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A GAME OF SLIDES AND LADDERS
MĀORI HEALTH PROVIDERS AND FUNDERS

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Prior to the economic reforms of the 1980s, New Zealand followed a Keynesian interventionism model that fostered government responsibility to look after its citizens.[1] The government took responsibility for affecting employment and unemployment rates and acknowledged when and where there were housing needs before being charged to take action to do something to address them. Deregulation in the 1980s meant the government was able to contract out services for which they had earlier taken responsibility, giving Māori opportunities to develop culturally centred service provision. An overview of the challenges afforded by these opportunities is presented throughout this chapter.

In 1986, the World Health Organization (WHO) published the Ottawa Charter.[2] With the New Zealand government's adoption of the Charter, a reorientation of health services towards public health took shape. This new approach was radically different from the sickness and individually focused treatment services that previously dominated. The shift in health service orientation and the introduction of other neoliberal reforms created an opportunity for Māori to take more control of their own health outcomes through the delivery of culturally relevant and appropriate services.[3]

Both the Ministry of Health (then the Department of Health)[4] and the Ministry of Māori Development (Te Puni Kōkiri)[5] provided advice as to how well, or not, the new process fitted with the elected government's

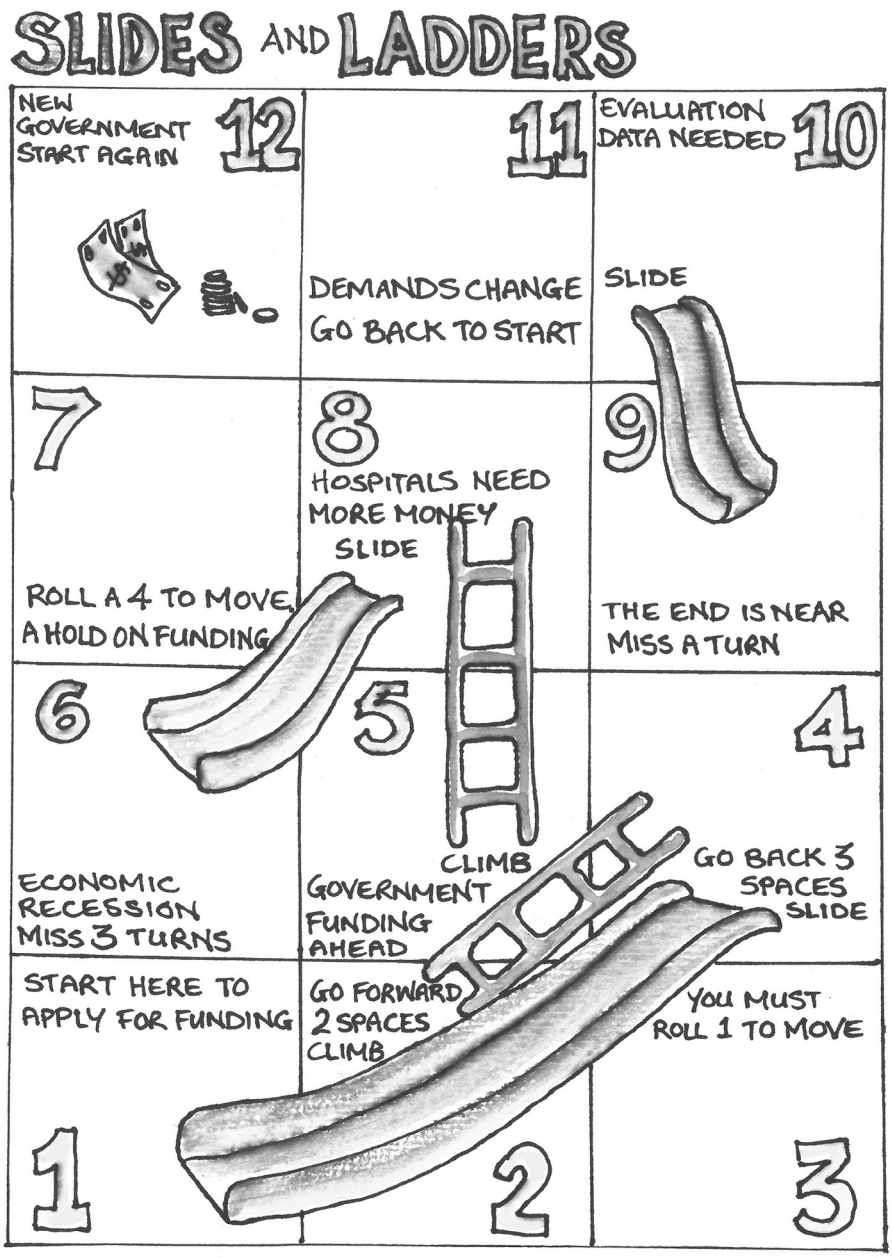
directive towards Māori health policy. Among Māori communities, this opportunity was grasped eagerly as a means of taking control of health delivery to their members; the changes were seen as the answer to calls for more autonomy when it came to improving outcomes in Māori health, education, justice and employment.[6]

Jump forward to 2017, and the shift to neoliberal economics and the virtual hegemony enjoyed among economic commentators, policymakers and business leaders has left no room for the 'social welfare' system of earlier times.[7] The National Government's neoliberal economic reforms of the 1990s carried forward the 'New Right' ideology by: 1, the continued corporatisation and privatisation of many government enterprises; 2, stripping back and restructuring the welfare state; 3, increasing user charges for health and education; and 4, devolving responsibility for the provision of health and social services to Māori communities.

This chapter focuses on the last point, and explains how the pressure to produce improved health, without the commitment of sufficient and continued resources, places Māori providers, and whānau by virtue of a flow-on effect, in a position of precariousness. Rather than describe in detail the level of inequity that abounds within health-service funding and provision, I attempt to take a humorous approach, by touching on the issues and making connection to a game of Slides and Ladders (renamed from Snakes and Ladders, as snakes don't fit with the health theme of the chapter). At the end of each paragraph below I have inserted a comment, for example [*Go forward*] or [*Slide backwards*]. These little asides serve as a reminder about the Slides and Ladders game.

HEALTH SERVICE PROVISION FOR MĀORI

While the devolution of state responsibility had a huge economic impact on Māori, it also allowed for local indigenous control over the design and delivery of community-based and culturally sensitive services.[8] There was a great desire to fill an unmet need and access funding that would enable the provision of appropriate services to Māori. Aotearoa New Zealand's commitment to the World Health



Organization's agenda of ensuring that everyone had access to an acceptable level of health services on fair terms gave New Zealanders the freedom to choose where to go for services that suited their individual and collective needs. This came alongside the opportunity for Māori service provision, which meant that 'by Māori/for Māori' programmes and services seemingly appeared overnight. [*Start game*]

The New Zealand health system went through a series of changes during the 1990s, but has always retained a significant public provision of health services.[9] Among the changes that took place was a split of the purchasing role from a providing role, which was premised on the perceived efficiencies that would eventuate from introduced competition[10] — the idea that the inherent superiority of the market would deliver better health outcomes by forcing providers to become more accountable to both purchasers and their patients. [*Go forward*]

Successive governments during the 1990s pushed for 'local solutions to local problems'. This suited the 'new' initiatives, such as Māori providers,[11] because it allowed them greater autonomy from government and increased their sense of control over their own destinies. 'Autonomy' was perceived as economic control — with a growth in economic control came a sense of autonomy. Goodwill grew between Māori and the government during this period.[12] [*Go forward*]

While the promise of autonomy was held out to Māori in one hand, the other hand held funding constraints and inequitable contracts between Regional Health Authorities (purchasers of health services — also known as the 'Funder') and Māori providers around the country, which hampered the promised health autonomy. [*Slide backwards*]

The ability to use Māori cultural constructs in the development and delivery of health programmes was seen as an acknowledgement of the government's willingness to recognise the place of Māori in Aotearoa New Zealand. Through development of a suitably acceptable proposal for service provision, Māori providers (and communities) believed that the government would give them access to the previously untapped Bank of Continued Funding, which had been continually available to mainstream service providers. [*Go forward — climb the ladder*]

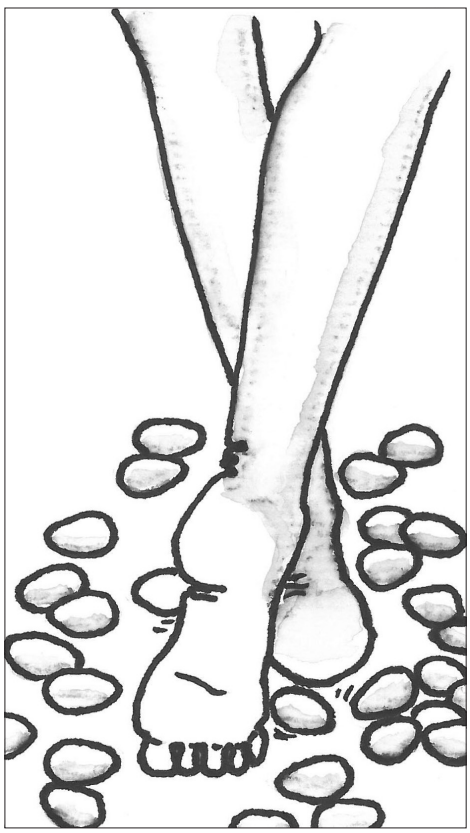
Since the establishment of the first hospitals in the 1880s, and the

introduction of the Public Health Act in 1872, the provision of health services has been seen as paramount in this country.[13] New Zealand citizens have had continual access to mainstream health and social services that have been funded to reduce negative health impacts. However, government reports over the decades (both before and since the health reforms) clearly show that negative health impacts have increased, rather than decreased, for Māori in mainstream health services. Yet the provision of funding has continued, if not increased. [*Lose a turn*]

Māori providers (and service users) believed that while they might make a few mistakes in the delivery of culturally centred services to their communities, they would be afforded the opportunity to learn from these mistakes and amend their service delivery appropriately until the desired health changes were achieved. Such had been their observations of mainstream service providers. [*Go forward*]

However, before Māori realised what had happened, their Māori service providers had entered a game of Slides and Ladders that involved a requirement to walk down the 'yellow brick road' made of eggs. The pathways in the service provider system required Māori providers to learn the skill of walking on eggs. As with any new skill, Māori providers being new to the game had to learn the art quickly, without any resources or tools to help them, and with the constant sound of a ticking clock reminding them that there was only so much time left before they lost their funding. [*Slide backwards*]

As with all health services, the provision, activities, outputs and outcomes of the provider's work must be reported to the Funder. All expenditure must be financially accounted for and tangible health gains must be achieved with every step (these translate as a measurable reduction in a negative health occurrence — such as fewer people dying of lung cancer as a result of smoking). Each of these demands on service providers can be equated to the 'eggs' that must be walked over in order to access the fabled Bank of Continued Funding. The ability to travel along this roadway without cracking (any) eggshells involves having absolutely robust mechanisms that meet the cultural norms of a health system set up to serve the dominant beliefs and values that fiscal worth equates to tangible benefits that can be physically counted



and seen. [*You must roll 4 to move*]

Let's face it, Māori are aware that the (health funding) system is not fair because the system was not set up to serve Māori needs in the first instance. (If Māori controlled the distribution of health resources to everyone in the country, would the health system look the same as it does now? What would it look like?) What has become more evident as government election cycles continue, with their promises of better healthcare services while at the same time injecting less money than needed into the sector — particularly less than needed in some parts of the system where Māori needs are greatest — is the unequal treatment of service providers.[14] Despite an increase in government spend on health services, inequity is demonstrable when resources are given to mainstream providers (such as District Health Boards — DHBs) who continue to control regional service delivery that does not meet the needs of Māori communities in their regions.

DHBs are more likely to access continued funding despite some major failures to achieve large health gains for Māori. Māori providers are more likely to be severely penalised (by being denied access to further funding) if they fail to meet one of the numerous demands to eliminate poor Māori health within their time and resource-constrained contracts. I liken the privilege afforded to DHBs in this instance (and other mainstream government-funded providers) to being given support by way of 'hover shoes'. Such support enables mainstream services to easily travel the pathway of continued funding without ever breaking any eggs along the way.

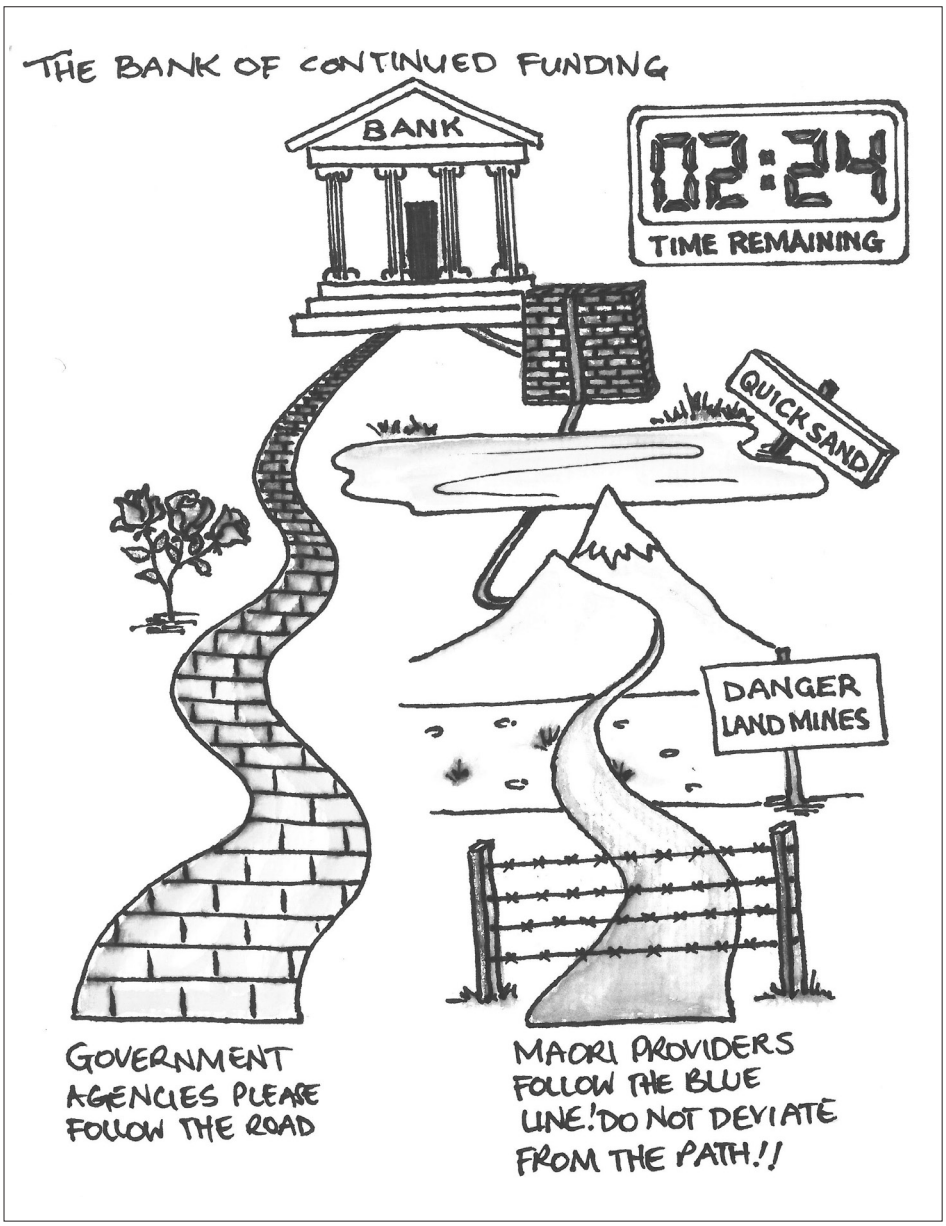
Government agencies (as funders, providers and auditors) are the tools of a system that was created by a privileged group with a specific set of values that reflect what is desired for those who look, think, believe and act like them.[15] Because the system was created by those in power to serve those in power, government agencies have a smooth road when it comes to accessing funding. The health system was not created by or for the Māori providers trying to access that same funding; nor does the health system have the same values and priorities that Māori do. As a result, even though the intended outcomes may be the same (that we live longer and in better health) what that picture of health looks like and the ways of measuring the successful provision of

services for Māori within the health system are less valued.

For Māori providers (and whānau), navigating the health system is like an uneven race. Some are given a clear pathway with no obstacles, and with helpful supports along the way, which enable them to access continued funding (as a provider) or (as individuals) have a long and healthy life with minimal disruptions to their everyday life. [*Slide backwards*]

The uneven and unequal pathways by which Māori and mainstream

Example of a funder requirement	**Impact of failure to deliver for Māori service providers (likely discontinued funding)**	**Impact of failure to deliver for mainstream service providers (given access to continued funding)**
Meet current reporting deadlines.	Unexpected loss of key staff means a new person must be hired to provide such information.	Unexpected loss of key staff means a new person must be hired to provide such information. Expectation that such information will be provided in the next cycle.
Report deadlines need to be adjusted (for whatever reason).	Lacking infrastructure, resources need to be redirected from delivery. Negotiation for a 'grace period' not approved.	Infrastructure in place to manage this but more time needed. Negotiate a 'period of grace' whereby the information will be provided in the next cycle.
Demonstration of fiscal accountability.	Transfer of funds to meet other identified areas of need is insufficient. Without additional resources further detail cannot be produced.	Transfer of funds to meet other identified areas of need is accepted. Further details can be produced on request, with additional resources.
A new requirement for an evaluation of services provided.	New skilled staff must be contracted to complete this task; more time required.	Other programmes of a similar nature were evaluated; here are those results instead.
Negative health impact factor reduced by 15%.	Community circumstances meant this was not achieved. Will keep trying.	Community circumstances meant this was not achieved. Will keep trying.



providers access resources have been demonstrated by a range of researchers and reports. [16]

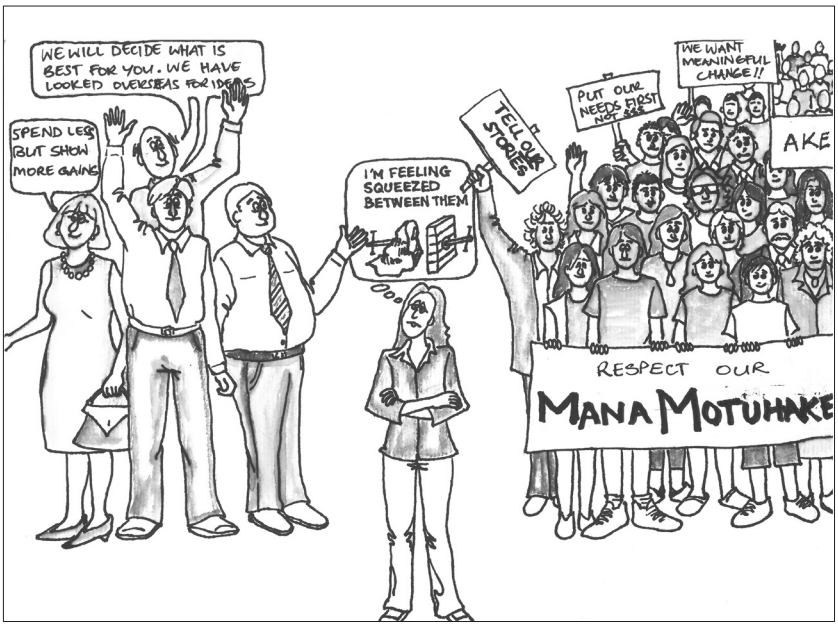
Māori providers can often be left feeling squeezed between 'a rock and a hard place' when it comes to meeting the demands of government funders and Māori communities whose demands for a culturally appropriate health service prioritise spiritual and cultural health over the absence of physical disease.

In such scenarios Māori providers can expend resources over and above what they have been funded to deliver in order to support whānau in ways that are more culturally familiar to them. Sadly, such additional activities are either not counted or are given less importance within the current reporting structures. Juggling the demands of both the funders and the service users is a difficult space for Māori providers to navigate; with the constant threat of losing their service contracts, Māori providers are in an under-recognised precarious position. [*Go back to the start*]

CLOSING COMMENTS

New Zealand's history is full of examples of well-meaning policies with the best intentions failing to achieve positive gains for those most in need. Long gone are the days of positive social welfare reforms. Instead, the New Zealand government has regularly been below the OECD average when it comes to social spending as a percentage of GDP. Money that could buffer low-income families and support them in ways that would enable them to be well is much harder to access. The health system is an example; the majority of its most vulnerable and in need of government resources are Māori. Māori (and other NGO) providers are trying hard to meet contracts that are administratively demanding and difficult to interpret, and which threaten their ability to provide culturally and socially relevant services.

Although New Zealanders have seen the closure of small (rural) hospitals and some major commercial providers have lost their contracts (for example, laboratory services), the history of government bail-outs for DHBs does not allow them to fail. The same is not true for Māori providers. Despite increasing demand and decreasing funding, Māori providers and whānau (service users, family members



and extended family) find creative and meaningful ways to continue. The continued existence of Māori providers suggests that some have 'cracked the code' and are able to keep playing the game of Slides and Ladders. I hope that my analogy, likened to a child's game, has helped to prevent people from getting bogged down in the negativity of the whole situation.

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1 Keynesian economics is based on a model that holds the central belief that government intervention can stabilise the economy.

2 World Health Organization, *Ottawa Charter for Health Promotion* (Ottawa: Canadian Public Health Association, 1986), http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

3 Jane Kelsey, *Rolling Back the State: Privatisation of Power in Aotearoa/New Zealand* (Wellington: Bridget Williams Books, 1993).

4 Department of Health, *Whaia Te Ora Mo Te Iwi: Government's Response to Maori Issues in the Health Sector — Health and Disability Services Bill* (Wellington: Department of Health, 1992).

5 Te Puni Kōkiri, *Progress Towards Closing Social and Economic Gaps between Māori and Non-Māori: A Report to the Minister of Māori Affairs* (Wellington: Te Puni Kōkiri, 1998); Department of Health & Te Puni Kōkiri, *Whaia Te Ora Mō Te Iwi: Strive for the Good Health of the People. Māori Health Policy Objectives for Regional Health Authorities and the Public Health Commission* (Wellington: Department of Health, 1993).

6 Mason Durie, *Papaki Rua Ngā Tai, Tides of Confluence: Māori and the State* (Auckland: Oxford University Press, 2005).

7 Jane Kelsey, *Reclaiming the Future: New Zealand and the Global Economy* (Wellington: Bridget Williams Books, 1999).

8 Augie Fleras and Paul Spoonley, *Recalling Aotearoa: Indigenous Politics and Ethnic Relations in New Zealand* (Auckland: Oxford University Press, 1999).

9 The New Zealand health system initially developed in the nineteenth century in response to the threat of infectious disease and early public health concerns with sanitation and water supply, alongside quarantine and vaccination practices.

10 J. Kelsey, *The New Zealand Experiment* (Auckland: Auckland University Press, 1994).

11 Bill English and Tuariki Delamere, *Māori Provider Development Scheme* (Wellington: Minister of Health, 1997).

12 There were other contributing factors to the growth in goodwill. For example, the first Treaty settlements, between the Crown and Tainui and the Crown and Ngāi Tahu, were reached — these engagements fostered a positive relationship between Māori and the Crown (through its representative, the government).

13 *The Napier Hospital Services Claim — WAI 692. The Napier Hospital and Health Services Report* (2001), https://forms.justice.govt.nz/search/WT/reports/reportSummary.html?reportId=wt_DOC_68596252

14 The exact number of Māori providers is not easily calculated. Databases that record the type of organisation do not record the type of contract. Databases about health contracts are kept confidential to protect the nature of contracts. For example, the Ministry of Health provider records do not reveal whether providers are iwi or Māori services, but instead report on the size of the organisation and the types of services offered. My current research project on hospital transfers has found that there is only limited routinely published information that provides detail on patterns of transfer between hospitals or receipt of hospital care outside one's usual place of residence. Such information tends not to be discernible by ethnicity. There is some data on inter-district flows; that is, payments from one DHB to another due to a patient moving between their DHB of usual residence to another to receive a health service, and hospital 'through-put' (see National Health Board, 'IDF Methodology Notes 2015/16' [2014], available online at: http://nsfl.health.govt.nz/finances/financial-standards-and-guidelines/inter-district-flows; and Ministry of Health, *Hospital Throughput 2003/04 for DHBs and their Hospitals* [Wellington: Ministry of Health, 2006]).

15 Evan Te Ahu Poata-Smith, 'The Political Economy of Inequality Between Maori and Pakeha', in *The Political Economy of New Zealand,* ed. Chris Rudd and Brian Roper (Auckland: Oxford University Press, 1997), 160–79.

16 Ministry of Health, *Hospital Throughput 2003/04 for DHBs and their Hospitals*; National Health Board, 'IDF methodology notes 2015/16'; F. Cram and K. Pipi, *Iwi/Māori Provider Success: Pilot Project* (Auckland: International Research Institute for Māori and Indigenous Education, University of Auckland, 2001); Fiona Cram and Vivienne Kennedy, 'Researching with Whanau Collectives', *Mai Review* 3 (2010), retrieved from http://www.review.mai.ac.nz/index.php/MR/article/view/382/561; Families Commission, *Partnerships with Māori: He Waka Whānui*, Research Report No 1/12 (Wellington: Families Commission: Kōmihana ā Whānau, 2012); Philippa Howden-Chapman and Fiona Cram, *Social, Economic and Cultural Determinants of Health*, Health Determinants Programme Background Paper 1 (Wellington: National Health Committee, 1998); Manatu Maori, *Maori and the Reformed Health System* (Wellington: Manatu Maori, 1992); Bridgette Masters-Awatere, Shaun Awatere, Linda Waimarie Nikora and Neville Robertson, *Indigenous Service Programs Plus Indigenous Evaluator Equals Whitestream Evaluation: What's Wrong with This Picture? (Reflections from my PhD)*, presented at the 50th APS Annual Conference: Celebrating the Past, Looking Toward the Future, held at the Gold Coast, Queensland, Australia, September 29 to October 2, 2015, http://researchcommons.waikato.ac.nz/handle/10289/9827; Kataraina Pipi, Fiona Cram, Rene Hawke, Sharon Hawke, Te Miringa Huriwai, et al., 'A Research Ethic for Studying Māori and Iwi Provider Success', *Social Policy Journal of New Zealand* 23 (2004): 141–53; Te Puni Kōkiri, *Māori Provider Views of Government Funding* (Wellington: Te Puni Kōkiri, 2000); Te Puni Kōkiri, *Iwi and Māori Provider Success: A Research Report of Interviews with Successful Iwi and Māori Providers and Government Agencies* (Wellington: Te Puni Kōkiri, 2002).