GOVERNMENT OBJECTIVES FOR MAORI HEALTH

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GOVERNMENT POLICIES

Although there is no single document which contains the Government's entire objectives for Māori health, an overall picture can be obtained from several reports. Some of these are related to Māori policy generally, others to health sector policies or to legislation.

Te Urupare Rangapu and Ka Awatea

Two particular reports are useful in understanding the parameters of the Government’s commitment to Māori development across the range of policies. Te Urupare Rangapu prescribed a relationship between Māori and the Crown which takes into account Māori structures, Government commitment to Treaty of Waitangi principles and devolution of certain roles to Māori (iwi) authorities.¹ Though not specifically about health or health services, Te Urupare Rangapu, provides a framework relevant to Māori policy and the provision of social services for Māori people. In particular a role for iwi (tribes), both in the formulation of policy and in the delivery of services was anticipated.

Ka Awatea further underlines the Government’s intention to give priority to key areas of Māori development and to provide, through the Ministry of Māori Development, Te Puni Kokiri, a mechanism for testing and piloting new policy areas, providing policy advice relating to mainstream departments and their responsiveness to Māori issues and assessing the impact of Government policies on Māori.² One of the key areas is Māori health.

¹ Wetere Hon K, 1989, Te Urupare Rangapu, Partnership Perspectives, A report from the Minister of Māori Affairs, Wellington
² Peters Hon W, 1991, Ka Awatea, A report from the Minister of Māori Affairs, Wellington
The Health and Disability Services Act 1993

Legislative direction for Māori health is contained in the Health and Disability Services Act 1993. Clause 7 refers to the ability of the Minister to give to a purchaser written notice of the Crown’s social and other objectives. These objectives may be in relation to a number of matters including (in subclause (d)) “the special needs of Māori and other particular communities or people for those services.” Otherwise the Act is devoid of specific Māori health objectives.

Whaia te ora mo te iwi (Government’s Response)

Probably the most comprehensive description of Government’s objectives for Māori health is contained in Whaia te ora mo te iwi a government statement circulated as a response to Māori issues in the health sector. In a foreword, the Minister of Health emphasised that the government “regards the Treaty of Waitangi as the founding document of New Zealand, and acknowledges that government must meet the health needs of Māori and help address the improvements of their health status.” Despite the absence of a Treaty clause in the proposed legislation, Whaia te ora mo te iwi spelled out Government responses to Māori health in a number of critical areas.

(1) “A statement requiring the new health agencies, Crown Health Enterprises, the Public Health Commission and Regional Health Authorities, to utilise the surplus land protection mechanism which is being developed, will be inserted in the instructions covering the transfer of assets to these entities.”

(2) “Specific reference is made to the special needs of Māori in Clause 7, Crown’s objectives, of the Health and Disability Services Bill, in respect of which the Crown may give to a purchaser written notice of the Crown’s social and other objectives.”

(3) “The Government will ensure that all health sector agencies are required, through the Statements of Intent and the contractual and administrative arrangements outlined in the Bill, to reflect Government’s commitment to improve Māori health.”

(4) “The Government will encourage the participation of Māori in the health sector through the “Good employer” provisions of the Health and Disability Services Bill.”

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3 Department of Health, 1992, Whaia te ora mo te iwi - Strive for the good health of the people, An explanatory document released after the Health and Disability Services Bill was introduced.
(5) "The Government will continue to seek suitably qualified Māori candidates for appointment to future Boards."

(6) "The Government will include a requirement in the Statements of Intent for the RHAs and the PHC to consult with Māori in the development of their purchasing strategies."

(7) "The Government agencies such as the Department of Health, the Public Health Commission and Te Puni Kokiri, will work together with Māori national organisations to contribute to the achievement of the Government's outcomes for health."

(8) "The Government will seek to work with Te Waka Hauora o Aotearoa should this initiative come to fruition."

(9) "The Minister, and Associate Ministers of Health will announce Government's general policy directions for Māori Health at a series of Health Reforms Communication Hui to take place in September - October 1992."

Core Services 1993/94

The publication of the Report of the National Advisory Committee on Core Health and Disability Support Services in October 1992, introduced another policy related dimension. Along with several other recommendations the Committee concluded that during 1993/94 more emphasis should be placed on "ensuring that primary care for Māori is effective, available, and provided in forms that encourage use by Māori for health maintenance, health promotion and for use early in disease."

The Committee also recommended mobile and marae based clinics and recognition of services provided by Māori caregivers within their own communities.

Policy Guidelines to Regional Health Authorities

In November 1992, Policy Guidelines issued by the Government to RHAs stipulated that RHAs must, among other things "improve access to health and disability support services for their members with lower health status, including Māori and Pacific Islanders." 5

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4 Core Services Committee, 1992, Core Services 1993/94 A Report to the Minister of Health, National Advisory Committee on Core Health and Disability Support Services Wellington

5 Health Services Directorate, 1992, Policy Guidelines to Regional Health Authorities, Wellington
The Guidelines were developed following advice from the Core Services Committee, the Public Health Commission, relevant Government departments and other agencies and individuals.

They emphasised that the Government will require purchasers to be guided by the Crown objective “The Crown will seek to improve Māori health status so in the future Māori will have the same opportunity to enjoy at least the same level of health as non-Māori.”

A number of policy directions to guide purchasing strategies were recommended:
- greater participation of Māori at all levels of the health sector
- resource allocation priorities which take account of Māori health needs and perspectives
- the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of health services.

RHAs were expected to indicate in their purchasing plans how they would meet these directions across all health service areas.

Whaia te ora mō te iwi (RHAs and the PHC)
Another document, also entitled Whaia te ora mō te iwi but aimed this time at a more direct statement of Māori health policy objectives for RHAs and the PHC was published jointly by the Department of Health and Te Puni Kokiri in 1993.6 Essentially it was a recapitulation of the Policy Guidelines to Regional health Authorities.

The Crowns Objectives for Regional Health Authorities
Following on from the policy guidelines, and as required under the Health and Disability Services Act 1993, the Minister of Health published objectives for all Regional Health Authorities in July 1993.7 The overall Government objective for Māori health was restated as one of several medium term objectives (“Seek

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6 Department of Health & Te Puni Kokiri, 1993, Whaia te ora mō te iwi Strive for the good health of the people Māori Health Policy Objectives of Regional Health Authorities and The Public Health Commission, Wellington

7 Ministry of Health, 1993, Your Guide to the Crown’s Objectives for Regional Health Authorities, Ministry of Health, Wellington
to improve the health status of Māori, so that in the future Māori will have the opportunity to enjoy the same level of health as non-Māori"). In addition all RHAs apart from the southern RHA were advised to “address the particular health status needs of Māori”. For each RHA unique characteristics and relevant concerns were highlighted. In the Northern region for example the high Māori concentration in rural communities was noted; in the Midland region around 21% of the total population was Māori although there was considerable variation between localities (e.g. 40% in Tairawhiti, 12.6% in Taranaki); in the Central region the proportion of Māori in the population ranged from 20% in Hawke’s Bay to 5% in Nelson-Marlborough while in the southern region low concentrations of Māori were recorded (4% in Otago, 8% in Southland). RHAs were requested to provide for “a more comprehensive and co-ordinated range of services to address the special needs of Māori.”

The Crowns Objectives for the Public Health Commission

In July 1993, similar objectives for the Public Health Commission were publicised. Apart from a reiteration of the general objective for Māori health, six public health goals were recommended. Five of these have particular relevance for Māori: cervical screening, immunisation, tobacco smoking in pregnancy, sudden infant death syndrome, hearing loss in children.

Te Ara Ahu Whakamua: Strategic Direction for Māori Health

In August, 1993, Te Puni Kokiri launched a discussion document outlining strategic directions for Māori health. Consistent with section 5 of the Ministry of Development Act 1991, the Ministry identified global goals (Treaty of Waitangi, leadership and innovation, managing Māori health information) and Health Portfolio Unit goals (improving Māori health through policy advice, monitoring the health system, development of Māori as health providers, attracting high performance people to the vision and mission of Te Puni Kokiri). For each goal a series of objectives were suggested including a monitoring framework.

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THE WIDER POLICY ENVIRONMENT
While the Government's objectives for Māori health arise within the context of restructured health services, they need to be considered in the wider arenas of Māori development, socio-economic reform, and the diversity of Māori realities. Indeed, it would be misleading to suppose that improved health status could be seriously considered in isolation from other key factors which play a part in determining the Māori position.

Māori Development
The policies of Māori development are particularly relevant. Over the past decade and in line with the goals of the Hui Taumata there has been greater Māori interest in self determination and active participation in Māori social and economic advancement. Positive funding, rather than negative spending has been advocated as more logical than concentrating only on the provision of remedial measures when ill effects become apparent. Central to the Māori development philosophy is the Treaty of Waitangi. From it, the principles of partnership (between Māori and the Crown) and tino rangatiratanga are derived.

Although the Treaty of Waitangi is referenced in several statutes that deal with physical resources (eg the Resource Management Act 1991, Te Ture Whenua Māori Act 1993), it is not included in any social policy legislation. A Treaty application to health, education, housing and employment has therefore not always been accepted, despite recommendations from the Royal Commission on Social Policy. Its particular relevance to health has also been described. In any event, the Treaty has, it appears, become integral to all policy

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10 The Hui Taumata was a Māori Economic summit meeting held in 1984. Arising from it was a commitment by Māori leaders, if not by Government, to place greater emphasis on positive cultural, social, economic development, Treaty of Waitangi principles, tribal authority and tribal delivery systems.

11 Tino rangatiratanga refers to the authority of tribes in respect of their own affairs. It stems from Article 2 of the Treaty.

12 Royal Commission on Social Policy, 1987, The Treaty of Waitangi and Social Policy, Discussion Booklet No 1, Royal Commission on Social Policy, Wellington

development and in a foreword to *Whaia te ora mo te iwi* the Minister of Health confirmed its significance in respect of the Crown's health policies.

During the decade of Māori development, and partly because of the Treaty position vis-à-vis tribes, tribal development emerged as a preferred vehicle for a variety of social and economic recovery programmes including Matua Whangai, Mana Enterprises, and Maccess Training. Underlying the objectives of positive Māori development twin themes have emerged; greater Māori autonomy and control, and an integration of cultural, social and economic development. Though focussed initially on jobs, an improved economy and sound tribal infra-structures, by 1987 better health had become one of the driving concerns of Māori authorities.

Not all tribes were at first convinced that they had a significant role to play in health development. For most of the century, Māori leadership in health had been steadily undermined by health professionals and major health institutions to the point that a passive approach to health problems had replaced initiative and a sense of ownership. An important precursor to a reawakened interest in health was the recognition that health could be conceptualised in a number of ways and that Māori had their own perspectives; it was a philosophical shift enabling elders to voice with greater confidence a Māori claim on health policy and planning, at least for their own people.

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14 Jointly sponsored by the Departments of Social Welfare, Maori Affairs and Justice, Matua Whangai was a programme which aimed to reunite alienated children with their extended families, in preference to placement in State controlled foster homes or institutions. It was only partially successful. Many families were not in a position to care for difficult children and often the funding available was inadequate to meet special needs.

15 Mana Enterprises provided for low interest loans to be made available to encourage Māori business development. For the most part loans applications were managed by tribal authorities.

16 Job training programmes approved by Māori authorities and delivered by Māori providers.


Socio-economic reform

The launching of the decade of Māori Development in 1984 coincided with the initiation of national economic and state restructuring. A rights based approach to social policy was modified by a contracts based approach, in which targeting of groups with special needs outweighed the State’s equal responsibilities for all its citizens. Arguments for universal provision of social services as of right assumed less credibility in the eyes of a Government concerned primarily with repaying the overseas deficit, reducing interest rates and lowering inflation. The Welfare State was apparently living beyond its means. Privatisation, offering choice, and the efficiency advantages of competition, became fashionable in an environment which had begun to emphasise freedom from dependency on the State, rather than the obligations on the State to guarantee dependants freedom from want. Deliberately, the size and functions of the State diminished. State owned enterprises, devolution and user pays policies left little doubt that whenever possible individuals would be expected to make their own arrangements for social services.

Inevitably social provisions such as health and education became part of the economic reforms and restructuring of the State.

Libertarian views regarding health as another commodity, and competition as a vital ingredient for economic savings, if not quality care, were evident in the Health Reforms announced in 1991. A funder provider split, competition as between providers and accountability based on contractual agreements signalled a move away from egalitarian philosophies and, to some, the prospect of a health sector characterised by privatisation with a safety net for the poor.

Māori reaction to the reforms was mixed. On the one hand the prospect that the State would have a reduced provider role caused some anxiety. Even though the Government had acted unevenly in respect of the Treaty of


21 Ibid, p226

22 Ashton T, 1992, Reform of the Health Services: Weighing up the costs and benefits in ed Boston and Dalziel, The Decent Society, Oxford University Press, Auckland
Waitangi, it had at least shown a recent capacity to listen and often to respond fairly. There was no guarantee that local authorities or private institutions would respond in a similar manner. And there was the added concern that targeting policies would be aimed at a narrow section of the Māori community, disadvantaging those on the borderline. On the other hand, however, there was considerable agreement with a deregulated approach to health care and the promise of a more direct role for Māori in the provision of services. When the enthusiasm for iwi health care plans had subsided, Māori still saw in the health reforms opportunities for positive roles in planning and in service delivery.23

Diverse Māori realities

Post World War II urbanisation, improved life expectancy and high fertility rates dramatically changed the profile of the Māori population. In the immediate years following the rural urban shift, tribal structures were discouraged on the grounds that they obstructed the assimilative process: tribe with tribe and then Māori with Pākeha. It was not until Te Urupare Rangapu that there was official recognition of the importance of tribal development. By then many third or fourth generation urban migrants were effectively cut off from any tribal links. Some had become well integrated into their new environments and were able to participate comfortably in mainstream New Zealand but many others had become alienated both from tribe and society generally. Some, though it is not known how many, remain or have become well integrated into mainstream Māori society and are able to access Māori institutions - the marae, kohanga reo, Runanga and tribal trust boards.24

Contemporary Māori live in several realities. On most socio-economic indices Māori are significantly disadvantaged. Generally in the lower socio-economic classes, many are also culturally impoverished being unable to speak Māori or to participate confidently in conservative Māori situations. While tribal organisation has flourished since 1984, and a range of cultural activities have

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23 In Your Health and the Public Health, 1991, iwi health care plans were advocated as suitable for iwi and consistent with tino rangatiratanga. By 1992, however, Māori and the Government had concluded that alternate health care plans were premature and should not proceed, at least in the medium term.

24 When presenting a submission at the Beehive hui to decide on the principles for the appointment of Commissioners to the Treaty of Waitangi Fisheries Commission, June Jackson from the Manukau Urban Māori Authority, claimed that as many as 50% of South Auckland Māori had no contact with their respective tribes.
emerged to enhance a Māori identity, not all Māori have shared in those developments and assumptions cannot be made about Māori aspirations or preferences. In short, there is no single Māori identity; the Māori population is as diverse as any other.

This has implications for health services and strategic directions for Māori development. An exclusive focus on tribal structures might bypass many Māori. Similarly, making the New Zealand mainstream more bicultural might do little to address the needs and interests of those who are so uncomfortable in society’s institutions that they will choose to ignore them if at all possible.

A DUAL FOCUSSED TREATY DRIVEN FRAMEWORK

Arising from the decade of Māori development, the Treaty of Waitangi has been promoted as a suitable framework within which to consider social and economic development. Though essentially a political statement, Māori have come to regard the Treaty as a statement of individual and collective rights, a charter for New Zealand as a whole, and a reminder to the Government of its obligations in respect of Māori people.

Some debate has occurred as to whether the Treaty is sufficiently relevant to act as a signpost in today’s world. Lack of agreement between the English and Māori texts, together with doubts about the motivation for a Treaty in the first place, have sometimes led to a conclusion that the Treaty simply cannot provide useful guidance for contemporary New Zealand. The Waitangi Tribunal on the other hand thinks it can, even in such areas as broadcasting and the way in which Māori are appointed to Government bodies. Several Government departments have also acknowledge that the Treaty of Waitangi is integral to their work and applicable to departmental core business.

If there is a debate about the significance of the Treaty to future development it is often about whether Treaty provisions or Treaty principles should be

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27 Ministry of Womens Affairs, 1993, *He Kaupapa He Hanga Tika A Foundation Shaping the Way, Responsiveness to Māori Plan* of the Ministry of Womens Affairs, Wellington
afforded the greater significance. Protagonists of a more literal interpretation of the Treaty prefer to speak of provisions. But wherever the Treaty is included in legislation it is the principles of the Treaty which are acknowledged, and it is the principles which the Waitangi Tribunal must consider. Yet both provisions and principles are important and both are capable of forming a Treaty framework against which the implementation of the Government's objective for Māori health can be assessed.

There are three key Treaty provisions each derived from an article of the Treaty. The first, Kawanatanga, is from article one. It is a provision for the Government to govern and is relevant not only to central government but also to agencies of state, regional government, state owned enterprises and Crown health enterprises.

The second key provision is tino rangatiratanga (article two) which provides for tribes to exercise authority in respect of their own affairs. The boundary between tribal authority and the authority of the Crown is not clear and in the distant and recent past litigation has occurred, with mixed results. Sometimes the term tino rangatiratanga is loosely applied to Māori people generally, in the pursuit of greater Māori autonomy. However, the provision, tino rangatiratanga, is at its strongest when it refers to the position of iwi/hapu as tangata whenua in a particular area or region. A characteristic of tino rangatiratanga is iwi autonomy.

The third key provision is oritetanga, a provision which stems from article three and guarantees equality and equity between Māori individuals and other New Zealanders. As long as socio-economic disparities remain the provision is unratified.

A number of Treaty principles have been proposed over the past two decades. The Waitangi Tribunal, the Court of Appeal and the Crown itself have identified several principles, though for different purposes. The Royal Commission on Social Policy enunciated principles of particular importance to

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28 In 1877 Judge Prendergast ruled that the Treaty was a “simple nullity” and dismissed a Ngati Toarangatira claim that the alienation of a block of land had been contrary to the Treaty of Waitangi. In 1987, the Court of Appeal found that section 27 of the SOE Act 1986 was in opposition to the principles of the Treaty and insisted that safeguards be added to protect Māori interests when Crown land was transferred to State Owned Enterprises.
social policies including health. 29 Those three principles are partnership, participation and active protection.

Partnership refers to an ongoing relationship between the Crown or its agencies and Iwi. A partnership with one iwi does not exclude a partnership with others, nor should it be presumed that one iwi can speak for another. Iwi may organise as Māori Trust Boards, Runanga, or Incorporated Societies. Within a single iwi there may be more than one constituted authority and a prerequisite for the implementation of any partnership is the prior identification of the appropriate authority as well as the identification of iwi in the area/region who are tangata whenua.

Participation is a principle which emphasises positive Māori involvement in all aspects of New Zealand society. There are at least three levels of participation: participation by Māori individuals (who may or may not hold a mandate), participation by iwi or hapu, and participation by invitation (but without necessarily a right to vote on all matters).

Active protection, the third principle, creates an obligation on the Crown to actively protect Māori interests. In health terms active protection is essentially about health promotion and preventative strategies and implies that the State will adopt pro-active approaches and seek opportunities for the enhancement of Māori health.

A combination of Treaty provisions and Treaty principles can be used as the basis for a framework in which Māori health objectives can be realised. 30 This dual focussed framework (provisions and principles) provides a sufficiently encompassing template for the development of strategies that will achieve gains in Māori health.

GAINS IN MAORI HEALTH
The Government’s objective for Māori health will require several strategies to address the current disparities in health status between Māori and non-Māori. Because of the complexities of the problem and its multi-factorial origins, there

30 A Treaty framework made up of provisions and principles was first used in a report prepared for North Health by G Doherty and MH Durie in June 1993
is no single method which will be sufficient to embrace the range of health problems or the diversity of Māori realities. Nor is it reasonable to suppose that the health services, by themselves will be able to effect dramatic changes in Māori health status. Indeed scepticism about the health reforms expressed at hui in 1992, often arose from the observation that health was closely linked to socio-economic conditions and that no amount of manipulation with primary or secondary health care would mitigate against the ill effects of unemployment, substandard housing, low incomes or inadequate housing.31

On the other hand it was also maintained that, precisely because of the socio-economic climate, Māori would be in even greater need of quality health care. Notwithstanding the obvious good sense in placing more emphasis on health promotion and prevention, in the foreseeable future there will remain a need for adequate treatment services. Ironically, when more preventive services are launched it is likely that they will lead to an actual increase in the utilisation of health services by Māori, a consequence of better case finding and more opportunities for liaison between Māori communities and the health sector.

At consultation hui organised by the Core Services Committee, options for more effective and efficient service delivery were frequently discussed.32 Not only was it seen as important for all services to be culturally appropriate, but for some types of health care Māori argued that they themselves would be more able to provide services which were accessible, integrated into the overall philosophy of Māori development and therefore more likely to be utilised.

It was this last point that gave the health reforms some semblance of credibility in the eyes of many Māori. Within the new climate of competition and limited deregulation, iwi and other provider groups saw fresh opportunities. Even discounting iwi health care plans, the potential for contractual arrangements with Regional Health Authorities and Crown Health Enterprises was greeted with optimism. Purchaser neutrality seemed an advance on the significant but inconsistent strategies Area Health Boards and their often paternalistic approaches to Māori development.

31 Barwick H, 1992, The Impact of Economic and Social Factors on Health, A report prepared by the Public Health Association of New Zealand for the Department of Health, Wellington

32 Core Services Committee, 1992, Core Service 93/94 A Report to the Minister of Health from the National Advisory Committee on Core Health and Disability Support Services
Not that there was total uncritical support for the reforms. From a Māori development perspective, the lack of a clear focus for Māori health within the reforms was one reason why a Māori Health Authority was recommended.33

**MAORI HEALTH GOALS**

By 1993, however, and recognising the diversity of contemporary Māori experience as well as the disparities in standards of health, it had become possible to identify three broad goals for the advancement of Māori health.

**Goal 1**

**Māori Socio-economic advancement**

The first broad goal requires substantial improvements in Māori socio-economic standing and in particular, better housing, less unemployment, improved levels of income and higher educational achievement.34 While it could be argued that these wider issues are outside the concern of the health sector, a stronger case exists for the health sector being unable to afford to ignore them or to recognise the direct and indirect influences that they will have for the quality and quantity of health services. Nor should the potential political influence of the new health structures be overlooked. Health policies are not the exclusive province of the health sector; indeed all policies have implications for health in so far as they are able to modify the health status of the population. For Māori, the greatest gains in health are likely to come from healthy socio-economic policies and it will predictably fall to the health sector to make the connections.

**Goal 2**

**Māori Self Determination and Māori Management**

The second broad goal stems from Māori interest in a greater measure of self-determination so that Māori themselves might be better placed to define their own realities and, among other things, manage their own health. This goal is epitomised by the National Māori Congress, the Kohanga Reo movement and to some extent by the plethora of Māori


health initiatives which emerged during the 1980s. While some were essentially controlled by health authorities, many were located firmly within Māori communities and were closely linked to iwi development. To a greater or lesser extent they were based on Māori perspectives and subject to Māori guidance. Difficulties arose, however, when issues of control and accountability were left unnecessarily vague so that, as in the case of Te Whare Paia, conflicting agendas and styles created tensions between mainstream institutions and Māori, detracting from the primary objective of improved mental health care.35

Goal 3

Enhancement of Mainstream Health Services

The third broad goal is concerned with the way mainstream health services provide services to Māori. It anticipates that Māori will continue to require access to general health services, that health services will need to become more responsive to Māori (and other ethnic groups) and that positive strategies will be a necessary part of purchasing and service plans in order to address Māori health needs. Many health institutions have made significant advances in recognising Māori cultural preferences but sometimes these efforts have been peripheral to actual service delivery and have had little impact on key issues such as waiting times, health outcomes and improved follow up. While cultural sensitivity is important, it does not represent a comprehensive response to improving Māori health status. It should be seen alongside other performance indicators which have a bearing on Māori health.

STRATEGIES FOR MAORI HEALTH ADVANCEMENT

The three broad goals are equally important though reflect quite different dimensions. For each goal a number of strategies might be employed, all with the overriding objective of improving Māori health and, in line with the Government’s objectives, seeking to give Māori the same opportunity to enjoy the same level of health as non-Māori. Already Regional Health Authorities have adopted specific measures and although there appear to be considerable differences in their approaches, their purchasing plans have incorporated Māori health goals and targets.

The strategies contained in Table 1, and explained later in more detail, are consistent with the dual focussed Treaty framework and can be operationalised within given time frames. Though not exhaustive, they represent relatively significant steps which might be taken by all health authorities, including the Ministry of Health, the Public Health Commission, RHAs, CHEs and independent providers.

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The strategies

1. **Promotion of healthy policies across the sectors**
   The health sector does not have a monopoly on policies which affect health. Most of the social policy areas but especially housing, employment, welfare, education, income maintenance, are critical for determining health status. Health authorities have a role to play in advocating that all policies should be assessed for their health impact. A refocussed health service as a way of improving Māori health status, for example, may be of less importance than policies of full employment.

2. **Intersectoral co-operation and co-ordination**
   Health care inevitably impacts on other sectors. Even though responsibility for funding disability support services has been transferred from the Department of Social Welfare to Regional Health Authorities, the interface between health care and housing, education (eg
Special Education Services), employment, justice (especially the Justice Department’s Psychological Services) and welfare (income, benefits), remains sufficiently blurred to warrant extra co-ordinating efforts. These will be necessary at national levels (Public Health Commission, Ministry of Health), regional levels (RHAs) and local levels (CHEs, providers). In the likely event that other sectors will not take the initiative for integrating activities, the onus may well come to rest with the health sector. It makes good sense reducing the likelihood of duplication and allowing for continuity of care.

3 An Integrated approach to Mãori development
The decade of Mãori development and the experiences of tribal authorities have confirmed the importance to Mãori of a co-ordinated and integrated approach to cultural, social and economic development. While sectoral division is the rule, Mãori have preferred to adopt holistic philosophies so that maximum cross-flow can occur between programmes within a consistent framework. Health programmes aimed at Mãori communities cannot be considered outside that wider context of Mãori development and opportunities for combined efforts, with other sectors and with Mãori authorities, should be pursued.

4 Partnerships
Partnerships between Mãori and health authorities may have different goals. They may represent little more than an agreement to meet from time to time in order to review progress and discuss priorities but without any formal contract. At the other extreme partnerships may be formalised as contractual arrangements between an iwi or hapu and a health authority. While the concept of partnership is strongest when it is applied to the Crown and the tribes, it is sometimes used to encompass a relationship with a representative Mãori organisation. Partnership is an obligation arising from the Treaty. The terms of each partnership will need to be negotiated since not all iwi are at the same level of development nor will all wish to devote their energies to health. They may have other priorities. Partnerships may or may not lead on to specific programmes. At the very least, however, they should provide an opportunity for a sharing of information and discussion on broad aims and general directions.
Joint ventures
A joint venture is a particular type of partnership in which an iwi, hapu or other Māori organisation agrees to work with a health authority towards a common goal and for mutual benefits in a way which is mana enhancing for all concerned. Joint venturing recognises Māori expertise and at the same time the overall aims of the health agency. Though relatively autonomous, each party agrees to accept a shared framework and a commitment to work together on a joint venture board made up of RHA representatives and Iwi appointees. Joint ventures might include a Māori health needs assessment, arrangements for purchasing health services, the selection of appropriate health care providers, or setting criteria for quality assurance and monitoring.

Māori as purchasers
A number of iwi and some RHAs are interested in a particular type of joint venture in which Māori assume a purchasing role. There is more than one option.

(a) Co-purchasing
Midland RHA is negotiating with groups of iwi to establish joint ventures which, in addition to the assessment of Māori needs for health and disability services, and monitoring the delivery of services, may lead on to co-purchasing agreements. Co-purchasing would involve agreement on the criteria for the purchase of health and disability services, recommendations to the RHA regarding the selection of providers, and the development of quality criteria to ensure that services were relevant and appropriate for Māori. The Midland approach has been to encourage iwi in sub-regions (eg Waikato, Taranaki, Tairawhiti, Bay of Plenty) to work together so that each joint venture board has more than one iwi represented.

(b) Independent purchasing
Some Māori are keen to become health and disability purchasers in their own right, rather than working within an RHA context. The possibility was first raised when iwi health care plans were mooted and the concept was extended to a national level at Takupuwahia in 199236 when a Māori Health Authority was

36 Durie MH, 1992
suggested. To date, however, no firm arrangements which are independent of RHAs have been made and it appears unlikely that there will be direct funding from vote: health to Māori, bypassing RHAs.

(c) Budget holding
In contrast to independent purchasing, Iwi and other Māori community interests have made some limited progress in fund holding. Charged with obtaining the best health outcomes for their people within capped budgets, and keen to ensure that choice is available to Māori consumers, Māori health interest groups have considered holding the health budgets for their members and then arranging health services which are appropriate and accessible and not necessarily provided by a single provider. Two options are evolving: one based on a primary medical care practice; the other linked to a community group with interests in health care. In time, there is also the possibility of exercising a greater level of control and choice in the secondary care area.

7 Māori providers
There are a wide range of Māori health providers operating from both iwi and community perspectives. Māori providers can be expected to access Māori networks and provide a specified range of services in a more predictable manner than other providers, at least for those Māori who have not been able to participate comfortably in mainstream health services.

It is likely that Māori providers will be more active in primary health care and disability support. In particular there will be a predictable focus from Māori on:
• well child care
• whanau services including preventative care
• primary medical care
• early intervention
• rehabilitation and community care

While co-operation with other providers will be important, if Māori health gains are to be part of the integrated Māori development approach then Māori health providers will more likely be able to integrate health care with
other aspects of cultural, social and economic development. That may be their most significant advantage, quite apart from their knowledge of Māori networks and cultural norms.

8 Policies for Māori health
While much of the focus on Māori health has been on the delivery of health services, Māori have not been unaware of the importance of participating in the formulation of health policies at both national and regional levels. To some extent, joint ventures and other partnerships will allow for an input into health policy, at least as far as policies at a regional level are concerned. At a national level the Public Health Commission, Core Services Committee and Ministry of Health have also taken the need to consult with Māori seriously and a large number of hui have been held in many parts of the country. Often, however, Māori communities have simply been asked to respond to frameworks already established and there have been few opportunities for major innovative policies based on Māori priorities. The place of traditional healing for example remains to be determined even though it has been strongly advocated by Māori as a core part of the nation's health services. Te Waka Hauora has emerged as a national Māori organisation with the potential to play a significant role in health policy and in that capacity it is likely to be recognised by the Crown.

Acting on advice received in a commissioned report, the Ministry of Health has also moved to establish a Māori Health Group under the management of an Assistant Director General of Health.37 The Group’s major role would be to provide consistent policy advice in respect of Māori health.

9 Contractual obligations
In the foreseeable future, Māori, like other New Zealanders, will require access to a full range of health services and for the most part these are likely to be mainstream services provided by a CHE or general practitioner. In the past Māori access to mainstream services has often been problematic. Sometimes the difficulty has been a motivational one

but it has also reflected the monocultural nature of health services and their slowness in responding to the needs of Māori patients.

In order to ensure that mainstream providers address Government objectives for Māori health it will be necessary to include generic and specific indicators in contracts. RHAs will want to know that the services they fund are:

- culturally acceptable
- culturally safe
- accessible in terms of cost and waiting time
- based on comprehensive information
- developed in consultation with Māori
- effective
- accountable to consumers as well as funders
- able to provide Māori specific information

**Workforce development**

Until Māori are more representative within the health workforce mainstream health services will need to give active consideration to training and employment strategies which will lead to a higher Māori profile within all health disciplines. In the long term proportionate Māori professional participation should be the goal. In the shorter term, however, other approaches may be necessary including Māori liaison or advisory officers to work alongside other professionals. In some areas such as mental health this will be particularly necessary.

**PRE-REQUISITES FOR ALL STRATEGIES**

Strategies for Māori health gains will be more likely to succeed if there is provision for consultation with Māori, mechanisms to ensure that Māori have a meaningful role in monitoring, and an adequate infra-structure to implement the strategy.

These three conditions - consultation, monitoring and an appropriate infra-structure - are related to successful outcomes. Too often potentially advantageous health initiatives for Māori have suffered because there have been inadequate processes in place to maximise opportunities for success.

Consultation is a an obvious step though there is no simple process nor any clear set of rules which can be applied in every situation. Importantly the
complexity of Māori society must be considered and consultation processes adjusted to meet diverse Māori situations. A distinction also needs to be made between a focussed approach with an expert group and a broad canvassing of Māori opinion. 38

Monitoring health agencies and health services requires that objectives are clear and that the monitoring process incorporates more than one perspective. There are several Māori groups able to assist in a monitoring process and monitoring may be a defined objective in a joint venture. Where health services are delivered by Māori, or within the context of Māori development, then it may be necessary to arrange for external Māori monitoring.

Infrastructures are likely to vary according to the task and type of organisation. The Ministry of Health for example will need a strong Māori health policy section while a provider group may need workers who can tap into Māori networks and who will have credibility in Māori eyes. Importantly, health ventures must have the capacity for sustained quality activity, that will include good information systems, adequate data collection, procedures to ascertain the extent of customer satisfaction, and cultural safety.

CONCLUSIONS
As the decade of Māori development and the decade of Māori health draw to an end, a new era of Māori health endeavour is emerging. 39 It appears to be less concerned with redefining health according to Māori perspectives, than with ensuring the best possible health outcomes for Māori. Emerging from the health reforms there has been a discernible shift from the dominating influences of health institutions and health professionals and towards health services which have measurable benefits, offer value for money, are fair, and consistent with the community's values and priorities. 40 Though new opportunities for Māori are evident there is also concern that without a strong central drive in terms of health service delivery, Māori will be penalised by a

38 Durie MH, 1993, Māori Development and Purchasing Plans for Māori Health, Contracting Quality Care Conference, Auckland
40 Core Services Committee, 1993, The Best of Health 2 National Advisory Committee on Core Health and Disability Services, Wellington 22
system which values contestability at the expense of relatively inexperienced health interest groups.

Of critical importance in the new environment, however, will be the ways in which Government objectives are interpreted and then met. No single strategy will be able to address the many facets of Māori health and nor should differing strategies be seen as necessarily incompatible. The reality is that Māori live in many environments and their lifestyles do not conform to a single stereotype. There will be times when Māori political intervention is required, or Māori purchasing power needed, or Māori provision of health services preferred. But mainstream health services must also be able to meet other Māori health needs.

In contrast to the bicultural philosophies introduced more than a decade ago, the emphasis is now on health outcomes for Māori rather than on the acquisition of bicultural skills by a predominantly Pākehā workforce. The issues are more sharply focussed on the core business of health and the obligations on health funders to ensure that Māori health needs can be addressed. Sometimes that will be by developing distinctly Māori strategies; at others it will by making sure that Māori access to health services is unimpeded in cultural, financial or social terms.

The Government’s objectives for Māori health place some obligations on Government agencies. They do not necessarily take into account the full range of Māori objectives or the health plans of Māori institutions. Although there is a substantial overlap, Māori goals are not identical to the Crowns, nor are they best articulated within the context of the health reforms.

Health services do not exist in isolation from other aspects of social and economic development. A Māori development model is based on an integrated approach which links sectoral interests so that health, education, employment, housing and training can be considered as parts of the same overall plan. In that respect, it is pertinent to note that the health reforms by themselves will have relatively little effect on Māori health if there are not corresponding shifts in other policies. The impacts of unemployment, educational under achievement and poor housing are more relevant to health than co-purchasing or other strategies for delivering health services. That is not to deny the substantial gains for Māori health inherent in the Government Māori health objectives; it is simply to place them in perspective.
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GOVERNMENT OBJECTIVES FOR MAORI HEALTH

Pre-requisites for all strategies

consultation
monitoring
appropriate infra-structure

Conclusions

the main issue: best possible outcomes for Māori health

three broad goals
socio economic growth
self determination
responsive health system

multiple strategies

integrated development
GOVERNMENT OBJECTIVES FOR MAORI HEALTH

Gains in Māori Health

STRATEGIES FOR MAORI HEALTH ADVANCEMENT

1. Promotion of healthy policies
2. Intersectoral co-ordination and co-operation
3. Integrated approach to Māori development
4. Partnerships: iwi/hapu - health authority
5. Joint ventures: health needs assessment, purchasing arrangements, selection of providers, monitoring
6. Māori as purchasers: co-purchasing, independent, budget holding
7. Māori providers: iwi/hapu, Māori community
8. Policies for Māori health: national, regional
9. Contractual obligations: RHAs, CHEs
10. Workforce development
## Government Objectives for Maori Health

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<td>2️⃣ Intersectoral co-operation and co-ordination</td>
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GOVERNMENT OBJECTIVES FOR MAORI HEALTH

Gains in Māori Health

BROAD GOALS FOR MAORI HEALTH

- Socio economic advancement
  housing
  education
  employment
  security of income

- Māori self determination and Māori management
  Māori control
  iwi development
  Māori delivery systems
  Māori health initiatives

- Enhancement of Mainstream health services
  improved access for Māori
  improved outputs for Māori health
  capacity to address Māori health needs
GOVERNMENT OBJECTIVES FOR MAORI HEALTH

The Dual Focussed Treaty Driven Framework

Treaty Provisions

kawanatanga
tino rangatiratanga
oritetanga

Treaty Principles

partnership
participation
active protection
GOVERNMENT OBJECTIVES FOR MAORI HEALTH

THE WIDER POLICY ENVIRONMENT

Maori Development

- the decade of Māori development
- tino rangatiratanga
- Treaty of Waitangi
- iwi development and iwi delivery
- positive funding
- integrated development

Socio-economic reform

- rights based - contracts based approach
- targeting - universal provision
- commercial environment
- competition
- devolution and deregulation
- funder - provider split

Diverse Māori Realities

- urbanisation
- socio-economic disparities
- access to Māori institutions
- access to society’s institutions
- alienation from Māori mainstream
- alienation from the NZ mainstream
GOVERNMENT OBJECTIVES FOR MAORI HEALTH

S 7 Health and Disability Services Act 1993 take account of

"... the special needs of Māori and other particular communities or people for those services"

Crown Objectives

"The Crown will seek to improve Māori health status so in the future Māori will have the same opportunity to enjoy at least the same level of health as non-Māori"
Government Policies

Te Urupare Rangapu 1989
Ka Awatea 1991
The Health and Disability Services Act 1993
Whaia te ora mo te iwi (1992)
Core Services 93/94
Policy Guidelines to RHAs (1992)
Whaia te ora mo te iwi (1993)
The Crowns Objectives for RHAs (1993)
The Crowns Objectives for the PHC (1993)
Te Ara Ahu Whakamua: Strategic Direction for Māori Health (1993)