disease prevention, and home care. The komiti wahine, along with their komiti marae roused their communities into health action and came together, on 2 September 1937, to form the Women’s Health League (Durie, 1994; Meha, 1995). From Meha’s (1995) account there was huge support from Māori women for a dual foundation – Māori and Pākehā. The name of the league was changed to reflect this duality, the Māori Health League

became the Women’s Health League and the word Māori was dropped from the Māori translation to Te Rōpu o te Ora. On 2 September 1937 the aims and objectives of the League were set out: “Nā taua hui tīmata, ka puta mai ngā ara hei whāinga roa, hei whāinga poto mā te Rōpu o te Ora.” They are stated below in Table 1.1, along with the aims and objectives that were re-stated in 1958 (the 20th birthday of the league) to highlight the relevance of the aims and objectives for Māori today, as Meha makes reference to “ahakoa he ngāwari ēnei ka pā tonu ki te ao nei” (Meha, 1995, pp. 12–13).

Table 1.1: Women’s Health League objectives 1937 and 1958

| WHL Aims and Objectives at 1937 | WHL Aims and Objectives at 1958 |
|--|---|
| <ul style="list-style-type: none"> • includes all denominations; • a body of women to help one another; • to take a keen interest in all matters to improve the health of the Māori people; • to encourage the making of flower and vegetable gardens and the planting of fruit trees; • that every member of this league learn Māori arts and crafts, especially weaving and insist on Māori dyes being used in dyeing flax and kiekie; • to gain knowledge in the care and feeding of babies, food values, correct methods of cooking, the value of fresh air and sunshine, thus building up resistance against disease; • that the secretary of each league keep a correct record of all births and deaths in their particular district; and • that each league work in harmony with their Komiti marae | <ul style="list-style-type: none"> • to promote fellowship and understanding between Māori and European women; • to provide opportunities for the discussion of subjects dealing with the health and welfare of the Māori people including the care of and the feeding of infants, the correct methods of cooking and the value of fresh air and sunshine; • to encourage the making of vegetable and flower gardens and the planting of fruit trees; • to assist in the teaching of Māori arts and crafts especially weaving and the insistence on the use of Māori dyes (in place of European dyes) for the dyeing of flax and kiekie; • to maintain through the Secretary of Branch Committees a correct record of all births and deaths in such Committee’s special district; • to encourage members to work in harmony with their Komiti Marae, and to assist financially towards improvements to the Pā and welfare of the Māori people; and • to give aid to members in sickness and misfortune |

Source: Meha, 1995, p. 13⁹; Durie, 1994, p. 48¹⁰

Te Rōpu o te Ora grew quickly, and over 300 members attended its second birthday. Later, other districts joined, including a number of branches from Tuwharetoa, Tairāwhiti and Whakatohea. By 1943 there were over 20 branch committees uniting under the motto Kia Hiwa Rā, Kia Hiwa Rā.¹¹ Membership of the league declined from the 1950s, Māori had

⁹ Meha takes her rendition of the aims and objectives directly from the Women’s Health League, Minute Books 1937.

¹⁰ Durie cites Erihapeti Adam’s commemorative booklet celebrating the 20th birthday of the League in 1958.

¹¹ Kia Hiwa Ra, Kia Hiwa Ra! The full version of this pēpeha is located in the minute books of the WHL. Kia hiwa ra, Kia hiwa ra, Kia hiwa rā e tēnei tuku, Kia hiwa rā e tērā tuku. The translation is as follows: Be on the alert, be on the alert, O hither terrace be on the alert, O yonder terrace be on the alert. It is a call of

started moving to urban areas during World War II and the urban drift increased after the War ended. As the League operated in the main through marae that were located in rural areas, the rural-based ideology of working through marae did not seem to fit well with the growing Māori urban population and the wide range of problems that came with it. The Māori Social and Economic Advancement Act 1945 led to the establishment of Māori councils, Māori committees, Māori welfare officers, and Māori welfare committees. The intention of the Minister of Native Affairs was to join the welfare committees to the Women's Health League. For various reasons the League declined the opportunity to become a national organisation, opting to retain a strong local presence in the Rotorua district, having spent almost 15 years working with marae and hapū, and succeeding in helping to improve conditions in terms of ablutions, working with whānau, and hapū through marae. Since then, the League continues to make substantial contributions to Māori health service delivery. In 1986 a health centre was opened dedicated to Nurse Cameron at Tunohopu, Rotorua. In its early days, the League established links with the Department of Health and with hospital boards, and has maintained these close relationships with health agencies, the Ministry of Health, hospital boards, area health boards, health funding agencies, to the current district health boards.

Criticism of the League has mainly centred on its apparent dependence on health professionals, but this criticism discounts the period in which it was formed and how it linked Māori cultural values with principles of public health. The health of Māori women and their children continues to be a major focus for the League, which provided Māori women with a foundation and security through the years of austere depression, WWII, and urbanisation (Durie, 1994, pp. 48–49). According to Meha (1995), the League is the oldest Māori health organisation in New Zealand.

Māori migration to the cities started during the War and was encouraged by the Māori War Effort Organisation. Before the War less than 10% of Māori lived in urban areas; however, by 1945 this percentage had increased dramatically to 19% and continued to increase after the War (King, 1977, p. 166). While assisting with the war effort was the initial purpose of the migration, other motives include the failure of the land development schemes to provide a living from Māori land alone. A declining rural economy and an expanding urban economy

warning used in the past to warn of approaching danger to the pa, the league uses this pēpeha in a similar vein as a warning to prepare for danger that may threaten the welfare of the people through illness, disease or neglect. The pēpeha was given to the league by members from Ngongotaha. (Meha, 1995, cited from the WHL Minute Books 1938).

fashioned a predictable pull towards the cities. Cities offered a different lifestyle, more alternatives for entertainment, and education, promising a satisfying and more affluent life. However, the intensity of the migration was not foreseen and the effect was added pressure on unprepared local bodies and central government. There was inadequate housing and Māori lived in overcrowded and insanitary conditions. New migrants encountered difficulties with salaried incomes, budgeting and hire purchase arrangements. Employers, accommodation providers, and hotel bars barely if at all concealed their racist practices. Together, these conditions were and still are conducive to impending social instability and conflict (King, 1977, pp. 166–167).

By 1951 the most fundamental and critical problems facing Māori were those associated with infant mortality, sanitation, hygiene, diet and the well-being of families moving to urban areas. Based on the Women's Health League in the Bay of Plenty, the establishment of welfare committees of Māori women was encouraged throughout the country. The intention was to merge these committees eventually with the Women's Health League committees to create a national organisation. By 1950 there were 165 welfare branches throughout the country but the Women's Health League refused to join unless the committees were under the constitution and control of the Women's Health League. The Women's Health League had formed relationships and become affiliated with the Department of Health and other health professionals; on the other hand the Māori women's welfare committees had been formed as an initiative of the Department of Māori Affairs and were led by department welfare officers. The merger was unacceptable to both organisations and their affiliated departments. Unable to resolve the situation, the Minister of Māori Affairs Ernest Corbett, called a conference of Welfare Committees in 1951 and proposed the formation of a national organisation based on a constitution that mirrored that of the Returned Services Association (RSA) (King, 1977, pp. 167–168). In fact some of the aims and objectives of the Māori Women's Welfare League also closely mirrored those of the Women's Health League and were to be a source of contention in later years (see Table 1.1). In the event, the Māori Women's Welfare League (MWWL) was established at that conference. The MWWL was to be made up of local branches, district councils and a dominion council, and the annual general meeting of the dominion council was to be the annual conference of the organisation. In between conferences, the work of the Māori Women's Welfare League as a whole would be conducted by a dominion executive. The first five objects out of 15 were to:

- promote fellowship and understanding between Māori and European women and to co-operate with other women's organisations, departments of state and local bodies in the furtherance of these objects;
- take an active interest in all matters pertaining to the health and general well-being of women and children of the Māori race;
- provide opportunities for discussion and instruction in the proper care and feeding of babies, the preparation of meals, the care and maintenance of the home, and in the benefits to be derived from fresh air and sunshine;
- encourage the making of vegetable and flower gardens, the growing of fruit trees, shrubs and plants, and the creation generally of attractive home conditions;
- encourage young mothers to learn knitting and dressmaking, needlecraft and kindred arts and crafts, and to assist and instruct them in the proper clothing of their children. (King, 1977, pp. 170–171; Durie, 1994, p. 50)

Walker (1990) stressed that the experiences of Māori women in the Māori committees of the Women's Institutes and the Women's Health League provided a breeding ground of quite formidable, enabled and articulate Māori lobbyists and that, combined with growing urbanisation, motivated Māori women to establish a forum of their own to articulate Māori needs outside and across the tribal arena (p. 202). The first president of the MWWL dominion executive was Whina Cooper, Te Paea Herangi was the Patroness, Frances Paki and Mairatea Tahiwī were vice presidents, and Rumatiki Wright was secretary. Rumatiki Wright later vacated the position and it was filled by Ralph Love (Welfare Officer for Wellington) for a time before the position was filled by Miraka Petricevich; Mira Szaszy was a later president. This group, under the direction of Rangi Royal, was to mould the MWWL into a functioning national organisation (King, 1983, p. 172).

The MWWL promoted and advised on improving sanitation in the home, children's health, the evils of alcohol, child rearing (benefits of breastfeeding), cooking, nutrition, household budgeting, exercise and gardening. The League was the first Māori organisation to speak with a national voice. Submissions from the League were taken seriously by both Government and its departments. By 1956 the League had more than 300 branches, 88 district councils and a membership of more than 4,000 (King, 1983, pp. 173–184). As with the Women's Health League, the MWWL was also heavily concerned with the health of Māori and committed to similar goals of advancing Māori health while preserving the optimal elements of Māori cultural traditions (Durie, 1994, p. 50). The League actively advocated for the establishment of health clinics that would be accessible and culturally relevant to Māori (Metge, 1967, p. 181). Along with health, the League also focused its energies on education, housing, and

inequities based on race. Disparities in any of these areas were raised at regional and national League conferences, resulting in submissions and resolutions to the relative government departments asking for remedies (Durie, 1994, p. 50). In this supportive and advocacy role the League flourished, quickly earning the reputation of champion of Māori women. Most resolutions of the League were taken seriously, and thousands of Māori women were introduced to the art of political lobbying (Walker, 1990, p. 174).

Early in its life, the Māori Women's Welfare League became involved in research. In 1952 the first president, Whina Cooper, concerned for Māori living in substandard housing in Auckland, led a survey investigating Māori housing needs. The findings from the survey confirmed that Māori, having been encouraged to move from the rural areas to the city for work opportunities, were forced into living in over-crowded dwellings. Further to this, the survey revealed these dwellings were insanitary slums and therefore a severe health risk. As a result, the Auckland City Council and the Department of Māori Affairs worked together to have the slums demolished and initiated a quota system to ensure Māori were able to access state and local council housing (King, 1983, pp. 175–177).

In 2001, the League celebrated its 50th birthday and its many achievements through the years. In relation to health, the League's achievements have led to nationally run programmes such as the healthy lifestyles programme, auahi kore, whānau ora, positive parenting, and ngā whare rapuora. A notable achievement for the League was a national Māori women's health survey in 1984, from which many of the above programmes emanate. The survey involved Māori women in all facets of the research process, and culminated in the initial development of kaupapa Māori research methodology or research that takes account of a 'by Māori, for Māori, with Māori' approach. It showed that Māori participation in research as initiators, investigators, inquirers, and scrutineers not only added value to the research process but offered Māori relevant solutions to immediate problems. Māori experiences of research before this had only been as a subject, many of the experiences of which were negative. Rapuora, the research, highlighted the lack of Māori participation in research and opened a previously closed environment (research) to Māori.

The work of the League has gone from strength to strength and remains focused on Māori health, education, housing, and economic and business development. The League is represented on the boards of many government, and non-government agencies, and continue to advise and petition the Government on a variety of Māori issues.

From a Māori community perspective and in a contemporary context the Treaty of Waitangi claims process brought community health concerns to another platform. An interaction at a national level brought home to many Māori and the general public the impact and future implications of modern progress on local communities. The WAI6 Motonui Waitara Report was the first claim to fully expose the human element of environmental health. Importantly it showed the links between Māori custom, human health, and the environment. In this Report it was made clear that the violation or prohibition of Māori customary food gathering and eating was in itself a health risk that went beyond risks to physical and social health to affect well-being at an elemental level. The Tribunal found that in prohibiting the gathering and eating of shellfish the Department of Health had stifled the application of a significant and highly valued Māori custom. Even though the prohibition was a safety measure due to effluent discharge from local factories claimants maintained that their customary rights and views had not been taken into account. In particular, the report accentuated the importance of Māori access to, and participation in the decisions relating to the regulation of the natural environment. Rather than prohibition the application of tapu, noa, and rahui, Māori regulatory systems, may have had more effect than government regulation (WAI6, 1983; Durie, 1994, 1998, 2003b).

The Te Pae Mahutonga framework (Durie, 1999), first developed as a tool for health promotion activities, also has application across a broader spectrum and therefore relevance to environmental health and health protection services, public health, mental health, community health, and workforce development. The Framework is based on the constellation of stars referred to as the Southern Cross and is used both now and in the past as a navigational aid to guide or illustrate the interconnections within the health sector. It has become a useful tool to bring together aspects of health that not only apply to Māori but may also have relevance and applicability to other New Zealanders, particularly in the area of health workforce development (Durie, 2003b).

The four central stars are described as:

Mauri Ora: access to te ao Māori, the Māori world, where the importance of cultural identity is considered critical for Māori participation in health.

Waiora: environmental protection where there is an acknowledgment of the interaction between people and the external environment. This includes the connection of the external environment to spiritual, cosmic, and terrestrial worlds, and the opportunities for people to experience these elements in their own way.

Toiora: healthy lifestyles, where health depends on personal behaviour but takes into consideration the risks associated with lifestyle choices or, specifically, inability to choose. For example, smoking, alcohol and drugs, nutrition, unsafe sex, and unsafe vehicle use, as risky behaviours become more pronounced when associated with poverty and youth, or where it is accepted as the norm or encouraged in communities.

Te Oranga: participation in society. It is dependent on the level of access to resources and services and the amount of control people have in the way in which they are able to participate in society in relation to active and positive participation in the economy, education, health services, sport and recreation, and in modern technologies.

Current Māori health workforce development owes much to these 19th and 20th century initiatives, which demonstrated that to be effective, health interventions for Māori should reflect clinical, cultural, community and leadership skills. The pioneers had high standing with their own communities, and strategies were sufficiently aligned to Māori aspirations, to be credible in Māori eyes. But they also learned how to bridge the gap between a Māori world and a world governed by professional, institutional and political ambitions. Managing that duality remains a challenge for the Māori health workforce in modern times.

Concluding remarks

This thesis then, argues that there are distinct Māori approaches that will advance Māori health, including the development of a Māori health workforce, with active Māori participation at different levels within the sector. Te Kooti demonstrated that land retention provided sustenance and a sense of autonomy, a control over wellbeing, and spiritual leadership provided unity and strength. Ratana brought people together outside their tribal groups, first under a spiritual banner and then under a political one. Te Puea recognised the links between health and culture, for instance, for Māori to be healthy access to te ao Māori would be a requirement along with clean environments and self-governance. Similarly, Buck and Pomare proved how small Māori communities were able to improve the health of their own people through providing leadership, accepting responsibility, and attending to a public health infrastructure. Current Māori health workforce development initiatives have similar objectives: to improve Māori health by blending both clinical and cultural aspects, by building a sustainable Māori health workforce, and by ensuring that these approaches and initiatives are aligned with overall Māori development and advancement goals, and, more importantly, with community aspirations.

Chapter 2

THEORETICAL AND METHODOLOGICAL PERSPECTIVES

*The observer went to a foreign setting to study the culture, customs, and habits of another human group. Often this was a group that stood in the way of white settlers*¹²

Introduction

This chapter describes the research approach, the methods, and the theoretical and methodological perspectives used in this study. It provides an overview of traditional Western strategies for research, distinguishes between quantitative, qualitative and mixed methods strategies, and reviews Māori approaches to research.

Knowledge claims

Creswell (2003, p. 4) puts forward a notion of ‘knowledge claims’ previously described as ‘paradigms’ by Lincoln and Guba (2000, 2005), ‘philosophical assumptions, epistemologies, and ontologies’ by Crotty (1998, cited in Creswell, p. 4), and ‘broadly conceived research methodologies’ by Neuman (2000, p. 6). Each knowledge claim states a position, a perspective, a stance, or a worldview, and provides a platform on which to base philosophical ideas and a framework to guide all facets of the research process. For example, Crotty (1998) identifies four basic questions that would have relevance in developing a framework that clearly outlines one’s philosophical ideas and often reflects the discipline of the researcher:

1. What epistemology or theory of knowledge embedded in the theoretical perspective informs the research (e.g., objectivism, subjectivism)?
2. What theoretical perspective/worldview lies behind the methodology (e.g. positivism/postpositivism, interpretivism, critical theory)?
3. What methodology, strategy or plan of action that links methods to outcomes governs our choice and use of methods (e.g., experimental, survey research, ethnography, case study)?
4. What methods, techniques and procedures do we propose to use (e.g., questionnaire, interview, focus groups)? (Crotty, 1998, as cited in Creswell, 2003, p. 4).

In the same vein Guba and Lincoln (1998) maintain that a paradigm is the basic belief system or worldview that guides the investigator, not only methodologically but in ontologically and

¹² Cited in Denzin and Lincoln (2005, p. 2).

epistemologically fundamental ways. As cosmologies and theologies do, this paradigm represents a worldview that defines for its holder, the nature of this world, the individual's place in it, and the range of possible relationships to that world and its parts. The beliefs are basic in the sense that they must be accepted simply on faith (however well argued); there is no way to establish their ultimate truthfulness (Guba & Lincoln, 1998). They examine the major paradigms and perspectives that they believe structure and organise qualitative research: positivism, postpositivism, constructivism, and critical theory (Denzin, 1998); and the participatory/cooperative paradigm (Lincoln & Guba, 2000). In their analysis of the axiomatic issues, they compare and contrast the qualitative or naturalistic assumptions with the positivist/postpositivist assumptions.

Reason and Rowan (1981) and Heron (1981, 1997) discuss the emergence of what they termed New Paradigm Research: alternative research approaches to the orthodox. Orthodox in this sense means the positivist stance. New Paradigm Research has application for those who engage in human inquiry. The participatory/cooperative paradigm (Lincoln & Guba, 2000; Creswell, 2003) has emerged from New Paradigm Research (Heron, 1981, 1997; Reason, 1981).

There are others still who maintain just two viewpoints – that of positivist and antipositivist. Depending on the discipline to which one belongs, these perspectives can also be conventionally referred to as 'normative' and 'interpretive'. The normative perspective or paradigm has two key positional ideas: that human behaviour is essentially rule-governed, and that it should be investigated by methods of natural science. In contrast, the underlying characteristics of the interpretive paradigm are the concern for the individual. Normative studies are positivist, whereas all theories constructed within the interpretive paradigm tend to be antipositivist, an exercise in understanding the subjective world of the human experience (Douglas, 1973).

Creswell (2003), advocating three essential elements of inquiry by conceptualising Crotty's model, asks

what knowledge claims are being made by the researcher (including a theoretical perspective)? What strategies of inquiry will inform the procedures? And what methods of data collection and analysis will be used? Conceptualized, these elements form the approaches to research which are then translated into practice – the design processes of research should be (p. 5).

Earlier Creswell (1998) described five philosophical assumptions – ontological (what is the nature of reality?), epistemological (what is the relationship between the researcher and that being researched?), axiological (what is the roles of values in the research?), rhetorical (what is the language of research?), and methodological (what is the process of the research?) in terms of the implications for practice. His analysis of axiological issues acknowledges the legitimacy of qualitative research in its own right. He focuses his discussion on the practical implication of each of these assumptions in an effort to form a conduit between philosophy and practice (Creswell, 1998).

Keeping in mind the practical orientation of Creswell, the ontological issue addresses the nature of reality. Given the numbers of individuals who may be involved in the research (researcher, participants, readers/interpreters) each with their own constructed reality, a situation of multiple realities or perspectives emerge (themes) enabling the reporting of divergent views. The relationship of the researcher to that being researched is the epistemological assumption, which provides space for the researcher to interact with participants, thereby minimising the ‘distance’ or the ‘objective detachment’ described by Guba and Lincoln (1998, p. 201). The researcher, depending on the type of study, may move from being considered an ‘outsider’ to being considered an ‘insider’. The distance closing relationship between researcher and participants, already mentioned, has implications for the axiological assumption and the role of values in a study. Here, the researcher acknowledges and reports the value-laden-ness of the study, which includes the researcher’s own values and biases and that information gathered from the field. The rhetorical assumption alludes to the specific language and terms used by the researcher in the narrative of the study. For example, a positivist/postpositivist is likely to use terminology that reflects objectivity and measurement such as ‘validity,’ ‘generalisability,’ ‘accurate,’ and ‘absolute truth.’ In qualitative research the terminology would reflect the research strategy used, for example, terms used in a case study would include ‘transferability,’ ‘dependability,’ ‘confirmability,’ emerging terminology in qualitative research includes ‘understanding,’ ‘discover’ and ‘meaning.’ The conceptualisation of the research process is the methodological assumption emerging from the distinctions about reality, the relationship between the researcher and that being researched, the role of values and the rhetoric of the study. Generally, a qualitative methodology starts inductively – generating themes then theory. This discussion is summarised in table 2.1.

Table 2.1: Philosophical assumptions with implications for practice

| Assumption | Question | Characteristics | Implications for practice – examples |
|-----------------|--|--|---|
| Ontological | What is the nature of reality? | Reality is subjective and multiple, as seen by the participants in the study | Researcher uses quotes and themes in words of the participants and provides evidence of different perspectives |
| Epistemological | What is the relationship between the researcher and that being researched? | Researcher attempts to lessen the distance his/herself and that being researched | Researcher collaborates, spends time in the field with the participants, and becomes an "insider" |
| Axiological | What is the role of values? | Researcher acknowledges that research is value laden and that biases are present | Researcher openly discusses values that shape the narrative and includes own interpretation in conjunction with interpretation of participants |
| Rhetorical | What is the language of the research? | Researcher writes in a literary informal style using the personal voice and uses qualitative terms and limited definitions | Researcher uses an engaging style of narrative, may use first person pronoun, and employs the language of qualitative research |
| Methodological | What is the process of the research? | Researcher uses inductive logic, studies the topic within its context, and uses an emerging design | Researcher works with particulars (details) before generalisations, describes in detail the context of the study, and continually revises questions from experiences in the field |

Source: Creswell, 1998, p. 75.

In relation to ideological stances, Creswell (2003) starts from the postpositivist stance, referring to the positivist perspective as 'that thinking before postpositivism,' i.e., constructivism, and then describes the knowledge claims advanced by Heron and Reason (1997), Tashakkori and Teddlie (2003), and Lincoln and Guba (2000) – advocacy/participatory

perspectives and pragmatism (p. 4). Table 2.2 below summarises alternative knowledge claim positions as espoused by Creswell (2003).

Table 2.2: Alternative knowledge claim positions

| | |
|---|---|
| <p>Postpositivism</p> <p>Determination</p> <p>Reductionism</p> <p>Empirical observation & measurement</p> <p>Theory verification</p> | <p>Constructivism</p> <p>Understanding</p> <p>Multiple participant meanings</p> <p>Social & historical construction</p> <p>Theory generation</p> |
| <p>Advocacy/participatory</p> <p>Political</p> <p>Empowerment issue oriented</p> <p>Collaborative</p> <p>Change-oriented</p> | <p>Pragmatism</p> <p>Consequences of actions</p> <p>Problem-centred</p> <p>Pluristic</p> <p>Real-world practice-oriented</p> |

Source: Creswell, 2000, p. 6.

Positivism as a ‘knowledge claim’ has its roots in ancient Greek philosophy, which dominated the epistemological ground of Western science through the Middle Ages and the Age of Enlightenment. Strongly placed within the positivist stance is objectivism, which holds that truth and meaning reside in their objects independently of any consciousness. This claim holds that there is objective truth, which can be brought about through appropriate methods of inquiry culminating in accurate and certain knowledge of that truth, which is the essence of the positivist stance. In the social science arena the positivist stance has come under considerable attack, but as a knowledge claim it is widely acknowledged as the received view of science that has withstood the tests of time and raging criticism and stands alone as a permanent claim – it has spawned during the storm while all other knowledge claims are still emerging. A positivist stance in research posits that there must be an attribution of objectivity, validity and generalisability to research findings (Harré & Rom, 1981). For example:

the scientific world is an abstraction from the 'lived' world; it has been distilled from the world of our everyday experiences, distances from the world of our everyday experiences, and takes us further still from the world of immediate experience lying behind our everyday experiences. Science imposes a very tight grid on the world it observes. The world perceived through the scientific grid is a highly systematic, well-organised world. It is a world of regularities, constancies, uniformities, iron-clad laws, absolute principles. As such, it stands in stark contrast with the uncertain, ambiguous, idiosyncratic, changeful world we know first hand. (Husserl as cited in Crotty, 1998, p. 28)

Postpositivism refers to the "thinking after positivism", both of which have traditionally governed claims about what warrants knowledge. Most commonly, postpositivist research is referred to as the 'scientific method,' 'quantitative research,' 'empirical science,' doing 'science,' and positivist/postpositivist (Creswell, 2003). Postpositivism does challenge the positivist stance in its recognition that researchers cannot be absolutely 'positive' about their claims of knowledge where the behaviour and actions of humans are concerned. It is deterministic in the sense that causes probably determine effects or outcomes. Therefore, the postpositivist researcher tends to study problems that reflect a need to examine causes that influence outcomes. The intent then, is to reduce ideas into small, discrete sets of ideas to test, making it reductionist for example, the variables that form hypotheses and research questions. Knowledge that emanates from a postpositivist view is based on careful observation and measurement of the objective reality that exists 'out there' in the world. Hence, the development of numerical measures of observations and the studying of individual behaviour are paramount for a postpositivist. Finally, the laws and theories that govern the world need to be tested, verified, and refined in order to provide an understanding of the world. The postpositivist, then, begins with a theory or law, collects data to support or refute the theory or law, then makes revisions and retests before conclusions are made (Creswell, 1998, p. 7). Phillips and Burbules (2000) agree, and maintain that in postpositivism five key assumptions are evident. First, that knowledge is 'conjectural', evidence is always 'imperfect and fallible' and the result is that hypotheses are not proven; instead the testing of hypotheses indicates a failure to reject. Second, the research process begins with the test of a theory. Third, the evidence and data shape the knowledge through observation and measurement. Fourth, researchers seek to 'advance the relationship between variables' in relation to the questions and hypotheses they pose. Finally, objectivity is essential and supported by tests for validity and reliability (Phillips, 2000):

Articulating scientific knowledge is one thing; claiming that scientific knowledge is utterly objective and that only scientific knowledge is valid and accurate is another. Since the emergence of positivist science, there has never been a shortage of philosophers and

social scientists calling upon it to rein in its excessive assumptions and claims. Many of these philosophers and social scientists have operated out of a quite different epistemology and worldview. As the twentieth century got under way, however, more and more scientists 'from within' added a chorus of their own. Without necessarily jettisoning the objectivism inherent in positivism, these insiders have challenged its claims to objectivity, precision and certitude, leading to an understanding of scientific knowledge whose claims are far more modest. This is a less arrogant form of positivism. It is one that talks of probability rather than certainty, claims a certain level of objectivity, and seeks to approximate the truth rather than aspiring to grasp it in its totality or essence. (Crotty, 1998, p. 29)

Constructivist knowledge-claim researchers address the processes of interaction among individuals, and focus on the specific context within which people live and work to gain an understanding of the historical and cultural settings of participants. The researchers position themselves, acknowledging that their own historical background and cultural experiences shape their interpretation in making sense of the world. Patterns of meaning or theory, are generated inductively by the researcher (Creswell, 2003). Constructivists are committed to the view that objective knowledge and truth is the result of perspective, and therefore a practical function of theory construction and knowing. Human beings do not discover knowledge, they construct or make it by engaging with the world they are interpreting (Crotty, 1998; Schwandt, 1998, p. 236).

Strong proponents of the constructivist knowledge claim are Egon Guba and Yvonna Lincoln, who had originally discussed their approach under the heading 'naturalistic inquiry' (1985). In the 1990s, they determined the constructivist researcher as a 'bricoleur,' a jack of all trades – a professional do-it-yourself. Researchers focus on their own ability to use a wide range of tools and methods, both conventional and unconventional, in the research process, thus drawing on 'inventiveness', 'resourcefulness' and 'imaginativeness'. The researcher in this sense is "adept at performing a large number of diverse tasks" – multi-tasked – and "is knowledgeable about the many interpretive paradigms (feminism, Marxism, cultural studies, constructivism) that can be brought to any particular problem" (Crotty, 1998, p. 49; Denzin & Lincoln, 1998, pp. 3–4.). Schwandt (1998) describes the constructivist and interpretivist (constructivism and interpretism) knowledge claims in relation to human inquiry as "general descriptors for a loosely coupled family of methodological and philosophical persuasions," continuing that "proponents of these persuasions share the goal of understanding the complex world of lived experience from the point of view of those who live it" (p. 221).

New Paradigm Research activity began in the late 1970s and continued through the 1980s and 1990s culminating in a variety of perspectives that originate from opposition to "the

postpositivist assumptions, imposed structural laws, and theories that did not fit marginalised individuals or groups or did not adequately address issues of social justice” (Creswell, 2003, pp. 8-9).

Many proponents of the advocacy/participatory (or emancipatory) ‘claims’ have drawn from the works of “Marx, Adorno, Marcuse, Habermas and Friere” (Creswell, 2003, p. 9). Two notable writers from this New Paradigm Research perspective are John Heron and Peter Reason who, in opposition to the traditional postpositivist view, argued that the constructivist/interpretivist stances did not go far enough in “advocating for an action agenda to help marginalised peoples.” Research, they contend, should be “intertwined with politics and a political agenda” facilitating political reform and social change. They insist that research must address and raise issues of “empowerment, inequality, oppression, domination, suppression, and alienation.” Within this knowledge claim is an acknowledgement that research is a collaborative, all-inclusive process that does not further alienate or marginalise participants or researched communities. Thus the participant’s ‘voice’ becomes a “united voice for reform and change” (Creswell, 2003, pp. 9–10).

Within the advocacy/participatory knowledge claims a space is provided for the voice of previously marginalised peoples. This includes an integration of their theoretical perspectives with philosophical assumptions constructing an image of the issues requiring examination, the people, communities and events to be studied, and the changes that are needed. Included in some of these theoretical perspectives are feminist perspectives, racialised discourses, critical theory, disability inquiry, and queer theory (Denzin & Lincoln, 2000).

Key features of the advocacy/participatory or emancipatory forms of inquiry are that participatory action is ‘recursive’ or ‘dialectical’ and is focused on bringing about change in practices, an action agenda for reform. Second, there is a focus on important issues or problems in society. Third, the enquiry is emancipatory in that the aims are to create political debate and discussion to facilitate change. Finally, it is collaborative because it is research that engages with others rather than on or to others (Creswell, 2003).

The pragmatism knowledge claim emanates from actions, situations, and consequences, and is not committed to any one philosophy or reality. Methods techniques and procedures are chosen to suit the needs and purposes of the researchers. Pragmatists are not limited in their

approaches to research and may use quantitative, qualitative or a mixture of methods. Truth is what works at the time; it is not based in a strict dualism between the mind and a reality completely independent of the mind. The focus for the pragmatist is on the 'what' and 'how' of the research, its intended consequences – where they want to go with it. There is agreement among pragmatists that research always occurs in social, historical, political, and other contexts. Questions about reality and the laws of nature are not important to the pragmatist. Pragmatism lends itself to mixed methods approaches to the research process, different worldviews, and different assumptions (Rescher, 1995; Crotty, 1998; Creswell, 2003; Tashakkori, 2003).

The characteristic idea of philosophical pragmatism is that efficacy in practical application – the issue of 'which works out most effectively' – somehow provides a standard for the determination of truth in the case of statements, rightness in the case of actions, and value in the case of appraisals. (Rescher, 1995, p. 710)

Pragmatism has become less critical since first initiated by Charles Peirce, and is described by Crotty (1998) as an "uncritical exploration of cultural ideas and values in terms of their practical outcomes" (p. 73). Proponents of this position situate themselves firmly in the field of mixed methodology, termed the - third methodological movement (Tashakkori & Teddlie, 2003).

Four knowledge claim positions have been presented: positivism/postpositivism, constructivism, advocacy/participatory, and pragmatism. Each of these has value to the researcher because each builds on an expanding world of knowledge. On one hand, the knowledge claim that is seen to have some relevance for this thesis is the advocacy/participatory knowledge claim, because it advances the idea of collaborative research, research that engages with communities. Advocacy/participatory research focuses on changes in practice, facilitating an action agenda for reform, which thereby concentrates on the important issues and or problems in society. In particular it aims to create political debate and discussion to facilitate change. On the other hand, the advocacy/participatory knowledge claim does not clearly articulate conducting research with indigenous groups. While it is inclusive of marginalised groups, ethnic groups, oppressed groups, disadvantaged groups, and other groups, it is obscure when it comes to the reality and the diversity of indigenous peoples. The implications surrounding research with indigenous peoples are substantial and unique and include, for example, specialised language and distinct cultural values, colonial

experiences, relationships with the environment, different ways of philosophising and theorising knowledge, and concepts of time and space (Smith, 1999, 2005).

Māori knowledge claims

Much of the research on Indigenous Peoples or ‘primitives’ has emanated from the disciplines of sociology and anthropology, which were “born out of a concern to understand the other” (Vidich & Lyman, 2000, p. 38). In this sense ‘other’ describes the ‘exotic other, the primitive non-white person from a foreign culture considered less civilised than that of the researcher’. It was, however, colonialists, who preceded the anthropologist and paved a way that turned the ‘dark-skinned’ other into the object of the researchers’ gaze, and thus establishing a colonial and postcolonial history thereby indicating that from the very beginning research has had racist orientations (Denzin & Lincoln, 2000, p. 2; Denzin & Lincoln, 2005, p. 2):

descriptions and evaluations of the races and cultures of the world were provided by western missionaries, explorers, buccaneers, and colonial administrators... written from the perspective of or by the representatives of, a conquering civilisation, confident in its mission to civilise the world... while thick descriptions of those practices of the “primitive” made salient to the observer by his Christian value perspective... their reports... are a reversed mirror image of their own ethnocultural ideal... present day ethnographers reject the earlier ethnographies as hopelessly biased. (Vidich & Lyman, 2000, p. 41)

In New Zealand, evidence of colonial scrutiny of the Māori, stems from the observations of James Cook and his crew in 1769. Later observers include Elsdon Best, Percy Smith, Augustus Hamilton and Sir George Grey, all of whom are considered by Western researchers as well versed in Māori knowledge and culture (Tomlins-Jahnke, 2005). Even though their perspectives and interpretations are, for example in Vidich and Lyman’s (2000) words, a reproduced but reversed “image of their own ethnocultural ideal” that contemporary ethnographers reject, much of their interpretations of the ‘native’ remain entrenched in contemporary New Zealand societal thinking. Some of these perspectives are even upheld by some Māori (Tomlins-Jahnke, 2005).¹³ Although Tomlins-Jahnke (2005) does point out that while some of these early commentators such as Sir George Grey and Elsdon Best had access to some of the most knowledgeable Māori informants of their time, they were only ever

¹³ Tomlins-Jahnke (2005) describes the work of Augustus Hamilton, his description of what constitutes Māori art and his disdain of Māori; Percy Smith’s Great Fleet orthodoxy is still the belief of many New Zealanders including some Māori.

allowed access to the rudiments not the depth and breadth of Māori thought. Even Elsdon Best, frustrated with his Māori informants is known to have complained (cited in Tomlins-Jahnke, 2005, p.12) “We have never been allowed inside the palisades of Māori thought” suggesting that Māori knowledge was not given over, completely. Vidich and Lyman (2000) point out that not only have colonialist reports now been ‘decentered’ or ‘disprivileged’ by notable present day ethnographers, but native accounts of their Western ‘discoverers’ are also being given serious consideration (Denzin & Lincoln, 2005; Vidich & Lyman 2000). The previously silenced voice of the colonised indigenous peoples is now emerging in resistance to the colonial view.

Vidich and Lyman (2000), Smith (1999), and others claim that decolonisation movements began to occur around the world within 30 years of the end of World War II, especially on the African and Asian continents, later in Europe, the Soviet and Pacific nations, effectively:

succeeding in ending the direct forms of Western global colonialism. This anti-colonial assault on Western ethnocentrism led to a critical attack on the idea of “the primitive” and on the entire ethnological thought that went with it, that is “underdeveloped” and “third world” tended to replace “primitive”. (Vidich & Lyman, 2000, p. 44)

Anthropologists and ethnographers underwent a vigorous and prolonged attack, in the main from academia, because they were seen to have cooperated with imperial governments in maintaining the suppression and exploitation of natives. Spokes people from the newly defined ‘primitive’ held anthropologists responsible for, and to have contributed to such suppression and exploitation. Still, there are some indigenous colonised groups, such as the American Indian, who have remained in a special kind of ‘otherness’ evident in the way they have been “confined to reservations of the mind as well as the body”(Vidich & Lyman, 2000, 43-46). Academic study of American Indians is that of ‘primitive’ peoples whereas “study of European and Asian immigrants, and Afro-Americans is an institutionalized feature of sociology courses on “minorities” and “race and ethnic” relations” (Vidich & Lyman 2000, pp. 43–46).

New Zealand has not missed the decolonisation movements of other continents and nations. Indeed, Māori academics along with other indigenous groups have voiced their concerns in international and national forums, both to challenge the legitimacy of Western knowledge claims and to resist privileging ‘Western ways of knowing’ (Smith, 1999, p. 183).

Much of the research on Māori has been undertaken using traditional Western research frameworks emanating originally from a scientific positivist/postpositivist perspective. In terms of this thesis it has been most useful in biomedical and epidemiological research, for instance, in the collection of incidence and prevalence data, and in the highlighting of morbidity and mortality data. The early works of Buck, Wirepa, Hercus, Turbott and Te Puea attest to great advances in raising the standards of Māori health. Buck, Wirepa, Te Puea, and to some extent Turbott, recognised the links between socio-economic and cultural information and attempted to combine these factors with clinical data. On the other hand, Hercus's goitre survey compared the Pākehā-Māori incidence without attempting to take account of socio-economic and cultural factors, thus reflecting the conventional Western focus of quantifying data to show incidence and prevalence of disease. For this reason, Wirepa was particularly critical of the Pākehā model because it did not take into consideration the Māori position but focused on the collection of data for comparative purposes (King 1977), and this remains static in much contemporary research. In keeping with Wirepa's view, Smith (1999) adds that the positivist/postpositivist perspectives most often tend to classify, categorise, systemise, compare and evaluate a group or society (e.g., Māori society), and provides a ranking system whereby a society is coded into the Western system of knowledge (Smith, 1999, p. 42). Māori have been highly critical of this systemisation of knowledge and since the 1970s have advanced a range of Māori approaches to research that have come to be generally accepted and acknowledged as kaupapa Māori research models, frameworks, designs, approaches, paradigms, methods, methodologies and knowledge claims. Other models have been developed using a Western philosophical framework; others again have evolved or found 'voice' through the works of critical theorists. For example, Smith (1999) contends that the feminist perspective in particular has informed many indigenous academics. And Kingi (2002), exploring the notion of kaupapa Māori, uses the Western paradigmatic framework proposed by Guba and Lincoln (1998, p. 203) to express kaupapa Māori research in ontological, epistemological and methodological terms (Kingi 2002).¹⁴

¹⁴ Using Guba and Lincoln's (1994, p. 109) descriptions of basic beliefs (metaphysics) of Alternative Inquiry Paradigms. These descriptions have been reproduced in 1998 in Guba and Lincoln's, *The Landscape of Qualitative Research: Theories and Issues*, Vol. 1, p. 203; and also in Lincoln, Y. S., & Guba, E.G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. Denzin and Lincoln, *Handbook of Qualitative Research*, pp. 163–188.

Kaupapa Māori is not restricted to research; rather it extends over many disciplines and is applied in different forms to practice. In education, for instance, kaupapa Māori is applied to Māori language immersion early childhood, primary, secondary and tertiary education (kohanga reo, kura, wharekura and whare wananga education). In health, justice, and social services, Māori providers often describe their services as kaupapa Māori because they are Māori, their clients are Māori, and they observe many aspects of tikanga Māori. In business, large accountancy, consultancy, marketing and law firms have established kaupapa Māori development units within their organisations; staffed by Māori these units recruit and work with Māori clients. Some Māori tourism operators describe their operations as kaupapa Māori because they provide a Māori experience or promote Māori culture in different forms. Common to all these examples is that Māori people and culture are featured as central to the activity. In a similar vein, while Māori approaches to research are expressed and described differently they have nonetheless become generally accepted and acknowledged as kaupapa Māori knowledge claims.

As an emerging research approach, some advocates such as Pihama and Cameron (cited in Smith, 1999 pp. 184–189), claim that kaupapa Māori is a paradigm and position it within their own disciplines to challenge or critique Western ways of knowing. However, the debate then becomes one of comparing kaupapa Māori with Western science and as such becomes unhelpful to Māori researchers. While it is acknowledged that kaupapa Māori has essential elements that make it a paradigm, in essence it is a ‘social project’ that extends across disciplines (as described earlier) and also focuses on those wider issues that have implications for positive Māori development (Smith, 1999, p. 190).

One approach to Māori research that has been advanced more specifically in Māori health is the Māori-centred approach (Durie, 1996a). This approach locates Māori people, culture, knowledge, and processes at the centre of the research. It focuses on and is consistent with Māori aspirations and is validated within a Māori cultural context and worldview. Māori-centred research provides an opportunity to undertake research based on positive cultural aspects in contrast to bio-medical and epidemiological research which locates disease and problems at the centre of the research rather than people. As with other kaupapa Māori approaches, the Māori-centred approach lends itself to the development and implementation

of new methodologies and methods and favours an analysis that takes account of Māori perspectives of health. Similarly, a Māori-centred approach extends across sectors and disciplines¹⁵ and encourages the occurrence of multidisciplinary and multi-method approaches to research, thereby contributing to a wider appreciation of health and well-being consistent with Māori views of health, and positive Māori development (Durie, 1996a, pp. 12–13).

Te Ahukaramu Royal (1998; 2002) proposed the Te Ao Marama ‘framework’/paradigm for the advancement of Māori knowledge and noted that a key Māori aspiration is that of cultural survival. The Te Ao Marama paradigm echoes ‘traditional Māori culture’ and is therefore “the paradigm of traditional matauranga Māori” (p. 79). Te Ao Marama provides a vehicle which draws on the past to inspire contemporary Māori theorising and ‘philosophical’ reflection – a form of reclaiming what Ken Newell (1954) acknowledged was previously present in traditional Māori society when he referred to the different levels of tohunga education. Newell noted that whare wananga were teaching institutions for tohunga with three distinct levels of tohunga education. The highest level of tohunga education concentrated on ritual and tribal lore, the next level provided in-depth “historical and genealogical” education and the third level involved education in healing. He concluded that in traditional Māori society, Māori were “scholars, scientists, philosophers, and theologians” (Newell, 1954, pp. 12–15). In this sense traditional matauranga Māori can be said to be culture-bound. Te Ao Marama allows for the resumption of these philosophical practices alongside contemporary and future thinking. Cultural survival, then, is assured when Māori are confidently able to perform/carry out what Royal (2002, p. 11) refers to as the “perpetuation of our knowledge, our traditions, our worldviews, our philosophies.”

Therefore, the key role of the ‘Te Ao Marama framework’ becomes one of developing interpretations of the traditional Māori worldview. Royal (2002) maintains that this mainly involves research into the principles of a traditional Māori worldview, establishing its basic views on ‘reality’, and applying those principles and views in new and ‘creative’ ways in a ‘contemporary’ Māori context. Te Ao Marama enables the investigation of indigenous knowledge and worldviews, bringing the contemporary experiences of indigenous peoples into focus and providing spaces for indigenous theorising and ‘philosophical reflection’ outside of a common colonial experience (Royal, 2002, p.15). In developing a framework for the study

¹⁵ see Soutar, 1999; Puketapu, 1999

of worldview and its definition, Royal (2002) draws on the works of the late Reverend Māori Marsden:

Cultures pattern perceptions of reality into conceptualisations of what they perceive reality to be; of what is to be regarded as actual, probable, possible or impossible. These conceptualisations form what is termed the 'world view' of a culture. The world view is the central systemisation of conceptions of reality to which members of its culture assent and from which stems their value system. The world view lies at the very heart of the culture, touching, interacting with and strongly influencing every aspect of the culture. (Marsden, 1975, cited in Royal, 2002, p. 18)

Essentially, the above definition explains the links between culture and people, their experiences and perceptions of reality, and their conceptualisation or understanding of that reality. The definition also identifies a natural tendency for people to categorise and sort into some sort of order or structure, to make coherent or synergise their views and ideas. It states that a worldview gives rise to values that determine behaviours. Finally, a worldview lies at the very heart of a culture, providing an implicit set of impressions, of invisible ideas of the world that lie deep within a culture and that are taken as 'given' – a worldview acts as a base on which values are developed and acted in the behaviour of a culture. Hence, by understanding the worldview of a culture we can come to an understanding of its values and thereby its behaviour. Māori research, then, places Māori culture at the core of Māori perceptions and this is reflected in the research (Royal, 2002, pp. 18-20).

Other indigenous worldviews are not dissimilar in orientation to Māori perspectives or worldviews. For example, Tomlins-Jahnke (2005, pp.6-9) draws from the works of Kawagley (1995), Cajete (2000), Little Bear (2000), Smith, (1999), and Duran and Duran, (2000), to stress the connection and relationships of indigenous peoples to their natural environments and local eco-systems. Indigenous worldviews:

...are expressed in stories, symbols, analogies and metaphor and are coded in mythology. Mythologies convey worldviews through cultural, spiritual, and social institutions, both formally and informally, and in conscious and unconscious ways [and therefore]...transmit the principles of harmony and respect that underpins the natural order of the indigenous world. (Tomlins-Jahnke, 2005, p.7)

In agreement, Te Rangihiroa (1949), notes that this harmonisation and respect is manifest in Māori oral tradition and used in explaining and understanding meaning of lived human experiences within the natural world, exemplified in mythology and metaphorical speech.

Drawing inspiration from Māori and indigenous worldviews, Māori researchers are continually developing methodologies or research strategies to apply, in practical and culturally relevant ways, to their own research. For example, Gillies (cited in Gillies & Barnett, 2002; Gillies, 2004; Barnett & Gillies, 2005; Gillies, Tinirau, & Mako, 2006) developed and applied Kōriporipo as a culturally affirming methodology for recruitment and selection of participants using the following visual representation of:

an aerial photograph of two launches, proceeding side by side on a tranquil sea. Their wakes crossed and recrossed each other in almost an infinity of lines. Yet despite the intricateness of this tracery, the picture gave an impression of great simplicity, because one could quickly perceive the generating principle of its design. (Burke, 1969, p. xvi)

Drawing on Western imagery and applying Māori figurative speech to explain a Māori perspective Kōriporipo is an emerging methodological framework that upholds Māori recruitment and selection strategies by acknowledging and applying links through whakapapa, waka, marae, iwi, hapū, whānau, networks (whakawhānaungatanga in action) and communities. As its name suggests (the wake produced in the water when a number of waka are rowed at speed), this methodology depicts intricate lines crossing and recrossing each other, and spreading to infinity as the waka move forward in the water. The wakes of both waka originate separately (as in whānau) and spread narrowly at first (hapū), then wider (iwi). The wakes then merge together at some point illustrating interaction between tribes at various points in time (intermarriages for example). The same interaction occurs when a number of waka are in the water at the same time and moving in the same direction. Because people are controlling, steering and moving the waka forward, sometimes at a different pace it creates different converging points and some turbulence but becomes more settled further in the wake. The splashes from the paddles also impact on the wake nearer its beginning causing it to vacillate, however, the wake at that point is stronger and survives.

The imagery Kōriporipo invokes connects the natural world to humankind and in this example to Māori, their life experiences, situations, knowledge systems, political systems, diversity, and their cultural perspectives. It is not always a smooth ride but ensuring the basic tenets are in place, such as consultation with participants (to build relationships, partnerships, alliances, and coalitions), is paramount (Gillies, 2004; Barnett & Gillies, 2005). Kōriporipo then attempts to reconcile and balance Western methods used (for example, interviews, meetings etc.) and Māori cultural concepts (such as kanohi-ki-te-kanohi, hui, koha, hui-a-rōpu etc.) and the protocols that go with these (for example, hui is not just a meeting, a focus

group, or a workshop). Kōriporipo is validated by a Māori worldview and is considered in various aspects of the research process.

Te Kōhao o te Ngira (refer figure 2.1) is a methodological process, the name of which is taken from King Pōtatau's vision for Māori unity in Aotearoa/New Zealand (Tinirau, 2004). Te Kōhao o te Ngira supports the application of various research strategies throughout a research project, and is presented diagrammatically below, showing the research process that may be followed. Each phase takes the same route through 'the eye of the needle' (Kaupapa Māori research, based on four key principles of positive contribution, partnership, participation and protection), and the framework identifies that some phases can occur simultaneously, separately or as with consultation, can occur throughout the entire process.

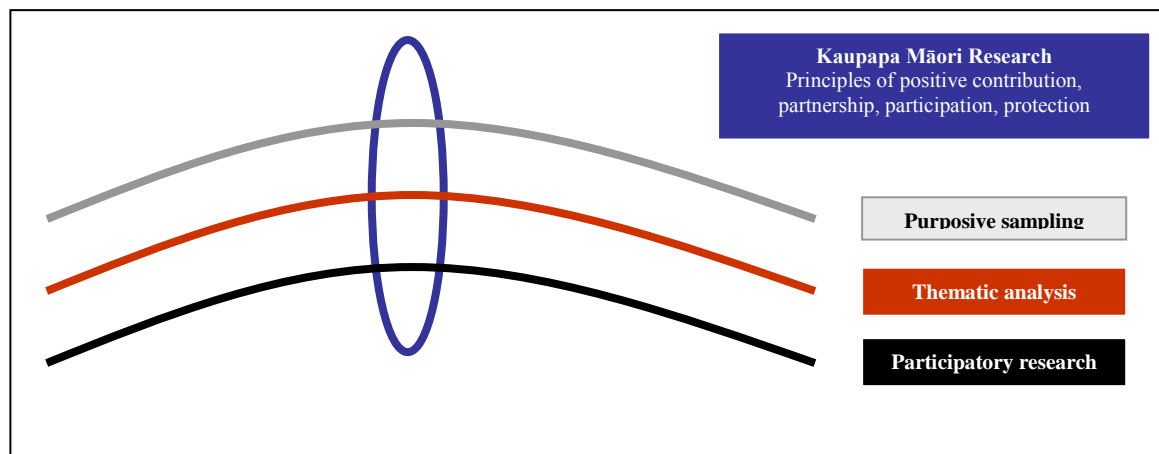


Figure 2.1: a methodological framework for research, epitomised by *te kōhao o te ngira* (Tinirau, 2004, p. 5).

The framework illustrates researcher interaction with Māori people, organisations and their communities, and the approaches made for participation in the research process. The framework highlights the utilisation of the following research methods.

1. A mixture of purposive (Patton, 2002) and network (Te Pūmanawa Hauora, 1996) sampling techniques utilised to select key informants for 'information rich' and 'illuminative' information, the aim of which is to gain insight and meaning from the information rather than empirical generalisation to the population (Patton, 2002);
2. Data organised and analysed using thematic analysis. Thematic analysis focuses on identifiable themes and patterns of living and/or behaviour. The analysis resonates the worldview of the community by involving the community in the analysis;

3. Tikanga Māori places people at the centre of the research, not the process; therefore a large part of the research ensures that consultation is an ongoing part of the process;

Research acknowledges the duality of the roles of the researcher and the researched community, and that ‘intimacy’ can also benefit the research (Walsh-Tapiata, 1998), providing a sense of security and safety for the research partners.

Bishop (1996), in developing Whakawhānaungatanga, a kaupapa Māori research strategy, acknowledged the deconstructing capabilities of kaupapa Māori in relation to hegemonies that have traditionally barred Māori from controlling and defining their own knowledge specifically within the context of unequal power relations in New Zealand (p. 13). He asserts that the Treaty of Waitangi should be seen as the “charter for power sharing in the decision-making processes... and for Māori self-determination”; that there is a responsibility for the non-Māori partner to assist in this process. Further, he contends that research within Māori cultural contexts needs to be part of the contemporary debate in social sciences development because:

The danger of not engaging in the contemporary debate is that Māori concerns and solutions will continue to be dismissed as irrelevant to mainstream. A Māori critical gaze on neo-colonialist practice is uncomfortable for some. However, unless this gaze is firmly positioned within the contemporary debate, it can too easily be marginalised. (Bishop, 1996, p. 69).

Whakawhānaungatanga as a research strategy keeps kaupapa Māori on the agenda in contemporary discussions. It maintains that kaupapa Māori research is located within an alternative worldview and utilises Māori cultural understandings and practice (Bishop, 1996, pp. 66–67). Whakawhānaungatanga comprises three interconnected elements that establish, develop and maintain whānau relationships, participant-driven approaches to power and control, and researchers involvement as lived experience (Bishop 1996, p. 216).

Materialising from the presentation of the approaches and methodological frameworks are a number of elements that have relevance for Māori worldviews, people, Māori research, the natural environment, and cultural identity (table 2.3).

Although a variety of Māori approaches to research have been presented, it is evident that there are more commonalities than differences. For instance, all the approaches advocate as a common goal the creation and diffusion of Māori knowledge; all approaches place Māori people at the centre of the research process. Māori values, beliefs and traditions are given

priority and are implicit in the process. Connections to the natural world are made, and past experiences are acknowledged. The approach taken in this research draws on a Māori worldview and applies many of the aspects described in the Māori approaches outlined earlier.

Table 2.3: Elements of methodology

| Elements of methodology | Explanation |
|-------------------------|---|
| Ngā whakaaro Māori | Māori worldviews and perspectives are prioritised |
| Tangata Māori | Involvement of Māori people are central to the research process |
| Ngā tikanga Māori | Application of Māori concepts and protocols in research eg whakawhānaungatanga, manaakitanga, tautoko |
| Ngā taiao | Connections to the natural environment and settings are acknowledged |
| Whakapapa | Recognition of the biological and kinship links between people |

Strategies of inquiry – quantitative, qualitative, mixed methods

At an applied level of research, three distinct strategies of inquiry provide specific guidance in social science research design and contribute to the overall research approach. Two of these, quantitative and qualitative, continue to be discussed in the literature at some length. However, Crotty (1998) maintains that this should not be the case:

The distinction between qualitative research and quantitative research occurs at the level of methods. It does not occur at the level of epistemology or theoretical perspective. What does occur back there at those exalted levels is a distinction between objectivist/positivist, on the one hand, and constructionist or subjectivist research on the other. Yet in most research textbooks, it is the qualitative research and the quantitative research that are set against each other as polar opposites. (Crotty, 1998, p. 14–15)

The third strategy, the mixed method, has only recently emerged and in doing so adds more fuel to the vigorous debate that takes place in many research discussions. In explanation, Creswell (2003) summarises the three distinct strategies in a simpler way.

Table 2.4: Alternative strategies of inquiry

| Quantitative | Qualitative | Mixed Methods |
|---|---------------------------------|----------------|
| Experimental designs | Narratives | Sequential |
| Non-experimental designs, such as surveys | Phenomenologies | Concurrent |
| | Ethnographies | Transformative |
| | Grounded theory Case studies | |

Source: Creswell, 2003, p. 13.

In quantitative research for instance, Hamilton (1998) points to Descartes' work, *Discourse and Method* (1637) as founding quantitative inquiry when he argued:

that natural philosophy should be refocused around the “certainty and self-evidence” of mathematics and that in the search for truth, investigators should stand back from those elements of the world that might otherwise corrupt their analytic powers... proclaimed the importance of mathematics and objectivity in the search for truth. (p. 116)

The quantitative inquirer in developing knowledge therefore uses the traditional scientific perspectives of positivism/postpositivism where cause and effect relationships are examined, observed and measured, hypotheses tested through experimentation, and theories confirmed or disconfirmed. Data are collected in a standardised manner using predetermined instruments, thereby eliminating biases from entering the results and facilitating an ‘objective’ observation and measurement. The purpose of quantitative inquiry is to explain, predict, and control measured variables: in the main, “numerical data is collected and statistical procedures are used to analyze and draw conclusions from the data”(Leedy & Ormrod 2001, p. 101; Leedy, 2001).

Qualitative inquiry in comparison with quantitative inquiry, presents a multitude of alternative perspectives in developing and generating knowledge. For example, Guba and Lincoln (1994), coming from a strong constructivist position, advocate a naturalistic and interpretive approach advancing the notion of the researcher as ‘bricoleur,’ a “Jack of all trades, a kind of professional do it yourself person” (Strauss in Denzin & Lincoln, 1998, p. 3). Creswell (1998) and Leedy and Ormrod (2001) add that qualitative research is a ‘complex, holistic picture,’ in

that the narratives¹⁶ in qualitative research tend to highlight the multi-faceted aspects of the problem, event, or issue (in the real world) and demonstrates it in all of its intricacies. Qualitative researchers rarely simplify their observations (Leedy & Ormrod, 2001, p. 147). Leedy and Ormrod (2001) describe qualitative research as that which focuses on the complexity of phenomena in natural settings (the real world) seldom simplifying observations and recognising the horde of layers and issues. Denzin and Lincoln (2005) suggest:

Qualitative research involves an interpretive, naturalistic approach to the world... researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (p. 3)

While there are some terminologies common to both approaches, in choosing a qualitative design or strategy the researcher aims to go through the research processes described in the table below.

Table 2.5: Choosing a qualitative approach

| | |
|-----------------------|--|
| Description | Reveal the nature of certain situations, settings, processes, relationships, systems or people. |
| Interpretation | Researcher can gain insight about the nature of a particular phenomenon, develop new concepts or theoretical perspectives, discover the problems that exist within the phenomenon. |
| Verification | Researcher can test the validity of certain assumptions, claims, theories or generalisations within real world contexts. |
| Evaluation | Provide the means through which a researcher can judge the effectiveness of particular policies, practice or innovations. |

Source: Peshkin, 1993 cited in Leedy and Ormrod 2001, p. 148.

The third strategy has been termed ‘the third methodological movement’ or a mixed methods strategy. While many researchers have used mixed methods in research activities during the 20th century it has only been since the 1980s that researchers have started naming their designs in such a unique way (Tashakkori & Teddlie, 2003). This strategy has evolved from the notion of ‘triangulating’ information from different data sources and methodologies, seeking a convergence across both qualitative and quantitative research. Mixing methods and methodologies came from recognition that all methods have limitations; that is, biases are

¹⁶ Narratives in this sense means the writing up of research in each of the five designs: ethnography; phenomenology; grounded theory; case study; and the narrative or biography design.

inherent in any single method, and mixing could neutralise or cancel these biases. Tashakkori and Teddlie (2003) maintain that mixed methodology emerged from the works of Fiske (1998) in psychology, and then Denzin and Lincoln, (1978) in sociology. It is in evaluation and nursing that mixed methodology has been fully applied successfully by researchers Patton (1990) and Morse (1995) respectively. Mixed methodology is most associated with the 'pragmatic' knowledge claim, although the pragmatic claim of knowledge is "dismissed by many as "naive" or "vulgar", an orientation that simplifies highly complex philosophical issues into "what works" (Tashakkori & Teddlie, 2003, p. x). However, there are those that claim mixed methods research has evolved to a point where it is a separate methodological orientation with its own worldview, vocabulary and techniques. These techniques are a unique combination of both quantitative and qualitative research strategies and provide answers to research questions that cannot be answered in any other way, thereby providing better and much stronger inferences¹⁷ based on the researchers "interpretations and expansions of the results" (Tashakkori & Teddlie, 2003, p. 35).

Creswell (2003) provides illustrations of mixed methods research procedures and names these as 'sequential procedures, concurrent procedures, and transformative procedures.' Sequential procedures are where one method is used to elaborate on another method. For example, qualitative exploratory research may be followed by a quantitative method in order to provide the ability to generalise findings to a population. This procedure also works in the reverse. Concurrent procedures are those that combine both quantitative and qualitative research at the same time and then integrate the overall information in the interpretation of the results. Transformative procedures are where the researcher uses one theoretical perspective in a research design that contains both quantitative and qualitative data (p. 16). Table 2.6 summarises procedures that are appropriate to all three strategies of inquiry.

¹⁷ See Tashakkori and Teddlie 2003 p35 for definitions of 'inference' – "Refers to final outcome of a study. The outcome may consist of a conclusion about, an understanding of, or an explanation for an event, behaviour, relationship, or a case".

Table 2.6: Quantitative, qualitative, and mixed methods procedures

| Quantitative Research Methods | Qualitative Research Methods | Mixed Methods Research Methods |
|--|---|---|
| Predetermined instrument-based questions. | Emerging methods open-ended questions | Both predetermined and emerging methods |
| Performance data, attitude data, observational data, and census data | Interview data, observation data, document data, and audio-visual | Both open-ended and closed-ended questions, multiple forms of data drawing on all possibilities |
| Statistical analysis | Data text and image analysis | Statistical and text analysis |

Source: Creswell, 2003, p. 17

This research adopts a Māori worldview as its epistemological base, and therefore kaupapa Māori knowledge claims, methodologies and frameworks are acknowledged as influencing the research process. Māori centred and Kaupapa Māori research takes new paradigm thinking in the form of advocacy/participatory knowledge claims further, in that it allows for a specifically indigenous perspective to emerge with its array of new ideas, concepts, and theories. A feature of Māori centred and kaupapa Māori research is the anticipation and encouragement of diversity and flexibility; therefore the patterns and themes that emerge are not prescribed as such but evolve from the process. Further, the emergent nature of these approaches take account of ‘views and perspectives of groups and individuals’ enabling specific guidance in the process and in the determination of ‘what conclusions can be established’ (Kingi, 2002, p. 74) from the research. In this research the methods and techniques used, while not specific to Māori, are applied from a specifically Māori perspective. For example, the appropriate use and understanding of te reo and tikanga Māori permeates the entire process and is harnessed using a qualitative research strategy, a case-study approach, to examine phenomena and their complexities in a natural setting.

Research approach

Case-study research has been prominent in the development of fields such as anthropology, sociology, psychology, political science, social work, management, and more recently in education. It is particularly useful in the description, exploration and explanation of processes and the dynamics of practice, offering insights into practice that have proved helpful by

informing policy. Case-study research has been used extensively in nursing and evaluation and as such is a legitimate methodological option in the design of research. A qualitative case study approach to research emanates from a holistic perspective, and in this sense is consistent with a Māori view of the world. In developing a case-study research design the researcher aims to gain an in-depth understanding of the phenomena and their meaning. The focus of case-study research tends to be on process rather than outcomes, context versus specific variables, and discovery rather than confirmation. Providing such insights into aspects of practice can have a direct influence on policy, practice and future research. As a research approach, case-study methodology is particularly suitable for dealing with critical problems of practice and policy, thereby extending the knowledge base of various aspects of development, education and training (Merriam, 1988).

Merriam (1988) states that “a qualitative case study is an intensive, holistic description and analysis of a bounded phenomenon such as a program, an institution, a person, a process, or a social unit,” and argues for case study as a specific genre of research incorporating its own set of data collection and analysis techniques (pp. xii–xvii). Other researchers such as Smith (1978), Stake (1978, 1995, 2000, 2003), and Yin (1994), for example, agree in defining case study as ‘a bounded system’, with integrated parts. Further, according to Guba and Lincoln the end product of a case study is a ‘thick description’, an interpretation of the meaning of data in terms of “cultural norms and mores, community values, deep-seated attitudes and notions” (cited in Merriam, 1988, p. 11.). Considering aspects of culture, values, perspectives, social issues and notions implies the inclusion of any number of variables in a case and, therefore contributes to its complexity. Stake (1995, 2003) advocates the inclusion of a wide range of variables and issues because the aim of case-study research is to gain in-depth understanding that focuses on the particular or uniqueness of the case:

the real business of case study is particularisation, not generalisation. We take a particular case and come to know it well, not primarily as to how it is different from others but what it is, what it does. There is emphasis on uniqueness, and that implies knowledge of others that the case is different from, but the first emphasis is on understanding the case itself. (Stake, 1995, p. 8)

While researchers agree that statistical generalisation is not the aim of case-study research, there can be analytic generalisation to previously developed theory where the empirical results of the case study are compared and replication is claimed if two or more cases support the theory (Yin, 1994, p. 31). Stake (2003) provides yet another mode of generalisation he calls naturalistic generalisation, where the reader of the case study “comes to know some things

told, as if he or she had experienced it. Enduring meanings come from the encounter, and are modified and reinforced by repeated encounter” (p. 145). Thus readers’ similar understandings and experiences add to the face-validity of the generalisations or assertions being made from the case. Located within a Māori centred and kaupapa Māori knowledge claim, therefore, case-study research adequately facilitates the incorporation of Māori cultural representations such as oral testimonies, values, experiences, traditions, beliefs, and language, throughout the process, and provides a methodologically disciplined arena for Māori research.

Case recruitment and selection

Robert Stake in discussing case selection in collective case studies, warns that:

case study research is not sampling research. We do not study a case primarily to understand other cases. Our first obligation is to understand this one case... the case is pre-selected... selection by sampling of attributes should not be the highest priority. Balance and variety are important; opportunity to learn is of primary importance. (Stake, 1995, pp. 4–6; 2003, p. 153)

In identifying the determinants of quality Māori health workforce development, Māori approaches and methodologies such as Kōriporipo, guided the case selection and recruitment for this study, not to ensure attributes were included but to ensure cases were selected to provide ‘balance,’ ‘uniqueness,’ ‘experience,’ and ‘variety’ and to demonstrate a process based on Māori philosophies and concepts.

Research methods

Given the implicit notions in relation to a Māori worldview and the theoretical framework under which this research programme was undertaken combined with a case study research approach, a multiple-methods approach was utilised to meet the objectives of the research. The use of multiple methods for data collection is a major strength of case study research. For instance, a multiple-methods approach allows for methodological triangulation to occur by combining different methods such as document reviews, interviews and observations in the study. In most instances the methods have a balancing effect, through which the flaws of one method are the strengths of another so that the best of each is highlighted, cancelling out any perceived deficiencies (Denzin, 1970 as cited in Merriam, 1988, p. 69).

Methods used in this research programme are first summarised on the next page in table 2.7 and summarised at the end of the section in table 2.8.

Table 2.7: Generic research methods

| Worldview | Purpose | Focus | Methods of data collection | Methods of data analysis |
|---------------|---|---|--|---|
| Kaupapa Māori | To understand Māori cultural specificities, preferences and practices | Māori individuals, groupings, whānau, hapū and iwi. Being Māori is a human right. Autonomy and control is recognised | <ul style="list-style-type: none"> • observations – iwi affiliations, language, culture and researcher participation • surveys – language • interviews – face to face, structured and unstructured • documents • audio-visual • oral – personal communication, views | <ul style="list-style-type: none"> • interpretation acknowledges insider outsider status, validity and legitimacy of the research is taken for granted. Methods of analysis are culturally appropriate |
| Māori centred | To understand the gains required as Māori in advance Māori development | Māori and their experiences are central to the research. It does not ignore methods and expertise from a western paradigm | <ul style="list-style-type: none"> • as above • structured or unstructured interviews with informants • document analysis and collection | <ul style="list-style-type: none"> • as above but there may be instances where other perspectives may influence the analysis |
| Design | Purpose | Focus | Methods of data collection | Methods of data analysis |
| Case Study | To understand one person or situation (or perhaps a very small number) in great depth | One case or a few cases within a natural setting (its) | <ul style="list-style-type: none"> • observations • interviews • documents • audio-visual | <ul style="list-style-type: none"> • categorisation and interpretation of data in terms of common themes • synthesis into an overall portrait of the case(s) |

Source: Adapted from Leedy and Ormrod (2001) Practical Research : Planning and Design p. 157.

The methodological elements presented earlier – ngā whakaaro Māori, tangata Māori, tikanga Māori, ngā taiao and whakapapa underpin the practical application required in the research process.

Tono – recruitment and selection processes

The tono process has a dual orientation. The first part involved identifying appropriate programmes and or organisations, and individuals to participate in the research programme. This was accomplished with guidance from colleagues and supervisors. The second part was initiated after appropriate case study sites had been identified and involved a formal process of inviting participation. This required a personal visit to the selected case study sites to provide information about the research, explain the purpose of the overall research programme, and provide opportunity for selected participants to ask questions about the research. It was pointed out to the prospective participants that:

- there would be personal academic gain and ensuing benefits for the researcher – it was important to be honest and open with prospective participants at the outset because the researcher was aware that Māori communities experiences of research in the past had not been positive for many (Smith, 1999; Durie, 2005) with mainly non-Māori researchers not indicating the gain they would personally receive.
- that the research would likely contribute to ongoing Māori health development and advancement - It was important to explain how the research might contribute to overall Māori health development and in what ways this case study, programme, or the work they were involved in would contribute to Māori advancement in general.
- that the research would contribute Māori knowledge- it was highlighted to prospective participants that input into the research programme would be invaluable and likely to generate new knowledge adding to an expanding Māori knowledge base.
- that their programme or organisation possessed specific and unique characteristics that enabled Māori health workforce development and that these characteristics should be explored to determine the potential contribution to Māori health workforce.
- that Māori cultural perspectives would be an ongoing feature of this research programme. This research intended to be a positive contribution to overall Māori development and advancement.

Whakawhānaungatanga

There are some aspects of research that can occur separately from others or simultaneously. Whakawhānaungatanga in this research programme was evident in several aspects and stages throughout. It is one of the most powerful of Māori concepts because it connects people to each other and people to the natural and spiritual environments. The concept of whakawhānaungatanga brings into the research arena the connections and access to case study participants and other key individuals in a myriad of ways. For example, through whānau, hapū, iwi affiliations, networks, collaborations, collegial relationships, coalitions, alliances, partnerships – resulting in meaningful engagement and interaction. Whakawhānaungatanga in both a broader non-kin sense and a biological sense played a major role in this research programme.

Tirohanga – observations and participation

In this research programme there was opportunity to observe participants on more than one occasion and in more than one context. All interviews took place on each case study site, and the researcher was later invited to spend time in the field with various participants. This gave the researcher the opportunity to observe participants in their work roles. Each evening, after a day in the field, notes were written and compared with any notes taken during the day. Observations confirmed much of the data gathered through the interviews, especially where it related specifically to work. Observations were later compared with the document and literature reviews.

An advantage of direct observation is that the researcher as an ‘outsider’ is more likely to notice things that may have become routine to participants but may advance a deeper understanding of the context. In seeing things firsthand, researchers are presented with the opportunity to use their own knowledge, experience, and expertise in interpreting what has been observed. Further, observational techniques generate data that relate directly to typical behavioural situations, which enables the recording of the behaviour as it is happening (Stake, 2003; Yin, 1994).

Hui – meetings, events, consultation

Once the tono and whakawhānaungatanga processes had begun there was opportunity for the researcher to discuss with supervisors and case study participants appropriate meeting times

and other events to attend that were relevant to the research programme. These included seminars, workshops, marae openings, conferences, symposiums, colloquiums, and appropriate wananga. It also provided an opportunity at the beginning to consult with participants, gaining insight into their views of the research parameters.

Kōrero-a-tahi – communication and interviews

The research programme required that open lines of communication be established at the outset to provide transparency and integrity with both the case study organisation and individual participants. This, it was decided would be beneficial particularly during the interviewing process to ensure that the focus of the research stayed on workforce development and those aspects of the organisation that influenced the workforce development initiative. Kōrero-a-tahi ensured that whakawhānaungatanga between individual participants and the researcher could also be established and acknowledged prior to the interviews taking place in an environment of the participant's choice.

Face-to-face interviewing provided the primary mode of data collection for this research programme. An interview schedule with identified themes¹⁸ guided the in-depth, open-ended, conversational style interviews with participants. In using a less structured format, participants were given the opportunity and encouraged to articulate their own unique perspectives in their own way. Thus, while providing guidance in relation to the issues and questions that needed exploration, the interview schedule allowed the researcher to respond to the emerging views of the participant, probing where appropriate for clearer understanding of specific views. In this sense, the interview schedule meets the objectives of case study research in that the focus is on understanding the 'uniqueness' or the 'particularity' of the case study. On the other hand, a structured interview, although it has advantages of uniformity, focus, and common vocabulary, may have imposed the researcher's perceptions of organisation and categorisation of data.

Whāngai Pānui - document review

The case studies selected for this research programme were unique and diverse. Two were education and training workforce development programmes and based within higher

¹⁸ Themes for the interviews were identified from gaps in an early search of the literature at the beginning of the study.

education institutions; Massey University and the University of Auckland. One of the case studies was based within a Māori health and social service provider, which offered on the job workforce development training and upskilling. The fourth case study offered the opportunity to explore a specific occupation within a quasi-government agency; a district health board. The case study organisations are summarised in table 2.7.

This research programme makes a distinction between the types of literature that were reviewed. Document review refers to documents produced or generated for the case study organisation (case) by the case study organisation. These documents are not produced specifically for the purposes of research but they provide the researcher with valuable information about the organisation or the programme under study. The documents tend to stimulate thinking in questionnaire or interview schedule development. The types of documents referred to in this research include training manuals, organisation constitution, rules and regulations, recruitment procedures, operational guidelines, funding contracts, budgets, job specifications, newsletters, brochures, vision statements and the aims and objectives of the organisation and specific programmes. For each case study participant organisation, a review of a wide range of organisational literature was undertaken to gain a general understanding of the organisation and its overall activities, including the programme of study and its intended 'fit' in the organisation. For instance, in one of the workforce development cases, the programme itself assisted in the establishment of the organisational infrastructure.

As organisational documents are not prepared or developed for research purposes there are limitations in relation to their completeness and are difficult to assess for their usefulness, authenticity and accuracy. However, if the documents are referred to by the organisation in daily practice they can be considered useful to the research programme because they exist and are used independent of the research.

Whāngai Pānui - literature review

Alongside the document review, a comprehensive review of other literature in relation to Māori health research specifically and Māori development generally was carried out to inform the research programme. The need to search the literature more broadly was a result of the scarcity of literature on Māori health workforce development. Literature search and assessment for relevance therefore became ongoing processes throughout the research

programme. Rather than have a dedicated chapter on literature, each chapter incorporates its own strand of literature. Some chapters required access not only to local and national library databases but also to international bibliographic databases. Again, previous research on programme evaluations and surveys was available and provided a source to corroborate data collected from interviews and other public documents. As a result, a wide range of literature was assessed, sorted and stored for later retrieval using a computer software package (see next section).

The document and literature reviews provided historical background for both the overall research and the individual case studies. Face-validity was achieved when documents were combined or compared with other data sources such as interviews and observation. Many of the public documents, such as the New Zealand Health Strategy, the New Zealand Disability Strategy, the Māori Health Strategy – He Korowai Oranga, Whakatātaka – the Māori Health Action Plan 2002–2005, and Raranga Tupuake – Māori Health Workforce Development Plan 2006, were primary sources.

Whakarongo – listening and recording

Listening skills are an important part of the research process. During the interview process listening for voice intonation and other verbal nuances provide a space for further probing of issues and clarification of points raised by the participants'. Interviews during the research process were audio-taped, given a reference number and then transcribed verbatim in Microsoft Word. When all interviews for each case had been transcribed, each was checked for spelling in preparation for transferring data into a format that could be read by a computerised qualitative software analysis programme (see later section on Qualitative Data Analysis).

Ngā Taputapu Awhi - technologies and innovations

The researcher took advantage of and made use of computer technology and innovative computer software packages to manage data and information collection and retrieval.

The Endnote bibliographic software package simplified the management of the literature in one database, enabling references, citations, notes, programme documents and other media to be stored securely on hard drive or on portable computer media for easy transportability. Features of this software include coding and cataloguing, the ability to 'cite while you write'

and the automatic provision of a list of references for a piece of writing currently being worked on. Endnote also has the ability to import references from other databases and libraries allowing the sifting and sorting of references at times to suit the user. Installed in Endnote is a large number of referencing styles unique to various disciplines so that the user can change the referencing style to suit the type of academic writing, for example, from a scientific writing style to the American Psychological Association (APA) requirements for this thesis.

Whakaaro-mai-tanga - qualitative data analysis

In this research, programme data collection and analysis were ongoing processes, beginning with the first piece of literature, the first interview, and the first observation. These initial activities provided clues and raised more questions, and stimulated an eagerness to delve further, to refine, and to reformulate questions. From these experiences it became evident that qualitative research is not a linear process – data collection activities and analysis occur concurrently. Thus “data analysis is complex and involves moving back and forth between concrete bits of data and abstract concepts, between inductive and deductive reasoning, and between descriptive and interpretation” (Merriam, 1988, p. 147). To help the analysis process and to ease data management, a computer-based qualitative content analysis tool was used. HyperRESEARCH eliminated the repetitive, labour-intensive aspects of traditional qualitative research methods of analysis. Traditionally, researchers would gather data, transcribe the source materials, make multiple photocopies of the text, assign codes, cut pages into coded passages or themes, and manually sort the coded texts. However, once source materials are in a readable format (text only documents), HyperRESEARCH allows:

- the coding of any amount of data any number of times,
- retrieval and manipulation of portions of coded source material,
- the testing of propositions about the data on any code or combination of codes using Boolean searches (operators AND, OR and NOT),
- the testing of hypotheses about the overall meaning of data using artificial intelligence.
- the printing, importing or exporting of retrieved data. (Hesse-Biber, Kinder, Dupuis, Dupuis, & Tornabene, 1994, pp. 1-1–1-3)

While HyperRESEARCH has reduced much of the labour-intensive aspects from data analysis, the final write up of the findings and the assertions and conclusions made required

more conventional approaches. Providing space for Māori perspectives in the analysis guided by themes emerging from literature, data and information collected through the research process.

Using such a powerful tool in many ways eliminates issues of data quality in relation to researcher bias and evaluative judgements. For instance, triangulation is made easier, replication is facilitated, generalisations can be made because there is the ability to determine which properties are shared and therefore presented in a broader context. Overall, HyperRESEARCH enhances the reliability of the findings because all coded material is presented simultaneously for analysis; the computer does not omit any coded data (Hesse-Biber et. al, 1994). Further, verbatim quotes from participants and those quoted directly from the literature are indented from the text, and parenthesis [] have been used to show researcher input.

Table 2.8: Summary of thesis research methods

| Method | Description |
|--------------------------------|--|
| Tono | Appropriate recruitment and selection methods combining Māori methodological frameworks such as Kōriporipo |
| Whakawhānaungatanga | Developing connections with groups through whānau, hapū, iwi affiliations. Accessing and developing networks, coalitions, alliances, collaborations, partnerships, and meaningful engagement |
| Tirohanga | Observations and participation in case study site visits |
| Hui | Meetings and consultation in relation to research parameters. |
| Kōrero–a-tahi | Communication channels established. Interviews conducted kanohi-ki-te-kanohi (face to face) in participants preferred environment. |
| Whangai panui | Literature, documents, reports and media samples reviewed |
| Whakarongo | Listening and recording of data |
| Ngā Taputapu Awhi | Combining the use of new technologies (computers etc) and innovations (new computer software) within the research |
| Whakaaro-mai-tanga | Māori analysis guided by themes emerging from literature, and data and information collected through the research process. |
| Methodological Elements | |

Ethical issues

In qualitative case-study research, ethical issues are likely to arise during the collection of data and in the dissemination of the findings. To ensure an ethical approach, the researcher provided each participant with an information sheet briefly describing the research and outlining the obligations of both the researcher and the participant. Further supplementary information was provided verbally, and participants were given an opportunity to ask more questions of the researcher. Consent forms were given to participants for signing only when the researcher was sure that the participant was fully informed. Confidentiality and safety of participant participation was discussed at length, and agreement was reached in relation to confidentiality of information provided by participants. The interviewing process discussed in an earlier section and in the Māori maintenance section that follows, ensured a comfortable and respectful environment for the participants so that they had control over their own self-representations. To prevent any effects that sometimes come with in-depth (ie the length of time eg 1-3 hours) interviews, and site participation, an interview schedule that incorporated the themes was used to guide questioning and probing.

Observations have their own ethical pitfalls such as privacy and informed consent. In this instance, the researcher was invited to observe participants in their daily work activities and interactions, which was offset by an undertaking on the part of the researcher to maintain an on-going feedback loop in relation to aspects of the data that required further clarification. A major issue in terms of observation is when to intervene, especially when the researcher has observed behaviour that is inappropriate, illegal, dangerous or exploitative. In this programme of study the researcher did not observe such behaviours. Interview data in this programme have not been used for any other purpose nor provided to other researchers to undertake secondary analysis.

Dissemination of findings from case-study research presents problems of anonymity because it is virtually impossible to protect the identity of the case and the people involved. Exposure through publication may present several risks, such as the danger of presenting the case in an offensive manner resulting in unwanted publicity or of exposing participants to legal, institutional, or governmental sanction because of observations or revelations from participants during interviews. It is intended that any publications, single or jointly authored by the researcher and participants, oral or written, will be offered to participants to ensure appropriate review.

Māori maintenance issues

The philosophical underpinnings of this research emanate from a distinctly Māori worldview locating Māori culture at the core of Māori perceptions and experiences. As such there was an obligation for the researcher to ensure that Māori custom, beliefs and values were not only presented in the research but were transparent.

Cultural support during the research came from three known experts. Two were kaumātua and women, both of whom had iwi, hapū and whānau relationships with the researcher. The third cultural supervisor was male and well known nationally for his cultural expertise. All three were experts in Te Reo and tikanga Māori generally.

All participants were interviewed kanohi ki te kanohi (face-to-face) by the researcher at their place of work in their own offices or a private space set aside specifically by the programme managers. One interview was carried out in the researcher's office at the participant's request. After interviews, the researcher was invited to spend as much time as necessary in the field with participants.

To create a comfortable and communicative environment for ease of conversation with participants before the interview started, the researcher established iwi, hapū and whānau links either to the participant or a person or persons known to both the researcher and the participant. At these times both Māori and English were used. The purpose of the interview was explained and the research described to the participant. The researcher was prepared for formal Māori protocols such as powhiri, mihimihi, waiata, and karakia.

The case studies

The case studies in this research programme are summarised in Table 2.9. The four case studies are presented in Chapters 6-8 of this thesis.

Table 2.9: Case study summary description

| Case Study | Description | Organisation |
|--------------------------|---|---|
| Vision 20/20 | A programme designed to increase Māori participation in medical and allied health professions –Chapter 6 | University of Auckland, faculty of Medicine and Health Science, Department of Māori and Pacific Health |
| Health Protection | An exploration of a specific health occupation to assess potential Māori participation and vocational choice – Chapter 6 | Ministry of Health, Public Health Section, District Health Boards New Zealand, City and Regional Councils |
| Tipu Ora | A Māori community workforce development training initiative within a Māori provider of health and social services – Chapter 7 | Tipu Ora – Well-Child And Whānau Facilitation Service |
| Te Rau Puawai | A programme designed to provide access to/or increase academic educational qualifications of Māori community health workers - Chapter 8 | Massey University, College of Humanities and Social Sciences, Te Pūtahi-ā-Toi, School of Māori Studies |

Conclusion

This chapter has provided a comprehensive discussion of the Māori knowledge claims, strategies, perspectives, methodologies and approaches that underpin this research. Five critical elements relevant for Māori research have been identified from the literature and incorporated into the research. Therefore methodologies utilised prioritise Māori worldviews and perspectives, Māori people are central to the research, Māori concepts and protocols are integrated into the research, connections to the natural environment and settings are acknowledged and, biological and kinship links are recognised. In addition Western strategies of inquiry, particularly case study research is employed alongside kaupapa Māori approaches to identify and provide an in-depth understanding of distinct Māori approaches that will advance Māori health workforce development and contribute to positive Māori development.

Chapter 3

CONTEMPORARY MĀORI DEVELOPMENT

*Our future lies behind us*¹⁹

Introduction

To understand and appreciate the complexities surrounding Māori development in the 21st century and beyond it is necessary to look back to understand the past, as it illuminates the present, and points the directions for the future. In this sense, Māori development has an historical background, a whakapapa that cannot be dismissed because it acts to ground and focus the future. Māori development should also not be restricted to one paradigm, context or set of circumstances (Puketapu, 2000), neither can it be placed solely in specific time periods. In general, though, Māori development focuses on economic, social, political, and cultural dimensions of development and can therefore be described as an ongoing process where Māori well-being and Māori resource growth, that are inclusive of self-management and control, and positive Māori advancement, are the ultimate goals. This chapter explores and focuses on contemporary Māori development, specifically the period 1984–2004. At Hui Taumata 2005 Government agencies were requested to provide hui participants with Māori statistical data and information relating to the period 1984–2004. This information provides a contemporary picture of Māori development within this time period.

Background to contemporary Māori development

Government policies that have benefited Māori and enabled development have emerged in the main from official inquiry, political protest, and Treaty of Waitangi claims. The Hunn Report of 1961, for example, emerged from official inquiry. The Report emphasised the extent of disparities between Māori and Pākehā despite the welfare state policies of equality. Later, in 1986, an inquiry into the practices of the Department of Social Welfare resulted in a report *Puao-te-atatu*, which exposed the practices of institutional racism embedded within the Department. The Report led to similar formal and informal reviews of other Government

¹⁹ This saying comes from the Foreword of Asher and Naul's planning paper No. 29 (1987), *Māori Land*. Edward Durie explains this phrase as one that encapsulates the Māori world view in that the authors have turned to the past to explain the present and pose the questions for the future.

departments, such as health, education and justice, which were also found to be operating under the same ideology as the Department of Social Welfare (Durie, 1998a; Durie, 2005a).

Māori political protest also became a feature of this period, for instance, the Māori Land March of 1975 brought attention to legislation that continued to alienate Māori from their land. At the same time, Ngā Tama Toa – a group of Māori University students – joined the Māori land march to Wellington and exposed other issues of Māori discontent highlighting the Crown's obligation to protect and support te reo Māori; they also drew public attention to the treatment of Māori in the court system. Results of their protests include the use of Māori language interpreters in the courts, the introduction of te reo Māori into the secondary school curriculum in 1976, and Māori language week. Two years later in 1977, Bastion Point, at Orakei, became the focus of Māori protest, and again Government disregard of Māori land rights was the issue. The protest was in the form of land occupation and lasted for 506 days (Walker, 1990; Durie, 1998a).

Māori political protests have become a regular feature of Waitangi Day. Each year it provides the opportunity for many Māori to voice their discontent in relation to a number of issues, although the main issue is the Treaty of Waitangi itself or rather the failure of successive Governments to honour the Crown commitment to the Treaty (Walker, 1990; Ratima, 2001). Ratima (2001) maintains that Māori political activism, with some assistance from trade and workers unions, has played a major role not just in Māori development but also in Māori advancement:

the relative disadvantage experienced by Māori, and a lack of control over their own affairs as a result of the perpetuation of historical injustices, alongside the growing momentum of social movements worldwide, provided the backdrop for Māori political activism of the 1960s and 1970s. (Ratima, 2001, p. 52)

A more recent protest march (hikoī) took place in April and May of 2004 as a result of proposed legislation involving the New Zealand foreshore and seabed. An estimated 20,000 Māori and non-Māori opposed to the proposed legislation came from north and south, and converged in Wellington on Wednesday, 5 May 2004, to walk from Te Papa Tongarewa to Parliament grounds. Again, the issue was land ownership; in particular the foreshore and seabed of New Zealand's coastline (Mulholland, 2005/2006). Furthermore, Waitangi tribunal claims such as Motonui, Kaituna and Manukau Harbour also had a strong role in raising the awareness of the wider community of Māori cultural values and links to environmental

concerns and lead to the inclusion of Māori environmental perspectives in government environmental policy.

Urban Māori migration

After World War II workers were required for current and new industries in New Zealand towns and cities. Māori were encouraged to leave the rural areas and take up jobs in the cities, working in the expanding manufacturing sector, in factories and in meat processing plants where no or low skills were required. Large-scale Māori migration to cities occurred from the 1950s through to the early 1970s. As Māori earnings were comparatively good, despite low levels of education, there were low incentives for Māori to improve their skill sets (Ringold, 2005, p. 14). By the 1980s Māori were almost at full employment but were grossly over represented in unskilled occupations as labourers and were vulnerable to sector restructuring as a result of the 1980's economic recession. Going back to the rural areas abandoned 30 years earlier was not an option for most urban Māori, some of whom were now second and third generation migrants, separated from whānau, hapū and iwi not only in a physical but also in a spiritual sense. For a number of Māori living in urban areas, links to their rural areas had diminished or were minimal; and rural circumstances were not necessarily any more favourable than urban circumstances. Urban living became a new Māori reality and required the development of new policies, strategies and structures to address socio-economic problems.

Devolution

The intent of the public sector reforms was to separate the policy and operational functions of Government departments. There was no doubt that Māori were keen to see the Government follow through their policy with the endorsement of supporting traditional “iwi structures to bring about appropriate policy development and delivery of services for Māori communities.” (Minister of Māori Affairs, 1988, p. 4). However, while Māori generally supported the intentions of the new policy, many remained dubious about the capacity of other government agencies “to respond sensitively to Māori issues given their record over many years” (Minister of Māori Affairs, 1988, p. 4). In view of these concerns, Māori maintained that the Department of Māori Affairs should remain, albeit in a restructured form. *Te Uripare Rangapu* (1988) outlines the Government's proposal for devolution of the Department of Māori Affairs. These objectives were to have a profound effect on Māori development during the

next decades. The objectives clearly resonated a commitment to honouring the principles of the Treaty of Waitangi; reducing inequities and inequalities in education, health, housing, income, employment, and the social and cultural well-being of Māori and that of non-Māori; supporting the achievement of Māori aspirations by providing opportunities for Māori economic development; ensuring Treaty of Waitangi grievances were dealt with fairly, justly and expeditiously; providing for an equitable allocation of resources to contribute to the development of Māori language and culture; promoting opportunities for Māori participation in policy, planning and decision making; and providing for and encouraging Māori participation in the political process (Minister of Māori Affairs, 1988).

In 1989 two separate organisations emerged and replaced the Department of Māori Affairs. The first of these was the Iwi Transition Authority whose function was to reinforce and support the devolution process, helping iwi prepare to take up their new roles as asset managers and service providers. The second organisation, the Ministry for Māori Affairs, became a policy agency. Devolution of the Department of Māori Affairs was to be phased in over a 5-year period, with a target date of 1994, and while the new National Government dis-established the Iwi Transition Authority when it came into office in 1991, responsibility for services delivery continued to devolve to iwi (Ringold, 2005). The Ministry for Māori Affairs was renamed the Ministry of Māori Development, Te Puni Kōkiri, and became an agency for Māori policy development and state sector monitoring. The Treaty of Waitangi State Enterprises Act and Amendment Bill were introduced along with the Māori Trust Board Amendment Bill, the Orakei settlement, and Māori Fisheries Bill. Proposals were made to transfer the Māori Land Court to the Department of Justice, and government agencies were to become more responsive; thus beginning the 5 years of transition, during which time Māori perspectives in the public sector emerged and were embraced.

The devolution process was not advantageous for some iwi groups. By 1988 the New Zealand economy was in recession and other issues had become more pressing. However, the Government was keen to “help iwi restore their independence... develop their own structures... administrative and negotiating processes, and measures of performance” (Minister of Māori Affairs, 1988, p. 5). Government focus was on enabling iwi to “become independent and self-sustaining” (Minister of Māori Affairs, 1988, p. 5). The key task of the Iwi Transition Agency during the 5 years of transition was to provide assistance to iwi in

building their capacity and capability at an operational level, thus enabling iwi to deliver services to their own people.

Devolution occurred in other sectors as well. For example, in education the new Ministry of Education became a policy development agency and much of the administration of schools passed to the communities, though Government retained a high measure of oversight, and curriculum control (Minister of Māori Affairs, 1988). The separation of policy from operations occurred across sectors. Many Māori saw devolution as an opportunity that would lead to greater self-sufficiency, higher levels of participation and responsibility and autonomy. Others saw devolution as a government mechanism for economic reform and an abdication of responsibility for Māori affairs (Durie, 2005a).

A number of events occurred that were to have a profound affect on Māori development. Hui Taumata 1984 (Māori Economic Summit) established a ten year development plan with a specific focus on iwi development (this is discussed in more detail in a following section). The Te Māori exhibition 1984, facilitated significant changes and a more collaborative style of management between Māori communities and art galleries/museums. It provided a positive international appreciation of Māori experience, art, culture and language. In 1985, the jurisdiction of the Waitangi Tribunal was extended to include the hearing of claims against the Crown dating back to 1840. *Puao-te-atatu*, a document released in 1986, called for consideration of Māori whānau being involved in the care and protection of tamariki (children). In 1987, Te Taura Whiri i te Reo Māori (Māori Language Commission) was established and Māori became an official language of New Zealand.

In addition, in 1988, *He Tirohanga Rangapu*, a discussion document that proposed ways in which the Government could improve the delivery of programmes and services to Māori communities, was released. Matua Whangai, a child youth and family support service, Mana Enterprises, a programme that encouraged Māori business formation and expansion, and Maccess, a Māori training for youth employment programme were all 'by Māori for Māori' programmes and considered to be consistent with the objectives outlined in *Te Urupare Rangapu* (Ministry of Education, 1991; Te Puni Kōkiri Ministry of Māori Development, 1996; Durie, 2005a). Also in 1988 the Poutama Trust, which focused on Māori business development was established.

Specific ‘by Māori for Māori’ programmes

Urban migrations from 1950-1970 had a dramatic impact on traditional Māori family units and required the development of new policies, strategies and structures to address socio-economic problems. Numerous Māori development strategies also emerged from the Government’s devolution policies. But, in the early 1980s it became apparent, particularly in Auckland, that urbanisation had been followed by social unrest for second and third generation migrants. Many people believed that the social problems urban Māori were experiencing were directly attributable to the breakdown of traditional whānau and hapū links, given that many people were unable to apply these links in a city environment (Waitangi Tribunal, 1998). For example, while unemployment was not an issue at the time, mortgage repayments and housing, budgeting for food and clothing, excessive alcohol consumption, parenting and child care had become issues of concern. Much of the usual whānau support that would have enabled resolution of these issues, such as kaumātua, extended whānau members and collective resources, remained in the rural areas and contact if any was limited.

As a result of the move to the cities and the fact that both parents could well be working meant children often went without proper food and appropriate before and after school care. This situation impacted on the health of children and on their school attendance, and ultimately on Māori educational achievement. Because there were plenty of jobs, children were encouraged by their families to leave school as soon as they were able and find employment. Even schools encouraged employment rather than further education and made little attempt to keep Māori children in school once they had turned 15. Therefore, many children left school without even minimum formal qualifications to find employment. These employment destinations were concentrated in sectors that required low or no qualifications and or skills (Waitangi Tribunal, 1998; Ringold, 2005).

The late 1970s and early 1980s also saw the emergence of gangs, children of people who had migrated to the urban areas in the 1950s and 1960s, for example, the Mongrel Mob and Black Power, whom many describe as a ‘product of the breakdown of whānau links’ (Waitangi Tribunal, 1998, p. 36). Many people believe (Waitangi Tribunal, 1998) that for these children the establishment of the gang was a way of recreating a collective structure that had similar collective support systems to that of whānau. Interaction with the law and court system became a normal occurrence for many of these families.

Māori communities responded to the social disorder and breakdown in a variety of ways. First, Māori committees were established under the Māori Welfare Act 1962 in the urban areas of Auckland where Māori populations were high. The committees operated at a community level with volunteer workers supporting parents and children in the Courts:

Family group conferences were initiated by Māori committees, well before they became formalised in law under the Children and Persons and the Families Act 1989. (Naida Pou, cited in Waitangi Tribunal Report, 414, 1998 p. 37)

Other initiatives included the promotion of tikanga and te reo Māori, horticulture, business, health, education and attempts to address Māori social needs. All these were undertaken from a Māori cultural perspective that was more holistic, that is, that catered to the whole person including whānau and environment. Much of the work undertaken by these committees was alongside other groups such as the Māori Wardens, and the Māori Women's Welfare League. Their common ground was the fact that they all believed Māori culture, iwi, hapū and whānau structures and tradition had a place in the cities. Some 30 or more years earlier the idea had been mooted for a marae that would support and provide a place for Māori living in the city, a place with which they could identify. With support of prominent Pākehā, Hoani Waititi marae was built. It was pan tribal, for people who could not readily gain access to their ancestral marae. Most notable is the way Māori adapted and transferred their kinship roles and responsibilities to people who were non-kin. Hoani Waititi marae became the linchpin that united and bound them together. There are generations of Māori who know no other marae, and feel more connected to urban marae than to those distant marae that were once 'home' to their parents and grandparents (Waitangi Tribunal Report, 414, 1998).

In 1978 the Department of Māori Affairs introduced the Tu Tangata programme, the aim of which was to assist Government and non-government agencies to acknowledge and recognize how Māori communities might position themselves to face the future. The Kōkiri Community Administration Programme aimed to support Tu Tangata by facilitating the devolution of decision making to Māori communities. A number of Kōkiri (activity or work centres for community committees) centres were set up around the country in urban areas with large Māori populations. Kōkiri provided an avenue for many urban Māori to participate in decision-making as well as a venue for a wide variety of programmes from education to training in Māori cultural arts and crafts.

Many urban groups with kōkiri centres formed trusts and worked co-operatively with other groups to deliver social services to their communities; some choosing to use the centres as a base for their operations. It was this environment that facilitated the emergence of Te Whānau o Waipareira Trust as an umbrella organisation to which various other groups became affiliated while maintaining their own independence. The objective was to strengthen the then “loose open forum community structure,” bringing resources together and allowing the organisation to take a stronger more stable advocacy stance, particularly in political and commercial issues. Taking a collective, consensual and coordinated approach to issues affecting the community was also perceived as the best way in which to access funding for the provision of a variety of services in the community (Waitangi Tribunal, 1998, p. 43).

In 1983 Matua Whangai, a joint venture between the departments of Māori Affairs, Social Welfare, Justice and Māori communities was piloted and then implemented nationally in 1984. Essentially, a child youth and family support service, Matua Whangai emerged as a result of Māori social service groups supporting youth and families in the courts. Matua Whangai was also based on the *Tu Tangata* programme where the concept of community decision making and support for Māori families with children at risk, was applied. The idea was that whānau or tribal groups would take more responsibility for the care, health, welfare and education of urban Māori children once the Matua Whangai team had established their links to a whānau or tribal group. It was felt that, placing the children with their whānau, sometimes even sending them back to their tribal areas, would provide the children with a sense of belonging and identity with their own whānau members as positive role models. Whilst the concept of whānau care and responsibility fitted with Māori values and traditions, in some instances children were strangers sent to strangers, and a different set of difficulties emerged. Children from the cities had difficulty settling in with whānau and hapū. In the rural areas employment for whānau and hapū members was an issue, so was access to some essential services and resources to ensure the care of children. It became clear that although the Matua Whangai programme had potential and fitted with Māori perspectives it was not resourced sufficiently to make a substantial difference for the young people *at risk* and their whānau. The programme survived until the early 1990s but was then discontinued. However, the ideas, concepts and aspirations of Matua Whangai as well as the experiences gained, are often referred to when new programmes are established (Turia, 2001).

Māori Access and Mana Enterprise, also ‘by Māori for Māori’ programmes, were established at about the same time as Matua Whangai. Māori Access operated alongside general Access programmes but was administered by Māori authorities and delivered by Māori providers. The aim of the programme was to improve the job prospects of unemployed Māori through training and retraining, specifically targeting people who were disadvantaged in the labour market. Disadvantaged people included those “for whom traditional training methods were unsuitable or unavailable.” In assessing the level of disadvantage and therefore eligibility to participate in the programme, a number of factors were considered such as level of education, literacy, numeracy, and the length of time an individual had been unemployed. In some respects Māori Access was a successful programme compared with similar programmes, but it was administratively complicated, qualifications varied among providers and across regions, and concerns were raised about the inconsistency and quality of skills acquired from the courses. The programme became ineffective from a cost perspective and was eventually incorporated into the Training Opportunities Programme (TOP) in 1993. Training became focused on:

school leavers and long-term job seekers with low or no qualifications...Providers were required to become registered with the New Zealand Qualifications Authority and accredited to deliver particular unit standard based qualifications. (Ministry of Education, 2005c, p. 6)

Almost all Māori Access programmes incorporated Māori language and culture components on the grounds that these were vital to trainees’ confidence building and self-esteem. Māori cultural aspects in training provided an opportunity for whānau to be involved and participate in a wide range of training options. Māori language and cultural skills were also in high demand at various levels nationally. Māori had become an official language of New Zealand; kohanga reo (early childhood education) was well established; and this was followed by kura kaupapa Māori (primary school education). Acquiring Māori language and cultural skills were highly sought skills.

The Mana Enterprises (Māori Authorities New Alliance Enterprises) pilot programme emerged in 1985 as an outcome of the 1974 Māori Affairs Amendment Act. Originally the aim of Mana Enterprises was focused on the employment potential of Māori businesses. Later unsubsidized employment through commercial viability became the central objective of the

programme. Mana Enterprises, along with Matua Whangai and Māori Access, was also one of the first programmes to be administered by iwi authorities and was consistent with the aims and objectives of *Te Urupare Rangapu*. All these programmes fitted the Labour Government's newly developed range of policies aimed at enabling communities to participate at decision-making levels. Māori authorities, both tribal and urban, were encouraged and supported in the delivery of services in their communities (Te Puni Kōkiri, 1996; Waitangi Tribunal, 1998). Essentially a business enterprise lending scheme specifically targeted to assist and nurture Māori businesses, Mana Enterprises made loans available to businesses below market interest rates. The intention was that these businesses would create long-term employment opportunities for Māori and would be self-sustaining without the need for further subsidisation. As part of the devolution process it was seen that these programmes would provide basic infrastructure, thereby strengthening tribal delivery systems and assisting in the process of Māori self-determination.

While the Department of Māori Affairs had responsibility for the funding and implementation of the programmes and services, the Ministers of Māori Affairs and Labour selected a Board of Māori Affairs to oversee the programmes (Mana Enterprises and Māori Access) and to provide an advisory and policy guidance role. But, as Mackie (1987) points out, the Board in effect was provided with the funds and responsibility for the implementation and management of the Mana Enterprise programme. The role of the Department of Māori Affairs became one of administrative support and training for both the Mana Enterprise programme and for urban and tribal authorities. The intention of the Ministers was to assist the Government in meeting the objectives of upskilling Māori authorities in preparation for the hand over of services delivery. The Board of Māori Affairs was seen to be the appropriate vehicle to oversee this objective. First, the make-up of the Board was representative of the Māori community, which was considered to be most important. Second, the competencies and experience of Board members assured that funding to the Māori authorities would be managed appropriately and that suitable mechanisms would be in place to enable apposite monitoring and evaluation of the pilots. Third, the Ministers were assured that the Government's employment objectives for Māori would be the focus of the board. Last, the Board of Māori Affairs would be accountable to the Government for appropriate allocation of funds and for the attainment of policy objectives. Eight authorities were chosen and agreed to pilot the Mana Enterprise programme: Taitokerau Māori Trust Board (Northland); Tamaki Employment Authority (Auckland); Te Rūnanganui o Takitimu (Hawke's Bay); Taranaki

Māori Trust Board (Taranaki); Te Rūnanganui o te Upoko o te Ika (Wellington); Ngai Tahu Māori Trust Board; Whanganui Regional Employment Authority (Whanganui); and the Whakatohea Māori Trust Board (Opotiki). These groups were chosen because they represented urban, rural, and regional areas. While the pilot highlighted a range of problems that required attention, there were specific areas in need of immediate remedy. In the first instance, the pilot had proceeded without the establishment of firm lending criteria for authorities to follow. Second, some authorities were newly established so their organisational structure and experience in service delivery was minimal. Third, the objectives, guidelines and operating procedures of the programme delivery were unclear (Te Puni Kōkiri, 1996, p. 12). Funding allocated for the pilots amounted to \$1 million and had come from Vote: Labour to the Department of Māori Affairs (Te Puni Kōkiri, 1996, p. 10).

Because verbal operating instructions, for the pilots had proved confusing and had raised valid concerns, a set of written operating instructions for the programme were made available in February 1986. Further key criteria were established for the allocation of funds that highlighted the focus of the programme on population size, unemployment rate, and capability of the Māori authority to manage a Mana Enterprise programme. By the end of 1986, Mana Enterprises was a national programme with funding of \$13.125 million transferred to the Board of Māori Affairs from Vote: Labour and 22 Māori authorities were allocated loan finance, administrative, and training grants in 1986/87. Table 3.1 shows the Mana Enterprise funding transferred to the Board of Māori Affairs for the 1985–1988 (Te Puni Kōkiri, 1996, p. 13).

In monetary terms, the objective of the Board was to create one full-time job for every \$70,000 received into the Mana Enterprise programme. In reaching this objective, the Mana Enterprise philosophy of supporting and nurturing loan recipients through the process from the initial loan applications to providing ongoing business advice with appointed regional Mana coordinators, was a key factor. Mana loans were not restricted to Māori although applicants were required to show how the funding would assist Māori employment/training opportunities. Mana loans were made available to a wide range of industries to assist in different aspects of business. The main areas of support included new business establishment, business expansions and business refinancing (Te Puni Kōkiri, 1996, pp, 13–20).

Table 3.1 Mana Enterprise funding 1985/86–1987/88

| Year | Funding from Vote | Amount (\$) |
|----------------|--------------------------|--------------------|
| 1985/86 | Labour | 1,000,000 |
| 1986/87 | Labour | 13,125,000 |
| | State Services | 400,000 |
| | Commission | |
| 1987/88 | Māori Affairs | 11,800,000 |
| Total | | 26,325,000 |

Source: Audit Office, 1987.

In hindsight, more time should have been spent in preparing iwi and urban authorities to take on the roles of provider and purchaser of services. Te Puni Kōkiri (1996) note that there was very little time for some authorities to recruit people with appropriate skills and expertise before the programme started. On one hand, while many authorities were prepared and had the capacity to take on these roles, there were others who would have benefited from more experience and skills. The shaky start to the programme highlighted administrative and professional support deficiencies for authorities and added difficulties arising from complexities surrounding procedures for loan approvals. Other issues such as under-resourcing and management problems added to the implementation difficulties and therefore affected the ability to appropriately monitor and evaluate the programme (Te Puni Kōkiri, 1996, pp. 13–17). Despite these and a number of other concerns, a review undertaken by Audit NZ in 1987 found that the programme itself had a positive effect on the Māori community and the overall commitment to the programme by those involved was impressive. In the same year, independent reviewers noted the Mana programme was ‘well conceived’ with ‘many strengths’ and ‘outstanding commitment’ (Te Puni Kōkiri, 1996, p. 18).

In 1989 the administration and funding of Mana Enterprises was transferred to the Iwi Transition Agency, and in 1990 Mana Enterprise funding was allocated to iwi authorities to support iwi business initiatives, highlighting that there was no longer an obligation for iwi to fund other business (Te Puni Kōkiri, 1996, p. 21). In 1990, the National Government put forward policy that advocated mainstreaming, that is, ‘mainstream agencies would be

responsible for delivering government programmes to Māori'. From the Governments' perspective, mainstreaming would make service provision more effective, reduce duplication, and improve access. In 1992, Mana Enterprise funding was transferred to other government agencies responsible for administering business programmes through the newly established Te Puni Kōkiri (Ministry of Māori Development). The Community Employment Group of the Department of Labour and the Business Development Boards of the Ministry of Commerce were allocated Mana Enterprise funding as part of the mainstreaming policy of government. Māori concerns at the time were that these agencies did not have programmes that focused on funding Māori enterprise initiatives, and many Māori would be disadvantaged.

Māori providers

What is accentuated in this chapter and in other parts of this thesis is the sense of purpose by Māori to plan for, develop and deliver services to Māori. In the period 1984 to 2004 the numbers of Māori providers has gone from zero to over a thousand, with Māori providers delivering a range of social, community and tribal services (Durie, 2005a). Government-assisted programmes such as those discussed in the previous section have provided more recent experiences of service delivery and highlighted the potential of Māori urban and rural communities in service delivery. A unique aspect of Māori providers is that they not only focus their services on 'Māori clientele, but also incorporate[d] Māori perspectives, values and worldviews into practice' (Durie, 2005a, p. 50). For example, chapter seven of this thesis describes how unique tribal and Māori perspectives are incorporated into service delivery. Chapter six details professional health workforce development and environmental health workforce development issues and the use of Māori concepts and values in education and training, and chapter eight looks at specific Māori components of a Māori mental health workforce development programme. Other examples of Māori service provision include the health, social, education, youth, justice and business services provided by iwi groups, whānau and hapū, Māori community groups, and professionals. Many iwi/Māori groups are currently well configured to deliver a wide range of services:

During the 1990s, many iwi organisations had also reconfigured their systems and processes in order to deliver a range of programmes, including health, justice, education, housing, youth, and social services, By 2003, for example, Ngai Tahu was heavily involved in environmental management, language revitalization, social development (health education, employment, welfare), and economic growth. (Durie 2005a, pp. 50–51)

By 2004, Māori had become firmly established primary participants in service delivery in health, education, social, and employment sectors. Durie (2005) points out that Māori were providing services across a wide range of sectors and in domains where Māori had, in the main, been the recipients of services rather than the providers. In education, for example, te reo Māori revitalization provided the impetus for the establishment of the first Kohanga Reo in 1982. The flow-on effect was increased through Māori participation as providers of education, first, as providers of early childhood education across the country, then moving to Kura Kaupapa Māori (primary schooling), and on to Wharekura (secondary schooling) and wananga (tertiary education).

In health, the numbers of Māori providers increased from 20 in 1993 to 250 in 1997 and have remained at approximately between 250 and 260. Māori participation in services provision across sectors looks likely to continue remaining a feature of New Zealand society – Māori providers are better able to connect with Māori people (Durie, 2005a).

Māori demographics

Despite non-Māori immigration and Māori emigration, the Māori population continues to increase with an approximate population of 620,000 or 15 percent of the total population of New Zealand, and by 2021 this figure is expected to increase to around 17 percent. While the Māori population is ageing, it still has a younger age structure than that of the general population because Māori birth rates are higher. In 2021 the median age of the Māori population will be 27 compared with the non-Māori population, which will be 43 (Statistics New Zealand – Te Tari Tatau, 2005).

The numbers of Māori children under 15 years is expected to increase by 9,000 or 4 percent, from 216,000 in 2001 to 225,000 in 2021, but they will make up a smaller proportion of the population in 2021 at 30 percent, compared with 37 percent in 2001. Māori children currently make up just over 25 percent of all New Zealand children and this is likely to increase to 28 percent in 2021. These differences are also attributable to higher Māori birth rates (Statistics New Zealand, 2005).

The Māori working age group (15–64 years) in 2001 was 350,000 or 60 percent of the population; it is projected to increase to 468,000 or 62 percent in 2021. This age group will make up 16 percent of New Zealand's total population in 2021 compared with 14 percent in

2001, and most of these will be in the older half of the age group. Māori in the 65 years and over age group are expected to treble between 2001 and 2021, and will account for 8 percent of the total Māori population. This population will reflect the large birth cohorts of the 1950s through to the 1970s. Indications are that there will be implications for the care and support facilities for this age group, and the burden placed on the 15–64 working age population will be higher. Even though the Māori fertility rate is falling it is still above replacement level. Māori population growth has been attributed to high birth rates and fertility, improved life expectancies and reduced mortality rates (Statistics New Zealand, 2005). Durie (2005a, pp. 31–32) adds that continued and accelerated population growth in the 20th century is also attributable to the work of inspirational Māori leadership (Apirana Ngata, Te Puea Herangi, Maui Pomare, Sir Peter Buck), improved public health amenities and regulations, improved living standards, better access to goods and services, including health, education, and housing.

Māori are more mobile than other sections of the population, which may reflect the younger age structure and low home ownership rates. Reasons for moving included whānau, education, climate, and employment. Movement from rural to urban areas or further is common in the younger age group but movement from the urban areas back to the rural areas is an increasing phenomenon of the middle and older age groups (Statistics New Zealand – Te Tari Tatau, 2005).

Māori economic development

The Hui Taumata 1984 (Māori Economic Summit) heralded what has become known as the decade of contemporary Māori development. The key resolutions that emerged from the hui, economic self-sufficiency and greater autonomy and control over things Māori, effectively called for the fetters of state dependency and practices of assimilation to be relinquished by governments. Taking this route was seen to be more positive for Māori development overall in the sense that it acknowledged the right to be Māori, promoted Māori self-determination, and encouraged the building of Māori capacities to accommodate future development (Durie, 2003b). Although the hui focused on current and future economic challenges facing Māori, it also became apparent that Māori development would not occur in a vacuum. Socio-cultural development would need to occur alongside economic initiatives. Māori development proponents advocated a change in the way Government allocated financial resources to ‘positive funding’ rather than ‘negative spending’, with greater emphasis on positive

investment and funding in education rather than increasing social welfare payments (Wetere, 1984; Durie, 1998a; 1998b; Ringold, 2005).

Hui participants appealed for a Treaty of Waitangi based partnership model, with the State supporting Māori development rather than directing it, being responsive rather than reactive. Suggestions of greater iwi or tribal involvement in Māori development, autonomy and self-determination seemed, in fact, to be in harmony with the Government's proposed programme of economic reform.²⁰ The Hui Taumata, in a sense, sanctioned the impending economic and public sector reforms of the late 1980s in so far as they envisaged devolution of state control and greater autonomy in the corporate and Non-Government Organisation (NGO) sectors.

By the end of 1986, the economic restructuring of the manufacturing, meat processing, farming and forestry sectors, as well as the stock market crash in 1987, were to have a dire effect on the Māori population – New Zealand was in deep recession. Chapple (1999) explains that Māori had been employed in these more 'vulnerable' sectors in large numbers; they were less skilled and educated and therefore bore a disproportionate burden of the recession than other populations. Māori unemployment levels soared in the late 1980s through to the mid-1990s, and this impacted on the Māori situation generally in relation to health, education, housing and social well-being. However, "between 1995 and 2004 Māori employment grew at 3.6 percent per annum exceeding the non-Māori rate of 2 percent... the employment rates of Māori women outpaced those of Māori men... at 4.6 percent and 2.8 percent annual growth respectively" (Ringold, 2005 p. 15). And, although Māori employment rates increased to around 26 percent in 2005, there remained concerns that Māori employment tended to be concentrated in sectors that required low skills or low qualifications; sectors with greater susceptibility during times of economic downturn. Increased Māori participation in the labour market saw positive improvements in relation to accessing health, social services, education and housing but also highlighted the variation within the Māori population (Ringold, 2005). There is also strong evidence that some Māori have not benefited from the economic recovery (Durie, 2005; Ringold, 2005), for example, those Māori who remain categorized as long-term unemployed even though there had been positive movements in long-term unemployment by 2000 (Ringold, 2005).

²⁰ see *Te Urupare Rangapu: Te Kārangī Kaupapa-Partnership Response: Policy Statement*, 1988

In 2005, the Government's macroeconomic policy emphasised the importance of 'inclusion' for growth, by investing in human capital and supporting labour market participation; the social policy strategy *Opportunities for all New Zealanders* (Ministry of Social Development, 2004), aimed to improve the welfare of disadvantaged individuals and groups, and to invest in the capacity of the population as a whole; and the *Sustainable Development for New Zealand Framework* aimed to increase economic growth, reduce inequality, and improve the standard of living of all New Zealanders in a manner that was environmentally, socially, culturally and economically sustainable (Ringold, 2005, p. 4).

Māori cultural development

International research undertaken in 2003 highlighted the importance of social and cultural aspects in the development of policy in individual countries, revealing that these two aspects are fundamental to the policy development process both at an individual and group level (as cited in Ringold, 2005, p. 4). New Zealand's experience in designing and implementing policies by and for Māori provides a unique example for other countries to follow and therefore has potential to lead global change in relation to policies that take account of social and cultural aspects (Ringold, 2005). Ringold points out that "the unique experience of New Zealand... is of broader interest globally" and therefore provides opportunity for New Zealand Governments to embrace and support the diversity of different population groups (Ringold, 2005, p. 3). While many people in New Zealand agree with policies that provide space for the inclusion of cultural and social elements, there are many others who tend to be less positive about diversity preferring policies to be exclusively majority focused. Roger Kerr (2005) has argued that if, for example, in Māori economic policy, Māori cultural and social factors are taken into account this would not be conducive to Māori advancement. However, in relation to policy development in New Zealand there is strong evidence in a range of sectors to the contrary. For instance, there is no home for Māori culture other than New Zealand and there is an "obligation on the state to ensure its retention and development" in all areas of Māori development (Durie, 2005a, p. 175; Ringold, 2005.).

Māori cultural development has been an action from within Māoridom, and while it has focused on advancing the Māori position there have been benefits to the general population in many sectors. In the early part of the 20th century Te Pūea Herangi saw Māori cultural

performances as not only assisting marae and hospital fundraising initiatives but also as educating and informing the non-Māori population. Māori cultural performing arts play a significant role in New Zealand tourism initiatives, and Māori cultural perspectives have been merged into the public sector services since the early 1980s (Puao-te-atatu, 1986). Māori views and aspirations for health are incorporated in Government health policy reflecting models of health such as Te Whare Tapa Whā that emanate from a Māori cultural standpoint. Another catalyst for Māori cultural development was the te reo Māori language revitalization movement that started in the early 1970s and that has maintained its momentum into the 21st century. According to Durie (2005a, p. 47), Māori language is a “major indicator of cultural identity” and has been the motivation behind the total immersion education initiatives of kohanga reo, kura kaupapa, and wharekura developments.²¹ Māori concepts, values and institutions such as manaakitanga, tautoko, awhi, aroha, whānau and marae have been applied in these total immersion settings.

Māori educational development

Hui Taumata 1984 highlighted educational achievement as crucial for Māori economic and social development. To this end Hui participants were full of praise for the new Kohanga Reo initiative. The Kohanga Reo (language nests, early childhood education) movement has been credited as the first by Māori for Māori-led initiative to characterise contemporary Māori development. Established in 1982, the first Kohanga Reo set a direction not only for Māori education and overall Māori development but also for future Māori advancement. The underlying philosophy of kohanga reo and its whānau-affirming principles has created space for the development of kura kaupapa Māori (Māori immersion primary schooling), wharekura (Māori immersion secondary schooling), and wānanga (Māori immersion tertiary education). A feature of Māori immersion education is its focus on involving Māori whānau and Māori communities in the education of Māori children. Deloria and Wildcat (2001, p. 158) confirms that ensuring “family genealogies and tribal traditions” are included in school curricula will “provide a solid foundation for children’s personal identity” and a context for teaching social development skills, building the child’s confidence and ensuring they are an essential part of an “ongoing human experience.”

²¹ There is a fuller discussion on these initiatives in the next section.

The success and philosophy of whānau and Māori immersion education has been enthusiastically applied in a range of other sectors. For example, whānau and kaupapa Māori in service provision were later identified as appropriate vehicles on which to base health and well-being initiatives for Māori. (Te Puni Kōkiri – Ministry of Māori Development, 2002). In 2006, Māori education policy recognises a whānau approach to increasing Māori participation in education and therefore the potential to contribute to positive Māori development (Durie, 2006).

Educational achievement remains an important if not the most important socio-economic indicator of Māori progress, and in order to gauge levels of Māori participation in education, reliable statistical data and information is required. To this end, Māori enrolment in education and the data gleaned provide some insight into levels of achievement and participation; and the ability to determine underachievement, which, as Durie (2005a, p. 39) points out, is “linked to workforce participation, and Māori levels of unemployment” attest to this correlation.

For Hui Taumata 2005, Māori statistics and information reports for the previous 20 years were requested by the hui organisers from various Government agencies in order to gauge Māori progress. Statistics in relation to participation in education revealed that in 2003 the number of Māori children in early childhood education had increased steadily. Approximately 34,000 Māori children were in some form of early childhood education and 31 percent of these were enrolled in kohanga reo, 32 percent were in other early childhood education and care service, and 22 percent were enrolled in kindergarten. This indicates that while Māori in Māori medium (kohanga reo) education is increasing, almost two-thirds (54 percent) of Māori children remain in mainstream early childhood education care services. However, the main point of note is that participation in early childhood education is increasing and the trend looks likely to continue (Ministry of Education, 2005a).

Similarly, participation rates of Māori children in primary school education have increased by “16 percent between 1995 and 2004” with approximately 160,700 Māori children enrolled in 2004; although, when compared with non-Māori, the increase is less pronounced because of the overall general increase in the numbers of children in primary schooling in the measurement period 1995–2004. This equates to an increase of Māori in primary education of

only, “one percentage point – from 20 percent in 1995 to 21 percent in 2004” (Ministry of Education, 2005a, p. 2).

Over the period 1986–2004 the proportion of Māori students still in secondary school has also increased but it has not been a constant increase over time. For example, there were large increases in the beginning of the measurement period from the late 1980s to the early 1990s; these then declined until 2001, then stabilized for the years 2002 to 2005.

Table 3.2: Percentage increases in Māori students remaining in school

| Age | 1986 % | 2003 % |
|----------|-----------|-----------|
| 16 years | 47 | 63 |
| 17 years | 20 | 37 |
| 18 years | 4 | 9 |

Source: Adapted from Ministry of Education, 2005a

Māori female students are more likely than Māori male students to stay at school, and this is especially true for 16 and 17 year olds. As a result of shorter stays at school more Māori students are still likely to leave school with less qualifications, which decreases employment options (Ministry of Education, 2005a; Ringold, 2005).

Māori in immersion education reported the highest increase of 164 percent between 1992 and 2003. In 1992, 4,618 Māori students were involved in Māori immersion education at some level, increasing to over 12,200 in 2003. Given the numbers of Māori students in Kura Kaupapa Māori there has also been a corresponding increase in the size and number of Kura Kaupapa Māori schools from 13 in 1992 to 61 in 2003 (Ministry of Education, 2005a; Ringold, 2005; Durie, 2006). These figures indicate that Kura Kaupapa Māori and other Māori immersion programmes are becoming the more popular choice of schooling for Māori children.

A further feature of Māori student experience in education is related to stand-downs,²² suspensions,²³ exclusions²⁴ and expulsions,²⁵ identified as some of the common methods used to deal with troublesome student behaviour. Again, Māori rates are higher than those experienced by non-Māori students but this is decreasing, especially in those schools participating in the Suspension Reduction Initiative introduced in 2001. Research in 2002 revealed that Māori student truancy rates were double that of European and Asian students, and occur more frequently. However, while the performance of Māori students is poor relative to non-Māori, there is evidence that gains have been made (Ministry of Education, 2005a; Ministry of Māori Development, 2005; Durie, 2006).

Changes in the secondary school qualification occurred in 2002 with the introduction of the National Certificate of Educational Achievement (NCEA), which replaced School Certificate, Sixth Form Certificate and University Bursary. Credits and unit standards can be gained in more than any one level in a year and can be carried through to the next. Māori success in NCEA is increasing, although it is still below that of non-Māori (Ministry of Education, 2005a). While Māori gained a higher percentage of credits than non-Māori in specific subjects, such as Health and Physical Education, other subjects such as science still reflect a lower percentage for Māori students (Ministry of Education, 2005a). Overall, however, Māori are more now likely to leave school with an NCEA level 2 or higher qualification or credits towards a qualification than they were before 2002 (Ministry of Education, 2005a; Durie, 2005a). In 2003 the proportion of Māori school leavers with no qualifications dropped to 30 percent from being well over a third of all Māori school leavers. Current measurements of school leaver attainment are new and they are still thwarted by the new changes in qualifications, and while it appears that improvements have been made, Māori rates of improvement remain lower than non-Māori (Ministry of Education, 2005a). Given the collection of Māori-specific enrolment data in schools has only become a requirement since 1995, the opportunity to monitor Māori student achievement in education over time has

²² Formal removal of student from school for a specified period, after which student returns automatically to school.

²³ Formal removal of a student from school until the Board of Trustees decides the outcome of the suspension. The board may decide to lift the suspension, extend the suspension, or exclude or expel the student.

²⁴ Formal removal of a student aged under 16 from the school, and the requirement of the student to enrol at another school.

²⁵ Formal removal of a student aged 16 or over from school. The student may enrol in another school.

become a reality. Both Government and Māori/iwi are now able to monitor progress and be more responsive in policy and planning.

Current policy for Māori participation in education encourages increased Māori involvement at all levels, including board of trustee and teaching levels. In 1997 board of trustee participation was 13 percent compared with 15 percent in 2003, which is a relatively small increase but indicates that Māori parent involvement in education is rising. The numbers of school teachers identifying as Māori has increased by 36 percent since 2004, and currently exceeds 5,700. The increase is most pronounced in Kura Kaupapa Māori: 270 in 1998 to 550 in 2004, which was expected, given the corresponding growth in the numbers Kura Kaupapa Māori schools (Ministry of Education, 2005a). These statistics provide information on two levels, first that Māori participation in Māori immersion education is increasing at a faster rate than in other areas, and second, Māori language and culture is becoming the preferred medium for educating Māori children and corresponds with other national efforts to progress and advance Māori development initiatives.

The most significant changes in Māori education have occurred at the tertiary education level especially over the period 2001–2005. In this sector, Māori were under represented at all levels until 1999 but since 2002 Māori are recorded as “having the highest participation rate of any ethnic group in New Zealand” (Ministry of Education, 2005b, p. 1). The most recent increases in tertiary education (2001–2005) have been induced by wānanga (Māori tertiary education institutions) which “increased Māori enrolments from 26,000 students in 2001 to 45,500 in 2002” (cited in Durie 2005a, p. 39). While the increase has been mainly in certificate-level qualifications, there is evidence that students are moving from certificate level into higher level qualifications of diplomas, degrees and then on to postgraduate-level study, although not at the same rate as non-Māori. Completion and retention rates for Māori in tertiary education are also improving, albeit at a lower rate than non-Māori. In 2003, for instance, the Māori participation rate at degree level was 3.2 percent compared with 4.1 percent for all students (Ministry of Education, 2005b).

Māori women are participating in tertiary education more than they have before 1998. In 2003, “almost two in three Māori students were women” – 64 percent of all Māori students. In the period 1998–2003 the enrolment of mature students (those over 25 years) tripled, and

those under 25 years doubled. The biggest increase, however, has occurred in the over 40-age group, mainly in wānanga (Ministry of Education, 2005b, p. 3).

Māori participation in research relates to the enrolments and completion rates of doctoral degrees. In 2003, Māori participation in doctoral programmes was half that of the non-Māori population, at 0.06 and 0.12 respectively. However, participation at this level has improved dramatically from only 7 PhDs completed in 1998 to 21 in 2002 and 28 in 2003 (Ministry of Education, 2005b, p. 6).

A change in the way the Government funds research in tertiary education began to take place in 2003. Funding was previously based on student enrolments but has now moved towards funding based on research performance (Performance-Based Research Funding – PBRF). Results from the 2003 PBRF process revealed that a total of 364 Māori staff across institutions submitted a PBRF portfolio. Overall Māori were rated lower than non-Māori; however, given the numbers participating and the emergent nature of the disciplinary area – Māori knowledge and development – there is likely to be an improvement in the 2006 round (Ministry of Education, 2005b, p. 7).

Growth has also occurred in the number of Māori participating in industry training and Government remedial training programmes; however, this has not been at the same rate because employment opportunities, especially in unskilled areas, have been increasing – many school leavers are opting to go straight into employment because of the stronger labour market (Ministry of Education, 2005b, pp. 5–6).

Māori health development

In 1987 the Māori Health Committee of the New Zealand Board of Health recommended that tribal authorities should have a greater role in health activities for Māori. The Committee suggested that the cultural differences in health perspectives between Māori and non-Māori warranted a place for Māori tribal authorities in the delivery of health services, especially at preventative and curative levels in the sector. What was clear to the Committee was that tribal authorities should not only be responsible for land management and administration of tribal funds but also participate in the promotion of health, social welfare, economic development, education and vocational training and education. In this sense, the structure of Māori tribal

authorities, the way in which Māori prefer to organize socially, and the management styles in relation to whānau, hapū, and iwi were noted for their capability, and capacity to incorporate health into marae activities. It was also pointed out that tribal authorities had obligatory responsibilities to all tribal members and could contribute to Māori health development in a wide range of disciplinary areas, thereby ensuring the inclusion of Māori cultural perspectives. Health promotion, care, protection, planning, and workforce development were highlighted by the Committee as being integral to overall Māori health development and were spheres of activity in which Māori tribal authorities could have a major role (New Zealand Board of Health, 1987).

Given that marae remain one of the few institutions where tribal authority is law and Māori culture is the central pivot of activity (New Zealand Board of Health, 1987; Walker, 1992; Mataira, 1994; Gillies & Barnett, 2002; Gillies, 2004a; Gillies & Barnett, 2004) Māori tribal authorities still have the ability to control nutritional habits, safety measures, emotional and spiritual care, mental stress and recreation activities on marae through kawa (protocol) and kaumātua influence. The potential role of Māori and their tribal elders as key change agents in health promotion activities was becoming increasingly evident (New Zealand Board of Health, 1987).

In relation to health care activities, three broad approaches were identified by the Committee as having applicability to Māori health development:

- Māori tribal authorities, through marae clinics, would have the ability to influence the integration of the different (Western and Māori) health care practices and systems of health
- Tribal authorities, through their local marae clinics, would facilitate training and education opportunities for local Māori community health workers and therefore contribute to developing a workforce that was both culturally competent and well trained.
- Funding health care through tribal authorities already structured and experienced in administering financial resources would alleviate uncertainties at local marae levels about funding responsibility and accountabilities for services provision. (New Zealand Board of Health 1987, p. 6)

Health protection and environmental health, and the care of natural resources were identified by the Committee as areas where Māori already had a reputation and longstanding experience that stemmed from the work of the Māori sanitary inspectors and from various Treaty of Waitangi claims, such the Motunui Claim, thus reinforcing traditional notions of the

relationship between Māori and the natural environment. Treaty of Waitangi claims in this sense had succeeded in highlighting that the pollution of waterways, sea and landscapes was not only a health hazard to the population overall but also culturally unhealthy. Yet these relationships and links between Māori and the environment had not been recognized in health legislation. Further, the committee identified the wider benefits that could eventuate for New Zealanders if more collaboration between tribal authorities and health occurred in relation to environmental and natural resource care (New Zealand Board of Health 1987, p. 8).

The Māori Health Committee of the New Zealand Board of Health accentuated the inability of New Zealand Universities and Colleges to provide the sum total of training and education in relation to the Māori health workforce. For example, the Report *Tribal Authorities as Advocates for Māori Health* (Māori Health Committee, 1987b) recognized that these institutions could not provide a Māori perspective in the courses they taught nor were they able to identify many of the issues that were relevant and important to Māori. Marae visits and hui for all students such as those first proposed in nursing education were not accepted at all levels of the industry. Later the endorsement by the New Zealand Nursing Council of the inclusion of a compulsory cultural awareness component to nursing education and training was vigorously debated in a variety of forums across the country. Challenges even came from students (Ramsden, 1994, 1997; 2002). Even with this opposition, tribal authorities were encouraged to collaborate with health training and education establishments, indicating that the potential for this kind of involvement could lead to a positive new dimension in tertiary education and possibly extend the training base for all health workers, which would not only provide more appropriate health care for Māori but better health care for all New Zealanders.

Opportunities for Māori participation in health planning emerged from the Hui Whakaoranga-Māori Health Planning Workshop in 1984. Workshop participants argued for greater levels of involvement in health policy and planning, and health services provision. Most importantly, the hui endorsed the relevance of culture to health and that culture and Māori spirituality should be included in health education and training. The focus on education and training also clearly highlighted concerns specifically in relation to developing the Māori health workforce.

In 1994, Durie (1994) identified ten Māori priorities for health development based on three broad parameters and goals (Table 3.3). The goals included the elimination of disparities

between Māori and non-Māori, the health and safety of future generations, and active Māori participation.

Table 3.3: Ten priorities for Māori health development

| Broad goal | Priority area |
|--|---|
| The elimination of disparities between Māori and non-Māori | <ol style="list-style-type: none"> 1. Healthy socio-economic policies 2. Positive development 3. Equitable distribution of resources |
| The health of future generations | <ol style="list-style-type: none"> 4. Prevention 5. Promotion 6. Primary health care/safety |
| Active Māori participation | <ol style="list-style-type: none"> 7. A national focus for health 8. The Māori health workforce 9. Purchasers and providers 10. A Māori development model |

Tino rangatiratanga

Source: Durie, 1994, p. 200.

Phases in Māori developmental initiatives, including health, have been notable for the consistent underlying theme of tino rangatiratanga. Whether in a collective or an individual sense, tino rangatiratanga assumes autonomy and control or at least supports the notion of Māori having greater levels of input into health policy development and service delivery and a share in the provision of solutions.

Emerging from a number of hui during the decade of Māori development was an emphasis on positive development. The Hui Taumata 2005 provided an opportunity to appraise Māori development initiatives and assess the gains made over two decades. Clearly some advancement had been made and the hui provided an occasion where Māori and Crown could engage in future planning and development discourse in a positive light. Highlighted at Hui Taumata 2005 was a continued focus on capacity building and cross-sector developmental initiatives. Building whānau capacities and leadership through enterprise and economic development provided a focal point for workshops and whānau as an institution was endorsed as providing a leading role in advancing future Māori potential.

Māori proposals to Government for positive spending and investment in education, health, economic development and employment rather than operating from a deficit model and inequitable distribution of resources, are themes that have guided phases in Māori development since 1984. Funding of Māori health development initiatives remains insufficient, with health contracts and other arrangements still in many ways focused on reporting on outputs rather than outcomes. Health sector reforms, while providing opportunities for Māori health providers, have meant adaptations to changes in funding regimes, competition, and uncertainties around future funding.

Māori perspectives of health focus on wellness rather than illness and while there is recognition that treatment services are necessary there is also recognition that many illnesses are preventable. Consistent with Māori perspectives of health Durie (1994) contends that positive development in health equated to the prevention of illness or injury. Examples of prevention activities that have produced positive results for Māori include immunization, whānau support, decreased smoking, and a decrease in alcohol consumption and abuse. Māori views of health in holistic terms, recognizes that achieving good health can not be separated from other socio-cultural and economic determinants such as educational achievement, employment, good housing, nutrition, and Māori identity. Good health for Māori means developing policies that take account of socio-cultural and economic determinants.

Initiatives involving the development of health promotion were identified as an area where Māori input could make an impact. Health promotion focuses on lifestyles and social networks and fits a Māori perspective because it focuses on promoting positive aspects of social interactions and interconnectedness (Ratima, 2001).

The potential for Māori participation in primary health care services was also recognised as a Māori health development priority (Durie 1994). Hospitalisation rates for a range of illnesses were relatively high for Māori, indicating that primary care services were not meeting the needs of Māori communities. Developing services in this area provided opportunities for Māori health workers to work closely with their communities. In many cases, primary health care workers facilitated access and information to and about appropriate services. Durie (1994) provides evidence of a relationship between primary health care and safety from violence, especially the safety of women and children.

Māori health development needs a national focus and representation at a national level in terms of policy planning and development. A number of organisations, advisory boards, ministry appointments and sections, working parties, and taskforces have taken on roles at a national level to advance Māori participation in this area and influence policies for Māori.

Māori health workforce development was identified as a priority (Health Workforce Advisory Committee, 2001). In 1994 the concern was the low numbers of Māori professional health workers, which was at less than 1 percent of the total workforce. The health reforms in one sense had provided opportunities for increased Māori participation in health services delivery but had also highlighted dire shortages in Māori capacity across the sector. Increasing the Māori health workforce in the new millennium remains a priority development objective for Māori. In 2002 the Government moved to take a leading role in health workforce development supporting a number of workforce development initiatives.

A major feature of the health reforms was the purchaser/provider split, which promised Māori participation at a new level – as purchasers of health services. The effect of this reform was increased interest in Māori health development by iwi authorities. Since 1984 Māori experience as providers of services had increased and many were ready and keen to develop various working relationships with Regional Health Authorities (RHAs) such as partnerships, joint ventures, and budget holding agreements. Changes in health funding regimes that occurred throughout the 1990s resulted in continual adaptation and uncertainty for Māori.

Although the constant restructuring in the health and other major sectors caused some anxiety for Māori, Durie (1994) states that it had a unifying effect or certainly a strengthening of resolve for “some Iwi to consolidate their own developmental plans in order not to be compromised by current expediencies” (p. 210). Therefore “cooperating” with funding authorities did not mean “being driven by them” (Durie, 1994, p. 210). A health sector approach to development was determined to be too narrow, limiting overall Māori development, which is broad and encompasses an integrated inter-sectoral approach:

The Māori development model, despite its uncertain funding and its sometimes doubtful mandate, is not burdened by the sectoral divisions which characterize policies generally. Fragmented approaches to development lead to inconsistencies and inefficiencies while divisions between social and economic policies create divisions and inequalities...The priority for Māori is not to have a health system which compares favourably with other sectors but to have a health system which is in accord with other areas of Māori

development and contributes to them. The corollary is that all sectors should be oriented towards health outcomes. (Durie, 1994, p. 210)

In 1998 the broad goals and priorities for Māori health development were incorporated into a thematic framework that has practical relevance. The Rangatira framework highlights the policy developments in other sectors and their pertinence to health.

Table 3.4: Themes for Māori health development: The Rangatira framework

| Themes | Issues |
|---|---|
| Rangatiratanga | <ul style="list-style-type: none"> • Treaty of Waitangi • Autonomy and self-determination • Māori control of service delivery to Māori |
| Access to quality mainstream services | <ul style="list-style-type: none"> • Mainstream services utilised by Māori need to be safe, equitable, culturally effective, and appropriate |
| New and existing Māori providers | <ul style="list-style-type: none"> • Not-for-profit services provided for Māori • Extension of a range of services provided by Māori • Active Māori health workforce development |
| Gains and outcomes | <ul style="list-style-type: none"> • Appropriate measures for monitoring progress • Outcome measures relevant to Māori |
| Aukati – prevention/promotion | <ul style="list-style-type: none"> • Disease prevention and health promotion are necessary for long-term gains – but treatment services should not be compromised |
| Tikanga Māori and kaupapa Māori | <ul style="list-style-type: none"> • Traditional healing • Services based on Māori health and well-being philosophies |
| Integration - intra-sectoral and inter-sectoral | <ul style="list-style-type: none"> • Integration within the health sector and between health and other sectors |
| Resourcing Māori health and independence gains | <ul style="list-style-type: none"> • Resources need to reflect the greater need, and should match the Government commitment to Māori health |
| Awatea – Māori development | <ul style="list-style-type: none"> • Māori health should be linked with Māori development as described in Ka Awatea • Māori development approach to health development |

Source: Durie, 1998b, p. 212

Māori societal development

Contemporary Māori societal organisation was built on a tribal heritage that still remains an anchor. In most instances it is encouraged because it provides individuals with a sense of identity. In other respects it also marginalises those who, for whatever reason, do not have access to their heritage, or choose not to participate in tribal activities. Essentially, Māori

society was organised around iwi (tribes – a group descended from a common founding ancestor). An iwi is made up of a number of hapū (subtribes), and each hapū comprises a number of whānau (family groupings). Iwi have an identified historical and territorial base, and iwi boundaries are commonly known not only among the particular iwi group but also by other iwi groups. In the 19th century the Māori Land Court had a major role in the identification and recording of tribal boundaries (Minister of Māori Affairs, 1988). However submissions from Māori highlighted that iwi should be left to define their own representation, structures, and geographical boundaries through processes that involve their people. *Te Urupare Rangapū* – The Partnership Response in 1988 suggested a definition of how these iwi groups are made up: those whose members actively identify with their iwi and live in tribal territory; those whose members actively identify with their iwi but reside outside their tribal territory; and those who because of residency, marriage or other reasons have become adopted members of another iwi. The document encourages iwi authorities to help people who do not know their iwi affiliations to establish links with iwi and continue their role in embracing Māori people who were unaware of their iwi identity. In this they advocated the concept of manaakitangata to have precedence in relation to iwi authorities who had people from other iwi living within their rohe (domain) (Minister of Māori Affairs, 1988, p. 9).

The specific role of iwi was acknowledged in *He Tirohanga Rangapū*:

Māori signatories to the Treaty of Waitangi represented a specific iwi or hapū. The strength of the traditional iwi structure is reflected in their continuing existence today. They are strong, enduring, sophisticated systems of cooperation and community effort and as such it has been advocated that they provide an appropriate means of delivering government programmes to Māori people. (Minister of Māori Affairs, 1988, p. 13)

However, in past legislation and Government policy there has been little room for iwi development in the sense of new iwi development. While the Iwi Rūnanga Act of 1990 allowed for tribal development it was short lived and was repealed in 1991. In order to facilitate the flow of benefits in cash and fishing quota to Māori, however, the Māori Fisheries Act 2004 outlines the process for iwi/Māori to receive and manage these assets, thus recognising iwi/Māori as major players in the industry. The Act prescribes appropriate structures for Māori and Crown interaction and not only includes tribal groups with large populations, as well as those with coastlines, but also allows benefits to flow to recognised smaller iwi and non-tribal groups such as Māori urban authorities and land-locked tribal groups. While new iwi development has been sporadic in the last century, held at bay by

restrictive policies and legislation, the new legislation has in many ways enabled Māori development both in a modern contemporary context and in a customary tribal context. For example, as a result of this process, Rongomaiwahine has been recognised as an iwi and along with Ngāti Kahungunu has taken steps to receive fisheries allocation on behalf of their tribal members. Other groups such as Te Whānau o Waipareira and Manukau Urban Māori Authority will also take responsibility for the distribution of assets for their Māori constituents.

Another feature of tribal development that has rarely eventuated since colonisation, is new hapū development. Historically, such development occurred as a natural process and for a variety of reasons (Te Rangihiroa, 1949). For example, whānau groupings would become too large and therefore warrant the establishment of an institution that could cope with their growth. On other occasions, discontent within the whānau groupings would arise or rivalries between siblings, parents or children would occur, as would leadership changes, events, and feats of heroism or bravery, all of which would signal the emergence of new hapū. The reasons for this type of development were numerous and occurred regularly. This did not mean ties, links and connections were cut with the hapū from which separation was sought; on the contrary those connections remained just as strong because whakapapa was essentially the major determinant of hapū (Mead, 1995; Te Rangihiroa, 1949). Gillies (in Waldon, Kingi, Cunningham, Coupe, Gillies, & Taite, 1998) described hapū institutions as organic, a phenomenon of natural development. Using amoeba, a one-celled microscopic aquatic organism, as an example to explain hapū development she maintained that new amoeba cells emerge from within the original amoeba but remain attached to it externally – there is always a connection to the original. In a similar way, new hapū development is never a total separation from the originating hapū; people will always belong to the parent hapū and remain subject to the same rights and obligations. One recent example of new hapū development occurred in 1995 within the tribal boundaries of Ngāti Raukawa in the Manawatū region. The Kereama extended whānau had grown to such a size that natural progression to hapū status was the most sensible outcome, and the hapū of Ngāti Mano Mano was established. In 1995, Mano Mano the Wharenuī was officially opened on Taumata o te Ra marae, at Hācolmbe near Feilding, to accommodate the diverse activities of the hapū.

Māori social organisation of hapū and iwi has emerged from the institution of whānau (Ballara, 1998) “the fundamental unit of tribal society” (Durie, 2005, pp. 10–11). While

whānau eventually came under the protection of iwi, their independence as social units and individuals continued to be acknowledged. The concept of whānau has also continued to influence Māori adaptation to the variety of urban environments with which they have come in contact.

The notion of whānau took on new meaning as a result of Māori migration to the cities. In the cities, neighbours, church groups, sports groups and other social and community groups became the 'whānau' with which many urban Māori affiliated. Whānau as an organising concept became the basis of pan-tribal, urban Māori organisation. In South and West Auckland two urban Māori organisations emerged based on the whānau concept. Te Whānau o Waipareira and Manukau Urban Māori Authority became major players in socio-cultural services provision in Auckland. In other major cities around the country similar organisational types were emerging to cater for the needs of Māori migrants.

What has been notable in relation to Māori societal development is that institutions of iwi, hapū and whānau have remained in tact albeit different forms of whānau, and different growth patterns of hapū and iwi. Maintaining these institutions into the 21st century attests to Māori resistance to policies of assimilation and Māori capacity to adapt to change – Māori endurance and Māori resilience:

If endurance depends on adaptation to new environments, urbanization represents an important Māori transition. While the costs have not been inconsequential, Māori resilience has nonetheless been striking. Fifty years of urbanization has demonstrated that it has been possible to live side by side with other New Zealanders without being assimilated into a homogenous way of life. It has been possible to retain links with whānau and hapū. It has been possible to recreate a sense of community that is not dissimilar to whānau. (Durie, 2005, p. 24)

Organisational capacities

While Māori societal development in relation to whānau, hapū and iwi has occurred over time, other Māori organisational developments have also emerged. Many Māori organisations are based on traditional Māori concepts, others have emerged from legislation, some from the need for new organisations to provide appropriate services to Māori clientele.

At the same time, Māori organisational development needs to account for the provision of appropriate management and governance structures to cope with both economic and cultural imperatives and public accountability requirements. Māori participation in different sectors

and with public funding has not always been successful, failures have occurred, in most cases attracting wider media attention than the Bank of New Zealand–Wine-box Inquiry or the Air New Zealand debacle. However, Māori capacity, and learning from mistakes and adaptation remains a constant feature of development.

What does stand out with Māori organisations and providers is their propensity to engage with Māori people at a variety of levels and in wide-ranging capacities and in most instances show an ability to reach those people that conventional Western organisations and providers can not. However, the growth in Māori provider organisations has accentuated areas where concentrated development within organisations is required. Durie (2005a) identifies Māori workforce development across sectors and management structures and systems as critical to provider success. He notes that the governance role in many Māori organisations is problematic and that customary methods of authority may not be suited for commercial, legal, contractual arrangements and accountability requirements for many organisations where high levels of compliance are expected. Examples he provides include the Te Rūnanga o Ngai Tahu Act 1996, which allows the Rūnanga to undertake commercial activities without first gaining approval from the Minister of Māori Affairs; accountability is thus to the tribe. Tainui is similarly structured, with Te Kauhanganui being more tribally representative (Durie, 2005a). In one instance, however, Māori authority, or more precisely, tikanga Māori in governance through kaumātua has added value in terms of strategic business decision-making: the maintenance of Māori relationships between hapū parties is a feature of the Wakatu Incorporation (MacKay, 2000; Harmsworth, 2005). And, thus highlights the innovativeness and unique potential for Māori cultural perspectives to add value to national policy, something that as Ringold (2005) points out would have value internationally.

Organisational governance in New Zealand is changing generally from a focus on shareholders, owners and beneficiaries, which has been influenced by a corporate or business model, to ensuring representation of communities and stakeholders in governance. While there is evidence in various pieces of legislation that Māori culture has the potential to influence decision-making in positive ways, research in this area is sparse. Further, Māori governance comes with its own complexities of representation, even at a community level where in most instances management and governance are combined. Based on a Western corporate governance model the functions of governance and management should, ideally, be separated. However, Māori development initiatives have always focused on having some

Māori representation, especially in Māori and Crown relationships and governance. This focus on Māori representation in governance at a national level has therefore spilled over into the corporate arena where businesses are required to show they have considered the impact of their business on society as a whole. Triple Bottom Line reporting, public consultation and a concern for stakeholders are becoming increasingly important. So, while there is a need for increased training for Māori in governance, management, and building workforce capacity, cultural perspectives and Māori aspirations for autonomy need not take a back seat, there is room for inclusion.

Emerging philosophies

Māori development philosophies have been largely influenced by state policies for Māori and Māori aspirations. Māori aspirations over time have remained resolute but the mechanisms used to attain those aspirations have been varied, politically charged, and governed by prevailing Western ideology and political systems. For example, in 1854 the settler Government in New Zealand introduced an Act to enact the Pleadings in English Act 1362 becoming the English Laws Act 1854. What this meant was that all English laws that were in effect in 1840 were adopted by the settler Government and became applicable to the New Zealand population from that time. English, or more specifically race-based laws and regulations, have been the most prominent feature of successive Governments, permeating the education, health, housing, justice, commercial, social, legal and environmental systems, and ensuring a blatant and ongoing disregard for Māori systems and Māori society in general:

Assimilation was the clear aim of the early European settlers. It was based on presumptions that Western values and lifestyles were demonstrably superior and that indigenous peoples were best served by adaptation to colonial ways. Essentially a process that required social, economic, and cultural subjugation, assimilation imposed policies and regulations that were ‘race-based’ – they depended on the cultural norms of foreign populations. Indigenous standards were simply discounted. (Durie, 2005a, p. 172)

Durie (2005a) puts forward four distinct policy directions that have helped shape Māori development and advancement. He identifies these as: policies of integration; bicultural policies; policies for Māori development; and policies for restitution. He argues that growing resistance by Māori to race-based policies of assimilation was to become evident after World War II and during the Māori migration to urban centres. Later, after Crown and Pākehā realisation that the Māori population was growing rather than ‘dying’ out (Hill, 2004), assimilation policies were replaced by policies of integration that seemed to accept,

accommodate, and encourage cultural and racial differences, promoting what Joseph Savage described as “economic equality and racial individuality” (cited in Durie, 2005a, pp. 172–175). Such statements make it clear that Savage at least was aware of and acknowledged the growing disparities between Māori and Pākehā and had some “respect for Māori distinctiveness.” Even so, with these policies of integration there was a presumption that Māori would become more like Pākehā because policies were focused on social disparities not on other aspects of importance to Māori such as land ownership, aspirations for autonomy, self-determination, and self-management. Integration policies, while more unifying still assumed one administration system for all and similar world-views and aspirations; an approach that assumes universality (Durie, 2005a).

A major feature of the 1980s in relation to policies for Māori was biculturalism. Biculturalism provided the opportunity for increased Māori participation in the public sector contributing to Māori workforce development within state agencies. Māori processes, language, and protocols were incorporated into state agencies and the Treaty of Waitangi became a guiding source for policy development at Government levels.

Devolution and deregulation resulted in major economic and social reform and public sector restructuring away from the welfare state. The policies surrounding the devolution process have been highlighted as a turning point that provided a real opportunity for meaningful Māori participation in contemporary Māori development initiatives. Māori and iwi authorities were seen as the appropriate vehicle through which Māori development and advancement could occur. They became the unique and innovative providers of services to Māori. Devolution enabled opportunities for Māori delivery systems to be put in place to service Māori communities. Tino rangatiratanga was deemed to be the intended outcome of policies for Māori development along with cultural revitalisation and strengthening of iwi structures to become providers of services.

Policies for restitution emerged in 1975 with the establishment of the Waitangi Tribunal and the development of processes and systems to facilitate grievances through inquiries and hearings. Later, the Government endorsed the hearing of historical grievances against the Crown with claims dating back to 1840. However, Government control over the settlements process has not allowed/led to unity for Māori. In determining the process of negotiation, the Crown elected to ignore hapū, whānau and other Māori, and negotiate only with iwi.

Tensions between Māori became strained because the Treaty of Waitangi had been signed by the chiefs of hapū, and the grievances requiring settlement were as a result of the hardship faced by specific hapū and whānau. In dealing only with iwi, settlements have resulted in iwi ownership of specific hapū lands and other resources. While there are other factors that raised tensions between Māori, basically what became clear was that the Crown process for negotiation was exclusionary and divisive, aggravating the tensions between Māori and compounding once again the effects of alienation. This time though, it was not just alienation from land and resources but alienation from participating in Māori society. Government requirement for iwi registers in order to distribute the benefits from the settlements resulted in further tensions within iwi and Māoridom generally. Contemporary Māori realities were not being considered, and assimilation was taking a different form, manipulated by the state but operationalised by iwi. Kelsey (1990) and Hill (2004) maintain that Māori development and advancement occur only at the prerogative of the state, and there is no doubt that the state controls the Māori agenda.

Māori development frameworks

Notable among recent Māori development and advancement has been the emergence of a range of Māori development frameworks based on Māori philosophies. Reclaiming ownership over Māori developmental processes has included the overarching notion that Māori must devise policies for Māori, and that the state's role should be one of facilitating the integration of those policies into the various central and local government structures. The processes and principles of consultation, for example, have gained wide public acceptance. Not only is there a requirement for consultation with Māori over a variety of issues, there is also a requirement to consult with the public. Treaty of Waitangi claims have raised national awareness of environmental issues that impact on the general population. Clearly, Māori struggles for autonomy and self-determination have provided meaningful benefits to the general public. Māori developmental frameworks therefore not only have the potential to enhance, improve and advance Māori as a nation but also have the potential to advance the nation as a whole because these frameworks are relatively dependent on the state for implementation and facilitation.

The first model presented here conceptualises Māori development as an interaction of three interrelated parameters. Figure 3.1 describes a Tri-Axial Framework – a determinants axis (vertical), a process or method axis (horizontal) and an outcomes axis (diagonal).

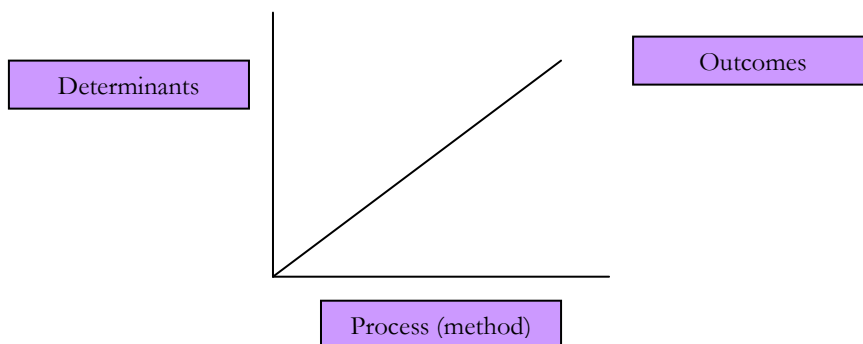


Figure 3.1: A tri-axial framework

The process axis encompasses the range of approaches that might underlie the implementation of Māori development, such as the application of Māori perspectives and Māori aspirations, a process that will be inclusive and take account of the diversity of Māori communities, be future- and forward-oriented in relation to Crown and Māori relationships, include active Māori participation at all levels, and take a sectoral and integrated approach (Durie, Fitzgerald, Kingi, McKinley, & Stevenson, 2002, p. 18; Durie, 2003b, p. 306).

Determinants are those factors that influence Māori health, are wide ranging and include such aspects as the impacts of colonisation, socio-economic and cultural indicators, demographic and societal changes, the Treaty of Waitangi, and participation in society.

The outcome axis is focused on the achievement of desired results, for example, economic growth should in turn have a positive impact on Māori well-being. Māori well-being includes access to a secure Māori identity, participation in and access to decision-making processes, access to resources, and the ability to progress Māori views of development. Māori aspirations for well-being, good health and wealth are no different from the aspirations of non-Māori populations and groups, indicating that there are crucial elements of Māori development that can be applied at local regional and national levels (Durie et al., 2002, p. 18; Durie, 2003b, p. 306).

The Tri-Axial framework provides a starting point for multi-faceted analysis because each axis can be explored separately in greater depth, and then linked back to enable appropriate evaluation and measurement of Māori development. For example, Te Puni Kōkiri has

developed a monitoring framework to help monitor other Government departments in terms of their responsiveness to Māori. Other groups (Durie et al., 2002) have explored the outcomes axis in more depth, linking them back to Māori development and advancement in terms of the interconnectedness of these on human and resource capacities. The result is *Te Ngāhuru*, a Māori Specific Outcomes Schema that in itself provides a foundation for the consideration of outcomes that are unique to Māori. Combining generic and Māori specific outcomes is more than likely to result in best outcomes for Māori. *Te Ngāhuru* is made up of:

- Five guiding principles for the application of outcome measurements – interconnectedness, specificity, Māori focus, Māori commonality and contemporary relevance;
- Two outcome domains – human and resource capacity;
- Four outcome classes – that include secure cultural identity; collective Māori synergies, Māori cultural and intellectual resources and the Māori estate;
- Ten outcome goals – which can be applied more purposefully to interventions and policies. The outcome goals link back to the four outcome classes;
- Outcome targets – should be developed in association with key individuals to meet each goal; and there could be more than one target assigned to achieve each goal;
- Outcome indicators – are required to be specific, relevant and capable of measurement to gauge goal achievement.

Table 3.5 on page 110 summarises the application of *Te Ngāhuru* in practical terms, most importantly *Te Ngāhuru* provides policy developers, planners, employers, both Māori and non-Māori, private and public sector, a foundational platform to consider outcomes that are particular to Māori. Further, when they are combined with more generic outcomes are likely to result in better outcomes (Durie et al, 2002).

The risks associated with development

Māori aspirations for autonomy have profoundly influenced the relationship between Māori and the Crown and therefore between Māori development and advancement initiatives:

the resilience and adaptiveness, in the face of great odds, of Māori political and cultural forms and aspirations. It has focused on the enduring Māori quest for Crown recognition of rangatiratanga, and the Crown's responses to this. Ever since 1840, whenever Māori demands for autonomy were asserted with any strong organisational backing, the colonial and post-colonial state sought to defuse or deflect them... it did so by incorporating organisational and ideological aspects of such movements into its own structures and apparatus – from officialised rūnanga, komiti and other Māori institutions. (Hill, 2004, p. 266)

Since 1840, both the state and Māori have known what each has wanted. This knowledge has provided strategic insight and ability to augment both their positions. From both sides have come concessions, adaptation, and opposition, although the Crown has always:

possessed overwhelming power and would always use this to pursue its own agenda; and that its goals had little connection with issues of indigenous justice or rights – unless... [it] happened to suit it at the time. (Hill, 2004, p. 266)

Many Māori development initiatives have proved to be successful, such as the te reo Māori language immersion education programmes (early childhood through to tertiary). However, these ‘Māori’ programmes – with both organisational and ideological aspects included – have been incorporated into state structures and operational systems, becoming subject to increased reporting requirements and public accountability (Meade & Podmore, 2002). While secure funding has been of benefit there have been sacrifices as well in relation to the perceived ‘Māoriness’ of some programmes.

Devolution of state services is argued here to have been an elaborate and expensive manoeuvre to extricate funding targeted for Māori through Māori Affairs into the coffers of other Government departments to use for the general population. The Mana Enterprise programme, for example, was ‘mainstreamed’, even though a review by the State Services Commission, while not discarding aspects of deficiency, generally highlighted its overall success. Further, while devolution may have provided increased Māori participation through iwi organisations as providers and enabled elements of autonomy to emerge, these were always controlled by the state (Hill, 2004).

In health development initiatives, there are numbers of Māori providers whose services extend over and above what they have been contracted to provide (Kingi and May, 2000; Tomlins-Jahnke, 2005) because Māori views of health extend beyond the physical and are not incorporated into contracts for service. This not only puts them at risk financially but, through reporting and record keeping adds extra work, often to an already heavy workload. Māori success in development initiatives may itself be a limiting factor, particularly within a political climate that may not or will not sustain Māori success.

Table 3.5: Te Ngāhuru – a Māori outcomes schema

| Principles | Domains | Classes | Goals | Targets (Examples) | Indicators |
|---------------------|-------------------|--|--|---|--|
| Inter-connectedness | Human Capacity | Te Manawa Secure Cultural Identity | 1. Positive participation in society as Māori | 75% employers recognize Māori culture in employment contracts | Number of employment regulations/contracts explicitly stating provisions for Māori |
| | | | 2. Positive participation in Māori society | 90% Māori are involved in Māori business | |
| | | Te Kahui Collective Māori synergies | 3. Vibrant Māori communities | 60% Māori residents listen to iwi radio | Radio listener surveys |
| | | | 4. Enhanced whānau capacities | Whānau are able to provide adequate care for 50% of older Māori | Māori disability support data |
| | | | 5. Māori Autonomy (tino rangatiratanga) | Number of Māori businesses increases by 20% pa | Companies records able to provide ethnic data |
| | Resource capacity | Te Kete Puawai Māori cultural and intellectual resources | 6. Te Reo Māori used in multiple domains | Prime TV has 25% Māori language programs | Analysis of TV content |
| | | | 7. Practise of Māori culture, knowledge and values | Tangi leave supported by employers Marae attendances increase by 20% | Employer records and government policies Aggregated marae attendances |
| | | Te Ao Turoa The Māori estate | 8. Regenerated Māori land base | Māori land valuations increase by 20% | LINZ records |
| | | | 9. Guaranteed Māori access to clean and health environment | Resource consents consistent with Māori environment ethic | Analysis of local authority consents using Māori criteria |
| | | | 10. Resource sustainability and accessibility | Kina stocks increase by 50% | MAF stocktakes |

Source: Durie, 2002, p. 96.

Conclusion

Recent Māori development approaches and policy development in relation to Māori provide a “valuable record of experience and innovation for New Zealand that has global relevance” (Ringold, 2005, p. 2). For example, international concerns on human development have recently centred on improving human development outcomes for indigenous peoples, ethnic minorities, and vulnerable groups. The debate has focused in particular on the extent to which policies should be universal, mainstreamed, or colour blind, should apply to the whole of society, and should be targeted or tailored to the needs of the group, by taking into consideration such factors as culture and language (Ringold, 2005, p. 2).

This chapter highlights the range of approaches for Māori development taken in New Zealand. These approaches include specific, targeted programmes, Māori efforts to work within mainstream services, as well as a mix in between. Examples of success and other data have been presented to provide a picture of the Māori position in most socio-cultural and economic measurement spheres. Information has shown that while some progress has been made, disparities between Māori and non-Māori remain. What seems to be evident is that programmes for Māori by Māori have not had full Government support and have been stymied in many cases before full evaluation.

Education, for instance, was identified as a key area of concern for Māori development and is particularly relevant for this thesis because educational achievement determines levels of workforce participation and future workforce development requirements across all sectors. Even though Māori participation rates have increased quite substantially in the education sector (eg early childhood, primary, secondary, tertiary, and Māori immersion), when compared to other New Zealanders disparities remain. Evidence that better educated people have better employment options, are likely to have better incomes, are able to afford better housing, and are likely to enjoy better health, is well documented. A Māori development model then, links different social, economic, cultural and political activities and aims for a planned coordinated approach to Māori advancement.

The New Zealand experience raises key questions that have yet to be answered. What have been the outcomes and results? What has worked and what has not? And what has made the most difference in improving outcomes for Māori in New Zealand? *The Tri-Axial* framework and *Te Ngāburu – A Māori Specific Outcomes Schema*, provide guidance for the appropriate analysis, evaluation and measurement of Māori development outcomes by highlighting what best outcomes for Māori might be.

Chapter 4

WORKFORCE DEVELOPMENT

Any initiative that influences entry to and exit from the health and disability sectors, education, training, skills, attitudes, rewards and the associated infrastructure²⁶

Introduction

This chapter provides an overview of workforce development in New Zealand and overseas. While the focus in relation to this thesis is on health workforce development it has implications for other sectors. Many overseas programmes for health workforce development have been developed using various forms of business models such as those from the human resource management, management and communication disciplinary areas. Up until the 1970's workforce was more often equated with labourers located in industry, for example car manufacturers, factories, wharf workers, and meatworks. However, current parameters of workforce now extend to the professions such as law, medicine, science, education and business. Further, it has become widely accepted that workforce development in most sectors is generally a global concern and as the diversity of the population increases so too does the urgency to develop a diverse workforce increase. Government policies and political philosophies either act to rescind workforce development or progress development and these are also based on international economic, market, and labour trends. The definition of workforce development highlights the broad coverage required and the effort needed to ensure an essential component of health service delivery is adequately addressed to meet health sector goals.

The contours of workforce development

According to (Mantell, 2003) Workforce development is a social process that requires shared involvement, collective action, leadership and innovativeness. Further, innovations in workforce development, the success stories, have largely been 'flax roots' initiated, a phenomena that creates an unstoppable momentum not just for societal change but for integration across and within sectors (Mantell, 2003). Seen in this light then, an essential component of workforce development is an infrastructure that not only supports societal capability to address workforce

²⁶ A definition of workforce development proposed by the Health Workforce Advisory Committee (2003, p. 26).

issues but also increases societal capacity (Hughes, 2003). Infrastructure includes appropriate government policy development systems both economic and social, information gathering and recording systems, and relevant data about delivery systems that aim to improve society in general. In health, welfare and education for example, infrastructure is reliant for the most part on Government funded agencies such as the Ministries of Health, Education and Social Development. Therefore these sectors, especially health and education, are heavily regulated and seemingly organised. Influencing all facets of society is the overall performance of the economy and the economic policies and philosophies of Governments.

Economic theories and policies²⁷

A commonly held view is that:

economics is the study of how men and society end up choosing, with or without the use of money, to employ scarce productive resources that could have alternative uses, to produce various commodities and distribute them for consumption, now or in the future, among various people and groups in society. It analyses the costs and benefits of improving patterns of resource allocation. (Samuelson, 1973, p3)

As a social activity, economics is concerned with the production, distribution and consumption of goods and services as well as the theory and management of economies or economic systems. Further, it is reliant on the fact that all resources are scarce, and not all human needs and desires can be met (Samuelson, 1973). There will be populations in the community who will bear the brunt of inequitable distributions of resources, even though the task of an economist is to ensure that resources are distributed in an efficient and equitable way.

Economic theory is separated into two major fields – macroeconomics focuses on entire economic systems while the study of micro-economics observes market activities and trends on individuals or groups within an economic system. The emphasis of macroeconomics on whole economies supports a focus on satisfying material wants through aggregate supply and demand for money, capital and commodities with resource allocation, production, distribution, trade and competition. It includes the studying of incentives, or making choices subject to varying constraints, and given this broadness, topics of study have ranged from marriage at an individual level to the study of optimal political institutions. In order to observe a total economy,

²⁷ The researcher is not an expert in economics, the material and diagrams that follow have been sourced from teaching materials, from Massey University Economic Tools for Schools Vol 1, No 1- 1999 Term 2 at <http://econ.massey.ac.nz/cppe>. From a website of the London School of Economics. Economic diagrams databank and glossary at www.bized.co.uk/glossary/big/clad_inc_lr/ retrieved 10/07/2005

conceptually (as Governments do) a combination of both macro and micro-economics, is required. Known as the theory of General Equilibrium, the assumption is that good macroeconomics has solid microeconomic foundations. Good macroeconomics in New Zealand then, should reflect solid, reliable, and representative data on the total population as individuals and or groups (Dalziel & Lattimore, 2004; Samuelson, 1973).

Demand and supply

Developing economic policies involves the use of price supply and demand models that serve to predict the consequences of decisions or events and therefore enables the analysis of society behaviours. Logically demand for goods or services, is reliant on desire or wants. For example, people have to want or desire a good or service and be willing and able to purchase it at a given price. Demand is also dependent on satisfaction and consumption of the good or service, that is, whether people who have consumed a good or service have been satisfied with it as this will impact on future demand. In the same way that economic demand and supply models are used for goods and services, they are also used to establish human resourcing requirements within individual organisations and general population studies. They are simple tools that can be applied across a wide range of sectors. Therefore the following diagrams show very simply the way in which the demand/supply relationship works. The demand curve shows the amount of a good or service that one or more consumers are willing and able to buy at different prices. A change in price never shifts the demand curve for that good or service. So in the diagram on the left, an increase in price results in a movement along the demand curve, in this case up the demand curve, showing a fall in the quantity demanded from Q1 to Q2 often referred to as a contraction in demand²⁸.

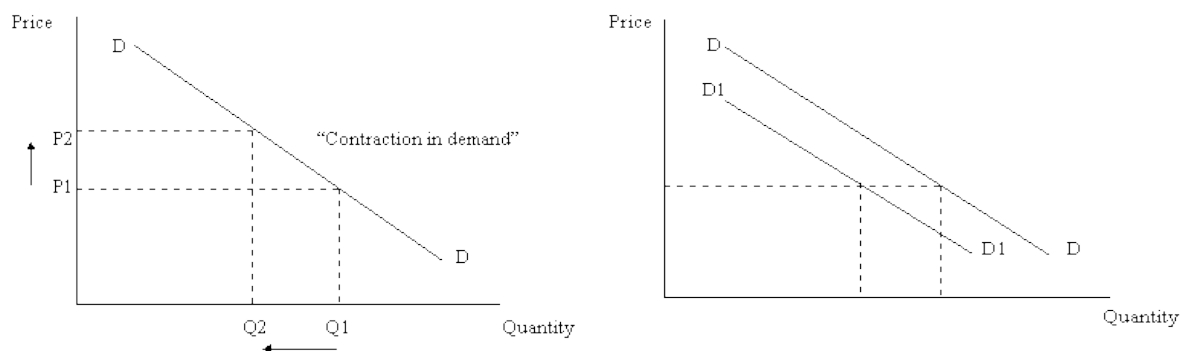


Figure 4.1: Demand curve and shifts²⁹

²⁸ See website www.bized.co.uk/glossary/big/clad_inc_lr/ and <http://econ.massey.ac.nz/cppe>

²⁹ See website www.bized.co.uk/glossary/big/clad_inc_lr/ and <http://econ.massey.ac.nz/cppe>

The diagram on the right shows a shift in the demand curve. This shift only occurs when there is a change in income, in taste, or in the demand for other good or services (substitutes or complements). A decrease in demand has shifted the demand curve to the left. An increase in demand would shift the demand curve to the right. In this case the new demand curve is D_1 D_1 , a shift to the left.

Similarly, supply is the amount of a good or service producers are willing and able to sell at a given price and depends on the price, the cost, and the supply of alternatives that the producer could make with the same resources, the supply of goods and services actually produced at the same time or any unexpected events that affect supply.

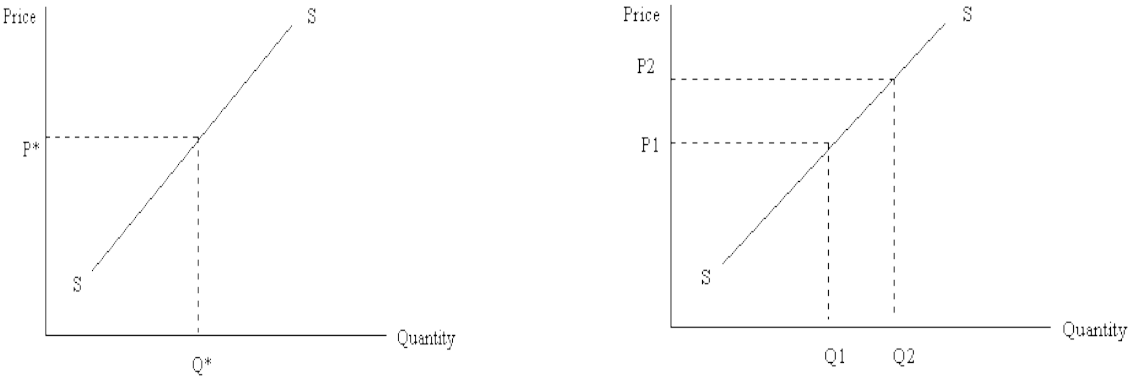


Figure 4.2: Supply curve and shifts ³⁰

In the diagram on the left the supply curve, SS shows the amount of a good or service one or more producers are prepared to sell at different prices. Again a change in price will never shift the supply curve but there will be movement along the curve and impacts on quantity can be seen.³¹ The only time that a supply curve shifts is when there is a change in costs; a change in the number of goods or services, or when an unforeseen event affects production.

In the diagram below it shows that an increase in supply shifts the supply curve to the right. The converse would be true if supply is decreased.

³⁰ See website www.bized.co.uk/glossary/big/clad_inc_lr/ and <http://econ.massey.ac.nz/cppe>

³¹ See website www.bized.co.uk/glossary/big/clad_inc_lr/ and <http://econ.massey.ac.nz/cppe>

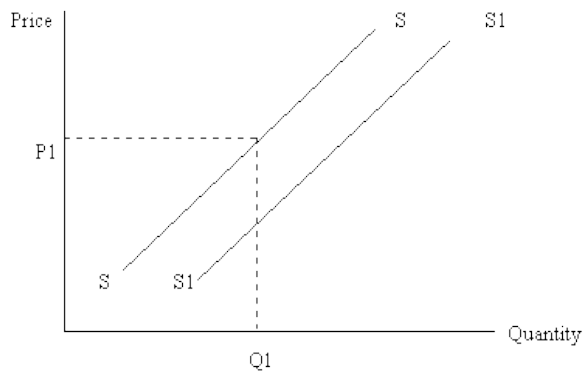


Figure 4.3: Supply curve and changes

The following diagram illustrates establishing an equilibrium market price, that is, the price where the amount consumers want to buy equals the amount producers are prepared to sell. At prices above the equilibrium (P^*) there is excess supply while at prices below the equilibrium (P^*) there is excess demand. The effect of excess supply is to force the price down SS , while excess demand creates shortages and forces the price up DD .

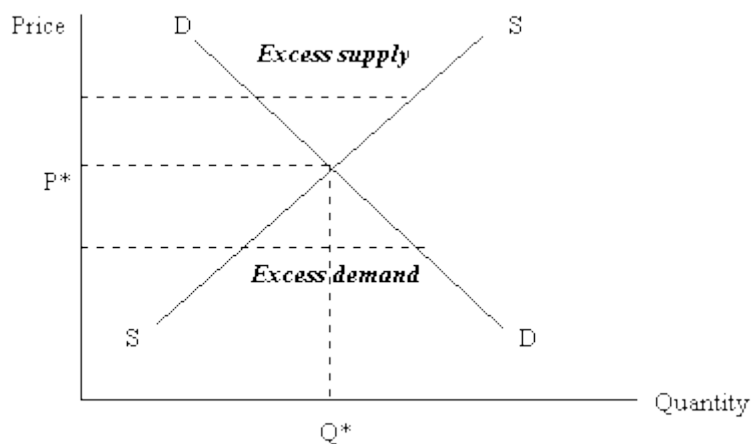


Figure 4.4: Equilibrium ³²

Price elasticity of demand

Price elasticity of demand measures the responsiveness of demand to a given change in price and is found using the equation: $PED = \text{Percentage change in quantity demanded} / \text{Percentage change in price}$ or, $PED = P/Q \times Q/P$ where P = the original price, Q = the original quantity (See Table 4.1).

³² See website www.bized.co.uk/glossary/big/clad_inc_lr/ and <http://econ.massey.ac.nz/cppe>

Table 4.1: Features of price elasticity of demand³³

| Feature | Elastic goods | Inelastic goods |
|-----------------------|-------------------------|--------------------------|
| PED value | Greater than 1 | Less than 1 |
| A rise in price means | A larger fall in demand | A smaller fall in demand |
| Slope of demand curve | Flat | Steep |
| Number of substitutes | Many | Few |
| Type of good | Luxury | Necessity |
| Price of good | Expensive | Cheap |
| Example | BMW | Petrol |

Price elasticity of supply³⁴

Price elasticity of supply (PES) measures the responsiveness of supply to a given change in price. PES = Percentage change in quantity supplied/Percentage change in price or $PES = \frac{\Delta Q}{Q} \times \frac{P}{\Delta P}$ (See Table 4.2).

Table 4.2: Features of elasticity of supply

| Feature | Elastic goods | Inelastic goods |
|-----------------------|-------------------------|--------------------------|
| PES value | Greater than 1 | Less than 1 |
| A rise in price means | A larger rise in supply | A smaller rise in supply |
| Slope of supply curve | Flat | Steep |
| The good is produced | Rapidly | Slowly |
| The time period is | Months | Days |
| The firm has | Large stocks | Limited stocks |
| Example | Screws | Cars |

³³ See website www.bized.co.uk/glossary/big/clad_inc_lr/ and <http://econ.massey.ac.nz/cppe>

³⁴ See website www.bized.co.uk/glossary/big/clad_inc_lr/ and <http://econ.massey.ac.nz/cppe>

Income elasticity of demand ³⁵

Income elasticity of demand (YED) measures the responsiveness of demand to a given change in income. $YED = \text{Percentage change in quantity demanded} / \text{Percentage change in income}$. If YED is negative then the good is considered inferior. People use an increase in income to buy less of this good and more of a superior substitute. If YED is positive then the good is normal. Consumers use an increase in income to buy more of the good.

Cross elasticity of demand

Cross elasticity of demand (XED) measures the responsiveness of demand for one good to a given change in the price of a second good, $XED = \text{Percentage change in quantity demanded of good} / \text{Percentage change in the price of good}$. If XED is positive then the two goods are substitutes. If XED is negative then the two goods are complements.

Models of demand, supply and their component parts, elasticity, inelasticity, and other effects such as the impacts of tax changes on an organisation can be applied to a broad range of areas including determining workforce requirements in both the public and private sectors. Taking health professionals for example and applying a simple demand and supply analysis in the health sector would currently reveal that demand for health professionals exceeds current supply. The next section on labour market trends explains how to use these tools in workforce planning.

Labour market trends

Labour market trends are influenced by changes in employment and unemployment surveys on skills available in the labour market, and information on possible future trends in job growth. It can have a short term focus where simple identification of unfilled vacancies in the labour market are made or have a long term focus that provides information on skill and occupational trends where choices can be made in relation to the most appropriate training. Labour market information is becoming an increasingly critical part of developing a knowledge economy and as such facilitating effective matching of capabilities with work opportunities. Further, accessing this information in a timely manner is important because workplace environments are changing rapidly, there is increasing diversity in the population reflecting a need for diversity in the workforce, plus the investments required in skill acquisition are often long-term thus informed

³⁵ See website www.bized.co.uk/glossary/big/clad_inc_lr/ and <http://econ.massey.ac.nz/cppe>

decision-making around education and training is necessary to meet the demands of the labour market (de Raad 1998; de Raad 2001; Hauk-Willis 2005).

As of March 2005, New Zealand's unemployment rate is the lowest among OECD countries at 3.6% compared with approximately 11% in 1991/1992 (Daziel & Lattimore, 2004, p.153). This record of low unemployment looks likely to continue in the medium term. From one perspective this is good news for both the country and the economy but from another perspective it presents a number of challenges because it highlights a shortage of both skills and labour. The focus for many organisations is on issues such as recruitment and retention and which organisation will people want to work for (Hauk-Willis, 2005). However, there are underlying trends that are impacting on the general labour market as well, such as the increasing age of the working population, the lure of the best and brightest to greener pastures overseas, the mobility of the workforce both in and out of sectors and in and out of regions to where they are more likely to be employed, and rapidly changing social expectations where jobs need to 'fit' employee lives. The response of the Government to these issues is a focus on both demand and supply, targeting women, older people, immigrants and those on benefits in particular. For example, encouraging organisations to 'think outside the box' in relation to providing 'flexible' work practices and to consider more work/life 'balance' highlighting that it is the demand side of the labour equation that industries, whether public or private can and should be able to respond to in the labour market equation. Most often this thinking outside the box, requires a culture change – a 'change in the way we do things around here' and for most organisations let alone sectors, culture change is slow (Hauk-Willis, 2005).

The health sector has not been exempted from the skills and labour shortage either, in fact, the health sector has been aware of workforce development needs since the early 1980's. More or less about the same time concerns were also raised about the capability of the state sector generally. Suffice to say that real movements or action in relation to health workforce development has only occurred more recently. Jean-Pierre de Raad (2001, p. 2) describes the health workforce "as a matter of stocks and flows," those people working in the health sector, those thinking about working in the health sector and those potentially available to the health sector are 'stocks'. Stocks expand or contract subject to 'inflows and outflows', that is, people entering or leaving the health sector. Thinking in terms of stocks and flows affords a practical way of reviewing health workforce statistics, and issues surrounding the health workforce are usually raised, explained and addressed in this manner. For example, inflows and outflows

highlight the shortages and surpluses (demand and supply) in the health workforce. This view provides insights into what may be happening with the health workforce, but it fails to fully explain why certain trends occur, nor how the workforce or employers could react.

Workforce incentives

While organisations both in the private and public cannot immediately respond to the supply side of the equation they can attempt to alleviate the demand side in a variety of ways. Usually this requires unrelenting commitment and leadership from top management because in many instances survival of the organisation may be at stake. First, Hauk-Willis (2005) suggests a culture change may need to occur, one that is supportive and responsive to attract and retain the best people. It includes working with people on the inside as well which means up-skilling managers in people leadership and improving their training and support. For example, establishing a buddy system for new managers, and performance feedback training for all managers focusing on positivity rather than negativity. Senior staff would have a crucial role-modelling function thus encouraging expected behaviours such as respect for other people's views, encouraging debate, setting appropriate meeting protocols, and making sure meetings were held in conventional working hours so that staff with families or other commitments, are not excluded. Human resource systems would need to be fine-tuned and focus on performance appraisal systems, promotion and remuneration keeping in mind the culture and behaviour aimed for. Most of all a heavy emphasis should be placed on knowledge management and its retention within the organisation. Often there needs to be physical change to facilitate culture change for instance, changing the physical workspace moving from a fairly insular office-based environment to one that is entirely open plan. Work incentives for staff would include increasing the flexibility in work arrangements to suit personal lives both male and female. This would include providing remote computer access for staff to work from home, providing access to leave bonuses both paid and unpaid and short or long term leave thus providing staff with choices about how they do their work, and where they work. Organisational commitment to flexibility improves the likelihood of staff returning to the organisation from unpaid or parental leave. Added to this the organisation could offer subsidies to pay for childcare costs or extra sick leave to retain highly skilled staff (Hauk-Willis, 2005, pp. 2-9). The Health Workforce Advisory Committee (2001) identified the same issues which have implications for the health sector workforce. For example, changes in culture and attitudes, changes in physical environments, flexibility in work places, providing incentives for health practitioners, and access to resources.

Workforce incentives in the health sector are impacted upon by national policies, regulations and practices (Salmond 1996; Salmond 2004) which according to de Raad (2001) affects the way the health labour market operates. For example in order to contain tertiary education costs, post entry training costs and further health expenditure, there is a fixed number entry restriction into medical and dentistry education programmes ultimately preventing supplier induced demand. The flow on effect of this is to limit entry into the workforce and contain the impact on wages and encourage the use of alternative recruitment strategies such as using other professionals for some tasks, repatriation and immigration. Entry to most health professions is regulated by competency assurance legislation this has the effect of alerting both “employers and consumers as to who is a competent practitioner” at the same time though it “inhibits change and reduces employer and consumer influence over what health professions do and how they evolve” (de Raad, 2001, p.4). Funding policies also have a direct impact on the labour market for instance a provider may be restricted in the services it offers, through its funding, and thereby limited in the type of health professional it can employ and thus constraining how a service is organised. There are other legislation that have impact in the health labour sector as well. For instance, the Employment Relations Act, social welfare provisions, the Commerce Act, the Finance Act, and general tertiary education policy (de Raad, 2001 p. 4).

Overall though, some workforce incentives that health providers may be able to offer are similar to those presented earlier. A large funder / provider like a District Health Board may be able to offer the same sort of incentives Hauk-Willis (2005) referred to in relation to the changes that have occurred and are still occurring in Treasury because it arguably has more resources at its disposal. A smaller provider on the other hand may only be able to make some of those changes on a smaller scale. In relation to the health workforce an organisation may be able to offer a number of scholarships or on the job training opportunities for its current workforce thereby developing and enhancing skills from within the organisation thus offering career development choices to their workforce (Health Workforce Advisory Committee, 2002). One key to recruitment and probable retention is for organisations to focus on providing first class working environments for the workforce, making their organisation the one of choice for individuals. This ability to not only recruit but retain people will, in times of a tight labour market, that is, where demand exceeds supply, will be crucial. Offering financial incentives may be appropriate in most instances but may not be seen by some as motivation to work for an organisation; lifestyle or location may be more important. Other work incentives include flexible hours of

work that takes into consideration family commitments, travel allowances, accommodation allowances and child care support systems (de Raad 2001; United Future Policy Statement 2002; Hauk-Willis 2005).

Political philosophies

The political philosophies, policies, actions and activities of governments have in the main been influenced by economics or rather economic policy development. Until 1973 New Zealand's unique export trading partnership with Britain, and the heavily protected domestic market made it one of the wealthiest countries in the world. However, in 1973 two events were to have an impact on the New Zealand economy. First, Britain entered the European Economic Community³⁶ which ended the longstanding partnership. Second, the first oil shock, sent oil prices soaring, the effect of which was to impact on the world economy quite significantly and New Zealand was not excluded. By 1975, the world economy was in recession. In New Zealand the Government sought to maintain domestic market stability by increasing overseas debt but this was ludicrously unsustainable in the long term. By 1977 New Zealand had begun to reduce its frenzied borrowing however it was to have a major impact on policy and influence the reforms over the next decades. (Hawke, 2002; Dalziel & Lattimore, 2004).

In 1984 an incoming Labour Government needed to take drastic action to reduce the level of state intervention and debt that had been a feature of the previous National Government. National's policy objectives of a controlled economy highlighted a failure to adjust to change or take seriously, international influences. Labour's market driven deregulated policies while having an overall objective of improving the living standards of New Zealanders by providing and encouraging competition, preference, and choice (Dalziel & Lattimore, 2004) was to have a dire effect on Māori (Ringold, 2005; Chapple, 1999, 2000) who were more vulnerable and whose position became more exaggerated during period of the reforms. What became clear is that the reforms benefited certain sections of the population. Many saw the dismantling of the social welfare system as an abdication of responsibility by the state to provide services to New Zealanders. Others saw the reforms as an opportunity to participate in service provision. Whilst Labour had initiated the reforms and implemented the first stage, when National returned to Government six years later they continued the process implementing further reforms including

³⁶ The European Economic Community – EEC, has become the European Union – EU.

the health and education sectors which had remained relatively heavily regulated during the first stage of reforms.

By 1993 the New Zealand economy had begun to recover and growth occurred over 1993/1994, unemployment had decreased, but living standards of New Zealanders had not improved at least not for some sections of the population in fact discrepancies had grown wider (Dalziel & Lattimore, 2004). The focus on economics, growth and wealth creation has had enormous social consequences although there are some who would argue that government philosophies have not been entirely focused on wealth creation but have in fact focused on development. Thus maintaining that government philosophies have consistently worked towards building a bigger and better society (Hawke 2002).

Workforce constraints

Labour, or human resources is a major constraint that impacts on specific programmes and has a limiting effect on the achievement of objectives. Thinking about human resources as constraint inventory enables conceptual organisation of the human resource inventory (Working Group on Select Diseases, 2003) or 'stocks' as has been described by (de Raad 2001). Some of the major issues constraining the overall labour market in New Zealand are to do with the demand side of the demand/supply equation. Organising these stocks for example into three main categories would facilitate analysis of stocks and likely the management of stock inflows and outflows. Simply the categories are as follows; quantity (lack of sufficient health professionals), limited performance (inadequate, quality training), and distribution (imbalances in available workforce) (Working Group on Select Diseases, 2003).

Quantity refers to the insufficient numbers of health professionals currently being produced by education and training institutes. There are also those under exploited human resources beyond the health sector who have not been presented the opportunities to participate more fully in the health sector. These include community based health workers, families, private sector (profit and not-for-profit), and NGO's. Movement of stocks in and out of the health sector (brain waste) and stock movements from public to private (brain-drain) depletes the numbers of health workers. Policy limitations due to restrictions, such as regulations that determine for instance the professional limitations of cadres and limitations to salary levels are very concerning (de Raad, 2001; Working Group on Select Diseases, 2003).

Limited performance issues include the mismatching of skills and programme needs through inadequate training and education. Often this is due to limited capacities of training institutes for instance, the quality of trainers, inadequate training materials, inappropriate or outdated curricula. On top of this there are issues relating to poor provider performance and low motivation due to limited management capacity and leadership and to low remuneration. An important issue that emerged in this area was the question of performance based incentives by setting targets, either in activities or in health outcomes(Working Group on Select Diseases, 2003).

There are striking imbalances surrounding the distribution or availability of workers for example geographic and location imbalances (Health Workforce Advisory Committee, 2002, 2004). Given choices individuals seem to favour urban rather than rural areas thus staff oversupply is common in urban areas and undersupply in rural areas. Even in the urban areas doctors prefer more affluent areas rather than poorer which impacts on ethnic groups and those who live in socially and economically depressed areas (de Raad, 2001). In the health sector there is evidence of imbalance between levels for example there are more workers at tertiary levels but the primary level is underserved implying a lack of clear distribution of tasks and responsibilities between the levels. Easily observable in the health sector are the gender imbalances with more women at the lower level of the system (Health Workforce Advisory Committee, 2004). There is also a tendency to allocate resources according to the professional perceived needs and to the needs of special programmes, rather than to the demand of services in the population. This mismatch between programme planning and stock planning may lead to an excess of supply for some programmes while for other programmes there is a shortage of personnel (Working Group on Select Diseases, 2003).

Generally barriers or constraints to workforce development are wide ranging, that is, human resources, stocks or inventory are not the only constraints. But in the health sector as in the education sector there is a requirement for an immediate and prolonged response. In some areas there has been some work done that goes some way to addressing some of the issues that have been identified. While labour market information has become crucially important there remains a lack of data enumerating and profiling of the health workforce and its continuing education needs.

The Health Workforce Advisory Committee (2003, 2004) identified the following issues that required urgent attention:

- a lack of consensus about the basic and cross cutting competencies or curricula needed in public health
- a lack of an integrated system for life-long learning
- inadequate incentives for participation in training and continuing education
- absence of a uniform approach to individual programme or system evaluation
- financing of workforce training and continuing education is hampered by the absence of a coherent policy and funding strategy framework
- no national framework for certification/obtaining credentials
- limited research to evaluate the relationship among individual competency, organisational performance and health outcomes
- limited data regarding effective strategies for sustaining workforce preparedness and translating research findings into interventions
- need to develop retention incentives³⁷

Career development

Given that this thesis focuses on workforce development and highlights issues of concern in relation to the labour market, human resource planning, capacity building, ‘stock’ planning and ‘inventory’ it is necessary to begin a discussion on the management of those resources (Salmond, 1993; Salmond & Bowers, 1997; de Raad 1998, 2001; Hughes, 2003; Working Group on Select Diseases, 2003). Specifically, career development, an aspect of human resource management that is closely connected to workforce development.

In the international literature, workforce development and career development are linked. For the purposes of this thesis career development is the alignment of an individual’s skills, values, interests, beliefs and culture with individual, organisational and community needs and requirements. This definition is supported by Gutteridge, Leibowitz and Shore (1993) where they state,

³⁷ See also Salmond & Bowers 1997; Health Workforce Advisory Committee 2002, 2003, 2004; Salmond 2004; Hauke-Willis, 2005

for any world class organisation seeking to survive economic uncertainty and unending change aligning individual aspirations with organisational requirements is a crucial business strategy (Gutteridge et al, 1993, p. xiii).

They maintain that there are still two further scenarios required to sustain this perspective. First, there must be some ability to monitor and plan for the future with some accuracy and second, there must be capacity to maintain a workforce that responds quickly to diverse consumer needs and highly competitive conditions (Gutteridge et al, 1993).

Other writers such as Mathews (1994), Humphries and Gatenby (1996), and Walley (1997) have included in their definitions of career development the notions of mentoring and networking and that building these relationships should be the first item on the agenda of an individual's personal career development plan. At an organisational level many have formalised these practices and promote the use of the recruitment process for employer organisations to complement current skills, reflect changes, and actualise career development within the organisation. Barnes (1994) highlights the research undertaken to determine whether management techniques, job satisfaction and career development can be used as motivators to increase overall organisational productivity. Whatever the method or strategies an organisation uses to provide career development paths for employees there are distinct advantages for the organisation, management and employees. The emphasis though in times of rapid change should focus on developing a flexible and sustainable workforce (Stevens 1992) and perhaps consideration of wider societal needs.

Research undertaken by Corin (1990), and McRae and Ramsey (1992), both point to the positive influence of mentoring in career development. One of the studies (Corin, 1990) was undertaken in a large New Zealand hospital where effective career development issues for nurses (almost all female) were raised. The other survey involved woman in senior management in both private and public sector organisations and explored the processes through which successful women obtained the skills, knowledge and support to advance in their careers. The results also highlighted changes in relation to flexible work hours and places of work, child care support, equity issues, and equal pay as incentives to stay in the health sector (Corin 1990; McRae & Ramsey, 1992). Thus emphasising that while career development is focused on individuals and then alignment with an organisation within a sector it remains an important element in developing a strong and flexible workforce.

Professionalism and unionism

From a combined workforce perspective the New Zealand Council of Trade Unions (CTU) maintain a need to be involved in any workforce development strategies for health workers. Their role is focused on health sector workers concerns and aspirations. The CTU has an advocacy role in relation to workers as well as a monitoring role in terms of assessing health sector regulations and practice, and government policies that have implications for health workers. Further, there is an expectation that public sector institutions, and policies will meet the needs of those groups who are over-represented in negative health statistics (Council of Trade Unions, 2003, p. 3).

New Zealand still has a heavily contractual health environment and often discussions are between government and the funder, usually the district health boards, not often do they include the worker. This is the legacy of the 1990's health reforms where a rift emerged between managers and clinicians that continues to strain relationships between these groups. On the other hand the CTU maintains that formalised union participation and involvement is one of the most significant contributors to building a responsive health workforce and improving the health of New Zealanders (Council of Trade Unions, 2003, p. 3). Because the labour costs within the health sector make up 70% of all expenditure therefore improving the capacity and capability of health workers is the most direct and fundamental way to improve the quality of care (Council of Trade Unions, 2003, pp. 3-4). Current recruitment and retention issues discussed earlier, illustrate the implications of not addressing these concerns. It becomes imperative that health workforce planning is not predicated on New Zealand being a low wage economy (Council of Trade Unions, 2003, pp. 3-4).

Given that the majority of the health workforce, are employed in hospitals a change in workplace culture from the market driven model of the 1990's has been slow to happen in many hospitals. It is imperative that structures are established which facilitate and support a collaborative tripartite approach, and reduce costly duplication. In *Educating a Responsive Workforce* the Tertiary Education Commission (2004) highlighted the need to build greater linkages between tertiary education and workforce development strategies. It is therefore crucial that tertiary education reforms ensure that more workers complete formal qualifications and are regularly retrained and upskilled (de Raad, 2001; Salmond & Bowers, 1997).

There was strong support from the CTU for the New Zealand Public Health and Disability Bill, which signalled a fundamental change in direction from a contractual market-driven approach towards a more cooperative and collaborative health system with increased community participation in the health sector. Public Health Organisations were seen to be a crucial part of this process because they focus on working within their communities highlighting potential increased involvement in health at local community levels. Increased public participation in local health issues would also likely arise through the introduction of largely elected District Health Boards.³⁸

Recruitment and retention strategies are required that include steps to address unacceptable workloads, introduce safe staffing standards, improve pay and working conditions, reduce student fees and debt (Health Workforce Advisory Committee, 2002). Furthermore, the health sector workforce should have access to regular industry-recognised, paid education and training. Any health workforce development strategy must have the ability to set and enforce labour standards and build the capacity of the workforce in general and for Māori in particular (Council of Trade Unions, 2003, p6).

Shaping a health workforce

Workforce development is a social process that requires shared involvement, collective action, leadership and innovativeness (Mantell, 2003). Further, innovations in workforce development, the success stories, have largely been ‘flax roots’ initiated, a phenomena that creates an unstoppable momentum not just for societal change but for integration across and within sectors (Mantell, 2003).

Workforce development, particularly medical workforce development, has a longer history stemming from the early 1970’s. In New Zealand the Medical Council of New Zealand held a national medical workforce planning workshop at Wairakei. This workshop specifically identified ‘manpower planning’ in mental health as a major concern (Salmond, 1993). The medical workshop was followed by workshops for other health sector disciplines such as nursing, physiotherapy, and general health administration. By 1980 it had become clear that taking a disciplinary approach to workforce development planning had serious limitations. Various workshops had concluded that not only a national effort would be required but that the approach

³⁸ CTU Fact Sheet 14: Health. General Publications and Articles: 15 July 2002

taken would need to be inclusive of all health sector occupations to reduce fragmentation. In 1982 the first national workshop on health workforce planning was held in Rotorua.³⁹ The proceedings from this workshop was not published until 1984 but it identified the importance of, and requirements for cost effective and careful planning of the health workforce. Further, the Report highlighted that planning a workforce was part of the wider task of planning health care and in this sense the government should have a leading role in both health care planning and workforce planning. Other features highlighted included the likelihood of future health care resource constraints therefore in order to conserve resources a significant and sustained improvement in the management of health resources would be required across the sector. Furthermore, it was noted that changing public attitudes would more than likely place a greater emphasis on specific areas such as health promotion, disease prevention, and delivery of health services in communities (Health Workforce Advisory Committee, 2002; Nahkies, 1996; Salmond, 1996; Beaglehole & Bonita, 1997).

A number of planning propositions were identified in the report encouraging the involvement of interested parties in the planning process such as employers, and for joint planning to occur among the health related occupations. Essentially coordination and integration of government action in health care and education was highlighted as being core to this development. Beaglehole and Bonita (1997) argued that improvements in public health would only occur if health, in a broad sense, became the focus of public policy making. Adding that issues such as role definition, standards, quality of care and productivity would require greater attention. At the time the focus on stocktaking and the supply side of workforce planning was more distracting than helpful (de Raad, 1998). They maintained that better planning processes in an integrated health workforce planning system would require structural change and would therefore assist in the prevention of the over supply of health workers in some fields. The Report recommended the immediate establishment of a Health Workforce Advisory Committee to the Minister of Health. Features of this recommendation included: the establishment of information systems, networks and working parties to address key workforce issues, the appointment of a key person to lead and manage the activities of the advisory committee planning secretariat and last, that a budget be allocated to the advisory committee that would support not only the activities of the committee but also significantly support a research and development programme (Nahkies, 1996; Salmond, 1996; Beaglehole & Bonita, 1997; Health Workforce Advisory Committee, 2002).

³⁹ The Health Services Manpower Planning Workshop, Rotorua, September 1982.

By 1984 when the proceedings from the workforce planning workshop was published the momentum, energy and commitment to support the recommendations had waned. Ministerial and government support, which had been positive at the workshop even to the point of implementing some of its recommendations, was lost. The incoming Labour Government rejected the recommendations. There were no health workforce development initiatives over the next decade. Even during the National Government's 1991 health reforms, the workforce development planning document and its recommendations advanced earlier were again rejected. Proponents of the 1991 health reforms felt that there should be no state interference in a market driven health system. A nationally co-ordinated effort to plan and develop a health workforce languished –structures dismantled, resources were withdrawn and the collection of health workforce statistics were discontinued⁴⁰ (Salmond,1996).

Prior to the health reforms in 1993 several issues were raised in relation to the management of resources in the health sector. Especially the relationships between health and care and aspects of health sector reform in New Zealand that included funding, production, workforce development, devolution and accountability (Scott, 1989). In 1993 the New Zealand health sector underwent major health reforms. Radical changes in the health system took place with no consideration of 'cultural imperatives'. Almost overnight a free public health system was dismantled and replaced with a 'user pay' system. Clinicians, in many cases were forced to become business and management focused with a commercial orientation, a situation that steadily became unbearable and by the time of the general elections in 1996 the reforms were at risk of failure and were high on the agendas of political parties (Hornblow 1997).

The socio-economic reforms of the early 1990s promoted a market driven approach to a previously state driven health and social service system. A purchaser /provider split while presenting opportunities for some groups once again highlighted health care staffing disparities in specific occupational and disciplinary areas. Mental health for instance had become a major concern in terms of workforce disparities. By 1994 both mental health and Māori health had become health gain priority areas. The opportunities offered through the purchaser /provider split enabled increased participation by Māori and other groups in relation to the provision of health services. The growth in Māori health providers was phenomenal increasing from around

⁴⁰ Initiatives recommended in the Workforce Planning Report such as the establishment of the Health Workforce Advisory Committee, a budget to support the initiatives of the committee including research, and the collection of statistics on the health workforce had been put in place prior to the publication of the Report by the National Government but were cut by the incoming Labour Government.

20 in 1993 to over 220 by 1997 (Health Workforce Advisory Committee, 2002, p13). Māori participation in health service delivery was a positive development, however no workforce development planning had taken place prior to this growth. Remedying the dearth of Māori health workers across all health occupations had suddenly become of paramount importance (Nahkies 1996; Salmond & Bowers 1997).

As one of the main outcomes of the 1993 reforms the purchaser/provider split aimed to increase effectiveness and efficiency in health services purchasing and provision including access to and better choice for consumers. Primary and secondary care services would be integrated and waiting times for essential services would be reduced. The overall response to the reforms was one of public opposition and high levels of concern from health sector professionals and individuals. In 1996 the first coalition government tempered the reforms by dismantling the major commercial profit and competitive objectives and endorsed a cooperative and collaborative approach to health service provision (Hornblow, 1997).

In 1996 issues raised at the Committee Advising on Professional Education (CAPE) workshop highlighted the lack of planning or description of future training needs for specific health professional groups. To this end it was reported that the present education and training delivery system was not meeting current needs let alone capable of meeting future needs. For example, mental health and Māori health staffing shortages were considered to be 'serious' constituting a situation, which severely constrained the effective and efficient delivery of health services in both mental health and Māori health (Salmond & Bowers, 1997). Hughes (2003) noted similar disparities with ethnic minorities in the United States in relation to workforce issues and diversity. Other health professional staffing shortages were occurring at the same time in areas such as physiotherapy and general practice. Māori representation in the health professions, as well as that of other minorities, was generally inadequate and increasing staffing was urgently required in order to cope with an increasingly diversified population. The ability to communicate and empathise with diverse populations was considered to be essential for effective delivery of health services. Educational institutions were deemed to have played a major role in health professional staffing deficiencies; however well intended they were, they had done "little to redirect education for health professionals to make them change agents not just for education but for health care delivery as well" (Pew Health Professionals Commission, 1993, p. 12-13). CAPE found that the New Zealand situation mirrored that of USA (Committee Advising on Professional Education - CAPE, 1996; Nahkies, 1996; Beaglehole & Bonita, 1997; Salmond & Bowers, 1997).

Other issues identified included the absence of a clear policy framework defining training goals and objectives and assigning responsibilities for delivery. This issue highlighted the tendency for excessive fragmentation and compartmentalisation instead of co-ordination and leadership in the development of policy for the education and training of health professionals across the sector (Nahkies, 1996). It was not clear though who should take responsibility for this role, some in the health system believed that responsibility for health workforce development lay with Government (Salmond & Bowers, 1997) others thought employers/providers should take responsibility. Either way sustainable health workforce development required an emphasis on leadership and long-term strategic focus including the collection and dissemination of appropriate workforce planning information for decision-making purposes.

For many employers/providers a long-term commitment to workforce development was difficult because of the way in which they were funded (1-3 year contracts). In this sense, the state was considered better placed to undertake a more formal leading role (Health Workforce Advisory Committee, 2003). As the earlier workshops on health workforce planning had indicated, state leadership and commitment is not only essential but required integration, collaboration, and co-ordination between three government agencies health, education and labour (Ministry of Health & Ministry of Education, 1996). The objective of the CAPE workshop in 1996 was to rekindle an interest in workforce planning and development. However, while interest was apparent and there was general agreement that workforce planning was urgent, no clear leadership role was undertaken and again efforts floundered⁴¹ (Martin & Salmond, 2001; Health Workforce Advisory Committee, 2002).

More recently there has been a renewed and wider interest and commitment to health workforce planning and development and a number of initiatives have emerged. In 2000 the New Zealand Public Health and Disability Act made provision for the establishment of the Health Workforce Advisory Committee (Health Workforce Advisory Committee) in April 2001. The Ministry of Health followed suit by establishing a Workforce Advisory Group within the Ministry of Health to co-ordinate workforce initiatives within the Ministry, and a workforce development focus is also a feature of District Health Boards. Given the rise in consumer awareness and increased expectations and the establishment of a Health and Disability Commissioner, workforce planners have had to adopt a more business-like approach taking into account not only cost and quality

⁴¹ CAPE was disbanded in 1999

issues in health service delivery but taking heed of consumer perspectives (Health Workforce Advisory Committee, 2002).

The Health Workforce Advisory Committee provided a comprehensive report (2002) that assessed current workforce capacity and outlined a number of issues that needed to be addressed in order to meet both the New Zealand Health Strategy 2000 and the New Zealand Disability Strategy 2001. In the report the committee acknowledged the need to establish the level of responsibility for different aspects of workforce development. The Committee identified specific roles for both the state and employers and opted to facilitate these roles and seek collaboration between the different organisations involved in developing a workforce, this continues to include employers/providers (Health Workforce Advisory Committee, 2002).

The New Zealand Health Strategy 2000 prioritises seven key strategies each of which requires specific workforce development initiatives to meet overall strategic objectives. Current priorities reflect those that were prioritised at earlier workshops in the 1980's and 1990's. For example Māori health and mental health workforce development remain Government priorities. Additional priorities are identified in the New Zealand Disability Strategy and the Primary Healthcare Strategy. Waiting times, diabetes incidence and impact and inequalities also feature as priority health gain areas. Clearly the overall strategy and the seven specific strategies indicate that a paradigm shift is taking place from a totally market driven approach to one in which the Government has a clear leadership role. Thus the roles of health practitioners, the education and training of health practitioners, and the management of health practitioners will be required to reflect these new service priorities (Ministry of Health, 2000).

Further, Health Workforce Advisory Committee's recommendations to the Minister of Health highlight priority areas for Health and Disability workforce development and are based on a strategic vision set out in the Government's policy documents. In 1996 Salmond commented that:

To build a strategic vision for the health workforce, we must start with a vision for health, within that a vision for health services, and within that again, visions for the health workforce as a whole and for its component parts. To build such visions will take time and effort. Policy makers, purchasers, providers, clients/patients and the health-interested general public, all must be involved in the gathering and sharing of information, in the development of scenarios, and the creation of a shared vision for health and health services. The structures and processes used to create visions and to set strategic directions are of the utmost importance. International research shows that companies which have a strategic

vision which is authentically communicated to their employees can tap higher levels of productivity from employees because it touches their hearts. (Salmond, 1996, p. 9)

In line with Salmond's commentary, Health Workforce Advisory Committee's vision contains the following key elements: the Treaty of Waitangi; a public health and primary care focus to development; equitable and affordable access to services; reducing inequalities; a safe, high performing and efficient health system; active user and community engagement (Health Workforce Advisory Committee, 2003). From these elements the recommendations for workforce development is the need to take account of the health workforce implications detailed in the Primary Healthcare Strategy; the development of healthy workplace environments; the evolution and further development of health workforce education; Māori health workforce development; Pacific health workforce development; the evolution and development of the health and support workforce to better meet the needs of disabled people; and to facilitate the enhancement of health workforce research and evaluation capability (Health Workforce Advisory Committee, 2003). For each of the recommendations there is a focus at different levels on consumer and staff satisfaction, career development and opportunities, recruitment, selection and retention of a quality workforce. This focus advocates the innovative application of a range of approaches that have previously seen most use in the domain of business.

A more business-like approach to workforce development, training and education ensures an involvement and consideration of all stakeholder groups. Whilst this thesis is focused on health workforce development, the processes and strategies offered in an international business context can be applied to a diverse range of organisations of different sizes and in differing cultural contexts and sectors. These same strategies and processes have been identified as being useful for private and public sector organisations including those that are commercially, culturally, and community oriented.

Training and education agencies

The Clinical Training Agency (CTA) was established to purchase post entry clinical training (PECT) of health professionals on behalf of the regional health authorities⁴². The role of the CTA is "to contribute to the health of New Zealanders by promoting the advanced training of

⁴² Changes in the health sector have occurred- RHA's became HFA then were assumed back into the MOH.

health professionals to a level of competency sufficient to meet the requirements of the health and disability support services” (Lawson-TeAho, 1997, p. 31).

It was identified that PECT would be vocationally focused rather than academic or research; clinically based with a substantial clinical component where employment in a clinical setting is integral to the completion of the qualification; assist in post entry development of professionals; that training would be formal and specialised; recognised by the profession and/or health sector and meeting a national service skill requirement rather than a local employer need.

Medicine can be studied at the University of Otago and the University of Auckland both of these institutions have Medical and Health Science schools at other locations. For example Wellington and Christchurch medical schools are attached to Otago and access to clinical training is provided in Hamilton via Auckland. Entry to medical education and training is restricted, for example in Auckland to 180. Capping numbers to medicine is mainly due to the high costs associated with the course of study. Increasing of funded places is doubtful if unmet demand cannot be achieved by other means such as immigration (Health Workforce Advisory Committee, 2002). The medical profession is regulated by the Medical Council of New Zealand, whose role is to maintain registers of medical practitioners, approve undergraduate education programmes, and promote continued training. There are also a number of other professional medical associations and vocational colleges that exist to support or advocate for their members, clients, and review policies. These include the New Zealand Medical Association, the Association of Salaried Medical Specialists, the Royal Australian and New Zealand College of Psychiatrists and many others. For most of the vocational categories there are additional specific training and education requirements to meet (Health Workforce Advisory Committee, 2002, pp. 70-71).

Nursing and midwifery training is provided by over 18 universities and polytechnics throughout New Zealand and while programmes might differ in structure they are all required to meet NZQA standards and requirements. As with the medical profession there are various organisations and associations that have a regulatory role or interest in the nursing profession. The Nursing Council of New Zealand has a similar role to that of the New Zealand Medical Council. Some of these groups include College of Nurses Aotearoa, National Council of Māori Nurses, and the New Zealand College of Midwives (Health Workforce Advisory Committee, 2002).

There are 8 Universities and polytechnics that provide education and / or training specifically designed for health managers. While this group is considered to be important in health service delivery, purchasing, administration and management, there is little data available to assess the size and scope of this workforce in relation to training and education requirements. Social workers are also seen as integral to the health workforce multi-disciplinary team approach to health service delivery, and training and education is offered in the Universities and most Polytechnics in New Zealand (Health Workforce Advisory Committee, 2002).

Training and education data for primary and allied service health care workers were identified in the Health Workforce Advisory Committee's stocktake in 2001. These include people whose work is intertwined or spans the boundaries of other sector groups such as GPs, mental health, and public health, and disability health services. It is clear that change is required across the board in the health sector and regular statistics on the state of the workforce is important. There were areas for which there was no information available at the time for example the numbers of community health workers was missing (Health Workforce Advisory Committee, 2002).

For most training and education programmes funding is accessed from the various Government agencies such as the Ministries of Education, Health, social development, Labour although some of the professional bodies also provide funding for training. Many employers/providers also offer training, education and up-skilling packages as part of remuneration.

The international scene

Some work has been undertaken in the last decade in relation to organisational career development. For instance (Gutteridge et al, 1993, p. xvii) describe organisational career development as "consciously linking people's career plans with the organisation's workforce needs, which has blossomed in the last decades as a strategy for improving workforce effectiveness." In the early 1990's an international study was undertaken sponsored by the American Society for Training and Development (ASTD). The study aimed to examine two questions: what is the 'state of the practice' of organisational career development in the 1990's and What is the 'state of the art.' This involved a range of different types of organisations from both the private and public sectors. The Study identified a number of important trends and issues that impact on an organisation's workforce that have relevance for the New Zealand situation and in particular the health sector in relation to developing workforce capacity.

While the clash between business culture and that of health practitioner is widely known the rapidly changing environment and focus on consumer satisfaction requires a more focused approach. Whether in health or business managing and developing a workforce to meet societal needs and aspirations requires knowledge in financial management, budget control, strategy development, planning, people management, communication systems and information technology (Health Workforce Advisory Committee, 2002).

Workforce and career development in New Zealand needs to be broadly defined to take into account both organisational and health sector goals and objectives thus linking business strategies with people and societal development becomes a priority. Not only is the wider economy continuously changing so too are workplace environments. Long-term job security is continually being challenged therefore, skills, commitment and energy are required for a strong and flexible health sector (Gutteridge et al, 1993).

Cross sector multi-disciplinary teams are becoming a feature of the New Zealand health workforce providing flexible work environments and hours of work to suit individuals within the team. This type of teamwork facilitates growth across the sector and within health organisations rather than moving upwards although small provider organisations may be constrained and less flexible or their size may enable more fluid movement across the sector. Building enduring co-operative relationships with other providers would be sensible in these situations (Martin & Salmond, 2001).

Current health sector workforce participation fails to reflect the diversity of the population but it has been identified that the health sector is likely to benefit with a more diverse workforce (Durie, 2003a). Therefore, increasing the numbers of women, minorities, Māori, disabled, and older workers means a focus on recruitment and retention of workers.

Business themes that emphasise customer service, excellence, and continuous improvement are already a feature of the health sector thus highlighting quality of services and better choices for consumers. With increased quality of services comes an increased awareness of the importance of the new competencies, effectiveness and efficiencies as these lead to the creation of atmospheres within organisations of learning and continual development. The health sector regulation systems could foster this process (Gutteridge et al, 1993).

New technologies have changed and transformed workplaces bringing the world in closer proximity which places obligations on organisations to ensure their workforce are continually up-skilled, up-dated and qualified to keep pace and operate in a global rather than a national context (Durie, 2005a; Health Workforce Advisory Committee, 2002).

In England the Grantham Model⁴³, as a planning tool, is widely used in the training and education of the workforce in many health organisations. The model uses the notion of marginal analysis developed in the field of health economics. It assumes that most training in an organisation will be based on accurately identified needs, which have been soundly prioritised, using the demand/supply models referred to earlier. In this sense workforce planning concentrates on evaluating changes that occur at the margins. There are 3 key stages to planning using this model:

1. it assumes existing training is useful and accurately targeted.
2. identify the changes within and outside of the organisation that will have training activities or marginal value, and
3. modify the existing pattern of training in line with the changes required at the margins, and then monitor the results through the continuing recording system.

Key information in designing a training database includes the number of trainees and the number of training days. With the inclusion of the number of positions by staff group, from these sets of data, a set of computerised calculations can be derived (Arnett, Johnson, & Teasdale, 1992, pp 23-26).

While the model mainly focuses on training within organisations it could well be adapted to take into account a number of other external elements and be broadened to include the culturally diverse inputs required for example, Māori professional health training.

Research literature in the field of workforce development suggests that knowledge is considered one of the most valuable commodities of a business and well trained workers its most valuable resource (Gutteridge et al, 1993). The means used by organisational leaders to prepare employees

⁴³ A model that uses economics /supply and demand for resources to determine career development initiatives for organisations is termed the Grantham Model because it was developed at Grantham in the UK and is applied in a wide range of Industries to determine career development and workforce needs. It is simply referred to as the Grantham model.

for work are varied, but an ever-increasing number of the most profitable American corporations are returning to institutions of higher education for this training. A key to the success of the corporate/college training collaborative is the assurance that the outcomes addressed in the college training curriculum will mirror those outcomes desired by the organisation, especially those organisations willing to embrace diversity (Clarke 1995). All too often this mirroring of goals does not occur. As a result, all across the US accrediting boards, legislators and local business partners are calling for greater accountability for, and reporting of, the effectiveness of public educational institutions. Embedded within these effectiveness processes are performance indicators which report how well college programmes are able to address the needs of local corporate partners. As college personnel begin to report on effectiveness, a pronounced gap often begins to appear between the processes or methods the college uses to provide training and measure its success, and those measures or processes valued by the corporate partner (The Pew Health Professions Commission 1993a, 1993b; Calaway 1998).

In the US changes in healthcare systems are profoundly affecting health professionals who work within them. Three health professions education and workforce issues are key:

1. 'changing or re-engineering,' the process by which healthcare is provided/delivered, to make delivery systems more responsive to the demands of cost, patient satisfaction, and quality of care,
2. regulating the healthcare workplace by updating the health professions practice laws that govern entry, define scopes of practice, and provide quality oversight, and
3. changing the size and orientation of the health professions workforce especially in medicine and nursing. (O'Neil & Riley, 1996, pp. 107-108)

Rapid change in the market place and national policy reform in the US health system are being challenged. Some of the issues that have been raised in various forums are the inevitability of change, which will affect both health professionals and patients/clients. An unparalleled explosion of the knowledge and technology industries further exacerbates the rapidly changing environment; cost consciousness and accountability will be the central tenets of the future health care system. Those favouring the market approach see the growth of managed care and the accompanying increases in competition as creating incentives for primary care and diminishing opportunities for sub-specialists (Leroy, 1994). As has been the case in NZ there is expected to be some resistance to the impending changes in the US health care systems for instance (Fox,

1996) ascertains that policy to subsidise the education of health professionals in the US has become contentious and uncertain.

From early in the century until the 1970's most decision makers viewed policy to subsidise the education of health professionals as self-evidently correct. As consensus eroded, proponents insisted to increasingly sceptical audiences that these subsidies created benefits for the public. Recently, decision-makers outside healthcare institutions have come to regard workforce policy as serving particular rather than general interests. (Fox, 1996, p. 825)

The changing work environment also has implications for employees in that organisations are initiating a more employee-driven approach to career development, using a formalised plan which includes assessment of skills, individual goal setting and training to improve any skills that are lacking. There is an opinion in relation to career development in that it requires an organisational culture change (Cohen, Duberley & Mallon, 2004). For career development processes to be successful, everybody, including the senior executives, need to adopt a new paradigm for career development. In the past, perceptions of career development were, to receive regular promotions for high performance, to accept assignments as given and to allow someone to make career decisions for them. Traditional areas for promotions were to positions as assistant managers or branch-facilities managers. But both these niches have been eliminated in the reorganisation or restructuring across the economic and social sectors. Concerns in some organisations were that a new career-development process would lead to unfulfilled expectations (Simonsen & Wells 1994).

A fresh approach to career development needs to be communicated for example, that it should be employee driven so that employees are empowered to manage their own careers, that employees should consider many types of career goals not just promotions, ones career should be considered in stages, rather than next-job thinking. This model helps people see the tremendous leadership opportunities in a team structure, even though there may not be a manager title, that individuals should link their career goals with the direction, needs and realities of the company/organisation (Gutteridge et al, 1993). People who will have opportunities in the future are those who plan their career strategically, positioning themselves with the skills, competencies and type of experience that the company/organisation will need for success in the future.

One of the requirements will be to access and develop skills. In the study by Simonsen and Wells (1994) employees most commonly identified assertive communication, conflict resolution, team building and linking skills, and goal setting for individual and team approaches. Encouragement

was given to attend additional external training in other fora (eg. educational institutions, seminars, and conferences). They found with the flattening of the organisation the career development programme could help all employees assess their skills, identify in what areas they required strengthening and to encourage employees to be more proactive in their own career development planning. A function of managers in this process was identified as being the ability to undertake some form of reality testing. In other words in addition to coaching employees, managers are expected to give feedback on how realistic employees' goals are, given the needs and realities of the company/organisation (Hauk-Willis, 2005).

To facilitate the implementation of the new career development process changes have also occurred in administration procedures such as regular performance review planning. The result is a continuing evolution for change and an increase in collaboration between individuals and organisations. Indeed, there is now a realisation that collaboration can only occur among equals; hierarchical systems do not in any shape, way or form support collaboration and co-operation (Simonsen & Wells, 1994; Hauk-Willis, 2005) .

In 1993, New Zealand implemented radical health sector reform, separating purchaser from provider and creating a competitive market. To determine the impacts and implications of the health reforms views from senior managers in public health services were collected. Comments on the 1994 survey of senior managers' perceptions of how well public health services were adapting to this more commercial environment were noted. Chief executives expressed generally positive views about the importance of public health, especially health promotion, within their organisations. Public health managers indicated a wide range of negative and positive views about the new system. They were especially concerned about service fragmentation, diminished information-sharing and decreased collaboration, especially with Māori and general practice providers (Laurence, Barnett, & Nuthall, 1996). This concern has become more evident in recent years.⁴⁴ More positive views were expressed concerning an improved focus on outputs and clearer directions, and none wanted to return to the former era of an entirely separate system for public health systems (Laurence et al, 1996).

As in most western countries the special position that health professionals have occupied and the ways in which changes threaten the foundations of professional work are under review.

⁴⁴ See for example Durie, 1994, 1995, 1996, 1997, 1998, TPH research reports 1994-1998, Lawson-Te Aho 1995, 1996, 1997.

Advocates for the status quo assert that the application of modern management principles to health care runs the risk of overriding the action orientation that is a defining component of professional work. Proponents for the status quo tend to seek opportunities for the preservation of “professional voice” as a countervailing force to ensure high quality care. They [the professional voice] recommend that contemporary models of change applied to health care workforce should include:

1. a professions model securing and maintaining professional jurisdiction,
2. a strategic adaptation model in which professions attempt to adjust to changing environments, and,
3. a model of redesigning patient care which applies total quality management and other industrial techniques to the healthcare workplace. (Schneller & Ott, 1996, p. 121)

Thus ensuring health professionals maintain a semblance of control over the health sector albeit in a more relaxed form. In many respects this is where the biggest changes need to occur because power and control has in the past been monopolised by the health professional workforce.

Whilst gaps in health workforce development have been recognised across the board there are identified needs for development in mainstream organisations working in the health sector. In particular the public health workforce has come under considerable attention. Early in 1997 the Health Research Services Centre based at Victoria University and under the direction of George Salmond⁴⁵ were commissioned by the Health Funding Authority to undertake an analysis of the status of the public health workforce and make recommendations for improved public health workforce development. Issues raised in the report included:

- infrastructure issues such as workforce and provider development being the responsibility of organisations providing public health services rather than a central government responsibility (Salmond & Bowers, 1997, p.16)
- a consideration of the broader social determinants of health such as socio-structural factors, poverty and inequalities in health, inter-sectoral linkages and the need for more inclusive educational and multidisciplinary approaches (Beaglehole & Bonita, 1997 as cited in Salmond & Bowers, 1997, p. 23).

⁴⁵ Comments on a comprehensive review of public health workforce development commissioned by the Transitional Health Authority. Looks at a seminar by Job Wyn Owen comparing NZ and Welsh health services (Salmond, 1997).

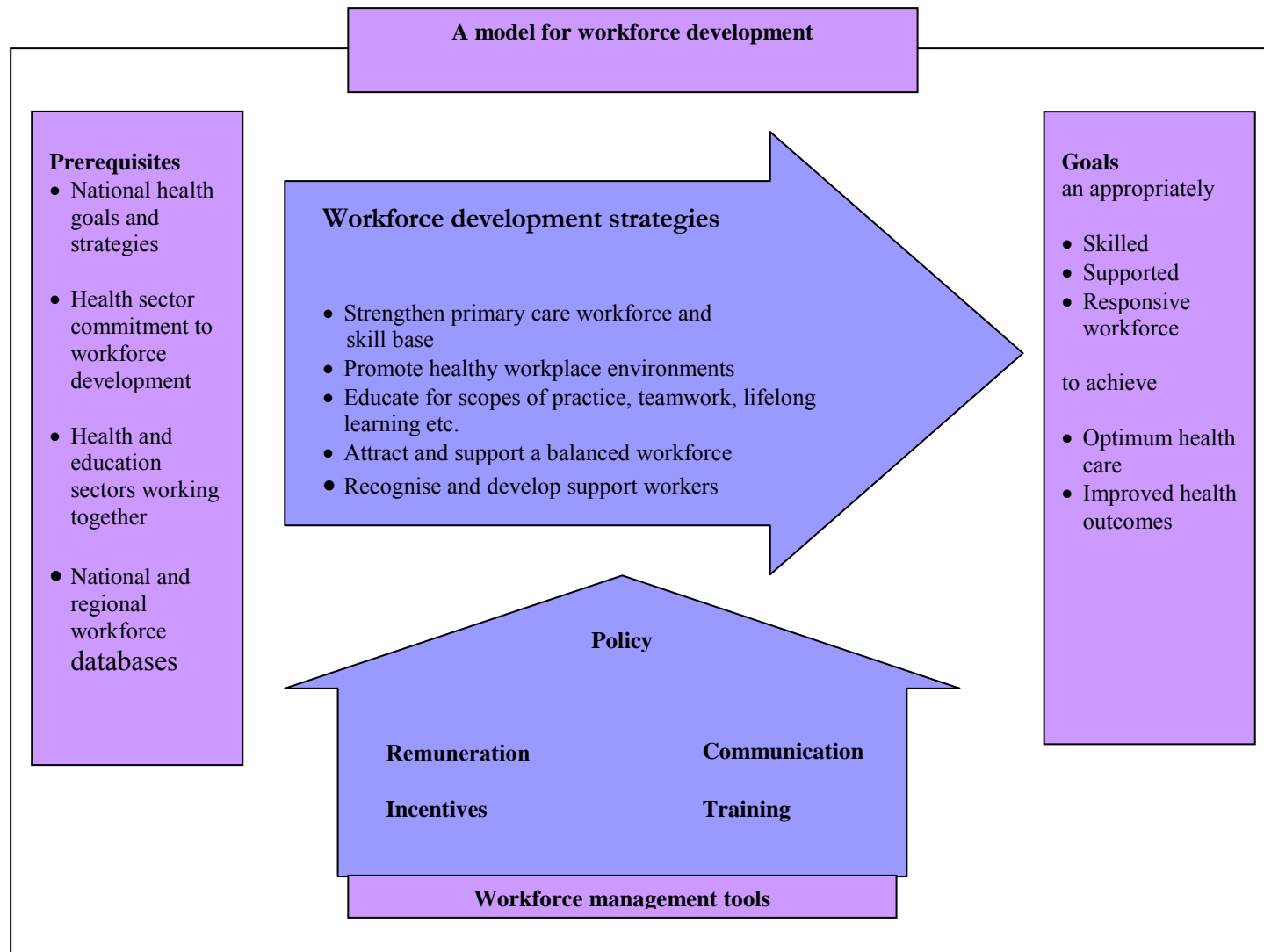
- indigenous peoples issues such as their dissatisfaction with their perceived place and role in society and actively lobbying for change (Salmond & Bowers, 1997, p. 25;
- workforce planning issues – lobbying for changes to traditional ways and means of planning and managing the health workforce (Salmond & Bowers, 1997, pp. 27-28)
- information gaps – new workforce development processes need to be information rich, timely, dynamic and flexible rather than ill informed, mechanical and rigid as they have often tended to be (Salmond & Bowers, p. 29).
- compared with other countries education and training opportunities in health and health management are extremely limited (Salmond & Bowers, 1997, p. 30)
- participation of consumer and community organisations in planning and management of services is not encouraged and (Salmond & Bowers, p. 31)
- issues of leadership and collaboration, which include the need for, increased public debate, reduction in income inequities, re-orienting governments, testing new coalitions, increased research and ability to challenge at high levels of influence. (Salmond & Bowers, 1997, p. 33)

Clearly the issues raised, and health workforce development are both a national and international issue, and in terms of indigenous peoples, a crucial issue. While many of the issues raised by Salmond and Bowers (1997), have been incorporated into the health sector and are being addressed by organisations and Government, the process is long and arduous for some groups such as Māori. In 2003 the Health Workforce Advisory Committee developed a model (figure 4.5) on the following page as key to health workforce development. The model for health workforce development has four separate but linked components. The first outlines prerequisites, those aspects surrounding national health goals and strategies, a committed health sector, integrated sectors of health and education, and the need for nationally and regionally linked databases. Second, that workforce management tools, which directly impact on individuals in the workforce – policy remuneration, incentives, training and education, must be considered in the development of strategies for workforce development. Third, that these strategies should aim to strengthen the workforce and skill base, promote a workforce environment that is in itself healthy, educate and promote practice teamwork and lifelong learning, ensure a balanced workforce, and to recognise and develop support workers. The final component highlights the intended or expected outcomes from workforce development initiatives (Health Workforce Advisory Committee, 2003, p31). The model, while specifically

developed for the health workforce development, can be applied in other sectors. Workforce development is not just a concern of the health sector there are wider implications.

Conclusion

That the health sector is influenced by global, and government change and economic performance is certain. Planning for change and continuous improvement in health service purchasing and delivery is likely to be an ongoing feature of the health sector. Developing a strong and flexible workforce should be a major component of future workforce planning across sectors taking account of health in a broad context. Given that the health sector can draw from other disciplines such as economics and business management practices provides access to useful planning and management tools for workforce planning. Issues relating to health workforce development are more generic than specific but require co-ordination, integration, and Government commitment, support and leadership. It will also be important in the future to link individual workforce training and education needs with organisational and sector needs through career development and planning. Further, given the diversity of the population the health workforce should also reflect that diversity and workforce planners should take into account the constraints and barriers that prevent individual and group participation in the health workforce. Embracing change and diversity will likely add new energy and commitment within the health sector and should improve organisational and sector ability to recruit and retain a competent workforce into the health sector.



Source : Health Workforce Advisory Committee, 2003, p31

Figure 4.5: A model for workforce development

Chapter 5

MĀORI WORKFORCE RESPONSIVENESS

*He taonga rongonui te aroha ki te tangata*⁴⁶

Introduction

Māori workforce responses to change and development over time is a central theme of this chapter. Participation in, and Māori experience of work across sectors, the before and after effects of social and economic reform of the period 1984-2004, and beyond, are presented to provide a backdrop to workforce development and participation in health.

Concentration of the Māori workforce

Māori health development and participation in the health workforce is not just about individuals and nor is it confined to the health sector. Māori views and aspirations dictate a broader collective approach, and focus on the wider parameters of Māori development to advance Māori health (New Zealand Institute of Economic Research, 2003). Māori collective contribution to work and participation in the workforce across a range of sectors has been substantial given significant alienation from land and other economic resources as a result of colonisation. Prior to colonisation and for a short time after the signing of the Treaty of Waitangi, Māori participation in work involved not only being the providers of produce for early European traders and other tribes but also the providers of employment for whānau and hapū. As a result early Māori agricultural and horticultural methods, techniques, values and philosophies continue to guide modern farming and market gardening practices (Tait-Jamieson, 2004, as cited in Harmsworth, 2005; Gillies, 2006) and many other Māori economic activities (NZIER, 2003, 2006).

In the 19th century land based activities, and a cash economy became a vital source of Māori economic growth and employment. Although large scale land alienation in the latter half of the

⁴⁶ In Mead and Grove (2004). Ngā Pēpeha a ngā Tipuna 738 Mackay: 1962:91 p. 122. 'Goodwill toward others is a precious treasure' – an acknowledgement to the whānau whānui o Rangitāne.

19th century reversed Māori status as landowners and employers to that of farmhands or servants to new settler owners. Even with this turnaround Māori remained rural dwellers struggling to survive while the cities and towns grew with mainly Pākehā immigrants. In the early 20th century, in an effort to safeguard Māori land that still remained in Māori ownership and to get Māori whānau and hapū back working their lands Sir Apirana Ngata encouraged Māori to participate in his Native Land Development Scheme. Te Puea Herangi and Awhina Cooper saw the future economic, health and cultural benefits that could accrue to their people with such a venture and took up Ngata's invitation (King, 1977).

Up until the end of WWII Māori continued to be based in rural areas working their own lands or in similar work for Pākehā farmers. However, as whānau expanded in size, the land base that had previously provided an adequate income and sustenance was unable to sustain a growing whānau. Migration to urban centres for work was encouraged by the Government to ease the labour shortages in a range of industries that had emerged after the war. By 1975 almost 75 percent of the total Māori population had migrated to the cities.

The bulk of Māori workforce participation was as manual labour concentrated in industries that required no qualifications and minimal skill. Many of these industries were also state or local government owned. Large numbers of Māori gained work on the railways, public works (road works), wharves, factories and freezing works. Those who still preferred a rural landscape and were more mobile worked in shearing gangs, forestry and scrub-cutting. Many jobs were seasonal, (e.g. freezing works, shearing) and paid well, allowing some workplace flexibility and variety for workers.

The effects of economic restructuring and rationalisation

In many respects full Māori employment is relatively the only positive legacy of the period 1950-1970. From 1970 not only the effects of urbanisation on Māori cultural and social structures had become apparent to Māori leaders but, New Zealand was about to enter a prolonged recession which was to have a severe impact on the Māori population generally (Chapple & Rea, 1998; Chapple, 1999, 2000; NZIER, 2003; Dalziel & Lattimore, 2004; Ringold, 2005).

The mistake of the National Government was to think that the oil shocks of the 1970s would remain in place for the long term. However well intentioned their policies to maintain economic growth, low unemployment, and cushion domestic markets, by 1977 unemployment rates had started to rise. By 1979 the Government had embarked on a strategy to reduce the country's dependence on imported fuel by investing in projects focused on developing new energy sources. The 'think big' projects included the "Petrocorp ammonia-urea plant, the Motunui synthetic fuel plant, the expansion of the Marsden Point oil refinery, the Waitara methanol plant, the Glenbrook steel mill expansion and the proposal for an Aluminium smelter" (Dalziel & Lattimore, 2004, pp. 22-23). The success and viability of 'think big' was reliant on the continued rise of oil prices through the 1980's. When oil prices dropped quite significantly the resulting debt of \$6 billion was added to previous debt. It became evident drastic measures were required to restabilise the New Zealand economy which was experiencing high interest and inflation rates and increasing unemployment. The impact of the recession and economic restructuring in the 1980s and 1990s affected Māori significantly more than other populations. Māori employment in low skilled occupations plummeted because of industry closures, restructuring, and downsizing. In 1986 the Māori unemployment rate soared to 11.3%, the highest it had been since WWII, it continued to rise to 26 percent in June 1992 but, by June 2004 had decreased to 9.5 percent (Department of Labour, 2005). In comparison non-Māori unemployment rates have never exceeded 8 percent even through the recession (Dalziel & Lattimore, 2004). Māori job losses in real numbers equated to 25,500 in the period 1986-1992.

Table 5.1: Māori labour market outcomes

| Māori labour market outcomes | | | |
|---------------------------------|---------|---------|---------|
| Calendar years | 1986 | 1992 | 2003 |
| Employment ^a | 134,400 | 108,900 | 186,800 |
| Participation rate ^b | 67.0 | 59.6 | 65.7 |
| Unemployment ^c | 11.3 | 25.4 | 10.2 |

Source: Statistics New Zealand (2005).

a: annual average.

b: % of the working age population, annual average.

c: Unemployed as a % of labour force, annual average.

Since 1992 Māori workforce participation rates have increased across the labour sector. However, Māori are still more likely to be employed in occupations that require no or low, to semi-skilled workers, are low paid, and are therefore still more susceptible than other population groups to economic fluctuations.

The reforms have changed the conditions and climate of employment. In most occupations evidence of school, academic and work achievements are necessary, it is no longer possible to step into jobs without some qualifications or experience, even in the lower skilled jobs. While there has been increased participation by Māori in early childhood and increases in Māori levels of attainment at secondary school, Māori educational participation and attainment is still below that of non-Māori.⁴⁷ The most significant increase in participation rates can be seen at tertiary level education although mainly in certificate level programmes. Despite these gains Māori are more likely to remain represented in low/semi-skilled occupations. But on the upside, Māori in the workforce are now more likely than they were in 1986 to have some sort of qualification thus providing better opportunities to enter and remain in the workforce. Higher qualification levels also lead to better employment and higher levels of income and therefore likely to lead to improved living standards. However, although there have been significant increases data still reveals that for any given level of qualification Māori still earn on average less than non-Māori (Dixon & Maré, 2005; Ringold, 2005; Statistics New Zealand).

Whilst urbanisation provided essential employment at a time when employment in rural areas was in decline, for many Māori urbanisation resulted in enduring harmful social consequences. For example, Government had not considered the accommodation needs of larger Māori families. Living conditions in the city were overcrowded and unhygienic (King, 1983). Coming from rural communities where rents for accommodation were unheard of, many Māori struggled with the concept and as a consequence eviction notices were a common feature of urban living. Furthermore, landlords were reluctant to rent properties to Māori, high rents were charged for sub-standard accommodation, and many of these properties had no essential services (water, power, heating) (King, 1983). In 1953 Awhina Cooper as president of the newly formed Māori Womans Welfare League, presented the findings of a housing survey carried out in Auckland, to

⁴⁷ Refer to chapter three for a more detailed discussion of Māori participation and attainment in education.

the Government. The Report highlighted the unsanitary, unsafe, and poor conditions many Māori families were experiencing. Conditions that she contended were leading to alcohol abuse, violence, child abuse – thus threatening Māori health and well-being (King, 1983). Government's response was to eventually include Māori applications for low cost housing under the State Housing Scheme and alleviated some of the conditions revealed in the survey but accentuated others:

For the Māori migrant at least three significant characteristics underpinned the urbanisation process: adjusting to living and working in close proximity with Pākehā and Māori from other tribal groups; conforming to the fiscal demands of a culture of capitalism; and maintaining the continuity of customary values through the redefinition of cultural imperatives. (Tomlins–Jahnke, 2005, p. 75)⁴⁸

Community development

Devolution and the increased tendency of Governments to relinquish specific roles and services to communities and community groups has had some influence on increased Māori participation in both paid and unpaid work. Interestingly, Māori women especially, are more likely to be involved in voluntary unpaid work in the community than non-Māori women (Statistics NZ, 1994; Ministry of Social Development, 2003). Therefore it is not unusual that Māori women in the main, have taken leading roles in Māori community and health development initiatives, and most often in a voluntary capacity.⁴⁹ Māori community development is considered as being a crucial element in Māori health development because of the obvious access to whānau supports, enabling participation in primary health initiatives, the development of relationships with health professionals, and enabling communities to take responsibility for their own health (Moore, 1990). Community development in the context of health is advantageous because servicing communities rather than individuals has far more benefits in terms of overall health gains (Adams, 1996). Since it enables and promotes community ownership of health whilst maintaining a community focus on prevention, wellness, and change, at the same time it is likely to improve health system accountability and responsiveness in terms of resources and services to

⁴⁸ Chapter three provides more detail of Māori urbanisation experiences and the realities of Pākehā immediacy, the ensuing political climates that dominated relationships between Māori and Pākehā and other Māori, and the re-engineering of Māori social organisation to sustain Māori identity and cultural values.

⁴⁹ See chapter one for the discussion on the Womens Health League, and also Meha, 1995.

meet community needs (Anspaugh, 1997). Similarly, both the Ottawa Charter (World Health Organisation, 1986) and the Treaty of Waitangi emphasise that adequately resourced community involvement and development is a necessary component of good health. In relation to Māori health workforce development, Taiepa (1999) concurs, indicating that Māori communities need more attention and resources:

capacity building is a key factor to facilitate Māori participation. The past actions of governments have weakened the infrastructure of Māori communities. Therefore the focus of capacity building should be to develop the workforce and skill base, and to provide access to information and resources including financial support. (Taiepa, 1999, p. 31).

Current Māori health workforce participation is not reflective of the population and while strategies have been developed to remedy the situation, in many cases the proposed outcomes of these strategies will not be realised for some time. Issues, relevant for Māori health workforce development include:

The first relates to the introduction of Māori cultural perspectives into the training of health professionals; the second to increase Māori participation in the professional health workforce; and the third to the emergence of a cadre of Māori health workers, including traditional healers, whose efforts are as much allied to Māori community development as to membership in the health professions. A focus on all three presumes that there is more than one way to achieve gains in health and that, just as Māori are diverse in terms of cultural identity and socio-economic circumstances, so a variety of approaches to advance health must be considered. (Durie, 1996b, p. 1)

New approaches to Māori health the 1980s decades have been premised on a range of innovative measures to bring health into an arena of Māori understandings, as well as the perceived shortcomings of generic service provision. Both premises have consequences for the health workforce. First, the growing dissatisfaction with existing conventional arrangements can be attributed to low levels of Māori participation among the health professional workforce. Second, there has been an excessive emphasis on sickness and illness. Third, there has, in the past, been a failure to recognise cultural identity as a necessary component of good health. Furthermore, the strongly sectoral approach to all social policy areas, including health, has not been in tune with a more integrated approach, which has come to characterise Māori development. In this sense then and given Māori broader views of health, and links to socio-cultural factors, Māori health and the health workforce should be viewed not only within the broad health/education

arena but also within the wider parameters of Māori development (Durie, 1996a, 1996b, 1996c, 1998).

Utilising an approach similar to that taken by John Rangihau in *Puao-te-atatu* (Rangihau, 1986), Durie (1996a) advocated that health workforce development programmes should consider a bicultural approach, where all health professionals would be required to have some education and training in Māori cultural perspectives to enhance their responsiveness to Māori clients. An increased focus on Māori community development through the provision of education and training opportunities for Māori community health workers, the outcome of which will be dual competent workers (clinical and cultural competencies) plus acknowledgment of their current participation. Finally, a recognition of Māori community ownership and leadership in health.

Political interest

The urgency of Māori workforce development particularly in health has spurred interest both positive and negative in the political arena.⁵⁰ However, there are aspects of Māori health workforce development that have been intentionally influenced by political interest or non-interest. For example the *Report on the Coalition Agreement* (1997) not only tempered the market oriented approach to health care but urgently recommended accelerated Māori provider and workforce development. The growth in Māori health providers from 20 in 1993 to over 220 by 1997, had signalled a need for immediate action. Provider development was encouraged in order to extend the range and quality of services for Māori but was not well resourced, the flow on effect of provider growth brought to light a range of gaps in the workforce as well as the lack of adequate resourcing. Recommendations from the Report sought to address these issues.

Māori provider development

Māori providers have an important role to play in Māori development. They contribute in two ways. Firstly, they are well placed to deliver appropriate and effective services to iwi, hapū, whānau and Māori communities... Secondly the development of Māori provider organizations contributes to building the capacity of iwi, hapū and whānau and Māori communities. (Te Puni Kōkiri, 2000, p.9, cited in Te Puni Kōkiri, 2002a, p.7)

The crucial role of Māori providers in building future Māori capacity and potential cannot be under-estimated. Recognising this, the Ministry of Health launched the Māori Provider

⁵⁰ Chapter four discusses the issues surrounding generic health workforce development.

Development Scheme (MPDS) in 1997. The administration and management of the Scheme came under the various funding arms of the Ministry of Health. However restructuring of the Ministry of Health in relation to funding administration, confused and angered many Māori providers at the time, who were trying to establish access to the Scheme (Te Puni Kōkiri, 2002a). The first administrator of the Scheme was, the Transitional Health Authority (THA), which later became the HFA in 1997/1998, and it was taken back to the Ministry of Health in 2001. Originally the scheme emerged as a result of recommendations from both *He Matariki* (Public Health Commission, 1995) and the Report *Implementing the Coalition Agreement on Health*.⁵¹ The Ministerial directive was - to develop and implement a strategy for provider development to be in place by July 1997. The scheme actualised the Government's commitment to improving Māori health and focused on:

- enhancing the ability of Māori providers to deliver effective health services;
- enabling sustained growth of a skilled Māori health and disability workforce; and,
- improving integration and overall co-ordination of health services to Māori.

Four funding categories were established to meet the three focal areas mentioned above:

- 1 Māori Health Scholarship – the scholarships are administered by the Māori Education Trust and therefore include scholarships for students attending high school as well as scholarships for community health workers and tertiary sector students with an interest in Māori health.
- 2 Provider Assistance – the aim is to develop more effective provider organisations by assisting in the development of sound administration and information systems for Māori providers. This will enable Māori providers to better plan and co-ordinate services if they have accurate up-to-date information. In this category there was also a focus on infrastructural support for Māori providers, which aimed to help Māori health service providers deliver quality services that are more accessible to their clients. In this way providers will be able to develop appropriate facilities that are well equipped, operated by appropriately skilled staff and follow well-defined operating procedures. This part of the scheme is administered by the HFA who envisaged a wider range of

⁵¹ The report of the steering group to oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health, 30 May 1997.

better co-ordinated services that would be more suited to the local community and are easier to use.

- 3 Workforce and Service Development Pilots – A high priority in Māori health is to increase the expertise of Māori health professionals working with Māori.
- 4 Best Practice and Procedure Models – Also administered by the HFA the aim of this category is to assist Māori providers or independent contractors who are working on the identification of best practice and procedure models. (Ministry of Health, 1997b, pp. 1-7)

Māori health service providers

The opportunities for Māori as a result of the health reforms was a commitment by Government to improve Māori health. A number of strategies (Ministry of Health, 1993) were put forward to meet Government objectives for Māori health. Strategies were threefold and focused on a bicultural approach – enhance generic provider responsiveness to Māori clients, application of a broader view that linked health and socio-economic status, and enabling Māori to manage their own health, their service development and provision, and the setting of their own priorities (Ministry of Health, 1993).

To ensure that Māori would in fact receive the most effective services the government, through the Ministry of Health and the four Regional Health Authorities (RHA's), were advised to take an integrated approach to improving Māori health status, and develop contracts with appropriate Māori providers to deliver health services for Māori. This included funding to develop new and existing Māori organisations. Ensuring providers had capability, opportunity to contract, that services recognised Māori aims and aspirations, acknowledged Māori staff training and development needs, and allowed for greater involvement of Māori staff within the organisation at various levels.

Overall the objective of integration was to identify, recognise and make use of ideal market conditions and incentives creating equal opportunity for Māori and non-Māori providers. Encouraging Māori and non-Māori providers to develop new services that would be culturally appropriate and innovative to meet the diverse needs of Māori communities. Interestingly, services

provided by Māori were perceived as being able to achieve direct and effective gains for Māori and should accordingly be supported.

Māori provider growth occurred quickly and by 1998 there were 250 Māori health service providers compared with 20 in 1993.⁵² Growth brought with it a range and variety of services across the primary health care sector including health promotion, health education, care and prevention services, to support services for Māori aged, and for Māori with disabilities. For most of the 250 Māori health service providers, input from health professionals was non-existent (Lawson-Te Aho 1997).

Unfortunately Māori providers found themselves in direct competition with each other as well as non-Māori health service providers. Although not surprising, considering the majority of the Māori health service providers who were contracted and established after the health reforms in 1993. Despite this, the health reforms allowed for and encouraged Māori participation, based on a market and commercial orientation that actively promoted competition.

However, the market approach sponsored by the health reforms, whilst promoting opportunities was diametrically opposed to the way in which Māori health service providers had intended their organisations to operate. Given a Māori holistic approach to health and well-being means broadly focusing on outcomes (quality) rather than outputs (quantity). But the way in which market forces encouraged providers to work meant the focus on outputs threatened their perceived effectiveness in Māori communities and, sustainability. Additionally, Māori providers experienced funding lags of up to three months after contracts had been signed. In the mean time they were expected to provide services at their own expense. Consequently, establishment costs were borne by the provider organisation. Non-Māori providers such as District Health Boards and Plunket for example, also experienced funding lags but their years of experience in health service provision and the resources they had accumulated over time shielded them from the effects of funding lags. On the other hand some Māori providers did not survive this experience and others have struggled.

⁵² Media Release in 1998 by the Hon Tau Henare, Minister of Māori Development, Wellington 1998.

Ironically, the health reforms had not intended to specifically encourage or support Māori provider development, provider collaboration and co-operation or Māori professional and community health workforce development. It was in fact, the tempering effect of the Coalition Agreement on Health 1996 which addressed these and other anomalies, and advocated the support for accelerated Māori health workforce development. Later research (Lawson-Te Aho, 1997) clearly pointed to a number of obstacles Māori providers experienced as a result of increased pressures for Māori participation in a sector where previous involvement had been minimal. Notably many of the issues raised at that time have remain unresolved (Te Puni Kōkiri, 2002a), most evident, was the lack of a qualified and appropriately skilled Māori workforce to sustain participation (Lawson-Te Aho, 1997; Durie, 2005).

Dealing with Māori under-representation in the health workforce across the sector became a priority for Māori health proponents. Attention for instance, to the development of Māori health professionals was urgent but development in this area needed Māori influence at both an operational and policy level (Lawson-Te Aho, 1997). In medicine for example Māori representation was less than 2 percent of the total medical workforce in 1999. In 1992 there were 51 Māori medical practioners increasing to over 200 in 2004 (Te Kete Hauora, 1996; Medical Council of New Zealand, 2005).

Services in the health sector quickly became fragmented, with high administration and operational costs and widespread duplication. In order to reduce costs providers were encouraged to integrate their administration and operational activities together, and share resources without compromising effectiveness, and foster conducive working relationships (Lawson-Te Aho, 1997). The research concluded that while integrated care must be emphasised for Māori health workforce and Māori provider development it should also take into account the broader issues and be inclusive of a general Māori consensus for future positive Māori development (Te Kete Hauora, 1996; Lawson-Te Aho, 1997).

Professional Māori health workforce development

The composition of the workforce should reflect the composition of its client base, in order that it be more acceptable... it should also match the needs of the community, yet be affordable, accessible, effective and appropriate (Te Kete Hauora, 1996, p. 11).

The size of New Zealand (four million) dictates the number of medical training and education institutions in New Zealand (Ministry of Social Development, 2003). Two Universities offer professional medical degrees, Auckland and Otago, with medical schools in Wellington, Canterbury and Hamilton.⁵³

Otago University has long standing Māori entry options⁵⁴ and are contemplating changes to the length of study time and extending entry criteria. Auckland University also has had similar Māori entry options. However, in 1972 Auckland University initiated the Māori and Pacific Island Admission Scheme (MAPAS), an affirmative action programme (quota type system) designed to increase Māori participation in the medical workforce. Originally it was aimed at ensuring the selection and recruitment of a specific number of Māori and Pacific Island medical students. Unfortunately, and for many reasons, the programme failed to produce the numbers of graduates needed to meet a level that an improvement in Māori health demands. That is not to say that the programme was unsuccessful on the contrary by 1997, 63 Māori and 34 Pacific Island doctors had successfully completed their studies in medicine (Gluckman, 1996; Gluckman & Mantell, 1997). However it became evident that critical gains and improvements in Māori health require greater effort (Te Kete Hauora, 1996; Durie, 1996a, Dyll, 1997; Lawson Te Aho, 1997; Salmond, 1997). Consequently, in 1997 Vision 20/20, a programme to accelerate Māori health professional workforce development was proposed and forms part of this research programme, the details of which are located in the following chapter.

In 1997 Māori doctors accounted for 1.6% of the total New Zealand medical workforce. Numbering 123 registered with active practising certificates and of these 44 were female and 79 male. Forty-eight were general practitioners while the rest were in a variety of vocational groups such as anaesthetics = 8; emergency medicine = 3; internal medicine = 6; other = 15; obstetrics

⁵³ Refer to chapter 4 for a more detailed discussion.

⁵⁴ For more detail refer to discussion in chapter one.

and gynaecology = 6; primary care = 4; psychiatry = 5; general surgery = 8. Some retired, overseas based and non-practising physicians remain on the register as well and account for the discrepancies in the numbers. Forty-three Māori doctors were based in Auckland, 12 in the Bay of Plenty, 10 in Canterbury, 6 in Manawatū, 11 in Waikato and 28 in Wellington. In terms of employment site, 64 were employed in CHE, 10 were private GP's, 32 in specialist areas and 5 worked in Universities and another 5 were identified as other (undefined) (Lawson-Te Aho, 1997). More up to date statistics are available but still indicate low Māori participation compared with non-Māori (Health Workforce Advisory Committee 2002). Table 5.2 provides percentage data rather than numbers.

Māori make up just 5.4 percent of the Māori health professional workforce of these social workers and nurses have the highest representation. There have been improvements in the numbers of Māori medical practitioners, and specialists which now number over 200 from around 60 in 1984, and doctors account for around 3 percent of the medical workforce. Furthermore there have been increases in the numbers of dentists which increased from 4 to 44 in 2005 (Durie, 2006, p. 10).

Table 5.2: Overall estimated Māori health workforce professionals

| Working Group | Estimated number (Total Pop) | Percentage Māori |
|-------------------------------------|------------------------------|------------------|
| Chiropractors | 218 | 0.7 |
| Dental technicians | 313 | 1.0 |
| Dental therapists | 569 | 5.7 |
| Dentists | 1591 | 1.5 |
| Dieticians | 343 | 1.6 |
| Medical laboratory technicians | 1292 | 0.2 |
| Medical practitioners | 8615 | 2.3 |
| Medical radiation technologists | 1459 | 0.7 |
| Midwives | 2081 | 3.4 |
| Nurses | 34895 | 6.3 |
| Occupational therapists | 1372 | 0.6 |
| Optometrists & dispensing opticians | 604 | 0.3 |
| Pharmacists | 2831 | 0.7 |
| Pharmacists | 2500 | 0.7 |
| Physiotherapists | 240 | 1.6 |
| Podiatrist | 1124 | 1.3 |
| Registered psychologists | 2697 | 18.0 |
| Social workers | | |
| Total | 66,989 | 5.4 |

Source: Adapted from Health Workforce Advisory Committee data (2002, p. 62).

Despite the progress and the increase in numbers that has been made Māori remain under-represented in health workforce groups across the sector from medical practitioners, nursing and midwifery, dentistry, in primary health care, allied services, mental health, public health, the disability sector, and in other alternative health areas of the sector (Health Workforce Advisory Committee, 2002, 2003). There has been an increase in Māori community health workers but not at the same level as non-Māori (Health Workforce Advisory Committee, 2003).

Māori health workforce development in research

From 1993 Māori health workforce development escalated across the sector included research in Māori health. The Health Research Council of New Zealand established two Māori health research centres (Ngā Pūmanawa Hauora), one under the direction of Professor Eru Pomare, Dean of the Wellington School of Medicine and the other under the direction of Professor Mason Durie, Head of the then Department of Māori Studies at Massey University. This was a major development for Māori health research because Māori levels of participation in research was previously as research subjects rather than researchers. After the untimely death of Eru Pomare in 1995 the centre in Wellington became Te Rōpu Rangahau Hauora a Eru Pomare under the direction of Dr Papaarangi Reid. Later other centres were established, Te Rōpu Rangahau Hauora o Ngai Tahu at Otago under the direction of Dr John Broughton, Tomairangi at Auckland under the direction of Professor Colin Mantell and later Dr Sue Crengle. Another centre, Whāriki was based within the Alcohol and Public Health Research Centre at Auckland and has since moved to the SHORE centre based at Albany, Massey University. The proliferation of these centres has been heartening and has assisted in building Māori health research capacity and capabilities.

The Health Research Council has been influential in the development of a strong Māori health research workforce through funding Māori health research, and large numbers of Māori health research career development awards at masters, doctoral, and postdoctoral levels. It will be recalled that chapter three noted the increase in the numbers of Māori doctoral graduates, over half of these have been in Māori health. Additionally, the Health Research Council and Foundation of Research Science and Technology have provided funding support for Māori

community research and knowledge development alongside other institutions, reinforcing the importance of increasing Māori community involvement in health research (Health Research Council of New Zealand, 2004; Te Puni Kōkiri, 1998, 2000, 2002a).

Māori community health workforce

There have been substantial increases in the numbers of Māori community health workers working with whānau (Health Workforce Advisory Committee, 2003). Training and up-skilling of these workers is largely left to the employing organisation and include both formal and informal programmes. Māori community health workers are considered to be a vitally important link to improving Māori health because of their ability to interact within their communities and whānau (Health Workforce Advisory Committee, 2002). This factor is further supported by Durie (1996c) he maintains that Māori community health workers are, in most cases, already culturally competent and have an intimate knowledge and experience of the communities within which they work. Further, the networking system within Māori communities advances the theory that community development is integral to Māori health and Māori people. A solution is to provide opportunities to train and provide access to higher learning opportunity to compliment the cultural skills of community workers equipping them with appropriate clinical or other professional skills to work more effectively in their communities (Durie, 1996c).

Māori demographic profile

Socio-economic status is considered and generally acknowledged to be linked to health.⁵⁵ Even though the Māori population is youthful, and increasing, it is ageing at a faster rate than non-Māori and will place greater demands on health and social services as dependency for care and support services increase (Department of Labour, 2005). Consequently, continued Māori provider and health workforce development will be crucial in providing care and support services to meet the needs of an ageing Māori population.

On a positive note, rates of educational attainment have increased quite dramatically especially in early childhood, primary, and tertiary education and Māori students are staying in secondary

⁵⁵ Refer to chapter three for a more detailed discussion of the Māori demographic situation.

school for longer. Additionally, this attainment is highest in areas where Māori educational strategies aimed at revitalisation of Māori language and culture. However, the majority of Māori school aged children are still in a generic education system. Even so, Māori initiated strategies and programmes such as kohanga reo (Early childhood); kura kaupapa Māori (total immersion primary schools); wharekura (total immersion highschoools) and whare wananga (Māori tertiary) provide Māori with wider higher education options (Ministry of Education, 2005b).

Understanding the relationship between socio-economic status and poor health, such as low income and inadequate housing, is critical for decision makers across all sectors. Generations of persistent levels of socio economic disadvantage are reflected in low educational achievement, institutionalisation, unemployment and poor health outcomes for Māori. Improvements in these areas require a concerted integrated and intersectoral effort (Ministry of Social Development, 2003).

The increasing diversity of Māori communities and their expectations can give rise to a tension between contemporary patterns of care and support and the capacity of the whānau to provide that support. It is becoming increasingly evident across a range of sectors, that increasing Māori participation in the workforce in all capacities will have positive outcomes in terms of overall Māori development (Health Workforce Advisory Committee, 2002) and cultural inputs will likely support that development (Ministry of Social Development, 2003).

‘Cultural competence’ is a term used to describe culture as a structure of care variable which impacts on and is important to the delivery of culturally competent care (Jones, Bond, & Cason, 1998). In health care provision four types of culture can be identified, the culture of the client, the culture of the health care professional, the organisation, the assessment procedures, management and outcome assessment (Jones et al, 1998). Culture of the client refers to the acknowledgement and respect towards clients of different ethnic backgrounds, client safety includes the client’s culture and is an important consideration in health care (Ramsden, 1997, 2002; Jones et al, 1998). Health professionals often have place of power and control it is inherent in their position of ‘health professional’ and they are usually ‘white’, their clients are subordinate and power an control can be used in an unsafe manner albeit unintentionally, when working with clients with a different cultural background to that of the health professional

(Ramsden, 1997, 2002; Jones et al, 1998). Western based frameworks, organisations, assessment procedures, and management outcome assessments are tools and systems used to wield control over others, dispensing drugs for ailments and controlling dosage, diagnosing are all domains of power, and are considered to be inherently racist instruments. Especially towards people from other cultures and should be recognised as such and used with care (Rangihau, 1986; Ramsden, 1997, 2002; Jones et al, 1998). Increasing Māori health workforce capacity would also alleviate Māori aversion to seeking health professional care and advice and encourage Māori to seek health care earlier. A culturally competent workforce is likely to lead to gains in health (Durie, 1996c; Health Workforce Advisory Committee, 2002).

Influencing factors in legislation and policy

The Treaty of Waitangi, Māori concepts and models of health such as Te Whare Tapa Whā and Whānau, and the Ottawa Charter for Health Promotion have had particular relevance for Māori on health policy and legislation. The Treaty of Waitangi is considered to be the founding document of the nation, and defines the relationship between Māori as tangata whenua, and the Crown (all other New Zealanders) (Ministry of Health, 1997a, 2002).

The Ottawa Charter (World Health Organisation, 1986) and the action strategies developed from the Charter provide a useful framework within which to consider health promotion. For example, many Māori provider organisations, while basing their services on the Treaty of Waitangi, have incorporated the five major components of the Ottawa Charter (Ministry of Health, 1997a; Kingi & May, 2000; Ratima, 2001) as part of their operating strategy. The relationship between the five Charter components and the Treaty of Waitangi are summarised in the following table:

The model outlines the relationships between empowerment and enablement and recognises that Māori communities and individuals are best positioned to identify their own needs and interests. Additionally, and in ideal circumstances, Māori communities are best placed to cater for those needs and interests. Interestingly, both the Treaty of Waitangi perspective and the Ottawa Charter emphasise workforce development at all levels of the health sector and are referred to in recent policy (Ministry of Health, 2002).

Table 5.3: Treaty of Waitangi & Ottawa Charter relationship

| Ottawa Charter | Treaty of Waitangi |
|---|--|
| Developing healthy public policy | Government objectives for Māori health prioritised. (Article 1) Right to good government. |
| Creating supportive social environments | Recognising and embracing Māori health concepts and practices by providing an infrastructure that supports Māori health development (Article 1& 2) |
| Strengthening community action | Māori having control over their own health and actualising Māori aspirations for self-management with equitable access to health resources. (Article 2 &3) Tino Rangatiratanga & Oritetanga. |
| Developing personal skills | Facilitating empowerment through provider, workforce development with equitable access to training and education both professional and community based. (Article 3) Oritetanga |
| Reorienting the health system | Enabling the provision of health services for Māori that are culturally appropriate, effective, safe, and contribute to improving the health status of Māori (Article' 1, 2 & 3). |

Source: Adapted from (1995) as cited in Ministry of Health, 1997a.

Relevant to this thesis are the Government objectives for Māori health outlined in *Whāia te Ora mo te Iwi* (Department of Health, 1992). Māori health workforce and provider development were not an intended focus of the health reforms in 1993. However, policy directions such as an acknowledgement of Māori perspectives and needs, and the development of culturally appropriate practices and procedures was a clear signal to Māori that greater participation would be inevitable and as a consequence increased Māori participation across the health sector at all levels (Department of Health, 1992).

The public health document *He Matariki: A Strategic Plan for Māori Public Health* (1994/5), developed by the Public Health Commission (PHC) after extensive nation wide consultation with Māori in 1995 also had important consequences for Māori health policy. Regretfully, the Public Health Commission was disestablished in 1996 but the document continues to influence policy in public health. In *He Matariki* the PHC acknowledged its obligation to support initiatives that would improve delivery of health services to Māori including the need to reflect Māori aspirations in terms of Māori participation in the purchasing and provision of services to Māori, and for Māori by Māori health service provision. The PHC undertook to assist the development of new Māori providers through Joint Ventures and various other forms of

partnerships recognising the need for culturally appropriate, high quality and effective health services for Māori (Public Health Commission, 1995).

Māori workforce development was also identified as an important issue during the consultation stage in the development of He Matariki. It was noted that Māori were under-represented in the health workforce, the existing disparities between non-Māori and Māori health status were also evident in health services provision, health purchasing and health policy development and planning. It was considered that the utilisation of health services by Māori would increase if Māori participation in all levels of the health sector increased. Further, it was recommended that non-Māori health professionals should also undertake training in providing culturally appropriate services in a culturally appropriate manner (Public Health Commission, 1995; Lawson-Te Aho, 1996). Current policy is still influenced by these documents in a major way.

Later health policies for Māori have reflected ‘the diverse realities of Māori’ (Durie, 1995) highlighting that Māori are not a homogenous population and are as diverse as any other group. Māori Diversity reflects a range of needs, realities and expectations. Accordingly, policies, programmes and service delivery systems need to be developed, monitored and evaluated in order provide for this diversity. The Ministry of Health further acknowledged that whānau, hapū, iwi and Māori community-based groups need to be acknowledged as structures with varied abilities and capacities to respond to, and participate in, the provision of health services for Māori (Durie, 1994; Minister of Health 1995).

In 1997 Keri Lawson-Te Aho was commissioned by the Clinical Training Agency (CTA) to develop a strategic plan for Māori Professional Education and Clinical Training (PECT). In doing so a comprehensive examination of all available information relating to Māori health workforce development was undertaken. Now, out of date and superceded by the work of the Health Workforce Advisory Committee and their ‘stocktake’ reports it remains a valuable record of Māori health workforce experience because it was written from a Māori perspective and provided more Māori specific data.

In 2000 the New Zealand Health Strategy outlined an inter-sectoral approach consistent with Māori approaches to health and wellbeing, advocating the four dimensions of Te Whare Tapa

Whā as providing an appropriate guide to achievement of good health (Ministry of Health, 2000). *The New Zealand Disability Strategy* sits alongside the *New Zealand Health Strategy* and together provide the Government's platform for action on health and disability. *The New Zealand Strategy* outlines the commitment to Māori workforce development in Goal 3: Māori development in health.

He Korowai Oranga: the Māori Health strategy was launched in November 2002 and extends the objectives and principles from both the *New Zealand Health Strategy* and the *New Zealand Disability Strategy* for Māori health (Ministry of Health, 2002). In *He Korowai Oranga*, Māori models and concepts of health are advocated and the achievement of overall whānau ora emphasised. The whānau structure, hapū, iwi, and Māori communities are recognised in the document as critical for the advancement of whānau ora (Ministry of Health, 2002, p. 5). *Pathway two – Te Ara Tuarua* of the strategy has relevance for workforce and provider development and sets out the goals to ensure full Māori participation in the health and disability sector is achieved (Ministry of Health, 2002, p. 9). Specific strategies and goals to implement Māori health workforce development are located in Raranga Tupuake: Māori health workforce development plan 2005 and 2006. They are:

- 1 Increase the number of Māori in the health and disability workforce
- 2 Expand the skill base of the Māori health and disability workforce; and
- 3 Enable equitable access for Māori training opportunities. (Ministry of Health, 2006, p. 1)

Māori mental health, public health and disability have service-specific workforce development plans. Māori mental health workforce development has been given high priority. Accordingly, *Kia Puāwai Te Ararau: National Māori Mental Health Workforce Development Strategic Plan 2006 – 2010* (Te Rau Matatini, 2006). Te Rau Matatini⁵⁶ was established under the *Tuutahitia te Wero – meeting the Challenges in the Māori Mental Health Workforce Development Plan 2000-2005*. It is intended that this programme will provide a model for wider Māori workforce development initiatives. The overall vision of the plan is - to strengthen the Māori workforce to maximise

⁵⁶ Te Rau Matatini was hosted by Te Pūtahi-ā-Toi, Māori Studies at Massey University – but is now based in Palmerston North City as a private organisation.

mental health gains for whānau with a key aim that Māori will make up 20% of the national dedicated mental health workforce and primary health care workforce. This target is based on a workforce population ratio of the projected 2011 population. The operational principles of the strategic plan is congruent with *He Koromai Oranga* and outlines workforce themes and workforce priorities for Māori mental health (Te Rau Matatini, 2006, p.11-13).

Māori mental health workforce development programmes

There are three Māori mental health workforce development programmes currently receiving funding from the Ministry of Health. Urgent need exists in Māori mental health workforce development because mental health is considered to be the primary health threat to Māori (Inglis, 2005, p.2). In the period 1960-1990 first time admissions to psychiatric facilities for non-Māori increased by 7 percent in comparison to Māori rates which increased 300 percent for the same period. Funding for Māori mental health workforce development programmes 2004-2007 are outlined in table 5.4.

Table 5.4: Māori mental health workforce development funding 2004-2007

| Year | Te Rau Matatini | Te Rau Puawai | Henry Rongomau Bennett | Total |
|-------------|------------------------|----------------------|-------------------------------|--------------|
| 2004/05 | \$1,910,000 | \$675,000 | \$235,000 | \$2,820,000 |
| 2005/06 | \$1,110,000 | \$675,000 | \$235,000 | \$2,020,000 |
| 2006/07 | \$1,110,000 | \$675,000 | \$235,000 | \$2,020,000 |

Source: Inglis, (2005, p. 1).

Te Rau Matatini is a centre of excellence and lead provider for developing the Māori mental health workforce. Established in 2002, Te Rau Matatini provides a range of Māori mental health workforce development programmes for Māori working with child, youth, adolescent, adult and kaumātua, NGO's and consumer groups (Inglis, 2005; Te Rau Matatini, 2006). Te Rau Puawai is a programme established to accelerate the development of a professional Māori mental health workforce and is a case study for this research programme.⁵⁷ Henry Rongomau Bennett is a

⁵⁷ Refer to chapter 8 for more details

leadership development and mentoring programme designed for doctors entering the registrar-training programme. It aims to make psychiatry an attractive option before deciding on their specialty training. Mentoring is provided by senior psychiatrists, in 2005 6 doctors have received scholarships and are undertaking registrar training, two at an advanced level. The programme also offers training for Māori general practitioners, recruitment and repatriation of Māori psychiatrists, and incentives for training in disciplines and sectors, and secondments to specialist services (Inglis, 2005, p.4).

Māori health professional organisations

National Māori health professional organisations working to further the development of Māori health professionals and to provide ongoing support for individual Māori health professionals have been established for medicine, nursing, psychology and dental care. Te Ohu Rata O Aotearoa – Māori Medical Practitioners Association consists of over 200 members. Te Ohu Rata provides a forum for Māori medical practitioners to engage in collegial relationships, networking and mentoring. The Association meets annually at different venues and uses the opportunity to discuss issues and presentation of papers and publications. There have been some workforce development contracts with Māori providers⁵⁸ (Lawson-Te Aho, 1997).

A survey of Māori medical practitioners found that Māori practitioners wanted culturally specific training included in training; Māori language and the capacity to converse in Māori; experience in working in Māori communities such as a placement system; link to iwi health development and cultural support from iwi; cross cultural communication; Māori health policy and Māori health research (Lawson-Te Aho, 1997).

National Council of Māori Nurses is an organisation that provides guidance and support and a forum for networking for Māori nurses in New Zealand. There are over 2000 Māori nurses compared to just over 1000 Māori nurses practising in New Zealand in 1997 accounting for approximately 6% of the total registered nursing workforce. These can be further split into

⁵⁸ See website of Te Ohu Rata o Aotearoa <http://www.teora.Māori.nz/>

enrolled and registered nurses⁵⁹ a large proportion of whom were working in psychiatric and long term care nursing. The northern region had the highest proportion of Māori enrolled nurses in active practice. Central had the highest proportion of Māori psychiatric nurses and Midland, the highest proportion of registered Māori nurses. The southern region had relatively low numbers of Māori nurses of either category.

Nurses are considered to be the most approached of the medical profession, often being the first point of contact for many Māori communities and individuals. It has become crucial that increased Māori health participation and development occurs in this sector given overall negative Māori health statistics. Gaps and training needs identified in this area include career planning, primary health care, traditional healing, administration and health promotion (Durie 1994; Durie 1996c; Durie 1996d; Durie 1996b; Durie 1998).

The Māori Psychologists Network has a small membership of over 60 in 2005, a 3.3% increase from 37 in 1998 (of total registered Psychologists). Increases from 10 in 1995, 23 in 1996 to 37 in 1998, and 60 in 2002, this has occurred mainly as a result of increased development of courses in both Māori and mainstream education and training institutions. Registered Māori psychologists practice in a range of sub disciplines such as clinical psychology, industrial and organisational psychology and community psychology. Registration has been identified as a workforce issue for these professionals. Registration takes seven years. Therefore support and resourcing must be considered to overcome this barrier. Training needs identified for this area include career planning, cultural and clinical training, cross cultural communication and public health approaches to psychology (Lawson-Te Aho 1997; Durie 2001; Health Workforce Advisory Committee, 2002).

Te Ao Marama - New Zealand Māori Dentists Association is a small but nationwide group first established in Rotorua. There are currently 44 registered Māori dentists practising in New Zealand who work across primary, secondary and tertiary services in multiple roles. The association has identified over 50 Māori school dental nurses. Gaps and training needs for

⁵⁹ For a more detailed breakdown of Māori nurses see the CTA Strategic Plan for Māori PECT by Keri Lawson-Te Aho, 1997 and the Health Workforce Advisory Committee (2002).

Māori school dental nurses are varied and include up skilling and training in advanced oral health techniques such as periodontics, x rays, pulp therapy and permanent extractions. The aim of the association is to guide training developments for Māori working in oral health (Lawson-Te Aho, 1997).

Current Māori workforce development initiatives

There are a range of Māori workforce training and education initiatives, by Māori for Māori health services, and those that enhance mainstream development. These initiatives cover a range occupational and health practitioner areas they include national certificate and diploma courses, specific certificates for entry into tertiary education, support, mentoring and supervision programmes, clinical and cultural training for GP's and nurses, Māori language and culture for Māori health professionals.

Workforce development experiences in Australia and USA

Māori representation or under-representation in the workforce is mirrored in other countries with indigenous and minority groups. In the USA diversity of minority groups is recognised and efforts have identified training opportunities for a range of minority groups. For instance one programme identifies suitable minority youth, places them in organisations, and prepares them for corporate and community leadership positions. INROADS, is a not for profit career development organisation run like a business. It recruits Hispanic, African American, and Native American students and prepares high school students for college. A number of colleges subscribe to INROADS in partnership arrangements for recruitment purposes and the college component of the arrangement it to help place students in two to four year internships with sponsoring organisations. Goals are achieved when a sponsoring organisation hires an individual after graduation from college. Usually about 80% receive offers of fulltime employment and accept those positions. The medical profession is one area where this type of recruiting is prominent. For this approach to work diversity must be embraced by top decision makers and it must spread throughout an organisation. Interestingly, diversity is embraced as a sound business decision, not simply an issue of equity (Clarke, 1995).

The health system in Australia along with other sectors is also undergoing changes. One area that has been identified as needing special attention is that of strategies to increase the Aboriginal workforce, and, in particular the Aboriginal health workforce.

A survey (Sibthorpe, 1998) of community-controlled and state health services was conducted as part of a needs assessment for a tertiary training initiative in applied epidemiology. The average time for Aboriginals in current positions was 4.8 years, 75% were in designated Aboriginal positions and 44% were health workers. Of the total, 49% had a diploma or certificate, but only 3% had a bachelor's degree. The high proportions of health worker designated Aboriginal positions, short tenure and low level of degree training suggest that there are a range of employment and training issues which need to be addressed if an appropriate level of indigenous health professionals are to have access to the same vertical and lateral employment mobility as non-Aboriginal workers. In particular there is a huge need to enhance Indigenous participation in health workforce training, and to develop strategies for certification and recognition of the wide range of non-course-based training being undertaken (Sibthorpe, Becking & Humes, 1998).

Māori workforce development, a contribution

Increasing Māori workforce participation in health requires a broad and collective approach that recognises Māori perspectives and aspirations. Consequently whānau, hapū, iwi, and Māori communities become a core factor in the development of individuals, and vice versa. Because separating individuals from the collective is not part of Māori psyche. Physical separation may occur but the connection to collective structures such as community development eventually emerges more strongly. If these structures are enabled through more resourcing the impact is likely to be higher and greater levels of participation, achievement and health gains. Resulting in Māori community ownership and leadership in health, advancing the theory that community development is pivotal to Māori health and Māori people.

Undoubtedly Māori providers have an important role in Māori advancement across sectors. The growth in numbers since the health reforms of 1993 is testament to the potential contribution that could be made to increasing Māori workforce capacity.

Māori providers have embraced competition, albeit not without trepidation and concern, and continue to operate in two systems. Even without the appropriate resourcing, the 'kaupapa', and Māori health improvements, keeps them focused. However operating in 'deficit' or in short time frames puts many of these organisations at risk, financially, physically and emotionally. Obviously there are clear differences in the ways two systems of operation view the way things should be. Getting the numbers is not always the key, but ensuring Māori perspectives are included and Māori needs are met is seen as a better outcome.

Workforce development, participation and achievement across sectors influences health improvements in communities and therefore suggests an integrated approach to health care services delivery is necessary. Despite the gains that have been made in health Māori remain under-represented in most socio-economic indicators and this is reflected in the Māori health workforce. Māori community health workers can have the most immediate impact because they are closest to their communities. Government policies and directions influence the flow of funding to areas of high need and this allows a concentrated and sustained effort in specific areas. A Māori health workforce requires two sets of skills, a combination of cultural and clinical, a dual competent workforce.

Chapter 6

PROFESSIONAL MĀORI WORKFORCE DEVELOPMENT AND ENVIRONMENTAL HEALTH

*Haere mai, e te rawhiti*⁶⁰

Introduction

Four case studies form the basis of this thesis; the summaries of the case studies, the research design, strategies and methods of analysis are discussed in Chapter Two. Data from the case studies are presented in the next three chapters in semi-narrative form to allow for the emergence of participant voices (Cohen, Duberly, & Mallon, 2004).

In this chapter, two of the four case studies are discussed. The first is focused on the training and education of the professional Māori health workforce and in particular is centred on a specific programme that supports Māori health professional development – Vision 20/20. The second explores Māori workforce development in environmental health with a specific focus on health protection. While both case studies are different there are certain similarities, for example, both cases highlight the need for specific academic entry requirements, both have an emphasis on physical science, and both have low Māori participation rates. The objective of bringing them together in this chapter is to illustrate how Māori values might be introduced and applied in an area where they have previously been thought inconsequential. Verbatim quotes from participants are used throughout the chapter not only to add emphasis to the discussion but to feed the discussion. Chapters seven and eight are presented in the same manner.

Case I - Professional Māori workforce development: Vision 20/20

Case description

The Vision 20/20 programme operates through the University of Auckland's Faculty of Medical and Health Sciences from within the Department of Māori and Pacific Health. The programme

⁶⁰ In Mead and Grove (2004). *Ngā Pēpeha a Ngā Tīpuna*: 295 p.56, Smith 1913a:113: Greetings to the sunrise – an acknowledgement to the whānau whānui o Ngai Tahu.

highlights the commitment of the University of Auckland to increasing the number of Māori and Pacific peoples training in a range of health disciplines and specifically assists access into the medical and other health professions. Vision 20/20 comprises three interconnected components: The Whakapiki Ake project, Hikitia Te Ora, and the Māori and Pacific Admission Scheme (MAPAS).⁶¹

As part of the Vision 20/20 programme the *Whakapiki Ake* project was launched in Hamilton on 29 October, 2003. It is a joint initiative between the University of Auckland, the Ministry of Health, eight District Health Boards, and participating secondary schools - their students and their whānau. The project aims to help Māori year 13 students gain access to the Certificate in Health Sciences (Hikitia te Ora) programme at the University of Auckland. Whakapiki Ake offers a comprehensive package which covers course related costs, work experience, summer scholarships - access to the Liggins Institute (the University's bio-medical research institute), and ongoing support services.⁶²

Enrolments of Māori students into the Certificate in Health Sciences (Hikitia te Ora - CHS) who participated in the Whakapiki Ake programme have increased each year since it was launched in 2003. For example, in 2004, 24 Māori students who had participated in Whakapiki Ake moved into the certificate programme, in 2005 Whakapiki Ake students made up (56%) or 45 of Māori student enrolments, and in 2006 they made up 49 (92%) of Māori enrolments in the certificate.⁶³

Hikitia te Oranga o te Inwi (Hikitia te Ora) – the Certificate in Health Sciences is a one year programme which prepares and supports Māori and Pacific students for tertiary study in health and medicine. It is designed to bridge the gap between school and university studies and focuses on ensuring students will meet the entry requirements needed to enter medicine or other health related disciplines. Enrolment as part of Hikitia te Ora ensures access to learning support,

⁶¹ This updated information was accessed mainly through internet access at <http://www.health.auckland.ac.nz/undergrad/cert-health-sci/> retrieved from the World Wide Web on 06/09/2006. It is also supported by participant interviews carried out in September 2003 and from programme documents received from participants at that time. Fuller presentations of participant views and information from the original Vision 20/20 proposal are included throughout Part I of this chapter.

⁶² Ibid plus <http://www.Māorihealthcareers.auckland.ac.nz/homepage.php>

⁶³ Ibid plus <http://www.Māorihealthcareers.auckland.ac.nz/homepage.php>

mentoring, counselling, cultural affirmation and support, whānau tautoko, and kaumātua guidance.⁶⁴

The third part of the Vision 20/20 programme is the Māori and Pacific Admission Scheme (MAPAS). This Scheme was first established in 1972 and is an affirmative action programme, reflecting an obligation by the University to increase the number of Māori and Pacific entrants to medical school. Initially the number of placements was three per year, this had increased to nine in 1979, 12 in 1990, and to 25 by 2003.⁶⁵

The original intention of the Vision 20/20 programme proposal was to accelerate Māori professional workforce development and therefore the 100 proposed Māori student enrolments for this programme were to be in addition to those of the Māori and Pacific Admission Scheme (Gluckman & Mantell, 1997). For the programme to reach its yearly target enrolments of 100 Māori and 50 Pacific students an analysis of the 1996 University Entrance Bursary Examinations & Scholarships data was undertaken (Gluckman & Mantell, 1997). The analysis found that only 6.1% (138) of Māori students who sat the bursary examination gained an A bursary and 17% (384) gained B bursary passes. Highlighting that in order to meet the target numbers of students there would be a need to recruit students with B bursary passes and mature students. Students with A bursary were already eligible to enter the MAPAS programme. The intention of the *Step Up* (later named Hikitia te Ora) programme would be focusing on supporting students to improve their academic grades in order to meet medical school academic entry criteria (Gluckman & Mantell, 1997). Included in the proposal was an outline that highlighted a capacity capability of around 180 students per year, current student numbers were then 110, therefore available capacity was assessed to be 70 additional students. The following table outlines estimated capacity and class make up based on 1997 student enrolments:

⁶⁴ Ibid plus <http://www.Māorihealthcareers.auckland.ac.nz/homepage.php>

⁶⁵ Ibid plus <http://www.Māorihealthcareers.auckland.ac.nz/homepage.php>

Table 6.1: Class make up

| | | |
|---|--------------------------|----|
| 1997 Intake | Pākehā | 95 |
| | Māori (MAPAS) | 8 |
| | Pacific Island (MAPAS) | 7 |
| Proposed 2000 Intake | Pākehā | 90 |
| | Māori (MAPAS) | 10 |
| | Pacific Island (MAPAS) | 10 |
| | Māori (Step Up) | 50 |
| | Pacific Island (Step Up) | 20 |
| Assuming a 90% completion rate, the current rate across the School of Medicine: | | |
| Graduating in 2005 | Pākehā | 81 |
| | Māori | 54 |
| | Pacific Island | 27 |

Source: Vision 20/20 Proposal (Gluckman & Mantell, 1997).

While students in the programme would continue to have additional cultural, academic, and learning support as a group through chosen degrees, they would be required to pass the same medical examinations as general students to graduate with a MBChB. The programme was identified as being courageous and was an initiative supported by iwi/Māori groups, Māori health providers and professional groups, the Regional Health Authority and Te Puni Kōkiri, Ministry of Māori Development. The proposal was presented to the Government with the support for funding consideration. The proposed budget for the first cohort and the estimated cumulative costs are outlined in table 6.2 as well as costs expected if the programme is continued after 2005 (see table 6.2).

Cultural affirmation and supports

Besides providing students with the opportunity of undertaking academic subjects for which they will gain transferable credits to other courses and or other institutions, the programme provides a range of culturally affirming courses which include te reo me ona tikanga. The objective of this is to provide students the skills, and confidence to work effectively with Māori

and in Māori communities. With iwi support of the programme and of their students it is likely that students will return to work in their own communities. Students of the programme are expected to actively support and participate in events and activities that are organised for them. Cultural, recreational, learning, academic and pastoral care supports include:⁶⁶

Table 6.2: Costs of first cohort

| Year | Activity description | Amount | Cumulative Est. |
|------|--|-----------|-----------------|
| 1998 | Preliminary work | 100,000 | 2,100,000 |
| | Capital works | 2,000,000 | |
| 1999 | Preliminary course (100) | 1,500,000 | 1,500,000 |
| 2000 | Plus 50 medical year 1 | 1,000,000 | 3,300,000 |
| | Plus 50 non-medical year 1 | 800,000 | |
| 2001 | 50 medical year 2 | 1,000,000 | 5,100,000 |
| | 50 non-medical year 2 | 800,000 | |
| 2002 | 50 medical year 3 | 1,000,000 | 6,900,000 |
| | 50 non-medical year 3 | 800,000 | |
| 2003 | 50 medical year 4 | 1,200,000 | 8,100,000 |
| 2004 | 50 medical year 5 | 1,200,000 | 9,300,000 |
| 2005 | 50 medical year 6 (includes training grant) | 2,000,000 | 11,300,000 |
| 2006 | Thereafter per annum until programme is wound down | | 11,300,000 |

Source: Adapted from the Vision 20/20 Proposal for the Development of the Māori (and Pacific Island) Health Professional Workforce (Gluckman & Mantell, 1997, pp.5-6).

⁶⁶ Ibid plus <http://www.Māorihealthcareers.auckland.ac.nz/homepage.php>.

Table 6.3 Vision 20/20 programme supports for Māori students

| Academic/Learning/Other Supports | Specific Māori Cultural Supports |
|---------------------------------------|---|
| Access to general student support | Māori learning support team |
| Scholarship application support | Māori Academic and peer mentoring |
| University of Auckland Access Award | whānau support/sharing kai |
| application support | Access to Māori and Pacific medical and |
| Range of sports activities | research staff |
| Work experience | Kaumātua guidance /access to marae |
| Additional tutorials | Hikitia te Ora & MAPAS ‘freshers’ |
| Summer studentship research | camp/marae noho |
| opportunities | Tuakana/teina and iwi support |
| Counselling | Pre-exam study noho |
| Access to District Health Boards | Access to Waipapa marae & kapahaka |
| Access to teaching and research staff | Te reo me ōna tikanga |
| | Treaty of Waitangi workshops |

Participant revelations

A Dream I Once Had

In the early 1990’s concerns for the health status of Māori was building momentum not just in Māori fora but over the health sector as a whole. Socio-economic reforms were providing opportunities for increased Māori participation in a range of sectors including health. A number of individuals such as Eru Pomare, Mason Durie, Rose Pere, Erihapeti Murchie, Colin Mantell, and many others, championed and led initiatives in Māori health research, health promotion, Māori mental health, policy development, and workforce development planning and implementation:

At the time it was the current state of Māori health that was bothering people and wondering what could be done about it. (Participant, V2020/702)

The idea for a specific programme to be developed to increase the numbers of Māori health professionals in terms of doctors, pharmacists, surgeons and other health specialists is not new in Māori thinking.⁶⁷

It wasn't really an idea that was specifically mine I know many other Māori people in many other disciplines that think on the same lines it was more of a nagging inside of me to do something (Participant, V2020/702).

However, implementing an initiative such as Vision 20/20 would require a *champion*, someone who believed in an idea and was prepared to promote, argue and debate the issues that would likely arise from various quarters. Māori development and advancement initiatives require passion, vision and knowledge of the environment (King, 1977). The environment in this sense was identified as being both specific and general (Robbins & Barnwell, 2006). For example, the proposal challenged the education and political systems alongside the professional bodies concerned with medical health workforce development (Gluckman & Mantell, 1997; Salmond, 2004). The proposal for the programme highlighted the low numbers of Māori gaining entry to tertiary or university education compared with non-Māori particularly in the areas of science and technology. Similar observations were made by (Schwab, 1996) with other indigenous and ethnic minority groups (Saenz, Wyatt, & Reinhard, 1998):

I wanted the University and especially the medical school at this University [Auckland]⁶⁸ to be just as familiar an environment for Māori and Pacific Island people as the marae or the community centre at Otara, or the rugby and league fields anywhere you go where you see a lot of Māori and PI's that's how I wanted to see this environment. (Participant, V2020/702)

Māori choosing to enter such institutions as Universities let alone to study medicine, is considered a rarity, a path that is out of the ordinary for most because according to Chapple (1999) Māori have no interest in higher education. While many families have high aspirations for their children, becoming a doctor still seems out of reach. However the aims and objectives for the Vision 20/20 programme are an attempt to reverse and change the thinking of many Māori and provide a route to medicine that might eventually become a well trodden path, a natural choice and as Jefferies (1998) states, with many role models:

⁶⁷ Refer to Chapter One, the discussion on the work of the Te Aute Students Association and the scholarships associated with the University of Otago.

⁶⁸ Vision 20/20 is a programme (Certificate in Health Sciences – Step Up/Hikitia te Ora).

I wanted to see Māori and PIs choosing medicine for a career as they would in say choosing a loaf of bread in a shop or making a decision on which pair of shoes to buy. (Participant, V2020/702)

Often the decision to do medicine is kept a secret even to those closest because there seems to be a natural tendency for people to be overly surprised even disbelieving when individuals state medicine as a vocation. In medicine exorbitant fees, restricted entry requirements, length of time required to study, evidence of high academic achievement, isolation, institutional racism, lack of support, and distance from whānau feed a Māori perception of the university environment as being inaccessible and success in these areas relatively unachievable (Jefferies, 1997, 1998; Nikora et al, 2002; Penetito, 1998; Saenz et. al., 1998; Schwab, 1996):

I wanted them to be able to make a decision to do medicine without people raising their eyebrows and straight away putting up the barriers so that eventually the choice to do medicine becomes “a dream I once had”. I want it to be a natural choice for Māori. (Participant, V2020/702)

However, bringing ideas such as a programme like Vision 20/20, to fruition is sometimes reliant on individuals or small groups of people with energy and expertise. While a sense of powerlessness is deterrent to action often the injustice, trepidation, and desperateness of a situation becomes more powerful (Saenz et al, 1998). Individuals within these institutions become more alert for the small windows of opportunity that arise such as job promotions. Promotions that allow entry into a higher level of decision making, or the ability to develop stronger collegial relationships within and external to an organisation become more realisable. Being a lone voice then becomes a company of voices supported by groups within the organisation eventuating in collective action and reality. In this way those concerns of an individual such as the very small pool of maturing Māori doctors, an ongoing concern about future numbers of doctors, and the ‘exclusion of Māori school leavers’ from health professions, provided the motivation to seriously consider a ‘courageous attack on the discrepancies between the health for Māori and non-Māori in New Zealand’ (Gluckman & Mantell, 1997, pp. 1-7):

I had been thinking about it for awhile as I said, but just didn’t know how to put it into practice...It wasn’t really an idea that was specifically mine I know many other Māori people in many other disciplines that think on the same lines it was more of a nagging inside of me to do something, I was getting on [in age] and most other Māori doctors I knew were getting on and there just didn’t seem to be enough young Māori doctors in the pool coming along behind us, so yes it just gnawed at me for a long time, and stayed there because for a long time I wasn’t in a position to influence the decision makers, I could only

ever hint or make suggestions which were in the main ignored, I was a lone voice and not a very loud one at that. (Participant, V2020/702)

There needed to be a person with influence and standing within the University to make Vision 20/20 a reality, someone who had some power to make changes and encourage others to support an idea. This was crucial because in many cases ideas that stem from Māori are not supported simply because they are Māori ideas (Hill, 2004):

“I talked with ...the head of the faculty at that time and he thought it was a good idea, others were hoping it would go away...” (Participant, V2020/702).

In New Zealand, ideas and initiatives that are promoted by Māori are either ignored, ridiculed or at best tolerated (Sharples, 2006). Hill (2004) insists that since colonisation Māori have been unwavering in their attempts to achieve positive Māori development and advancement via a number of initiatives and activities aimed at regaining autonomy and maintaining a Māori cultural identity. In most instances these initiatives have been hindered by a western hegemony of assimilation. Advancing an ambitious programme such as Vision 20/20 would be heavily criticised without the support of influential people.

To reach our goal

Once an idea has been germinated and then supported by those in power, implementation then becomes the focus, that is the what, when, how, who and where. There are two sides to the where and who, therefore in relation to where and who would run the programme was already decided as the University of Auckland and the Auckland Faculty of Medicine and Health Science through the Department of Māori and Pacific Health would:

We pulled together a small working party and started to bounce ideas around about how we might pull it off...what we needed in terms of a programme to reach our goal. (Participant, V2020/702).

where would we get the people/students for the programme, what would it look like, staffing, support staff, funding and other resources, getting buy in from the faculty. (Participant, V2020/702).

After approximately three years of major discussions and consultation with various individuals and groups, both Māori and non-Māori, a proposal for funding was made to Government in 1997 for an accelerated professional health workforce development initiative to graduate an

additional 50 Māori doctors per year for ten years. The proposal was aimed at Māori secondary school students. Detailed in the proposal was the plan to “recruit 100 additional Māori students into a ‘step-up’ programme⁶⁹” the length of which would be one year after which it was expected that “half of these students would enrol in the medical course and be supported through the course⁷⁰” in terms of financial and other mentoring and academic based support systems. The other half would be encouraged to undertake alternate health care courses from which other professional health care careers could be pursued such as psychology, health management, nursing, technical training and radiology training. Students would be able to access academic mentoring and pastoral care support (Gluckman & Mantell, 1997). The decision for a step-up programme was based on national bursary statistics which highlighted Māori secondary school students educational disadvantage. The step-up programme would therefore be designed to help prepare students for a range of health professional courses (Gluckman & Mantell, 1997):

while knowing that increasing the numbers of health professionals doesn’t automatically improve the health standards of a population, not straight away anyway, we knew that the deficit was there. It was, I felt, of great, huge importance to start making something happen to alleviate the deficit in relation to the shortage of Māori doctors and eventually when you do that, you know, put more health professionals, especially Māori into the workforce it will become a normality. (Participant, V2020/702).

Even with an emphasis targeting the training of Māori individuals, it was identified that it would still take 18 years or more for the numbers of Māori in medicine to reach something like 10% of the medical workforce. In 2003 the numbers of Māori in medicine was 2.7% (Medical Council of New Zealand, 2003) of the total medical workforce. Such statistics are concerning, given that Māori make up approximately 17% of the total population of New Zealand and this is expected to treble by 2050 (Statistics New Zealand, 2005):

it is shocking that it has got to that stage. I believe it should be a normal thing to see Māori doctors anywhere you go not a rarity. (Participant, V2020/701)

Underlying the previous comment is the acknowledgement that Māori are severely under-represented in Medicine and other professional health care occupations plus there is a suggestion from supporting material that Māori participation in these areas should at least be reflective of the Māori population (Medical Council of New Zealand, 2003). The proposal recognises that

⁶⁹ Participant, V2020/702

⁷⁰ Participant, V2020/702

while general socio-economic factors have, and continue to be strong determinants of health (Pomare, Keefe-Ormsby, Ormsby, Pearce, Reid, Robson., & Wātene-Haydon, 1995) there is strong evidence that biomedical science has and should continue to have, a major impact on improving health (Durie, 1998). Further, across the sector Māori participation in professional health care is very low and without dramatic action such as the proposed step-up programme, is unlikely to exceed 2 or 3% of each discipline's registrants. The proposal questions the professional bodies concerned in relation to allowing such discrepancies to occur and implicitly challenges both them and Government to begin a regime to remedy the situation (Gluckman & Mantell, 1997).

Why set them up to fail?

It meant changing attitudes of the schools themselves because when they were first approached there were comments about their kids such as, 'they don't care', 'it would be too hard for them', 'they wouldn't be able to cope', 'why set them up to fail', 'why special treatment for them, they won't appreciate it', you know, a lot of negativity towards Māori is out there. My answer to those comments was that they [the schools] by their comments were failing the kids themselves, they didn't believe in their kids, they provided them with no encouragement and therefore no hope, they were turning their [schools] negativity onto the kids. (Participant, V2020/702)

In the proposal Gluckman and Mantell (1997) maintain that the current secondary education system is remiss in preparing Māori secondary school students for careers in health care professions. Penetito (1998) and Jefferies (1998) support these observations suggesting that secondary schools should be doing more to encourage Māori students to stay at school longer and enter tertiary education. Even when students are known to have the potential to succeed there is no encouragement from their teachers, or the school to go further. The negativity that emerges from the secondary schools and placed on Māori students is eventually internalised and deemed natural providing a school environment that impedes their learning and achievement:

and of course the kids would naturally oblige. (Participant, V2020/701)

The main problem with the schools is that the programme is seen as providing certain sections of the community with special treatment:

the schools haven't been that forthcoming in putting forward students or allowing us to go in and talk to students so getting the information to Māori and PI kids in schools has been difficult. (Participant, V2020, 702)

Even when provided with Māori workforce statistics and knowing the disparities that exist between Māori and non-Māori in a wide range of socio-economic areas, schools in the Auckland catchment area with high numbers of Māori students have been unwilling to provide Māori students with information on higher education opportunities:

Where to get the students was another one, because we were aiming for Māori students and the majority of Māori kids are in the lower decile schools [especially in Auckland] mainly around south Auckland, we needed to get those schools involved in preparing students for recruitment, their support was and still is of great importance. (Participant, V2020/702)

Initially the response from Auckland schools was not as positive as had been expected. It was necessary to include schools from other areas as well as mature students into the first intakes. Iwi were also approached to nominate and support students through the programme. The response from iwi was very positive:

Barriers have been the schools themselves they are the ones who should be feeding us the students into this programme. Don't get me wrong not all of the schools are being stubborn. We have overcome this by encouraging other schools in other parts of the country to feed into this programme, which may impact later on the south Auckland schools. We have kids from Gisborne, Opotiki, Hastings and Wellington who have moved here to be part of the programme. We also contacted iwi/Māori organisations and the Māori boarding schools around the country...they are keen to feed into this programme and are really supportive of the initiative. (Participant, V2020/702)

Initially the programme had focused on schools in the Auckland catchment area, and specifically the South Auckland low decile schools, but in order to get the numbers of students it was broadened to include other regions. The approach to iwi/Māori organisations acknowledges overall Māori needs and objectives to improve Māori health and educational achievement. The programme itself coincides with and is complementary to the range of sectoral strategic planning initiatives of various iwi/Māori groups. Many iwi/Māori groups have undertaken stocktakes of Māori educational achievement within their own boundaries, have identified the shortcomings of schools in their areas, collected relevant statistics, and developed strategies to improve Māori student achievement. Schools in these areas have been challenged by iwi to reduce Māori student failure rates by working more positively and in partnership with Māori (Tomlins-Jahnke, 2002).

Given the low numbers of Māori secondary school A bursaries the step-up programme was intended to provide the larger numbers of B bursary students and more mature students an

opportunity to meet medical school entry requirements. Thus taking a wider sweep of potential participants to enter the programme and meeting the recruitment goals of the proposal (Gluckman & Mantell, 1997).

That's an unusual choice for a Māori

Oooh you know the usual “you have to be real brainy to do that”, “it takes years to become a doctor”, “what if you fail”, “its going to cost heaps – where are you going to get the money from?”, “that’s an unusual choice for a Māori”, “why can’t you just get a job and start paying your own way”, “you’ll have to move to the city and it will cost you heaps”, all those sorts of barriers and yes they are all true and very very real for many people and 6 maybe more years can put a terrible strain on resources and families. (Participant, V2020/702)

When participants were asked what barriers, both real and potential existed for Māori secondary school students who voiced a desire to study medicine, a range of barriers were identified. Intellect, difference and cost were the most common barriers Māori students had to deal with. Participants also highlighted that usual comments also included the time it takes to become a doctor and the increased pressure and strain they, [Māori students] would place on families. In many cases comments such as those expressed tend to leave students feeling guilty about contemplating medicine or other professions as a career (Nikora et al, 2002). It was clear though, that these sorts of comments were not coming from the students’ own families but by well meaning non-Māori teachers and school careers advisors. Many students’ families seemed to have an opposite view. Cost, negativity and hardship, while acknowledged barriers to participation, are secondary to aspirations for educational success for their family member:

I was good at school but chose plumbing, but my mother and friends encouraged me to do this course because they didn’t see me as a plumber...It was a bridging course for a science degree – so you could do medicine. My mother first heard it on the radio, being advertised on the radio, and she called up to find out about it then she called me to tell me to apply so I did and I got on. (Participant, V2020/703)

Students indicated that initial encouragement to participate in the programme came from other family members and extended whānau rather than the schools:

I got dux of my school...but before that my dad and my uncle had heard about this programme to study medicine. I was going to do a computer course at polytech but the whānau everyone, aunties, uncles, cousins almost the whole iwi had a hui about me, it was decided that I should go to medical school and become a doctor if that was what I wanted and it was. I just hadn’t thought that it was possible. (Participant, V2020/704)

Even though some Māori students achieved well at school gaining A bursaries and school prizes, attending University still seemed to them not to be an option. Given the financial situation of many Māori families it may be that Māori students go for the lesser and/or the closer option or perhaps the thought of leaving home and moving away from friends and family is the concern. Jefferies (1998) commented that perhaps students feel the quicker they get a qualification the better, there is less strain on whānau. Durie (2005) states that while Māori participation in tertiary education has increased many are not choosing science, engineering, or technology degrees either. A degree in medicine consists of seven years training compared to three years for most other options. Even so it appears that the influence of whānau and iwi on Māori student decision-making is recognised as a key determining factor for this programme. Whānau are encouraged to be involved in the overall Vision 20/20 programme starting with the Whakapiki Ake project.

It costs a lot of money to run a programme like this

We then started approaching various agencies to access funding it costs a lot of money to run a programme like this... But we got the funding, we got what we asked for. The funding would also help to support those students who got accepted into the medical school. Funding was the big one really, once you get the money, people usually become more agreeable to a situation. (Participant, V2020/702)

Funding of the programme was identified as one barrier if not the major barrier in the establishment of the programme. The funding required to support students through a medical degree amounted to approximately \$120,000. For many Māori families \$120,000 represents a mortgage. Even though the cost is a barrier the programme objectives were in line with recommendations from Hui Taumata 1984 where, increased investment in education was a resolution passed by the Hui Taumata in 1984, (Minister of Māori Affairs, 1988; Kingi & May, 2000) therefore there was strong Māori support for this initiative. Gluckman & Mantell (1997) provided funding requirement detail in the proposal, which was “slightly higher than standard EFTS (Equivalent Full Time Student) costs for medicine because of the additional teaching involved, and the need to provide additional study space of an appropriate nature” and it was estimated that it would cost \$60,000 more per doctor than the standard cost of the medical course to put in place the whānau support and spaces for the students (p.5).

Talking about space

There are two houses made available for us, one for Māori students one for PI students where we can gather and have hui and study sessions and just you know hang out. We mostly hung out together though the PI's and Māori because there wasn't many of us, but yeah there was space for both cultures, you know to do whakawhānaungatanga (get to know each other) and manaaki (help each other in times of need), and throughout the year there were events to go to that were arranged just for us. It was great I really liked it (Participant, V2020/703).

Student participants were generally positive about the spaces provided for them through the programme and the events and activities that were arranged for students were well attended by all students. Students highlighted the ability to use their own cultural knowledge in their own ways and on an informal basis:

Social events were organised as well both day and night events and I went to most of those, really enjoyed it. I noticed though that the mature students were more focused on their work and did not join in the evening social events perhaps because they have children and other commitments. Not like us younger ones we or I socialised weekly I guess but now I know that maybe I shouldn't have – should have stayed focused. (Participant, V2020/703):

This participant expressed on several occasions that they should have been more focused on the study rather than the socialising because most of their friends from this participants year group had been accepted into medical school and they had had to choose a degree in another health discipline:

I got a ton of support from everyone when I needed it... and these spaces [the whare] were a source of comfort because I realised that others had been through what was happening to me...the whare was my haven...and the people here too, they are my whānau as well. (Participant, V2020/704)

It was clear that students found the 'whare', the spaces that had been set aside for them, as their place. Māori cultural concepts of whānau, whakawhānaungatanga, tautoko, karakia and manaaki were drawn upon to not only enhance the university experience but to discuss, explain, and provide an understanding of the issues that many of them faced or had faced in the past.

Problems encountered?

you know you don't give birth to a baby and then abandon it, well you shouldn't anyway, you nurture it through all of its after birth problems, teething, sitting up, crawling, talking, walking - you don't just abandon it. (Participant, V2020/701)

One participant highlighted that the programme started well but that problems had begun to emerge. They referred to the programme as being still in its baby stages and as such, struggling to survive by itself. Using figurative speech and metaphor, Te Rangihiroa (1949) explains, is often used by Māori to describe situations in a way that is not only acceptable and understandable but natural. On one hand the comment implied that someone should be held accountable and responsible for the problems on the other hand indicating that what had happened, was a natural phenomena and the situation could be saved with more attention. Māori programmes like any other programmes need to be supported through the early stages of development and implementation. Just as an infant goes through its developmental stages and reaching notable milestones so too do programmes such as the step-up programme. Abandoning a child after its birth would be considered socially unacceptable therefore it was considered that some real attention be paid to the programme to put it back on its feet:

there has been no nurturing from its birth parent in terms of this certificate course so no wonder it is floundering. Things like encouraging and supporting the staff teaching on the programme, ensuring that the faculty acknowledges the work of the staff and highlights the positives of the certificate, ... ensuring that it remains a talking point for all staff. You don't give birth to a child and then leave it to fend for itself. (Vision 20/20, Participant)

There was a suggestion that more responsibility and active involvement in the programme should be shown by senior staff especially from those who were involved in its initial development. Individuals who had taught on the course but were not currently involved raised concerns as to how the programme was currently operating because key programme support staff had resigned their positions and some academic staff had new roles within the Faculty of Medicine and Health Science. One participant admitted that after the first year of operation they had not been involved with the programme as there had been some disagreement over the roles of some individuals and therefore was not as close to the programme as they had previously been but felt the programme was not running as well as it should be from their perspective. Although support for the programme to continue remained.

On the other hand, from a student perspective, the step-up programme had no perceived problems. Concerns raised earlier about the programme having operational problems have not impacted or become apparent to students of the programme:

There are no problems with the programme, the certificate year is free which is good, would be good if it was all free. (Participant, V2020/703)

I found it to be a huge learning experience and a really good introduction to university life. (Participant, V2020/704)

While there were some concerns about the costs involved in university study it was apparent that students appreciated the support the programme offered either financially or as a way to become familiar with the environment and with the people in the environment.

the course was really, really hard, science papers such as biology, chemistry, physics all the subjects that you have to have for medicine and you had to get really good marks. Before this course there were a lot of the Māori and PI's failing their courses especially biology. They got past students who had passed all of the papers to become a type of buddy/tuakana to the certificate students, they supported us and throughout the year we had lunches, BBQ's, hangi get together for all the Māori and Pacific Island students...it was great, now I am the tuakana and buddy to new students. (Participant, V2020/703)

For students of the programme it appears to be a positive, enjoyable and comforting introduction to university life that has provided a huge learning experience and a solid foundation for future study:

For me I am really happy with the programme and having been accepted on it because it has provided me opportunities I never would have had, for example I know a lot of people now, I know how to do my work on computers, widened my employment opportunities, increased knowledge in technologies, I have research skills and understand the process of research. (Participant, V2020/703)

Comments about the programme indicated, the gratitude that some students felt for being accepted into the programme in the first place. Even when students passed all of their papers but marks were not good enough to get them into medicine, the benefits of the programme were evident in terms of further study, actually wanting to stay in the system, other career options, and networking:

I am a 3rd year health sciences student and was among the first group who undertook the Vision 20/20 programme i.e. The first year certificate in health sciences bridging course. For me it was a foot in the door, although, I wish I had worked harder and got better grades. I passed all the papers but I could have done better, I could have been part of the group doing medicine if I had worked harder but anyway I enjoyed the social life...I carried on with another course because I didn't want to leave the University yet, it's great. (Participant, V2020/703)

Students attribute their higher levels of confidence, self-esteem, and comfort in the University environment to the programme. That is, it becomes an orientation type of programme that is likely to influence the retention of students (Maxwell-Crawford & Gibbs, 2003) because it is

welcoming and comforting. For some students, continuing education is likely to become a lifelong venture. It appears from the following quote that students valued the opportunity to meet and get to know other Māori and Pacific Island students who had successfully navigated the University system and had made their way into medicine:

We also got to network with past students they would come in to meet us. I know the medical students, 3rd and 4th year students would buddy up with 6th year students to help them through their final years. They have an introduction camp for 1st year med students in January, which is funded by past students who are already interns. This camp is hosted by the 2nd year students, and they support the first years through, it makes a difference in terms of settling into the medical degree courses. But yeah during the certificate year you are literally spoon fed through the course and if you are lucky enough to become a 1st year medical student the 2nd year students literally do the same, really comforting. (Participant, V2020/703)

Clearly the experience of Māori students who have been through the programme are likely to have long term benefits in a variety of ways as suggested by Gluckman & Mantell (1997). For instance the payoff for the hard work, family stress and strain, and overcoming other constraints is not only future financial gain, which is assured with higher education in today's environment, but is likely to have flow on effects with other whānau and friends as the following comment describes:

but educational achievement for yourself and other members of your family (once one goes through then others are more likely to follow), the flow on effects with better education is higher income, better housing, better living standards, more choices and so on. Need to look long term, further down the track. Need to start telling Māori kids from birth that they are going to University, going to be a doctor, going to be a pharmacist, a surgeon, a lawyer, an accountant take away the ingrained thought that their lot is to leave the education system at 16 or 18. (Participant, V2020/702)

Level of Māori involvement in the programme

As highlighted earlier senior management within the Faculty of Medicine and Health Sciences do not have as much to do with students on the programme as they did when the programme was first established. Their involvement has become more indirect through the Director of the programme since that position was established. This approach fits with general management theory in relation to delegation of duties, authority, and responsibility, leaving senior management to maintain interest at other levels of the organisation (Robbins, Bergman & Coulter, 2006; Robbins & Barnwell, 2006; Samson & Daft, 2005):

We have some Māori lecturers involved in teaching the papers, providing tutorials or providing other support. The rest of the lecturers are non-Māori but they are keen and do assist when they can. The director of the programme and their administration support are Māori. There are also the learning support co-ordinators who are Māori and PI then there are the students and their whānau and support groups so yes there is mostly Māori involved in the programme. (Participant, V2020/702)

The importance of whānau and iwi support groups was highlighted in the proposal as an important aspect of the programme for three reasons. First, is for whānau to support and encourage their tamaiti/mokopuna to go to University. Second, to provide them with the strength and knowledge of who they are, that is, ensure they are secure and safe in their identity and third provide support and encouragement to ensure students remain in University (Deloria & Wildcat, 2001; Durie, 2001b). In relation to iwi support the following comment highlights:

It motivated me to do well at school and when I got dux I was accepted into Medical School straight away and offered a scholarship of \$30,000 a year for six years from my iwi. (Participant, V2020/704)

Being chosen by iwi not only places an obligation on an individual but with this student a sense of excitement and a resolve to do well in school which resulted in acceptance into medical school:

but even if I hadn't done as well as I did or got the scholarship, it had been decided that I was going to be a doctor no matter what the cost... my whānau would have fundraised and mortgaged their houses I am glad they don't have to but that is what they would have done. (Participant, V2020/704)

Whānau had an important influencing role in terms of making a decision on behalf of the student to not only attend university but to choose medicine. Whānau aspirations for this young person were manifest in their love and commitment to ensure she was well supported first by whānau and hapū, alongside iwi. Iwi support for this student also highlighted the support for the programme, and that their achievement had future benefits for the iwi as a whole. It also indicated that other promising students could look forward to the same level of iwi support. Importantly it showed iwi commitment to and the priority placed on Māori education and health development and the potential gains from such an investment:

I didn't have to do the programme I could have gone straight into med school year 1 but I wanted to go through with a group of other Māori, I didn't want to be on my own, if I was going to be away from my whānau I needed to be with other Māori at least at the beginning, I was so homesick. (Participant, V2020/704)

The importance of whānau to this student was evident in the preceding quote, of the choice made to enter the programme and undertake study with other Māori students, thus replicating the participant's knowledge and seeming dependence on whānau, in the University environment. Forming a whānau at a distance that would serve a similar purpose to biological whānau (Durie, 2003; Metge, 1995):

this is my third year there but second year med school and I will be 21 this year. I nearly pulled out of the med school this year...you know working on dead people it freaked me out, I couldn't sleep or eat, even though I knew what to expect it was hard. We had to have whānau hui I couldn't deal with it, I had counselling and my whānau at home brought up a tohunga [to Auckland] to work with me...that was good, and I had my fellow students some of whom were mature students and they helped me through it, they all helped and I am still there...I have gotten through it...just... but you know I need the karakia before and after class. We do it as a group but I always do my own to myself now, even though religion is a big part of my family, this is different...I needed to understand from a Māori perspective what was going on and how Māori treat a tupapaku both now and in the past. (Participant, V2020/704)

The spiritual element of well-being was a real test for the participant in terms of Māori cultural practices surrounding death or more precisely dead bodies. Being able to share, compare, and analyse these with whānau, tohunga, kaumātua, and other students was seen as invaluable and has aided in the retention of this student in medical school. Iwi have obligations to their scholarship recipients as well and for this student it was enacted at a particularly difficult time:

There is little or no Māori input into some of the courses such as chemistry, but there are strong Māori examples provided and input into some of the other papers. The certificate is worth 120 credits and passing the certificate allows entry into a healthcare career providing Māori with specific opportunities in medicine or some other health related field. (Participant, V2020/702)

I lectured on the certificate course in the first year and found it relatively easy to incorporate a Māori perspective. I think students enjoyed it...I also included a research component... I think it is important that they learn a variety of research skills from differing perspectives including Māori...because they will spend many years being involved in bio-medical research they need to be accepting of other perspectives. I found that Māori students are more accepting of other ways of doing things, not just research but in everything...they are bright cookies no doubt about that. (Participant V2020/701)

Māori perspectives, while not a feature of the course itself are incorporated into the teaching programme by individual members of the teaching staff. The potential to extend Māori perspectives into the physical sciences may eventuate in the future given Māori propensity for innovation, adaptation and acceptance of learning new knowledge in different ways.

Measuring programme success

There are varying ways of measuring the success or otherwise of this programme. For example, the main objective of the Whakapiki Ake project was to promote medicine and other health disciplines as an attainable vocational choice for young Māori. Therefore one measurement of this project is identifying the numbers of Māori who have accessed Hikitia te Ora or MAPAS from this initiative. Measuring Hikitia te Ora would involve the same process because one part of the programme is about ensuring students meet required academic entry criterion. For instance, Gluckman and Mantell (1997), identified a prevailing student pass rate of 90 percent in the medical degree programme. Therefore given that Māori students in this programme have gained entry based on the same academic criteria as other students the expected pass rate for Māori students studying medicine is likely to reflect or better the prevailing pass rates. Actual pass rates in medicine and other health disciplines would then reflect well on the programme.

Participants including the student participants provided a range of measures they thought may be relevant for measuring the success of programme. Apart from the numbers most of the suggestions were about measuring future results and gains and for the students the focus was on how beneficial the programme had been to them personally and their families. For example the ease and comfort they feel about being in the medical and University environment, having access to resources such as support and whānau, having that special person to look out for them (tuakana/teina), developing ongoing networks with peers (whakawhānaungatanga) and the contemplation of having lifelong career options and choices:

Measures of success? Well I guess students passing their courses successfully... being successful in their life and chosen careers is perhaps a future measure... dramatically increasing the numbers of doctors that was the original aim and it still is but... giving them that opportunity firstly to choose to come to the University...choose where they wish to have a career. Future measurements also include measuring the increase in the levels of income, housing, education of Māori families. Also see if professional careers is becoming the norm for Māori families. What has been the impact on Māori families ie has it made a difference to things like poverty, improved the health and income and education choices of future generations. What is the impact of more Māori role models in the community? What has the impact been of having more health professionals. Have the attitudes of schools changed? We need to work with schools so that Māori are making those choices earlier in life rather than later, having longer careers. (Participant, V2020/702)

While much of the programme focuses on recruiting Māori students directly from secondary schools, it became apparent early in the implementation phase of the programme that it would

be necessary to accept older Māori students to help make up the numbers. Older students bring a different perspective into the programme⁷¹, in many instances they are more focused on their studies and sometimes this has positively influenced the younger students:

We also took older students into the programme. I think the variety of ages of students adds a different dimension and there really are tuakana/teina relationships developing within year groups as well as between year groups. There are set groups of students who are focused and others who are not so focused, some who want to have experiences and others who have had experiences, there are single people and people with children studying together so some are used to compromising, prioritising, sharing and helping, others are not used to that. So basically we are going to have differences in each of the graduating groups but by the time they finish the course [certificate] they are a close-knit year group and help each other through. (Participant, V2020/702)

What has helped to advance the programme

Participants were clear that there were aspects of the programme that required refining, redefining, and perhaps restructuring. While faculty and organisational support in terms of marketing the University as a safe environment for Māori was noted as a positive aspect, greater emphasis was placed on the students, friends and whānau as having a greater influence in relation to the programme moving forward. For instance, that it could only move forward if Māori could see the advantages it could bring to their families and if they could see respect for their own cultural perspectives reflected in the programme and the organisation as a whole:

Faculty support but most importantly the students themselves, their friends and their whānau have helped to advance this programme. Word of mouth, with friends and family is really important. If we can get children, brothers, sisters, cousins, aunts, uncles, and grandparents of students talking about the programme and encouraging others to apply to the programme then that will advance the programme. Better marketing of the programme within the University and external to the University and to those communities where University seems to be not an option. Advancing the programme means we have to make this place, this environment, a place where Māori are seen to be at home, a natural environment for them to be in. The learning support services have been hugely beneficial to helping the students get through the course. Tikanga Māori, allowing tikanga to have a place in the University and showing that it exists in this setting is important. (Participant, V2020/702)

⁷¹ The students interviewed for this research were younger students one straight from high school (18 years old) and the other had been out of school for just over a year and was almost twenty years old on enrolment. The timing of interviews (during school holidays and exam preparation time) was perhaps not the best time to access students for interviewing. Originally students were not going to be interviewed because the focus of the research was in fact on the programme but staff were determined that I should interview at least one. There were no older students around on the days that I was in site participation therefore their perspectives are reported by a key informant to this study.

Continuous improvement

Improvements to the programme are ongoing, and according to participants is dependent on accessing more funding to attract more Māori staff both at support and teaching levels within the programme. Much of the student mentoring is carried out by senior students who provide their time voluntarily. Students are also encouraged to participate in any way they can as well as suggest improvements to the programme. Regular newsletters and information sessions about the programme overall is important to ensure prospective and current students and their whānau are informed about the programme in a variety of ways:

There are always ways of improving, more Māori staff would be good – lecturing. Course if you are given the funding you can do anything and mainly it is about money. If we got money, we could support more students, get more staff to help with the support and teaching. You can always make a programme better in many ways but often it involves money that nobody wants to give. Ideally though it is up to whānau to ensure that the word gets around about the programme. (Participant, V2020/702)

Portability

Participants were generally of the same view in that they felt the programme was transportable to other sites within New Zealand and if funding permitted could be replicated in other countries because the basic principles of the programme could be applied to any group including indigenous groups.

Yes it is, if you have the funding you could take it anywhere but given that there are only two medical schools in the country transporting it would be easy. The basic principles of the programme are applicable to anywhere in the world really and if groups are well funded they can produce similar packages specifically tailored to meet the needs of their groups i.e. Māori, PI, Native America and other indigenous groups. It is not new, tautoko, is not new to any group, it is how it is applied (Participant, V2020/702).

Contribution to Māori health development

Given the programme itself is likely to contribute to increasing the numbers in the overall health workforce participants all agreed that the contribution to Māori health workforce development would be immense. Continued funding was identified as an essential component for ongoing health workforce development generally and for Māori health workforce development specifically (Nakhies; 1996; Salmond, 2004):

I would have to say yes it has in a number of different ways. People who would not thought of doing medicine are doing medicine, people who had only dreamed of health science careers are identifying health professions that they can be a part of. At the

beginning of this programme my focus was on getting Māori into medicine as doctors, surgeons, pharmacists – the clinical side of things. I still have that first instinct to direct people into medicine but there is also a huge need for the other health professionals as we well know the managers, providers of health services, administrators, counsellors, community health workers. We need innovation in the way we manage Māori health so we need a whole variety of health career opportunities for Māori to participate in, at senior levels too. So yes it has contributed in terms of education and for training later when the degree is finished they will be able to participate in the training aspect more competently. For many, they may want to stay in education for longer to do postgraduate and postdoctoral work – eventually their knowledge will need to be put into practice so yes to both education and training (Participant, V2020/702).

There was a strong feeling that the overall programme of Vision 20/20 was making a difference not just for individuals but for families as well. Whilst in the beginning the programme had focused on having more Māori doctors the relevance of having more Māori in health related and allied services was noted as being just as important. It was also mentioned that having more Māori in health would ensure Māori perspectives would be included more readily thus promoting new and innovative opportunities to participate in health areas where Māori had not previously been able to participate. That the programme would impact in a wider context, for example on the wider New Zealand population, by providing for a health workforce that was not only clinically competent but would also be culturally adept and attuned to the growing diversity within the wider population as a whole.

Case II - Contemporary health protection environment: Health Protection

Painting a picture of sameness

the generic 'one size fits all' approach to health protection, essentially delivers inequitable services and results in outcomes that disadvantage Māori communities at a time when breakthroughs are needed to reduce disparities. (Participant, HP)

The generic approach to health protection implies 'universality', that is, everyone is the same, live in similar environments, have the same needs and aspirations, have access to the same resources, employment, income, living conditions, the same cultural perspectives and place importance on the same issues. Evidence that these notions of universality prevail in the 21st century should be of concern to society in general because it maintains the culture of one people while at the same time marginalises, sustains barriers, discounts realities and experiences, and prevents other cultures from positively participating and contributing to overall societal development.

A disease versus health focus

The current focus of health protection on physical environments and public safety remains an important area of public health risk management. However, Durie (2001) maintains that while the focus on environmental safety is important, the new contemporary lifestyle environments have created far greater health problems (diabetes, cancer, heart disease, suicide and obesity) for specific populations. Thus, suggesting that a different approach to health protection measures should be considered and applied with the same urgency and intensity, as they were in the early 1900s to combat the spread of infectious disease. Given the high susceptibility and prevalence rates in these diseases for Māori, and the analysis from Durie (2001), two factors are highlighted from the respondent comment above. First, the noted inequities and disadvantage that emanates from the current focus of health protection on pursuing safety regulations and second; the implied exclusion of Māori communities from being involved in the development of health protection initiatives. Durie (1994, 1998, 2001) also suggests that the use of Māori perspectives and concepts such as tapu, noa and rahui to provide guidance in the development of health protection regulations and laws are more likely to have relevance for Māori. In any event, for contemporary lifestyle diseases he advocates a stronger emphasis should be placed on, for example, in relation to diabetes, nutritional standards and oral intake. Thus highlighting the

‘mouth’ as the main entry point to the body, for many contemporary diseases. These include for example alcohol, drugs, smoking, and food.

One of the most recent threats to public health is Bird Flu and the possibility of a world-wide pandemic. While it has not yet mutated to human (passed from human to human), experts in the field indicate that this may only be a matter of time. Given the history of Māori susceptibility to infectious disease it is likely that when mutation to humans does occur Māori populations may be more vulnerable, and, as they did in the 1918 influenza epidemic, bear the brunt of the pandemic (Maclean, 1964).

It was the threat of bubonic plague from which the Department of Public Health was established (Maclean, 1964). Sanitary inspectors were appointed and dispatched to the regions. Originating in Asia the plague spread throughout the world and millions of people died. While the disease arrived in New Zealand it did not spread as quickly or as widely as it had in Asia and Europe. There was much speculation as to why this was so and geographic isolation, seasonal influences, and rat eradication were some of the reasons cited (Maclean, 1964).

In the 21st century however, New Zealand does not have the luxury of isolation to help keep its population safe. People are mobile and travel to all parts of the globe within a few hours. Therefore exposure to the disease in New Zealand is a real possibility. However, communication and information technology advances will ensure that the public is much more informed and advised of necessary action in a timely and appropriate manner. Health protection services have a major role in prevention of disease in communities including Māori communities. Given the earlier discussions and examples of Māori participation and the experiences of disease combats of the early twentieth century there is argument and potential for Māori perspectives to emerge and contribute to health protection in a contemporary sense.

The contemporary focal point of health protection services is provided in Table 6.5 and describes health protection activities that are currently required of health protection officers. More recent evidence that supports a stronger Māori involvement in health and environmental protection services include Treaty of Waitangi claims. For example, the Motunui, Kaituna and Manakau claims ‘successfully challenged projects which were contributing to environmental

pollution' (Pomare, et al, 1995, p.165). The benefits of these claims have accrued to all New Zealanders and have been the impetus for the establishment of government agencies such the Department of Conservation. Legislation has also been as an indirect result of these claims, for example the Resource Management Act 1991. Yet although Māori have proved themselves able and willing barriers to participation in health protection services remain.

Regulatory role of health protection

The health protection officer role is a statutory role...our powers and duties are set down by a number of Acts of parliament...Health Act, Food Act, Local Government Act, Toxic Substances Act for example plus there are a number of regulations that HPO's are required to enforce to keep the public safe...Water Supplies Protection Regulation, Health (Quarantine) Regulations, Food Hygiene Regulations and so on. (Participant, HP)

Table 6.4: Examples of conventional health protection priorities:

| | |
|---|----------------------------------|
| FOOD | RESOURCE MANAGEMENT |
| Food complaints – investigation /prosecution | Submissions to councils |
| Food-related illness outbreaks | Protocol & liaison |
| Food samples – imports/ labelling /compliance | WASTE MANAGEMENT |
| Food hygiene premises inspection | Sewage treatment/disposal |
| Shellfish Sanitation Programme | Refuse disposal (Landfills etc.) |
| INFECTIOUS DISEASE | Hazardous waste disposal |
| Follow-up cases notified | BIOSECURITY |
| Medical Officer of health work | Port health procedures |
| Meningitis cases and contacts | De-ratting ship cargo etc |
| National database stats (EPISURV) | Vector control (e.g. mosquitos) |
| TOXIC SUBSTANCES | EARLY CHILDHOOD |
| Spraydrift complaints | Inspector for charter |
| Pesticide applications | OCCUPATIONAL HEALTH |
| Hazardous substance procedures | Links with OSH e.g. asbestos |
| Licensing procedures | Private monitoring e.g. noise |
| Bulk containers | LIQUOR LICENSING |
| Fumigations | Host responsibility |
| WATER | MOH report |
| Drinking water – surveillance | SMOKEFREE |
| Water treatment plants | Illegal sales & ‘sting’ |
| Complaints | Workplace smokefree policies |
| Recreational water monitoring | Enquires |
| Swimming pools | BURIAL AND CREMATION |
| Algal blooms | Disinterests |
| Grading supplies | Burial in special places |
| National database | Cemetery inspections |
| | Export of bodies |

Source: Environmental Health Newsletter, April, 2002.

Formal Māori health protection in New Zealand has a long history stemming from the New Zealand Public Health Act 1900 and the subsequent emergence of the Department of Public Health in 1901. However, Māori laws and regulation of tapu, noa and rahui pre-date European contact (Buck, 1949; Walker, 1990; Smith, 1999; & Durie 1994; 1998, 2001). What are now known as health protection and environmental protection officers began as territorial sanitary

inspectors and were officers of the Department of Health based in district public health offices, and council offices, focused on supporting approaches to public health that were responsive to national priorities at the time (Durie, 2001). Formal Māori community involvement in health protection, began with the appointment of Maui Pomare in 1901 as Māori Medical Officer to the Department of Public Health. Pomare's ecological approach to improving the health of Māori communities focused on working closely with Māori leaders who were not health professionals but who had influence in the communities they lived in. Māori community leaders were appointed to positions of health inspectors, sanitary inspectors and health commissioners. Māori involvement in early health protection was widely acclaimed.⁷² Suffice to say here that Māori communities pioneered and were successful in providing health protection services at a time when the threat to Māori survival was imminent. The roles of the sanitary inspectors were statutory and Māori involvement was specifically sought by the Health Department. However, once the perceived threat of infectious disease and Māori survival had passed, the Health Department abandoned the involvement of Māori communities in health protection terminating the Māori appointments in favour of 'sanitary inspectors and public health nurses well versed in public health practice' thus making health a 'professional concern rather than a community responsibility' (Durie, 2001, p5.) effectively excluding Māori participation in positive community health initiatives.

Working relationships

Health protection services is based in the Ministry of Health funded Public Health Unit in each district along with health promotion and advocacy services. While we are based in the Public Health Unit, Health Protection Officers work independently of both promotion and advocacy services and in most cases independently of each other. (Participant, HP)

What becomes clear from the comments above is that responsibility for health protection services in New Zealand has not changed apart from being based within District Health Boards or local councils. The Ministry of Health remains responsible for health protection services and enables their activities in the regions through funding district public health offices based within a District Health Board area if not in the District Health Board itself. While based in the Public Health Unit, health protection is a distinct service that operates independently of other services

⁷² See Chapter One of this thesis for more detail on the work of Māori sanitary inspectors.

that are based in the Public Health Unit such as health promotion, health education, and advocacy services. Health protection officers also work independently of each other. Being independent and working independently has in one sense connotations of collegial respect, recognition of skills, ability to work unsupervised and control over the work environment. In another, there is a sense of authority and power that sometimes appears with law enforcement:

if I am out in the community then the work is piling up at the office...if I am sick my specimens and water testing in my area are not being done. (Participant, HP)

On one hand working in this way assumes the work of health protection services are specialised and that their work roles are specific and narrow. Organisation theory and management writers (Inkson & Kolb, 1998; Robbins & Barnwell, 2002; & Robbins., Bergman., Stagg., & Coulter, 2006) suggest one particular advantage of specialised work roles is the ability to foster capability and expertise by focusing on individuals and making them proficient in a narrow range of activities and thus more cost effective because it reduces training costs. However, the disadvantages of specialisation in changing workplace environments, means that when individuals are absent from their workplace, for whatever reason, there is no other person able or willing to fill their role. In this instance the organisation would benefit from having people with the ability and skill to adapt to changing situations with more generalist skills. On the other hand the disadvantages in training individuals in a wider range of tasks and skills are that it would not take full advantage of the specialist skills that individuals can build nor would it be cost effective:

Here we don't interfere with other HPO's [work by ourselves] Anyway I do all of the Māori communities in this area, marae, schools ... none of the others want to go there...I do though. All the same, I wish I could work more closely with other HPO's and gain from the experience. (Participant, HP)

We are given and made responsible for our own specific areas. Because of the high Māori rural population in this region and I guess me being Māori I have been designated the rural areas. Which is ok, I am comfortable with that. On occasions I have joined the Health Promotion team when they have been into my areas. (Participant, HP)

In health protection services, specialisation, in the sense discussed above, tends to limit individual obligations to specific areas of tasks and populations rather than maximising specialist skills for the benefit of the public. The opportunity to learn from others, share experiences, skills and understandings are not imparted. It also implies that for many of the non-Māori health protection officers, working in Māori communities is too difficult or uncomfortable for them.

Māori cultural training and awareness has not been part of their scientific training, there is no value added and therefore has no place in their professional health protection activities. On the other hand the comment implies perhaps, collegial respect for each other, an acknowledgement of professional expertise, the recognition of working autonomously or an acknowledgement that being culturally competent means that a person is better able to work and or communicate with their own Māori communities. For this person though, there have been occasions where there were advantages to working with health promotion services especially when they were going into the areas where this particular health protection officer was working. There are possible explanations as to why health protection officers might diverge from working autonomously in the community. One is the possibility that clear messages, information and education of a specific health issue to the Māori communities was necessary, for example the meningococcal awareness and immunisation campaign. A second, is that being Māori and a speaker of Māori, the health protection officer involved was following Māori tikanga and protocols of manaakitanga (hospitality, assistance, caring) and practising related concepts of tautoko (support) and awhi (helping) thus ensuring the observation of the kawa of their area was upheld. A third possibility is that, given a Māori view of health, there is a sense that health protection is not divorced from other aspects of health service provision and in this sense, opportunities to link health protection with other service activities is a natural phenomena.

Māori capacity in health protection

For this DHB region there are 11 HPO's. About, 50-60 in Auckland plus 30 or more environmental officers, overall about 140 HPO's and approximately 200 EPO's. Here, we are accountable to a regional supervising HPO who is accountable to a general manager based in the DHB and is accountable to the Ministry of Health. The supervising HPO also sits on management committee's for health protection. Decision making for health protection takes place mainly at regional committee level as opposed to one manager having the decision making role. Does that make sense? Anyway I think they work to keep it a flat structure with group decision making which I guess at times is a good thing at other times its death by committee. At the end of the day, it is a Crown agency and therefore at times smacks of bureaucracy. (Participant, HP)

The size of the health protection workforce is small compared to other areas within the health sector. Main regions like Auckland would have larger numbers of health protection officers and probably around 30 environmental protection officers. Small regions like this have around 10 to

15⁷³. For New Zealand overall, there are approximately 140 health protection officers and 200 or more environmental health protection officers. While most health protection officers are based within a District Health Board there are some who are employed through local and central government and private organisations.

Reporting and accountability for health protection officers is through a supervising health protection officer, then a district general manager through to the Ministry of Health.

The respondent suggests that the health protection profession, while being regulated by statute, operates in the districts under a fairly flat structure with few levels of authority. Flat structures tend to be more flexible, responsive and cost effective. However they also have the tendency to increase the levels of stress for individuals because they have more people to be responsible for wider spans of control (Inkson & Kolb, 1998). According to the comments above flat structures are conducive to shared decision making and open communication. But, as with many structures, there are advantages and disadvantages and to ensure there is a health protection voice being heard, often the voice of health protection is left to an individual/s who in many instances spread themselves thinly, participating on a number committees, which adds further pressures. While these structures are said to be less cumbersome and more responsive, a hint of bureaucratic machinations remains for some aspects of service provision.

As with the private sector, the public sector has also experienced wide restructuring and downsizing in order to meet changing economic and market conditions.⁷⁴ In the past, the public sector had been heavily subsidised by successive governments. However, with the removal of subsidies, increased overseas competition resulted in forcing economic reform. New Zealand organisations had to become 'leaner and meaner.' This meant formal hierarchical structures and their tendency to be uncompetitive, inefficient, over staffed and over-managed would not survive in the new environment. Flatter more flexible structures would be less unwieldy and more responsive to the new competitive environment. As a consequence the health sector

⁷³ Participant, HP

⁷⁴ Chapter 3, Contemporary Māori Development discusses the restructuring of Government departments in particular the restructuring of Māori Affairs which became the current Te Puni Kōkiri- Ministry of Māori Development.

among others has not been immune to restructuring, reorganising, rationalisation or downsizing (Inkson & Kolb, 1998 pp252-255):

there is a word I would call it [structure] hybrid, where you have some functions that are centrally focused and others that have been devolved, decentralised management and then particularly with health protection a sort of level of independence which is protected in contracts with the Ministry...protects our level of independence not compromise it because we are regulatory officers designated by the Ministry. (Participant, HP)

Health protection officers, even those who have not been in health protection for a long period are fully aware of the responsibilities and required regulations that they are employed to enforce. In this sense, comments from the respondent highlighted the devolution process and how the restructuring of health protection services worked at both a local level where functions had been decentralised and at a national level where specific functions remained centralised. Many public sector organisations or quasi-government organisations such as in health, education and housing for example have adopted the type of structure that is an amalgam of a formal and informal organisational structure (Robbins & Barnwell, 2002). This hybridity in health protection service structure, serves to enable organisational flexibility and promote organisational responsiveness while at the same time acknowledges the ability and authority of health protection officers to undertake their formal enforcement roles of health protection services.

Māori health protection

there are approximately four Māori Health protection officers across the country, two of those position job descriptions reflect non-generic roles, i.e., have a Māori health perspective. (Participant, HP)

The numbers of Māori health protection officers across the country is very small and regularly fluctuates from 5 to 3 equating to approximately 1.5 percent of the total number of health protection officers. Currently there are three Māori health protection officers in New Zealand. Just two of those positions are designated Māori positions, in which a Māori perspective within their role is considered. The other health protection officer is employed under generic health protection services specifications. While the demand for Māori health professionals, such as health protection officers to work alongside Māori communities, is clearly evident., there remains a serious shortage of Māori health protection officers in the current workforce:

a challenge for us is that we are directed, by our supervisor, who liaises with and takes advice from the Māori health services unit which is based within another tribal area. This DHB office is based within another tribal area, it is not based here, so we have to get those sorts of things in line. (Participant, HP).

The current structure of District Health Boards allows for the participation of health protection in local decision-making through, in most cases, a supervising Health Protection Officer. Further, based within District Health Boards are Māori Health Units with whom the supervising Health Protection Officer will liaise. One of the concerns raised by participants is that District Health Board regions often do not reflect nor are they inline with tribal boundaries. For example, the main District Health Board office of a region may extend over more than one tribal boundary. This raises a different set of dynamics and challenges for both iwi (tribes) and the Māori Health Protection Officer. The realities of one tribe are often vastly different to the realities of others in a number of ways. What becomes apparent in this sense is the safety of the workforce who are required to work in different tribal regions simultaneously:

at the moment we are perceived as being influenced or servicing from [another iwi's]⁷⁵ perspective, that we reflect [the other]⁷⁶ iwi perspectives, tikanga and kawa (Participant, HP).

While in some cases there is waiata and moteatea training offered to all staff there is no specific cultural awareness training offered. Even this waiata and moteatea training opportunity places the Māori workforce in a potentially unsafe or uneasy environment:

because our kaumātua council is based in the main district in [another tribal]⁷⁷ area, the waiata, kawa and tikanga are often theirs as well, sometimes it makes you feel like you are trampling on the mana of the local tangata whenua. (Participant, HP)

In this sense the structure of the service and placement of individuals is culturally inappropriate. Not all iwi have been given the opportunity to ensure that their own tribal perspectives are catered for within a region. The iwi where the main district health board has its office tends to be able to dominate or have influence in terms of their kawa and tikanga over surrounding tribal groups.

⁷⁵ The name of the iwi has been excluded to assist with anonymity of participants, however given the small number of Māori working in health protection services it is likely that this may not provide the required confidentiality.

⁷⁶ As above

⁷⁷ As above

On occasions individuals have been put at risk culturally by their own colleagues albeit unwittingly:

Even I have been [put at risk] pulled in to sit on the paepae [specific tribe]⁷⁸ at a consultation hui, which is not a good situation to find myself in, you know, me speaking for [specific tribe]⁷⁹ you know, I don't belong here, it was for the DHB, but I still don't belong here... just lucky I guess that I am known around here...but it sure didn't feel right to me.
(Participant, HP)

Situations such as the one just described are not unusual. They are becoming common practice especially for those who work in non-Māori dominated organisations and occupations. While organisations such as District Health Boards have cultural advisory groups it is likely they are there for the benefit of the organisation rather than to ensure tribal differences are negotiated and agreed. At the other end of the spectrum where non-Māori organisations have set aside a place for Māori tikanga and kawa it has at times come under negative public scrutiny through the media and often at the request of non-Māori individuals when aspects of Māori tikanga and kawa have been felt to be discriminatory and degrading.⁸⁰ In these situations tikanga and kawa Māori have been placed at risk of ridicule and shame because non-Māori have not understood or mis-interpreted specific aspects of tikanga and kawa:

What you need is recognition of the over and above things that a Māori such as myself brings to the role, an understanding of protocols, the language, skills of engagement with Māori communities, cultural competencies, accountability to Māori communities.
(Participant, HP)

In an area such as health protection services where a non-Māori workforce predominates and engagement with Māori communities is expected, it would seem sensible for this workforce to acquire some knowledge and or training in Māori perspectives of health, tikanga and kawa. According to Webber (2004, p8.) health sector reviews, especially in relation to health protection services, have paid little or no attention to Health Protection and have excluded Māori perspectives there is little evidence of systematic cultural safety, ethical guidelines, codes of practice or audits addressing the needs of Māori. Further, there is no recognition, through either

⁷⁸ As above

⁷⁹ As above

⁸⁰ Two cases where Māori cultural aspects have received undue media attention was when a nursing student was failed the Māori component of her training by kaumātua Hohua Tutengahe. The other case in 2005 was the case of a female corrections officer who objected to sitting behind men at a departmental powhiri.

remuneration or acknowledgement given to those Māori staff who have come to the role with Māori cultural skills, expertise and knowledge (Webber, 2004) :

I know the Auckland Healthcare Strategy is to target young Māori in the schools and it is important to awahi young Māori science students, we should all be doing that, I just disagree with their strategy. (Participant, HP)

Māori are under-represented in most health professional occupations including health protection. The strategy referred to above, is designed to increase Māori participation in the health protection and environmental protection workforce and is part of an Auckland Healthcare initiative with Auckland University of Technology (previously Auckland Institute of Technology) and the University of Auckland. The strategy aims to recruit young Māori from secondary schools and support them through a focused applied health science degree. Until recently Massey University provided the only approved course for health protection, the Bachelor of Health Science. While both qualifications focus on the student acquiring competencies required by the Ministry of Health for designation as a Health Protection Officer there is very little by way of a Māori perspective included in the courses. The Massey course has one Māori paper – He Tirohanga o Mua: Māori custom, law and economics; and the AUT course has a paper - Health in the Context of Aotearoa which may have Māori perspectives included.⁸¹

I try and target schools while I am about doing my business, look for young Māori students but we also should strategise for what is going to make the industry strong apart from recruiting from other industries we should be recruiting those experienced in Māori development. For example, those people who may not be versed in their culture, but are prepared to push. (Participant, HP)

While supporting young Māori science students through their courses is acknowledged as important, the feeling that encouraging and developing a strategy to support more mature students who would likely have experience in overall Māori development might be more beneficial to the health protection industry:

if we only get young Māori graduates into the industry we see them chewed up and spit out and we won't progress as well as if we got some solid mature development effort going on. (Participant, HP)

⁸¹ http://www.aut.ac.nz/schools/applied_sciences; <http://www.hauora.com/careers/index.cfm>

Given low Māori representation in science generally, and the relatively strict entry requirements, strategies to increase Māori participation in these areas could be more reflective of the needs of the community. For instance, it was felt that there is a:

need to look at the approaches used for recruiting HPO's and in particular Māori HPO's...I think there needs to be a certain amount of maturity, the ones that have left [here] were young, I think that is why I am still here I am more mature, settled and have managed to keep myself safe...younger people seem to need more pastoral care, alcohol seemed to play a large role in the younger ones lifestyles, I think they lacked maturity and couldn't cope with their positions. (Participant, HP)

What seems to be clearly highlighted is that the role of a health protection officer is fraught with one-sided, non-Māori or western-based modes of working (Webber, 2004) which tends to negatively impact on younger Māori health protection officers more quickly than on those who are more mature. In another sense it is possible that younger Māori health protection officers have yet to have 'life' experiences, those experiences that help them to become more confident and assertive in their interaction with non-Māori colleagues and the organisations they work in:

Young people have passion and energy but don't know how to channel those things, they get angry, disillusioned, and burn out and we never get them back and that is sad. (Participant, HP)

It is not unusual to find that when one has a negative experience in a workplace that has resulted in a resignation it is more than likely that the exit will be permanent. Losing a well trained individual can have severe consequences for an organisation in a variety of ways but to lose a well trained Māori from health protection is critical in terms of building Māori capacity in a profession where Māori representation is already low:

We have lost a lot of staff [Māori] over the last year, two of those were HPO's, we need to find out why they are leaving, need to have exit interviews, I don't know if they had exit interviews. Obviously they had been put at risk culturally by the organisation. (Participant, HP)

Exiting the health protection role has raised concerns for those who remain working in the field. Exit interviews as suggested have the potential to provide useful information about organisational practices if conducted in a positive non-threatening manner for the exiting employee. Taking time to explore why individuals leave fosters a unique opportunity for organisations to enhance, change, or eliminate offending organisational practices and thus improve work environments (Sligo, 1988). While there are obvious benefits for organisations to

conduct exit interviews the practice is rarely applied thus leaving the remaining employees to form their own views of why individuals have left. Often these views reflect their observations, empathy with an exiting colleague, their experiences, and in some situations, their cultural perceptions:

for Māori staff, there have been times of uncertainty, concerns over how Māori issues are dealt with and whether or not we are a Crown organisation trying to be responsive and deliver to Māori or whether we are still tauwiwi dominated, those kind of issues. Some of those regular difficult things come up like what to do with tangihanga, is it leave or is it community networking, there is a need for more clarity around those sorts of things. (Participant, HP)

Māori cultural issues remain areas of concern for Māori working in most organisations whether they are Crown or private institutions. Cultural issues may have also impacted on Māori attrition referred to earlier where thinking was highlighted in regard to employees of the organisation being placed at cultural risk and leaving for those reasons. One concerning issue is tangihanga (bereavement) which is an area where employment contracts, in many industries remain blurred, or they are prescriptive in terms of detailing the number of days an individual is allowed to have off work for a bereavement and for whom. This prescriptiveness contrasts dramatically from a Māori cultural perspective of tangihanga where attendance at tangihanga of people who are other than close whānau is an important acknowledgement of respect and an accepted way of supporting that person's family through their bereavement. While organisations such as Crown agencies, indicate a willingness to be more responsive to Māori and their communities they do so on their own terms with no or very little regard for the Māori perspective at all (Webber, 2004).

There was a feeling of wanting to do more, to make more use of the competencies and cultural abilities within the profession. However on one hand these abilities and competencies while potentially useful to the organisation were not valued by the organisation. On the other hand individuals needed to be aware of where and how these were used. Often workers did not have choices about these issues:

I feel that I am not using all of my competencies and when I do I often get abused for it, my cultural abilities, you know if I am pulled in onto the paepae, because I am not mana whenua here, I sometimes get abused. (Participant, HP)

Supported, tolerated, joined

Advocating for Māori perspectives to be acknowledged and respected within the health protection profession is also another issue. Within the District Health Board there is some support in various areas but for most staff, workload means that intentions are there but there is no time to take action:

I feel like I am the one pushing , pushing, pushing and most people when they get into a busy cycle, you know workloads and what have you, they have only got so much capacity to join the push so I am supported and tolerated but not often joined. (Participant, HP)

Energies of a single advocate wane because there is little support from other Māori colleagues whose workloads dictate not only their time but, it seems, their rights in the workplace to maintain a sense of one's own culture. These types of issues are also experienced by other indigenous groups, Saenz, Wyatt, & Reinhard (1998) describe the same pressures are placed on indigenous peoples working or training in Western institutions such as Universities.

Māori development

It was felt that it was important to increase the numbers of Māori in health protection to ensure that future generations could be involved and have some control over their own environments. Comments about what the future may hold for the generation or generations to come were evidently a concern:

looking on 50 years what will Māori communities look like, what will Māori development bring about? (Participant, HP)

Regular attendance at conferences, workshops and seminars in relation to Māori development and health tend to provide inspiration and encouragement for individuals working in health protection. However, the momentum is difficult to sustain in the workplace if other colleagues have not participated in the same types of forum. Individuals tend to become left alone, or humoured until the enthusiasm dissipates. Although, Webber (2003, 2004) maintains that it is important and necessary to be seen and participate in a variety of forum to ensure inclusion in relevant and beneficial discussion or debate, to become part of the group that leads development. The challenge for notable Māori leaders is to ensure that these forum and areas of influence for discussion and debate are sustained, persistent and with the right people:

Every conference, hui, workshop whatever that you go to there is always a lot of talk about Māori development, what we should be doing to move forward. I get all enthused when I go to a conference and listen to different speakers, get all fired up to do my bit, and okay for a couple of weeks, but nothing changes... it actually needs to come from the top...our Māori leaders should be continually talking to the country's leaders...that's who holds the purse strings and have the power to make change...they should just let us go for it we may do a better job, with the power and resources I mean. (Participant, HP)

Facilitating policy change

Being a member of professional bodies and government advisory committees, and groups provides further insight into the machinations of decision-making especially within a quasi-government agency such as a District Health Board:

I have been on a number of government working groups and they all try and twiddle their papers and rearrange the words like deck chairs on the Titanic you know? I am new but I have seen it all, I know it just goes round and round in circles...at the end of the day the same implementers, the same middle management decision makers and thinkers trying to apply the same paradigms and not a lot changes. (Participant, HP)

There is a requirement for many of these groups to have Māori membership, or a requirement to consult with Māori. Many of the issues discussed in these forums however, often remain agenda items for a longer time than is necessary. Māori issues are often sidelined and while participation might be required eventual decision-making is still made by senior management. The key though is to stay involved:

it is about reaching the right level and immersing yourself in the right conversations and you'll just make that breakthrough to another paradigm. (Participant, HP)

Further, the political environment changes regularly and in health organisations such as District Health Boards restructuring occurs almost every time there is a change in government or change in policy at that level. Health protection services usually remain the same with very little change:

it is a pessimistic view but nothing changes...we still come under the Ministry, we still have an enforcement role...the name changes from Area Health Boards to Crown Health Enterprises, to Regional Health Authoritys, Health Funding Authoritys to District Health Boards, Public Health Organisations, the dollars spent in restructuring government agencies is enormous. (Participant, HP)

A Western science approach fails to consider in its processes any other view or perspective in determining the health protection needs of Māori communities and in most instances, suggestions to consider a different way of doing things, a different view, or change practice is

met with opposition or resistance. One suggestion was that health protection officers get together regularly and thoroughly debate the issues that way people become more informed, aware, and respectful of cultural difference and perhaps learn to embrace diversity rather than resist it:

best practice is not just around any one thing it is finding out what it is that will have people have a change of heart... a healthy 'boil up' once a week you know getting together and thrashing things out together... we are so busy writing policies about it that we don't ever go into each others' communities, be a part of each other's communities...we as Māori have to do all of the compromising. They make no effort to really get to know what is happening our communities. (Participant, HP)

There appears in health protection to be an assumption that Māori already get enough money from the government in terms of social payments and targeted scholarships. But participants felt that this to be discriminating because there is a large amount of funding, in terms of scholarships that are available and kept aside for the non-Māori population (Webber, 2004). Most of these funds are managed through local regional and city councils, community groups, banks and charities and Māori are not encouraged or expected to apply for these:

If I think about how lucky I was to get a scholarship to enter this industry compared with hundreds and thousands of dollars in scholarships for tauwiwi [non-Māori] you know gate-kept for tauwiwi, fed through the councils, and charities or whatever I feel a strong sense of injustice from what I see has gone on. (Participant, HP)

Working inside institutions such as the District Health Boards and Government agencies provides individuals access to information that is often not in the best interests of Māori communities. Being an employee places restrictions on what information individuals can pass on and what information is not to be passed on. A further issue raised was when a Māori community is put at risk or is neglected for service thus highlighting serious ethical, moral, and conflict of interest issues and feelings of powerlessness. There were also feelings of resentment that emerged because of unfairness in the way Māori communities are not provided the appropriate services because of the tax exempt status of marae for example:

Even as we sit here today tauwiwi are making decisions, creating new legislation about something that will stand to disadvantage our communities. If Māori were able to access ... tauwiwi funding and participate fully in the decision making then we could have balanced conversations ...but we need to get to that level. "Millions of dollars" have been used for sewerage subsidies in cities and towns but not in small rural Māori communities or the marae where they need it most... because they are not taxpayers or rates payers... it isn't fair and to me it is immoral. (Participant, HP)

Incentives

There have been a number of suggestions from various quarters in regard to providing incentives for staff working in health protection. For example, incentives for Māori staff suggested by Māori staff is for the organisation to recognise in financial terms, Māori competencies such as abilities in te reo me ōna tikanga, karanga, whaikōrero, and whānau connections for example. However as mentioned earlier these competencies are not valued by the organisation:

Performance bonuses linked to Māori competencies are not suited to the New Zealand situation generally, Māori knowledge and competencies are not considered essential for the job so are not acknowledged appropriately or highly valued. (Participant, HP)

Making a difference

While the Ministry takes the opportunity to recruit Māori staff into health protection services they are normally employed on a generic health protection officer contract. And while competencies in Western science is a prerequisite for the position, Māori cultural competencies are not considered essential for the position. Therefore staff with te reo me ona tikanga capabilities are not compensated for these skills. There is a feeling that if the skills are not valued in the organisation then perhaps the individual is not valued either. And if they are not valued then they are not making a difference, not making change in the organisation or in the community. Webber (2004) in presenting the results of a survey of health protection officers (both Māori and non-Māori) highlighted that recruitment and retention of staff generally is a problem but is glaringly so for Māori:

the thing for me is, in terms of workforce development, is that if what I am doing is not making a difference then I will want to leave so the main thing about workforce development is what is the organisation doing to retain me. (Participant, HP)

Whilst the survey was to gauge responses from the general health protection workforce about Māori health protection workforce development most respondents clearly saw no difference or a need for specific Māori workforce development initiatives within the service. Many saw that because there were no Māori health protection officers in their specific regions that there was no need to address or rectify the situation (Webber, 2004).

There was a major concern that the organisation was not doing enough to make Māori staff feel valued and therefore did not seem concerned about the retention of Māori staff in this field.

Cultural perspectives were absent from most processes within the organisation and even when they were included it was seen as an after thought or tokenism, not properly understood by the organisation and therefore not applied appropriately:

the Ministry genuinely think they are being culturally sensitive by stating in their hand book that water samples will not be taken from the roof of a wharenuī (as the wharenuī is an ancestor). (Participant, HP)

While Māori cultural sessions were open to all staff to participate in very few of the non-Māori staff chose to undertake these sessions. However it was clear these sessions were attended by Māori and a few non-Māori staff. For the Māori staff these sessions were beneficial in the sense that they could endeavour to maintain their own cultural identity within their daily work environment:

I attended all the cultural safety sessions, but my non-Māori colleagues haven't. I also attended the waiata, and the waiata moteatea training offered to staff just as a way of trying to maintain my own identity within a generic role and to resist being assimilated on a daily basis which is quite hard to do"...it keeps me grounded (Participant, HP).

sometimes they separate out Māori training, Treaty training, tauīwi ones, mixed ones. The pre-entry ones are all pretty standard. (Participant, HP)

Generally the Ministry of Health booked training in other specific areas for the health protection services teams which staff could apply to undertake:

the Ministry of Health makes funding available or makes courses available that they pay for but you have to apply for it. In two years I was sent on one course... I applied for more but they agreed to one. (Participant, HP)

There was an expectation that given the Ministry of Health is leading workforce development and especially Māori workforce development in other areas of health that health protection would receive the same sort of attention. Fast track development in Māori health protection workforce was identified as being essential if the Ministry of health was seriously thinking about increasing Māori participation in health protection. Suggestions of a more Māori responsive workforce through enhancing the training of generic health protection officers was also mentioned:

I kind of expected that if the industry is trying to get more Māori involved, have them more involved then you would get a good almost fastrack development, head start into the industry but that's not so... you could say that there is development stuff available in a generic sense although I am critical of the generic training because it seems exclusive of

Māori perspectives so I am finding those little hurdles and I challenge them. If the Ministry is wanting to be Māori responsive then the trainers need to be able to train the industry appropriately to be responsive, if the trainers themselves are not responsive then it is a complete waste of time in my view. (Participant, HP)

In many ways it was felt that workforce development was available to health protection services at a generic level although this was not planned well and not well aligned with an individual's ideas of where they sought further development:

from my perspective it [workforce development] is supported but none of it is well planned, I fell into those things cause they were there and there was nothing else planned... I don't think we do a very good job of nutting out our priorities, what we need to achieve and go do it...only recently they have instituted a workforce development plan where someone independent has come in and said 'so where do you want to be in five years time? So we are probably doing better than most so yes I would say there is something there how effective it is, is hard to say, because if I say I wanted to do a course on shellfish kaitiakitanga or whatever, that might not necessarily fit with what is available or what the organisation has got, so while there is a plan there I haven't seen much of it other than responding to or reacting to what external groups have made available to us, you know the Ministry of Health or Māori Health Services. (Participant, HP)

Indications were that some staff have indicated their training requirements quite assertively in some instances. But there was a general feeling that other areas of public health are better serviced in terms of workforce development. Health promotion for example was mentioned as being better serviced. One reason for this, according to participants, could be the general nature of how health promotion worked – in teams, rather than in isolation as in health protection:

Yes I have formally identified areas where I wouldn't mind training in. Informally as well, through my own modes of communication, when an issue has come up that I am passionate about I raise it as an important issue that needs to be developed... actually I have chased the organisation for training in certain areas without any result like training in bio-security and shellfish but in other areas I haven't chased them. Other staff seem to think promotion are better looked after I am only speaking from a protection point of view and both protection and promotion do their own thing, protection has been kind of on their own, individual approaches, promotion seem to work in clusters and groups and have a more co-ordinated and integrated approach to service provision and training. (Participant, HP)

Contribution to Māori health development

Case II has highlighted a significant disparity in relation to meaningful Māori participation in health protection services but has also brought to light a wide range of possibilities to increase Māori involvement. The low numbers of Māori health protection officers implies that the

discipline is of no interest to Māori generally. However, chapter one in the main, as well as other chapters maintain that this is not the case. The focus on regulatory requirements and its law enforcing roles may be contributing to Māori perceptions of health protection services as being solely the domain of non-Māori because there seems to be no encouragement for Māori participation from the discipline and neither does it seem to be included in the Ministry of Health's Māori health workforce development strategy. Health protection officers tend to work in isolation of each other, taking on responsibilities for specific areas without interference or consultation with other colleagues. From this case, it can be seen that current Māori health protection officers would prefer a more collegial and collective working arrangement, plus they also see the benefits of building relationships with Māori communities to lead specific roles in health protection. Some of these roles can be applied immediately with minimal training but others would need specific training which they acknowledge can be done within Māori communities with support from the district health boards or the Ministry of Health, through offering sponsorships and scholarships and workplace experience.

Chapter 7

TIPU ORA: MĀORI WORKFORCE DEVELOPMENT AND COMMUNITY DEVELOPMENT

*Ko te Arawa e waru pūmanawa*⁸²

Introduction

The Tipu Ora well-child services was selected as an appropriate case study for this thesis and is presented in this chapter because of the particular approach it takes to Māori health workforce development. Tipu Ora focuses on Māori health workforce development within the Māori community at whānau, hapū and iwi levels. Again, a semi-narrative presentation allows the expression and emergence of participant voices.

Establishment – Kia Hiwa Ra! Kia Hiwa Ra!

Chapter one provides a discussion on the development and establishment of Māori womens groups in the early part of the 20th century. One such group was the Women's Health League established in 1937 in Rotorua (Meha, 1995). The idea of establishing a Māori women's health group was first conceived in 1931 by Māori women of Te Arawa concerned for the health of their children and families (Meha, 1995). They enlisted the assistance of their local district health nurse, Robina Cameron. With their guidance, Nurse Cameron led the development and eventual establishment of the Women's Health League. Dow (1999) maintains that although the initiative was lead by Nurse Cameron, its establishment along tribal lines can be attributed to the women of Te Arawa. Given the involvement of Māori women and tribal elders in its establishment, the League operates by supporting Māori values and beliefs while at the same time giving consideration to Western public health principles (Durie, 1998b):

it's about teaching people about planting and weaving and all those other parenting skills that used to be handed from generation to generation, all this knowledge that is not peculiarly or solely Māori knowledge nor pākehā, it is human knowledge, but the way that it

⁸² In Mead and Grove, (2004), p. 251: 1537 Wikiriwhi 1955:12.48 – 'The Arawa of the eight pulsating hearts'- in reference to the tribes of te Arawa – an acknowledgement to te whānau whānui o Te Arawa.

is imparted to our people is, in a sense, Māori knowledge...it's about not only having the right message but the right messenger. (Participant, TO/606)

The right message with the right messenger

Concerns for the health of Māori children and their families stemmed from the disestablishment of the District Health Nursing and Public Health Nursing schemes. In an attempt to prevent this disestablishment, the Women's Health League put forward submissions to the Department of Health. Later the Women's Health League lobbied the Government to re-establish the schemes in Māori communities, but was turned down. According to the Government, the schemes had become outdated, cumbersome, and expensive to run, and as the scheme was originally put in place to service the mainly rural Māori communities, Māori migration to the urban areas had rendered the service obsolete. The Government proposed that because many Māori had moved to the cities and towns they could now access other services such as Plunket, and funding was re-directed from the district health nursing scheme and applied to better support Plunket's well-child services among other established health services (McKegg, 1991, 1992):

the only thing left was to focus on this region and develop a programme of our own. (Participant, TO/606)

The idea for the development of a Māori well-child programme emerged during the 1980s while Inez Kingi (founder and patroness of Tipu Ora) was working in Wellington as senior advisor to the Ministry of Health on Māori Workforce Development. Tipu Ora Well-Child Programme "was born out of the Womens Health League" in 1990 (Participant, TO/603, 607). The establishment of Tipu Ora is based on a feasibility study carried out by the Womens Health League in which a survey of 200 Māori mothers and their families were asked whether a programme such as Tipu Ora would be acceptable if it was available (Department of Health, 1992a, 1992b, 1993; Ratima, 1996). Ninety percent of participants responded positively to this question. Further findings from the survey revealed that existing services, for example, Plunket, were not meeting the needs of young Māori mothers and their babies in a number of ways. The results and findings of the survey were presented as evidence to the Minister of Health to support a proposal to fund Tipu Ora Well-Child Programme.

A large amount of support for a programme like Tipu Ora also came from kaumātua in the Bay of Plenty region. Kaumātua, who as children had grown up in communities serviced by district

health nurses, were keen to have elements of that service revived, though in a more relevant manner (Meha, 1995). Their thinking was that the principles could still be applied in modern times:

I was a nurse Cameron baby and so was my husband. There are lots of us who are kaumātua now, here in Te Arawa, who benefited from the work of the district health nurses...many of us are nurse Cameron babies. (Participant, TO/606)

Tipu Ora Well-Child Programme therefore incorporates aspects of the work of the District Health Nurses Scheme, particularly those aspects or elements that involved working in the homes with families, specifically with the women and children. After the disestablishment of the district health nursing scheme, the Women's Health League continued to promote and work with Māori women and their communities through local marae especially in the Bay of Plenty area (Meha, 1995):

we have taken the things that worked in those days and replicated them in this programme in just a slightly different way. (Participant, TO/606)

we have taken the kaupapa from the district health nurses scheme, and it works. (Participant, TO/603)

Tipu Ora began delivering a well-child service for young Māori mothers and caregivers and their children from 0 to 5 years of age in 1992, after piloting a successful 1-year well-child service in 1991 sponsored by the Department of Health (Ratima, 1996, 2001). The Tipu Ora well-child service is currently delivered in the Rotorua, Bay of Plenty region, which includes Murupara, Te Puke, Opotiki and Te Kaha. These are also the areas from which membership of the Women's Health League takes its strength. There is a clear relationship between the three movements of the District Health Nursing Scheme, the Women's Health League and Tipu Ora. For example, much of the work undertaken by the two older organisations continues to influence the practice and philosophy of Tipu Ora. Such practices include promoting the growing of vegetables, fruit trees, needlework, food preservation, cooking and general homemaking along with advising mothers on baby and childcare:

we help young mothers with their babies, teach them mother crafting like having veg gardens, you know, having the basic things to survive at home rather than going out and having to spend money on these basics. (Participant, TO/603)

Further, the approach of the League through Nurse Cameron, in highlighting health or other issues to Government, was to invite officials to a function or hui at a specific marae where

concerns had been raised so that they might make firsthand observations. This practice of bringing the issues into the open had a better result than writing letters and submissions to the various Government departments. Tipu Ora, through its governance board and patroness Inez Kingi, works in much the same way:

She [Nurse Cameron] got officials to the marae somehow or other so that they would get a first-hand glimpse for themselves, the living conditions, and do something about it...she invited them here to Tunohopu because there was no running water and while she was showing them that there were no taps or pipes she would also point out the health risks through lack of sanitation...that was her tactic, I call it, and I notice that Inez must have clicked to it and does the same, invites government bureaucrats and policy makers here so they get a first hand glimpse in to what is actually happening in Māori communities around here. (Participant, TO/606)

The main point of difference between the League and Tipu Ora on the one hand and conventional nursing services on the other, is the focus on disease prevention, the promotion of health, and education provided in a culturally appropriate way. For Tipu Ora this meant providing a service that was driven by Māori, taking knowledge from the Western world and blending it with knowledge from the Māori world so that it would be both relevant and meaningful, becoming what Thurnheer (1999, p. 1) describes as “institutions between two worlds.” It was decided that the key to successful programme delivery would be to ensure the service was Māori community based with the right message – a message based not on illness but on health:

It was decided that there was a need for something that was community-based along the same orientation as the League...that it was based not on disease treatment or any kind of deficit-based model but based on disease prevention, health promotion and education. They put together a model that would envelop all of the principles and ideals that the women in the League think, because League members were women of the marae, women of the community, they were living there, they were working there, they were the women in the kitchens, they were the women that were raising their mokos, they were in church, doing all those things that our nannies did, and saw that as being a really good model for Tipu Ora as well, because those women had authority, they had respect, they had their own mana. (Participant, TO/606)

Governance along tribal lines

Members of the Tipu Ora Trust Board, management, programme co-ordinators and kaitiaki (community health workers) are drawn from the Te Arawa Confederation of Tribes. Kingi and May (2000) attribute the success of Tipu Ora to the shared ongoing relationships built with iwi authorities. Tipu Ora also has links to several levels of the Māori community with connections

to marae, land trusts, and incorporations that are maintained through the boards, trustees, beneficiaries and shareholders of those entities (p. 65). In total, the Tipu Ora Trust Board maintains health service delivery relationships with over 40 Māori entities. Interactions with these entities are purposefully and respectfully nurtured not only from a tikanga Māori point of view but from a peculiarly Te Arawa one. An illustration of this distinct Te Arawa kawa is described in Chapter One of this thesis by Meha (1995) in her reference to the way in which the Women's Health League was established with an approach to the chiefs of Te Arawa. Without the support of the Te Arawa chiefs the Women's Health League as an organisation would possibly not exist today. In line with Te Arawa kawa then, Tipu Ora kaumātua take a leading role in initiating, developing and maintaining relationships with iwi and hapū and other Māori organisations:

They [Bishop and Inez] deal with other iwi in a real tikanga based way which is awesome for us younger ones learning how they do that. From my own personal perspective sometimes I wonder about this thing called iwi mandate and who is it that says that this is kaupapa Māori and that sort of thing, then you hang out with Bishop and Inez and you get a real sense of exactly what that is, you know, in the way they deal with other Māori groups and other iwi groups like its really unique because the kaupapa is tuturu and they recruit in a uniquely Māori way and the way they operate hasn't changed in all these years at all. They stick by what they believe in and they have these Māori ways of dealing with other Māori groups. Like Bishop will deal with kaumātua at their level and our management will deal with their management at that level – we as management don't deal with kaumātua; all that is cleared for us before we go in and start to negotiate contractual relationships or anything. (Participants, TO/603 & 606)

A tikanga Māori influence that has remained constant in Tipu Ora and reiterated by the Trustees in terms of Tipu Ora attendance at Māori events in other regions, for example, kapahaka, hui, wananga, and tangihanga, is the assurance that the kawa and tikanga of other iwi are respected and that concepts such as tautoko (support), and manaaki (hospitality) are observed:

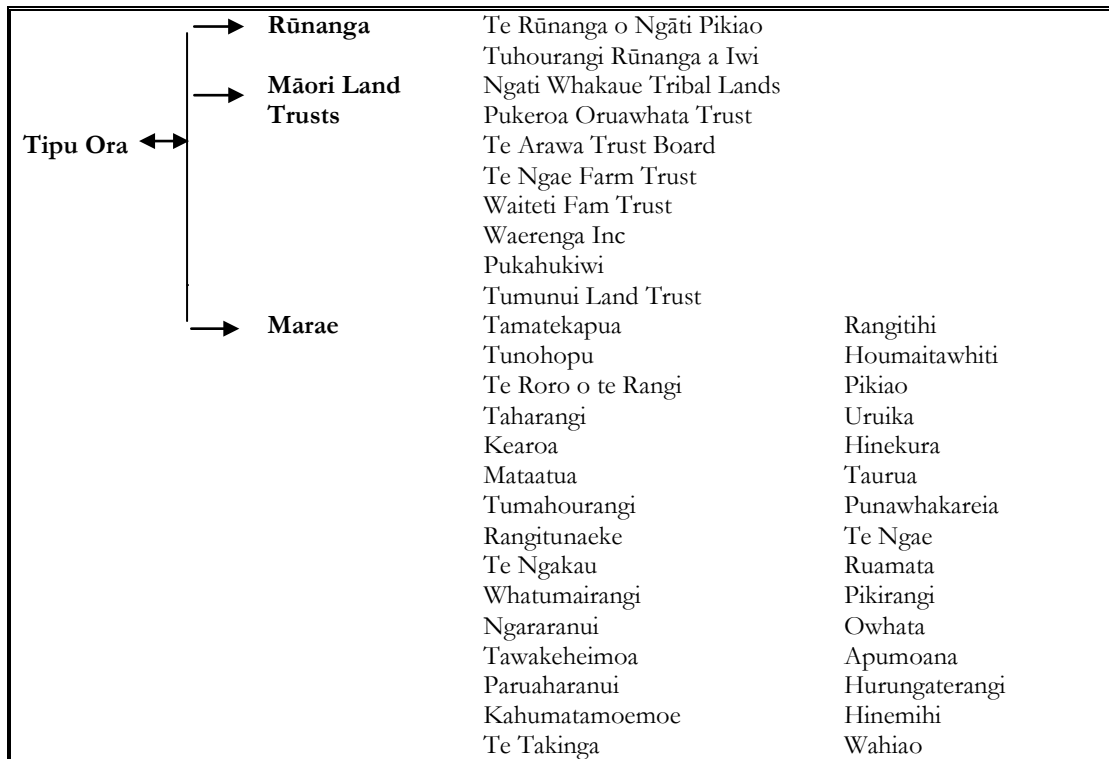
The other good thing that we do is that as an organisation we will go on mass to big Māori events that are happening or to tangi. We do that really well so, for example, Ngati Whatua ki Orakei invited us to do the nanny tent for the kapahaka nationals. Our tikanga for that weekend was that we were there at their invitation so we were not there to be whakahihi or to promote our kaupapa or whatever, we were there to tautoko their kaupapa, which was to manaaki their manuhiri and do that well. You can do those things in a peculiarly Māori way. (Participant, TO/606)

While tikanga Māori processes are considered time consuming by some staff, kaumātua members of the board insist these processes are beneficial to the organisation in the long term. Building and maintaining relationships with other iwi/Māori groups and organisations emphasises the

strategic focus of the Board, enhances Tipu Ora reputation and ensures longevity, at least in the eyes of Māori:

Sometimes you get a bit cynical, you know. I mean, I sometimes get a bit hoha with this whole “Go to the approved iwi authority” because, you know, who says that that is the mandated authority...another thing that TO trustees really care about is that they don’t work according to mainstream principles in terms of consultation it just so doesn’t happen – here consultation with our own is what it is you know, kōrero to the kaumatua with Bishop leading that, then we go to meet with them, and then we do all the whakawhānaungatanga stuff, get to know one another stuff, then get to the business which may be to ask for Tipu Ora entry into an area or something. You went through a similar process to get access to us, eh, but it wasn’t difficult for you because your whakapapa here but, yeah, same thing really. (Participant, TO/606)

Figure 7.1 below is a diagrammatic depiction of the Te Arawa iwi, hapū and marae, their connections and relationships.



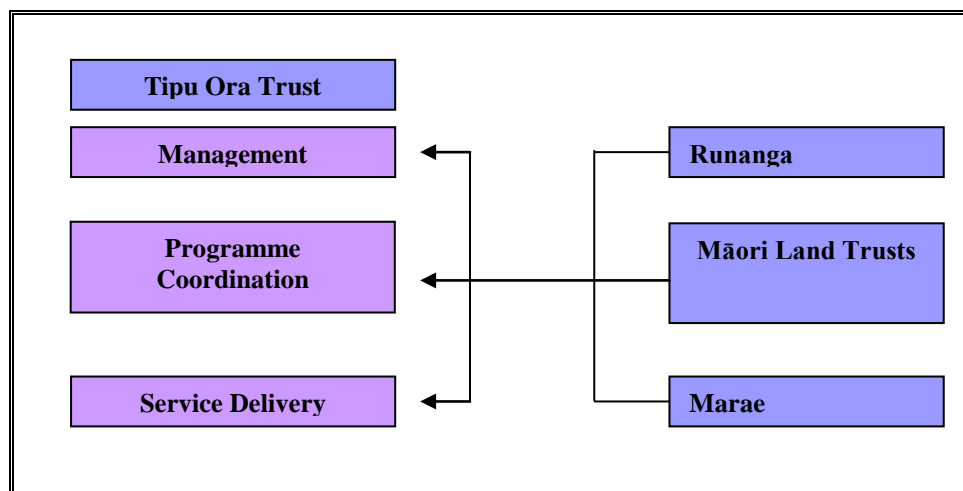
Source: Kingi and May (2000, p. 65).

Figure 7.1: Iwi relations in Te Arawa rohe

The following diagram shows how the beneficiaries and shareholders, consisting of whānau and hapū, are represented at all levels within the organisation of Tipu Ora. These are also the areas from which the Board and Tipu Ora staff are drawn. Kaitiaki in particular, need to represent all

the marae. Each marae is likely to be linked to three or more hapū and therefore also to a number of the iwi and organisations:

I would say that everyone working here, except for our Pākehā clinicians, whakapapa to one or more of the marae, hapū, and iwi, that's probably 99.9% of us...every brown face here is Te Arawa. (Participant, TO/611)



Source: Kingi and May (2000, p. 66).

Figure 7.2: Iwi, hapū and whānau representation in Tipu Ora

Early in its life the Trust Board endorsed Māori values and beliefs to formulate its guiding principles, philosophical orientation, and mode of operation to culminate in the kaupapa of Tipu Ora. The kaupapa encapsulates a strategic philosophy of *Māori to be healthy and Māori*, which highlights the following objectives: the achievement of total wellbeing; the utilisation of culturally appropriate monitoring frameworks that affirm wellness and intervention strategies; and that future development of Trust activities blends, complements and accords with the Tipu Ora kaupapa (Kingi & May, 2000).

Tipu Ora takes into consideration a traditional Māori perspective of health that utilises Te Whare Tapa Whā model of health (Durie, 1982, 1994; Murchie, 1984) as a practical framework for monitoring specific activities of service delivery. Te Whare Tapa Whā also emphasises the achievement of total well-being through the optimum balance of the four sides – taha wairua, taha tinana, taha hinengaro, and taha whānau (Durie, 1994; Kingi & May, 2000). The table below summarises the overall Tipu Ora kaupapa.

A Māori worldview was described in some detail in Chapter Two of this thesis with reference to the work of Marsden (1975), Smith (1997, 1998, 1999), Durie, (1996), Bishop (1998), and Royal (2002). In addition Tomlins-Jahnke (2005, p. 13) argues that whakapapa is embedded in Māori notions of world-view, providing “a framework for understanding patterns, linkages, and connections.” Whakapapa linkages, connections and patterns are relevant to the kaupapa of Tipu Ora.

Table 7.1 Tipu Ora Kaupapa

| | |
|-------------------|--|
| Paradigm | Māori worldview |
| Philosophy | Māori to be healthy and Māori |
| Principles | Interconnectedness Self-determination Māori identity Quality Whānaungatanga Aroha Community credibility Value Strength |
| Strategies | Cultural affirmation Intergenerational transfer of knowledge Māori domains Iwi endorsement Links to Māori development Whānau-focussed, child centred service Utilisation of Māori community resources Strength based delivery of services |

Source: Kingi and May (2000, p. 25).

The overarching philosophy of the Tipu Ora Kaupapa, Māori to be healthy and Māori (Kingi, 1999, p. 9) provides a sense of endurance. Durie (2005a) defines endurance as being:

founded on two dimensions of time and resilience... time-has a past and a future, but not necessarily a single starting point nor a final destination it [time]can be synchronised, measured, and used as a coordinate to give meaning to events, people and places... Resilience... also has a past and a future... But unlike time, which acts as a testimony to progress, resilience is an expression of the effort needed to steer a steady course. It recognises both adversity and triumph, and celebrates strength of purpose, determination and a capacity to survive-... an inner force and an element of indefatigability...a capacity for adaptation and a propensity for turning adversity into accomplishment. (Durie, 2005 p1)

Māori to be healthy and Māori then, makes allusion to the long and arduous history of Māori health progress and the determination of Māori to remain Māori throughout the process.

The principles of the Tipu Ora kaupapa are a practical guide for daily operations and governance of the organisation, and are based on Māori concepts, traditions, values and beliefs. The principle of interconnection, for example, is evident in Māori worldviews discussed earlier in this thesis and in this chapter, where reference is made to the connections Māori people have with their environment. Self-determination implies a sense of both control and accountability. In Tipu Ora, Māori have control at all levels and with all aspects of services policy, planning programming and delivery, and at the same time they are accountable to whānau, hapū, and iwi. The principle of Māori identity is also encapsulated in *Māori to be healthy and Māori*. It considers the aspirations, knowledge, whakapapa, culture, institutions, perceptions, resources, diversity, and lived realities of Māori people (Durie et al., 1995). Whānaungatanga as a principle is explained as:

acknowledging, recognising, and maintaining relationships with whānau, hapū and iwi, our kin ties, nurturing and expanding those kinship relationships... but it is also about caring and helping being there to support. (Participant, TO/611).

The principle of aroha inspires a love of people, dedication and caring. One participant stated:

You have to love being Māori yourself, to love and respect Māori people, in order to work for and with them. (Participant, TO/607)

Community credibility brings to life the Tipu Ora kaupapa through the well-child programme, in particular the kaitiaki recruitment process. Kaitiaki are 'chosen' and endorsed by their own community, based not on their professional qualifications and expertise but on the extent of their life experiences, status, and connections with the community.

One definition of value as “an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence” (Rokeach, 1973 cited in Harmsworth, 2005, p.7), provides support for Tipu Ora, pointing out that as an organisation it contributes to improved Māori health outcomes through the principle of value. The final principle depicted above refers to 'strength' and is explained as:

when we refer to the principle of strength as an organisation we are saying that we are a very strong advocate for Māori health, you know, we are a large organisation, we are supported by a large iwi base, not many health providers have iwi mandate so we provide a strong voice...then if we talk about individuals within the organisation, we each have different strengths, skills, you know, and they make us strong as well. (Participant, TO/607)

The strategies outlined in Table 7.1 are more to do with implementing Tipu Ora services and emerge in later discussions related to management, kaitiaki selection, recruitment, training and education. Because of hapū and iwi involvement in the employment process the Board also takes an active role in the employment of individuals, especially kaitiaki positions.

As a governing body, the Trust has responsibility for overall Tipu Ora programme development, of which well-child services is a core function. Tipu Ora also provides other services, e.g., Parents as First Teachers (PAFT); Family Start (FS); health promotion; child 2–5 years dental services; and a Māori community workforce development training programme run jointly with the Waikato Institute of Technology (May, 2001).

The governance responsibilities, obligations and functions of the Trust are broad, and Thurnheer (1999) maintains that there are distinct differences in approach and style specific to Māori understandings. For example, Tipu Ora's approach embraces Te Arawa kawa with policies and procedures linked to Māori cultural perspectives. Thurnheer (1999) emphasises that to maintain their kaupapa, Māori providers in general work to sustain and ensure they do not compromise their cultural values. She comments that in trying to harmonise the requirements of the laws of the land and Māori lore there is continual overlap in policy; however, as Māori providers following a Māori kaupapa, the emphasis is on ensuring they do not always have to concede or override their Māori worldview.

In order to compete for funding, especially government contracts, tax, and employment contracts, Tipu Ora has been a constituted charitable trust since in 1991. The purpose of the Trust is to address the health and well-being needs of children, their whānau, and their extended whānau. Tipu Ora is the first Māori child- and whānau-centred health service delivered by Māori for Māori. The trust's investments are in education, prevention and intervention rather than remedy, reform and rehabilitation – “the fence at the top of the cliff rather than another ambulance at the bottom” (Kingi & May, 2000, pp. 20–22). The Tipu Ora Well-Child contract is similar to other Whānau Ora and Tamariki Ora contracts in the sense that they are also about

well-child care and recognise kaupapa Māori approaches. However, the Tipu Ora contract emphasises facilitation of services rather than diagnosis and treatment:

After the pilot we got a contract; it is called a facilitation contract and is different from any other Tamariki Ora contract. Tamariki Ora contracts are always what you call diagnosis and treatment contracts... or they are whānau support, or they are Plunket, Karitane or Kaiawhina type contracts. Tipu Ora is the only contract of its kind and basically what it is we do is that we do the scheduled Tamariki Ora visits in the home instead of the family coming to the clinic; we do the well-child checks – so we do the measuring, weighing and monthly baby checks to the age of 5 years, although we are not officially funded to do that, our core contract is to deliver health promotion and enable access to general practitioners and other health services, contracted to facilitate an enabling process, so to speak. In reality we are a whānau health service. (Participant, TO/606)

To uphold the vision and kaupapa of Tipu Ora, the service extends beyond the parameters of the contract. The way the contract has been written up and possibly because of the source from which the funding has been allocated, the Tipu Ora service contract is regarded officially as a well-child contract, whereas Tipu Ora's focus is on whānau well-being through the mother and child. For instance:

we are pushed into being called a well-child service by virtue of the fact of where our funding comes from and how the contract is written up, but in fact Tipu Ora is a whānau health service so we are not going to go into a home and see a koro who is half dying and not seeing a doctor and not do anything about it because we are only contracted to go into the home and talk to them about car seats and what have you, so we are a whānau service, and one of the things we are doing with this District Health Board is to make them more aware and enlightening them about what it is we are actually doing. (Participant, TO/606)

The Trust makes use of three specific frameworks to monitor operational and organisational effectiveness. First, the Treaty of Waitangi provides an overall framework for the organisation and situates each 'article' with corresponding service area, key responsibility, and output and outcome areas.

The second framework utilises the Ottawa Charter (WHO, 1986) to help monitor programme services coordination. Each 'action' of the Ottawa Charter guides and is linked to specific service measures, key activities, and outputs.

The third framework monitors and ensures the delivery of culturally appropriate health services and is based on Te Whare Tapa Whā model of health, where four cornerstones of health are used to describe a Māori perspective. All three models indicate the relevance of Māori health workforce development and support the notion of positive Māori development.

Table 7.2: Treaty of Waitangi monitoring framework

| Action | Discussion | Service Measure | Primary Responsibility | Key Activity & Outputs | Outcome |
|---|---|--|------------------------|------------------------|--------------------|
| Kawanatanga: Good Government | Resource allocation priorities which take account of Māori health needs and perspectives | Allocation of resources towards Māori health priorities | Management | Research | Strategic Planning |
| Tino Rangatiratanga: Self determination | The development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of services | Utilisation of culturally appropriate practices and procedures | Service Coordination | Service Development | Service Provision |
| Oritetanga: Equality | The greater participation of Māori people at all levels of the health sector | Increasing the participation of Māori | Service Delivery | Consultation | Facilitation |

Source: Kingi and May (2000, p. 32).

Tipu Ora provides leadership and guidance, particularly in areas of Māori health and public health. Participants agree that Tipu Ora is a storehouse of knowledge. At a national level there are Tipu Ora representatives on various ministerial advisory committees, in particular in the technical advisory group for the Ministry of Health for the well-child strategy, although input into that committee was minimal for various reasons. There is an expectation in the community that Tipu Ora provide strong leadership and have a role in developing national policy, especially for future generations:

absolutely, we owe it to our mokopuna to lead the way, a responsibility to ensure that what ever we do, we do it with honesty and integrity, that we write everything up, all of our wahine knowledge document it, write it into our contracts, they must reflect our own knowledge and values...we sit on a range of technical and ministerial advisory committees and we should be a major player in writing up major policy for tamariki and their whānau, for all aspects of child health but even though I know we are represented on those committees I haven't seen from all of that effort a whole lot of what we have said put into services or put into dollars or put into more appropriate care or taking into account cultural factors...so we owe it to our mokopuna to ensure that when we write up our competencies that it is done in a way that is peculiar to us rather than going along with mainstream ideals about how it should be if we fail to articulate those competencies we might as well be just a mainstream provider who happens to deliver to Māori. (Participant, TO/606)

Government officials, health professionals, researchers and students from all over the world have visited Tipu Ora to observe or experience activities. In election years the incumbent Prime Ministers visit and spend time at the centre. Further, a group of British health experts visit Tipu

Ora annually keen to see the unique features of a Māori well-child service in action and, working in two worlds (Thurnheer, 1999):⁸³

one thing I have learnt from working closely with Inez and Bishop: they hold firmly to the kaupapa and to tikanga Māori. Heaps of people come here, heaps from all over the world, students, lots of students, lots of politicians, Helen comes here... yep, I am on a first name basis with the Prime Minister and that's all because of what those two have started here, you know, and it's about being good hosts, manaaki tangata to anyone that comes. (Participant, TO/606)

Table 7.3: Ottawa Charter monitoring framework

| Action | Discussion | Service Measure | Key Activity | Main Output |
|---|---|--|--------------|------------------------|
| Building healthy public policy | Specify Māori health priorities and develop an action plan | Māori health action plan | Research | Strategic Planning |
| Creating supportive environments | Promote the Māori view of health | Māori participation strategy | Consultation | Consumer participation |
| Strengthening community action | Ensure the delivery of a coordinated integrated health promotion network of support services | Specialised project teams | Facilitation | Service integration |
| Developing personal skills | Provide training to the workforce in the development design, utilisation, promotion and evaluation of specific health education tools and resources | Promotion of effective and relevant health education tools and resources | Training | Workforce development |
| Re-orientating Health services | Develop integrated health promotion programmes in active partnership with specific groups (e.g., rangatahi, Kaumātua) and relevant agencies | Health promotion programme intervention | Education | Service provision |

Source: Kingi and May (2000, p. 32).

⁸³ For example, Kathryn Thurnheer was a Swedish student whose father was Swedish ambassador to New Zealand during the time Inez Kingi was based in Wellington with the Department of Health. The Thurnheers became good friends with Bishop and Inez Kingi and when their daughter, Kathryn decided to do her masters thesis in New Zealand, Bishop and Inez Kingi were approached by her parents to help provide her with the connections she needed to undertake her data collection.

Table 7.4: Te Whare Tapa Whā monitoring framework

| Taha | Discussion | Activities |
|-------------------|---|------------------------------------|
| Te taha hinengaro | Personal development, growth and motivation | Education training and employment |
| Te taha tinana | Physical health, strength, vitality and longevity | Physical healing and health |
| Te taha whānau | Social relationships and environment | Social development and maintenance |
| Te taha wairua | Link to tīpuna, whānau, te reo me ona tikanga | Cultural practices and procedures |

Source: Kingi and May (2000, p. 24).

Given the nature of the work of Tipu Ora, the numbers of people it employs (approximately 45–50), the numbers of whānau (over 600 whānau equating to approximately 2800 children) that are supported through its various services, the strong positive relationships and networks it has developed, and the unwavering adherence to kaupapa Māori, Tipu Ora also takes a leadership role in terms of Māori development:

hmmm, if we were an organisation that held the same contracts as mainstream providers but we happened to deliver that to Māori, then I would say that we are not into Māori development. But if we are an organisation who actually has a vision for Māori development and we hold those contracts as a Māori provider who is in to Māori development, then I think we are contributing to Māori development. Our facilitation contract is a good example: we will deliver the kaupapa irrespective of what is stipulated in the contract so the contract criteria is a, b, and c and we deliver on that but to deliver on our kaupapa we deliver on a, b, c, d, e, f, and g, and that is because we are into developing Māori in terms of giving them a good service, better information, better advice, more appropriate ways of working, that sort of thing, not a handout but a hand up...we don't just provide a Māori face we provide a Māori heart. (Participant, TO/606)

On a local level, Tipu Ora is represented on several council and District Health Board committees in Rotorua as well as having strong roles in local iwi authorities, trust boards and Māori incorporations. Through its employees and trust members it also provides leadership and guidance and seeks leadership and guidance from over 30 marae in the Te Arawa and Mataatua regions:

The mere fact that the organisation employs 40 or more women who are mainly Te Arawa is a fantastic achievement for Māori development. One of the things that I really respect about Bishop and Inez is that they single handedly probably support over 500 people because of their vision and because of their idea of what Māori development should mean in a true Māori community sense. We are probably one of the biggest charitable trusts in the country, we have really good services, our staff are well, their families are well, we hope

they are not too over worked, we allow for tikanga to be built into everything we do, and just looking at it in that way it's gotta be leadership in its true sense and it's gotta be Māori development. (Participant TO/606)

Participants agreed that the Tipu Ora model is transportable and as such has the potential to be useful to other iwi in their own regions. In fact Ratima (1999) found that the Tipu Ora model in terms of its transportability could have wider application not just to other Māori communities and iwi but to other indigenous groups. One participant commented that one other iwi had taken the concept on board, not in its entirety, but had transposed some aspects of the model into their services, applied their own tikanga and kawa, and it seemed to be working for them. However, another group in another region, not under an iwi umbrella, had tried to operationalise the model but had failed. The participant felt the failure could perhaps be attributed to the lack of iwi involvement, reinforcing the notion that this model needs to be driven by whānau, hapū and iwi.

While Tipu Ora is funded to provide specific well-child services to caregivers and their children, as with other Māori health providers, they operate at a wider level, incorporating the broader elements of Te Whare Tapa Whā⁸⁴, and provide over and above what they are funded to provide. Given this common element among Māori providers of health services and their workforce development initiatives, Durie (2005a) maintains there is a determination or rather a resilience among Māori providers that encourages self-help skills and innovation in relation to delivery of services and workforce development.

The aims and goals of Tipu Ora highlight the health and well-being of whānau through Māori caregivers and their children. This seems to be particularly apparent in the way it provides its core well-child services through ngā kaitiaki (caregivers) who are grandmothers with childrearing experience. Comments from participants and the literature (Kingi & May, 2000; May, 2001) indicate that Tipu Ora ascribes to a kaupapa Māori model of delivery and therefore adheres to accountability mechanisms that are whānau, hapū and iwi driven. For example, kaitiaki work within their own hapū or iwi;⁸⁵ also, in the recruitment of kaitiaki the tono (application process

⁸⁴ A model of health incorporating a Māori worldview of health that includes elements of whānau, physical, spiritual, mental.

⁸⁵ Te Arawa Confederation of tribes is made up of eight iwi.

of recruitment) is taken to hapū and iwi who then nominate an appropriate member to work with their whānau. Kingi and May (2000) suggest that these accountability mechanisms are an integral part of the kaupapa and overall strategic direction of the organisation. Tipu Ora the programme, recognises the links between health and culture, focuses on being Māori as a major factor for gains in Māori health, and at the same time locates health in a Māori development context. (Department of Health, 1992a)

Management

The general manager has overall responsibility for the various Tipu Ora activities. Organisational management includes overseeing the daily operations of the various programmes. Specifically, the manager provides leadership and promotes the values and principles of Tipu Ora while managing the administration and finances of the organisation. The general manager is accountable for accurate timely financial service reports, financial planning, service planning, reporting on service outcomes, and liaising with and reporting to the Ministry of Health and other funding organisations with which Tipu Ora might be involved. The general manager is a member of the Tipu Ora Trust Board and has a role to report back to the Trust keeping them informed and up to date with service contracts. Contracts need to reflect the vision of Tipu Ora and take into consideration the ability to work in a Māori way as well as the issues of compliance, financial accountability, results and impacts.

Tipu Ora receives the bulk of its funding from government contracts, and the well-child service contract, as mentioned earlier, is Tipu Ora's first contract, and although not their biggest contract, remains the core service. Other service contracts have been as a result of the reputation built by the well-child service and the infrastructure that the service has enabled. Tipu Ora believes that while a reliance on government service contracts is not ideal, there are limited options for Māori providers. As an organisation, Tipu Ora services a number of contracts that are varied and are funded from different government agencies. Health services form a major part of service provision, but Tipu Ora also has social service and education contracts.

The following diagram depicts Tipu Ora accountability relationships especially where Ministry of Health contracts are concerned.

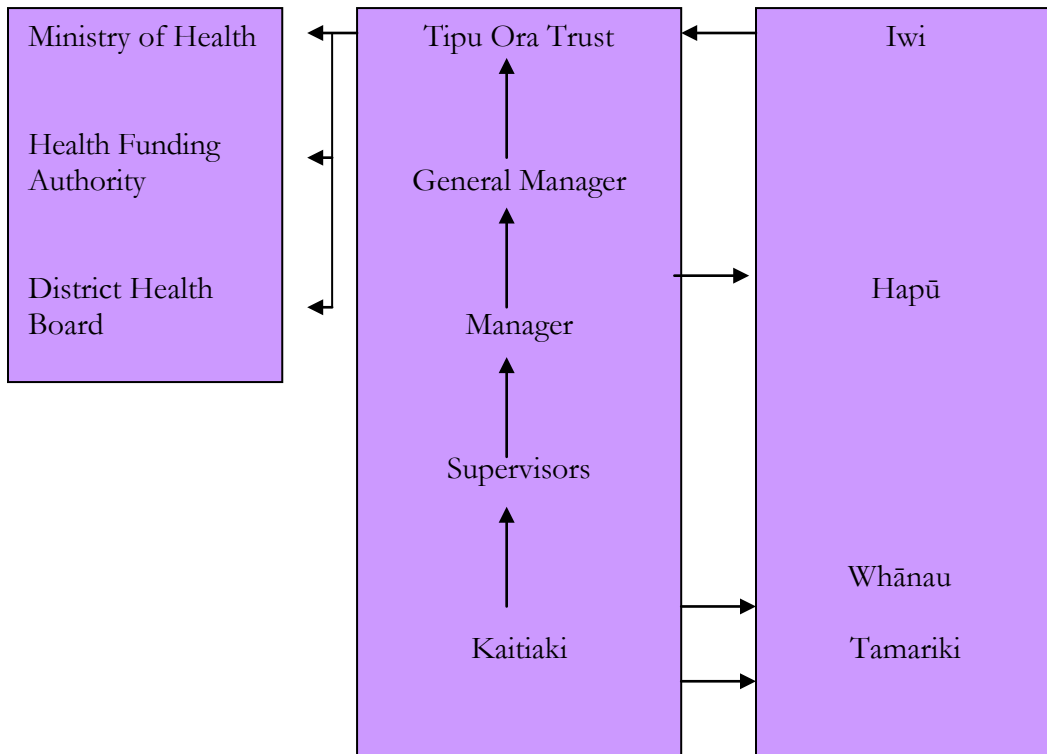


Figure 7.3 Lines of accountability for service provision contract

Source: Adapted from Kingi and May (2000, p. 47)

A major concern of Tipu Ora in relation to the well-child service is the increase in the number of registered families over the years; however, funding to provide the service has not increased at the same rate. This funding shortfall puts appropriate service provision and delivery at risk. However, to retain the core service, Tipu Ora covers the shortfall with other contracts rather than reduce the well-child service. This situation is not unique to Tipu Ora. Tomlins-Jahnke (2005) describes similar situations with other iwi/Māori health and social service providers. Another difficulty for many Māori providers is rental and lease agreements for the premises occupied by the service. Government contracts for service are relatively short term and normally range from 1 to 3 years maximum, which makes it not only difficult to plan for service provision but also to negotiate rental and lease agreements (Tomlins-Jahnke, 2005). Some Māori service providers opt to be based at a hospital or other District Health Board premises to relieve the pressure and uncertainty of the rollover of service contracts and rental/lease agreements, and to provide continuity and access for clients. Some Māori providers such as Jean Te Huia of

CHOICES- midwifery and well-child services, in Hastings, have secured mortgages or personal loans to provide continuity to clients or relieve the financial pressure of increasing accommodation payments. In this sense, Tipu Ora is fortunate in that Tunohopu Health Clinic (where Tipu Ora is currently) was formerly based at Tunohopu marae but is now situated a few metres to the west. A purpose-built building, extended to include a new dental clinic with office space, is established on land donated by whānau:

We are so fortunate that we have our own building on land that belongs to whānau and still so close to the marae. We can go over there and help when there are things on, like tangihanga; we are not so far away and the marae is still part of us. (Participant, TO/607)

Human resource and employment contracts are also the responsibility of the general manager, although the Board takes a special interest in the employment of the kaitiaki mainly because of the relationship with hapū and iwi. The general manager is also guided by the Board in situations of employment difficulties: because kaitiaki have been employed based on recommendations from hapū, Tipu Ora can not and will not dismiss any kaitiaki. In the search for resources both human and financial, the manager and the Board work together to ensure the kaupapa of Tipu Ora is upheld without compromising tikanga Māori values and beliefs. When a contract has been agreed, the Tipu Ora management team will take a leading role in final contract negotiation and 'sign off':

they [Board] do the initial contract negotiation, if it is a new contract they do all of the initial stuff and once that is done we [management] do the rest until the contract is signed off. (Participant, TO/611)

Tipu Ora has a comprehensive and up-to-date information system and database, and management has taken responsibility for the regular maintenance and appropriate security of the system. Under the Tipu Ora kaupapa all staff are encouraged and supported in developing and maintaining networks and links with various communities locally, nationally and internationally (Thurnheer, 1999). Given the international links, Tipu Ora is keen to foster reciprocal exchange opportunities with both indigenous and non-indigenous groups, which management has a role in facilitating.

Ngā Kaitiaki – the caregivers

As mentioned in the previous section, ngā kaitiaki provide core well-child services for many of their whānau. While kaitiaki are normally young grandmothers who have childrearing experience, one participant revealed that at one time they had among the kaitiaki a young woman who had no childrearing experience but who had been nominated by the hapū. Despite Tipu Ora concerns this person was one of the best kaitiaki they had employed. This, however, was a unique occurrence. The ages of kaitiaki range from around 35 years of age to around 66 years of age. Ngā kaitiaki and the way they are required to work are credited as being the most unique feature of the Tipu Ora well child service, contributing in a major way to Tipu Ora's adherence to kaupapa Māori, especially the service delivery component. Described as the linking pin, kaitiaki facilitate a specialist communication service that covers a broad spectrum of sectors that include education, housing, and justice alongside health and health-related areas. The growth of Tipu Ora and its continued existence through some turbulent years has been attributed to these women. They remained focused on caring for whānau while the organisation was externally reviewed, evaluated and challenged on a range of issues including lack of appropriate policies, financial accountability and transparency, and service delivery. Kingi (as cited in Kingi & May, 2000, p. 5) paid tribute to the kaitiaki for their “enduring goodwill” and dedication’, during arduous times. The following comment is revealing:

We are not perfect, what organisation is? We have had our ups and downs like any other and have made mistakes but we are learning from them. It was not a good time having auditors, lawyers, accountants running around all over the place but we have survived. You know yourself, as Māori, that any negative external attention can ruin a business like this but it was a kaupapa we all believed in so we made it through. We now have all of that stuff... you know, the legal, financial and government contracting stuff... all sorted. (Participant, TO/606)

All kaitiaki employed by Tipu Ora during the data collection stage of this research agreed to participate in the interviews. Some of these women had been involved with the programme as a kaitiaki since the pilot. One of these had also participated as an interviewee in the initial research undertaken by the Women's Health League in 1990. Another two had assisted with the research as interviewers. It was clear in this research that all the kaitiaki had a strong belief in the kaupapa of the well-child service. Comments from kaitiaki were:

I work as a kaitiaki because I love it...I totally believe in the kaupapa...it is a beautiful kaupapa... I wish I could have had it when I was a young mummy... it should be available for all Māori babies all over New Zealand...I am totally committed to this work... I don't think of it as a job because I can do it, it comes naturally to me... most of all I like working with our people, in our own way... I love the babies, that is the best thing about it. (Participants, TO/601, 602, 603, 604, 605, 608, 609, 610, and 611)

Highlighted in the comments from kaitiaki and in the long-term involvement of some kaitiaki in the programme are the dedication and endurance referred to above. Kaitiaki themselves recognise their own importance to the organisation. For example, two participants noted that:

without us, the kaitiaki, there would be no Tipu Ora. (Participants, TO/601 & 609)

The contract under which kaitiaki operate is the first contract won by Tipu Ora and has been described earlier as the facilitation contract – the only one of its kind in New Zealand during the time of this research. This contract enables Tipu Ora kaitiaki to deliver a whānau health service through mothers and their babies. By working with mothers and babies they facilitate Tipu Ora access to the whole whānau and by providing information and advice in a way that is appropriate they empower whānau in terms of being better informed about health and wellbeing. Kaitiaki normally have a 5-year relationship with whānau as clients; longer if those particular whānau have more babies. They start visits when the baby is 6 weeks old and record weight, length, head circumference, and check for ailments. The kaitiaki will check the mothers, sometimes take ante-natal classes, pregnancy checks, assist with a range of household chores if necessary, shop, organise visits to doctors, chemists and other such appointments, as well as provide advice on nutrition:

After I have checked baby and mum and I see other things that need doing around the house like vacuuming, dishes, baby's washing, even cooking – then I will do it. All the time talking about things like if they are breast feeding – don't eat too much of this or that it might give baby a sore puku, just have small portions. Breast feeding takes a lot of energy from the mum and they need to get rest so I help with other things so the mum doesn't get stressed about the housework or the cooking, or shopping and getting themselves to the doctors if they haven't got a car. I do those things and I know the other kaitiaki do it too. (Participant, TO/602)

Recruitment and selection

Kaitiaki are chosen because they have status in their hapū as young or relatively young grandmothers. They are nominated or put forward by their hapū and marae to work with families of their own hapū:

I was told by my hapū, hey, you are it, you are the one we want, you are the one we will support – it didn't really matter if I wanted it or not, they just wanted me, I was so humbled by their faith in me. (Participant, TO/602)

In order to work as a kaitiaki, professional, formal qualifications (such as nursing) are not a requirement:

I am a trained nurse, and that may have influenced the hapū to choose me, but that never came up when I was approached; they focused on things like I was well known by the younger people, my children and grandchildren were well known, we always worked at the marae, those sorts of things. (Participant, TO/602)

While qualifications enhance the work of the kaitiaki it is more important for the function of this position that they are known and respected in their own communities. It is their knowledge about birthing, childrearing and of the families with whom they are to work that is the most important for their communities:

Well, we do interact with iwi all the time, that's why we are chosen, each of us, each kaitiaki has been nominated by their hapū, by their kaumātua so we have to be committed and need to be seen working around the place by the people. Everyone knows you and you go from marae to marae, it is part of our life. (Participant, TO/601)

The idea of having a grandmother is a good one, they get better access to places others can't get to – the image of the grandmother has been successful because clients and their whānau have that respect for grandmothers. (Participant, TO/603)

Kaitiaki employment process

Tipu Ora Trust has links with the Te Arawa Confederation of Tribes and as such is able to provide information to a large number of hapū and marae in the region. All iwi groups and hapū in the region have copies of kaitiaki job specifications to use as a guideline for making appropriate nominations for kaitiaki positions. All the kaitiaki have whakapapa links to a number of hapū and perhaps to two or three iwi in the confederation. Nominations from the hapū or iwi are usually required to reflect these affiliations.

Kaitiaki positions are not advertised in local media. Iwi and hapū are normally notified of any kaitiaki vacancies by Tipu Ora members or staff with a role on iwi or hapū health committees.

Tipu Ora invites hapū and marae to make their kaitiaki nomination:

When there is a vacancy for a kaitiaki we let the marae health committees that we are involved with know that there is a vacancy. All of the kaitiaki are on various hapū or marae health committees so they are also encouraged to get the word out. From there it goes to the marae committee, maybe, or straight to the hapū. While the relevant iwi are aware of the vacancy they usually leave it to the marae or hapū to identify and nominate an appropriate person. We provide them with further information about which may mean we send out the specifications and guidelines again. We try and get them to nominate a person who affiliation-wise fills the gap vacated, for example, the same whakapapa links to the hapū and iwi involved as the person who has just left, that way we ensure all hapū and iwi remain represented. (Participant, TO/611)

The formal part of the selection process occurs when the hapū have decided who their nomination will be; they then bring the nominee and wananga with Tipu Ora. The hapū speak on behalf of their nominee and are expected to support the nominee fully in the role of kaitiaki. Tipu Ora will then offer the nominee a trial period, usually 3 months, during which a full induction into the role is given. This allows the prospective kaitiaki to have a part in the employment decision. By the end of 3 months the prospective kaitiaki makes a fully informed decision on whether they see themselves permanently in the role of kaitiaki. Tipu Ora will then offer them the position.

The hapū nominate them, they bring them in to hui with us, they convince us that this is the person they want, we don't really have a say, it is their decision and we go by it, after all who are we to say to the hapū that they have made the wrong choice. (Participant TO/606)

One participant indicated that because Tipu Ora encourages hapū participation in this way there is a degree of risk attached to the process. For instance, the person nominated may not be the right person for the job. The 3-month induction process is considered by one participant to be a way of minimising the risk to Tipu Ora of employing the wrong person:

The induction process does a number of things for us as an organisation. It allows us to observe the nominee and confirm or otherwise what the hapū have told us. It allows us time to show her how and what the organisation does. If they are trained nurses it allows us time to explain our philosophy and how their training can enhance the kaitiaki role, not take it over. The process also helps us to determine what their immediate training needs might be and this is designed specifically for each of them, especially for the 12 weeks. Most of all it gives them time to decide whether this is what they want to do as well. (Participant, TO/606)

This process works well in situations where only one person is nominated by hapū; however, participants described an occasion where two kaitiaki positions were vacant and three people were nominated. All three participated in the induction process and found it competitive, stressful and uncomfortable:

We knew that only two of us would get the jobs so even though we got on with each other, sort of, there was always this uneasiness between the three of us. When we were given tasks we would try and beat one another. It was like one big competition. The one that missed out on the job was so sure she would get one of the jobs, even said to us that she would get one of them. I used to go home at night and worry because I had given up my job to do this induction and I thought it would be me that would miss out. It was probably one of the worst experiences of my life but then again I learnt so much during that 3 months. Still, I don't think I would do it again, no. I am glad they chose me, though, I love the work. (Participant, TO/604)

In describing the same situation, Tipu Ora management agreed that at that time the process had not worked well and there was room for improvement. For instance, Tipu Ora encourages hapū to put forward more than one nominee. This gives Tipu Ora more opportunity to select the right person for the job. However, Tipu Ora usually selects their preferred candidates before putting them through the induction process. On the occasion described above, Tipu Ora made the decision to select two from the three candidates after the induction process was completed. It was a management decision to change the process, which in hindsight was not a good decision, and the process could have been managed better:

what we decided was to bring all three on and take them through the 12 week induction and at the end of it picked two so one of them had to come off. So we put them through all sorts of loops and circles and they really struggled in terms of their confidence and in terms of whether they were going to be chosen to stay. It wasn't a good situation for them, they felt threatened, and I would not do that again. (Participant TO/606)

At the Board level Trustees were clear that such a situation should never have occurred with these women. They were concerned that Tipu Ora integrity with hapū had been jeopardised. Their role after the situation occurred was concerned with damage control and re-building of relationships with hapū.

We must never undermine the mandate from the hapū nor damage the relationship we have with them. (Participant, TO/607)

The induction process overall is considered to be a good one, but, as can be seen, Tipu Ora has on occasion had difficulty with the process:

some of them truly don't work out and they can't do the job for whatever reason it is really hard to get rid of them not because of the legislation but the kaupapa and the way they were appointed by their hapū and who are we to say that they are not doing their mahi, so one of the things that we had to reconcile is how do we do that in a way that supports the kaupapa rather than compromise or denigrate it. (Participant, TO/606)

Overall, however, the positive aspect of the induction is that kaitiaki have more confidence in what they are doing when they go into the community. Training during the induction is specific not only to the job but to the needs of the kaitiaki:

Kaitiaki who have gone through the induction process are better workers, I am pretty sure about that, especially those two who emerged from the situation I talked about earlier. They made sure they did all of the assessment and completed all of their delegated tasks, they did them really well and as a result they are fantastic workers, just awesome. (Participant, TO/606)

There have also been times when Tipu Ora has needed to extend the induction time for kaitiaki who have taken longer to orientate themselves into the position:

We put them on for a further 3-month trial, and we let them know the reason why we wanted a further 3-month trial, the main reason was attitude. You know, I told you about unlearning and relearning, yeah, well, she stayed in the unlearning mode and didn't quite take on board the kaupapa, and for some reason, either from her background or whatever she just couldn't take it on board and found it really difficult to understand why we don't diagnose and why we don't talk about certain things with families and that we are only about health promotion, prevention and education not intervention. Because for them the disease stuff is the most important, it is the only reason why you are in health, don't you know. (Participant, TO/606)

Kaitiaki education, training and development

The co-founder of Tipu Ora, Dr Jacqueline Allen, designed the Tipu Ora kaitiaki training, which included all 0–5 years health advice training such as childhood illnesses, infant illnesses, ante-natal training, the effects of smoking and alcohol on the foetus, as well as a range of medical training (May, 2001). Dr Allen provided full training to kaitiaki on how to be a public health nurse without a formal qualification. While kaitiaki are trained in medical matters and can provide health advice, they do not diagnose nor do they provide an opinion on treatment. When a family presents with medical problems, the kaitiaki, to recognise various illnesses, will immediately refer clients to a doctor or other appropriate service such as a paediatrician or hospital. While kaitiaki are not formally qualified and therefore cannot be considered trained

nurses, informally they have had full medical public health nurse training and can therefore facilitate families to the appropriate service.

Kaitiaki have a wide range of educational qualifications and experiences, and each has different training needs. Tipu Ora's training coordinator meets regularly with kaitiaki to discuss training and development needs:

I meet with them quite regularly to discuss what I am about to offer or what we have had and also how their training is going and whether it is too much or not enough or whether the content is adequate, and we have kind of done a whole lot of experiments, unfortunate or fortunate, I am not sure, but we have used them as guinea pigs a lot to figure out which is the best formula for them in terms of our tikanga and in terms of their learning needs. (Participant, TO/606)

Once training requirements for kaitiaki have been identified and agreed on, the co-ordinator will make arrangements for the appropriate training. In most cases, kaitiaki training is undertaken in a wananga forum at a local marae – a method of training, especially for Māori kaupapa, that is preferred by the kaitiaki:

we find that wananga-type training is the best kind of training for them, we have a couple of kaitiaki who are snoring by about 1pm in every session but probably taking it in, anyway. (Participant, TO/606)

As the age range of the women ranges from around 35 to 66, designing a training regime also needs to take account of their knowledge and experiences.

I think because the average age of our kaitiaki is about 54 – there are some who are over 66 – so they are actually from a generation that spans 100 years and they have been brought up with some pretty neat traditional kind of ways of doing things...so we should take cognisance of their experience and learn from and make sure we take these into account when we are writing up the training structure, you know, we take on board and learn from that type of experience. (Participant, TO/606).

After the development in 2002 of operating guidelines for Tipu Ora, a training manual was designed to reflect both the formal and legal requirements of the well-child service and tikanga Māori.

we knew that it was a specialist programme and we needed specialist training ... there is really no one else doing this sort of work and because they straddle more than just health promotion or education you have to equip them with a whole range of information so they need to know about the Social Security Act, the Residential Tenancy Act, they need to

know about the Privacy Act, and they need to know about all of those things in a kaupapa Māori context. (Participant, TO/606)

Kaitiaki work with their hapū members at a very basic level in the homes of whānau. One of the reasons they are chosen to become kaitiaki for their hapū is because they have specific and in-depth knowledge about the whānau they work with:

they have a knowledge about how things were dealt with in the past and we cannot ignore that, we cannot say that how things were dealt with in the past has no relevance now, and how they deal with it now. In section 7 of the Privacy Act, for example, it says that without the clients written consent you are not allowed to divulge certain information – but if we worked like that then we dismiss completely the absolute essential role of being able to be a guardian for the mokopuna who might be being abused or tutu'd with. (Participant, TO/606)

one of the essential elements of the kaitiaki is that because she comes from the community then she whakapapas to the family, and because she does know the whakapapa of each of the families then she understands what has happened in each of those generations they will understand that if a child is being abused and she [kaitiaki] will know where that abuse generates from. So we had to design the training to show they can deliver within the terms of the Acts and in a practical way to ensure the safety of the child. (Participant, TO/606)

Kaitiaki training therefore revolves around their knowledge and experiences, and facilitators for those aspects of the training are matched to different training components. For example, training in child abuse would require an expert in the legal aspects and requirements of the Children Young Persons and Their Families Act, a practitioner (social worker), and an expert in tikanga Māori to provide guidance in applying the Act in a Māori relevant way:

and if she is not allowed to divulge any of that in a Māori way, you know, to work with whānau and hapū around the needs of the child then it totally undermines the work of our kaitiaki. So we had to reconcile the needs of the child and the kaitiaki to enable her to undertake her guardian role and the training. (Participant, TO/606)

Choosing appropriate facilitators for aspects of training can also be problematic. While they are experts or have relevant experience, facilitators also need to be fully aware of the role of the kaitiaki in the community:

if we give them facilitators who don't have an empathy for the way in which they work, then they actually don't take it in, they don't even buy into it, they listen but they don't actually apply it to practice so those are the sort of things that we have to design into our training. (Participant, TO/606)

Over the years Tipu Ora has identified the core competencies required to undertake the role of the kaitiaki, competencies which include Māori values, beliefs, and traditions, and have attempted to embed these in kaitiaki training modules:

we have gone to our kaumātua and asked them how did our people deal with this and that, you know, mai rano. How do you suggest we deal with it now? Do you think this is a good idea? Do our kaitiaki need to know this? Do you think this is part of their role? And so on. (Participant, TO/606)

Training facilitators

Training facilitators are difficult to find for some aspects of training, and over the years Tipu Ora has become wary of the way some training facilitators, including Māori training providers, operate. One participant commented that training content and delivery are often not well matched. Further, facilitators in their quest for evaluation feedback at the end of a session will unwittingly, perhaps, place kaitiaki in the difficult position of choosing between good manners and an honest evaluation. This becomes even more apparent if assessment on each trainee is due from the facilitator:

we find that some facilitators are really good at facilitating but their content lacks... or really good content but not good facilitation. I am not sure if it is like this across the board in WFD but certainly in my experience we have booked different facilitators and you come to do their evaluation and it is a process that is quite corrupt because they have you sit in front of them and ask how you felt the session went and fill out the forms in front of them and you can't say that you didn't think it was very good at all, you know, that is quite impolite. (Participant, TO/606)

Generally, however, regular kaitiaki training is a necessity to keep them safe and up to date in their work as well as arming them with the different types of information they need to do their work well. In the view of participants, some training facilitators have been excellent:

A lot of the trainers we wouldn't use again and some of them we would get back everyday if we could afford them. (Participant, TO/606)

Training facilitators, more often than not, are also the recipients of new learning. Tales of kaitiaki experiences and situations with the families they work with are sometimes discussed in a training session. While in some instances these stories or issues may be everyday experiences for the kaitiaki, this is not the case for many of the training facilitators:

but that's, yeah, part and parcel of the unique audience that these facilitators have to work with. Often most of them comment that it is a real privilege to teach these women because

they actually are learning themselves, and that it is the women who are doing the teaching, yeah, really information rich. (Participant, TO/606)

The Tipu Ora training coordinator raised concerns about the cost of training; indicating that some trainers were very expensive. A suggestion was made that perhaps funders of workforce development could develop national standards, a set pricing structure that provided both purchasers of training and training providers with a formula for pricing specific training. Current training providers, from the viewpoint of Tipu Ora, over-charge for training or are inconsistent in the amount they charge. On the other hand, in a free market economy, charges for training, as with other commodities, will be linked to what the market is willing to pay:

I think the pricing of some of them [trainers] is quite expensive: we can pay \$5000 a week, or \$1500 a day, or \$1500 for an overnight wananga. It is really weird because we then have the paediatricians who come down here and do the clinical and medical training for nothing. So, yeah, should have set criteria, I guess, at a national level and once you have a criteria set for whatever a competency is, you then attach a formula for funding the training of the competency and the criteria for the type of facilitator with a set pricing structure as well. (Participant, TO/606)

Tipu Ora's role in kaitiaki training

Tipu Ora maintains that in the training of kaitiaki or well-child workers there is a place for organisations such as Tipu Ora to take a leading role and assist policy makers and planners at a national level. For instance, there is scope for a role in the development of core competencies for kaitiaki and other well-child workers who work with Māori families. They believe other organisations that do not have an understanding of how to incorporate Māori understandings into their work practices would benefit, or at least learn, from Tipu Ora's experience and way of doing things:

So a good example is another health provider going in and seeing bruises on baby's arm and saying "How did baby get that bruise?" And they say, "Oh, fell over", and "How do you know they fell over? Are you sure there is no one in this house abusing this child? Well, I am going to make a referral to CYPs". And they go off and report to CYPs. We just don't work in that way, we would never be allowed back in that house. The other thing that is different about us is that we are allowed to go into families that no one else is allowed in, so we have to be mindful that these women have to [be] armed with a whole lot of knowledge because it's quite possible that no one else is giving them that information, and you have to do that so that they take that training on board and want to apply it to their practice. (Participant, TO/606)

Opportunities for career advancement as kaitiaki are limited to supervisory roles based on both experience and seniority. However, kaitiaki are also given the opportunity to identify training that will help them pursue other relevant career options. The training coordinator and kaitiaki work together to develop a personal development plan. For example, one kaitiaki expressed an interest in social work and has started on this path by enrolling and being supported by Tipu Ora, in a Certificate in Social Work. This particular kaitiaki has no professional qualifications and last attended school over 40 years previous to gaining a position with Tipu Ora. The training and work with Tipu Ora has given her the confidence to return to study:

I have been with Tipu Ora for 5 years and I have learnt so much, it has been a blessing for me, I am confident in myself now because they had confidence in me and took the time to train me so that I could do my role properly. (Participant, TO/605)

Kaitiaki also have ongoing input into training content and will in some instances identify the best training facilitator for specific training. Kaitiaki who have been with Tipu Ora for a long time may only need refresher courses in some aspects of their work, while others will want to try something new:

What I did was with the health advice training that they get from the paediatricians and GPs once a month. I went down to their [kaitiaki] end of the building and sat down with them and said “OK, what are the most common medical things you are coming up with this winter or last winter?”, you know, and they just rattle off the top of their heads, “Oh, bronchitis, asthma, meningitis, blah, blah, blah”, and I say “Alright”, then I come back with a draft and say “Ok, this is the type of training for the next 12 months. Is this what you want?” And they say “yep”, then I take it to the paediatricians and they block list them into their specialists’ areas and then I take the list back to the kaitiaki and say “This is what the paediatricians have put together, is this what you want?” and they say “yep” and that is basically how we did that training. (Participant, TO/606)

The Tipu Ora commitment to training is evident in the employment of a fulltime training coordinator whose role is mainly one of monitoring and observing the work of kaitiaki to determine, and align training to the needs of the kaitiaki:

What we did with the Waiariki short course Certificate in Community and Social Work was that we identified from the operating guidelines and from what I observed from their actual practice, I worked out what they needed in training and then I just asked them, “Would you like some training on ethics and would you like some decolonisation stuff?” Yeah, we had a decol course which was really needed for a lot of them because I think with them coming from their own communities and because they live and breath social, health and economic issues often they don’t have a breather, you know, time or space to put their head above the water and take the time to look around about why it is the way that it is, and in fact it is really valuable to teach them about new knowledge they need; unless you offer them that

opportunity to accept sort of new knowledge so... from doing field observations and the operating guidelines there were specific areas that I wanted them to cover. (Participant, TO/606)

Given the generation of these women, their commitment to work at a basic level within their communities, and the likelihood that being a kaitiaki formalises a lifelong experience of working at a community level, there is evidence that some of these women are not aware of the issues surrounding colonisation:

well, I had heard of the Treaty, but I never really knew what it was really all about, but that was one of my first lot of training with Tipu Ora. I know the others that have been here longer than me they love it, and I enjoyed it, but I am just new so I look forward to more of it, you know. (Participant, TO/602)

Some [kaitiaki] have never heard of the Treaty of Waitangi and that is a classic example because they have lived in their communities and they have been living it all their lives so they haven't had the opportunity to think about why it is the way it is, so I sort of wanted to offer them a glimpse of the decol stuff along with the health advice stuff and the job description stuff, that kind of thing. (Participant, TO/606)

There is an onus on Tipu Ora to ensure that children from the families Tipu Ora services are kept safe; therefore Tipu Ora requires kaitiaki to go through a self-awareness process before they are formally allocated to work with families. While this process is undertaken for new kaitiaki at the time of their induction, other kaitiaki are encouraged to repeat the self-awareness sessions periodically. Supervision sessions and counselling also provide a space for kaitiaki to vent their frustration:

I also wanted them to do some self-awareness stuff, too, just because you can't work well if you are not well in yourself, and because they are put out as being kaitiaki with their mokopuna I wasn't going to let them loose on mokopuna when they weren't well within themselves, yeah, and that's not to say that any of them have any grave issues or anything like that, it was just to get them to do some self-awareness stuff and reflect on it. (Participant, TO/606)

The facilitator for a stress management and self-awareness session used one kaitiaki's experience to illustrate the effect their own home life could have on the work they do in the community:

I went to this stress management and self-awareness wananga with them and one of them [kaitiaki] had literally flown into Te Puke doing 150 km in a 50-km zone because she had had a fight with her tane or something... but she was about ready to write herself off because she was driving too fast, so the facilitator related that experience to all of them that you know they had all been there at some time and how it affected them. They took huge learning from that, you know, how they walk out the door in the morning is going to affect

them in the way they do their work that day, how they do their babies and that [session] and the outcome from that has been a realisation by all of them, it has been a key factor in them being able to do their jobs better. If that is one of the objectives of why you train people then it [training] has worked. (Participant, TO/606)

One participant acknowledged that kaitiaki are receptive to taking on new knowledge and learning, and growing from their training sessions, noting that this receptiveness is not only restricted to the kaitiaki but to Māori people in general:

Being Māori we take that on really easily – we are OK about doing a lot of growing and taking on new knowledge. (Participant, TO/606)

While Tipu Ora deems training to be important for kaitiaki, there is a feeling by management that too much training may be provided:

I don't actually like all the training – you train dogs to jump through hoops not people. (Participant, TO/606)

However, there is evidence in the literature that supports the notion of training being one of the most essential elements in organisational effectiveness and productivity (Gutteridge et al, 1993; Teasdale, 1992; Cohen et al, 2004).

The training of kaitiaki, then, starts from the day they enter the service:

We have a standard structure for their[kaitiaki] training... when they enter the service they... have a 12-week training induction which includes their paperwork, data collection, field observations, facilitated workshops, question and answer sessions, theory stuff which includes a workshop on how that would be applied in practice, and then see it for themselves by observations. From there they do extensive health advice training. (Participant, TO/606)

While training is more centred on the newer staff, training sessions are also booked for the older staff, but only if the specific session has not been run before:

I... only book training for the oldies where they haven't done it before, so if you have been here 12 years you would have done meningitis or bronchitis probably 50 times now. (Participant, TO/606)

As the core of Tipu Ora, kaitiaki training is crucial (Kingi, in Kingi and May, 2000):

There would be no Tipu Ora without the kaitiaki. (Participants, TO/601 & 607)

Even so, management consider “training to be a privilege not a right” (Participant, TO/606)
kaitiaki are expected to attend training sessions that have been booked:

We try and make sure that they get a certificate, something tangible, for the training because for some of them, for example, the Waiariki short course, they were given a certificate, it was their first qualification ever. Even though I reckon they could have facilitated the session themselves ten times over with their knowledge, but there you go, they were stoked. (Participant, TO/606)

Kaitiaki work at a whānau level and, given the realities within each whānau, kaitiaki experience a diverse and sometimes horrific range of situations. To support kaitiaki in their work Tipu Ora provides weekly supervision and debrief sessions, the aim of which is to allow the venting of feelings about various issues so they are not taken home with the kaitiaki; this also allows Tipu Ora to guide kaitiaki through sensitive situations:

Yep, yep, it is mandatory for them to undertake 1-and-a-half hours clinical supervision each week and in that supervision they are encouraged to debrief all of the issues of the families that they have worked with – we do not want them to take stuff home, although it is difficult for them because they are on call 24/7. (Participant, TO/606)

In reality, despite the debriefing sessions, kaitiaki often find it difficult to let go of the issues they have come across, which means other methods are needed:

We have one kaitiaki who really passionately takes on board people’s issues so there was kind of a need to kia tau with her... what we did was offer her a male supervisor so she could have cultural and clinical supervision and also she could let off some of that steam and ground her again – so we offered that as a specific need for her ... the others often have peer supervision with each other – younger staff with older staff. I have noticed with the older ones they talk to each other, use each other and let off steam and debrief. (Participant, TO/606)

Much of the training they undertake is, in reality, teaching the kaitiaki how to deal with the issues they encounter and how to provide support for each other:

Part of the training is to teach them how to deal with those issues and, where they can’t deal with them, talk to one of their peers ... keep themselves safe and then do supervision. We have one really excellent facilitator, her background is in counselling and she [is] really excellent in teaching peer supervision and teaching the self-awareness stuff: you know, getting stuck on an issue and not being able to let it go and getting amuamu about it and taking it home with them. It is a 24/7 job for all of them and they do come back with some horrific stories; my door is always open to them for practical advice, you know, legal stuff, because I am a lawyer, or social work but, yeah, they do sit on some pretty heavy things. (Participant, TO/606)

One participant described becoming involved with “a gang rivalry situation” that involved one of her mothers and the mother’s baby:

I don’t think that any amount of training prepares you for what I did, but because I live here and know this community so well, know all of the families, know the gangs – there are three gangs here in this area and I know all of them. Anyway, one of my mothers and her baby were in the house of ...gang, there was another gang involved – the issue was drugs, armed defender squad and police were everywhere, I was so worried about the baby and the mum that I just walked up to the house and demanded they let them [mother and baby] out... oh, I was scared, alright, but I knew that they knew I was no threat, I just wanted the baby and mother. (Participant, TO/604)

Incorporated into kaitiaki training are accountability mechanisms that consider not only Tipu Ora’s legal reporting requirements but also iwi, hapū and whānau values, traditions, and belief systems. The training focuses, in particular, on the health and well-being of mothers, their children and their families.

Specific role of kaitiaki

Kaitiaki provide family and whānau support advocacy; individual and group health education, and informal well-child checks, and also build relationships with health professionals and other support services. There is often a need for referrals to a range of health and social support services and facilitation of follow-up care. However, based on Tipu Ora kaupapa, kaitiaki also undertake a number of other activities, many of which have not been traditionally embraced as health focussed, for example, advice on financial management; provision of transport to health and social services; provision of childcare; help with household matters such as grocery shopping; the finding of accommodation for whānau; giving awhi to whānau with issues; and ensuring mokopuna are well and safe.

Kaitiaki are available to families 24 hours a day, 7 days a week, as outlined in their job descriptions. While they mostly work with mothers and their babies, often the whole whānau may be present when a kaitiaki visits. In most cases, kaitiaki advocate and promote advice and practice that were passed to them from their own mothers, that is, intergenerational knowledge. In working this way with young mothers they ensure intergenerational knowledge that has worked in the past also has a place in this generation:

We do similar things to what Plunket does but we do it better, we are 24 hours a day 7 days a week, not 9–5pm for us. We get lots of calls day and night and our system of service delivery hasn't changed since we started really. (Participant, TO/603)

When I first started I went to see my first mummy and she was having problems, the baby wasn't sleeping, so I wrapped baby, bound him up cause that's what I did with mine, and then I put him on his side, and the mummy said What are you doing? The books I have read say not to do that". I told her that we were taught to wrap babies and put them on their sides, so that if they have wind or want to be sick it will go out the side of their mouth, if they are on their back, where is it going to go. (Participant, TO/601)

Our numbers have increased and I have found that Tipu Ora gets the majority of the very hard cases – Plunket passes their hard basket to us because they can't, won't, or are not able to get in the door with many families. (Participant, TO/603)

Tipu Ora's relationship with other iwi/Māori organisations

Tipu Ora are an iwi-mandated Māori health provider organisation. The organisation has emerged from the Women's Health League established in 1937 by Nurse Robina Cameron and the Māori women of Te Arawa, which was also mandated by the tribes of Te Arawa. As with the Women's Health League, Tipu Ora maintains that it is answerable to the iwi. One participant stated that having iwi mandate "is precious," it is preferable to being answerable to the Government. In 1951, the Women's Health League was approached by the Government of the day to set up what is now known as the Māori Women's Welfare League. The offer was turned down because answerability to the Government was not considered an option even when it meant Government financial support would be forthcoming:

Being iwi mandated is precious to us. They asked WHL to be the MWWL but because they [WHL] didn't want to be answerable to the Government, they said no, no, we will stay iwi accountable, thanks. (Participant, TO/ 607)

An ongoing function of the Trust is to actively develop relationships with other iwi/Māori groups as well as maintain those relationships they already have. There have, however, been times when other iwi have withdrawn from a relationship with Tipu Ora for various reasons:

we have just pulled back from... [iwi] we lost one of our kaitiaki [died] over in ...[region] and we had to determine a process where we either stayed in... [region] or we gave the contract to them to run. They decided for themselves that they would like to do it; they didn't want us to do it or be in there and that was fine with us. We offered them a database and free training so that they could learn how to do it and score the contract. But they didn't come and get the database or take up our offer of training and didn't get the contract,

which is really unfortunate for those mokopuna who had received our services for a number of years. (Participants, TO/606, 607)

Kaitiaki perceptions of workforce development

Kaitiaki viewed their training and development enthusiastically, with the newer kaitiaki keen to have more and the older kaitiaki identifying specific training needs:

training makes me more able to cope with what is happening in some of my families...it helps me to deal with things like abuse. (Participants, TO/602, 601)

Most kaitiaki have been with Tipu Ora for a long time, and acknowledged that training had been very extensive in some areas, for example, the medical training they receive from the paediatricians:

Yes, it has been great. I have had a lot of training. We have had medical training with Tipu Ora – heaps of it, starting in 1995: training in Asthma and bronchial diseases. Out here in Murupara it is really damp so those diseases are really prevalent in the community. (Participant, TO/605)

Since the appointment of the training coordinator there had been some focused training in conjunction with Waiariki Polytechnic and all the kaitiaki mentioned the value of this to their work. Another positive aspect for the kaitiaki was that they received a NZQA qualification from the Waiariki training:

The training we did through Waiariki was big – over 1 year the programme went for; one day a fortnight and we got a certificate out of it. (Participant TO/601)

We all did a child development programme recently with Waiariki. It was a 1-year programme and we just graduated. (Participant, TO/603)

The training we had through Waiariki was really good value; run in different sections, for example, we had one on TOW. The programme was really good. (Participant, TO/605)

The Waiariki training also included sessions on Treaty of Waitangi; both pre-Treaty and post-Treaty aspects were covered, as well as focus on colonisation and decolonisation, different sections of abuse:

There was a session on ethics which included Treaty/post treaty happenings; differences in colonise and decolonise; the probation area in justice are some of the things we covered. (Participant, TO/605)

The session on abuse was divided into different areas of abuse, i.e., sexual abuse, domestic violence, mental abuse, jealousy abuse/violence, etc... and I identified more training for myself in child protection issues. (Participant, TO/601)

I liked the stress management part of the course – that was very interesting, you know, recognising the stressors in your life and working through ways of dealing with stress in yourself and in others. (Participant, TO/604)

Participants felt that even though they had regular training there was still a need to ensure that tikanga Māori was incorporated into the training, especially Māori concepts of health and wellbeing, things learned from tipuna, and the relating of humankind to aspects of the environment:

We use the elements to guide us as well, you know, the earth and sky, in our mahi. The sea, the wind (strong wind often will mean that people will be angry), thunder (anger) also, the rain is (cleansing) in our teaching we try to develop the good side of anger. (Participant, TO/605)

Kaitiaki generally felt that training and education was very important for them because they needed to be as professional as they could in their work. There was an acknowledgement from all the kaitiaki that they felt other professional workers, such as doctors, nurses, Plunket workers, did not see kaitiaki as being professional workers:

Other health professionals don't see us as being professional workers – just community workers – and kaitiaki are a lot more than that. I was a nurse, and have life skills that have been important in this role. I take advantage of any training that has come along and we are really at an advantage now 'cause we have ongoing training organised by our coordinator. Yes, we just take advantage of any of the training that comes our way if it means doing our job better. There are medical people we can ring up at the hospital, paediatricians that we can ring and ask if this is good or not. We have a good relationship with them, a good rapport. (Participant, TO/603)

As much as kaitiaki would like to have received training or work alongside Māori doctors and nurses, the shortage of these Māori professionals is very pronounced (Durie, 1998). The relationships that have been developed with the paediatricians and doctors at the hospital provide kaitiaki with an avenue for advice and support when situations occur.

We have the paediatrician coming down here; we have a lot of trainers here but at different times for different things and phases of the training for different workers. We would like to have Māori doctors but there are not many of them around the country. I don't think there are any Māori doctors here [Rotorua] at the moment but we wouldn't mind them coming to do training with us and be a part of our training. So, often we just use the doctors from the

hospital or some of the local GPs to come and talk to us and work with us. (Participant, TO/603)

Kaitiaki felt that hapū mandate was important for their work and personal development, and all had a strong sense of commitment to keeping their hapū fully informed about health issues:

For me, I wouldn't be without my hapū because they are my strength and they are my support. My kaumatua come with me – I have had to go to functions and hui and they all come and support me. I go back and talk to them, too, about things, especially about the changes in the health system. I belong to Ngāti Pīkiao – we have a rūnanga and I talk about what is good for our community, our mothers, and about general things that keep us healthy. (Participant, TO/603)

Kaitiaki identified that the coordinator was in the process of designing a new community health workforce development training programme in collaboration with the Waikato Institute of Technology. The design involved developing unit standards for the programme and running the course nationally. The qualification would be a Certificate in Māori Community Health (May 2002) and would take 2 years to complete:

I think they may have been working towards having this big training that is gonna go for 2 years. Not sure if all of us will be doing it at the same time but in the mean time until we know what is happening with that course if I want training in something. I just say so if I think it is relevant...Kaitiaki do, too, if they see anything, they just come and ask, but most of the things they have asked about are, like, child protection studies, or early childhood courses – they bring it to me and, yeah, we let them do it most of the time, although now we have some set training for them but they can do what interests them. (Participants, TO/603, 606)

From kaitiaki feedback it was clear there was general satisfaction with the training with which they were provided in order to do their jobs. Before the appointment of a dedicated training coordinator, their training had, at times, been ad hoc in terms of types of training. It had been mainly focused on training from a medical standpoint, and was very theoretical. More recent training, such as the Waiariki training, had provided tools and knowledge that could be applied in a practical sense when dealing with mothers and babies. It was clear, however, that the diversity and circumstances of the families they work with required a practical knowledge and understanding of some very sensitive issues. All kaitiaki acknowledged that their training helped them do their jobs better and provide a culturally appropriate and relevant service to whānau and hapū.

Tipu Ora in summary

This Chapter presents, in semi-narrative form, a description of the Tipu Ora Well-Child programme. Semi-narratives provide a space for participants' voices to emerge naturally and guide the prose. To understand Tipu Ora as an organisation, questions were related to the various roles and responsibilities within the organisation and the relationship of these roles and responsibilities to workforce development. Four specific areas were the focus of the interviews. First, the function, roles and responsibilities of the Tipu Ora Trust Board were pinpointed and elaborated. The role of governance, for example, demonstrated that the Board has clear responsibility to provide leadership, political liaison, policy development, setting and ratification, strategic planning and direction, and relationship building, and also to ensure the security of the status of the organisation as a legal entity for contractual purposes. The second area focused on Tipu Ora management roles and responsibilities and the day-to-day coordination of operations that included human resource management and staff development and training, financial management and budget control, and contract management. At both the governance and management level of the organisation there was a clear, long-standing commitment to customised workforce development training for kaitiaki through the employment of a full-time training coordinator. Third, the area of service coordination highlighted the importance of service design and development, evaluation, supervision and assessment, workforce training and education, information collation, and liaison with other services. The fourth area, examined the emphasis on service delivery, in which kaitiaki have a major responsibility for the facilitation of the service, and this responsibility includes advice to and advocacy for whānau, whānau liaison and referrals to other services, and data collection. Much of the training for kaitiaki was geared to service delivery in a Māori relevant and appropriate way.

Chapter 8

TE RAU PUAWAI: MĀORI WORKFORCE DEVELOPMENT AND COMMUNITY MENTAL HEALTH

*Ki a koe tētehi kīwai, ki a au tētehi kīwai*⁸⁶

Introduction

Te Rau Puawai Workforce 100 was selected as a case study for this research because of its focus on accelerating the development of Māori community health workers in the mental health workforce through academic qualifications. As with the previous two chapters, this chapter is presented in semi-narrative form to allow the emergence of participant voices.

The emergence of a health workforce development support package

Māori staff in the School of Psychology at Massey University had been concerned for some time by the attrition of Māori students in their department. In 1997, the Department of Psychology employed two Māori staff who had discussed different ways by which they could encourage Māori students to remain in the School. Both the concerns of these staff and some of the ideas they developed were discussed in a University-wide Māori staff forum (Te Matawhānui). It became apparent at this forum that Māori student attrition in psychology was not an isolated incident; such attrition seemed to be occurring in other disciplines as well, although not to the same degree as in the health disciplines. Further investigation highlighted Māori attrition rates in nursing, rehabilitation, food and nutrition, foundation science, and social work and social policy. Māori staff discussed numbers of possible remedies that might stem Māori student attrition rates in these areas and agreed to develop a support package for Māori students.

With specific guidance from Professor Mason Durie⁸⁷ a generic support package was developed for Māori health workforce development. The proposal was sent to different sections of the

⁸⁶ In Mead and Grove, (2004), 1295: 'For you one handle of the basket for me the other'- The work should be shared equally – an acknowledgement ki te whānau whānui o Raukawa

⁸⁷ At this time Professor Durie was Head of the School of Māori Studies (Te Pūtahi-a-Toi), at Massey University. His current position is Deputy-Vice Chancellor (Māori) at Massey University.

Health Funding Agency⁸⁸ (HFA) and District Health Boards and was eventually picked up by the Mental Health Group in the HFA. The proposal was adapted to reflect and focus on supporting and increasing Māori capacity in mental health:

it was before my time but as far as I know the bones of what a support package for Māori workforce development might look like was put together by Ephra Garrett, Paul Hirini, and Professor Durie and then with the support of Te Putahi a Toi and Te Matawhānui a proposal for funding was developed and submitted to the HFA – now the Ministry of Health. (Participant, TRP/801)

The focus on increasing mental health workforce capacity came about through knowledge of the long-term under-representation of Māori in the mental health workforce. At that time, the mental health *Blue Print*,⁸⁹ highlighted the need to increase Māori mental health workforce participation across disciplines, and coincided with the government *Moving Forward* objective to increase Māori participation rates in the mental health workforce by 50% by 2005. In 1999 progress towards meeting these objectives was not happening in quite the way that had been expected. Although there was a definite increase in Māori non-government mental health organisations, thereby giving the impression of an effective increase in Māori participation rates, this was at a Māori community support level rather than at a level where opportunities could be provided that would enhance skills or even recognise those community skills through qualifications in mental health-related disciplines. The support package developed by Massey was presented to the HFA as a way to help the Ministry of Health in meeting its own long-term objectives.

The support package therefore had a strategic focus, the outcomes of which would be definite and measurable; HFA commitment to the support package required a similar strategic focus. The proposed outcome of the support package was to graduate 100 Māori students in a mental health-related discipline over 5 years. Given most government contracts rarely extend past a 3-year period and are subject to annual review, establishing the 5-year contract for Te Rau Puawai was in reality a testament to the people who had put the package together, to their integrity,

⁸⁸ As a result of sector restructuring the Health Funding Authority has been disestablished; its responsibilities devolved to the Ministry of Health and some funding responsibilities to District Health Boards.

⁸⁹ The Mental Health Commission produced the document *A Blueprint for Mental Health in New Zealand* in 1998, as a result of the Mason Report. Mental health providers continue to use the Blueprint as a guide in the provision of appropriate mental health services.

reputations in the field of mental health, and the capacity of Massey University to deliver on the programme. In 2002, an independent evaluation of Te Rau Puawai – Workforce 100, was carried out by the Māori & Psychology Research Unit at the University of Waikato. The evaluation highlighted the success of the programme, especially in relation to the graduation of 100 students over the 5-year period. In fact, the numbers of graduates exceeded the required 100 by three.

Te Rau Puawai – One hundred blossoms

Te Rau Puawai – Workforce 100 programme is a joint venture between the Ministry of Health and Massey University (Nikora, Levy, Henry, & Whangapirita, 2002). Established in 1999, the programme aims to graduate 100 Māori students committed to Māori health advancement, over a 5-year period (Durie, 1998 #338). The rationales for the programme were threefold. First, the participation rates of Māori in health-related disciplines were unacceptably low as outlined in the Blue Print. Second, there was a strong demand for Māori to become involved in health services provision in their own communities. Third, Government, in line with the earlier conviction of the *Coalition Agreement on Health 1997*, which had identified the development of competent Māori health providers as being critical to improvements to Māori health status, recommended “the accelerated development of Māori providers and the Māori professional workforce” (Minister of Health, 1997, p.). The Te Rau Puawai programme is specifically focused on supporting those with an interest in or those working in mental health-related occupations at both a paid and voluntary level:

the idea was to put a long-term strategy in place to be able to attract more Māori into training and onto pathways for mental health and in assisting those who are currently working in mental health to be able to upskill so there are more qualified professional roles that are being held by Māori across a wide range of different areas in Māori mental health. (Participant, TRP/803)

A place for Te Rau Puawai

Within the University system, Te Rau Puawai is based in Te Pūtahi-a-Toi (School of Māori Studies). Sitting under the umbrella of the College of Humanities and Social Science, Te Rau Puawai, through the School of Māori Studies, provides access to and support for Māori students in a wide range of academic units at local and national levels through Massey’s extramural service. Massey University provides multi-modal as well as multi-campus flexible learning,

teaching and research opportunities. Te Rau Puawai bursars have the benefit of choosing which way they will participate in the tertiary education environment.

‘Without feathers a bird cannot fly’⁹⁰

When the programme started, criticism was levelled at the HFA by other tertiary institutions who felt the programme could have been run nationally with funding distributed between a number of institutions:

the HFA was experiencing some flack as a result of choosing one tertiary institution to run TRP through, there were other tertiary institutions who had found out that Massey University was receiving 1.75 million dollars and they were not very happy that they were not given an opportunity to be a part of that. (Participant, TRP/801)

However, as mentioned earlier, the idea for the programme had not come from the Health Funding Authority but had emerged from within Massey, and more importantly from Māori staff.

Funding for the Te Rau Puawai support package was proactively sought by Massey University through Te Pūtahi-a-Toi (Māori Studies). The HFA was approached and agreed to support the programme with a 5-year funding commitment of \$1.75 million: Funding has continued with renegotiated contracts. A review in 2005 revealed the programme was meeting outputs and meeting Governments goals and priorities. Funding for 2004-2007 is \$625,000 per year (Inglis, 2005, p1).

the HFA had not knocked on Massey’s door, Massey had actually proactively approached the HFA, there was no tender process, Massey had approached HFA not the other way around. (Participant TRP/803)

apparently the HFA were very excited about it and with running with a 5-year contract. (Participant, TRP/801)

⁹⁰ Adapted from the words of a song written by Anne Gillies for the Waimarama sports club in the 1940s this part of the song goes ‘Mā te huruhuru hoki, ka rere ai te manu, ki tōna tauranga’ – ‘a bird must be adorned appropriately, i.e. must have feathers, to enable it to fly to its destination’. The Waimarama sports club would perform kapahaka concerts to raise funds in order to travel to sports events, and these words were part of an action song they performed during the concerts. Originally the words come from a well-known whakatauaiki ‘He ao te rangi ka ūhia, mā te huruhuru te manu ka rere’ – ‘As clouds cover the sky, so do feathers enable a bird to fly’. In this thesis and in relation to Te Rau Puawai, without support, both financial and human, the blossoms will not produce fruit, and the programme objectives will not be met.

The functions of the Health Funding Authority shifted to the Ministry of Health as a result of restructuring in 2000–2003. The evaluation of the programme in 2002 supported a further application to the Ministry of Health to fund Te Rau Puawai for a further 5 years. While the programme had been successful, the HFA and then the Ministry of Health did receive some criticism from other tertiary education institutions for choosing one particular institution to deliver the programme rather than a range of tertiary providers. However, as mentioned earlier, the programme was not initiated by the HFA, the idea for the programme and its development had emerged from Massey University Māori staff. Even so, while the proposal for future funding of the programme was aimed at another 5 years, the Ministry of Health agreed to a 3-year commitment, bringing the contract more inline with current Ministry and Government timeframes:

I think one of the barriers for the programme was the difficulty around obtaining a second 5-year contract. The Ministry doesn't do 5-year contracts anymore. A 5-year contract would allow for long-term planning for the whānau of TRP as well as for staffing and support systems and as TRP is moving into a new phase with a new contract... 5 years would be ideal. (Participant, TRP/801)

The Evaluation Team described the College of Humanities and Social Sciences as the 'hub', or linchpin to the overall University system; different in structure from other universities in relation to Māori Studies schools and departments. In the University of Waikato, for example, Māori Studies is equivalent to a Massey University College; Māori Studies at Massey University is based in the College of Humanities and Social Sciences, giving Te Rau Puawai bursars access to a broader range of disciplinary interaction, a unique but "academically coherent framework to link Te Rau Puawai to other schools, departments and institutes within the college." This provides the programme bursars with a broad range and variety of learning opportunities required for a range of careers in the Māori mental health sector (Nikora et al., 2002, p. 4). In addition, Māori Studies had a long-standing interest in health and had established a Māori health research centre in 1993.

Academic leadership, support and nurturing is provided by Te Pūtahi-ā-Toi in relation to te reo Māori me ona tikanga, and through the diversity of its teaching programmes in Māori health, Māori development, Māori society and culture, and Māori arts:

It physically sits in the school of Māori Studies although officially part of the College of Humanities and Social Sciences under the Pro-Vice Chancellor's Office. It was put under

Te Pūtahi-ā-Toi's umbrella, as I understand it, because of the additional support that would be available to the staff and to the programme but, as I understand it, is hosted by Pūtahi-ā-Toi but the contract is with Massey in the College of Humanities and Social Science and therefore that is why the Pro-Vice Chancellor of the College is the Chair of the Board. (Participant, TRP/801)

Te Kawanatanga o Te Rau Puawai

Te Rau Puawai Board was established simultaneously with the programme as part of the contract, and reflects the nature of the contract as a joint-venture relationship between Massey and the Ministry of Health via the Health Funding Authority. Nikora et al. (2002) identified that while the board of Te Rau Puawai is described as a Board of Management its function is to provide the systems for strategic leadership in terms of the programme. This includes systems for decision-making and the gathering and distribution of information relevant to decision-making (Health Workforce Advisory Committee, 2003).

The Board comprises four Massey University staff members: the Pro-Vice Chancellor who chairs the Board; and three others who are appointed by the Vice Chancellor or Pro-Vice Chancellor; and three from the Ministry of Health appointed by the Deputy Director General of Mental Health (Nikora et al, 2002):

my understanding is that the Board was set up simultaneously at the same time as the contract, so the HFA and Massey University both jointly agreed who would be on the board. It is only a small board with seven members and so they... at the time the HFA put two HFA reps on, and there was a MOH representative as well, and several Massey University staff, so at the time of negotiating the contract, as I understand it, they settled on what the board would look like. It is a joint initiative so there was to be a joint board to reflect that and, as far as I understand, it was signed off with a contract. (Participant, TRP/801)

The Te Rau Puawai Board takes a leading role in the selection of bursars, and all applications for bursaries are considered by the Board to ascertain bursar commitment and career direction, and to ensure that current and future needs of the Māori mental health sector are being met. In this sense the Board actively participates in the management of the programme but at the same time maintains the strategic emphasis of programme and government objectives (Nikora et al., 2002, p. 5).

The two joint venture partners, Massey University and the Ministry of Health, have distinct responsibilities of support. First, the Ministry of Health provides the financial support for the programme, including covering the costs of bursar fees, course materials, travel to on-campus courses and attendance at the two headstart hui held at the beginning of each semester. Second, the fulltime co-ordinator and administrator positions, staffing of the call centre, website, database and the regional visits by Te Rau Puawai staff to meet with and support bursars are also covered by the Ministry of Health. Their responsibility is to monitor the funding and to report back to appropriate government officials.

The role of the University is to facilitate the delivery of the programme, mostly in terms of access and accommodation. For instance, being hosted by Te Pūtahi-ā-Toi, School of Māori Studies provides not just Māori academic guidance and leadership but opportunity for the maintenance of te reo and tikanga Māori aspects of the culture; it allows cultural aspects to take place in an appropriate area. In relation to access, Massey University also provides the venue and site of the Thursday night call centre, academic mentors, computer and internet access 24 hours per day, a huimanga for the headstart hui. The University also covers the overhead costs associated with running the programme, for example, costs relating to full and part-time staff, as well as other associated costs such as power, phone, and some equipment.

The operational team was established in September 1999(check year). An initial concern about recruitment was raised. Where would the students be drawn from, given the set-up timeframes and the start of the next academic year. There was little time to advertise or fully publicise the bursary, therefore to get up and running quickly students for the Te Rau Puawai bursary programme were chosen from current internal Massey University student enrolments. The following year, bursary applications were distributed nationally and students were invited to apply from all over the country.

A further barrier that emerged at the time of the first contract renewal was that other workforce development providers wanted the opportunity to compete for the same funding. For instance, the District Health Boards were also funded by the Ministry of Health for workforce development:

At the same time as the contract came up for its first renewal, concern was raised by the bursars about the continuity of the programme, especially for those who were in study programmes that would extend past the end of the first 5 years. For these students, the bursaries had provided financial security and the ability to study at a tertiary level with the appropriate support systems to help them through the process. To cease funding the programme would place financial burden on whānau, or, which was worse, would see the withdrawal from the system of a large number of the bursars (Nikora et al., 2002).

Te hanganga o Te Rau Puawai

The first function of the Board after its establishment was to decide the best and speediest way in which to progress the Te Rau Puawai programme. A recruitment and selection process was undertaken to find a person who, with guidance from the Board, could put in place the mechanisms for an immediate start to the programme. An informal structure to the programme then developed and the position of co-ordinator became pivotal not only to the success of the programme but also to its formal structure (Nikora et al., 2002). In the first year of the programme two levels of organisation were established, and by the middle of the second year, with input from bursars and a significant increase in their numbers, a third level of organisation emerged that reflected core elements of the support package.

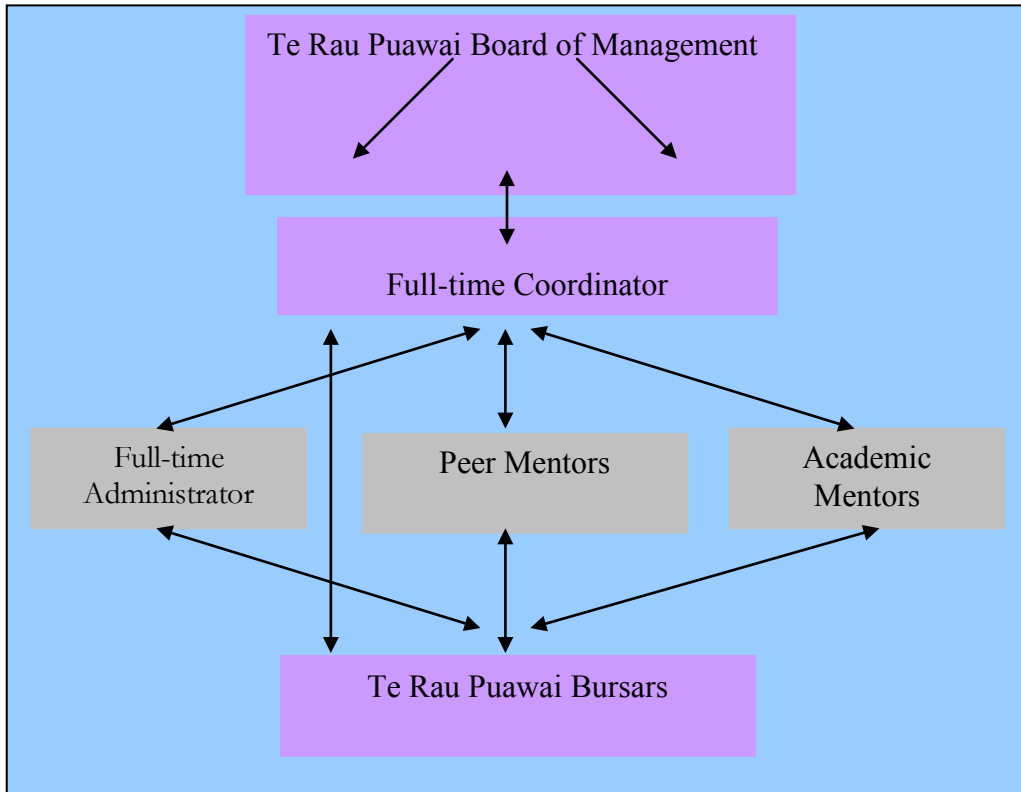


Figure 8.1: Te Rau Puawai organisational framework

Source: Nikora et. al. (2002).

The organisational framework depicted in Figure 8.1 highlights the pivotal role of the coordinator in establishing, managing and maintaining the relationships between bursars, programme staff, volunteers, and the Board. The third level of organisation consisting of the fulltime administrator, peer mentors and academic mentors was established in the second year of the programme and has become a core aspect of the support package offered through the programme. Through the development of the programme since its establishment in 1999 the bursars continue to play a major role:

I think the bursars primarily during the first 3 years they had input at all levels around what supports were going to be in place, what supports were working, what supports weren't, what would be useful to try the following year. They were also holding each other accountable and they – not all of them but a large majority – took their responsibility of being a part of TRP really seriously in terms of trying their best to make good to the commitment that had been made to them. So I think the bursars primarily would be the first ones who will always have input into the programme. (Participant, TRP/801)

The arrows in Figure 8.1 highlight communication channels and the multiple levels of input from each organisational area and, most specifically, the pivotal role of the coordinator. Promoting

and publicising the Te Rau Puawai programme is acknowledged at all levels as a core function of the organisation as a whole (Nikora et al., 2002).

Te tuituinga o Te Rau Puawai

Overall responsibility for the management of the Te Rau Puawai programme rests with the full-time coordinator. The role of the coordinator is and has been pivotal to the continued success of the programme. For instance, the coordinator assists with the recruitment and selection of bursars, providing practical advice to the Board based on experience, and following through with regular monitoring and reporting to the Board on the performance and progress of bursars:

Yes, in the current selections I make recommendations to the Board on who should continue in light of the progress or not that they are making and that is based on the reports and feedback from tutors and lecturers. There is a process we follow and the bursar is supported through the process to the final decision by the Board. I am up front with the bursars all the time – I don't beat about the bush. (Participant, TRP/802)

At an operational level it is also the role of the coordinator to ensure the development of, and ongoing personal and learning support for, bursars through establishing 'whānau' networks at local and national levels, placing bursars with appropriate academic mentors, and liaising with College staff responsible for delivering relevant academic programmes:

I provide progress reports every 6 months [to the Board] on how the students are progressing or not, and progress reports on the management side, the day-to-day operations so they [the Board] are kept informed every 6 months. Their main role is the strategic direction but I think lately it has just been more about approving day-to-day operations. (Participant, TRP/802)

A further feature of this role relates to liaising with external stakeholders such as health providers and other health agencies to promote Te Rau Puawai and to assist with student recruitment:

We regularly visit our bursars in their own communities, on marae or in the homes. We have established relationships with their whānau and it is their whānau that look after us when we travel to the regions. We have also established close working relationships with the organisations, the providers that our bursars work with. We have taken on the role of liaising with the wider community in an effort to make things easier for our bursars to study. (Participant, TRP/802)

On several occasions Te Rau Puawai has assisted providers in other ways such as with administrative training and the setting up of management and administration systems within the provider organisation. While this clearly is not part of the contract Te Rau Puawai has with the

Ministry of Health and has been described by the Board of Management as not being the role of Te Rau Puawai, to ensure the bursar has adequate time to study, it has often been necessary for Te Rau Puawai to step in to help the provider organisation:

you know, a lot of our provider organisations out there need leadership skills, need management skills. I have had to send our PA to a couple of organisations because they didn't have the skills or knowledge in terms of management and administration – just to get basic admin and filing systems in place, otherwise our students would have to spend 15 or so hours at work. So we do it so that our students spend 8 hours at work and can study for the other half of the 7 hours at least, things like that... just putting simple things like that in place for them. (Participant, TRP/802)

The example of sending the administrator to help providers highlights the flexibility of the programme to adapt to situations to ensure the needs of the bursars are paramount. It specifically highlights the strong relationships of the staff, as well as their commitment to the positive experience of the bursars.

Hei pae āwhina

The third level of organisation, which emerged by the second year, consists of the core support functions developed for and by Te Rau Puawai bursars, the co-ordinator, and the Board. By 2000, students supported by Te Rau Puawai scholarships had increased from 32 to 113, and with this increase in numbers the administrative workload of the coordinator escalated threefold. In that year, the Board approved the employment of an administrator to assist the coordinator, and at the same time a bursar peer support team was put in place to focus on the students.

The peer support team consisted mainly of students currently at the University, who were also bursars, familiar with the academic requirements for study at tertiary level, were often more mature and could relate to and help students as a result of their own experience of the university system:

and so, for example, we have our students who have been in an academic setting for quite sometime so they are very familiar in how to write assignments, very familiar in knowing how to enrol in papers, they know what to do, they know all the academic language, and all of those sorts of things. What they haven't experienced yet is the reality of working in mental health and what that is like. (Participant, TRP/802)

As the new bursars often had no academic knowledge but had a wealth of work and life experience, peer mentoring was also about students building relationships with one another and helping each other in different ways:

The other group of our whānau are those that maybe commonly have dropped out of school and formal education at form 4, 5, or 6, many years ago and haven't engaged in University study before. What those whānau have is a wealth of work experience and understanding of the reality of what it is like to work in Māori mental health or in Māori communities. (Participant, TRP/801)

The Te Rau Puawai whānau is made up of two groups: one with academic knowledge, the other (usually the new bursars) with the practical knowledge. Developing an on-going supportive relationship between the two groups has been a major feature of the support programme:

What is really wonderful is that we found our whānau – these two groups had shifting roles in some contexts: at different times one would be the tuakana and at others they would be the teina... encouraging the students to access not only the supports of the coordinator and TRP but also be able to support each other and to be able to foster within an educational setting important Māori relationships that we know already things like tuakana and teina was really important. (Participant, TRP/802)

A role reversal often occurred when a bursar on placement⁹¹ for psychology or social work, for example, might be placed in the same provider organisation as a bursar they were mentoring; a practical example of this role reversal occurs within the different programmes of study and it is not unusual for bursars and mentors to find themselves switching from one to the other in these situations. Peer mentors also provide academic mentoring, especially if they are mentoring bursars who are involved in the same programme of study. The formal academic mentoring component of the programme, however, is provided by academic staff mainly from the College of Humanities and Social Sciences.

Academic mentoring is an integral part of the Te Rau Puawai programme and delivered in two ways: first, through the co-ordinator and Te Rau Puawai peer mentors and support staff; second, academic staff or post-graduate students are identified and invited to participate in the mentoring programme because of their involvement in the individual bursar's study programme, either as paper or course coordinators or tutors. For this part of the programme, bursars are required

⁹¹ Some degree programmes such as social work, psychology, etc., require students to complete a number of hours of practicum. On these occasions, students spend time with provider organisations in the community. In Māori Mental Health many of these provider organisations are also in areas from which bursars are drawn.

first to make contact with their mentor. However, Nikora et al. (2002) found during their evaluation, that many of the mentors are rarely contacted by their bursars. The evaluation highlighted several issues that could have been preventing bursars to approach their mentors: one was the power differentials of the lecturer/student relationship; another was the perceived conflict of interest between paper coordinators and students taking the same paper. Whatever the reason for the lack of contact, some bursars were not interacting with their mentors. The evaluation team suggested this situation needed to be investigated further, and it might be more appropriate for the mentors to make first contact. They recommended initial contact between mentors and bursars should be a shared responsibility of the staff member involved and the bursar. While the bursars seem to prefer to have Māori staff as academic mentors, a number of Pākehā staff have also been invited to participate as mentors in the programme.

While the Te Rau Puawai board and programme staff provide and facilitate core support, a range of strategies have been put in place and have been proposed and enacted by the bursars themselves:

the frameworks of how the programme works, for example, the regional visits, national hui, conference calls, the phone teams, the assignment database, all of those supports, newsletters, etc., have been focused on the students and developed by them as well. So the frameworks for the supports are feedback to us by the students and they identify what they need to help them and frameworks are developed from there. The whole process except for the governance role and the management side in terms of funding, but everything else is from the students, they are the ones that develop the systems so they are involved in that – the in-house systems – and they continually improve and make suggestions and we do that at every hui. They send in feedback, say ‘how about we do it this way’, and they continually make suggestions so the systems are continually improving all the time. So they play a big role in how the programme runs. (Participant, TRP/802)

As an example, the head-start hui originally arranged to welcome students to the University and provide basic information was identified by the bursars as being a crucial avenue to network with their peers, meet University staff, learn and participate in study skills workshops, and become familiar with the campus. These hui have become compulsory and are held twice a year before the start of semesters one and two:

The whānau apparently (before) whānau were not allowed to come to head-start hui but now they are. Children are allowed to come, their whānau are welcome, too. They can stay the whole weekend, come for dinner not just the whānau of taura but also the whānau of our other supports, the lecturers, the mentors, because we need to acknowledge all of the support mechanisms – the whānau of those people – because without them the programme

would not be successful. We want to acknowledge the voluntary time that people have given to the programme by supporting, and mentoring students, that is time that we have taken away from their own whānau so we include all the whānau acknowledging the extended whānau. (Participant, TRP/802)

The 0800-telephone support system was established in 2000 and has proved an essential element for maintaining regular weekly contact with bursars. The 0800 support team currently operates on a Thursday night from 6pm to 8pm. Each support worker has experience and/or expertise in specific programmes of study and is allocated a number of bursars studying in their areas of expertise. Bursars are encouraged to use the 0800 number to keep in touch with their support worker. The 0800 phone line remains a cost-effective method of one-to-one interaction with bursars.

The Te Rau Puawai coordinator and support team regularly travel to the regions to meet bursars individually and in groups; they also meet with provider organisations and whānau of the bursars:

when we go to the regions, we often go to their marae, and it is their marae, the extended whānau, who look after us so we want this to be reciprocated in what we do too, so they become part of the TRP whānau as well – we keep them informed, newsletters go out to them, and they are invited to our head-start hui as well. (Participant, TRP/802)

Other supports for bursars include a monthly newsletter with articles from support staff and bursars, a website that has a facility for students to workshop and discuss their study, a Kia Ora Doc that provides a biographical sketch and photo of bursars and is circulated to all bursars to help them network with each other, and the availability of a 24 hour workspace with computers and internet access.

Ngā karahipi

Te Rau Puawai bursars are drawn from a wide range of Māori communities and organisations from all over New Zealand. Many are mature students and bring to the programme life skills, work experience, and in many instances cultural expertise. Navigating the University environment is usually a new experience for them, and often one they thought they would never experience. They enrol and are supported through a diverse range of study programmes related to the areas of mental health in which they work or have an interest. Their study programmes

are wide ranging and they often find they are the only Māori students enrolled in certain papers. Having the support of Te Rau Puawai and other bursars is usually what gets them through these courses.

Nikora et al. (2002) identified that many of the bursars would “not have entered university study without Te Rau Puawai,

I think competition for the funding is coming from the DHB and other providers who probably would have liked to have had the putea that we have and that we will be having for the next 3 years. I think they would have liked that funding for them to provide those services. So, yes, for this new renewal there are barriers from the DHB and maybe other providers as well. (Participant, TRP/802)

especially in terms of the financial support that is offered. In many respects, this support has provided an opportunity for Māori to participate in the education system at a level they would not normally have contemplated nor been able to afford.

Māori aspects of Te Rau Puawai

Bursars were positive about the programme and keen to make suggestions to improve it in various ways. One of the unique programme features bursars were keen to promote is its Māoriness – the way that it is culturally responsive to the bursars (Nikora et al., 2002):

there needs to be a balance, and although academia was the main aim of it[Te Rau Puawai], I believe that tikanga comes into it as well, because at the end of the day they are going to go out there and work with our people. (Participant, TRP/802)

An important aspect of the Te Rau Puawai programme is its whānau orientation and practices of whānaungatanga and whakawhānaungatanga. All students and their whānau are actively encouraged to participate in head-start at the beginning of each semester. Invitations to attend these hui are also sent to lecturers and academic mentors, support staff and administrators of various departments of the University. The Te Rau Puawai programme staff work hard to ensure that interaction and communication with bursars and their whānau is continual. Whānau, friends, and provider/community organisations are considered to be part of the Te Rau Puawai network of stakeholders. These relationships are important and care is taken to ensure they remain strong:

Basic tikanga is paramount, you know, manaaki manuhiri is really important, tautoko each other, awhi – help others, clean up after yourselves, we have a kuia and a koro to help us out and provide valuable advice when we need it. (Participant, TRP/802)

Getting together with the whānau was not favoured by all students but there were other aspects such as study groups, and networking that were satisfactory. Generally, though students benefited from participating in a whānau atmosphere and many enjoyed the cultural input (Nikora et al, 2002).

yes it has been ok I like the study groups and what not ...I am nearly finished my degree and I want to do further study, while I have the opportunity and while the kids are at school. I sort of like the whānau stuff but I have been to only one Headstart since I started, I enjoy it but not really into you know what I mean – I hate sleeping in the whare ...but they pay my fees and that's what I am really grateful for I could do without all that other stuff (Participant, TRP/807)

yep all of it the cultural perspective was the best...wish it could go through the whole of my course (Participant, TRP/808).

Destinations of graduates

Over 70 percent of Te Rau Puawai bursars are part-time extramural students studying to complete a qualification while working full or part time. Seventeen bursars were fulltime students before graduation and just two were unemployed at the time of graduation. Many students, once they have completed a qualification, have remained working for the same organisation; a few have changed their jobs within their organisations or have moved to another organisation or location, and continued their study; and a few have chosen to work overseas. Bursars who participated in the Te Rau Puawai programme 1999–2003 were drawn from a wide range of both Māori and non-Māori provider organisations. Many students also worked in quasi-government agencies such as Children Youth and Family Service, and District Health Boards and the Police.

Māori community health workers from 14 District Health Board regions have participated in the Te Rau Puawai programme. Regions include Auckland, Bay of Plenty, Canterbury, Capital Coast, Central, Counties Manakau, Hawkes Bay, Hutt Valley, Midcentral, Midlands, Nelson Marlborough, Northern Region, Tairāwhiti, Waikato, Wairapapa, Five from Auckland, two from Bay of Plenty, two from Canterbury. The range of work roles in their communities range from

social workers, Nurses, clinical psychologists, whānau workers, managers, policy and welfare workers, consumer advocates, fieldworkers, and researchers for example.

Breakdown of qualifications

The following table lists the qualifications gained by students supported by a Te Rau Puawai bursary from 1999 to 2005. Approximately thirty-five different qualifications are listed with at least three students supported through more than one qualification. Students studied in a variety of mental health-related disciplinary areas. The most popular of these were social work, psychology, Māori development and nursing. Almost 48 percent of the students were postgraduate students, indicating that the bursaries were effectual in supporting those who had previously studied to gain higher qualifications, and in 2005 culminated in the graduation of two PhD candidates.

Table 8.2: 1999–2005 Qualifications gained through Te Rau Puawai bursaries

| Type of Qualification Postgraduate | Graduates | Type of Qualification Undergraduate | Graduates |
|---|-----------|--|-----------|
| Advanced Diploma (Mental Health Nursing) | 2 | Bachelor of Arts (Business Psychology) | 1 |
| Bachelor of Arts (Hons) Psychology | 2 | Bachelor of Arts (Psychology & Māori) | 13 |
| Bachelor of Arts (Hons) | 1 | Bachelor of Arts (Māori) | 1 |
| Master of Arts (Māori) | 1 | Bachelor of Arts (Māori & Social Policy) | 2 |
| Master of Educational Psychology | 1 | Bachelor of Arts (Psychology) | 17 |
| Master of Nursing | 5 | Bachelor of Arts (Social Policy) | 4 |
| Master of Nursing (Mental Health) | 4 | Bachelor of Health Science | 2 |
| Master of Philosophy (Māori) | 2 | Bachelor of Health Science (Psychology) | 1 |
| Master of Social Work (Applied) | 7 | Bachelor of Health Science (Rehabilitation) | 1 |
| Postgraduate Certificate in Health Science (Dual Diagnosis) | 4 | Bachelor of Nursing | 2 |
| Postgraduate Certificate in Nursing | 5 | Bachelor of Social Work | 28 |
| Postgraduate Diploma in Arts (Māori) | 2 | Certificate in Arts Psychology | 1 |
| Postgraduate Diploma in Cognitive Behaviour Therapy | 2 | Certificate in Arts (Rehabilitation) | 2 |
| Postgraduate Diploma in Psychology | 1 | Certificate in Rehabilitation | 3 |
| Postgraduate Diploma in Rehabilitation | 3 | Certificate in Social and Community Work | 10 |
| Postgraduate Diploma in Nursing | 1 | Graduate Diploma in Māori Development | 10 |
| Postgraduate Diploma Social Service Supervision | 1 | Graduate Diploma Arts (Psychology) | 2 |
| PhD (Māori Studies) | 1 | | |
| PhD (Psychology) | 1 | | |
| Total – Thirty-five Qualifications | 46 | | 102 |

The aim of Te Rau Puawai was to graduate 100 students over 5 years. The pie chart below provides information on the total numbers of graduates for the period 1999-2005. The graph shows 148 graduates, two of these graduates gained two qualifications through the programme.

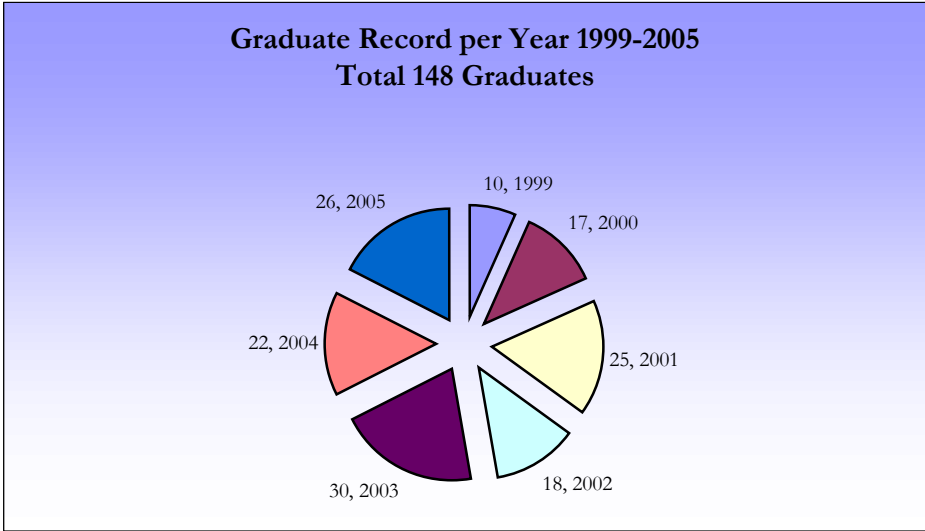


Figure 8.2: Numbers of total graduates 1999-2005

The following pie-chart shows the number of undergraduate students 1999-2003. On average it shows that each year the numbers of graduates have increased gradually. This is because the networks have grown and the programme is more well known. Since the first intake the bursaries for Te Rau Puawai support have been over subscribed with over two hundred applications each year. The programme capacity is for 100 students, depending on the numbers of students who graduate each year the average yearly intake is approximately thirty bursars.

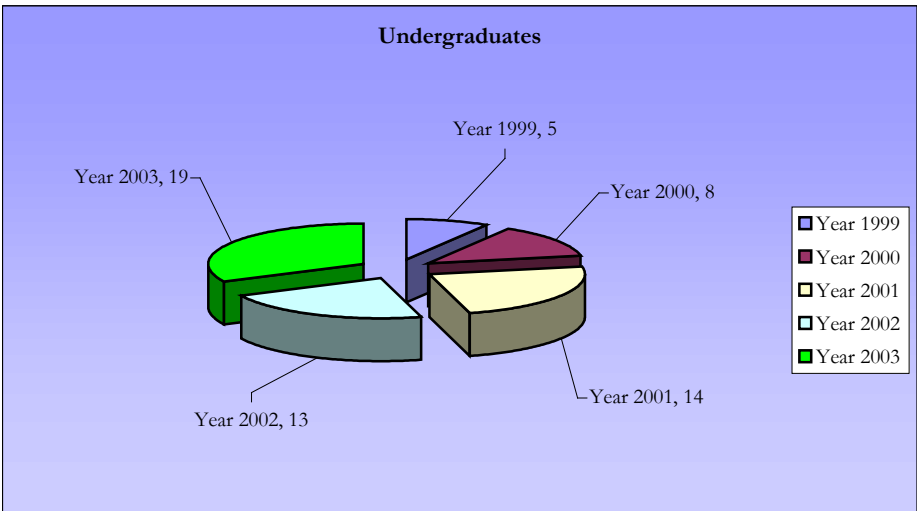


Figure 8.3: Numbers of undergraduates 1999-2003

The following pie-chart highlights the numbers of students completed a postgraduate qualification in the time period 1999-2003. On average the numbers study at a postgraduate level have increased. Current figures showed there are 17 postgraduate students being supported by the programme.

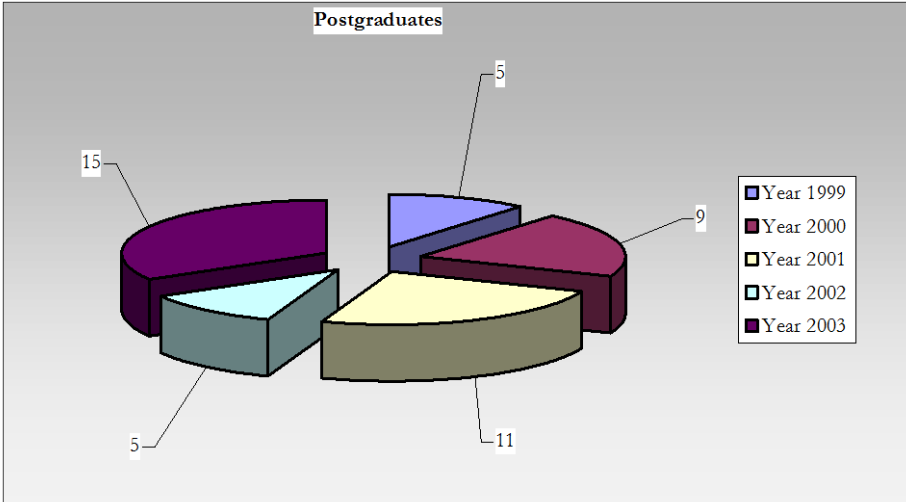


Figure 8.4: Numbers of postgraduates 1999-2003

Pass rates

Te Rau Puawai supported 32 students in 1999, drawn from those that were already enrolled in courses internally at Massey University and at various stages of course completion. Ten of these students graduated. Te Rau Puawai has recorded high pass rate and has maintained high levels of retention through the programme. After the first year the numbers of students graduating has been maintained at between 17-25 per year. There are relatively high pass rates reported by the programme of 84 percent (Nikora et al, 2002)⁹²

Workforce contribution

Te Rau Puawai bursars are drawn from Māori communities from around New Zealand covering over 12 District Health Board regions. The programme exceeded the required target of 100 graduates over a five-year period and has continued to support Māori community health workers to enhance or gain access to qualifications. The majority of students are undertaking postgraduate study but there are bursars who have gained certificates, degrees, diplomas, masters and PhD qualifications. Enhancing and increasing Māori participation in the mental health workforce is a high priority and funded accordingly. Te Rau Puawai uses a whānau model of

⁹² Programme documents and reports and electronic database.

support and incorporates Māori perspectives to support bursars in maintaining a level of cultural expertise and learning that will hold them in good stead for the future. Bursars enter the programme in order to enhance and compliment those skills and 90 percent will return to work in their communities. Training and higher education, measurement and benchmarking are linked to quality aspects required for appropriate service delivery and therefore enhancing the education and skills of community health workers ensures a quality workforce in mental health and likely future health improvements in their communities.

Chapter 9

MĀORI APPROACHES TO WORKFORCE DEVELOPMENT

*Look at things not with the eyes in your face
but with the eyes in your heart⁹³*

Introduction

This chapter opens with a quotation from an indigenous North American Indian medicine man, Leonard Crow Dog. In the context of this thesis the words provide guidance but also act as a reminder that two worldviews have shaped this research programme, a Māori worldview, and an indigenous, Western worldview. Although the two do not always sit comfortably together, a key finding from the research is that when both are present a programme can be considerably enhanced.

While this thesis is philosophically founded on Māori experience and views of the world and attempts to be less concerned with comparative or the re-interpretation of Māori experience through Western eyes, there remains a ‘fine line’ to be walked between the two worlds. ‘Look at things not with the eyes in your face but with the eyes in your heart’ conceptualises this interface.

Chapters six through to eight presented the views and perceptions of the participants from the four case studies. This chapter brings together those perceptions and in an aggregated form and presents an analysis that reflects an indigenous Māori experience that focuses on one level on workforce development and on another level on the significance of ‘being Māori’.

The chapter is largely a discussion of the key themes that have emerged through the research process. Those themes include: Māori concepts of health, Māori leadership, Māori destinations, funding, policy priority, critical mass, concept of whānau, and iwi participation. Woven through the themes are a number of strands: strengths, limitations, similarities, differences, and unique aspects. The chapter closes by examining critical factors that influence successful workforce development

⁹³ A saying by Leonard Crow Dog a fourth generation Sioux medicine man in Crow Dog Four generations of Sioux Medicine Men (Crow Dog and Erdoes, 1995, p. 1).

Research at the interface between worldviews brings with it difficulties that need to be acknowledged. For example, the limited literature relating to Māori workforce development theory and practice required a broader approach and recourse to literature that in many respects was peripheral but also integral to the specific topic. Human resource development literature focuses mainly on the career development of individuals rather than the collective development of a group or a required workforce. Literature relevant to indigenous, minorities and ethnic perspectives was also limited and, made more obviously deficient by career development theorists in Australia and New Zealand who concluded that, because various studies have revealed similarities with the American experience there is no need to replicate or test these theories with other cultures (Smart & Peterson, 1994, as cited in Prideaux & Creed, 2002, p. 23). Western theoretical perspectives were also found to dominate much of the literature relating to training and education, and mentoring and learning support.. Much of the Māori specific literature sourced focused on Māori development in general and health in particular and was valuable in highlighting the concerns relating to workforce development and in confirming or otherwise the views of the participants in this research programme. Government concerns in relation to workforce development generally including the Māori workforce was clearly evident in reports, policies and planning, strategies and funding of specific programmes, and added weight to Māori participant viewpoints.

Emerging themes

Māori concepts of health

Māori workforce development in health is premised on Māori perspectives and understandings of health and wellness, that emphasise customary values and belief systems alongside influences of social and cultural factors. Importantly, broader holistic views of health are expressed in ways that reflect Māori understandings and make sense to Māori, combining elements of both health and social order. Most often they are articulated figuratively, to illustrate that concepts of health include collective aspirations (Durie, 1982, 1984; Henare, 1988; Murchie, 1984; Ngata and Dyll, 1984; Pere, 1984). Accordingly, the application of Māori models and perspectives of health have become an integral component in health service delivery and for the achievement of the Ministry of Health's Māori Strategy - *Whānau Ora* (Ministry of Health Manatū Hauora, 2002).

While there are others, a commonly used model of health that incorporates a Māori perspective is Te Whare Tapa Wha. Described metaphorically as, 'the four sides of a house' it frames Māori

concepts of whānau (family health), tinana (physical health), hinengaro (mental health), and wairua (spiritual health). When all sides of the ‘house’ are in harmony it is likely that good health has been achieved. Reconfiguring health in this way takes the emphasis off disease and illness (a medical model) and focuses on health and wellness in a way that not only makes sense to Māori but is in accordance with Māori aspirations to take ownership of their own health, participate in health, and have a leadership role in health (Durie, 1984, 2005, p. 10).

A commonality shared by case study participant organisations, programmes and individuals was the application of Māori concepts, perspectives and models of health in varied and unique ways. Exemplars include the use of Te Whare Tapa Whā as a practical monitoring framework for client/whānau case management and monitoring, organisational definition, programme implementation, training and education, cultural safety mechanisms, and community development. Apart from its value as a clinical tool, Te Whare Tapa Whā has obvious application in a range of areas

Evidence of such versatility can be found in other chapters in this thesis. Most notable are the extensions of these perspectives and models in Māori immersion education, the development of contemporary Māori organisations and associations, provider development, and iwi/Māori planning cycles (eg. generational). Furthermore, the inclusion of Māori perspectives in legislation and policy development attests to a general acceptance of Māori views albeit from a different standpoint. The ‘models of care’ approach for instance advocates an intersectoral approach but remains ‘person centred’ (Health Workforce Advisory Committee, 2002), and whānau conferences have become a feature of the work of social workers working with families but is only applied when ‘deficits’ of family functioning warrant rather than as a vehicle for prevention (Pou, 1998, cited in Waitangi Tribunal Report, 414, 1998).

While some participants in this research programme focused on specific aspects of Te Whare Tapa Whā, mental health, whānau health, or physical health for example, all sides of the ‘house’ were required and apparent in practice in order to achieve predetermined goals. However, a challenge for participants was the incorporation of these frameworks within contractual expectations and institutional settings that were primarily based on western constructs and practices. On one hand encouraged to operate in a Māori context but on the other required to satisfy accountability measures based on Western paradigms created conceptual confusion and often made for difficult working relationships. Working ‘inside but outside’ was common and

required dual competencies with a capacity to 'be Māori' but also to operate within a wider cultural and social arena.

Māori leadership potential

Underlying Māori workforce development are the principles of re-generation and generation of leadership potential. Because each of the cases illustrate mechanisms for developing leaders who are culturally literate and clinically competent across a broad range of health disciplines and services, Māori health workers will often be seen as leaders at local, national, and even international levels. It is therefore important to determine whether the initiatives described in this research provide adequate leadership training for the wider role. Quite apart from the 'task oriented' training and specialised education programmes, future leadership roles in Māori communities also need to be recognisable.

A central theme that emerged from the research programme was the determination of individuals and collectives to navigate a course for the Māori workforce, that would ensure safe passage through an often alienating and changing environment. For various reasons this did not appear to be always possible. In some situations strategies were pointed, that is, they selected and recruited from within Māori whānau, hapū, iwi and Māori communities. By doing so it was envisaged that existing Māori cultural support systems could be utilised and tribal imperatives maintained. Consequently, enabling Māori communities to contribute to building health workforce capacity, especially a health workforce that would be highly educated, well trained, and culturally attuned to Māori understandings and perspectives, gave a greater sense of relevance and congruence.

Drawing from Māori communities to improve the health of Māori is not a new strategy. It will be recalled that in chapter one there was a focus on the work of Maui Pomare, Te Rangihiroa, tribal leaders and their efforts to combat infectious disease and Māori decline. Combined with the later developments of the Womens Health League and the Māori Womens Welfare League, Māori leadership and participation in health is not without substantial historic contribution.

However, participants pointed out that all too often there was a lack of Māori workforce participation and development in specific areas. Accordingly, the absence of meaningful Māori representation in some occupations was unsettling given a national commitment to increase the Māori health workforce across the sector is a priority. Ironically, while the criticism was directed

at the constraints imposed by Government agencies, current leaders in Māori health were challenged for their despondency. It was suggested that Māori leaders should be doing more to push those in power to effect change.

Drawing on recommendations from the Hui Taumata 1984 participants in this research were particularly clear about what workforce development meant for the health sector. A continued and increased investment in education, training, prevention and development, that is 'positive funding' rather than a focus on 'deficit models' of illness and disease, under-achievement, that is 'negative spending'. However, rather than a focus on iwi development as in 1984 participants at the 2005 Hui Taumata felt the focus should be on whānau development because the methods relevant to iwi development were not always the same as those that would advance whānau (Hui Taumata, 2005).

An important aspect of Māori leadership according to participants was building strategic relationships and alliances, networks with other Māori and non-Māori individuals, groups, and organisation, illustrated by their representation on ministerial advisory boards, local councils, rūnanga, trust boards, and their willingness to transfer and share these with the workforce and others.

Māori workforce destinations

At one level Māori workforce development in health is concerned with individuals because it is individuals who undertake training, education and career development with assistance from various workforce development programmes, or initiatives within a health service. Individuals could be seen as the sole beneficiaries of workforce development programmes, and in many respects, they are. Trainees and students stand to benefit from up-skilling, improved work opportunities, increased income, career advancement, higher learning, health leadership and vocational choice. However, individuals within each of the case studies presented had a common goal - to work in health and specifically in Māori health. In other words apart from the private good acquired through training, there is also a public good which results from the work that health workers do among their own, and other communities. To a greater or lesser extent the individuals interviewed in the research were mindful of the public good and were often motivated by the prospect of giving effect to Māori aspirations.

Three of the case studies focused on training and educating a workforce to work in specialised areas of health. In one case study, gaining qualifications was not a primary objective but regular

training, up-skilling and education, cultural knowledge and language, experience, life skills, standing in the Māori community, and whakapapa affiliations and networks were important. Consequently for this group career advancement and vocational choice outside their own immediate communities may be limited and restrict opportunities to work in a wider Māori context despite the high quality and comprehensive training programme. Portability was limited by the focus on a particular programme and the decision not to issue a qualification that could be recognised in other situations. Furthermore, given New Zealand's volatile economic and political environment emphasized in earlier chapters, and Māori susceptibility to economy fluctuations it is likely that this group will be less employable without nationally recognised qualifications. Under the current climate however, the contribution this organisation makes to tribal development and therefore overall Māori development is significant. Workforce training, even for this group, should enable people to move around, across or to higher levels within the organisation or to similar occupations outside the organisation albeit in New Zealand or overseas.

Simultaneous specialised training and acquisition of higher qualifications was a major focus of the other case studies sometimes at the expense of Māori cultural perspectives. Gross under-representation of Māori in the mental health and the medical workforce prompted high prioritisation for workforce development in both areas. Distinctive destinations for the trainee workforce were defined at the outset.

Because one of the case studies drew from a pool of Māori community workers there was an assumption that Māori cultural experience and knowledge could be taken as 'given' and emphasis was therefore placed on higher education and clinical training, with access to formal qualifications. Career advancement in relation to moving within and to higher levels within an organisation or occupation was evident as a motivating force. However, the focus on mental health, and the commitment to mental health may have reduced the ability to move across the health sector with implications for long-term vocational flexibility. For example, given, global 'contraction' and easier access to the world, there are implications about the fairness of committing recruits, especially school leavers to a lifetime in mental health. Furthermore, a qualification in mental health may restrict graduates from gaining experience in a global context. Are the qualifications sufficiently portable and versatile to enable global interaction?

There are two factors which will both limit and extend application to global areas. First specialist knowledge is often not applicable in a broader context. For example, a qualification in alcohol and drug addiction may not have ready applicability to the management of first-time psychosis.

Second, however, a qualification that endorses Māori world views and Māori methods of practice, may find applicability with other indigenous people and communities elsewhere in the world. In that respect a focus on Māori mental health will not by itself necessarily equip workers for practice in the health sector generally but will enable workers in a wide range of occupations, to understand the indigenous situation.

A generic approach to training provides more opportunities to move in and out of the health sector locally, nationally and internationally with more vocational choices available and a wide range of clinical skills. But training and education alone is unlikely to adequately equip individuals to work in Māori communities unless it is accompanied by deliberate preparation to gain cultural expertise and experience within Māori communities.

While cultural support is provided at the 'periphery' in terms of pastoral care, and its importance acknowledged generally, it may not be enough. Chapter five signalled that Māori communities and Māori medical practitioners for example would prefer a greater intertwining of Māori perspectives in the clinical training and education of health professionals. Nevertheless gauged from the current level of 'whānau' support it is expected that Māori health professionals should not only be professionally competent, but should also be culturally attuned to Māori, their communities and their aspirations. Not all cases had clear work destinations but the potential for increased Māori participation was evident and considered by some to be urgent.

When viewed from an occupational, scientific, or a government controlled perspective aspects of 'Māoriness' are not always apparent when looking 'through the eyes in your face', and in one case study low Māori participation was seen as problematic. . When there are no links to 'Māoriness', 'being Māori', the 'Māori situation' or the 'Māori experience', the lack of obvious relevance will not lead to favourable consideration as a career option even though there may be real (but masked) relevance. The relevance of Māori perspectives are confirmed when optimal outcomes and gains in Māori health occur. Māori perspectives, values and beliefs are taken as 'given' and understood. For example a culturally competent Māori health workforce is likely to lead to health gains for Māori (Health Workforce Advisory Committee, 2002), or a Māori health service that focuses on health and wellness.

Funding

A prerequisite for Māori workforce development in health is adequate and continued financial resourcing. Clinical training and education is generally expensive compared with many other disciplines. In addition the required length of time in training and education increases the costs of supporting workforce development. Nonetheless, commitment to increasing the Māori health workforce across the sector is a national priority and coincides with Government objectives for improved Māori health outcomes. Furthermore, there are specific government objectives and national strategies for Māori mental health workforce development.

Funding for Māori health workforce development initiatives studied in this research programme came from a variety of sources. But in the main funding was sourced from the Māori Provider Development Scheme, and vote health and education. Funding allocations varied from very large to quite small amounts. The smaller amounts in some instances were defined in employment contracts for staff and career development.

The individual amounts of funding for each of the case studies are discussed in other chapters. For example, mental health funding allocations are outlined in chapter five, health professional workforce development funding in chapter six and funding for Māori community health development in chapter seven. These allocations range from an average of \$2.5m to \$10,000 per annum with one programme's funding increasing to \$11.3m per year from 2005 onwards. Māori mental health workforce development overall, received close to \$7m for the period 2004-2006/07 (Inglis, 2005).

Generally, participants agreed that funding was an ongoing dilemma. For example, a three-year contracting cycle for two of the cases was problematic because it did not allow for long term future planning. The dire shortages in the workforce for some cases means an urgent need for long term planning to meet the objectives of increased Māori participation in health workforce across the sector. Planning impacted on the ability to recruit and retain a high quality and skilled workforce. Furthermore, the funding contracting cycle had implications on case study clients (trainees and students) who were reluctant to commit to long-term training and education if support was not assured. In some instances education and training were part time, which extended the timeframe to gain a qualification and therefore the continued reliance on adequate support past three years.

Māori health providers as referred to in Chapter five, are generally contracted to provide services to Māori based on addressing health needs within a Māori cultural context. The funding and contracting environment is not always receptive to Māori perspectives (Te Puni Kōkiri, 2002). Funding regimes were sometimes seen as limiting and the options available to a community workforce consequently restricted the training and education opportunities. In one instance an amount of \$10,000 per year could only be used for job-focused workforce training. In reality this was not enough to encourage further training or education in other areas of health. For example, funding allocated to a specific region had been shared among five Māori health providers. A further arrangement was made to share training sessions, that is, to sit in on other provider training sessions and vice versa. Otherwise, there would not have been adequate training for workers. Sometimes individual career development training was negotiated if funding allowed.

Funding was identified as being restrictive and presented many challenges for three of the programmes in this research. Cut backs, or shortfalls impact on the people for whom the training and education is provided but also has implications for the providers. The main concerns centred around the ability to attract and retain good quality staff, pay them well, and train and upskill. The apparent inability of funding agencies to appropriately provide for Māori perspectives within contracts for services was clearly a problem. Contracts specifically asked providers to be culturally responsive but this was not reflected in contracts. Workforce development funding is important because quality and best practice is linked to training and education. When providers are unable to provide education, training and up-skilling for their workers it affects the ability of the provider to maintain a service, existing staff are unable to up-skill or participate in training and consequently reduces the quality of the staff, reducing skill levels and expertise within the organisation.

Policy priority

Māori workforce development in health is largely governed by government policy and is reflected in and given direction from the overall government objective to improve Māori health. Government policies stem from both the The New Zealand Health Strategy and the New Zealand Disability Strategy providing a manifesto for Māori health that is articulated in He Korowai Oranga. Emanating from these documents are Whakatātaka the Māori Health Action Plan, Raranga Tupuake – The Māori Health Workforce Development Plan 2006 and further

service specific Māori workforce plans within the sector Mental health workforce development is also set within this broader context and is further guided by the Blueprint for Mental Health Service in New Zealand and Kia Puawai te Ararau: National Māori Mental Health Workforce Development Strategic Plan 2006-2010.

Participant perceptions of policy relating to workforce development were mixed. They agreed that on the outside policies designed to increase the number of Māori in the health and disability workforce were appropriate given the under-representation of Māori in the health workforce (Health Workforce Advisory Committee, 2002). But how that was being done was a concern for some. For instance, how was the funding being allocated and who gets what, and why some and not others, were questions that suggested policies were divisive.

Being 'high priority' or 'targeted' was an advantage because it was not necessary to justify the need for funding, thereby taking pressure off competing for it. Meanwhile, reinforcement from strong professional associations to increase numbers was crucial for others. These institutions were seen by funders, to be able to give adequate assurance that outputs would be met with guaranteed funding. Therefore infra-structural aspects were considered sound and costs justified. Many were relieved that the government was making a strong commitment to improving health for Māori by investing in workforce development because if left to professional bodies there would not likely be any Māori workforce development.

However, in some instances concerns were raised that the policies amounted to lip service due to inadequate resources. It was recognised that if there was no policy there would be no funding for workforce development. Participants noted that workforce development strategies for some sectors of health were not applied with the same urgency to others. Some wondered at just how many policies, strategies and plans would it take to get some movement in their specific area of health. Suggesting that valuable resources, that could be allocated to these areas, were being spent unwisely.

Expanding the skill base of the Māori health and disability workforce was identified as critical, by participants however, there were concerns about the competition for what seemed to be a dwindling pool of resources. Even providers who had proved their worth in terms of demonstrated health gains were required to compete for workforce development funding, suggesting that Government policies encouraged short-term approaches. Therefore while the

objectives of policies may have intended good outcomes there were underlying issues of unfairness and injustices that the infrastructure and finances to support an outcomes approach was inadequate and prevented achievement of those outcomes. Participants found that training opportunities for the workforce would remain stressed until the perceived inequities were resolved. There was general agreement that Government policies and funding are dependent on each other.

Critical mass

Māori workforce development in health requires critical mass, that is, larger numbers of Māori people working together so that benchmarking (best practice and experience), peer support, shared information and mutual learning can occur. Building critical mass was an overarching aim of all case studies. Each case study had a different approach to building potential capacity in their respective fields and targeted different areas of the health sector but each was driven by a common goal – improved health outcomes for Māori through increasing Māori health workforce participation.

Building critical mass was also influenced by targeting policies to areas of specific need. The purpose of two case studies was to accelerate the development of a specific workforce. As such, one programme focused on increasing the numbers of medical practitioners by 500, and 500 other health professionals by 2020. This was considered crucial for Māori health workforce development so that professional development could be enhanced and a more representative workforce established.

Māori community health workers are considered to be an essential component of the Māori health workforce but often their work is not recognised nor acknowledged in many ways. Nonetheless their work alongside of health professionals facilitating access into Māori communities and providing cultural support has added value to Māori health development overall. One case study focused on recruiting Māori community health workers to undertake academic study in a mental health related qualification. By 2006, 146 Māori community workers had gained qualifications in 33 disciplinary areas, ranging from certificate to doctorate level. Furthermore, the programme contributed to building research capacity in Māori health, effectively expanding and enhancing the academic and skill base of the Māori mental health workforce.

Funding for some of the case studies was a constraining factor especially in training and educating the workforce. Responding to these constraints were varied but some participants indicated that sharing of resources helped to utilise and retain critical mass but also restricted ability to effectively build capacity to a significant degree. A notable aspect of the case studies was the incorporation of Māori perspectives in workforce development training and education even when resourcing was not favourable. Participants felt Māori perspectives were core to training and education and should be resourced accordingly. For some participants this indicated that 'being a Māori' organisation was perceived as an, 'attracting' feature of the service. A Māori whānau organisation, working with whānau, hapū and iwi was what appealed most to some workers, suggesting that working within a whānau was what kept them in the workforce.

Unfortunately, the low numbers, no priority, and no specific target in one case study, identified a foreseeable need to build capacity given imminent global change. Generally, participants agreed that the benefits of having an increased or enhanced workforce would add to improved health overall, suggesting that it would increase representation and opportunities to participate in decision-making, planning and policy development across the sector providing stronger and well informed Māori advocates and leadership in health.

While recruitment and retention of a Māori health workforce is important in sustaining gains in health but all of the participants indicated that the same value and importance should also be placed on ensuring cultural perspectives and Māori community input were present as that would enhance workforce development in health and attract more Māori into the health arena. Furthermore, all participants identified that critical mass is about the availability of a substantial pool of Māori health workers and that a concerted effort must be made in communities and within professional groupings to achieve this.

Whānau concept

Based on the biological definition of whānau described in chapter three a whānau model provided the framework that guided interaction and relationships both within organisations and programmes, and between individuals, and was a common characteristic shared by contributors to this research programme. Generally participants highlighted the positive aspects of the whānau model although noting the difficulties of applying a 'Māori' concept within Western confines.

For example, application of the whānau framework within higher education settings took various forms and facilitated Māori culturally affirming perspectives and practices into institutions perceived to be cold, alien, unwelcoming and unfriendly by Māori/iwi communities. However, given that the case study programmes were designed for specific populations the use of the whānau model or perhaps the way it was applied may also have had other effects on other Māori within those settings who were not clients. Documentation revealed practices such as collecting pass rate data of students in the programme and comparing them with the pass rates of other Māori students. A positive aspect of this from one viewpoint was that this type of information would allow the assessment of programme success, but in effect could defeat the purpose of using a whānau model of support because the support was not available to all students. In this sense the whānau model of support would not only be exclusionary but compliant in supporting a 'deficit' and conventional form of measurement.

Wider whānau, hapū, iwi and communities were encouraged to participate in a knowledge sharing and exchange process where cultural knowledge and experience complemented the acquisition of academic qualifications. For some students though the cultural aspects of the programme were more overwhelming. Sometimes, access to the University was the only support they required. Furthermore, whānau as a concept extends beyond the parameters of just 'family' responsibilities and encompasses responsibilities and obligations to reciprocate or give back to Māori communities in ways that are value-added. In some instances however, this unwittingly added pressure to an already stressed whānau or placed pressure on students to participate when they would rather not. Nonetheless, the programme results showed that pass rates were much higher than average and retention rates were similarly high.

In other situations whānau obligations extended to employing other whānau members who did not have the skills or qualifications. This was preferred because it offered the opportunity to train the worker to work in the way the organisation wanted. The downfall though was the extra effort required to train individuals who were too close (whānau) and risk meeting contractual requirements or expecting workers to perform in areas where they have no expertise. The focus on whānau, hapū, and iwi employment in some instances was too accommodating, on the other hand it also offered opportunities to exploit whānau employees in various ways. A reliance on employing whānau brought with it other problems imposed from outside the organisation, and

unwarranted publicity. Western views for example, of employing whānau (nepotism) have a negative connotation.

Sometimes the expectations of whānau employees and the organisation were unrealistic in relation to the job. Both tended to accommodate each other at times. Similarly, whānau employees tended to over accommodate whānau clients. Māori providers tend to work outside their negotiated contracts to try and meet the needs of their client whānau. Sometimes client whānau had unreasonable expectations of workers. The result was that workers became overburdened with client whānau problems and had limited avenues of professional support. The whānau worker's impressions of what their obligations and responsibilities were often blurred. Preferring to ignore service contract obligations (ensuring outputs are documented) because the whānau worker, saw the paperwork as an interference in their work with whānau clients.

Having whānau, hapū and iwi connections was identified as an advantage in two ways. First it gave organisations' better access to Māori communities but also made it possible for other colleagues to avoid working in Māori communities, because there was a 'Māori' person on staff to handle and advise on Māori issues, speak on behalf of the organisation when required, and work in communities other colleagues preferred not to. Most often these cultural attributes were not valued by the organisation, not well supported, not remunerated nor on some occasions respected. Second, initiatives and work of the health protection officer was supported by whānau and hapū and provided individual guidance. This support was sometimes felt to be more useful and more positive than support from the organisation itself – setting in place room for potential conflict.

As a mode of workplace practice the whānau model was used quite substantially. A Māori view of health is holistic and broad, and acknowledged models of health include whānau as an essential element. Since the case studies were all health related it may have influenced the choice of using whānau as a practice model. Other models used by organisations, programmes and individuals were also inclusive of whānau. Whānau as the basic unit of customary Māori social organisation is fundamental for Māori advancement.

However, there are other models that may be worth investigating in terms of a support in practice model. One such model that could be adapted to a New Zealand / Māori situation is the Grantham Model described in chapter four of this thesis. The model is a workforce and

career development, planning tool, most commonly used in the training and education of the health professionals by hospitals and other organisations in the United Kingdom. The model is based on the supply and demand principles found in economics, it does not account for disparity, culture or ethnicity but could be broadened to include the culturally diverse inputs required for a Māori workforce.

Iwi participation

Māori workforce development in health requires active iwi participation at different levels. Iwi as an extension of whānau has ability to influence whānau participation in health activities. Some participants gained iwi participation in their initiatives by requesting iwi endorsement because it sent a clear 'signal' to Māori communities and other 'key stakeholders' the accountability arrangements they wished to establish for their organisation. It is a reciprocal relationship in that the organisation will be responsible back to iwi and stakeholders in return (Te Puni Kōkiri, 2002, p.44).

Case study participants agreed that gaining iwi mandate or endorsement was not only a way of gaining support for initiatives but to engage iwi participation for various reasons. Some organisations actively sought formal engagement with iwi others preferred an informal arrangement. For some of the participants it meant acknowledgment of tangata whenua as mana whenua. Evidence that a precedent had been set earlier meant there was obligation to follow through with this process to establish 'along tribal lines (Meha, 1995; Lange, 1999). Depending on the iwi involved there are specific kawa and tikanga that need to be followed and often there is an expectation to be involved in any initiative that involves whānau from their own iwi.

Participants generally demonstrated both a commitment to endorse tribal imperatives at all levels from having iwi representation at governance level, management, administration, through to workers. Iwi participation involved the nomination, selection and recruitment of workers. In some ways it represented control and responsibility for the organisation but in others it ensured hapū and whānau participation.

Because iwi are an extension of whānau and the case studies were operating or wanted to operate under a whānau model, recruiting trainees and workforce from whānau was an effective way of getting whānau involved in health workforce development or health services provision. One

participant noted that recruitment levels had increased since iwi groups had been involved in the programme. They are important because they provide the type of support that Western institutions are unable and they are invaluable for their networks to other constituents.

For some organisations iwi participation was a requirement in recognition of the Treaty of Waitangi and the partnership role this advocates with the state. Sometimes this role provided support for individuals in their work roles. But there is also an element of risk because in some regions tribal boundaries often conflict with boundaries set by regional councils. Consequently contributing to potential situations of inter-iwi conflict when boundaries extend and encroach on tribal notions of appropriate delineation. Boundary conflicts were considered to be a deterrent for Māori community involvement in environmental health because responsibilities, and obligations may be confused.

Consultation hui with iwi were held, for one case study to gauge support for the programmes and to build ongoing future relationships with the intent to encourage iwi to endorse, and support their own students. Since the programme now has a national spread, relationships with iwi have been extended to include other regions with high Māori populations. Iwi nomination and financial support of students was an indication of iwi endorsement and considered to be essential for both trainees and the programme. Local iwi and kaumātua are also involved with the programmes to provide cultural guidance and support which helps with student and worker retention.

Contribution to health

Contribution of Māori workforce development to health can be measured by outcomes and the attainment of goals. Measuring the impact or the contribution of each programme to Māori health development proved challenging. For instance, the ability to measure the impact of the Vision 20/20 programme on Māori health development is difficult because the results will not be apparent for some time in the future. That there will be more Māori doctors is likely but given increasing Māori population projections will the increase in the numbers of doctors be a proportional reflection of the population and will it make a difference? Indications are that it will and in many ways.

Similarly, with Te Rau Puawai, students are mainly drawn from the Māori community health sector and 90 percent of graduates continue to work in the sector. In terms of increased numbers this reflects little change, however the intention of the programme was to increase the number of Māori health workers with relevant academic qualifications and this is easily measured. The implications are that earlier diagnosis will eventuate and therefore prevention of problems in the long term more likely. Measuring the expected health gains attributable to Māori with professional qualifications, may prove more difficult for many reasons.

Of concern for health protection, is the low number of Māori working in the field. This was surprising given Māori affinity with the natural environment and the historical connections between Māori and their environments, situations, skills, knowledge and experiences. In addition to a documented history of participation, a time when strong Māori community leadership and the incorporation of Māori cultural values, perspectives and practices in environmental and health protection played a significant role in reversing Māori decline.

Tipu Ora's refusal to accept the 'deficit model'⁹⁴ bio-medical model as the underlying basis of a health service, provided the impetus for 'job specific' training of their unique workforce. The organisation, its environment and how it develops and sustains workforce participation, by adhering to Māori tribal concerns and concepts was insightful. The contribution made to Māori community and tribal health in Te Arawa has been substantial. For example, recorded and sustained reductions in sudden infant death syndrome (SIDS), and rates of smoking among pregnant Māori women, and an increase in the uptake of immunisation (Department of Health, 1992, 1993; Ratima, 2001)

Conventional measures and perspectives, while useful cannot fully explain or gauge the need for distinct and effective Māori approaches because of divergent fundamental principles and differing expectations. Māori expectations and aspirations are predisposed towards unleashing suppressed potential and innovativeness whereas conventional ideology assumes a universal 'one size fits all'⁹⁵ mode of measurement that limits and controls aspirations, and outputs rather than potential

⁹⁴ Participant, TO/606 described the deficit model as that which is focused on illness and sickness rather than health and wellness.

⁹⁵ Participant, HP in Chapter six of this thesis.

outcomes govern expectations. Therefore measuring effectiveness of Māori approaches requires measures that are culturally relevant, make sense, and are achievable.

Critical success factors

Targeted strategies

Māori workforce participation in health is under-represented across the health sector and requires remedial attention. Māori views of health are broad and therefore Māori workforce development and workforce potential initiatives should be seen as an extension of this broader view. Increasing the numbers of Māori in the current and future health workforce will ensure that Māori health gains and improvements can be sustained. Targeted strategies of accelerated workforce development in specific health areas have been applied and found to be successful. Utilising the same strategies in other areas of Māori health is needed to maintain momentum.

Critical mass

Increasing Māori workforce participation in health ensures future generations of Māori whānau will be healthier, better informed, better educated and stronger advocates for good health. Māori whānau, hapū, and iwi and Māori communities have a major role in achieving increased levels of Māori participation and sustaining that achievement. Building critical mass is an essential component to overall health and wellness because it builds leadership in health but also has flow on effects. Future capacity and capabilities will in turn be responsive to Māori whānau, hapū, iwi, and Māori community needs. Recruitment and retention forms part of building workforce capability in Māori health but the same value and importance should be placed on ensuring cultural perspectives and Māori community input are present to enhance workforce development in health and attract more Māori into health. Critical mass is about the ability to deliver effective services to Māori and is therefore a major determinant of success.

Committed funding

Adequately resourced initiatives and programmes were found to be essential for continued and sustained Māori workforce development. Specialised training and education in health is expensive, and there is a time component attached to higher education and training. Funding of Māori community providers of health services for workforce development initiatives will need better resourcing if national priorities are to be attained. Funding and policy are inextricably

linked and initiatives that are not part of the prioritisation schedule require adequate funding to continue.

Autonomy

Increased workforce participation in health will generate and regenerate many proponents of health and contribute to Māori leadership growth and potential across sectors and at higher levels. Autonomy is about ‘being Māori’, ensuring Māori cultural perspectives are included in workforce development initiatives in health, whilst maintaining Māori identity through whānau, hapū, iwi, and Māori communities. The ability to work in a dual environment will ensure full and equal participation in governance and administration of Māori health. Expanding Māori participation in the workforce will produce people that are culturally attuned to Māori perspectives and tribal aspirations for autonomy. These people will be more able to work in a Māori environment but also participate in a global context – as Māori.

Setting a course for Māori workforce potential

The diversity within which Māori reside is reflected throughout this thesis and inherent in the choice of case studies by which this research programme has been informed. The four case studies represent different approaches and four broad strategies that have been taken in response to Māori workforce need and overall national policy priorities and directions for Māori health development. These are summarised in Table 9.1:

Table 9.1: Case summary

| Strategies | Approach | Priorities |
|------------------------------|---|---|
| Community Development | Tipu Ora | Māori provider/whānau |
| Specialist health workforce | Environmental and health protection | Workforce inclusion and extension |
| Māori mental health | Te Rau Puawai | Māori mental health – workforce enhancement |
| Māori professional workforce | Māori professional workforce – Vision 20/20 | Increased workforce |

Eight themes emerged from the research: Māori concepts of health, Māori leadership potential, Māori workforce destinations, policy priority, whānau concept, iwi participation, critical mass,

and funding. From the themes four factors were found to be critical to the success or other wise of the case studies. These were: targeted strategies, critical mass, committed funding, and autonomy.

Each of the themes and the critical success factors are also encapsulated in national goals, priorities, policies and directions for health workforce development as defined in the New Zealand Health Strategy, outlined in He Korowai Oranga, and actioned in Raranga Tupuake. These are also inextricably linked to overall Māori development and advancement goals: access and participation, cultural identity, outcomes, and planning. The following table is a visual representation of these relationships.

Table 9.2: A charter for Māori health workforce development

| | Goals, priorities, policies and directions : New Zealand Health Strategy, He Korowai Oranga | | | |
|---------------------|---|--------------------------------|-----------------------|-----------------------|
| Critical Success | Participation and Access | Cultural factors 'being Māori' | Outcomes and measures | Generational planning |
| Targeted strategies | | | | |
| Critical Mass | | | | |
| Committed funding | | | | |
| Autonomy | | | | |

Along the first horizontal platform are national goals, priorities, and directions that guide and sustain Māori health workforce development. The second horizontal platform identifies the Māori development and advancement goals and critical success on the same platform, critical success, sits at the interface between factors that influence success: targeted strategies, critical mass, committed funding, and the goals priorities, policies and directions. The critical success factors are not in any specific order, because they are interconnected and interactive.

To explain, using Te Rau Puawai as an example, mental health generally and Māori mental health specifically are high need, high priority areas. Moving from left to right of the platform:

- Targeted strategies to meet and enable Māori mental health workforce development needs by facilitating access to higher education that enhances workforce participation. Utilises a whānau model of practice to maintain cultural identity. Monitors and measures progress (pass rates of papers). Course planning in mental health related disciplines to meet sector goals

- Critical mass, building capacity, bursars access and participate as a group. Whānau and iwi, involvement, to ensure Māori perspectives are included. Progress of group monitored and measured, assessment. Planning for new intakes of bursars.
- Committed funding facilitates access and participation through bursaries. Funding of hui and whānau support staff and travel. Budget control and financial accountability. Financial, staffing and operational planning.
- Autonomy is equal access to and participation in sector workforce. Individual and collective choice as Māori to identify as Māori. Ability to gauge progress of both competencies & outcomes and measures that are sensible and achievable. Participate in future planning, decision-making, governance roles and leadership planning.

Table 9.3: Māori workforce responses

| | Goals, Priorities and Directions | | | |
|--------------------------|--|--|--|--|
| | Participation and Access | Cultural factors 'being Māori' | Outcomes and measures | Generational planning |
| Tipu Ora | Community development limited provider development | Whānau, hapū, iwi Health providers Communities Governance | Reduced SIDS Reduced smoking, immunisation uptake | Limited planning for staff training, limited workforce funding |
| Vision 20/20 | Increase health professional clinical training and education | Whānau model consultation with Māori communities | 500 doctors and 500 other health professionals | Longterm planning required and committed funding |
| Te Rau Puawai | Enhanced workforce Access to higher education | Whānau model Māori community Iwi and hapū | 148 graduates over 7 years, budgeting, monitoring | High priority longterm planning need, targeted funding |
| Health Protection | Minimal participation, no perceived access | Individual whānau, hapū, iwi | Low numbers, recruitment and retention issues | Long term training, potential need - climate changes, potential to participate |

The model is flexible and fluid allows the application of each critical success factor to gauge progress and plan for change. A tool, that can be integrated to fit, workforce strategic planning and accommodate other models. It draws from Māori developmental advancement goals and the Māori frameworks described in chapter 3, that have been applied in other sectors- the Tri-Axial Framework, Te Whare Tapa Wha, and Te Ngāhuru – Māori Outcomes Schema. This model supports the formulation of the conclusions to this research. In this respect the model is future oriented and has much wider applicability.

Chapter 10

CONCLUSIONS

*Kobiakobia ngā maramara o Mātaatua*⁹⁶

This research articulates and generates themes that contribute to understanding Māori workforce development and future potential, and contributes to an expanding platform of knowledge to guide further advances. It should be seen as a beginning, a small part of the conversation, initiating debate, exchange, and critique.

*Kia Taupunga*⁹⁷ *te Ngākau Māori* - anchoring Māori health workforce potential, draws on perspectives and viewpoints that emphasize Māori worldviews and knowledge, views that imply an interconnectedness between the natural world and human experience; a tracery of rich heritage, tradition, and transformation that has endured the navigation for a thousand years or more. The imagery of Kōriporipo for example, uses metaphor that invokes a connection of the natural world to humankind and in this thesis to Māori, their life experiences, situations, knowledge systems, political systems, diversity, and their cultural perspectives. Māori workforce development occurs within the context that is essentially modern but recognises a worldview that is distinctly ancient. Māori live in both domains and a workforce that can address Māori needs must be similarly attuned to both spheres.

The development of a Māori workforce in health is new in one sense but old in another. Māori customary approaches to health care drew on the laws of tapu (unsafe), noa (safe) and rahui (protective bans), put into effect by tohunga to guide community health practices. European arrival and subsequent colonisation struck at the foundations of Māori social order, destabilising and subverting established health, knowledge, economic, and social systems. However, remnants of these systems and institutions have endured to influence Māori adaptation, progress, participation and access, and potential, within a new order that has often been in opposition.

⁹⁶ 'Let the chips of Mātaatua be gathered together'. When the chiefs of Ngāti Awa wished all their people to meet, this expression was heard. In Mead & Grove 2001:1390 p. 228. An acknowledgement to whānau and hapū of Ngāti Awa.

⁹⁷ Taupunga is the name of the wharenui at Waimarama marae, it is named after the rock that anchored the waka, Takitimu when it stopped to rest, on its voyage to Te Waipounamu (South Island)

Māori health and other Māori development frameworks, models, plans and structures are useful in theory development, demonstrating and guiding practical application, identifying appropriate outcomes and measures, and determining workforce participation. They are flexible and adaptive reflecting change and progress over time, and anticipate new opportunities. Further, many have been well tested. Te Whare Tapa Whā, for example, and 'Whānau' have been subjected to a series of validation tests in relationship to specific areas of practice. It is likely that they will be useful as Māori seek to extend their participation in a rapidly changing global environment. This thesis employed an emerging methodological construct, Kōriporipo, which was based on metaphor and operationalised during the research.

Essentially, this research set out to identify the determinants of quality health workforce development. Although the focus was on the health workforce it was found that there are wider implications aligning with broader Māori societal goals and these need to be taken into account when developing a Māori workforce. Underpinning Māori workforce development are the aspirations of Māori as individuals and collectives to actively participate in all levels of society across a range of endeavours.

Six broad conclusions can be identified:

- workforce development can provide endorsement for Māori cultural perspectives and aspirations to sustain a Māori identity
- a well prepared Māori workforce is one that has appropriate academic, professional, and technical qualifications and is well attuned to Māori cultural norms
- targeted Government policies and programmes are important for building a critical mass of Māori in particular vocational categories
- effective Māori leadership is an important prerequisite for workforce capability building
- adequate and targeted resourcing is necessary to ensure growth and sustainability
- while the Māori workforce is largely sectoral (e.g. health, education, law, communication) there is an overlap of sectors with implications for a co-ordinated approach to workforce planning.

These broad conclusions can be incorporated into a Charter for workforce development, a tool that has practical application and which draws from Māori experience and worldviews. A clear

benefit of a Charter is that it would provide guidelines to policy makers, service providers and educational/training institutions all of whom carry responsibility for ensuring that the Māori health workforce is able to make substantial contributions to Māori health.

A Charter for anchoring Māori health workforce development & potential

| Government Goals, Priorities, Policies and Directions | | | | |
|---|--------------------------|--------------------------------|-----------------------|-----------------------|
| Anchors | Participation and access | Cultural factors 'being Māori' | Outcomes and measures | Generational planning |
| Māori leadership | | | | |
| Māori perspectives | | | | |
| Government policy | | | | |
| Qualified workforce | | | | |
| Interaction | | | | |
| Adequate resources | | | | |

This thesis has shown that when government policies and programmes have been prioritised the resulting outputs and potential outcomes are more likely to contribute to improvements and gains because priorities provide direction and are supported with targeted funding. Consequently, the flow on effect is an increased and enhanced workforce capability. Conversely, programmes and initiatives not considered to be high priority are less likely to be adequately funded for workforce development.

This has major implications for Māori providers, whānau, and individuals in terms of training and education, recruitment and retention, leadership generation and regeneration, and the ability to build infrastructure and critical mass in Māori communities directly. Māori providers are able to effect immediate change in Māori communities but require adequate resourcing to sustain momentum and grow the workforce.

The research also illustrated that when Māori cultural perspectives and understandings are not incorporated into workforce development programmes, or adequately factored into outputs, difficulties arise. Not only are Māori likely to ignore the initiative but there is an inability to deliver services in the way they were intended, and in line with Māori views and values. Compromise and trade-offs occur. Conversely, where cultural paradigms are well accepted and seen as integral to workforce development, programmes are likely to flourish.

Identified in the research were opportunities to build meaningful relationships within the sector, between providers, programmes, Government, the workforce, and across sectors, the aim being, better outcomes for Māori clients. Developing a workforce that has a range of skills, education and training will provide opportunities to link up with workers in other disciplines and sectors.

Interaction has taken other forms, for example contemporary Māori health workforce development has emerged from within a Māori developmental framework but positioned alongside generic health workforce development. Prioritizing health workforce development has tested Government commitment through policy and funding, and shown that continued Government support is pivotal to Māori health workforce capability. Ensuring future relationships within the sector, the state, and private sector, will be a challenge for the future.

While findings from the case studies have been significant, they do not adequately determine whether a Māori workforce makes a difference to Māori situations. That would be another study, beyond the reach of this research.

Obviously further research in relation to the portability of the training and qualifications and the destination of trainees would represent a further study. In an increasingly global society, trainees and students will be interested in qualifications and work experience that can be recognised and utilised in settings beyond New Zealand and in workplaces outside a single sector.

Exploring and examining the challenges of using Māori models of practice within Western frameworks provides another opportunity for research. Finally the question as to why there are not more Māori in environmental and health protection is a matter that could well be explored in greater depth.

Based on the findings from *Kia Taupunga te Ngākau Māori* – anchoring Māori health workforce potential, it has been possible to construct a charter for the realisation of Māori workforce potential. The vertical axis contains the six key conclusions from the research while the horizontal axis contains key themes - goals, policies, priorities and directions. The charter for Māori health workforce potential takes into consideration Māori custom, values and practices that are uniquely Māori and blends these with generic goals for health and wellness in a broad

sense. Inherent are Māori aspirations to be Māori, for control over their own health and wellbeing, wealth and sustainability, and security and safety.

Navigating the divide to attain greater workforce potential is premised on embedding Māori philosophies, perspectives, aspirations, and worldviews within a context that allows targeted workforce development to match need.

Glossary

Māori terms provided in this glossary are explanations for use in the context of this thesis only. They are not definitions as many words can be used in different ways, which give different meaning in different contexts and dialects

| | |
|-----------------------------|--|
| Aroha | love, close friendship |
| Awhi | help, assistance |
| Hapū | family groups joined through kinship |
| Hui | meeting, interview, gathering of two or more people |
| Iwi | kinship groups joined through common objectives, ancestors and geographic locations |
| Kahui ariki o te kingitanga | leading family group of Waikato, chiefly line |
| Kanohi ki te kanohi | face to face, upfront, interviews |
| Kaumātua | older Māori |
| Kaupapa | reason behind an action |
| Kawa | in some areas this means the same as tikanga in others it can be made specific eg. a certain marae's kawa may be different to the marae down the road. |
| Kohanga reo | language nest – early childhood total immersion based on Māori philosophies |
| Kōrero-a-tahi | conversing, interviewing one on one |
| Koroua | older Māori male |
| Kuia | older Māori woman |
| Kura Kaupapa Māori | total immersion Māori primary schooling (Māori philosophical base) |
| Manaakitanga | caring for, looking out for |
| Māori | indigenous New Zealander |
| Marae | community gathering area or complex |
| Matakite | a seer, person who sees the future |
| Mihi | acknowledgement and greeting to people |
| Noa | safety, safe areas, unharmed |
| Pākehā | white New Zealander |

| | |
|---------------------|--|
| Pēpehā | can be a part of a mihi introducing the speaker/writer providing listeners or readers know who they are without giving their name. |
| Rāhui | ban, restrict |
| Tapu | dangerous, unsafe – sacred |
| Tautoko | helping, assisting, supporting |
| Tīkanga | customary practices, criteria and conditions, procedures, processes and policies, and culture. |
| Tino rangatiratanga | self determination, control and self management |
| Tirohanga | observations, watchful |
| Tohunga | healer, specialist, scientist etc |
| Tono | approach, request, apply |
| Waka | Canoe, mode of transport |
| Whakapapa | Genealogy, kinship links |
| Whakawhānaungatanga | Building relationships, coalitions, networks, kinship links |
| Whakarongo | Listen |
| Whānau | family - both nuclear and extended |
| Whānaunga | kin, relative |
| Wharekura | total immersion Māori secondary schooling (Māori philosophical base) |
| Whare Wānanga | Māori tertiary (not necessarily total immersion) |

Abbreviations

| | |
|------|---|
| CAPE | Committee Advising on Professional Education |
| CTA | Clinical Training Agency |
| HFA | Health Funding Authority - Current purchaser of all publicly funded health services previously RHA and THA. |
| HWAC | Health Workforce Advisory Committee |
| MOE | Ministry of Education |
| MOH | Ministry of Health |
| PECT | Post entry clinical training |
| PHC | Public Health Commission - disestablished in 1995 |
| RHA | Regional Health Authority, established after the disestablishment of Area Health Boards to become health funders |
| THA | Transitional Health Authority – previously Regional Health Authorities, now Health Funding Authority, purchase all publicly funded health services. |

Appendix 1

INFORMATION & CONSENT

Who is the researcher?

Annemarie Gillies (Ngāti Kahungunu, Ngāti Awa, Te Whānau-A-Apanui, Te Arawa) is a Lecturer and researcher in the department of Management at Massey University. Annemarie is currently enrolled as a PhD candidate with Te Putahi-ā-Toi, School of Māori Studies at Massey University. Dr Monty Soutar and Professor Mason Durie are supervising this research with Professor Tairahia Black providing te reo Māori me ona tikanga support.

Where can I be contacted?

| | | |
|--------------------------|--------|--------------------------|
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| Massey University | | |
| Palmerston North | | |

What is the research about?

This is a doctoral research study and is about Māori health workforce development. The research will look specifically at Māori health workforce development policy, practice environments and the training and education of the Māori health workforce using a case study approach.

What will I have to do?

Answer some questions about your perceptions, your expertise and your involvement in the area of health that you have chosen to work in. It doesn't matter if you think you haven't got much to say, I would still like to talk to you. Interviews can be at a time and place suitable to you.

How much time will be involved?

Participation may be intermittent over a time period of 1 year. The first interview may take more than two hours however subsequent interviews and discussion may be undertaken in much less time and could possibly be by phone if preferred.

What are the benefits of the research?

The interview will give you a chance to have your say about your experiences of health workforce development for Māori, in your organisation's specialised area of work. Your contribution to the research will be gratefully acknowledged in a manner you prefer. For me, as a Māori researcher I will have the opportunity to make a contribution to Māori health development and gain academic recognition.

If you take part in this research, you ...

- can refuse to answer any questions or stop any time.
- can ask any questions you want about the research.
- can ask another person to be present at the interview.
- will not be identified if preferred.

E rere tonu ngā mihi ki a koe. No reira tēna koe

INTERVIEW CONSENT FORM

I have read or have had read to me, the information sheet for this study and have had the details of the research explained to me.

My questions about the research have been answered to my satisfaction, and I understand that I may ask more questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular question in the study.

I agree to provide information on audio tape to the researcher on the understanding that it is completely confidential. I agree to participate in this study under the conditions set out in the *Information Section* of this document.

Name: _____ Signed: _____

Date: _____ Phone: _____

Address:

VERBAL CONSENT *[fill in section below]*

Interviewers signature:

Interviewers name:

Respondents name:

Date:

Appendix 2

Māori Health Workforce Development Case Studies Training and Education ----- University Schedule to Guide the Interview

| | |
|--|--|
| <p>Why was the ----- programme established?</p> <ul style="list-style-type: none"> - identified need - whose idea - who generated support - where did support for the venture come from - what were the barriers encountered in establishment <p>Where does ----- fit into the University organisation?</p> <ul style="list-style-type: none"> - embraced by the University - any special Māori or other characteristics - does it fit comfortably in the University setting - what type of structure does it operate - in what ways and levels are Māori involved <p>Describe the students who are currently enrolled in the programme?</p> <ul style="list-style-type: none"> - high achievers from school - other school leavers - adult learners <p>How would you measure ----- level of success?</p> <ul style="list-style-type: none"> - pass rates - recruitment - retention <p>What barriers to success have been encountered as the programme has progressed?</p> <ul style="list-style-type: none"> - how were these barriers overcome - how has it changed or not changed the programme - what has been learnt from these experiences | <p>What barriers to success have been encountered as the programme has progressed? (continued)</p> <ul style="list-style-type: none"> - has this affected the programme -what/how? <p>In what ways are tikanga Māori / Māori cultural aspects incorporated into the programme?</p> <ul style="list-style-type: none"> - are kaumātua involved - are whānau involved - what Māori support is available - does the university encourage this interaction <p>Describe what has helped to advance the programme?</p> <ul style="list-style-type: none"> - high achievers - learning support - study groups <p>What would make it an ideal programme?</p> <ul style="list-style-type: none"> - what needs to be put in place - location - facilities <p>Has Vision 2020 contributed to the education and training of a Māori health workforce?</p> <ul style="list-style-type: none"> - in what ways - describe the training component - describe the education component <p>Is it a portable model?</p> <ul style="list-style-type: none"> - can it be packaged and used by others <p>Do you have a role within the programme?</p> <ul style="list-style-type: none"> - advisor - lecturer - support - other <p>Is there anything else you wish to add?</p> |
|--|--|

Appendix 3

Māori Health Workforce Development Case Studies Training and Education

----- **Organisation**

Schedule to Guide the Interview

| | |
|--|--|
| <p>Describe ----- organisation?</p> <ul style="list-style-type: none"> - where does your section fit in the organisation - how is it structured - how do you fulfil your role - what workforce development initiatives are there - how important is workforce development <p>Where does ----- fit into the organisation?</p> <ul style="list-style-type: none"> - embraced by the organisation - any special Māori or other characteristics - does it fit comfortably in this section of the organisation - what type of structure does it operate - in what ways and levels are Māori involved <p>Describe the from your perspective the workforce skills and qualifications?</p> <ul style="list-style-type: none"> - high achievers - community - mature - what are the skills and qualifications required <p>How would you measure ----- level of success?</p> <ul style="list-style-type: none"> - at a personal level - at a whānau and hapū level - at tribal level - community level - recruitment and retention - training and education <p>What barriers to success have been encountered in relation to workforce development?</p> <ul style="list-style-type: none"> - has this affected workforce development - how were these barriers overcome - how has it changed or not changed workforce development - what has been learnt from these experiences <p>In what ways is tikanga reflected in workforce development?</p> <ul style="list-style-type: none"> - are kaumātua involved - are whānau involved - what Māori support is available | <p>In what ways is tikanga reflected in workforce development? (continued)</p> <ul style="list-style-type: none"> - tribal and community involvement - relationships with other organisations - describe management/governance role in workforce development - is it important to have tikanga Māori reflected in the organisation and in workroles <p>Describe the education and training opportunities offered?</p> <ul style="list-style-type: none"> - describe the training component - describe the education component - where do you purchase workforce development - what else is needed to assist workforce development <p>What levels of funding is there for workforce development?</p> <ul style="list-style-type: none"> - is it enough - how much more - is tikanga Māori supported with funding - is there acknowledgement of tikanga Māori skills in a monetary sense - how is it acknowledged and by whom <p>Governance and Management?</p> <ul style="list-style-type: none"> - describe what Māori development is - how does this impact on workforce development in the organisation - describe the differences between this organisation and others - where and when does this organisation observe tikanga Māori - what makes this organisation unique - what are your views /expectations/experience in terms of leadership and guidance - What roles should Māori take in workforce development - are there any other issues in relation to this study you would like to mention |
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