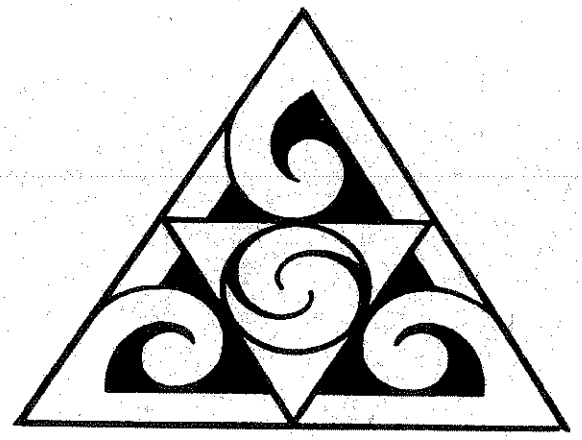
TE ROOPU MAORI TAKAWAENGA TOHUOHU KI TE MINITA HAUORA

MINISTERIAL ADVISORY COMMITTEE ON MAORI HEALTH



HUI HAUORA A IWI

KAUPAPA

TE ARA HOU MO TE HAUORA O TE IWI MAORI

PATHWAYS FOR THE ADVANCEMENT OF IWI HEALTH

VENUE

TAKAPUWAHIA MARAE

PORIRUA

11 APRIL 1992

CONTENTS

Disclaimer
This report was collated by Te Wahanga Hauora Maori, for the Ministerial Advisory Committee on Maori Health. It comprises papers and ideas presented at Hui Hauora A Iwi, April 1992.

The purpose of the report is to inform discussion, and assist in future policy development at Iwi, regional and government levels. The options expessed in the report do not necessarily reflect the official views of the Department of Health.

Moana Herewini
Co-ordinator te Wahanga Hauora Maori
Strategic Health Policy

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HUI HAUORA A IWI

FOREWORD

Tēnā koutou.

On Saturday 11 April 1992, the Ministerial Advisory Committee on Māori Health sponsored a Hui at the Takapuwahia marae, Titahi Bay. There were two major objectives. Firstly, iwi throughout the country had requested an opportunity to discuss the health reforms so that they might be better informed and able to participate in the health services on behalf of their people, in an active and productive manner. Secondly, iwi wished to comment on the reforms and to play some part in shaping those aspects which were critical to Māori health.

Nearly 100 people representing several iwi and a number of Māori health interest groups, attended the sessions.

This Report contains the papers presented at the morning session. They provide thoughtful commentaries on the nature of the reforms and their implications for Māori health.

During the afternoon, an open forum led to considerable discussion, not only about the reforms, but also about other avenues for the promotion of Māori health. Concerns about qualifications for example, were raised in connection with criteria for counselling ACC victims and Court referrals. Strong opposition to the export of placentae for the extraction of blood products and continuing disquiet about procedures for autopsies resulted in a call for further dialogue with the Minister of Health both in respect of the Coroner's Act and the Human Tissues Act.

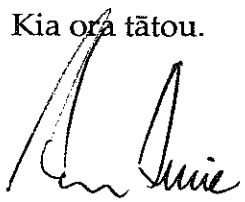
For the most part, however, discussion at the Hui centred on the new health reforms. Opportunities and obstacles were identified and there was considerable fear expressed that the new competitive climate would disadvantage many community groups as well as smaller iwi hoping to provide services under contract. Partly in response to that concern, the Hui participants welcomed the suggestion in the opening address for a Māori Health Authority. A unanimous resolution was passed that the Māori Women's Welfare League, the New Zealand Māori Council and the National Māori Congress, jointly take further steps to establish such an authority, able to represent Māori on health issues of national importance and, if appropriate, to act as a vehicle for the protection of Māori health interests.

The Hui finished on a positive and optimistic note. Uncertainties about the effects of the health reforms were balanced by the prospect of new opportunities and the potential for a more unified Māori approach to health policies and services.

The Ministerial Advisory Committee would like to thank those who attended the Hui and particularly the speakers who guided participants through the Health Reforms and their implications.

Takapuwahia proved to be a most appropriate venue and the support and encouragement provided by Ngāti Toarangatira set the stage for a successful Hui.

Kia ora tātou.



M H Durie
Chairman
Ministerial Advisory Committee on Māori Health

TE ROOPU MAORI TAKAWAENGA TOHUTOHU KI TE MINITA HAUORA

MINISTERIAL ADVISORY COMMITTEE ON MAORI HEALTH

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	Waireti Walters	Auckland
	Elizabeth Cunningham	Christchurch
	Jacqueline Allan	Auckland

SATURDAY 11 APRIL 1992

8.30 am — **POWHIRI/MIHIMIHI**

10.00 am — ***SESSION ONE***

Chair: Kevin Prime

Dr Mason Durie

Maori Development, Maori Health And the Health Reforms

HE PATAI/KORERO

11.00 am — ***SESSION TWO:***

Chair: Druis Barrett

Panel Discussion

Subject: A Guide to the Health Reforms

Ian McPherson:	Chief Executive, National Interim Provider Board
Heather Thomson:	Member, Public Health Commission Implementation Group
David Smyth:	Director, Health Reforms Directorate
Lorna Dyall:	Manager, Health Policy, Te Puni Kokiri
Troy Newton:	Peat Marwick Consultancy

HE PATAI/KORERO

1.00 pm — ***KAI***

2.00 pm — ***SESSION THREE*** **- IWI FORUM**

Chair: Elizabeth Cunningham and Mason Durie

An opportunity for Iwi delegates to raise issues and share ideas for the promotion of Maori Health

4 30 pm — **SUMMARY**

Concluding Remarks
Challenges and Opportunities

MAORI DEVELOPMENT, MAORI HEALTH AND THE HEALTH REFORMS

MASON DURIE, CHAIRPERSON
MINISTERIAL ADVISORY COMMITTEE ON MAORI HEALTH

INTRODUCTION

The establishment of the Department of Public Health and the passage of the Maori Councils Act occurred in the same year, 1900. Maui Pomare, the first Maori Health Officer within the Department, was quick to recognise the links between health improvements and local communities and recommended a close working relationship between the new Department and Maori Councils. In his view, improvements in Maori health required Maori leadership and Maori organisational networks if the people most in need of health services were to be reached. Although the subsequent improvements in Maori standards of health could probably be attributed to several causes, dramatic changes did occur with a sharp reversal of the depopulation trend that had earlier threatened Maori survival. By 1930, however, Maori Councils, had become defunct and the Division of Maori Hygiene within the Department of Health was disestablished, its duties being passed over to district medical officers. Increasingly health services became dominated by health professionals and health institutions and Maori participation was confined, for the most part, to a passive consumer role.

Eighty-seven years later, the NZ Board of Health, through its Standing Committee on Maori Health, recommended that a number of health services should be taken over by Iwi Authorities.[1] It was a timely reminder that health professionals did not have a monopoly on health and, more importantly, that improvements in health would require the active participation of individuals and communities. Furthermore, cultural perspectives were regarded as being of crucial importance in the delivery of health care and the development of health policies.

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1 Standing Committee on Maori Health (1987) "*Tribal Authorities as Advocates For Maori Health*" New Zealand Board of Health.

At the same time a re-evaluation of Maori social organisation was leading to the conclusion that iwi structures, far from being outmoded, were entirely relevant to the closing years of the twentieth century and likely to have implications for economic and social development as well as for cultural revival. Iwi development, Maori advancement and improved Maori health had emerged as different aspects of the same challenge.

THE DECADE OF MAORI DEVELOPMENT

The 1984 Hui Taumata[2] prescribed a decade of Maori Development within a framework of Maori self sufficiency and Maori control. Reduced reliance on the State, the conversion of negative spending into positive funding, and confidence in tribal delivery systems were emphasised in order to enhance Maori social and economic advancement. While the major thrust was on economic initiatives, a paper on Maori health, and several reports on Maori unemployment left no doubt that social policies were to be integral to Maori development and that Maori people themselves were ready to be the major agents for change.

In retrospect it is likely that the Hui Taumata findings were used to support free market policies and to strengthen the case for a minimal state. Devolution, restructuring of the Department of Maori Affairs and a user pays philosophy became Government priorities. To some extent, Maori aspirations for greater independence from the state and a greater measure of economic and political autonomy appeared, at least on the surface, to support those objectives, despite warnings from iwi that hasty decisions and inadequate funding could undermine any advantages that devolution might bring to Maori authorities.[3] A dilemma for Maori was beginning to emerge. *Tino*

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2 Arising out of the Economic Summit Conference convened by the newly elected Labour Government in 1984 was a parallel Maori Economic Summit Conference, the Hui Taumata. An analysis of the Summit's mixed agendas can be found in Kelsey J. (1990) *"A Question of Honour"* Allen and Unwin, Wellington.

3 Submissions to the Royal Commission on Social Policy stressed the need for devolution to be accompanied by a genuine sharing of resources. In the Royal Commission's *"April Report"*(1988) Vol.1, 297, Sir James Henare's views are summarised: "He doubted that devolution could be seen outside the concept of partnership and saw a need for each partner to be brought to similar levels of preparedness before rushing into contracts that might be attractive in the short term and even politically expedient, but that would not necessarily be able to promote well-being on a long term basis".

Rangatiratanga and its promise of greater Maori autonomy could be construed as offering implicit support for privatisation or at least for reduced state provision of services. Having made a case for greater Maori control, iwi and other Maori authorities were faced with the prospect of using meagre resources derived in part from the state and in part from their own coffers, to provide a range of economic, social and cultural programmes. The state in turn seemed poised not only to encourage the private provision of some social services but also to curb the level of State spending on health, education, housing and employment. Social indicators left no doubt that the socio-economic position of Maori was, to say the least, disadvantaged and that iwi might unfairly be expected to rectify a situation that had developed over the decades as a result of misguided government policies.

In the years immediately following the Maori Economic Summit, few if any of the Hui Taumata aspirations were fully realised. Two developments combined to frustrate progress and to compound the mixed and at times contradictory objectives already evident in Wellington and in the regions. Firstly, having been made aware of the extent and nature of partnership deriving from the Treaty of Waitangi, as expressed in the Court of Appeal during the NZMC-SOE case (1987),[4] the Crown appeared to step back from its earlier interest in Maori autonomy, including economic self-reliance. Instead, contractual relationships premised on the delegation of certain state functions, but within constrained and narrow frameworks, were favoured over a partnership based on a sense of constitutional equality. In its own interpretation of the Treaty principles, the Crown referred to the Rangatiratanga principle as the Principle of Self-Management under which Iwi have the right to organise as iwi, and, under the law, control the resources they own[5]. There was little in that wording to favour autonomy or self determination on the part of iwi but the recognition of iwi as key players in economic development was at least consistent with the intention to devolve to them some resources, and delegated authority. Thus while seeming to address the concept of partnership, the State's role for iwi appeared to be a limited one that allowed no significant

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4 NZ Maori Council v Attorney General (1987) 1 NZLR 641; widely regarded as a victory for the NZ Maori Council and for the acknowledgement of Crown obligations in respect of the Treaty.

5 Dept. of Justice (1989) *"The Crown and the Treaty of Waitangi"*.

part in the formulation of economic policy but encouraged a relatively minor management and delivery role.

A second obstacle to positive iwi development came about as a result of Government enthusiasm for off loading state obligations to iwi authorities, as part of the devolution process. Matua Whangai, Maccess and Mana programmes quickly became the focus for many iwi, often at the expense of their own plans and aspirations and frequently to their considerable inconvenience. Maori development it appeared, was being determined by state agendas, and Maori priorities were having to be accommodated within programmes and parameters set by central policy makers. Far from determining their own futures, many iwi were caught in the ironic situation of being providers for government programmes but without any real opportunity to shape the programmes or to give attention to their own plans. Further, while Mana Enterprises in particular was often highly successful, it suffered not only from centrally imposed regulations but also from a failure to secure a longer term commitment from Government. Maori development, and iwi development in particular, ran the risk of being a euphemism for culturally sensitive government programmes, delivered at relatively low cost by Maori.

The first half of the decade of Maori development then, had been characterised by conflicting and confusing objectives, inconsistent signals from Government, intense rivalry that divided and diminished Maori, and above all a failure to substantially improve the Maori economy.

Partnership masqueraded as tino rangatiratanga; competition was confused with efficiency; and devolution merely created the illusion of self determination. While the call for a decade of Maori development had come from Maori leaders at the Hui Taumata, the actual prescription bore more of the stamp of Government, while the right to dispense had been assumed by the bureaucracy. Missing was Maori control and Maori ownership.

Nonetheless Maori enthusiasm for iwi development remained high and Maori interest in the formulation of health policy and the delivery of health services was steadily escalating. At the Hui Whakaoranga convened by the Department of Health in 1984 a positive approach to Maori health was stressed and the

relevance of Maori philosophies and health initiatives was affirmed.[6] Participants were unanimous in their desire for Maori to have a greater voice in the allocation and distribution of health resources and there was a recommendation that priority be given to tribal and marae-based initiatives in terms of capital development and on-going salary maintenance."

By 1986 iwi delivery systems had gained the attention of the state and support from Maori, and tribes were recognised as having a special role to play in the advancement of Maori health. The Maori Health Standing Committee of the Board of Health regarded health as an aspect of Maori development which ought to be integrated into the total range of tribal services; and recommended that tribal authorities incorporate health programmes into their social and economic programmes[7]. The Committee also noted that "tribal authorities have obligatory responsibilities to all members of the tribe regardless of their level of participation in tribal affairs". A similar point was made by the Royal Commission on Social Policy.[8] "The Commission encountered enthusiasm for programmes which allowed proactive and caring policies to be managed by communities themselves, and agree that inevitably the obligations on Maori people are such that they must be seen as the trustees and guardians for their own people"

Those iwi committed to health advancement for their people quickly learned that their own input into the health system and, perhaps more importantly their ability to access funds, were very much governed by area health board attitudes and policies. The Area Health Boards Act (1983) contained no statutory obligation to address Maori health issues nor even to conform to the principles of the Treaty of Waitangi[9] and with the greater devolution of funding responsibilities to boards from the central Department of Health, many Maori health interest groups felt disadvantaged. While the appointment

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6 Department of Health (1984) *"Hui Whakaoranga."* A report on a Maori Health Planning Workshop held at the Hoani Waititi Marae 19-22 March 1984.

7 Standing Committee on Maori Health (1987).

8 Royal Commission on Social Policy (1 988) *"The April Report"* vol. 1 1, 61.

9 Section 10 of the Act, however, required boards to consult widely and section 39M of the 1988 Amendment required general managers to recognise "the aims and aspirations of the Maori people"; 'the employment requirements of the Maori people- and -the need for greater involvement of Maori people as employees of the area health boards'.

of at least one Maori member to all area health boards by the Minister of Health in 1989 reduced some concerns, in most areas the Ministerial appointments were made with limited Maori consultation and in isolation from other iwi programmes.[10] Largely in response to these concerns the Ministerial Advisory Committee on Maori Health[11] prepared a report for area health boards strongly recommending that boards establish "dialogue and co-operation with iwi authorities in their area in order to collaborate in the development of their respective policies".

After a period of some uncertainty, boards and iwi began to develop useful relationships leading on to innovative approaches to health policy and to health care. A partnership model emerged in the Bay of Plenty with a regional Maori body, Te Whanau-o-te-Poutirirangiora-a-Papa, representative of all iwi in the Boards area, assuming the role of a partner with the Board itself. Other boards dealt directly with each iwi though were usually not averse to meeting with regional groups who were more widely representative. Some progress was being made though there had been insufficient time to make any substantial evaluation of the joint endeavours before boards were dissolved in 1991.

Overall, however, five or more years of area health board domination had proved helpful as an introduction for iwi into the health system and, more importantly into the ways in which they might advance Maori health. On the one hand inadequate funding, short term goals and limited roles, had been frustrating. Yet at the same time valuable experience had been gained in health policy formulation, the management of health services (no matter how limited), community health work and programmes of health promotion and disease prevention. Useful links had also been established with a variety of service providers and health administrators.

In the event a change in government in 1990 heralded major reforms to the health system.

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10 There were exceptions. The Taranaki appointments for example were made after discussion and recommendations from the Taranaki Maori Trust Board.

11 Ministerial Advisory Committee on Maori Health (1990): *"Policies for Maori Health; Guidelines for Area Health Boards"*, Wellington.

Even prior to the announcement of health reforms, however, an interest in Maori health was signalled by the Minister of Maori Affairs in a report, Ka Awatea, released in March 1991. Four priority areas, one of which was health, were identified.[12] While the report was short on specific details, it recommended two main strategies, a health promotion programme and a strengthened health policy function (for a new Ministry of Maori Development). What was not clear in Ka Awatea was the role envisaged for iwi. Indeed,there was some concern that a renewed central state focus could detract from iwi and community initiatives. On the other hand the inclusion of health as a priority area for the new Ministry was welcomed as a sign of greater potential support for Maori health, especially positive health promotion, by the Government.

One further Maori health endeavour requires to be mentioned. In response to concerns about the welfare of Maori patients discharged from psychiatric hospitals, the Maori Trustee commissioned a review[13] which concluded there was an important role for the Maori Trustee as an advocate and primary case worker for Maori who suffered from mental disability. There was a suggestion in the Report that some central form of oversight would be preferable to iwi based responsibility. The Report has not been accepted as policy but provides useful information on an aspect of health care that will predictably assume greater significance as the implications of deinstitutionalisation and community care are felt.

MAORI DEVELOPMENT: THE LESSONS LEARNED

Since 1984 Maori development has been exposed to numerous, and often contradictory, paths from which it has been possible to chart a course for Maori advancement on cultural, social and economic fronts and to define those policies and programmes which might best achieve the desired goals. While the issues were not always clear, in hindsight they can be described as a series of options each requiring iwi to make some fundamental decisions about a preferred approach. Working through the issues has in itself been valuable.

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12 Ministerial Planning Group (1991) *"Ka Awatea"* A Report to the Minister of Maori Affairs, Wellington.

13 Mason K (1991) *"Atawhaitia"* a report to the Maori Trustee.

1 Restructure

Reorganising departments of state is neither a new phenomenon nor one which has always advantaged Maori people. An early taste of restructuring occurred in 1852 with the passage of the New Zealand Constitution Act. Although the Treaty of Waitangi had been signed with the British Government, twelve years later the Constitution Act provided machinery for authority to be devolved to a settler government representing not only the settlers but also the other Treaty partner. Links and trust established with the Colonial Office were of limited value in the new arrangement. When Maori views stood in the way of "progress" they were ignored or legislated out of contention. Progressive delegations to London were likewise to discover that justice could not be dispensed there; it was the Parliament in New Zealand which must decide those matters.

For most of New Zealand's history, central government has been unresponsive to Treaty inspired demands or to Maori aspirations for a degree of self determination. But by 1980, perhaps because of the Waitangi Tribunal's reinterpretation of NZ's history, a new climate could be discerned and by 1984, when the Labour Government assumed office, central government embraced biculturalism in a deliberate manner, if not with overt enthusiasm. Maori began negotiating with various departments of state including the Department of Health. Understandings evolved and an atmosphere of partnership and cooperation slowly evolved; only, as it happened, to be diluted by the process of devolution. In the case of health services a strong partnership between Maori and the Department of Health amounted to little more than a pleasant memory when area health boards assumed responsibility for funding health services while the Department accepted a relatively minor role, at least in respect of funding community health initiatives.

Undeterred, iwi resumed the task of developing new partnerships, this time at a district level with area health boards. For many boards the Treaty was a relatively new discovery and Maori health perspectives were viewed somewhat sceptically. The situation was not always helped by the appointment to area health boards of Maori individuals who were often unversed in Maori development or in health matters. There was a great deal of variation in the extent to which Boards responded positively to Maori health

interests; many were plainly uninterested; some were perplexed and a few were antagonistic. The Ministerial Advisory Committee on Maori Health produced a report[14] in 1990 to help boards grapple with their new responsibilities and eventually most showed a willingness to explore possibilities with iwi in their areas.

The dissolution of area health boards in 1991, however, again placed iwi in the position of having to face new institutions and to reopen their case for special consideration based either on Treaty obligations or the unsatisfactory state of Maori health. It would be inaccurate to conclude that negotiations with area health boards had been entirely successful or that Maori aspirations in health were about to be realised. But some gains had been made and iwi were now left pondering the nature of relationships which might or might not evolve with the more remote and commercially oriented regional health authorities. Not surprisingly they also wondered whether it was worth repeating the exercise.

Lesson one: *Restructuring carries with it the likelihood that the emergence of new institutions will require fresh approaches from iwi. The partnerships and agreements carefully negotiated with precursors of the new structures cannot be assumed to have any ongoing significance.*

2 Maori Representation

There are fundamental differences in the ways that Maori and the state determine representation on councils, boards and committees. Political processes often take into account party loyalties, community standing and personal qualities. Iwi choices tend to favour popular Maori support but particularly iwi affiliation and the capacity for leadership. Both processes can be justified on their own terms but representation based on one method cannot be said to do justice to the other. A Maori appointed to a board may well bring a Maori viewpoint though does not necessarily represent Maori or even one sector of the Maori community and does not provide an alternative to other forms of consultation or advice. In this respect Maori participation on official bodies can be both token and misleading unless its limitations are

14 Ministerial Advisory Committee on Maori Health (1990).

acknowledged and there are other compensatory processes to ensure that representative views can find full expression.

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

3 Policy making

Over the past decade conflicting goals between iwi and area health boards have led to frustration and often animosity. Boards have been at pains to measure outcomes against their defined objectives; iwi have been interested in other outcomes, no less significant, but categorised according to broader criteria. At the heart of the misunderstanding is confusion about expectations and accountability. Even though funded from the public purse iwi may have presumed a license to implement their own health plans, while boards may have regarded iwi as no different from other agents charged with delivering specified services. The issue highlights the need for clearly defined and negotiated parameters so that false expectations are not created under the blurred guise of biculturalism or partnership. Iwi may well decide that they have no interest in acting as agents for the state simply to deliver a service that might be better managed by others; while boards may have no interest in a service related to Maori development but without obvious application to health care or health services. The different perspectives are likely to be worth exploring; they relate directly to the *Kawanatanga / Tino Rangatiratanga interface* and the utilisation of authority to facilitate or impede Maori development. Devolution has added fuel to the debate. There was, and still is, confusion as to the role iwi might play in shaping the overall dimensions of a programme, rather than simply delivering a prescribed service.

There appears to be diminishing Maori tolerance for a constrained service delivery function and even less interest in a peripheral supplementary role that makes no significant difference to actual outcomes.

Lesson three: *Iwi fully expect that they will be able to play a positive role in the formulation of policies as well as in the delivery of services. That is no less true for health policies and services.*

4 Long Term Planning.

In planning for the future, iwi have been mindful of the dynamic state of Maori society and the needs that will emerge over the next decade and the next generation. Too often longer term goals have been pushed aside by the demands of other short term measures. A recurring problem with area health boards was the yearly budgeting cycle and the inability to guarantee funding for more than a year at a time. Longer term planning was jeopardised by uncertainty and a lack of obvious commitment. At a national level iwi have been similarly disadvantaged by the three year political cycle, and even within the life span of a single government, it is likely that major policy changes will require substantial operational adjustments. The lesson is that serious planning by iwi for the future will require a more sustained focus on longer term goals, possibly by the development of Maori institutions that are separate from ministries and departments and which have the capacity and motivation to plan for more than two or three years ahead.

Housing is a good example. Perturbed by government indecision over Maori housing and some reduction of role for both the Housing Corporation and the Ministry of Maori Development, iwi are seriously exploring the possibility of establishing a separate Maori Housing Authority where continuity, consistency and a deliberate Maori focus can contribute to the formation of sound policies for better standards of housing and "the provision of affordable housing for Maori tribes and their members".[15]

A Maori Education Authority has been similarly mooted,[16] not only to promote Maori language and culture, but also to introduce some stability into the planning process so that longer term aims can be achieved without the distractions of competing, contradictory and unpredictable state policies. In this regard iwi have emerged with greater resolve to manage the future themselves and to avoid knee jerk reactions to whatever policy is in vogue. Time, energy, and resources are too scarce to be committed to a raft of short

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15 Housing Committee Report to the Congress Executive (15 Feb.1992), National Maori Congress.

16 One of the 8 goals for priority action by the National Maori Congress (1991) was the establishment of a Maori Education Authority.

term programmes unlikely to survive the ballot box or the next round of state restructuring.

Lesson four: *The message is clear. If Maori development is to address future Maori needs, then it must be driven by longer term Maori agendas based on Maori needs rather than short term political expediencies.*

5 Positive Development

The Hui Taumata recommended positive approaches to Maori development. Delegates argued that most government expenditure on behalf of Maori was essentially negative spending, directed largely at supporting, or at least containing Maori individuals in prisons, hospitals, special classes, foster care, health camps or emergency housing. Frequently, and perhaps quite rightly, iwi have been asked to take over those caring roles and to provide ameliorative social services where the state has failed. It has created a dilemma. Keen to help their own people and to respond in a caring way, many iwi have been seriously distracted from proactive goals. They have come to devote their entire energies to addressing needs created by inconsistent state policies: institutionalisation and then deinstitutionalisation; imprisonment and then habilitation; educational failure and then pre-employment training; urbanisation and then homelessness. More often than not iwi responses have been generous and rewarding but with doubtful long term benefits and at the expense of preventative and positive strategies likely to improve the future outlook for Maori people.

Lesson five: *Iwi energies are better spent in the development of fresh approaches rather than in the reparation of the ill effects of past policies. In this respect iwi interest in health lies clearly with health promotion, disease prevention and early intervention. Primary health care has been recognised as singularly important and an obvious focus for positive health*

6 Co-operation And Competition

Driven by the belief that competition would enhance performance, create efficiency and lift the economy, free market strategies inevitably found their

way to iwi. Competition between iwi produced tensions and divisions that, far from creating efficiency, led to a multiplicity of poorly funded, under-resourced authorities with high overheads and an incapacity to grapple with the wide ranging demands of iwi development. Iwi were pitted against each other. Although there were luke warm attempts to foster voluntary associations of iwi, the reality was that additional smaller bodies, each with its own claim to autonomy and uniqueness were established. The short lived Runanga Iwi Act (1990) may have accentuated that trend; certainly in the lead up to its enactment, inter-iwi rivalry and competition for minimal resources saw new tensions emerge, sufficient to threaten co-operative Maori development. A series of semi-independent, under-resourced economic ventures emerged, many with doubtful financial arrangements and depending on political goodwill for their survival. While larger iwi with well established administrative structures fared relatively well, those of limited size and means were ill placed to compete in the market place and to prosper.

The emergence of the National Maori Congress created an alternative environment in which it was possible to redress some of the balance. From 1990, an increased preference for co-operation between iwi was evident. For one thing economies of scale demanded that iwi work together, pooling expertise, sharing overheads, and, while retaining a degree of autonomy, collaborating on wider issues that confronted many iwi. Joint iwi ventures in fishing, environmental management and claims against the Crown in respect of asset sales,[17] demonstrated a capacity for iwi to work together in a co-operative rather than a competitive manner.

At wider levels, competition with large corporations has often threatened iwi economic survival. Individual iwi have not been slow to realise that in economic and business terms they are small players, ill equipped to compete with national and multinational corporations, and not always able to depend on the backing of the Crown. But they have also been quick to appreciate that as part of a regional or national Maori federation their prospects for performing well are markedly improved.

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17 For an example of joint iwi action see Crown/Congress Joint Working Party(1991) *"Arrangements in Respect of Surplus Crown Railway Properties and Treaty of Waitangi Claims"* Information Brief, National Maori Congress.

Lesson six: ***Economies of scale and a revitalised sense of whanaungatanga have dispelled the notion that iwi need compete with each other in order to promote Maori social, cultural and economic development. Similarly, competition with large corporations, will be more fruitful when iwi act in concert.***

THE 1991 HEALTH REFORMS

Despite their drastic nature, the health reforms proposed by the Minister of Health in July 1991[18] were not entirely unexpected, nor for that matter were they totally out of step with earlier moves towards user pays, targeting, competition, greater economic efficiency and a reduced role for the State[19]. Briefly the 1991 reforms recommended a separation of treatment services from public health services. A Public Health Commission with regional Public Health Agencies will have responsibilities for health protection, health promotion and disease prevention while treatment services will be the prime responsibilities of Regional Health Authorities (RHAs). For both there will be a separation of funder and provider roles. Four Regional Health Authorities (the funders) will be charged with purchasing health services from a mixture of public and private interests (the providers). Unlike area health boards, which had a vested interest in maintaining their own services, the new regional authorities will be technically neutral as to the competing providers and therefore more able to focus on efficiency objectives.

Leaving aside the impact of co-payments for hospital treatment and prescriptions, iwi were particularly interested in two aspects of the reforms. Firstly, they could tender to provide services under regional health authorities. The very considerable experience already gained in health delivery, in geriatric care, community health work and health counselling would place some Maori providers in an advantaged position to continue those services on contract and without area health board domination.

But of particular significance to Maori was the possibility that, as an alternative to regional health authorities, iwi could establish their own health care plans, receiving bulk funding to provide a comprehensive range of health services.

While alternate health care plans were not directed only at Maori, they were strongly commended to Maori at post-budget briefing sessions held in Auckland, Hamilton, Dannevirke, Porirua, Christchurch and Dunedin,

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18 Upton Hon.S (1991) *"Your Health and the Public Health"* Wellington.

19 Hospital and Related Services Taskforce (1988) *"Unshackling the Hospitals"*. A Report prepared for the Ministers of Health and Finance, Wellington.

attended on most occasions by the Minister of Health and officials from the Department of Health[20]. Among the anticipated advantages was the opportunity for partnership between Maori and the state in accordance with the Treaty of Waitangi. In a discussion document prepared by the Task Force on Funding and Provision of Health Services,[21] health care plans were enthusiastically acclaimed as "supporting the empowerment of Maori people" thereby giving expression to tino rangatiratanga. It was an extravagant claim not entirely backed by supporting evidence but serving, nonetheless, to underline official encouragement for the concept and for Maori control of a comprehensive range of health services. The Hon.W.Peters[22] described health care plans as a "bold, innovative and proactive idea which may actually bring about positive outcomes. Maori, as any other group in New Zealand, may be able to opt out of the mainstream health system and access or join their own, or any other, health care plan. Whereas in the past Maori consumers have had to accept a "system" or lump it, consumers of health services can now opt out and choose a scheme which better meets their needs". The Minister was, however, careful to note that alternative health care plans did not equate with alternative medicine: "What is contemplated is alternative delivery systems more answerable to the taxpayer and providing a better service for consumers". Noting that health was one of the four key areas highlighted in the Ka Awatea report the Minister gave an assurance that the new Ministry of Maori Development would provide assistance by accepting at least one proposal as a lead project.

Health care plans were promoted as alternatives to the public system. If a different style of health care was sought (from that available through regional health authorities) then individuals would be able to have their entitlements from Vote: Health transferred to an approved alternative health care plan.

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20 The Takapuwahia (Wellington) Hui is described in: Department on Health (1991) *"Health"*, 40,17,14-15.

21 Task Force on Funding and Provision of Health Services (1991) *"Health Care Plans, An Option for Maori"* a Discussion Document.

22 Department of Health (1991) "Winston Peters-health care plans a key alternative for Maori" in *"Health"* 40.17,12-14.

Essentially health care plans would undertake on behalf of their members, to purchase a comprehensive range of health services funded in part from the government and in part from supplementary sources (health insurance, personal membership fees). Health care plans would be of particular interest to special groups seeking more from a health care system than regional health authorities could be expected to provide. There was a suggestion in the proposal that the public system might lack finesse or individual sensitivity and that private or semi-private arrangements would be necessary for "extra" considerations. Women, Maori, provincial centres and trade unions were mentioned in the 30 July media statement from the Minister of Health as groups which might be interested in developing their own plans.

Certainly there was strong Maori interest tempered perhaps by warnings that the development and management of health care plans would be a "complex issue"[23] and that financial viability would require a minimum of 25,000 members (or 50,000-60,000 if a Plan were to employ its own medical and specialist staff). There was of course concern about other issues including the linking of health care plans with what could amount to a private health service for which the State might assume progressively less responsibility. The last thing that was needed was a health care system which was less accessible than the mainstream service or which for financial or management reasons was forced into delivering a substandard level of care.

A mixture of enthusiasm and scepticism prevailed; it was not always possible to separate the issue relating to health care plans from the other measures introduced in the health reforms nor were iwi confident that they would have any effective voice in a system built so deliberately on competition and deregulation.

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23 Task Force on Funding and Provision of Health Care Services(1991) Discussion Document.

HEALTH REFORMS AND MAORI DEVELOPMENT

The health reforms can be further assessed in light of the lessons learned from the decade of Maori development.

1 Relationships with Maori

When the reforms are viewed as a whole, it is clear that there is no particular formula for Maori representation or participation. Neither the Health Reform Directorate nor the National Interim Provider Board have consulted Maori or iwi on a wide scale. While there will be a Maori person on each RHA and possibly on CHE'S, no emphasis has been placed on a negotiated partnership with Maori either in the formulation of the reforms or in their application. The links are not evident and the processes to ensure a continuation of Maori involvement in health are not apparent. It is a matter of some concern not only to iwi who are keen to consolidate their own health programmes but also to those wishing to build on the progress already made with hospital boards and area health boards.

The relationship between RHAs and Maori people has similarly yet to be defined. Contractual relationships alone will not address Maori concerns nor bear any relationship to the concept of partnership deriving from the Treaty of Waitangi. Maori experience with SOEs has been uneven and frustrating. It is not sufficient to simply package information into acceptable bundles for distribution to iwi; a more active negotiating process to clarify relationships, goals and the implications of restructuring is necessary.

Of particular interest to iwi will be the process to be adopted for the disposal of Crown assets which are surplus to the needs of health authorities. As CHEs prepare to shed unnecessary property, questions will be asked about the origins of their lands. Throughout New Zealand, hospitals were sited on land either gifted or purchased from Maori on the understanding that health care would be accessible and that iwi needs would receive special attention. The relationship of Ngati Whakaue to the Rotorua Hospital illustrates an explicit arrangement; many others were implicit and further investigation is required before disposal is contemplated. When faced with the same situation, Railcorp eventually entered into an arrangement with the National Maori Congress so that land could be cleared for disposal with minimal time delay and an

avoidance of lengthy and expensive litigation. A similar process is needed to ensure that Maori claims and interests in hospital properties are not overlooked.

By the same token, the relationship between CHEs and Maori should take into account previous understandings relating to the terms under which lands were made available for the establishment of hospitals and other health care facilities.

2 Iwi Health Care Plans

Of all aspects of the reforms, alternate health care plans have attracted the most comment from Maori. Possibly they have also acted as a distraction from other changes and opportunities. In any event their appeal is linked closely to the possibility that health care plans might fit comfortably with iwi development. Two significant considerations have emerged so far. Firstly, economies of scale have been acknowledged and iwi are interested in working together. One aggregate, Te Roopu Hauora a Iwi contains twelve iwi and potentially 60,000 members. Secondly, there is general agreement that primary health care should be the focus, at least in the early years and that iwi health care plans should take an active role in arranging quality care and treatment which is consistent with Maori needs and at the same time superior to other services.

The funder provider split, however, creates something of a problem. Iwi experience with Mana Enterprises and Maccess has been that iwi authorities have some obligation to encourage iwi based initiatives rather than relying only on providers who are already able to compete "on the level playing field". It would be ironic if iwi health care plans purchased services from mainstream providers, bypassing iwi providers because they did not conform to some narrow criterion. Underlying the notion of iwi development is the desirability of maximising and developing iwi resources, including human resources. A case could be made for iwi to be decidedly biased towards iwi health providers, affording them more than "preferred provider" status and in fact deliberately blurring the funder-provider boundary. To some extent it will depend on the acceptance of iwi health care plans as the focus for iwi health development as well as the funders of health care.

A further problem, and perhaps the obvious one, is the availability of funds for iwi to operate their own health plans. There is general recognition that state funding based on entitlements will not be sufficient to operate a quality health care plan and that either members, or sponsors will need to provide an additional "top up". Given the current state of the Maori economy, annual subscriptions from members, especially those for whom the plan will have the greatest potential benefits, will not produce significant revenue. There has been a suggestion that iwi might contribute on behalf of their members, though at this stage, iwi might also have difficulty in securing funds for health care plans. A matter which has not yet been decided, but which is highly relevant, is the formula for ascertaining entitlements. Age and gender appear to be the significant parameters but iwi consider that entitlements should also be based on known health risks. A risk adjusted entitlement would reflect a much more realistic appreciation of the Maori situation and could guarantee to Maori a level of funding commensurate with the task ahead.

Iwi health care plans will encounter competition from several sources. There will be other plans many of which will be directed at the Maori market; but more serious competition will predictably come from regional health authorities. They, like iwi, will be aiming to retain the largest possible membership and will not readily give up entitlements if it runs the risk of constraining their own flexibility. RHAs will not be exposed to the same risks as health care plans; in the end they will be able to count on state support; will be operational before other plans and will not be allowed to fail. In the competitive environment the playing field will not be level and iwi will be keen to make the most of a direct relationship with the Crown rather than with RHAs.

A further concern and it is related to long term planning as against short term initiatives, is the uncertainty about the fate of health care plans should there be a change of government. It appears that a Labour government would retain RHAs and the funder provider split[24] but encouragement for alternate health care plans would be much less likely. Iwi are reluctant to expend time and energy on a measure which might have limited application and a brief life span.

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24 Helen Clarke as reported in the Dominion 7/4/92.

3 Iwi as Providers

There are opportunities for iwi to participate in the new health services without necessarily forming iwi health care plans. As providers they will be able to tender for a range of services or could elect to concentrate on one type of core health service geared to Maori needs. Contracts with RHAs for defined services will offer iwi the chance to compete with other providers, possibly with other iwi. Te Roopu Hauora a Iwi hopes to promote a network of health centres[25] within the lower half of the North Island, either directly (unless the funder provider split prevents it from doing so) or by assisting iwi to establish centres that can offer medical, nursing and community services with a focus on early intervention, prevention and deliberate outreach programmes. Satellite mobile clinics on marae or elsewhere would be consistent with a policy of active health delivery. Tainui are interested in another approach; a capitation practice adapted to the needs of iwi and providing comprehensive primary health care for a largely Maori population.

A positive approach is needed to assist Maori health providers prepare for future contracts within the reformed health system. For many, the reforms remain confusing and pose significant obstacles to Maori entry into the new competitive environment. The Maori Health Unit within the Department of Health has taken a leading role in providing guidance and advice and more recently Te Puni Kokiri has entered the scene. Both will obviously have pivotal roles in assisting Maori groups wishing to tender for contracts with RHAs or iwi health care plans.

4 Public Health and Health Care

The health reforms anticipate a separation of public health measures from treatment and care. There is a danger that the split will lead to a type of primary health care which is fragmented and administratively complicated. Maori health initiatives have been characterised by an integration of health promotion and health care, and that has been their strength. The new reforms must address the question of how each section will relate to the other so that

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25 Te Roopu Hauora a Iwi (1991) *"Proposal to Establish a Multi-Iwi Health Care Plan".*

an integrated approach to health can continue. Probably there is no reason why providers should not have contracts with RHAs and Public Health Agencies and for that matter with Iwi Health Care Plans. But the matter is one requiring further explanation.

Prevention and treatment together, will be particularly important should Kohanga Reo decide to provide services for Maori children.

5 A Maori Health Authority

A weakness in the health reforms is the absence of a clear mechanism for representative Maori participation at a national level. The Ministerial Advisory Committee on Maori Health is able to offer comment but not on a sustained basis and not without Ministerial approval. The Maori health unit in the Department of Health has provided strong leadership for Maori health and has played a valuable role in the development of health policy. But ultimately its effectiveness is a function of departmental priorities. Te Puni Kokiri has some national influence but does not necessarily represent iwi views and does not have an extensive background in health affairs. Another option, already attracting favourable iwi comment, would see the establishment of a Maori Health Authority by Maori people. It would be able to negotiate health policy, including health reforms, directly with the Crown and able to receive funding without the need for RHA mediation. It would fill the current gap and in effect would become a fifth RHA serving not a particular region but a national Maori membership. It could be seen as an umbrella organisation which provided a stronger base for iwi interested in health care plans and at the same time a national focus for the promotion of Maori health.

A Maori Health Authority would sit comfortably alongside RHAs and like them would have direct links to central government. As a voluntary health plan available to all iwi, a membership of 200,000 - 300,000 could be reasonably expected.

Irrespective of the reaction of the state to a Maori Health Authority, there is a strong possibility that iwi themselves will move towards its establishment and that in Maori eyes it will become a focus for Maori health policy, Maori health advancement and Maori health care delivery. It will present an opportunity for the state to take a proactive role in a partnership for health.

THE HEALTH REFORMS: A SUMMARY OF MAORI CONCERNS

1 To date, Maori participation in the reform process has been limited.

2 The principle of partnership is relevant to RHAs and iwi.

3 There should be a clear agreed upon process for the disposal of all surplus Crown assets.

4 Earlier understandings and arrangements between iwi and health authorities should be reflected in CHE policies.

5 The relationship between funders and providers should be capable of facilitating iwi health development.

6 Health entitlements should acknowledge health risks.

7 Any competitive advantages unique to RHAs should be matched with compensatory provisions for Maori Health Care Plans.

8 Guarantees beyond three years are needed for effective long term planning.

9 Potential Maori health providers will need assisted entry into the new system.

10 Prevention and treatment should go hand in hand. The Public Health Commission must develop close and uncomplicated links with the funders and providers of treatment services.

11 A Maori Health Authority should be given similar status to RHAs

CONCLUSIONS

Improvements in Maori health over the past century have been substantial and should not be minimised; nor should it be forgotten that the major advances have occurred after active involvement by Maori communities. Claims that Maori health standards are comparable to third world populations are extravagant and misleading. But problems do remain and there is considerable room for improvement, especially at the primary health care level. Two recent reviews of Maori ill health[26] [27] have both concluded that access to primary medical care remains problematic, not necessarily because of a bias on the part of the practitioner but for a variety of reasons, including cost, motivation and information.

Improved standards of Maori health, however, cannot be achieved by health professionals alone. A total commitment is needed from individuals, the state, communities and Maori authorities. That message is consistent with the philosophy of Maori development and the increasingly active role taken by iwi in economic, social and cultural reforms. Reforms in health should be consistent with those wider reforms and should not be seen in isolation from other aspects of Maori development.

While the new health structures will obviously attempt to address Maori issues, there remains a need for a health focus which is Maori driven and Maori owned. A Maori Health Authority could furnish that dimension provided it had Maori support and was able to play an effective role in the formulation of health policy and the development of health services.

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26 Pomare (Convenor) (1992) *"He Mate Huango Maori Asthma Review"* A Report to the Minister of Maori Affairs from the review team to consider asthma among Maori people.

27 Durie (Convenor) (1989) *"Whakarongo Mai Maori Hearing Impairment"*. A report to the Minister of Maori Affairs from the review team to consider hearing impairment among Maori people.

A GUIDE TO THE HEALTH REFORMS

Panel Discussion: Panellists

Ian McPherson	:	Chief Executive National Interim Provider Board
David Smyth	:	Director Health Reforms Directorate
Heather Thomson	:	Member Public Health Commission Implementation Group
Lorna Dyall	:	Manager Health Policy Te Puni Kokiri
Troy Newton	:	Peat Marwick Consultancy

NATIONAL INTERIM PROVIDER BOARD
IAN MCPHERSON, CHIEF EXECUTIVE

EXECUTIVE SUMMARY

In July 1991 the Government published policy principles, based on the separation of purchasing from provision, to govern the reform of the New Zealand health system. In August 1991 it appointed the National Interim Provider Board to recommend, within that framework, structures for future public hospital provision of health services.

Introduction

Health care is a unique industry. It deals with matters of life and death for every citizen. It is among the biggest industries in the world. Spurred on by intensive research, it is also one of the world's most dynamic industries. Continuous change and development are central features.

Historical Perspective

It is a central responsibility of Government to ensure our health care system is flexible, innovative and cost-effective, so that affordable gains in quality health care are continuously delivered to all New Zealand citizens with minimal delay. The present system is unable to meet these crucial criteria.

Structural deficiencies in the present system create conflicting objectives and loyalties, make it sluggish in its response to changing health care practice, and inadequately responsive to the needs of the public. They also create built-in incentives to waste money, fragment the provision of services, engage in expensive cost shifting between services, cut services instead of optimising efficiency, run down State assets, and accumulate increasing levels of debt. These problems have been fully documented in past independent reviews.

The previous government, in its first four years, increased health funding significantly. The output of hospitals hardly increased. Ironically, in some ways, more progress was made under later, more stringent regimes, but it remained variable and insufficient to meet the needs of the public. Reform

initiative was increasingly focused on the structural and incentive problems responsible for these inadequate outcomes.

Purchasing Health Care

Structural reform aims to make the interests of those who use the health care system the central and overriding priority in all aspects of its activity. The Government will set the goals for four new Regional Health Authorities, and fund them to buy the health care required by the public. As purchasers, their role will be to ensure all New Zealanders have affordable access to core health services. They will have no other responsibility or conflicting loyalty. They will independently set quality standards, and buy health care from providers - public, private or voluntary - which offer care to those standards in combination with the best value for money.

The new integration under RHAs of purchasing from all providers resolves many profound problems created by past fragmentation. Among other things, it promises improved co-operation among health care professionals, better health care for smaller communities, and new opportunities for hospitals to develop valuable local services along more cost-effective lines.

The New Environment For Providers

The new purchasing system automatically sets the future environment for providers. They become dependent on the quality and efficiency of their own health care service provision to win RHA contracts in constructive competition with alternative providers. Institutions will no longer be in a position to put their own needs ahead of those of patients. Provider managers and staff at every level will have direct incentives to maximise both excellence and efficiency in the service of the public.

The initiative in implementing or rejecting new ideas will no longer rest with bureaucracies. The need to win RHA contracts will give managers and staff at every level direct incentives to maximise the excellence and the efficiency of their services. Providers will actively seek new ways to improve their existing organisation and methods. Within a framework of stronger performance-based accountabilities, they will have a new autonomy to make their own decisions on the most effective means of meeting RHA standards of service and user

satisfaction. Efficient, effective institutions will be able to expand. Inefficient institutions will get direct financial signals that they need to improve their own performance if they want to stay in public health care.

Creating A Competitive Health Provider Industry

The NIPB's key role has been to recommend methods of organising and structuring State-owned hospitals to meet the challenge of the new environment. Two broad options are available - under both, making a financial surplus would be necessary to pay staff, maintain facilities, and invest for the future:

(a) The non-profit approach, taken by 85 percent of United States health care institutions. No dividends are paid. Surpluses are ploughed back into the institution. But because no owner exists in this model to exert pressure for efficiency, part of that surplus tends to be siphoned off as extra benefits for senior staff.

(b) The profit-making businesslike model where dividend payments give the owner - State or otherwise - direct incentives to keep the institution efficient, flexible and innovative. The NIPB recommends this model for New Zealand as more likely to provide the incentives initiative and innovation to overcome the inefficiencies entrenched in the present system. It recommends that *Crown Health Enterprises,* the new organisations which will run public hospital health from July 1993, be built to this model.

The report spells out eight key principles for CHES:

(1) Clear commercial objectives;
(2) High-quality directors who are replaced if they do not perform;
(3) Performance objectives set by shareholding Ministers;
(4) An arm's-length relationship between the Government and operational management;
(5) Transparent subsidy where the Government wants to provide extra assistance to buy services which would not otherwise be commercial;

(6) A competitively neutral environment in which public hospitals have neither advantage nor disadvantage over alternative providers, and win their contracts through efficient delivery of quality services;

(7) Managers with the autonomy to make effective use of resources; and

(8) Mechanisms to hold them strictly accountable for their performance in meeting Ministers' objectives.

The NIPB has not aimed to provide a detailed structural specification at local level. Instead, it recommends a framework within which the system will evolve on sound, consistent principles by continuous initiative and innovation by health professionals at all levels. These principles emphasise the importance of diversity in meeting the wide variety of public health needs. *Community trusts* are specified as one of many options where groups drawing on community support are prepared to pay a fair transfer price for the ownership of local institutions, and compete with alternative providers.

Managing The Transition

To ensure a seamless transition, CHEs will be required initially to maintain a range of services virtually identical with those presently offered. Significant change will not occur until RHAs have made their own assessment of public needs, and reflect it in their purchasing.

A decentralised process, conducted to national guidelines, is seen as essential to take full and adequate account of local problems and opportunities which may not be evident to any centralised management operating at a distance.

National guidelines from the NIPB and approved by the Government will set the broad framework. *Advisory Committees* of five to six people with high levels of commercial skill will be appointed in June 1992 by the Government for each existing area health board. To ensure co-ordination with national policy, each Advisory Committee will include one executive or consultant of the NIPB. After detailed local study, they will, by 30 September 1992, recommend the initial number and configuration of the new CHEs to replace that area health board. The NIPB will review those recommendations and advise the Government.

As soon as Government decisions on initial CHE numbers and configuration are announced, the Advisory Committees will make recommendations for:

(1) Allocation of area health board assets to a provider unit, an RHA, the Public Health Commission or a residual management unit dealing with surplus assets;
(2) Allocation of all staff to CHEs, community trusts, RHAs or the Public Health Commission (most will go into work similar to their present jobs);
(3) Transition management arrangements allocating all area health board services to viable provider units to ensure continuity of services;
(4) Co-ordinated transfer of all purchasing staff or assets to RHAS;
(5) Terms of reference for CHE Boards Designate, in line with NIPB guidelines and local circumstances; and
(6) Allocation of current area health board regulatory functions to other appropriate agencies.

The Government, with NIPB advice, will then announce approved plans to establish CHEs.

Those establishment plans will be implemented by Government-appointed *Crown Health Enterprise Boards Designate,* which will be renamed Crown Health Enterprise Boards as soon as their assets are vested in them. They will implement the management and organisational restructuring, business valuation and capital restructuring required by the approved establishment plan. Members of these boards will require a broader range of skills than the Advisory Committees, along with solid commercial experience. Advisory Committees will then be restructured to wind up area health boards, and perhaps to manage their residual assets and liabilities. The definitive CHEs will be formed as each is ready, between late 1992 and July 1993, when the new system becomes fully operational.

Monitoring Crown Health Enterprise Performance

The Government, as owner of Crown Health Enterprises, will need specialist advice to help set their annual objectives, monitor their performance against

objectives, set dividend payments, handle requests for equity capital, and appoint and replace board members.

High level advice will also be crucial in areas such as:

(1) Evolution of organisational diversity, including mergers, chains, joint ventures and contracting out;
(2) Ongoing rationalisation and decisions on assets no longer required by CHEs;
(3) Monitoring, forewarning and advising on underperforming CHEs which are at risk of business failure;
(4) Proposals to divest Crown assets to community trusts;
(5) Development of CHE and contracting skills and settling differences if significant contractual inadequacies arise.

The NIPB therefore recommends the Government set up a *Supervisory Board for* these commercial purposes. It will need people of the highest commercial calibre, serviced by a chief executive officer and a group of highly skilled executives. The Establishment Supervisory Board should be appointed in the latter part of 1992, and become operational in January 1992 as the first CHEs are formed. Its existence would be reviewed in December 1994. It should be wound up in June 1996, unless reason is then established to retain it.

Some Crucial Underlying Issues

Competitive neutrality is an essential requirement for the development of a competitive market. It involves two elements:

(1) *Neutrality of funding* - RHA contracts must be awarded irrespective of provider ownership to give patients the best care, and taxpayers the best value for money; and
(2) *Neutrality between alternative providers* - so State-owned providers have neither competitive disadvantage nor advantage over other organisations, whether profit-making or non-profit. To achieve this, publicly owned providers must earn normal business rates of return on capital, value assets fairly and operate on commercial balance sheets with debt/equity ratios comparable to those of alternative providers.

Otherwise, they can win contracts without being forced to match the performance levels of competitors.

Political neutrality is also critical. The incentives and accountabilities of the system - and its performance - will be eroded if State-owned providers are subjected to political pressures against their fundamental interest in competitive efficiency. The dynamism of the reforms would then be seriously compromised.

New Zealand's traditional health system has always been *a mix of public, private and voluntary provision.* Private sector participants include GPs, midwives, nurse practitioners, specialists, pharmacists, physiotherapists and many others. Private hospitals provide 30 percent of total hospital beds and 58 percent of geriatric beds. New kinds of organisations founded on the co-operative initiatives of health professionals are already emerging in New Zealand. This diversity will increase and expand in the new system. This does not imply any diminution in the Government's responsibility for access and fairness. The Government has announced its intention to remain the dominant funder of health care in New Zealand, through RHAS.

Only one important area has been identified by the NIPB as unlikely to produce strong competition. That area is *24-hour acute care accident, emergency and trauma services.* No private competition exists in this area because it requires continuous provision of staffing, spare beds and equipment to cope, at zero notice, with unpredictable demand levels. Private hospitals operate by ensuring high, continuous usage of their facilities by careful advance planning of their caseloads.

To ensure adequate competition is created, where practicable, the NIPB has recommended that, if existing area health boards have two or more 24-hour acute care hospitals, those boards should be transformed into two or more competing Crown Health Enterprises. This recommendation is subject to careful evaluation of both the costs and the benefits to the individual communities of following that course. It is likely that 20 to 25 new CHEs will emerge from the present 14 area health boards.

Tax neutrality is one important factor in competitive neutrality of health care provision. Some providers currently have tax-exempt status. They would have major competitive advantages over taxpaying providers, and could undercut them without being forced to rely on their own efficiency to win business. Essentially two options exist - either all providers become taxpayers, or they all become exempt. Both approaches involve practical difficulties. The successful political management of those difficulties will be important to the success of the Government's health reform programme as a whole. The NIPB will be reporting further in a separate paper.

Contracting is a specialised skill new to the health care industry. It will take time for RHAs and CHEs to develop that skill. Some trial and error is inevitable. The establishment Supervisory Board has all important role to play initially in assisting these developments.

Some sources have suggested that a competitive system of provision will increase present fragmentation. On the contrary, RHAs have full power to purchase *"seamless care"* where they see that as an advantage. Competition will require CHEs to adopt any arrangement that promotes cost-efficient health care service delivery to RHA specifications.

As a safeguard against anti-competitive abuses, the health care sector should be made subject to the *Commerce Act.*

The NIPB expects that the Crown's general *Treaty Of Waitangi* policies will continue to apply to health sector assets and activities in the new system.

Treaty of Waitangi Issues

The NIPB expects that the Crown's general Treaty of Waitangi policies will continue to apply to health sector assets and activities after the reforms.

Although area health boards are not part of the "legal" Crown, the Waitangi Tribunal can consider claims relating to Acts or omissions by the Crown in respect of area health board assets or activities, and has done so. The process of transferring these assets to Crown Health Enterprises and Regional Health Authorities does not change any Treaty of Waitangi obligations the Crown

may have and does not weaken the position of Maori claimants as the assets remain in Crown-owned entities.

The NIPB will report further on other Treaty of Waitangi implications of the reform process.

Assets Gifted To Area Health Boards

Many area health boards own, or hold in trust, substantial land and assets donated by indivuduals and community groups. They range from Maori land gifted for health purposes in the 19th century to valuable medical equipment gifted through fundraising. In respect of these matters, Crown Health Enterprises will inherit all rights and responsibilities of area health boards. The NIPB will report further to the Government on these issues.

Asset Debt And Debt/Equity Issues

Many public hospital assets are outmoded, underused or run-down. The hospitals' value arises, however, not just from the physical assets, but also from the quality of their staff, and their likely future cash flows, CHEs will need to identify the most efficient and economic configurations to achieve their future business plans. This will inevitably involve reconfiguring, disposing of redundant assets, and adjusting to ensure a continuing flow of contract revenue from the RHAS. Simultaneously, however, new opportunities will open up for CHEs to compete with private providers in non-core health care services.

Existing long-term area health board debt will need restructuring as some boards are transformed into more than one CHE, and to place CHE debt levels on a basis which permit them to be commercially viable. While decisions have yet to be made, the NIPB expects a significant part of initial CHES' debt funding, for at least some, may come from the Crown, then be refinanced over a short period of years on to a normal business-like basis. Area health board debt was $616 million at the end of 1991.

To maintain commercial discipline and neutrality, CHEs should pay dividends to the Government comparable to those in the private sector. The Government has decided that these will be credited back into health funding. The NIPB will report further on valuation, capital restructuring and debt restructuring later.

The NIPB is satisfied productivity and efficiency gains as a result of reform will more than offset any transitional restructuring costs and dividend or capital charges levied. As in any restructuring, however, a time lag occurs before those benefits can be fully delivered, so there is an upfront cost which is more than repaid by later gains. The Government will need to take account in the budgetary process of any impacts from taxation, capital charging and restructuring costs, and of the timing of the subsequent gains. The NIPB will report further on these matters.

Some business failures occur in any commercial environment. The possibility of failure is one of the factors driving business managers to excel. It is important for the public and providers to understand that facilities do not cease to exist, and do not ordinarily cease to function, when business failure occurs. Inadequate boards and managers are replaced and the business is reorganised to ensure it does better in future. In publicly provided health care, the Supervisory Board's monitoring can be expected to give early warning and advice to Ministers on appropriate measures. RHAs will also have a commitment to continuity of service and a profound interest in the ongoing viability of their health care suppliers.

Benefits Vastly Outweigh Reform Costs

Change always involves some risk, but when structures are seriously defective, there are much greater risks in refusing to change. The NIPB's recommendations have been made only after careful evaluation of both the costs and the benefits involved in health care provider reform.

The Government has repeatedly emphasised its commitment to a universal tax-funded system under which all citizens remain entitled to high-quality core health services similar to those already provided, via publicly funded RHAs purchasing health care.

The run-down, underused state of some CHE assets makes it a crucial issue that CHEs should have the freedom to rationalise, lease or sell assets surplus to requirements, as area health boards have already been doing. This should be seen as a gain, not a loss, for the system. Otherwise, important potential gains for the public will be jeopardised.

Many changes and opportunities are being forced on health care providers worldwide through changes in technology and demand, regardless of reform. But it is a principal benefit of the changes recommended by the NIPB that they will accelerate the delivery of those gains to the public.

Area health boards in recent years have funded considerable restructuring and rationalisation from their own budgets. CHEs should continue to do so, to ensure restructuring decisions are properly traded off against the need to maintain and improve services.

Some area health board staff may become surplus to requirement, but the NIPB does not expect those numbers to be significant. The health service has no surplus of good professional staff.

The NIPB has prepared this report to place accurate information before the public about the substance of provider reform, as a sound platform for informed public and professional discussion and debate. Because health care providers will in future be competing for business, they will have strong incentives to satisfy both patients and the RHAS, acting as the agents of patients. This new focus on the people who use publicly funded health services embodies one of the most important long-term benefits of these reforms for all New Zealanders.

A GUIDE TO THE HEALTH REFORMS

DAVID SMYTH, DIRECTOR OF HEALTH REFORMS

REGIONAL HEALTH AUTHORITIES (RHA) ESTABLISHMENT BOARDS

Regional Health Authority Establishment Boards will be responsible for establishing effective health care purchasing organisations which will be ready to operate on July 1, 1993. These boards will be disassembled when the RHA's begin operating.

The boards match the areas which will be covered by the four RHA's.

The establishment boards are responsible for detailed development of the RHA's.

This includes :

- developing the mission, purpose, goals and objectives of the RHA's;
- appointing the chief executives;
- developing a strategic development plan;
- identifying an appropriate management and organisational structure for the RHA and the human resource skills required;
- developing effective financial management control procedures;
- developing expertise in consumer and market needs assessment (which will involve communication and consultation with Maori and other health interest groups; consideration of community input options; and development of market research skills);
- developing the capacity to purchase health services and negotiate contracts with providers;

- developing a purchasing strategy for the 1993/94 year;

- establishing initial relationships with primary, secondary, tertiary and other health care providers including maintaining relationships with the National Interim Provider Board (NIPB) and Crown Health Enterprise (CHE) advisory committees;
- developing a relationship with the Department of Health.

Members of the four Regional Health Authority establishment boards are:-

NORTHERN RHA

Chairman	Harold Titter
Members	Donald Beasley Lindsay Fergusson Denese Henare, (Tribal affiliation: Ngati Hine, Nga Puhi) Lesley Hax Derek North

MID NORTH ISLAND

Chairman	Sir Ross Jansen
Members	Bill Gallagher Neil Leuthart Paratene Ngata, (Tribal affiliation: Ngati Porou. Georgina Te Heuheu, (Tribal affiliation: Ngati Tuwharetoa) Sally Wilkinson

CENTRAL

Chairman	Hutton Peacock
Members	Kevin O'Connor Bill Potaka, (Tribal affiliation: Te Atihaunui O Paparangi and Ngati Tuwharetoa) Michael Sewell Dr Libby Smales Christine Tuffnell

SOUTHERN

Chairman	Ian Farrant
Members	Sid Ashton Bev Clark Philippa MacKay Hugh Ross

PUBLIC HEALTH COMMISSION IMPLEMENTATION GROUP

HEATHER THOMSON

The Public Health Commission Implementation Group was appointed in November 1991, to prepare for the establishment of the Public Health Commission, as discussed in the Government paper "Your Health and the Public Health".

The Public Health Commission Implementation Group is chaired by **David Skegg,** Professor of Preventive and Social Medicine at the University of Otago. The Implementation Group was appointed by, and reports directly to, the Minister of Health. **Dr Gillian Durham** has been appointed Transitional Manager of the Implementation Group.

The membership of the Implementation Group is as follows:

John Aburn	Company Director, Wellington;
Robert Beaglehole	Epidemiologist, Department of Community Health, University of Auckland;
Adam Begg	Farmer, Stirling, Otago. Membership of other organisations has included the NZ Meat Producers Board and the Otago Area Health Board;
Andrew Hornblow	Professor of Community Health, Christchurch School of Medicine;
Stewart Reid	General Practitioner, Lower Hutt, and Chairman of the Communicable Disease Advisory Committee;
Heather Thomson	Manager, Maternal and Child Health Services, South Auckland, Auckland Area Health Board; and
Charles Willmot	Environmental Engineer, Wellington.

The timeframe for the establishment of the Public Health Commission includes having some parts in operation during 1992, and being fully operational next year.

Public health has been defined as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society". Public health activities include disease prevention, health promotion and health protection.

The Public Health Commission will:

- advise the Minister of Health on public health goals and objectives;

- design and coordinate public health programmes; and

- act as the purchasing body for public health.

In addition to defining the specific roles of the Commission, the Implementation Group is considering the working arrangements between the Commission and organisations providing public health services. The funding and delivery of public health services are key areas of interest for the Group.

The Implementation Group is in close liaison with other health reforms agencies. Discussions have also begun with the newly appointed National Advisory Committee on Core Health Services to examine the boundaries between personal and public health.

The Implementation Group is involved with the Health Reforms Communications Strategy and is aware of the need for effective consultation to enable both the community and health professional groups to become familiar with the changes in the management and delivery of public health.

While the work of the Implementation Group is essentially to prepare for the establishment of the Public Health Commission, there is a wide range of tasks involved in order to meet that objective.

Some of the issues under consideration include:

- current public health activities;
- public health expenditure in New Zealand;
- legislative issues;
- public health information requirements;
- ways in which the Public Health Commission should consult with community interests;
- Maori consultation; and
- identification and separation of public health purchasers and providers.

All area health boards have been consulted by the Implementation Group, with David Skegg meeting with staff to discuss options for the delivery of public health services.

It is believed that the establishment of the Public Health Commission will raise the profile of public health and lead to better planning and coordination of public health initiatives in New Zealand.

TE PUNI KOKIRI VIEW OF THE PLACE OF MAORI IN THE REFORM OF THE NEW ZEALAND HEALTH SYSTEM

LORNA DYALL

Te Puni Kokiri view of the place of Maori in the reform of the New Zealand health system.

Thank you for inviting Te Puni Kokiri to be part of this panel and to contribute to the discussion of the reform of the New Zealand health system. It is a great privilege to contribute and to put forward Te Puni Kokiri's view and vision for the future in relation to health and Maori development.

For those of you who have forgotten because of the amount of change continually occurring around us and the never-ending restructuring of government agencies. Te Puni Kokiri was established on 1 January 1992, under the Ministry of Maori Development Act 1991.

Te Puni Kokiri was established based upon the report "Ka Awatea" commissioned by the previous Minister of Maori Affairs Hon. Winston Peters. It is an important document for it describes the general circumstances of Maori in relation to health, education, training, economic and resource development. Authors of the report highlight the major under-development of Maori and the cost of this to Maori and to the development of New Zealand. Further, the authors of the report suggest that new policies and mechanisms for service delivery must be developed and implemented to overcome the barriers that impede Maori from using services.

Te Puni Kokiri is charged with improving Maori achievement in health, education, training and employment, economic and resource development. It also has a responsibility to influence the responsiveness of mainstream agencies that provide or have the responsibility to provide services to or for Maori.

Te Puni Kokiri is at an early stage in its development, and as an organisation we are committed to supporting Maori development. Our vision is to assist in the development of an environment of opportunity and choice for tangata whenua consistent with the Treaty of Waitangi.

This is a powerful vision and as a member of the policy unit we have translated this "to provide policy advice which upholds the tino rangatiratanga of whanau, hapu and iwi"

As an organisation, we have a vision to break the dependency cycle of Maori and to support Maori to become self-reliant, no longer vulnerable to the ever-changing government policies and benefits which affect our everyday lives.

We are keen to see that Maori have the opportunity to be "free", in the sense we have the resources to have control over our daily lives and are able to support our whanau, hapu and iwi. We have a vision for Maori to stand tall, to feel good about ourselves, to participate in the development of this country as equal partners and to contribute internationally. Further, we have a vision that our culture will be recognised and valued.

This vision aims to support our institution's values and beliefs. This vision is not easy to promote at a time when Government policies are in many respects aimed at restricting the Government's risk, instead of supporting people to get up to a level where they are able to take advantage of opportunities and able to care for themselves with minimum state interference.

In 1985, I was the secretary for the Standing Committee on Maori Health of the New Zealand Board of Health. This committee was the forerunner to the Ministerial Advisory Committee on Maori Health. At that time, the committee issued six challenges for the future direction and development of health services in Aotearoa.

The challenges were that:

* the three articles of the Treaty of Waitangi be regarded as the foundation for good health in New Zealand

* Maori tribal authorities be regarded as the proper trustees for Maori people

* resources be made available to those authorities to enable them to include health in their own development programmes - improvements in Maori health are likely to come about through whanau, hapu and iwi development

* Maori health issues can only be addressed by the involvement of a greater number of Maori people in the delivery of health care and the setting of priorities

* for Maori people, the health team must have the support of the Maori community and must include both Western trained health professionals and people trained in Maori schools of learning

* training programmes must reflect the bi-cultural nature of New Zealand society. If training institutions are unable to adequately prepare people they should contract out to those organisations equipped to do so.

These challenges, I believe, are important and still relevant as foundations for the reform of the New Zealand health system. I would like to take each of these challenges and consider where they fit in the reforms.

Firstly, I believe the Treaty of Waitangi should be the foundation or the overall umbrella for the development and implementation of the health reforms. Maori should be fully involved and represented on all of the influential advisory and establishment bodies, such as the National Interim Provider Board, the National Advisory Committee on Core Health Services, the Public Health Implementation Group, Regional Health Authorities Establishment Committees, and the committees which will guide the creation of Crown Health Enterprises.

All three articles and the spirit of the Treaty of Waitangi should be implemented. All of these advisory bodies must involve, consult with Maori and integrate Maori views in the development of their respective part of the health service.

Each of these agencies, such as the Public Health Commission, Regional Health Authorities, and Crown Health Enterprises should have a specific responsibility in improving the health and wellbeing of Maori. This should be in "statute" so that Maori do not have to invest considerable energy in encouraging these authorities to recognise the tangata whenua and our health needs.

Further, as a group of people, through our experience we cannot feel secure that our wellbeing will be protected and enhanced through contracts. Our experience is that contracts are often not implemented in good faith, and secondly, one player can change the rules and use the judicial system to support its views.

Our interests must be protected, and there must be specific recognition of the Treaty of Waitangi in the proposed legislation and part of the overall legislation that will enact the health reforms. It is not good enough, as it has been said to me "the Treaty always speaks", when from our experience it can easily be forgotten.

The Crown must be held accountable for its responsibilities and it cannot establish new agencies and argue that they do not have to take account of the Treaty of Waitangi. Section 9 of the State Owned Enterprises Act should not be removed without adequate discussion and negotiation with Maori. Further, the Government should not use the notion of the national good as a means of riding roughshod over Maori as we begin to get close to resolution of a number of Treaty grievances and the fiscal implications of such decisions.

Considering the second challenge, there are opportunities in the health reforms for iwi to be regarded as the proper trustees for Maori people. There is provision within the reforms for interested individuals and groups to establish or join a health care plan of their choice.

I am aware that a number of iwi groups are investigating the feasibility of this option, and are exploring how they can move towards receiving a significant sum of Government money to become a purchaser of services for a defined group of people.

There are real opportunities for iwi authorities to be both purchasers and providers of health services. I would suggest to iwi to consider carefully at this stage, whether you want to go all of the way to establish a health care plan and take on fully the Crown's risk, particularly when we can anticipate that in the future the health of Maori is not likely to significantly improve due to the effects of smoking, and unemployment, low education achievement, and so forth.

I would, however, encourage iwi to explore the possibilities of becoming a budget holder responsible for the purchase and possibly provision of a range of health services such as primary health care, pharmaceuticals, community domiciliary care, disability care, health promotion and public health. These are just some examples.

Further, I would encourage iwi to establish a close working relationship with the recently announced Regional Health Authorities Establishment Committees. Iwi groups might wish to negotiate the development of a purchasing plan which a regional health authority could purchase on your behalf. It may be possible to negotiate with the authority to manage your section of the regional health authority's purchasing plan. As part of your responsibility, you may be able to identify the most appropriate providers for your people.

I am aware that this sounds all "gobbeldy gook", but hopefully Te Puni Kokiri will be able to assist you shortly. I am hoping by the end of the month to have negotiated a contract for the provision of high quality technical advice which will assist you in your aspirations, and help iwi to realise the new opportunities that now arise. It is important in this new environment that we are able to work together, with iwi groups sharing their knowledge and skills with other iwi to ensure that we are able to realise many of the new opportunities and not set one iwi against another.

It is important in a competitive contestable environment that we co-operate with each other. We must protect our values and beliefs in an environment which encourages individualism.

Considering the next challenge, Maori must be involved in health needs assessment which will become one of the major areas of work of regional health authorities. In the identification of our health needs, there must be acceptance by regional health authorities that Maori must be involved in the development of strategies to address our needs. For we know "whoever defines the problem controls the range of solutions". Maori must define and own the problem, and decide how it should be addressed.

Regional health authorities, the Public Health Commission, the National Advisory Committee on Core Health Services must recognise Maori health priorities and definition of health. It is with concern, that in the implementation of the health reforms, each part in developing its own view of health, boundaries, and responsibilities has forgotten that the whole is always far greater than the sum of the parts.

Considering the next challenge, about the membership of health teams, it is important that Maori are fully informed about the health reforms, so that both members of the Maori community and health workers are able to negotiate a place in the health team and how health services should be delivered.

The health reforms will be challenging to Maori health workers, for many they will need to decide "who" and for "whom" will they work for. The reform opens up the opportunity of Maori health workers being employed by iwi authorities, being self employed or in trusts, independent businesses, sub-contractors or being employed by a Crown Health Enterprise.

Depending upon which organisation you choose to work with and for, will influence your view of the health services that are important and to whom you are accountable.

I am pleased to hear that shortly there is planned to run a number of seminars throughout the country to inform people about the health reforms. I would hope that a significant number of Maori people are invited to these seminars so that Maori are able to gain an overview, and are to identify their particular place in the purchasing and provision of health services.

I am also pleased to hear that the Maori Health Policy Unit of the Department of Health, is planning in conjunction with the National Council of Maori Nurses to organise a major hui for Maori health workers to discuss the implications of the health reforms. It is also planned in the near future to have a hui focusing on Maori traditional healing seeking advice from healers as to where they fit in the provision of health services. There exists the possibility of healers becoming part of the mainstream system of delivering health services. However, in considering such an option there are both advantages and disadvantages. I congratulate the Maori Health Policy Unit of the Department of Health, in supporting healers to discuss these issues, for I am very much aware these matters are extremely sensitive.

Considering the last challenge, I am very much aware that the health reforms open up the possibility of new people providing health services. We can expect in the future to see considerable deregulation in the provision of health services, in which there will be considerable thought of the amount of training and professional qualifications required to do a particular job. This is already beginning to happen with the provision that immunization now does not have to be supervised by a doctor, but can be given by someone adequately trained.

I am hoping in the future, that Te Puni Kokiri will be able to support a number of different training programmes to assist Maori deliver health services for Maori and the wider community.

In the implementation of the health reforms, I would also hope that you watch carefully that overseas health professionals are not excessively recruited to reduce the overhead costs of training, taking work opportunities away from Maori.

Further, it has to be questioned the appropriateness of recruiting health professionals from overseas, when they are not familiar with our values, beliefs and the Treaty of Waitangi. Health workers need continual training to understand the need to deliver health care which is appropriate, accessible, acceptable and affordable. The four A's are important and it is hoped they will be considered by the National Advisory Committee on Core Health Services.

This is just a brief overview of the opportunities that now arise from the health reforms. I would hope that the various implementation bodies would consider seriously the Steering Committee on Maori Health challenges for the future development of health services in Aotearoa.

They were proposed in 1985 and are still relevant and appropriate to base and implement the health reforms:

"Whaia e koe ki te iti kahurangi ki te tuohu koe me maunga teitei."

Seek the treasures you value most dearly, if you bow your head let it be to a lofty mountain. Let nothing but the insurmountable turn you from your purpose.

No reira tena koutou, tena koutou katoa.

A GUIDE TO THE HEALTH REFORMS

TROY NEWTON, PANEL MEMBER,KPMG PEAT MARWICK
MANAGEMENT CONSULTANTS

"As the only panellist who could be regarded as coming from the private sector, and as someone involved in business, I have a healthy respect for practical good common sense. And, broadly speaking, the Government's objectives for health reform are quite sensible.

Indeed the analogy I would use would be to consider the reform is that of shopping in a store. Sometimes I will ask the salesperson's opinion. I may either take or ignore that advice. If, however, I took the advice and subsequently found it to be poor, then the next time (If there is a next time) I buy anything from the store I will probably ignore the salesperson and rely on my own judgement.

Now imagine I am attempting to buy the materials and tools to build a house for the first time - an extremely complex and imposing task. I have a building plan but it is fairly crude - so that I am completely dependent on quality of advice provided. The store is a very large hardware and building supplies outlet with lots of different tools and products. Furthermore the staff in the various store departments, for whatever reason, don't work very well together. Each department also has a different view about the best way to build a house - some staff even question the validity of the building plan.

This analogy in some ways represents New Zealand's healthcare system. Historically the provider (Salesperson in the analogy) and not the purchaser has controlled the way the healthcare dollar is spent in New Zealand. Furthermore there has been a poor level of integration between various types of provider services. Although these issues have been understood for some time, institutional and professional impediments, among others, have made change difficult.

The reform attempts to address these issues by forcing an organisational split between the purchaser and provider of health services. This split is intended to make it more difficult for existing providers and patterns of provider care to dominate the health system. At the same time the reforms seek to encourage an element of competition between providers, This is potentially exciting news for purchasers as it enables them to demand more efficient and responsive services.

As indicated earlier the reform also encourages competition at the purchaser level. In particular Health Care Plans are an opportunity for individuals to take their share of the Government's health care budget away from Government administration and put it into a private administering body of their choice. In this context the attractiveness to Maori of iwi based Health Care Plans may represent a significant threat to the membership size and therefore purchasing power of the Government's Regional Health Authorities.

There are two brief issues, cum questions, I would like to direct to the representatives of the Government's two reform agencies (the National Interim Provider Board and the Health Reform Directorate):

Firstly, what specific plans do you have in mind for empowering iwi and other Maori groups in terms of :

1 Making available financial resources;
2 Establishing a systematic process of consultation;
3 Providing access to policy background information;
4 Assisting in the transfer of skills;
5 Ensuring a level playing field for Health Care Plans.

The extent to which these things happen in a material way will be a substantial factor in the extent to which Maori will be able to benefit from the reform rather than lose as in the past.

The second point I want to make is in relation to the Health Reform Directorate's activities. When will the urgently required research into Maori healthcare needs be made? So far no attention has been paid to this key area even in the mainstream. I would ask how effective "partnership" based policy can be developed without this information. KPMG Peat Marwick believes the

Health Reform Directorate has not provided an adequate response to this issue and we do not accept that they can simply defer this crucial area until after legislation is in place and Regional Health Authorities are up and running.

Finally I would like to comment on the implications of the reform's purchaser/provider split for iwi based health developments, including Health Care Plans. As Mason commented earlier an iwi purchaser, whether in the form of a purchasing plan or Health Care Plan, may not consider it appropriate to regard all potential providers equally. Providers from within the iwi or other Maori groups may be given priority over others regardless of strict financial criteria.

However if dual health and Maori/iwi development goals are being sought then there must be a continual process of output measurement and evaluation to ensure that the mix of benefits sought remain optimal and consistent with pre-defined goals. Otherwise there is a risk that an environment of inefficient cross-subsidisation will develop to the detriment of the effectiveness of the Maori health dollar"

RESOLUTIONS FROM HUI

RESOLUTION 1

That the hui support the establishment of a Maori Health Authority.

CARRIED

RESOLUTION 2

That the New Zealand Maori Council, Maori Women's Welfare League and National Maori Congress be asked to facilitate the establishment of a Maori Health Authority.

CARRIED