



Health Reforms 2001 Research Project

Report No. 6

MĀORI HEALTH AND THE 2001 HEALTH REFORMS

Lynne Pere, Amohia Boulton, Kirsten Smiler,

Tai Walker and Larna Kingi

On Behalf of the Health Reforms 2001 Research Team

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Introduction to the Health Reforms 2001 Research

In 2001, the New Zealand government introduced reforms to the structure of New Zealand's health and disability sector. Under the New Zealand Public Health and Disability Act 2000, the government introduced a number of overarching strategies to guide the health and disability sector and it established 21 District Health Boards as local organisations responsible for population health and for the purchasing and provision of health and disability support services at a local level.

In 2002, funding was provided to chart the progress of, and to evaluate, these reforms as they were implemented. The research took place between 2002 and 2005. This paper is one of a series reporting on findings from the research. The papers in the series focus on:

- *Health Reforms 2001 Research: Overview Report*
- *Governance in District Health Boards*
- *District Health Board Strategic Decision Making*
- *Financing, Purchasing and Contracting Health Services*
- *Devolution in New Zealand's Publicly Financed Health Care System*
- *Māori Health and the 2001 Health Reforms*
- *Pacific Health and the 2001 Health Reforms*
- *Overview Report of the Research in Five Case Study Districts*
- *Print Media Reporting of the DHBs*
- *Performance of New Zealand's Publicly Financed Health Care System: A Focus on Performance Under the New Zealand Public Health and Disability Act (2000)*
- *Public Sector Management and the New Zealand Public Health and Disability Act*

The project was funded jointly by the Health Research Council of New Zealand and by the Ministry of Health, the Treasury and the State Services Commission through a grant from a Ministry of Research, Science, and Technology Departmental Contestable Research Pool. We are grateful to them for their funding of this research and for the excellent support and advice they provided during the project.

The Research Team warmly acknowledges the support of Board members, DHB staff, providers and stakeholders who have contributed to the various strands of this research. We thank all those who so willingly shared their knowledge and opinions with us.

Research Team Members

Research team members in August 2007 were:

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He Mihi – Acknowledgements

He mihi tēnei mō ngā whakaaro rangatira o ngā kaiwhakahaere i tautoko i te mahi rangahau hauora nei. I ahu mai rātou mai i ngā District Health Boards e rima, ngā Rūnanga me ngā kaimahi o ngā rōpu hauora Māori o rātou rohe.

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This team warmly acknowledges the support of all participants in the research, including District Health Board members, committee representatives, management, staff, providers and stakeholders, for giving generously of their time, knowledge and understanding of the issues and questions we raised with them. We also gratefully acknowledge the involvement of representatives of non-District Health Board providers and stakeholders, for contributing a unique community view to the research and providing valuable insights into how the model is working.

We would like to particularly acknowledge the hospitality and collegiality extended to us by each of the five participating District Health Boards in this research. Their assistance in facilitating the research process and in providing frank and open discussion has been invaluable.

The writing of this Report – *Māori Health and the 2001 Health Reforms* – is especially attributable to the work of Dr. Amohia Boulton (Ngāi Te Rangi, Ngāti Ranginui, Ngāti Pukenga), Larna Kingi (Te Aitanga a Māhaki, Te Whānau ā Apanui), Dr. Lynne Pere (Kāi Tahu, Ngāti Kahungunu, Kāti Māmoe, Rangitāne, Ngāti Porou), Kiri Simonsen (Whakatōhea, Ngāi Te Rangi), Kirsten Smiler (Te Aitanga a Māhaki, Rongowhakaata, Te Whakatōhea), and Tai Walker (Ngāti Porou).

Acronyms

CEO	Chief Executive Officer
CPHAC	Community Public Health Advisory Committee
DHB	District Health Board
DSP	District Strategic Plan
GP	General Practitioner
HRC	Health Research Council of New Zealand/Te Kaunihera Rangahau Hauora o Aotearoa
HSRC	Health Services Research Centre/Te Hikuwai Rangahau Hauora
MoRST	Ministry of Research, Science, and Technology/Te Manatū Pūtaiao
MoU	Memorandum of Understanding
MPDS	Māori Provider Development Scheme
MPO	Māori Provider Organisation
NZPHDA	New Zealand Public Health and Disability Act 2000
PHO	Primary Health Organisation
SSC	State Services Commission/Te Komihana o ngā Tari Kāwanatanga

Executive Summary

Introduction

The Health Reforms 2001 Research Project was undertaken to chart the progress of, and evaluate, the health reforms enacted by the New Zealand Public Health and Disability Act 2000 (NZPHDA) as they were implemented.

The research was jointly funded by the Health Research Council of New Zealand/Te Kaunihera Rangahau Hauora o Aotearoa (HRC) and Ministry of Research, Science, and Technology/Te Manatū Pūtaiao (MORST), through the Departmental Contestable Research Pool managed by the Ministry of Health/Manatū Hauora¹, the Treasury/Kaitohotihu Kaupapa Rawa, and State Services Commission/Te Komihana o ngā Tari Kāwanatanga (SSC).

The Health Services Research Centre/Te Hikuwai Rangahau Hauora (HSRC), Victoria University of Wellington/Te Whare Wānanga o te Ūpoko o te Ika a Māui managed the project through leadership of a team of independent researchers in Wellington, Auckland, Palmerston North and Christchurch. The objective of the research was to document, comment on, and assess the strengths and weaknesses of alternative ways of organising strategic decision-making, governance, purchasing and accountability arrangements which developed under the NZPHDA.

¹ The 'Ministry of Health/Manatū Hauora' is referred to as the 'Ministry' for the remainder of this Report.

This project drew on four main sources of data which were collected in separate streams by Pākehā², Māori and Tagata Pasifika researchers:

- **Documents:** The District Health Boards (DHBs) and other key stakeholders made available a variety of documents on request to the researchers. Documents were collected from June 2002 to September 2004.
- **Interviews:** Two rounds of key participant interviews were undertaken two years apart – in mid 2002 and mid 2004 – with DHB members³ (including all those who identified as Māori), senior managers, clinical staff, non-government providers (including Māori and Tagata Pasifika providers), Primary Health Organisation (PHO) participants, the media, community representatives, and other stakeholders such as Ministry staff. Altogether, a total of 59 interviews were undertaken and analysed, mostly by the local researchers. The Māori and Tagata Pasifika research teams took responsibility for the (14) Māori and (17) Tagata Pasifika interviews and their analyses. Interviews were semi-structured and based on a national template, but adapted for local use where appropriate. Some included more than one person. Interviews were transcribed and checked by those participants who wished to do so prior to analysis.
- **Observations of Board meetings:** Initial informal observation of Community Public Health Advisory Committee (CPHAC) meetings (public section) was undertaken by the researchers. Two researchers then formally attended two Board meetings and one CPHAC meeting between February and June 2003 to record observations, using research tools adapted from Peck (1995). Board minutes (mostly public section only) were also reviewed for the period from July 2002 to February 2004.

² The term ‘Pākehā’ is used interchangeably throughout this Report with the term ‘non-Māori’ to refer to non-Indigenous New Zealanders.

³ The term ‘DHB member’ is used throughout this Report to refer specifically to a Board member, as opposed to a staff member of the DHB.

- **Interviews with District Health Board members who identified as Māori.** For this report *Māori Health and the 2001 Health Reforms*, key informant interviews were also held with nine DHB members who identified as Māori, while an additional two DHB members who identified as Māori supplied written answers to questions, in mid-2004.

The analytical framework for the Māori Health Report was developed from the Treaty of Waitangi, main themes, and sub-themes arising from the key participant interviews. The analysis involved collating interview material from multiple participants, then checking for consistency and varying viewpoints. Where possible, documents were used to confirm and supplement the data by triangulation. NVivo software was also used for coding the interview data, and the same coding schedule was used to classify documentary and observation data.

Methodology of the Māori Health Report

Thematic analysis was undertaken on a number of the research reports from the Health Reforms 2001 Research Project as the foundation of the Māori Health Report.

The data on which the Māori Health Report is based were compiled in two time periods: from June 2002 to June 2003, and from June to September 2004. These time periods provided ‘snapshots’ of the DHB’s progress in relation to the implementation of the Treaty of Waitangi and other clauses related to Māori health in the NZPHDA. Data collected in a second time period also allowed assessment of how issues identified as relevant to Māori health in the first time period – a time when the DHBs were still in the early stages of implementing the reforms – had evolved as changes were consolidated and further developed.

Whilst all data from Māori key participant interviews form the basis of the Māori Health Report, the findings are not specific to these participants. Data informing this Report also come from interviews completed with non-Māori participants, collected as part of overall interviews for the Health Reforms 2001 Research Project. All data provided pertaining to Māori are included in this Report.

Some views expressed in the Māori Health Report are also personal to the key participants and may not reflect the majority view. Nonetheless, they provide useful insights into the issues that are currently of relevance to some key personnel. Such views are indicated as being minority perspectives.

Framework of the Māori Health Report

The Māori Health Report reflects the key themes of the Health Reforms 2001 Research Project: governance, partnership with Māori, strategic decision-making, funding and contracting, Tagata Pasifika issues, the progress of devolution, and insights on the NZPHDA model, as well as the research project sub-themes which run through all these: accountability, health and disability sector capacity and capability, and an assessment of the strengths and weaknesses of the new model. Particular emphasis has been placed on: the Treaty of Waitangi; relationships with Māori; and specific issues identified by the Ministry's Māori Health Strategy – *He Korowai Ōranga* (2002a) – including whānau ora, workforce development, ethnicity data collection, Māori health and disability service providers⁴, and PHOs which include Māori providers. Findings in relation to Māori health have been set out under these headings.

The Māori Health Report has three objectives:

- To report the reforms in relation to Māori participation and Māori health as implemented in the selected DHBs from the point of view and observations of participants, supplemented by documentary evidence.
- To present this alongside the vision of the reforms.
- To report and make a preliminary evaluation against the legislated model of health delivery to Māori as specified in the NZPHDA.

⁴ 'Māori health and disability service providers' are referred to as 'Māori providers' for the remainder of this Report.

Summary of Findings

A key issue for Māori working in the NZPHDA model is the relationship between the Crown as a Treaty partner and Māori, and how DHBs fit within this framework. There were clearly distinguishable views on this issue, with some participants in the research continuing to express concern over the establishment of relationships at the DHB level as opposed to the Crown level. Other participants felt that they could work within a Treaty-based relationship rather than within a Treaty relationship *per sé*.

A related issue concerned the responsibilities of the Ministry. Although a variety of responses were elicited, a general view was that the Ministry was not meeting its Treaty obligations, particularly at a local level, and in relation to service delivery. Key to this was the view that the Ministry should have a relationship with tangata whenua⁵, whānau⁶, hapū⁷, and Iwi⁸ at all levels of the infrastructure (and that having intermediary agencies such as DHBs and PHOs was not helpful), should recognise the rights and responsibilities of different groups, and should consult more. The on-going poor health status of Māori was also an issue in this context.

The DHBs have clear responsibilities in relation to Māori health, and in terms of meeting and respecting the principles of the Treaty of Waitangi with respect to partnership, protection and participation. In this research, we have found that the degree to which DHBs honour that commitment varies. Participants in one DHB were particularly concerned about the lack of attention to the Treaty of Waitangi and Māori health issues, and later, about overt racism in meetings.

⁵ The term ‘tangata whenua’ (literally meaning ‘people of the land’) is used to refer to an Aboriginal or Indigenous person or people of Aotearoa/New Zealand.

⁶ The term ‘whānau’ is used throughout this Report to refer to a family or families.

⁷ The term ‘hapū’ is used throughout this Report to refer to a sub-tribe or sub-tribes.

⁸ The term ‘Iwi’ is used throughout this Report to refer to a tribe or tribes.

Generally, participants in this research viewed both *He Korowai Ōranga* and *Whakatākaka: Māori Health Action Plan 2002-2005* (Ministry of Health/Manatū Hauora, 2002b) very positively, noting they give a vision for organisations to aspire to, and are cognisant of Māori aspirations. Some DHBs were seen to be working hard to promote the Strategy, although not everyone interviewed knew of it. The lack of funding allocated for the Strategy was also a key issue for those participating in this research.

A key component of the Strategy is the concept of whānau ora. *He Korowai Ōranga* describes whānau ora as healthy Māori families, supported to attain their maximum health and wellbeing. Notwithstanding this is the overall aim of the Strategy, we found a multitude of understandings as to what whānau ora actually is. DHBs and Māori were working to identify what whānau ora might mean for those working at the local level, and although this may work to encourage the development of local ways of working, it will be difficult to monitor implementation of the Strategy and performance towards achieving whānau ora in this context. A continued lack of connection between the concept of whānau ora and current contracts was also noted in this research.

The Ministry is less concerned with what a whānau ora model of care looks like however, and more interested in how Māori providers and the health and disability sector work towards the realisation of whānau ora through the Strategy's four proposed Pathways: development of whānau, hapū, Iwi, and Māori communities; Māori participation in the health and disability sector; effective health and disability services; and working across sectors. This attainment is the overall aim of *He Korowai Ōranga*.

This research has also found on-going issues relating to ethnicity data collection. The need to improve ethnicity data collection has been recognised for a number of years now, and although it is acknowledged that there is recognition of this as an important issue and that the quality of data collection has improved, there is still some way to go.

Poor ethnicity data collection was also shown to contribute to uncertainty in the actual number of Māori in the health and disability workforce in Aotearoa/New Zealand. What is known is that Māori are under-represented in almost every area of the health and disability workforce. A number of initiatives established over recent years to contribute to Māori workforce development, including the Māori Provider Development Scheme (MPDS) and targeted mental health funding, are making some progress on this front. Retention of the Māori health and disability workforce was also recognised as important. Training of the Māori health and disability workforce is a further area where DHBs reported varying levels of success. Of concern are the reports that this training has become a further responsibility of Māori providers.

Māori providers had a number of comments to make about the funding and contracting of their services. There was general agreement that funding levels were inadequate to deliver all which *He Korowai Ōranga* required. Many Māori providers indicated that they did not feel well supported by their DHB and that their DHB did not have a good understanding of the models of care they employed; others however, found the DHB helpful and felt that it was getting better at working with the community. There was a clear expression that ‘by Māori, for Māori’ health care was the preferred model for Māori. Capacity issues for Māori providers were mentioned, in terms of both staff availability and also the small size of providers which limited their ability to see more people.

DHB members who identified as Māori, interviewed for this research, had mostly been appointed to their DHB, agreeing that their role was to ensure the interests of Māori were advanced. As in the case study research, the analysis of the interviews with DHB members who identified as Māori found some confusion over DHBs’ actual Treaty obligations and responsibilities (versus the obligations of the Crown), and a range of structures and models being created to foster an active Treaty partnership in the health and disability sector. In general, DHB members who identified as Māori, felt they worked well with other DHB members and were well supported by their colleagues, and most DHB members who identified as Māori participating in the research considered their Boards to be well informed.

However, there were some concerns raised over racist attitudes and not acknowledging or validating Māori health and Māori strategies. Some concerns were also raised over continuity of direction as a result of a short three-year DHB member term.

DHB members felt the intentions for Māori health are clear, relating to: the importance of the Treaty partnership between the DHB and manawhenua⁹; and the goals of reducing health inequalities between Māori and non-Māori, increasing the Māori health and disability workforce, inter-sectoral approaches to health, and promoting whānau ora. In some cases, DHB members felt the various government strategies – including *He Korowai Ōranga* – were being implemented in some Boards, while in others there was little more than ‘lip service’ being paid to Māori health.

Barriers to progressing implementation included staff capacity, lack of guidance on how *He Korowai Ōranga* would be implemented, and different understandings of whānau ora. Lack of resources was a key issue in terms of achieving health gains for Māori, in particular where DHBs were managing large deficits, and lack of capacity and skills to address Māori health were also a challenge.

In spite of these problems, a range of initiatives had occurred within DHBs which were identified as achievements for Māori health. These included: Treaty workshops for staff; the establishment of a Treaty relationship between one of the DHBs and Iwi, which was seen to signal a commitment to work together to improve Māori health outcomes; the appointment of a Manager of Māori Health; having Māori representation on statutory committees; community consultation with Māori; and simply accepting the work Māori are already doing in the health and disability sector. Finally, according to one DHB member who identified as Māori, the greatest achievements of the DHB model were the opportunities it allowed for greater understanding of community need, for innovation, and scope to try different models of practice.

⁹ The term ‘manawhenua’ is used throughout this Report to refer to local Iwi – those who are recognised as having a whakapapa connection to the area. The ‘non-manawhenua population’ are all other people.

Looking at the NZPHDA model compared with earlier organisational arrangements in the Aotearoa/New Zealand health and disability sector, we found that perceptions of the DHB model in comparison to the HFA/THA model varied. Some participants in the research preferred the latter, whilst others felt the more collaborative DHB model allowed a more friendly, open and informal contracting environment. It was claimed that under the DHB model Māori providers do not enjoy the “same level of communication” they did under the HFA, and this influenced some providers’ opinions of the model. Concerns were also expressed over the role of DHBs in not only planning and funding services but also in delivering services through their own provider arms, and the implications of this for non-DHB Māori providers.

Overall, the NZPHDA model has support from those we interviewed for this research, although some participants continue to express greater support for the HFA model, where the growth of Māori providers over time was likely to have been the greatest and where there was an identified group of skilled Māori working together on Māori health issues. The NZPHDA model has seen the development of relationships at a local level, but there remains a concern that the Treaty relationship really lies with the Crown and not with DHBs, and not all DHBs were seen to be supportive of Māori health or cognisant of the Treaty of Waitangi.

The research has identified positive support for *He Korowai Ōranga*, and participants provided a number of examples of new activities resulting from *He Korowai Ōranga*. However, there is some confusion over the meaning of *whānau ora*, and hence some confusion over how *whānau ora* can be operationalised. In addition, the need for improved ethnicity data collection was a key theme throughout this research.

Finally, there are on-going concerns over a lack of resources to implement *He Korowai Ōranga* and to improve Māori health (including for capital development for non-DHB Māori providers), and we have found on-going problems in relation to capacity and capability. The key issues then, in improving Māori health, concern reiterating the importance of the Treaty of Waitangi, ensuring sufficient resourcing for Māori health, and continued attention to upskilling and supporting the Māori health and disability workforce.

1 Introduction

The Health Reforms 2001 Research Project was undertaken to chart the progress of, and evaluate, the health reforms enacted by the NZPHDA as they were implemented.

The research was jointly funded by the HRC and MoRST, through the Departmental Contestable Research Pool managed by the Ministry, the Treasury/Kaitohotihu Kaupapa Rawa, and SSC.

The HSRC, Victoria University of Wellington/Te Whare Wānanga o te Ūpoko o te Ika a Māui, managed the project through leadership of a team of independent researchers in Wellington, Auckland, Palmerston North and Christchurch. The objective of the research was to document, comment on, and assess the strengths and weaknesses of alternative ways of organising strategic decision-making, governance, purchasing and accountability arrangements which developed under the NZPHDA.

The research took place over three and a half years (2002-2005) and was in four streams:

- **Stream 1:** Collation of the expectations and experiences of the reformed system. Data sources included: document analysis; key participant interviews with ministers, officials and others; a postal survey of all DHB members; interviews with all DHB Chief Executive Officers (CEOs), Chairs, and Planning and Funding Managers; and for the Māori Health Report, key informant interviews with nine DHB members who identified as Māori (and additional written answers to questions from two other DHB members who identified as Māori).
- **Stream 2:** An examination of five case study DHBs in greater depth.
- **Stream 3:** Documentation of the policy context in which the reforms are embedded.
- **Stream 4:** A comparison of this model with the previous models of health system organisation in Aotearoa/New Zealand.

The research was set in a process evaluation framework, reflecting the government's intention to alter the way that the health and disability sector performs its work, and in recognition of the fact that it is not possible to assess health and economic outcomes of the reforms within a three- or four-year project.

The research tracked the implementation of the reforms over time, to capture experiences and challenges as they occurred. Data were collected primarily in two time periods: the first from mid 2002 to mid 2003, and the second from mid to late 2004 and early 2005.

The project drew on three main sources of data which were collected in separate streams by Pākehā, Māori and Tagata Pasifika researchers:

- **Documents:** The DHBs and other key stakeholders made available a variety of documents on request to the researchers. Documents were collected from June 2002 to September 2004.
- **Interviews:** Two rounds of key participant interviews were undertaken two years apart – in mid 2002 and mid 2004 – with DHB members (including all those who identified as Māori), senior managers, clinical staff, non-government providers (including Māori and Tagata Pasifika providers), PHO participants, the media, community representatives, and other stakeholders such as Ministry staff. Altogether, a total of 59 interviews were undertaken and analysed, mostly by the local researchers. The Māori and Tagata Pasifika research teams took responsibility for the (14) Māori and (17) Tagata Pasifika interviews and their analyses. Interviews were semi-structured and based on a national template, but adapted for local use where appropriate. Some included more than one person. Interviews were transcribed and checked by those participants who wished to do so prior to analysis.
- **Observations of Board meetings:** Initial informal observation of CPHAC meetings (public section) was undertaken by the researchers. Two researchers then formally attended two Board meetings and one CPHAC meeting between February and June 2003 to record observations, using research tools adapted from Peck (1995). Board minutes (mostly public section only) were also reviewed for the period from July 2002 to February 2004.

- **Interviews with District Health Board members who identified as Māori.** For the Māori Health Report, key informant interviews were also held with nine DHB members who identified as Māori, while an additional two DHB members who identified as Māori supplied written answers to questions, in mid-2004.

The analytical framework for the Māori Health Report was developed from the Treaty of Waitangi, main themes, and sub-themes arising from the key participant interviews. The analysis involved collating interview material from multiple participants, then checking for consistency and varying viewpoints. Where possible, documents were used to confirm and supplement the data by triangulation. NVivo software was also used for coding the interview data, and the same coding schedule was used to classify documentary and observation data.

Methodology of the Māori Health Report

Thematic analysis was undertaken on a number of the research reports from the Health Reforms 2001 Research Project as the foundation of the Māori Health Report.

The data on which this Māori Health Report is based were compiled in two time periods: from June 2002 to June 2003, and from June to September 2004. These time periods provided ‘snapshots’ of the DHB’s progress in relation to the implementation of the Treaty of Waitangi and other clauses related to Māori health in the NZPHDA. Data collected in a second time period also allowed assessment of how issues identified as relevant to Māori health in the first time period – a time when the DHBs were still in the early stages of implementing the reforms – had evolved as changes were consolidated and further developed.

Whilst all data from Māori key participant interviews form the basis of the Māori Health Report, the findings are not specific to these participants. Data informing this Report also come from interviews completed with non-Māori participants, collected as part of overall interviews for the Health Reforms 2001 Research Project. All data provided pertaining to Māori are included in this Report.

Some views expressed in the Māori Health Report are also personal to the key participants and may not reflect the majority view. Nonetheless, they provide useful insights into the issues that are currently of relevance to some key personnel. Such views are indicated as being minority perspectives.

Framework of the Māori Health Report

The Māori Health Report reflects the key themes of the Health Reforms 2001 Research Project: governance, partnership with Māori, strategic decision-making, funding and contracting, Tagata Pasifika issues, the progress of devolution, and insights on the NZPHDA model, as well as the research project sub-themes which run through all these: accountability, health and disability sector capacity and capability, and an assessment of the strengths and weaknesses of the new model. Particular emphasis has been placed on: the Treaty of Waitangi; relationships with Māori; and specific issues identified by *He Korowai Ōranga*, including whānau ora, workforce development, ethnicity data collection, Māori providers, and PHOs which include Māori providers. Findings in relation to Māori health have been set out under these headings.

The Māori Health Report has three objectives:

- To report the reforms in relation to Māori participation and Māori health as implemented in the selected DHBs from the point of view and observations of participants, supplemented by documentary evidence.
- To present this alongside the vision of the reforms.
- To report and make a preliminary evaluation against the legislated model of health delivery to Māori as specified in the NZPHDA.

2 Te Tiriti o Waitangi – The Treaty of Waitangi

The NZPHDA adopts a number of measures to fulfil its responsibilities set out in s(4) – “to recognise and respect the principles of the Treaty of Waitangi” – with a view to improve health outcomes for Māori. Part 3 of the NZPHDA provides the mechanisms for each DHB to achieve this objective. These mechanisms reflect the general Treaty principles of partnership, protection and participation, derived from the Royal Commission on Social Policy (1988); specifically the special relationship between Māori and the Crown, and the Crown’s commitment as a Treaty partner to protect Māori taonga, including health.

In general the measures include:

- DHBs’ establishment and maintenance of processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement – s23(1)(d).
- DHBs’ continued fostering of the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori – s23(1)(e).
- DHBs’ provision of relevant information to Māori to enable effective participation – s23(1)(f).
- DHBs’ participation, where appropriate, in the training of health professionals and other workers in the health and disability sector – s23(1)(j).
- Minimum Māori membership on Boards of DHBs – s29(4).
- Provision for Māori membership of DHB committees – s34,35,36.
- Accountability in annual reports – s42(3)(b).

The requirement in legislation that the principles of the Treaty of Waitangi and the relationship as Treaty partners be recognised is also present in the *New Zealand Health Strategy* (Ministry of Health/Manatū Hauora, 2000). This Strategy identifies seven fundamental principles that should be reflected across the health and disability sector. The overall aim of *He Korowai Ōranga – whānau ora* – is directly built upon these principles, one of which is the acknowledgement of the special relationship between Māori and the Crown under the Treaty of Waitangi:

‘He Korowai Ōranga’ recognises that both Māori and the Government have aspirations for Māori health and will play critical roles in achieving the desired outcome for whānau. Realising those aspirations requires putting the Treaty of Waitangi principles of partnership, protection and participation into action. (Ministry of Health/Manatū Hauora, 2002b, p.3)

Treaty of Waitangi Relationship Between Māori and the Crown

This special relationship of Treaty partners exists only between Māori and the Crown. However under s21(1) of the NZPHDA each DHB is considered a Crown entity under the Crown Entities Act and therefore are at least considered an agent or representative of the Crown.

The structure of the sector in this way – and the devolvement of responsibility for it – has been cause for concern amongst Māori who do not consider the DHBs to be a Treaty partner. This was evidenced throughout the research in statements such as:

“Crown entities need to be careful with the Treaty because the Treaty is with the Crown itself.”

“The big problem is the lack of understanding of what Treaty relationships mean... The Treaty relationship is not between the DHB and Māori. It is between the Crown and Māori...”

“...The Treaty relationship ought to be with the Iwi and Government and not with the Board.”

Some participants in the research were resolute in their stand on this matter, and there were those who had a different view, but most Iwi consider the primary Treaty relationship to be with the Crown rather than DHBs. This was upheld by a Crown Law opinion which distinguished between the Crown as a Treaty partner and DHBs as Crown agents (Ministry of Health/Manatū Hauora, 2003a). The Ministry are still working through these issues and the Treaty relationship between DHBs and Māori is sometimes referred to as a ‘Treaty-based relationship’ rather than a Treaty relationship, *per sé*.

Treaty of Waitangi Responsibilities of the Ministry of Health/ Manatū Hauora

Participants from each DHB were asked to identify the responsibilities the Ministry has as the Crown’s health and disability sector representative, and therefore as a Treaty partner representative. Participants were also questioned about whether they felt the Ministry was meeting its obligations in this regard. Responses were varied, although there was a general view that the Ministry was not meeting its Treaty obligations to Māori, especially at the service delivery level.

A number of participants in the research reflected the view of one participant, that there was an increased need for the Ministry to have a relationship “with tangata whenua, whānau, hapū, and Iwi at all levels of the infrastructure”, to recognise the rights and obligations of manawhenua, mātāwaka¹⁰ and tauwiwi¹¹, to consult more, and that the DHBs should not be seen as agencies to whom Treaty obligations could be shifted. Memoranda of Understandings between the Ministry and Iwi were seen by one participant as an important component of an on-going relationship between Iwi and the Crown.

¹⁰ The terms ‘mātāwaka’ and ‘taurahere’ are used interchangeably throughout this Report to refer to Iwi who reside in an area which they do not have a recognised whakapapa connection to.

¹¹ Whilst the term ‘tauwiwi’, meaning a foreigner or foreigners, is often used to differentiate between non-Indigenous New Zealanders born in Aotearoa/New Zealand and non-Indigenous New Zealanders born elsewhere, here the reference is to all Pākehā (non-Indigenous New Zealanders).

The Ministry was also seen to be responsible for working to improve the health status of Māori, to allocate resources to Māori, and to monitor new arrangements, such as the establishment of DHBs, to ensure they make a difference.

Some participants in the research clearly felt that Treaty obligations were not being met very well given the continued poor health status of Māori and the lack of progress in resolving debates around the Treaty of Waitangi. Some participants also recognised the importance of working across sectors if the health status of Māori was to improve. The compartmentalised nature of the Aotearoa/New Zealand public sector was seen here as a barrier to improving the health of Māori.

Some participants expressed support for the Ministry's position on getting Māori health to the same level as non-Māori:

“I think [the Treaty of Waitangi is] well understood by the Ministry [who] have indicated an acceptance of the Treaty and a need to respect the Treaty obligations... and I think they are pretty even handed about it. You've only got to look at the publications coming out of the Ministry to show that they are pretty good in that respect.”

Treaty of Waitangi Responsibilities of District Health Boards

DHBs have specific statutory responsibilities to “recognise and respect” the Treaty principles required under s4 of the NZPHDA. There are also many specific requirements and mechanisms for DHBs to achieve these principles set out under part 3 of the NZPHDA.

A number of actions outlined in *Whakatātaka* in order to meet the objectives of *He Korowai Ōranga* require consideration and inclusion of the Treaty principles. Specifically these relate to the objectives to:

- Increase relative investment in Māori health.
- Monitor progress of *He Korowai Ōranga*.
- Increase Māori participation in decision-making.

In order to increase relative investment in Māori health, DHBs are instructed to work collaboratively “with local Treaty partners” and the Ministry to set targets to increase funding (Ministry of Health/Manatū Hauora, 2002b, p.9). A similar approach is required to monitor progress of *He Korowai Ōranga*.

The key DHB performance indicator which explicitly requires consideration and inclusion of Treaty principles is related to these first two objectives. It suggests that annual monitoring to “determine the extent to which the DHB meets with its Treaty partner(s) on a regular basis in order to review and monitor planning and funding for Māori health gain” should indicate the level of engagement and participation of local Iwi/Māori in DHB decision-making (Ministry of Health/Manatū Hauora, 2002b, p.43). This Māori-specific requirement should also indicate the level of engagement and participation of local Iwi/Māori in the development of strategic plans for Māori health gain – a requirement of DHBs under s23(1)(d) of the NZPHDA.

Furthermore, under s38(3)(5)(6) of the NZPHDA, the requirement for DHBs to enable Māori to contribute to strategies for Māori health may also extend to District Strategic Plans (DSPs) and any amendments that adversely affect Māori. This is an implied requirement of DHBs to engage Māori participation, so as not to be inconsistent with the *New Zealand Health Strategy* (Ministry of Health/Manatū Hauora, 2000) and *The New Zealand Disability Strategy: Making a World of Difference: Whakanui Ōranga* (Ministry of Health/Manatū Hauora, 2001a).

In addition, under s42(3)(b) of the NZPHDA the DHB is also required to include in its annual report, a report on the extent to which each DHB has met its objectives for Māori in respect of improving Māori health outcomes.

Other examples of Treaty-based partnership approaches to meeting *He Korowai Ōranga* objectives include DHBs, the Ministry, and Treaty-based partners being jointly responsible for “training and networking opportunities for DHB members to ensure effective governance that leads to improved whānau ora” (Ministry of Health/Manatū Hauora, 2002b, p.19). This is to enable Māori participation in decision-making to increase.

To enable greater participation in the health and disability sector and in the development of strategies to improve health outcomes for Māori, each DHB is also expected “to provide for the needs of Māori” by ensuring “that complete and high-quality ethnicity information is included, where relevant, in the information provided to their Treaty-based partnerships and to other Māori” (Ministry of Health/Manatū Hauora, 2002b, p.48). This is also a requirement under s23(1)(f) of the NZPHDA that DHBs will provide Māori with relevant information to enable effective Māori participation.

District Health Boards' Commitment to the Treaty of Waitangi

He Korowai Ōranga states: “the Government is committed to fulfilling the special relationship between Iwi and the Crown under the Treaty of Waitangi” (Ministry of Health/Manatū Hauora, 2002a, p.2). The principles of partnership, participation and protection which continue to underpin that relationship are accordingly threaded throughout the Strategy. The degree to which DHBs honour that commitment however, varies.

In two case study DHBs, there are formal relationships between the DHB and Māori, and a strong recognition of the principles of the Treaty of Waitangi in formal documents and ways of working. In these two DHBs especially, these arrangements were praised, but with some warnings over the need to ensure that there were tangible outcomes from the various arrangements in place. In another DHB, the DHB's formal position on the Treaty of Waitangi was reported as being consistent with that stated in the NZPHDA which aims to “recognise and respect the principles of the Treaty of Waitangi” (Ministry of Health/Manatū Hauora, 2002a, p.35). One DHB participant suggested that the Board had identified the principle of partnership as being particularly important, but was still working on the principles of protection and participation.

In a fourth case study DHB however, participants were more scathing of their Board's commitment to the Treaty of Waitangi, particularly as the partnership had not proceeded well at governance level. A perceived lack of commitment by the DHB to Māori was seen to be a real problem, and delays in appointment processes had not assisted in improving the way in which the DHB works with Māori. In spite of these problems, some participants in the research noted that Māori had had an impact on the Māori Health Plan, and the Māori Manager was also credited with having made some positive impact. It was acknowledged however, that this was not sufficient influence on its own.

Partnership Between Māori and the Crown

Partnership between Māori and the Crown is one of the principles of the Treaty of Waitangi. *He Korowai Ōranga* defines this principle as “working together with Iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services” and outlines the responsibilities of DHBs as representatives of the Crown, in this regard (Ministry of Health/Manatū Hauora, 2002a, p.2):

‘DHBs have the primary responsibility for planning and funding health and disability services and improving Māori health. They are expected to work in partnership with Iwi and Māori communities to ensure their decision-making effectively leads to whānau ora improvement and supports the achievement of Māori health aspirations.

They are required to involve Iwi and other Māori communities in developing strategies to improve Māori health and to enable them to influence the planning, purchasing, delivery and monitoring of services to build Māori health.

No single partnership model will suit every Iwi and DHB. Iwi, Māori communities and DHBs need to work together to develop models that meet their needs.

In addition to developing partnerships with Iwi and Māori at the governance and operational levels, DHBs are also expected to consult with Māori communities (as they are with the wider community).’
(Ministry of Health/Manatū Hauora, 2002a, p.15; NZPHDA s23(1)(d))

Again, the arrangements between DHBs and Iwi and Māori communities to implement partnerships vary across our case study DHBs. Formalised arrangements include the use of Memorandum of Understandings (MoUs), and partnerships involving representatives from the manawhenua and sometimes taurahere¹² (e.g. through a pan-tribal organisation), although it is not always clear how representatives are ‘mandated’ in their roles. Under s24(1)(a) of the NZPHDA, a DHB may enter into a co-operative agreement or arrangement with any person whether or not they are involved in the health and disability sector, to assist the DHB to meet the objectives of Māori health.

In one case study DHB, a partnership board is made up of both manawhenua and taurahere. Here, the taurahere population is much larger than the manawhenua population, but manawhenua have greater representation, causing tension. Some saw this as being consistent with tikanga¹³, where manawhenua hold a “Treaty relationship”. One participant in the research noted that manawhenua have an obligation to interact and consult with taurahere Māori as a part of their duty to “manaakitanga¹⁴ – to look after and listen”. In spite of the tension reported, Māori leadership at the governance level of the DHB was still seen to be providing a major role in enabling Māori input into all Board activities – planning, policy advice, and strategic directions. There was reference made to the perceived poor resourcing however, for Māori input.

¹² The terms ‘taurahere’ and ‘mātāwaka’ are used interchangeably throughout this Report to refer to Iwi members who reside in an area which they do not have a recognised whakapapa connection to.

¹³ The term ‘tikanga’ is used throughout this Report to refer to custom or meaning.

¹⁴ The term ‘manaakitanga’ is used throughout the Report to refer to the act of according others total support, hospitality, goodwill, respect, and dignity.

In a second case study DHB, there is also a formalised Treaty relationship between the DHB and Māori, through three Memoranda of Understanding signed with a Māori caucus and two tribal authorities in the region. In this region, ‘mutual respect’ was seen as the key to successful relationships, while legislative requirements and agreements ‘on paper’ were not enough. It was suggested there was much room for development in the Treaty relationship between the DHB and Māori of the region, and it was again noted that the challenge is to bring Māori health up to the same level as everyone else. In this DHB, several participants felt that Māori were very well represented in the work of the DHB.

In a third case study DHB, the formal relationship is between the DHB, a Rūnanga¹⁵, and a hapū-representative group. Again, there were participants who felt that although the relationships between the DHB and the hapū-representative group was an amicable one, it had “...some distance to go in terms of maturity”. Here, there was a desire for less of a controlling and directive approach, and a greater focus on allowing Māori to develop, with more autonomy. Also within this DHB was a desire, by a key Iwi, for a range of relationships between the DHB and Māori to develop, so that the DHB would “have a strong relationship with the local community”. At least one participant in this region described the relationship between Iwi and Māori communities as “excellent”. This participant referred in particular to the existence of good networks at the community level. Interaction at the Rūnanga, hapū, and marae¹⁶ level was similarly described as productive when things needed to be done.

In a fourth case study DHB, the DHB has made a concerted effort to establish formal relationships, through MoUs, with both manawhenua and mātāwaka health providers, and through development of a Māori Health Plan. Several informants suggested that the relationship with Māori had “improved” as a result of these partnership arrangements. “Wider engagement with Māori” was indicated to be more difficult, however.

¹⁵ The term ‘Rūnanga’ is used throughout this Report to refer to an assembly, institute or council of common Iwi.

¹⁶ The term ‘marae’ is used throughout this Report to refer to the traditional meeting place or places of whānau, hapū or Iwi.

In a fifth case study DHB, there is an MoU with an Iwi consortium. This group is widely seen as representing Māori at Board level. Various mechanisms are in place to share information, with the consortium having input into steering groups, strategic planning process, and the development of significant policy documents, such as *He Korowai Ōranga*. There is also a jointly developed work plan between the two organisations. The relationship is seen by some to be working very well. However, others were less positive – one stating that the partnership model was not working well, given advice was not always well recognised. There was also a concern about the lack of resources made available to the consortium and the need for monitoring to ensure agreed action is implemented. As a result of some of these concerns, an internal Māori group was to be established, made up of managers and advisors within the DHB, in order to give “good grounding advice to the CEO, but also ensuring that the work programme that they agreed to with manawhenua is followed through and actioned at every point”.

Participation of Māori

Another of the principles of the Treaty of Waitangi is referred to as the principle of participation. Within the health and disability sector *He Korowai Ōranga* defines this principle as “involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services” (Ministry of Health/Manatū Hauora, 2002a, p.2). This is a requirement under s23(1)(d)(e)(f) of the NZPHDA. DHBs are required: to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement; foster the development of Māori capacity for participating in the health and disability sector, providing for the needs of Māori; and provide relevant information to Māori to meet these ends.

One aspect of increased Māori participation in decision-making is Māori membership within DHBs. This is a requirement under s29(4)(a)(b) of the NZPHDA to ensure Māori membership is proportional to the number of Māori in the DHB resident population, and in any event there are at least two DHB members who identify as Māori. There is also a requirement for Māori representation on DHB committees (those being CPHACs, Disability Support Advisory Committees, and Hospital Advisory Committees) (NZPHDA, s34,35,36).

Furthermore, DHBs must ensure all their members – not only members who identify as Māori – “are skilled and knowledgeable about Treaty of Waitangi and Māori health issues and about their local Māori communities” (Ministry of Health/Manatū Hauora, 2002b, p.6). This is also a mechanism provided for under s23(1)(j) of the NZPHDA. It is a requirement of DHBs to “participate where appropriate in training of health practitioners and other health workers”.

In one case study DHB, the working dynamics enabled by having a relationship between the DHB and a separate partnership board were seen to be positive, and there was a focus on key issues for Māori within the DHB: funding and planning for Māori health services, and capability with a focus on the Māori health and disability workforce; the development of a Māori Health Plan; and a general increase in Māori participation within the PHO and provider sector. A recently appointed Director, Māori Health, holds overall responsibility and works at a governance level with the partnership board. Within this region, the majority of the PHOs had included representatives from local Iwi and some had extended this relationship to include taurahere representatives. However, despite Māori participation at this level, there were concerns amongst participants over the development of Māori provider capacity.

In a second case study DHB, participants were clear about the requirement stated under the NZPHDA for Māori “to contribute to decision-making and to participate in the delivery of health and disability services” in order to “improve health outcomes for Māori”. Having good representation of Māori on the governing DHB was seen as a key first step in achieving this. In this region, Māori have input into decision-making within the DHB through numerous channels, such as through a partnership, MoUs, Rūnanga, advisory staff in different parts of the DHB (e.g. funder and provider arms), and through other Māori leadership roles, which offer technical and cultural support and policy review. In addition to these decision-making avenues, Iwi and hapū feedback on the DSP were seen to have enabled the incorporation of many views on improving Māori health.

In a third case study DHB, a number of formal arrangements are in place to promote participation. However, participants’ comments revealed concerns over the Board’s own understanding of the Treaty of Waitangi, and its implications for Māori participation. One participant noted that racist comments were passed and feelings of marginalised participation of DHB members who identified as Māori, were described. Another participant noted that although all papers being considered by the Board are supposed to consider issues for Māori, that this was often not the case. In this Board, during the course of interviews it was apparent that participants were hesitant to discuss Māori issues and many participants delegated responses to questions to the Māori . One participant went so far as to suggest that they were “not allowed to talk about the Treaty.”

Both Māori and non-Māori participants in this DHB reported their disgust and embarrassment at comments made by some DHB members about Māori and Tagata Pasifika. At least four different examples of inappropriate behaviour were relayed, which included the demonstration of an arrant lack of understanding of the value of the Treaty of Waitangi by one DHB member:

“One of the candidates that got in was on the platform that the Treaty was a lot of crap and you know should be deleted from every Act of Parliament and that sort of thing. So it’s those sorts of attitudes.”

Whilst DHB members who identified as Māori, were particularly aware of these positions on the Treaty of Waitangi and Māori health, they were not alone in considering them to be “definitely racist”. Some described the difficulties for them when these attitudes were expressed:

“That’s the level of debate at the table. So rather than launch into the history lesson once again [when] I was asked to reply... I said, “Oh no... It’s just not worth it.” Like you have this much energy and you can either expend all that energy trying to convince people who don’t want to change their opinion or you can just save it and use it in another way.”

There were also issues regarding the Board’s ability to participate in a relationship with their DHB members who identified as Māori, and Māori communities, in a way that is meaningful to Māori, with the Board seen to put too much responsibility onto the Māori manager.

There appeared to be questioning amongst participants in the research, as to whether or not the NZPHDA model worked in the best interests of Māori, especially in terms of the value Māori place on ‘face to face’ access with the Treaty partner – the Crown through the Ministry. Provider participants expressed a desire to communicate directly with the Ministry, in partnership with the DHB, rather than the DHB being an intermediary between them. However, it was also noted that the PHO environment was more cognisant of Māori participation on PHO Boards and engagement with Māori communities.

In a fourth case study DHB, participants were equally clear about the requirement of DHBs, under the NZPHDA, to “improve health outcomes for Māori”, and to enable Māori “to contribute to decision-making on, and to participate in the delivery of, health and disability services”. In the first round of interviews, it was found that, despite the formal relationships between the DHB and manawhenua and mātāwaka groups, some Māori felt under-resourced, and that they had little decision-making authority. Some felt they could not adequately participate in decision-making, in part as a result of perceived multiple accountabilities of DHB members who identified as Māori – to the Crown, the DHB, Māori DHB personnel, Māori Provider

Organisations (MPOs), Māori communities, and Māori living in their rōhe. PHO development for Māori was expected to be the first big challenge for the DHB in this regard, particularly as it was reported that there was little information to assist such decisions.

A majority of both DHB personnel and non-DHB participants in this region were generally supportive of the DHB model, but a number of Māori and Tagata Pasifika participants were more in favour of the HFA model. This was seen to include a clearer focus on, and commitment to, the Treaty of Waitangi, and to promote workforce development. Although the DHB environment was seen as less competitive, there were issues around the duplication of infrastructure, the integration of provider/purchaser functions, and increased MPO vulnerability due to the establishment of a DHB-based Māori provider arm and the need for processes to monitor and assist MPO development.

Protection of Māori Health, Cultural Concepts, Values and Practices

Protection of Māori health, cultural concepts, values and practices is the remaining principle of the Treaty of Waitangi. *He Korowai Ōranga* clearly outlines the responsibilities of the DHB as representatives of the Crown in this regard, defining this principle as:

Working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

(Ministry of Health/Manatū Hauora, 2002a, p.2)

The NZPHDA fulfills the principle of protection through mechanisms to enable Māori to contribute to decision-making and participate in the health and disability sector, in order to protect Māori interests. The principle promises Māori the same rights and privileges of British subjects, and provides for the recognition of tino rangatiratanga¹⁷ and of things Māori, which require the need for appropriate health and disability services which are sensitive to and respectful of cultural needs, and accessible by Māori.

The principle of protection is often referred to as ‘active protection’– a concept which implies more than a superficial acknowledgement of the requirement by the Crown to provide equity and equality for whānau, hapū and Iwi. Active protection recognises that the Crown needs to be pro-active in health promotion and the development of preventative strategies for Māori. This may mean putting in additional resources so that Māori are able to enjoy equitable health status with non-Māori. This was recognised clearly in one of our case study DHBs:

“We know the health status for Māori is lower, so we will try to equalise it, not to bring Europeans down, but to lift everybody up and ensure it is equal across the Board. If that requires allocating resources differently, that’s fine, because the objective is equal health status. The DHB is well aware of that and they’re doing the best to ensure it happens.”

In relation to protection, racism is of particular concern. Racism was identified earlier as an issue in one case study DHB. It was also noted in a second case study DHB, but where participants had identified strategies for addressing racism. Given the responsibilities of the Crown to protect Māori health, cultural concepts, values and practices, grounded in the Treaty of Waitangi, the evidence of racist attitudes in some DHB members working as its representatives is a concerning finding of this research. The language, tone and content of the transcripts coming from some DHB participants in particular provided blatant examples of racism.

¹⁷ The term ‘tino rangatiratanga’ means absolute principality or sovereignty and is used in this context in reference to the concept of self-determination.

This will be an ongoing challenge for the DHB concerned, which requires careful management. Both Māori and non-Māori DHB participants reported their disgust and embarrassment at comments made by some DHB members about Māori and Tagata Pasifika and about the place of the Treaty of Waitangi in Aotearoa/New Zealand.

In a further case study DHB, several DHB participants felt that responsibilities to Māori under the Treaty of Waitangi were “clear” and ensured that “a range of services which are responsive to Māori and specifically meeting the needs of Māori” were developed. For one participant the measure of success by the DHB in this regard was in seeing “whether Māori have equal access to services as the general population”. This participant suggested that at the time of the first round of interviews, this was not the case. A community-based DHB participant in the second round of interviews indicated a continued commitment by the DHB was needed to protect Māori health, cultural concepts, values, and practices, not simply as a matter of obligation. For non-DHB providers within the region however, commitment to the Treaty principle of protection appeared to be stronger.

3 He Korowai Ōranga: Māori Health Strategy

Māori health status is consistently poorer across many indicators than that of non-Māori. *He Korowai Ōranga* was released in November 2002 in response to this disparity. Its overall aim is the achievement of whānau ora – healthy Māori families, supported to attain their maximum health and wellbeing. Four Pathways are proposed to accomplish this:

1. Development of whānau, hapū, Iwi, and Māori communities.
2. Māori participation in the health and disability sector.
3. Effective health and disability services.
4. Working across sectors.

He Korowai Ōranga provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of whānau, by placing whānau at the centre of public policy (Ministry of Health/Manatū Hauora, 2002a).

Whakatātaka was also released in November 2002 to accompany *He Korowai Ōranga*. *Whakatātaka* sets out specific expectations of Crown agencies for each of the Pathways by describing the actions to be implemented in order to achieve the objectives of *He Korowai Ōranga*. Prepared with input from DHBs and Māori health groups, *Whakatātaka* guides implementation of *He Korowai Ōranga* by outlining roles, responsibilities, performance expectations, measures, and initiatives for achieving the Strategy.

The Role of District Health Boards

All DHBs are required to indicate how they will achieve their Māori health objectives and implement *He Korowai Ōranga* in their strategic and annual plans, and are expected to report on progress annually. Accordingly, some of the DHBs examined in the case study research had developed Māori Health Plans, specific to their DHB, which outlined these expectations.

Two of the case study DHBs' Māori Health Plans establish a commitment to implementing the recommendations of *He Korowai Ōranga*. The Māori Health Plan of a third DHB was similarly reported to be in line with *He Korowai Ōranga*, although it was also described as being deliberately “loose” to allow flexibility in its implementation. In a fourth case study DHB, while there was no specific Māori Health Plan, the DHB referred to the incorporation of *He Korowai Ōranga* into other key plans (e.g. DSP and District Annual Plan). MoUs with local Rūnanga also provide a framework for the DHB to work with their local Iwi and Māori communities to develop and implement effective strategies for whānau ora.

The Role of Māori Providers

He Korowai Ōranga describes Māori providers as key players in improving access to, and the effectiveness and appropriateness of, health and disability services for whānau (Ministry of Health/Manatū Hauora, 2002a:16). DHBs therefore must engage well with Māori providers – particularly as they are assessed on how they do so to improve the capacity and effectiveness of providers with regard to Māori health. The inclusion of specific performance expectations in service agreements and systems to effectively monitor providers' performance against those expectations are an essential part of this assessment (Ministry of Health/Manatū Hauora, 2002a:30).

He Korowai Ōranga states that DHBs have a statutory obligation to continue to foster Māori capacity to participate in the health and disability sector and to provide for their own needs, although only one DHB referred specifically to such nurturing (Ministry of Health/Manatū Hauora, 2002a:16). Fostering Māori health and disability workforce capacity includes exploring new provider models if Iwi or Māori communities identify these as appropriate to their needs (Ministry of Health/Manatū Hauora, 2002a:16). The importance of appropriate provider models was referred to by one participant in the research, who emphasised the diversity of Māori and the according need to provide diverse services. Another participant cautioned that despite the change in patterns of service and altering of stereotypes since the advent of Māori service provision, “a lot more monitoring of the approaches towards Māori” still needed to occur.

Perceptions of He Korowai Ōranga and Whakatātaka

In general, participants in the research viewed both *He Korowai Ōranga* and *Whakatātaka* very positively. *He Korowai Ōranga* in particular, was not only seen as a Strategy that gave organisations a vision to aspire to, but importantly it was also seen as being cognisant of Māori aspirations. Other participants noted that it was a positive sign that there was a Māori Health Strategy sitting alongside other key strategies at a national level. It was suggested that the Strategy provided the foundation towards improving health for Māori, and in developing it, the Ministry had provided a platform “for moving things” and “a mechanism for us to make things work”.

In one case study DHB, the advent of *He Korowai Ōranga* was seen by one participant to have heralded some changes, including greater expectation of better engagement between the health and disability sector and the community, and increased accountability for Māori health (in part close attention to the Māori component of DAPs). In another case study DHB, participants indicated satisfaction with the practicality of *He Korowai Ōranga*, in particular with it being written into contracts and with participants seeking resourcing against the Strategy, including for the funding of personnel.

Not all participants in the research articulated such engagement with *He Korowai Ōranga* however, or such optimism about it. For example, one noted that although it was a good Strategy, it was not “as broad ranging and perhaps as controversial or as pointed as it could have been...”, and alarmingly, not all providers even knew of *He Korowai Ōranga*.

Other participants were wary of the lack of funding of *He Korowai Ōranga* and *Whakatātaka*. One participant suggested that the dearth in funding allocated to its implementation directly reflected the lack of importance placed upon it. Consequently, Māori health was perceived to be of little significance in that DHB, with progress in implementing *He Korowai Ōranga* very slow, while primary care on the other hand was seen to be important – evidenced by the significant level of resourcing allocated to it.

An interesting observation was made by one participant in the research, who cautioned against parading *He Korowai Ōranga* and *Whakatātaka* as Māori health outcomes. This participant suggested that as a single Strategy, *He Korowai Ōranga* was ineffective. Positive Māori health outcomes required an holistic approach that looked beyond the health and disability sector:

“You take the issue of the foreshore and seabed and how much anxiety that actually causes our people and how much mamae¹⁸ that causes... and you know, that’s a health effect. But they don’t understand that. When they were going around making decisions to close down schools because their rolls weren’t that high... the level of anxiety that arises in the homes [due to that]... that’s an effect on health. So while they may look at cocooning or siloing health and saying “Look! We’ve done very well here. We’ve got ‘Whakatātaka’, ‘He Ōranga Korowai’...” But what about those issues? Because of the way that we view our people in their wholeness... you can’t operate them independently.”

Another participant noted that further work needed to be done to develop positive indicators to measure progress on the Strategy’s objectives of Māori health:

“I think we need to nail about 5 to 10 tests, key things that all Māori health workers can get in their heads. Saying “well, how is this one this year?” And some of them will be things that we can measure on a monthly basis, some will be annual, and some will be sort of census related.”

¹⁸ The term ‘mamae’ is used to refer to pain, ache or stress.

4 Whānau Ora

He Korowai Ōranga describes whānau ora as healthy Māori families (kuia¹⁹, koroua²⁰, pakeke²¹, rangatahi²² and tamariki²³), that is:

- Whānau supported to achieve their maximum health and wellbeing.
- Whānau able to shape and direct their own lives.
- Whānau achieving the quality of life Māori are entitled to as tangata whenua of Aotearoa/New Zealand.

The achievement of whānau ora is through:

- The recognition of both Māori and Government aspirations and contributions, described as the two broad Directions of the Strategy.
- The threading of three key themes (rangatiratanga; building on the gains; and reducing inequalities) throughout the Strategy.
- The implementation of four Pathways for action (development of whānau, hapū, Iwi and Māori communities; Māori participation in the health and disability sector; effective health and disability services; and working across sectors), each with defined objectives (Ministry of Health/Manatū Hauora, 2002a).

¹⁹ The term ‘kuia’ is used to refer to an elderly woman or elderly women.

²⁰ The term ‘koroua’ is used to refer to an elderly man or elderly men.

²¹ The term ‘pakeke’ is used throughout this Report to refer to an adult Māori or adult Māori (plural) who is/are learning and preparing for kaumātua status.

²² The term ‘rangatahi’ is used throughout this Report to refer to youth (singular or plural).

²³ The term ‘tamariki’ is used throughout this Report to refer to children.

Defining Whānau Ora

An important undertaking of this research was gaining an understanding of what participants considered whānau ora to be. Difficulty in defining whānau ora was an issue identified by all participants in the research. Definitions varied widely as participants attempted to encompass the holistic nature of the concept, and its pluralistic nature - total wellbeing and wellness for the individual person within the context of his or her whānau, hapū and Iwi; while others focused on how organisations work with Māori to improve health.

For example, within one of the case study regions, whānau ora was encapsulated as working together to ensure the best possible health and disability services to the Māori community. One participant in the research envisioned this goal as being able to get all your services from one holistic service. Elsewhere it was suggested that this commitment to a holistic approach often required health workers to spend much longer periods of time on consultations, in settings where consumers of the service felt comfortable. Another suggested it was the right of Māori, not the Crown or anyone else, to define whānau. However, someone else suggested that one of the biggest barriers to achieving Māori health gain was “the lack of understanding of what we mean by whānau ora in terms of... assisting services to understand the notion what it actually translated into.”

Assigning the definition of whānau ora to Māori however, does not lessen the complexity of the issue. Amongst Māori providers alone, there is wide variability in interpretations of whānau ora. This was demonstrated by one participant who noted that whilst some providers focused specifically on the recipients of care in their interpretations of whānau ora, others focused on the manner in which services were delivered. Another provider described whānau ora as “tikanga”, including self-determination.

The research found that not all DHB employees knew of whānau ora, although this did not necessarily impact on their ability to deliver services:

“I have never heard of whānau ora. I imagine it is looking at the whole health of the family from the spiritual, religious, cultural and health point of view. If that’s what it is, it is certainly what we are trying to do.”

Delivering Whānau Ora

A number of the DHBs involved in this research referred to whānau ora models of care – their importance and the challenges associated with them. Although no clear definition was provided, the implication was that such models of care were not only inclusive of whānau, but may also be led by whānau.

In the first round of interviews, it was suggested that there was potential to develop such a whānau model for particular services, such as with children’s services, and cardiovascular and diabetes programmes, with a focus on “keeping a person well”. Some non-DHB providers have since either adopted whānau ora as a focus of activity, are moving towards a whānau ora model of care, or are now operating according to other Māori models.

In one case study DHB, the focus was on how the DHB would respond to the concept of community models of care, the impact on taurahere, and the challenges it posed. In particular, issues around Iwi providers and pan-tribal providers were raised, including how these fitted with whānau ora models of care. The focus here was also on strength-based models of care, and on the continuum of care from community to hospital and back again.

Consistent with their interpretation of whānau ora which considers the whānau within the context of the community, participants in another DHB explained how the organisations they worked for delivered whānau ora, in terms of helping them discover who else they are connected to. This was a particular issue where traditional whānau/hapū/Iwi connections are no longer the reality for whānau in urban situations.

For these people the MPO becomes part of their whānau, strengthening their health and wellbeing. To this end, whānau are encouraged to look at the community involvements they do have and to extend these positive connections that contribute to their overall health.

Implementing Whānau Ora

The implementation of whānau ora has been undeniably challenging for DHBs. One participant in the research felt that it was extremely difficult “getting down to the nuts and bolts of how you develop that, and how people implement that, at a practical day-to-day level”. A further challenge was in relation to the perceived dichotomy between manawhenua and taurahere, as at the service delivery level, the model of whānau ora implies ‘by Iwi, for Iwi’. Another participant suggested that implementing the concept of whānau ora requires “flexibility” and “open-ended” thinking.

Contracting Whānau Ora

Like the funding of whānau ora, contracting whānau ora has also proven to pose problems for DHBs. A number of participants in the research expressed disquiet about “contracting not matching the model of whānau ora that exists in the community” – mirroring the disparity reported between whānau ora models of care and funding models.

Problems identified in contracting whānau ora include inconsistencies between whānau ora requirements and the finances available; lack of connections between existing contracts and the concept of whānau ora, and concerns over the ability to realign contracts as these are set nationally; and problems aligning a contractual approach with an emphasis on whānau extending their community involvements and investigating the principles and values of their hapū and Iwi, in order to strengthen their overall health and wellbeing. One participant suggested that Māori managers needed to strive to ensure Māori contracts work for the Māori community, rather than

agree to deliver on goals that do not easily fit with what is perceived to be the way forward.

Integrating whānau ora into the wide range of services provided by the DHB was another issue raised by participants in the research.

Measuring and Monitoring Whānau Ora

Some participants suggested it was less important to define whānau ora, than to measure its performance. How this may be achieved however, generated diverse responses. Some participants suggested that “surrogate measures” which indicate whether or not things are going well for whānau, such as the numbers of Māori with diabetes, may be better replaced with a focus on the functional, specific changes that need to occur, such as the tangible measures of Māori access to services, Māori health status, average life expectancy for Māori, and the number of Māori using mental health services. Alternative outcome measures suggested included the number of people who kōrero²⁴ Māori, immunisation rates, the number of Māori aged over 70 years, the number of those with access to traditional kai, and consumer satisfaction with services. At a personal level, different measures would be relevant to wellbeing for different individuals, but irrespective of this, the quality of relationship with whānau was important.

Some DHB participants referred to the development of specific mechanisms and processes within their DHBs to measure progress towards whānau ora, although in the first round of interviews, it was recognised that there was still much work to be done. Some progress towards auditing had been achieved in one case study DHB in our second round of interviews, while in another case study DHB the focus was on helping people to connect and clarify where they stood on issues. Whānau ora was measured in this context by the degree to which people were socially connecting in

²⁴ The term ‘kōrero’ is used throughout this Report to refer to a discussion or discussions, or to the act of talking or speaking.

healthy ways. In other case study DHBs, progress had been slower, with reported difficulties in one, in terms of developing appropriate outcome measures that were actually meaningful, but with an increased focus on working with whānau to achieve whānau ora.

Resourcing Whānau Ora

Some participants in the research referred to the importance of not defining whānau ora too narrowly as this could mean people being missed out of this funding loop. Others focused on how a narrow definition of whānau ora would also be inconsistent with the holistic and diverse views Māori hold of wellness.

In terms of resourcing whānau ora, one participant focused on giving people appropriate information – for example, in how to support their whānau member after discharge from hospital, while another suggested that wellbeing in his or her community was “about resourcing the whānau to participate more fully in their health”.

Participants in one case study region referred to capital development needs amongst MPOs, but noted that these were only part of the wider pool of resources they wished to have access to. In another region, it was minuted that resources should be committed to the development of models of care based on whānau, but not all participants were convinced of the DHB’s success in this regard, in part due to the DHB not grasping the importance of “Māori aspirations and the contributions and the Crown aspirations and contributions”. Another participant from the same region however, did consider that concrete attempts to resource whānau ora models of care in the community were being made.

Funding Whānau Ora

Commitment to whānau ora models of care by DHBs is enormously hindered by the fact that there are no funding models for whānau ora approaches. Many participants in the research, particularly from one case study region, voiced their concern over this disparity. The funding and planning issues related to the mismatch between the whānau ora models of care being practiced by Māori providers, with funding formula being based on historical utilisation and not on more recent data, especially where more Māori were accessing services over time. Participants suggested that if whānau ora models are to work effectively within the community, then funding needs to be organised in a way that “reinforces [Māori providers], not undermines them”.

Whānau Ora Policy and Other Strategies

Discussion surrounding the acceptance of *He Korowai Ōranga* and the whānau ora policy in particular, was generally supportive. However, participants in the research suggested that there needs to be recognition that this will take time and involve many small steps. In one case study region, changing the structural policy environment was seen as the greatest barrier to achieving Māori health gains – even more so than resources. In another, participants referred to the need for all policies, including whānau ora, to be relevant to local communities.

One participant suggested that it would be impossible to address all that whānau ora means within health provision, but this should not deter from work focusing on prevention, education and delivery models that will reach Māori with culturally acceptable approaches.

5 Ethnicity Data Collection

A particular issue of interest of this research, and one which was given emphasis, was the collection of ethnicity data. Reliable ethnicity data are crucial for a number of reasons. The focus of the Government and the Ministry on improving Māori health and reducing inequalities is redundant if accurate ethnicity data are unattainable. Service delivery is also reliant on accurate information for funding and planning purposes.

Provision of Services to Māori

In this research, a number of participants specifically referred to the contractual requirement of PHOs to collect ethnicity data. A non-DHB Māori provider in the second round of interviews noted requirements varied depending on the specific contract. However, most contracts simply require the numbers of clients by ethnicity, and this does not include Iwi affiliation data.

The lack of recognition of the importance of Iwi affiliation data, and its consequential non-inclusion in any ethnicity data collection, was raised by participants in two case study regions. One participant suggested it was particularly important for Iwi and hapū data to be collected for accountability purposes; in a region where the non-manawhenua population are the largest population grouping and where the bulk of the health contracts have been allocated to local Iwi, this participant felt that in order for taurahere to achieve whānau ora, they need to know exactly how manawhenua are dealing with them specifically.

A separate but related issue of concern was raised by one participant who was critical of DHB strategic plans that used statistics and information that applied to Māori in other parts of Aotearoa/New Zealand, for the local Māori population.

Primary Health Organisations

Participants in one case study DHB at the first round of data collection referred to the development of systems for the collection of ethnicity data by PHOs. They reported a very high acceptance of these ethnicity data collection systems, resulting in a good uptake by General Practitioners (GPs), and noted their inclusion of Iwi data. In a second case study DHB, a participant commented that although “the data’s still in its real raw infancy stage, most of the providers actually have the capacity to collect [it]”. It was expected to take another three to five years “to tidy up” before “we’ll see some good data”. Once the DHB had good ethnicity data for primary care, this would be used to map incidence rates for Māori versus non-Māori, for strategic planning purposes.

In direct contrast, collecting ethnicity data at the provider and PHO level was seen by participants in another region as complex. One noted that historically the health and disability sector had never required any ethnicity data from primary care, and as a consequence very few primary care providers had bothered to collect it. Another participant in the research noted the importance of ethnic identification of a service’s population as vital to determine funding eligibility within *The Primary Health Care Strategy* (Ministry of Health/Manatū Hauora, 2001b). The research found however, that by the second round of interviews, progress had been made in the area of concentrated ethnicity data collection within this region.

Mainstream Responsiveness to Māori Health

A specific objective of *He Korowai Ōranga* is to improve access to, and the effectiveness of, mainstream services to Māori. Participants were therefore asked about the ways in which they were working to improve whānau access to, and the effectiveness of, mainstream providers.

Although Māori access to mainstream providers was considered a high priority area for one case study DHB, assessing and improving this access was hindered by the lack of data on ethnicity, which meant it was not possible to identify how much money was actually being spent on Māori health. One case study DHB was to be attempting to put in place frameworks for the collection of data as a first stage for monitoring current services.

Māori Spend

The inadequacies of ethnicity data collection meant that some questions of interest in this research could not be answered. In particular, the ability to determine how much money is actually spent on Māori health is reliant on accurate ethnicity data. Although the money being allocated to Māori providers is known, they do not deliver services exclusively to Māori. The allocation of resources to Māori receiving services from Māori providers is not known, nor exactly how much funding is provided for Māori health through the DHB's provider arm.

An obvious consequence of this inability to absolutely determine Māori spend is that it is extremely difficult to measure the priority given to Māori health.

Further compounding this issue is the contention that there is a “lack of evaluation of Māori providers” being undertaken. The participant who raised this concern suggested that as a result, outcomes for Māori health funded investments were poorly understood. This participant argued that such evaluations “would guide us in terms of what investment has been done in our area”, but without this information “we don't know” how Māori health is progressing: “all we know is that Māori health is increasingly getting worse”.

Progress

Although ethnicity data collection in two case study DHBs was described as “problematic”, particularly in regard to the lack of clarity around absolute spend on Māori, there were indications that some sections of the DHBs were addressing the issue.

Participants in two DHBs referred to issues related to the collection of ethnicity data that were linked to the Census. One participant referred to issues around the inaccuracies in the population projections through the Census, whilst another noted that delays in improving the collection of staff ethnicity data was compounded by the review of the Census question on ethnicity that Statistics New Zealand/Tatauranga Aotearoa were undertaking during the time of this research.

Workforce planning is another area that is dependent on accurate ethnicity data. Participants in two case study DHBs noted that workforce planning within their DHBs was hampered by inadequate ethnicity data for staff. Without this vital information, it is impossible for DHBs to either undertake a stocktake of their health and disability workforce by ethnicity, or to assess the need for Māori workforce development.

Tools and training for those collecting ethnicity data

A number of participants referred to the need for those collecting ethnicity data to feel comfortable about doing so. In other cases, ethnicity data were transferred from one collection to another, without necessarily any accuracy checks. Some participants in the research noted information technology problems, which hampered progress, while others noted the occasional reluctance of people of all ethnicities to disclose their identity, including DHB staff.

To counteract all these barriers, *Whakatātaka* directs the Ministry to work with DHBs to develop tools and training for those collecting information, and provided a timeline for the implementation of this work: by December 2003 (Ministry of Health/Manatū Hauora, 2002b:28).

Very few participants referred specifically to the development of such tools and training, however. One participant noted that their DHB had begun work on an “enabling” framework to ensure staff were comfortable in asking the ethnicity question. The orientation presentation for new staff was also being revised accordingly. And participants in another DHB reported the development of training and education about the importance of accurate ethnicity data collection within their DHB.

District Health Board Reviews of Standards and Systems for Collecting Ethnicity Data

Whakatātaka states that to ensure awareness of the need to improve the collection of ethnicity data, DHBs will review their standards and systems for this data collection. The timeline provided for the implementation of this work was once again by December 2003 (Ministry of Health/Manatū Hauora, 2002b:28).

A number of participants in the research referred to such reviews of systems for ethnicity data collection within their DHBs, although in one case some skepticism was expressed about the accuracy of the results found by these reviews.

The purpose of reviewing standards and systems for the collection of ethnicity data is so that clinicians, administrators and consumers are aware of the need for high-quality information across all services (Ministry of Health/Manatū Hauora, 2002b:28). Participants in three case study regions all reported such an awareness of the importance and the need of collecting these data.

A note of caution was expressed by participants in one case study DHB who expressed some wariness as to the usefulness for Māori of strategies to increase accurate ethnicity data collection, however. The general feeling was that “on the ground” activities that worked towards the same aim were more beneficial than written strategies.

6 Workforce

The Ministry sets out specific expectations of Crown agencies in regard to workforce and provider development in *Whakatātaka*. In order to “provide for the needs of Māori”, each DHBs is expected to “make progress in developing its Māori workforce, promote workforce development among its contracted mainstream providers by ensuring that mainstream services are culturally effective, and promote the development of Māori providers” (Ministry of Health/Manatū Hauora, 2002b, p.48).

Increasing the Number of Māori in the Health and Disability Workforce

Of the estimated 67,000 professional health workforce in Aotearoa/New Zealand, Māori practitioners make up 5% (Health Workforce Advisory Committee, 2002). They are under-represented in almost every area of the health and disability workforce. These figures are only estimates however, because poor ethnicity data collection amongst DHBs ensures accurate figures cannot be provided. Without this crucial baseline data, progress in Māori workforce development is impossible to accurately determine.

Māori Health and Disability Workforce Initiatives

A number of initiatives have been established over recent years to contribute to Māori workforce development in both the education and health and disability sectors, including the MPDS and targeted mental health funding.

Attracting Māori School Leavers into the Health and Disability Workforce

Active promotion of health as a career option for Māori school leavers is one way of addressing Māori health and disability workforce capacity. The majority of DHBs involved in the research referred to efforts made by their specific DHB to target school leavers in this way. DHBs also recognise the importance of targeting students before they leave school to ensure they consider health as a viable option and an attractive career.

Increasing the Māori Mental Health Workforce

Initiatives to increase the Māori health and disability workforce include a specific focus on the Māori mental health workforce and targeted mental health funding. This focus is a probable contributor to the noticeable greater number of Māori working in mental health rather than other areas within some DHBs.

Despite these reported greater numbers of Māori within the mental health workforce than in other areas of the health and disability workforce, there is still a dearth of skilled Māori in the mental health workforce, in particular clinical staff.

Increasing the Māori Nursing Workforce

Medical practitioners and nurses collectively make up approximately two-thirds of Aotearoa/New Zealand's health practitioner workforce (Health Workforce Advisory Committee, 2002). Nurses make up the greatest proportion, with more than 50,000 members nationwide, of whom around 6% are Māori²⁵ (Nursing Council of New Zealand, 2004).

²⁵ The New Zealand Nursing Council issues 51,583 nurses and midwives with annual practising certificates in the year ended 31 March 2004. 3,224 of these nurses and midwives were Māori.

Given the size of this workforce, investment in nursing by DHBs is very important. A number of the DHBs involved in the research referred to the specific efforts made in their regions to increase the Māori nursing workforce. Efforts included the development of nursing-specific projects in one DHB, which have allowed the employment of Directors of Primary Health Care Nursing who in turn, are developing a professional development framework. The location of nursing training establishments within DHB regions was another contributor to the ease or difficulty of attracting nurses.

Māori Workforce Development Plan

The Ministry, in consultation with the Health Workforce Advisory Committee, planned to develop a Māori workforce development plan to “identify the numbers and skill mix of Māori required to support the achievement of whānau ora, co-ordinate activities between the health sector and the education sector, and address barriers to achieving the necessary workforce” (Ministry of Health/Manatū Hauora, 2002b, p.21). Although no reference was made by any of the participants in the research to such a Māori workforce development plan, many referred to the workforce development plans or Action Plans, and Māori Health Plans, which had been developed within their specific DHBs.

Improving the Skills of the Māori Health and Disability Workforce

The lack of a skilled Māori health and disability workforce was identified by second round participants as a barrier to achieving health gains for Māori. Māori providers reported a need for the development of workforces with skills at all levels – administration, management and medical. Limited health and disability workforce capacity was reported at all levels and in all areas, causing one participant in the research to comment on the “unbelievable insufficiency... of Māori care workers... and specialised workforces”.

One Māori provider described the need for Māori with business skills and management skills, but also noted the need for skills “in terms of knowing Māori”, whilst other participants talked of the need for operational skills.

One issue identified in the research in regard to the lack of a skilled Māori health and disability workforce, was related to patient safety. Participants suggested that due to a lack of professionally trained Māori clinicians in some fields (particularly mental health), non-professional staff were forced to fill the gap. That these staff may work “relatively unsupervised” and “sometimes do things which are of concern”, is an alarming result of limited health and disability workforce capacity and capability.

Increasing the Māori Health Management Workforce

One of the challenges identified by Māori providers is finding people with management experience. Often providers start small and grow but the infrastructure and skills of the health and disability workforce do not grow at the same rate. One participant in the research suggested this left providers struggling with poor governance.

Increasing the Māori Community Health Workforce

An important point highlighted in *He Korowai Ōranga* is that “Māori community health and voluntary workers, many of whom are Māori women, have a pivotal role in improving the health of Māori whānau”. Accordingly, the Ministry has aimed to work with the Ministry of Education and Tertiary Education Commission “to extend or develop programmes to recognise and strengthen the skills and availability of whānau and community workers”.

Increasing the Māori community health workforce was highlighted by some participants in the research, as one way of improving community access and participation. One participant emphasised the importance of not just focusing on professional groups but also on the development within the community and what is needed there.

Retaining the Māori Health and Disability Workforce

Addressing recruitment of Māori into the health and disability workforce is pointless without addressing retention alongside it. A couple of issues were identified by participants in regard to retention of the Māori health and disability workforce. Problems with retention of new Māori graduates were mentioned as well as the burdens placed on existing Māori staff who were expected to be the Māori advisor on all things, which may in turn lead to burnout. There was also recognition that once Māori are trained they are in high demand and may go elsewhere.

Training the Māori Health and Disability Workforce

The need for more trained Māori “at all levels” was highlighted in the research. Workforce development on this front was recognised however, as “a slow process”. One participant commented that “traditionally, the training for health professionals in the health sector takes quite a long time and you are expected to take the training as part and parcel of the career and the profession”. Of concern is that Māori workforce training in some DHBs has fallen on the responsibility of providers, adding to an already heavy workload, particularly in terms of accountability. Some very positive results concerning the training of staff were reported in the research, however.

Cultural Competency of the Health and Disability Workforce

In a number of case study DHBs, there has been a focus on the cultural competency of the health and disability workforce. In one case study DHB, several participants mentioned developments such as a Māori staff network, and general training and education in Te Reo Māori²⁶ and the Treaty of Waitangi, as being positive contributions. Another positive spin-off identified was staff feeling confident enough to identify as Māori, when in the past they may not have done so, due to developing policies of positive cultural sensitivity and slowly but surely breaking down barriers. The importance of cultural audits alongside cultural competency training was also highlighted.

Māori Workforce Development

A number of other issues relating to Māori workforce development were mentioned by participants in the research. These included: difficulties in identifying what sort of health and disability workforce was needed now, and how this may differ for future planning; the constraints of different models of care; the lack of Māori in key decision-making positions to influence and prioritise Māori health and disability workforce development; and a lack of adequate funding. One participant noted that although there have been central Government initiatives to build the Māori health and disability workforce through *Whakatātaka*, this was seen as relatively ineffective without resourcing or support to enforce it.

²⁶ The term ‘Te Reo Māori’ is used to refer to the Māori language.

7 Māori Providers

Finance, Funding and Contracting

Māori providers had a number of comments to make on issues relating to financing, funding and contracting. In one case study DHB, it was felt that the DHB was preoccupied with the hospital and managing the deficit and that this was at the expense of new initiatives. This preoccupation also stifles provider development:

“I think there’s a clear need to design new integrated services, whānau wellbeing driven services for Māori, but not just around health but around intersectoral approaches. And that is almost impossible... Most Māori providers around here are quite small and really focused on providing the service that they’re providing now... There’s no providers that have got real comprehensive funding to deliver from [a] whānau-centric sort of approach, and that’s a line that I’ve been pushing for a while.”

Many of the participants in the research referred to an inadequacy of funding. Some providers suggested one of the ways they manoeuvred around this was to change the way they delivered services to suit funding. However, this was not a realistic option for many providers who had targeted their service to meet the needs of their clients.

Some providers did not feel well supported by their DHB and felt that the DHB did not have a good understanding of some providers’ models of care; for others they found the DHB helpful and felt that it was getting better at working with the community.

Another issue raised was in relation to the provision of services. Because of the small numbers of Māori involved in health, some individuals have multiple relationships with providers such as being the funder, the planner, and the developer of services, as well as the manager. Providers described some of the characteristics that made for successful provision of health services to Māori, including the absolute importance of having a health background, and of being culturally safe as well as clinically safe.

These characteristics were necessary to be able to give Māori the best possible care and to be accessible. Another provider explained that there is absolutely no doubt that Māori have a preference to have their care provided by Māori. There was a clear expression that ‘by Māori, for Māori’ health care was the preferred model for Māori.

In the second round of interviews conducted in mid-2004, one DHB participant based at a Māori provider discussed capital expenditure in terms of its effect on providers. The participant agreed that providers are not funded by the DHB for capital expenditure. Rather there is an expectation by the DHB that health service providers will lease premises and equipment where necessary. However, this participant noted that Māori providers believe it to be less risky to own property and buildings, rather than rent or lease them. As a result Māori providers will try to find money within their contracts so that they can afford to purchase capital items.

Other issues for DHB Māori providers included maintaining the number and capacity of providers in the DHB, the effectiveness of Māori providers, and contracts and the contracting relationship. For a number of DHB Māori providers, issues with contracting have become even more complex with the introduction of an additional organisation between them and the funder, namely the PHO. At the second round of interviews, comment was made about this environment being difficult for Māori providers. In one DHB region, participants commented that Māori providers felt “subsumed” and “swamped” by the PHO environment. One DHB participant suggested that “Māori providers have been significantly marginalised in the PHO development” because they have not had an ability or capacity to “play a lead role” in any PHO initiative, due to the low number of registrations and the high number of casual patients arising with the transient Māori population. Difficulties determining who is accountable for the objectives in a PHO contract where a PHO includes a number of providers, was just one of the concerns raised in the 2004 round of interviews.

Performance monitoring is likely to be fraught as the stakeholders are “more ambiguous” than when contracts were directly between a funder/purchaser of services and a provider of services. In addition, contract terms appear to be evolving as PHOs themselves are emerging and evolving. PHOs were considered to be GP-focused, whilst Māori primary health care providers have a strong focus on community services. One participant in the research went so far as to say that there had been “significant neglect” in terms of Māori providers, and the issue was not being addressed.

For Māori providers, one of the concerns with contracts relates to the intent of the contract and who should benefit from the contract:

“We’re satisfied in terms of goodwill. We’re not satisfied in terms of actually what that means at the business end. So the DHBs want to act in goodwill and good faith and be transparent in their processes of allocating their contracts, but when it actually comes to allocating them there’s obviously a bias by the DHBs to purchase or to allocate contracts to providers that best help the DHBs in their business, as opposed to Māori health gain.”

A further concern is the inequality of resource to meet contracted objectives when compared with the resource available to the DHB provider arm:

“The provider arm of the DHB, it’s infrastructure, is from the DHB itself, so you can access a greater amount of information in contracting experience, clinical experience, and management experience... whereas if you’re a Māori provider and your management team’s only got four people... it’s hard for you to compete with the DHB provider arm when it comes to terms of the contract. ...The huge amount of infrastructure, depending on the contracts, is with the DHBs. So providers are disadvantaged, heavily.”

8 Experiences of District Health Board Members who Identified as Māori

A specific component of the Health Reforms research was the collection of data from DHB members who identified as Māori, through nine face-to-face interviews and two written submissions during a one month period from 25 August – 25 September 2004. The views reported in this chapter of the Māori Health Report therefore represent a “snapshot” in time from a small sample of DHB members.

Becoming a District Health Board Member

Ten of the 11 participants in this research were current DHB members; one had resigned. Only one had been elected to the DHB. All others were Ministerial appointments to their respective Boards. Most would be willing to stand for reappointment, two would make themselves available for election or reappointment, and one would stand for election only.

For six DHB members, this was their first time on a DHB, while the remainder had previous DHB experience; all had previous (and in some cases ongoing) experience of health and the health system. Many of those who participated in the research also had extensive experience in governance roles.

Three considered themselves “expert” representatives (having been appointed to the Board for some particular skill or degree of health expertise they possessed), two tangata whenua representatives, and two Māori representatives. One believed they were expert and tangata whenua representatives; two said ‘neither’; and for the elected DHB member the question was not applicable.

Participants were asked about their personal goals as members of DHBs. Perhaps surprisingly, not all of these were specifically related to improvements in Māori health. For example, some DHB members who identified as Māori, spoke generally about wanting to achieve “total population health” or equity and accessibility of services for all the people in their DHB. Goals related to Māori health included working towards health gains for Māori, improving Māori health and/or the reduction of disparities, and to see an increase in the number of Māori involved in health service provision.

Experiences of District Health Board Membership

A number of participants commented on the unease they felt with regard to whether the views of all Māori were adequately represented at the Board table, or within other governance groups. Most of those interviewed agreed that their role was to ensure the interests of Māori are advanced.

Only two categorically stated they were accountable to the Minister of Health as appointed DHB members. The majority of participants considered themselves accountable to a number of people or groups at the same time – from the Minister, to the Board itself, Iwi, and the Māori community more widely.

Participants spoke of both formal and informal evaluation processes of their work as DHB members. In general DHB members who identified as Māori, felt they worked well with other DHB members and were well supported by their colleagues.

Government's Intentions for Māori Health

DHB members generally agreed that the government's intentions for Māori health are very clear, and they identified a number of key messages. The first relates to the importance of the Treaty partnership between the DHB (as an institution of the Crown) and manawhenua. A second is the reduction of health inequalities between Māori and non-Māori and this was regarded as an area where DHBs need to concentrate their efforts. A third key message involved recruiting, upskilling and retaining the Māori health and disability workforce, and ensuring people had the skills and abilities to work intersectorally. Greater inter-agency collaboration and service integration, particularly in the area of primary health care, were also mentioned as being of importance to the government, along with an emphasis on whānau ora.

There were a range of views on how DHBs were implementing the *New Zealand Health Strategy* (Ministry of Health/Manatū Hauora, 2000), *The New Zealand Disability Strategy: Making a World of Difference: Whakanui Ōranga* (Ministry of Health/Manatū Hauora, 2001a), *He Korowai Ōranga: Māori Health Strategy* (Ministry of Health/Manatū Hauora, 2002a), and whānau ora – from generally good performance through to 'lip service'. Barriers to progressing implementation included staff capacity, lack of financial resources, lack of guidance on how *He Korowai Ōranga* would be implemented, and different understandings of whānau ora.

Most of the DHB members who identified as Māori, who participated in the research, considered their Boards to be well-informed.

District Health Board Ability to Contribute to Māori Health

A number of participants in the research raised the issue of there being insufficient resources to really achieve health gains for Māori and the risk of reductions at times of financial pressure. This seemed to be of real concern in those DHBs who were managing large deficits. The lack of capacity and skills to address Māori health was also raised as being a challenge for some of the smaller and more isolated DHBs.

An issue raised by some participants is the importance of the regular collection of high-quality ethnicity data so that DHBs are able to track their progress in meeting the goals outlined in the government's strategic plans.

Treaty of Waitangi Obligations and Relationships

The research indicated a high degree of commitment to the Treaty of Waitangi, even though many participants also commented on the degree of confusion or uncertainty about the DHB's actual Treaty obligations and responsibilities. A range of structures and models were being created in an effort to foster an active Treaty partnership in the health and disability sector, including through a Memorandum of Agreement between the DHB and the Iwi Health Board (governance group), or by establishing and working with a Māori Rūnanga. However, it was not considered sufficient to say that the Treaty partnership or relationship is operational simply because a Māori governance group exists.

Another issue identified was who represents the Crown partner in Treaty relationships in the reformed health and disability sector: the Minister of Health, or by devolution, DHBs themselves.

Relationships with District Health Board Māori Staff

Most of the participants in the research identified that their respective DHBs had created or affirmed a senior Māori management position, such as a Māori Director, since the inception of the model. However, whilst in one DHB, Māori staff had increased, in others the lack of Māori staff to implement the government's stated policy directions was a real concern.

Good relationships were noted with Māori staff. However, one participant clearly stated that the distinction between the roles of governance and management meant they would not “step over the mark” in terms of becoming involved in management issues. Another reflected on the awkwardness of having dual roles – as a member of a provider organisation in the community the DHB serves, and as a DHB member.

Progress in Māori Health

A range of initiatives or changes had occurred within DHBs which were identified as achievements for Māori health. These included Treaty workshops for staff to educate them about Māori; the Treaty relationship that had been established between a DHB and Iwi which was seen to signal a commitment to work together to improve Māori health outcomes; the appointment of a Manager of Māori Health; having Māori representation on each of the statutory committees; community consultation with Māori; and simply accepting the work Māori are already doing in the health and disability sector. Finally, according to one DHB member who identified as Māori, the greatest achievements of the DHB model were the opportunities it allowed for greater understanding of community need, for innovation, and the scope to try different models of practice.

Major Barriers to Progress

Impediments to improving Māori health outcomes included difficulties at the primary/secondary care interface, with the Māori rate of referral to secondary services lagging behind that of non-Māori; the lack of skilled Māori staff in the health and disability sector; racist attitudes and not acknowledging or validating Māori health and Māori strategies; and the problem of ensuring that the DHB is talking to the right people when they consult with Māori.

Other impediments to progress that were identified were lack of resources, the slowness of the system to adapt to change, and the need for an intersectoral approach to reducing health inequalities. One participant raised issues about the Ministry bureaucracy, including the time it takes for the Ministry to respond, the unavailability of the Ministry to sit down and discuss a problem, and their practice of gate keeping.

Other Issues and Challenges Identified by District Health Board Members who Identified as Māori

Election and Appointment Process

Some DHB members who identified as Māori, raised the issue of continuity as a key concern in the lead-up to the next round of elections. There was concern over the length of the three year-term, noting that while democratically elected DHBs were a positive aspect of the model, three years was insufficient time for DHBs to make effective changes.

One DHB member who identified as Māori, stated that Rūnanga need to become more strategic when proposing names for appointments onto DHBs, and more education and information was required at the Rūnanga level so that they put forward the best candidate for the DHB positions.

Chairs who had been appointed to their position must balance managing the government's expectations and demands against the needs and demands of the wider community, as espoused by the elected DHB members. The strain of trying to manage this dual set of expectations can lead to resignations and skilled people leaving the Board altogether.

Capacity, Competency and Depth of Māori Health and Disability Workforce

A number of participants noted that while strategies may be developed at a Ministry level for implementation by DHBs, there is a limited Māori health and disability workforce to ensure the translation and implementation of these plans into DHB activities. This was particularly so in some of the smaller DHBs.

At a management level, some DHBs considered themselves fortunate to have a General Manager Māori, while others noted it was a key achievement to appoint someone to that position. Where there were General Managers Māori, these people were often expected to deal with every "Māori issue" and as a consequence could be spread "too thin".

Regular Collection of Good Quality Ethnicity Data

One DHB member who identified as Māori, noted that a key challenge for their DHB was the collection of good quality ethnicity data which was considered essential to address Māori health disparities. The data is needed to create and drive policy, to find out if Māori are receiving services, and to enable DHBs to demonstrate whether they are achieving improved health outcomes for Māori.

9 Strengths and Weaknesses of the NZPHDA Model

A number of participants in the research made comments about the strengths and weaknesses of the NZPHDA model compared with earlier models.

In one case study DHB, one perceived weakness of the HFA/THA model was that it was a competitive model and some Māori providers are still in the competitive mode. However, because the DHB model is based on collaboration, it provides a more friendly, open and informal style. It is however, “risky” because “professional viability” is threatening for some providers. There is a lack of “professional supervision, not enough people with the right skills, heavy case loads, unmanageable job descriptions and the move to evidence-based [medicine]”. This leaves Māori providers vulnerable as they set up fast and some of the professional issues have not been addressed.

However, for another Māori provider the relationship with the HFA had been “very, very good” because the HFA had established and maintained close links with Māori providers. It was claimed that under the DHB model Māori providers do not enjoy the “same level of communication” they did under the HFA.

The view of community-based Māori providers in the second round of DHB interviews was that competition between non-DHB providers and the DHB provider arm is an issue for not just for them, but for all those involved in the delivery of primary health care services. There is an expectation in the community that many of the services currently provided by the DHB should be devolved to “the primary care sector and not held within the hospital”. One participant in the research noted that community-based providers must meet more stringent and more robust accountability requirements than those faced by the DHB.

Another second round interview participant noted that relationship between the DHB and Māori providers would “work a lot better if the Board wasn’t focused on shifting Māori providers to be inside PHOs”; an approach this participant objected to strongly.

In a second case study DHB, other barriers to achieving gains in Māori health were identified:

“The greatest barrier would have to be that we don’t have complete buy-in from the powers that be. [And] the second barrier that follows not too far behind that is that, as a Māori community, we have not got a strategic vision... We [Māori in the area] need to actually come together and say, “This is what we all agree on.””

This participant thought that the NZPHDA reforms have helped Māori in terms of giving Māori providers more autonomy and power, as “the DHB now did not do too much without ensuring that its Māori health providers are fairly happy with things”, but was concerned that the secondary arm of health was “coming in a poor second, and the majority of [Māori] were still ending up very unwell and in hospital”.

In a third case study DHB, participants felt that the DHB model looks at building on the gains made already, and as one participant said:

“I think we prefer to see some of them begin sustainable contracts with an ability to grow and do the job they want to, rather than a scattergun approach where everybody’s only got a piece of the pie.”

Another participant in the research suggested that one of the biggest challenges is:

“Getting a whole lot of small providers perhaps to work in a bigger framework. One contract provider’s doing just small parts of the service. It’s not viable long term.”

This message was also relayed by providers who reported that, at a recent consultation meeting, they had got the message from DHBs that the focus was to consolidate rather than increase the number of Māori providers:

“I think they’re looking towards the development of PHOs as an opportunity for Māori.”

At the second round of interviews conducted in July 2004, a provider participant in this DHB commented that one of the important health and disability workforce issues for them was around understanding the contracts better:

“Sometimes the contracts that we receive are so onerous, time consuming, complicated, and I really do believe it can be done a lot better... The reporting requirements are just horrendous.”

In this case study DHB, the HFA model was viewed by some participants as being a favourable model because of the development of Māori providers and the fact that providers had a direct relationship with a national contract manager.

One participant from the second round of interviews commented that the DHB model did not suit them as well as the RHA which had a regional focus. Currently the provider was working with four different DHBs. There was considerable variation in the relationship between the different Funding and Planning sections.

Another participant in the research felt that Māori providers were “starting to compete with each other. And it’s destructive to their relationships and their communities overall because they start to drive down their cost in order to secure contracts. Then they don’t deliver them well because they’re not funded adequately to do it well”. This participant felt that a better scheme would be a community development plan, so that with gambling, for example:

“Work [out] which is the best provider in your community to do the gambling services, and the rest of them awahi that provider through it... Let’s all awahi that provider instead of them all trying to develop in everything.”

At the second round of interviews, one participant was still critical of the DHB structure in terms of its impact on Māori providers, stating that the advantages of the HFA had been “a consistency and uniformity... throughout the whole country”. This participant felt that a level of trust had been built up, and good relationships developed, because of the separate Māori funding and the Māori Unit “who looked after that”, and that “a lot of really positive things had happened and suddenly everything got regionalised again”.

One participant in the research described how under the HFA system “there was a huge proliferation of Māori health services set up”. The advantage of this system was that “it was a one-stop shop; there was one place to go, which covered the whole country”. This participant described “a whole lot of anxiety amongst providers early on about the switch to DHB”. However, the participant felt that over time these providers had developed local Iwi relationships which is a “really, really good thing for them”. Another participant commented that one of the strengths of the DHB system was that under the DHB system there was localised funding which “looks at localised needs”.

In a fourth case study DHB, a majority of both DHB personnel and non-DHB interviewees were generally supportive of the DHB model. However, a number of Māori and Tagata Pasifika participants were more in favour of the HFA model. As one participant in the research put it:

“Devolving functions out to the DHB, in my view, has been a total waste of time. In fact, I mean I have no doubt that it has had a serious impact on Māori health gain and development.”

Reasons for the preference for a single purchaser amongst Māori participants included: a clearer focus on, and commitment to, the Treaty of Waitangi; the need for only a single point of contact; and the development of a critical mass of expertise in the area of Māori health. In the primary sector there was also concern that there it is now the PHOs, rather than Māori providers, who negotiate contracts with the funder.

One of the main perceived weaknesses was the fragmentation of the critical mass of skills and relationships, especially for Māori and public health, which had been developed under the HFA.

10 Summary and Conclusions

The Māori Health Report has focused on issues relating to Māori health, the Treaty of Waitangi and Māori experiences of the NZPHDA model introduced into Aotearoa/New Zealand in 2001.

A key issue for Māori working in the NZPHDA model is the relationship between the Crown as a Treaty partner and Māori, and how DHBs fit within this framework. There were clearly distinguishable views on this issue, with some participants in the research continuing to express concern over the establishment of relationships at the DHB level as opposed to at the Crown level. Other participants felt that they could work within a Treaty-based relationship rather than within a Treaty relationship *per sé*. This is clearly an on-going issue for Māori working in the health and disability sector, and is likely to cause on-going tensions at times, in particular as Māori providers continue to develop and to seek cross-sector solutions to the issues facing Māori.

A related issue concerned the responsibilities of the Ministry, which elicited a variety of responses, but with a general view that the Ministry was not meeting its Treaty obligations, particularly at a local level, and in relation to service delivery. Key to this was the view that the Ministry should: have a relationship with tangata whenua, whānau, hapū, and Iwi, at all levels of the infrastructure (and that having intermediary agencies such as DHBs and PHOs was not helpful); to recognise the rights and responsibilities of different groups; and to consult more. The on-going poor health status of Māori was also an issue in this context.

The DHBs have clear responsibilities in relation to Māori health, and in terms of meeting and respecting the principles of the Treaty of Waitangi, with respect to partnership, protection and participation. In this research, we have found that the degree to which DHBs honour that commitment varies. Some DHBs have developed formal relationships which are seen to be working well, while others are seen not to have a commitment to the Treaty of Waitangi and to working with Māori. Participants in one DHB were particularly concerned about the lack of attention to the Treaty of Waitangi and to Māori health issues, and later, about overt racism in meetings. Another issue at a local level was the respective status of mana whenua and

taurahere, which in some DHBs was an important factor in the developing relationships between DHBs and Māori and in how the Treaty principles are implemented at a local level. Yet a further issue raised often related to the perceived lack of resourcing for Māori working on governance and funding and planning functions, and the limited number of people available to undertake key governance and funding and planning roles.

Generally, participants in this research viewed *He Korowai Ōranga* and *Whakatākaka* very positively; giving a vision for organisations to aspire to and cognisant of Māori aspirations. Some DHBs were seen to be working hard to promote the Strategy, although not everyone interviewed knew of the Strategy, while the lack of funding allocated for the Strategy was also a key issue. One participant felt however, that the Strategy could not go far enough in promoting an holistic approach, given its focus on only the health and disability sector.

A key component of the Strategy is the concept of whānau ora. Here, we found a multitude of views as to what whānau ora actually is, although at a local level DHBs and Māori were working to identify what whānau ora might mean for those working at this level. Although this multitude of views may work to encourage the development of local ways of working, it will be difficult to monitor implementation of the Strategy and performance towards achieving whānau ora in this context. A continued lack of connection between the concept of whānau ora and current contracts was also noted in this research, and clearly a key challenge for the next few years is how to align agreed constructs of whānau ora with contracting processes and documentation. Participants in the research also felt that the funding is not available currently to really implement whānau ora appropriately.

This research has also found on-going issues relating to ethnicity data collection. The need to improve ethnicity data collection has been recognised for a number of years now, and although it is acknowledged that there is recognition of this as an important issue, and that the quality of data collection has improved, there is still some way to go in improving the quality of data available. This is seen as a crucial step in the monitoring of Māori health and use of health and disability services by Māori. An on-going gap is the inability to identify how much funding is spent on Māori health issues at a local level.

Poor ethnicity data collection was also shown to contribute to uncertainty in the actual number of Māori in the health and disability workforce in Aotearoa/New Zealand. Without accurate baseline data, it is impossible to accurately determine progress. What is known is that Māori are under-represented in almost every area of the health and disability workforce. A number of initiatives established over recent years to contribute to Māori workforce development, including the MPDS and targeted mental health funding, are making some progress on this front. DHBs also reported varying degrees of success in targeting the school-leaver population, and focusing on the Māori nursing workforce and the Māori mental health workforce. Retention of the Māori health and disability workforce was also recognised as important, particularly given the multiple accountability of workforce members. Training of the Māori health and disability workforce is a further area where DHBs reported varying levels of success. Of concern are the reports that this training has become a further the responsibility of Māori providers.

Māori providers had a number of comments to make about the funding and contracting of their services. There was general agreement that funding levels were inadequate to deliver all which *He Korowai Ōranga* required. Many Māori providers indicated that they did not feel well supported by their DHB and that their DHB did not have a good understanding of the models of care they employed. Others however, found the DHB helpful and felt that it was getting better at working with the community. There was a clear expression that ‘by Māori, for Māori’ health care was the preferred model for Māori. Capacity issues for Māori providers were mentioned, in terms of both staff availability and also the small size of providers which limited their ability to see more people.

DHB members who identified as Māori, interviewed for this research, had mostly been appointed to their DHB, agreeing that their role was to ensure the interests of Māori were advanced. There was some unease over whether the views of all Māori were adequately represented at the Board table. As in the case study research, the analysis of the interviews with DHB members who identified as Māori, found some confusion over DHBs’ actual Treaty obligations and responsibilities (versus the obligations of the Crown), and a range of structures and models being created to foster an active Treaty partnership in the health and disability sector. In general, DHB

members who identified as Māori, felt they worked well with other DHB members and were well supported by their colleagues, and most DHB members who identified as Māori considered their Boards to be well informed. However, there were some concerns raised over racist attitudes and not acknowledging or validating Māori health and Māori strategies. Some concerns were also raised over continuity of direction as a result of a short three-year DHB member term, and over the need for Chairs appointed to their position to balance government expectations and demands against the needs of the wider community.

DHB members felt the intentions for Māori health are clear, relating to: the importance of the Treaty partnership between the DHB and manawhenua; and the goals of reducing health inequalities between Māori and non-Māori, increasing the Māori health and disability workforce, inter-sectoral approaches to health, and promoting whānau ora. In some cases, DHB members felt the various government strategies – including *He Korowai Ōranga* – were being implemented in some Boards, while in others there was little more than ‘lip service’ being paid to Māori health. Barriers to progressing implementation included staff capacity, lack of guidance on how *He Korowai Ōranga* would be implemented, and different understandings of whānau ora. Lack of resources were a key issue in terms of achieving health gains for Māori, in particular where DHBs were managing large deficits. Lack of capacity and skills to address Māori health were also a challenge.

In spite of these problems, a range of initiatives had occurred within DHBs which were identified as achievements for Māori health. These included: Treaty workshops for staff; the Treaty relationship that had been established between a DHB and Iwi which was seen to signal a commitment to work together to improve Māori health outcomes; the appointment of a Manager of Māori Health; having Māori representation on each of the statutory committees; community consultation with Māori; and simply accepting the work Māori are already doing in the health and disability sector. Finally, according to one DHB member who identified as Māori, the greatest achievements of the DHB model were the opportunities it allowed for greater understanding of community need, for innovation, and the scope to try different models of practice.

Looking at the NZPHDA model compared with earlier organisational arrangements in the Aotearoa/New Zealand health and disability sector, we found that perceptions of the DHB model in comparison to the HFA/THA model varied. Some participants in the research preferred the latter, whilst others felt the more collaborative DHB model allowed a more friendly, open and informal contracting environment. It was claimed that under the DHB model Māori providers do not enjoy the “same level of communication” they did under the HFA, and this influenced some providers’ opinions of the model. Concerns were also expressed over the role of DHBs in not only planning and funding services but also in delivering services through their own provider arms, and the implications of this for non-DHB Māori providers.

Overall, the NZPHDA model has support from those interviewed for this research, although some participants continue to express greater support for the HFA model, where the growth of Māori providers over time was likely to have been the greatest and where there was an identified group of skilled Māori working together on Māori health issues. The NZPHDA model has seen the development of relationships at a local level, but there remains a concern that the Treaty relationship really lies with the Crown and not with DHBs, and not all DHBs were seen to be supportive of Māori health or cognisant of the Treaty of Waitangi. The research has identified positive support for *He Korowai Ōranga*, and participants provided a number of examples of new activities resulting from *He Korowai Ōranga*. However, there is some confusion over the meaning of whānau ora, and hence some confusion over how whānau ora can be operationalised. The need for improved ethnicity data collection was a key theme throughout this research. Finally, there are on-going concerns over a lack of resources to implement *He Korowai Ōranga* and to improve Māori health (including for capital development for non-DHB Māori providers), and on-going problems in relation to capacity and capability were also found. The key issues then in improving Māori health, concern re-iterating the importance of the Treaty of Waitangi, ensuring sufficient resourcing for Māori health, and continued attention to the upskilling and supporting the Māori health and disability workforce.

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