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Tihei Mauri Ora:
A Māori response to health disparities

A thesis
submitted in partial fulfilment
of the requirements for the degree
of
Master of Māori and Pacific Development
at
The University of Waikato
by
ALIETA JEI WAITOA



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WAIKATO
Te Whare Wānanga o Waikato

2014

Abstract

Māori bear a disproportionate burden of health problems which, in concert with other factors (e.g. poor housing, low socio-economic status and low education attainment), contribute to and maintain low health status. It is noted that there have been multiple attempts to reduce health inequities – however, such attempts have been largely unsuccessful. Barriers to success include government reticence, restrictions on Māori participation in determining health directions/solutions, current contract paradigms and a reluctance to engage in meaningful partnerships with Māori. Those barriers occur within a cultural framework which defines (and therefore prioritises) the health of an individual over the needs of the collective.

The hypothesis of this research is that Māori health disparities are best addressed via the development and delivery of Māori health models by services which are oriented to kaupapa Māori principles. Utilising a case study approach, this thesis looks at the outcomes generated when a kaupapa Māori service applies key Māori principles to health service delivery. The case study, in tandem with focus group interviews identifies the key elements necessary to developing services which are responsive to the needs of Māori.

This study identified the importance of promoting change (and ultimately improve Māori health status) that encompasses the formation of a framework which considers collective benefit over individualism, encompasses Māori values, acknowledges and accepts Māoricentric clinical interventions. In addition, the thesis asserts that Māori health status will improve once Māori are active participants rather than recipients of health services.

Acknowledgement

Ko Te Amorangi ki mua

Ko te Hapai Ao ki muri

Tihei mauri ora

To my supervisor Professor Linda Tuhiwai Smith thank you for your guidance and support during my research – you are an inspiration. To Brian my heartfelt thanks to you for your guidance, support, belief and understanding during my postgraduate study and research.

To rangatira Wayne and whaea Rei thank you for providing me with this opportunity, having faith in me, providing me with access to resources, and the continuous support throughout the process.

To Baz and my wonderful mum - none of this was possible without you! Thank you for everything - for picking up my role as ‘mum’, keeping our tamariki happy, and for the uplifting I required every now and then.

Finally to my tamariki Shayarn, Kaeley, Kaea and Jeanne thank you for understanding that this research was important to me and for seeing the light at the end of the tunnel. I hope that this research will in some way contribute to a health system that will better meet your needs, our tamariki, our taonga, our future.

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Introduction

Māori realities in Aotearoa New Zealand include poor education outcomes, high unemployment, low income levels, high government benefit dependency, high government housing dependency and poor standards of living (Statistics NZ, 2013). Statistics reveal these circumstances contribute to Māori low health status. Regardless of the efforts by numerous Māori health providers, Māori health status remains low. This thesis sets out to identify what can be done to improve Māori health status. Continuous health disparities between Māori and non-Māori indicate that change is required and that flaws in the current health and disability system seem to be a factor in impeding progress.

Gaining insight into the dynamics facing Māori health providers operating under Aotearoa New Zealand's health and disability framework will assist with understanding how the current paradigm addresses the diverse realities of Māori whānau (family), hapū (sub-tribe) and iwi (tribe). The scale of the disparities is such that this research must also consider the need for a paradigm shift that reflects a Māori world view.

This chapter introduces some of the fundamental understandings that are required when discussing Māori health. I will define the meaning of health from a non-indigenous, indigenous and a Māori perspective. I will outline the health and disability system, and the Aotearoa New Zealand government's commitment to the United Nation's Declaration of Rights, and compare that level of commitment to their support for Māori. I will examine the context of broader health policy and the subsequent framing of Māori health policy in the context of Māori participation in developing and implementing such policy, and its monitoring and compliance reporting. Finally, this study's research intentions are outlined. Non-indigenous, indigenous and Māori definitions of health are now considered.

Defining health

The World Health Organisation (WHO) is the United Nation's overarching health authority. WHO provide leadership on global health matters, set rules and guiding authority, determine health research priority, set norms and standards (World Health Organisation, 2014). Aotearoa New Zealand is a member state of the United Nations therefore WHO is considered our overarching health authority

WHO (1946) defined health as:

A state of complete physical and social well being, and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all (p. 100).

WHO's definition of health prescribes it as an *individual necessity* that leads to the attainment of peace and security for all.

The Aboriginal Health and Medical Research Council of New South Wales (2011) explains indigenous Aboriginal health as:

Not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life. (p. 3)

In contrast to WHO's definition, the above explanation reflects an understanding of health which is collective and community based.

A Māori model of health

Māori is considered by the Crown as their Te Tiriti o Waitangi (Māori pronunciation for Treaty of Waitangi partner). Te Tiriti is an agreement first signed on 6th February, 1840 by representatives of the British Crown and various Māori chiefs from the North Island of New Zealand. Māori had their health defined holistically by Mason Durie's Māori health model – 'Te Whare Tapa Wha' (Durie, 2005). In 1982 Te Whare Tapa Wha was first presented in a training session to the Māori Women's Welfare League research project Rapuora (Morice, 2006). Te Whare Tapa Wha supports Māori to reclaim a sense of rangatiratanga (sovereignty) over their own health. The model also assists non-Māori to understand the ways in which Māori perceive the holistic nature of health rather than being the definitive. The model defines health as the balance of the four walls of the whare (house), each representing the foundation which will stand strong:

- wairua (spirituality);
- hinengaro (mental processes and behaviour);
- tinana (physical); and
- whānau (family/social).

It is believed an individual and whanau/families experience positive wellbeing as long as the four walls (i.e. individual's spirituality, mental processes and behaviour, physical health and family and social supports) are balanced.

The "Māori Health" section on the Ministry of Health's website makes reference to Māori health models. The section states "The Māori philosophy towards health is based on a wellness or holistic health model. For many Māori the major deficiency in modern health services is taha wairua (spiritual dimension)" (Ministry of Health, 2014, para. 1).

The Ministry of Health (2014) website references three Māori health models: Te Whare Tapa Whā; Te Wheke; and Te Pae Mahutonga. It appears the Ministry of health acknowledges that many Māori perceive Western models of health as deficient in meeting all of their health needs – particularly wairua and the collective nature. By acknowledging the deficit, it would appear the Ministry of health understand the necessity of developing and utilising a model of health which can positively influence Māori health status. Māori health models, particularly the positive aspects of utilising such models for the benefit and wellbeing of Māori are discussed further in Chapter Three – Literature Review.

In relation to Māori health models, Morice (2006) claims:

Māori health perspectives are holistic, inclusive and relational. Māori have always assumed a psychosomatic unity. In a Māori world view, the language of the body is inextricably linked to relationships. This is apparent in our language – whenua is ‘land’ as well as ‘placenta’, iwi is ‘tribe’ as well as ‘bones’, hapū is ‘extended family group’ as well as ‘pregnant’. The body/tinana, and the extended family/Whānau, affirm their connection to each other and with Papatuanuku/Earth Mother (and Ranginui/Sky Father), through whakapapa, mythology, creation stories, lore and waiata/song. (p. 2)

Indigenous and non-indigenous definitions of health highlight variations regarding emphasis for personal and family health. For instance, WHO’s and Government health policy (discussed in next section) focuses on the individual while an indigenous approach to health focuses on the community. Hence future policy and services need to recognise and respond to such diversity. The Aboriginal Health and Medical Research Council of New South Wales (2011) further proposed that in relation to health services attempting to meet an individual’s holistic needs:

“Health care services should strive to achieve the state which every individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community” (p. 3).

Again, the indigenous approach emphasises working to meet the diverse needs of a community rather than adopting a ‘one approach suits all’, which is reflected in the WHO’s definition. In the Aotearoa New Zealand context it seems logical that health legislation and policy would focus on meeting community needs, while simultaneously developing services, in partnership with communities, to eliminate barriers to improving Māori health status. Consequently, to address Māori health, service purchasing frameworks may need to focus on addressing community needs. In addition, compliance reporting requirements will need to include:

- i) assessment of how services are addressing community needs: and
- ii) the impact of services delivered in order to understand the success of the purchasing framework.

Aotearoa New Zealand’s health and disability system

The Minister of Health oversees the Health and Disability Sector (see Table one). The Ministry of Health is the Minister of Health’s primary health policy and regulation agency that prepares recommendations for government consideration to improve, promote, and protect its citizen’s health (Ministry of Health, 2011). Secondary agencies supporting the Minister of Health include: the National Health Board; Health Workforce New Zealand; the National Health Committee; and other ministerial advisory committees, including Te Puni Kokiri (Ministry of Māori Affairs) whose role is the lead public policy and advise the government on Māori wellbeing (Ministry of Health, 2011). The Ministry of Health emphasises its commitment to improving the health of all New Zealanders (Ministry of Health, 2011).

Despite the multitude of advisory boards and committees. The current health and disability system does not reflect Article 18 of the United Nations’ Declaration of Rights of Indigenous People (“the Declaration”). In relation to indigenous peoples’ rights, the Declaration states:

Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions (United Nations, 2007, Article 18, p. 5).

On 13 September 2007, the General Assembly, of which New Zealand is a member state, adopted the declaration. The declaration was in response to a study undertaken by Special Rapporteur José Ricardo Martínez Cobo on the problem of discrimination faced by indigenous peoples (United Nations, 2007). (See Appendices for a copy of the Charter).

Māori aspirations

Māori have been prolific in voicing aspirations to manage their own health needs and improve their health status. Those aspirations are consistent with Article 18 and tino rangatiratanga (a Māori concept of desiring self-autonomy and self-determination to achieve growth, development and prosperity). In support of the ideology of tino rangatiratanga, Durie (1997) states that:

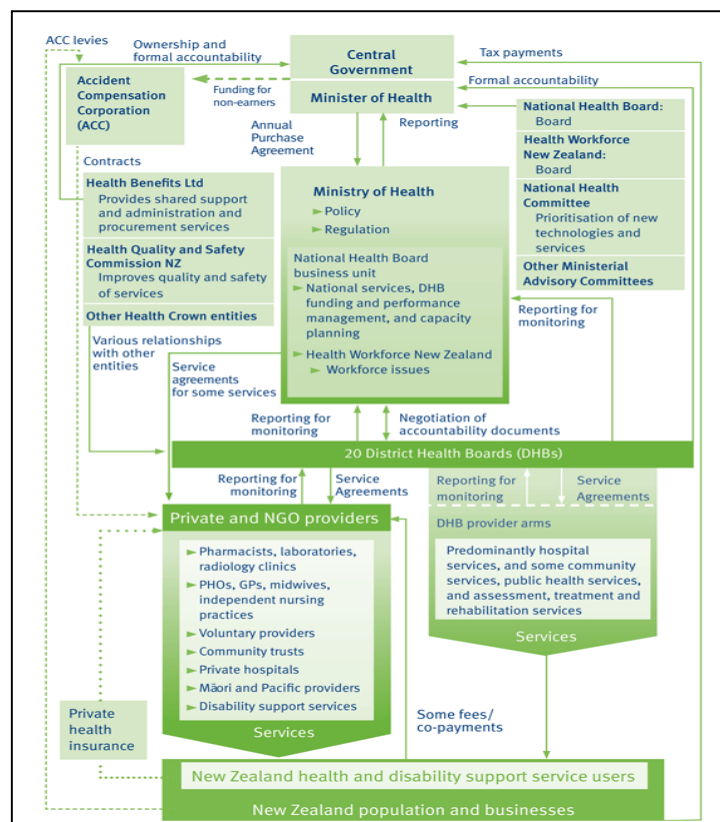
Māori deliver best on national goals for social and economic advancement if they deliver it themselves under policies of their own choosing. The nation benefits when Māori take responsibility for those matters. For the government it means as a negotiating face to deal with when policies require public expenditure, a face mandated through a Māori owned structure and the resolution of Māori issues through a settled Māori process. (p.112)

Despite Article 18's intent, and the adoption of the Declaration by the New Zealand government, there is little evidence Māori are provided with an opportunity to participate on their own terms (e.g. select their own representative) in decision-making with the Crown on health policy. Additionally, there is an absence of a strategic plan specifically intended to establish and maintain a Māori strategic decision-making institution (Durie, 1997). Moreover, despite Māori aspirations to achieve tino rangatiratanga, the current governance structure over the current health and disability sector does not support such ambitions (see Table

one). Māori are only present at the ‘provider’ level yet remain absent from the governance of the health and disability system. This is despite Government documents acknowledging Māori as te Tiriti o Waitangi partners (Ministry of Health, 2001, Ministry of Health 2002, National Health Committee 2001). The Māori voice appears to lack an opportunity to feed into governance and executive levels, and influence future strategic health and disability initiatives, their implementation, compliance monitoring, and their evaluation and audit.

Governance reporting lines (see Table one) demonstrate a ‘top down’ structure, where providers report to district health boards, which report to the Ministry of Health, which informs the Minister of Health and Central Government. The structure does not reflect a te Tiriti o Waitangi partnership. Māori voice (whānau, hapū and iwi) are classified as ‘Māori and Pacific providers’ remaining at the bottom of the hierarchy consistent with the ‘top-down’ approach. If Māori are to have a voice within the current system it must be “bottom-up” and reliant on “upper level” agents to act on their behalf. In a true partnership, it is assumed that Māori would appear at all levels of the governance structure.

Table One: New Zealand’s Health and Disability Sector



Te Kete Hauora

Supporters of the current governance structure might argue that the Māori voice is represented via Te Kete Hauora. Te Kete Hauora, Māori health directorate, is the Ministry's Māori health policy advisory business unit. A primary health policy advisor to Government on Māori health, Te Kete Hauora comprises four key roles: Deputy Director General Māori Health; Māori health policy; Māori research; and Māori participation and directorate support.

With only four key personnel to canvas and convey the views of the Māori (whānau, hapū and iwi), it is likely their ability to do so is limited. The rationale for establishing Te Kete Hauora appears to be based on Māori staff working on behalf of Māori to develop health policy to achieve equity. There is no statistical evidence, which is the only quantitative evaluative mechanism currently available, that policies supported by Te Kete Hauora, have achieved health equity for Māori. Prolonged poor Māori health statistics suggests a review of Te Kete Hauora's effectiveness is required.

In addition, Te Kete Hauora remains in an advisory role only. Hence, there appears to be little evidence to support the Ministry's stated commitment, on behalf of the Government, to fulfil a special relationship between Iwi and the Crown under te Tiriti o Waitangi principle of 'Partnership' (Ministry of Health, 2002). It appears the Crown is utilising Te Kete Hauora as a mechanism to legitimate a "consultation" process with Māori.

It seems unclear whether there is a potential conflict of interest with Te Kete Hauora advocating for Māori while also being the Ministry's directorate. Having a Māori flavour in health policy is appealing to many Māori and non-Māori but considering current health inequalities, significant changes are required to health policy, its development, and implementation. Māori communities require an opportunity to participate in identifying health priorities, have input into developing policy and be involved in the implementation and delivery of such policy. Te Kete Hauora and Māori health policy are managed by the Ministry of Health, rather than a Crown funded independent Māori governed unit to represent Māori views on Māori health policy, its implementation, and audit and evaluation.

Aotearoa New Zealand Government commitment to Māori

In 1991 the Māori Health Commission released a report 'Ka Awatea' (Māori Health Commission, 1991). This report highlighted the poor state of Māori health compared to non-Māori, and outlined recommendations to improve government policy for Māori health. Since the release of this document the Minister of Health, with the advice of the Ministry of Health, and other government agencies (i.e. Te Puni Kokiri, and the National Health Board) produced policy that acknowledged the unacceptable state of Māori health and outlined their strategies to improve its status.

Despite numerous reports detailing the on-going poor state of Māori health, to date, no report was located indicating the effectiveness of, or the outcomes achieved from, previous health policies. Additionally, no figures were located indicating the financial investment made in developing and implementing health policies that are intended to achieve health equity for Māori. A history of poor Māori health statistics suggest that the amount expended on health policies has not been allocated prudently because such policies have not achieved health equity for Māori. Similarly, Hunn (as cited in Kamira, 2003) suggests that with meaningful increases not being achieved in Māori capacity, capability, cultural capital and social capital, "Māori continue to feature disproportionately in almost all of the negative statistics" (p. 2). It may be that systemic anomalies exist in the health structure because current policy and programmes are not achieving significant health gains for Māori.

Compliance reporting

The Ministry of Health collect mental health service activity and outcome data and refer to this as PRIMHD (programme for the integration of mental health data). Ministry of Health (2013) states:

PRIMHD data is used to report on what services are being provided, who is providing the services, and what outcomes are being achieved for health consumers across New Zealand's mental health sector. These reports enable better quality service planning and decision-making by mental health and addiction service providers, at the local, regional and national levels. (para. 3)

In brief, the current legislation (New Zealand Public Health and Disability Act, 2000), and policy framework (He Korowai Oranga, 2002) reveal a history of poor Māori health status. The legislation and policy framework, and Māori health status appear to lend credence to an assertion that the Government retains authority over Māori, and can therefore exclude Māori from the decision making process at a governance level (Dodd, 2000). Current health legislation and policy acknowledge responsive health services for all, including Māori, but services purchased and compliance reporting schedules do not mirror the ethos of such legislation or policy (i.e. “Ministry of Health PRIMHD data collected: number of referrals, exits, discharges, consumer ‘whānau’ national health index number, service, and healthcare worker, facilities and organisation”) (Ministry of Health, 2013, p. 10).

Consequently, Māori health models and Māori traditional practices appear to be overlooked because the outcomes from historical health policy are reflected in the poor status of Māori - Māori life years are significantly less than non-Māori. Moreover, Māori women die 9 years earlier than non-Māori women and Māori men die 8 years earlier than non-Māori men (Matheson, 2004). Further, at least half of the life expectancy gap between Māori and non-Māori is explained by socio-economic disparities (Matheson, 2004). The policy and legislation analysis section, within the literature review chapter, examines specific health policy and legislation more closely.

Ministry of Health’s Compliance reporting framework

While the Ministry of Health acknowledges Māori as te Tiriti o Waitangi partners, in practice they have implemented compliance reporting schedules that ensure traditional Māori practices such as karakia (prayer), mihi mihi (greetings), and whanaungatanga (relationships) are not acknowledged (see Appendix for copy of Ministry’s compliance reporting schedule). The compliance and reporting schedules do not request the collection of traditional Māori practices which can be, and in some cases are, utilised by Māori organisations as ‘interventions’ (e.g. karakia, mihi mihi, whanaungatanga). Collecting data on all interventions used would provide an accurate account of what is working and what is not working for Māori. Failure to collect such data is likely to leave Māori uncertain around

Crown commitment to their Tiriti partners and undervalue traditional Māori practices. Such an approach seems ironic since the Ministry of Health templates for service specifications acknowledge Māori as tangata whenua (indigenous people of New Zealand) and state the importance of responding to Māori needs.

Despite the Ministry's compliance and reporting schedules acknowledging support for Māori, unless Māori traditional practices are acknowledged, the Ministry of Health's actions may be perceived as self-serving. This study's intent is now outlined.

Research's intent

As influencing socio-economic factors such as education, employment, and housing for Māori remain in a negative state, so too does Māori health status with disparities still evident. Review of the dynamics facing Māori whānau, hapū and iwi to improve their health as well as those Māori health providers trying to support Māori health needs within the current health and disability framework of Aotearoa New Zealand is overdue. It is time to consider whether the implementation of a Māori centred model of health could work better to improve Māori health status. Reflected in health data, Māori health status remains poor, which suggests further exploration is required on whether other areas of the health and disability system are contributing to the current Māori health status. It may be the entire or just components of the current health and disability structure do not work for Māori. It may be that a revised health structure that better reflects te Tiriti o Waitangi principles of 'Participation' and 'Partnership' for Māori at all levels may assist with improving Māori health status. Alternatively, or underpinned by Tiriti principles, it may be that Durie's (1994) Te Whare Tapa Wha model warrants inclusion in the health system to meet Māori health needs. There is one thing I am certain of at this early stage of my research and that is that the current health and disability system is not achieving health equity for Māori.

This thesis considers whether an indigenous centred model of health could improve the health status of Māori. It may be that based on the fact that previous health policies have failed Māori health, holistic Māori-led initiatives (e.g. Māori developed health policy) could improve not only Māori health but also build Māori capacity, capability, social and cultural capital. Building on from Māori developed health policy, would be the purchasing of health and disability services around Māori health needs, which would support Māori diverse realities, and embrace Te Ao Māori (the Māori world). Purchasing those services that drop out of Māori health policy is likely to eliminate barriers to service access and therefore encourage whānau, hapū and iwi to seek health services, which would be more likely to improve their health and wellbeing.

Summary

In summary, I have defined health from a non-indigenous, indigenous and Māori perspective. I outlined the health and disability system of Aotearoa New Zealand and the New Zealand government's commitment to the United Nations Declaration of Rights and compared this to their commitment to Māori as the indigenous people of Aotearoa New Zealand. I have examined the context of broader health policy and the subsequent framing of Māori health policy within Aotearoa New Zealand's health and disability system, in the context of Māori participation in developing such policy, and its implementation, delivery, monitoring and compliance. Finally, I outlined the intentions of this research.

As the researcher, my reason for delving into this particular topic is due to my involvement working within a Kaupapa Māori organisation and my awareness of the difficulties faced when an organisation whose philosophy is about working to meet the needs of the people, rather than working to meet the needs dictated by funding, policy and a health and disability framework that clearly is not supporting Māori to regain health equity. I am motivated by the opportunity I have to provoke thought by the reader who may or may not be aware of the current health and disability paradigm and the barriers Māori face within this paradigm. I want the reader to be aware of Māori opportunity to provide input on health policy and health services aimed to improve the health status they currently occupy. Also as a wahine Māori with tamariki (children), I want to be sure that

they will live in a country that accepts and responds to their diverse realities which will encourage their growth, development, and prosperity.

The methodology chapter outlining and explaining the research methods and analysis process is now considered.

Methodology

In this chapter I outline the methodology employed to carry out my research. The research methods are outlined, and explanation is provided on how the research data and information was analysed.

The methodology assisted the researcher to consider whether an indigenous centered model of health could improve the health status of Māori. The researcher remained aware that “researcher’s” beliefs, values, and intellectual style contribute to the theoretical and methodological choices that they may make” (Bishop, 1994, p. 396; Patton, 1990; Stanfield, 1994). Further, the political, social, historical, spiritual and cultural environments in which the research is assumed also impacts the research method (Bishop & Glynn, 1999; Doolin, 1997; Patton, 1990; Stanfield, 1994; Tuhiwai-Smith, 1999).

Methodological choices were strongly influenced by my commitment to see Māori grow, develop and prosper as Māori. As a wahine Māori working within a Māori organisation, I acknowledge the importance of Māori interventions such as karakia, mihimihi, whakawhanaungatanga, te reo Māori (Māori language), and waiata (Māori song). I am aware of barriers that exist for Māori in achieving health equity. These barriers exist because many Māori feel that health service procedures, processes and policies are not responding to their needs (Harcourt, 2000). Barriers must be eliminated to improve Māori health status. This study also examines barriers to improving Māori health.

This study intended to make a contribution to the debate on the effectiveness of the health and disability system for Māori. To collate enough information to contribute to the discourse, this study employed research methods including: a literature review, an analysis of health policy and legislation, a case study, and interviews (one on one and group).

The qualitative methodological approach engaged provided insight into how health policy has impacted Māori. Significant national initiatives were considered that intended to increase Māori capacity, capability, social capital and cultural capital. Early stages of the research were restricted to secondary source material in the construction of the interpretative framework.

An indigenous analysis of Māori health status was undertaken which came from a Māori world view. While not excluding western influences, my aim was not to find some kind of indigenous limpidness, but rather the thesis considered the effectiveness of the current health and disability system to respond to Māori. The thesis invited consideration of an assertion that a new Māori centered paradigm, if implemented, will contribute to improving Māori health status.

Methods

Literature Review

Aotearoa New Zealand Government's implementation of the United Nations Declaration for indigenous people, which they supported, was reviewed. The role of Māori within the health and disability system was discussed. The colonisation of Māori within Aotearoa New Zealand through legislation and policy and eventual health disparities was outlined. A discussion on current Māori health status, the rationale and approach for improving Māori health status was discussed. Barriers for Māori within the current health and disability system, policy, legislation, and compliance and monitoring reporting were considered. Māori models of health were outlined and Māori interventions producing positive outcomes were suggested. Māori driven initiatives which have produced positive outcomes for Māori were examined. The intention of the literature review was to assist the reader to understand that current policy, legislation, and governance has not improved Māori health and therefore asked whether it was time to consider a change and if so then what would such a change look like.

Literature Review - Health Policy & Legislation Analysis

The health policy development framework which includes consultation, implementation, and delivery of policy, as well as the effectiveness of health policy was covered. Such an approach intended to seek insight into participants' actions in planning health services for Māori, and how they determined that the policy would improve health deficiencies for Māori, and whether there were other approaches. As a result of Māori prolonged poor health status, the effectiveness of current health policy required deliberation. The culmination of information from reflection on the legislation and health policy should inevitably have implications for future policy development and witnessing tangible improvements in Māori health status.

Case Study

A case study, with interviews, was undertaken with a Māori mental health provider that works with a Māori health model focusing on clinical and cultural practice. Such an organisation has dual governance related responsibilities:

- i) Crown via Ministry of Health contracted funding; and
- ii) iwi via a mandate.

Interviews

The study's intent was to, through interviewing no more than 10 personnel:

- i) Examine the perceptions and experiences of those involved in the organisation's development, implementation of health policy and/or policy advice;
- ii) Examine the perceptions and experiences of those involved in the development, implementation and delivery of Māori health services; and
- iii) Examine the perceptions and experiences of the managers, and practitioners involved in delivering health services to whānau/families.

Recommendations are offered to improve the organisation's model of practice.

Interviewees' comments were analysed collectively, taking into consideration areas of similarity, areas of difference, and areas from a specialist perspective. No individual or organisation was identified.

The selection of participants was based on their organisation's involvement in developing, implementing and/or delivering services to Māori. I was also interested in what employees of these organisations believed was required to improve health services' responsiveness to Māori health, including whether they believed a Māori model of health could improve Māori health.

Interviewees were asked about their views on the current Māori health status, health and disability system and Māori participation within this system, and the process for the development, implementation, and delivery of current health policy. I was also interested to discuss observable and/or reported benefits to Māori when a Māori health model was guiding interventions with whānau/families. Views were also sought on Māori representation at the health sector's governance levels and whether they believed such representation met te Tiriti o Waitangi obligations.

As a wahine Māori working in a Māori organisation, I was familiar with the required protocols around interacting with other Māori (i.e. karakia, mihi, waiata, whanaungatanga). A tane was available to provide appropriate cultural guidance and support, as required, when interviewing personnel. I negotiated, but was guided by the organisations' and interviewees' intended cultural welcome, and expectation for my interviews with them, which influenced whether a Kaumatua accompanied me to support the interview process.

Summary

In sum, this chapter explained the research methods employed and framed the research question, its process and its purpose. The research methods: literature review; literature review of policy and legislation; case study; and interviews were outlined, and explanation was also provided on how the research data and information had been analysed.

The first methodological approach was the literature review which looked to understand how the Aotearoa New Zealand government committed to supporting Māori health improvement. A literature review of health policy and legislation was also considered.

Literature Review

Introduction

This literature review considers what is required to improve Māori health because Māori remain disproportionately over-represented in all ill health statistics. Firstly, I will discuss the United Nations' Declaration for Indigenous peoples and Aotearoa New Zealand Government commitment to the declaration. An example of successful Māori driven initiatives is outlined, which suggests there is evidence of improved Māori capacity and capability, and social and cultural capital. Consideration of such an example is important in understanding the features that would improve Māori health. The United Nations Declaration for Indigenous People is now considered.

United Nations Declaration for Indigenous People

The United Nations' Declaration for indigenous peoples acknowledges historic injustices occurred as a result of colonisation and dispossession of land and resources (United Nations, 2007) (see Appendix One). The Declaration promotes indigenous people developing as an indigenous nation; hence it endorses indigenous rights, and emphasises the value in signed treaties/agreements, and no doubt accompanied by an expectation that governments will honour these. However, New Zealand, United States of America, Australia, and Canada initially voted against the Declaration and said they could not support it. Opposition to the Declaration was based on their concerns over provisions related to self-determination, land and resource rights, language giving indigenous peoples a right of veto over national legislation and State management of resources. In April, 2010, almost three years after the declaration was adopted by the United Nations, Sir Pita Sharples announced that Aotearoa New Zealand had finally endorsed and supported the Declaration of rights for indigenous people (Sharples, 2010). In contrast, Prime Minister Hon. John Key's (Key) statement (Key, 2010) reflects a reluctance to commit to its implementation:

This Government has reviewed New Zealand's position on the declaration. The statement of support acknowledges these areas are difficult and challenging but notes the aspirational spirit of the declaration and affirms to continually progress these, alongside Māori, within the current legal and constitutional frameworks of New Zealand.

(p. 1)

The tenor of Key's statement suggests an unwillingness to modify the legal and constitutional framework to accommodate the Declaration's intent. It seems the current legal and constitutional framework of Aotearoa New Zealand cannot accommodate the Declaration, in its entirety; this is despite the government knowing this when they agreed to endorse it. It is concerning on the basis of ethics and principles of honesty and fairness, if the government signed the Declaration as merely a symbolic gesture. Despite my own concern, the government's action suggests they lacked enthusiasm to support not only the Declaration but to also fulfil te Tiriti o Waitangi obligations, including its principles (e.g. tino rangatiratanga/self-governance).

The tenor of Article 23 (UN, 2007) in relation to the current health structure is in contrast with the Declaration - current Māori input into health is primarily 'advisory' (i.e. Te Puni Kokiri Ministry of Māori Development, and Te Kete Hauora – Māori health directorate) (Ministry of Health, 2011). Additionally, Māori institutions are currently managing, via government contracts, health, housing, education and other economic and social programmes; however the government determines what services are purchased and associated compliance frameworks. This in turn influences delivery of services (i.e. in health how many clinical and non-clinical positions will be funded for a service provider) which can compromise effectiveness of that service and therefore compromise how promptly, if at all, Māori are supported. Such an approach by the Crown, without consultation with Māori, appears to undermine the spirit of the signed Declaration, and Te Tiriti o Waitangi.

The Declaration (UN, 2007, Article 21) supported by the Crown, states “Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security” (p. 6).

Article 21 in the Declaration endorses tino rangatiratanga (self-governance) for indigenous peoples, and within Aotearoa New Zealand it supports Māori being able to determine their own ways to improve their health; utilising their methodology and cultural practices. Additionally, Article 23 (UN, 2007) states:

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions. (p. 6)

Article 23 asserts the right of indigenous peoples to self-direct and self-manage their approach to determining health and health influencers – housing, economic development and social initiatives.

It is not unreasonable to believe that the UN, and constituents whose government was a signatory to the Declaration, expect governments will honour their obligations. However as per Table One (New Zealand Health and Disability System) Māori are not in a position, within the current health and disability system, to exercise their right to development or to develop and implement their health priorities and strategies. Given the disparity between what is expected and what actually exists, it is pertinent to question what actions, if any, the Crown intends to take to meaningfully meet any obligations that exist under the Declaration.

Colonisation, Indigenous Health and Self-Governance

Dodd (2000) and Dodson (2002) suggest colonisation has been a history of destabilising indigenous nations' traditional governance structures. Colonisation, acculturation and destruction of traditional sustaining practices (i.e. kinship bonds) were the reported results, for aboriginal peoples, from enforced legislation and policy. New South Wales Government (2013) provides examples:

- Aborigines Protection Act – Exemption Certificates, (1909) - allowed aboriginal people to live independently as long as they severed all ties with their Aboriginal culture and kinship.
- The Invalid and old age pension Act (1908) - provided payment for invalids and old age pensioners but excluded all aboriginal or 'native' people.
- The Commonwealth Defence Act (1909) - excluded all non-European from the armed forces.

Examples of similar colonial legislation and policy in Aotearoa (New Zealand Government, 2013) include:

- The Suppression of the Tohunga (traditional Māori healer) Act (1907) – illegalised traditional Māori spiritual and educational practices.
- The advance to settlers Act (1894) – provided low interest rates to settlers for land and purchase development. Māori were excluded until 1930.
- Old Age Pensions Act (1898) – made it difficult for Māori to qualify for the old age pension until the 1930s.

The colonising legislation and policy has cultivated and prolonged disparities between aboriginal and non-aboriginal people. Consequently, many indigenous people are now likely to find meaning in their life, as an indigenous person, through colonising ideology (Woolsey, 2008). The next section of this chapter – Literature review of policy and legislation – examines specific health policy and legislation, intentions and outcomes.

Māori self-governing structures are “socially constructed hybrids of a colonial past!” which according to Dodd (2000, p. 4), need to be grounded in principles, values, and traditions (customs and practices) that Māori know to legitimately represent them. While aspirations of Māori delivering services underpinned by traditional concepts and practices is inspirational, the reality seems to be that day to day management of indigenous and non-indigenous business remains primarily western-based.

Dodd (2000) also suggests that for the past 150 years, British Governments have devalued Māori as the indigenous people of Aotearoa New Zealand, as well as Māori language, culture, principles, and aspirations for tino rangatiratanga. Furthermore, Smith (1999) refuses the term “post-colonialism” as this suggests it no longer exists – however the current disparities and governance structures do not support the end of colonisation. A British intent to overrule various cultures has also undermined Māori wellbeing, and disconnected Māori from their culture and circumvented any attempt by Māori to regain sovereignty, and to strengthen their wellbeing and determine their own future (Dodd, 2000). Moreover, Dodd (2000) suggests those governing Aotearoa New Zealand are not Māori and therefore they cannot govern Māori, nor can they determine who should govern Māori.

A history of disparities between Māori and non-Māori suggest current Crown governance structures (e.g. Aotearoa New Zealand Health and Disability Structure (See Table one) do not accommodate traditional Māori infrastructure or customary law and practices such as tikanga. Tikanga Māori can be described as law which serves the needs of the tangata whenua (people of the land) and is based on a set of underlying traditional principles including: whakapapa (genealogy), whanaungatanga (relationships), mana (authority, power, control), manaakitanga (hospitality), aroha (love), wairua (spirit) and utu (concept of reciprocation) (Mikaere, 2006).

Colonisation by legislation and policy

Dodd (2000) claims Governments have used legislation and policy to retain authority over Māori, and exclude Māori from the decision making process. As referred to earlier, an example of this includes Te Puni Kokiri and Te Kete Hauora that assume advisory roles only rather than having direct decision making responsibilities (See Appendix Two for the Ministry of Health's organisational structure, and the positioning of Te Kete Hauora – Māori Business Directorate). The "consultation" mechanisms (e.g. Te Puni Kokiri and Te Kete Hauora) appear to fit into a Government process of adopting advice if and when considered legitimate, rather than working in partnership or seeking leadership from Te Puni Kokiri and Te Kete Hauora. I will discuss more about legislation and policy within the next section of this chapter - Literature review of policy and legislation.

Against the background of Māori being employed in the State sector, many Māori elites, according to Smith (1997) are appointed to senior positions and they:

need to remember how they got to the position they are in, how they perform their role and who they are working to benefit. They also need to remember those values and principles that are of significance and forget assimilation of a western 'corporate' approach. (p. 97)

Despite Māori being employed in the State sector, Durie (1998) asserts that the governments' reluctance to engage and develop a solution-focused Māori-Crown relationship suggests shared decision-making remains absent from the Government's agenda:

There is no Māori body politic. In its absence, policy making for and on behalf of Māori is assumed by the Crown, with irregular Māori input and, inevitably, increasing Māori discontent. Even policy decisions about Māori resources rest with the State, not Māori. While the key participants are Māori, the accountabilities, reporting lines, and appointment processes lie with the state. (p. 237)

Reflecting the tenor of Durie's (1998) quote, authors (Dodson, 2002; Dodd, 2000; and Winiata, 2001) assert that current governing authorities can not resolve 'gaps', 'disparities' or 'problems' with a shift of paradigm. Comprehensive indigenous-driven strategies are required because statistics indicate a lost generation of Māori youth (Beecroft, 2005). One-off short-term initiatives by Māori, often touted as revolutionary, have proven ineffective. The Closing the Gap Policy (1999) is a case in point. However, the lesson learnt was that they "measured what they could instead of what they should, gaps didn't close, and changes in outcome indicators occur over a longer timeframe period than politics!" (Comer, 2008, p. 8).

Fleras and Spoonley (1999, p. 147) state that "Māori don't want to be passengers on the bus. We want to be driving the bus with our hands on the steering wheel". Authors (Dodd, 2000; Dodson, 2002; Winiata, 2001) also support indigenous models of self-determination, including Māori representatives working collaboratively with the Crown, to realise a better future for Māori and for the nation. Such collaboration could improve indigenous academic achievement, increase indigenous employment opportunities; and improve indigenous health and wellbeing status; thus enhancing the nation. It seems that indigenous authority is the empowering tool that is rightfully owed to indigenous peoples.

Rata (2005), a critic of Māori development whose views are in opposition to Māori health experts like Mason Durie, argues restoration of kinship as the structuring principle of socio-political organisation of "retribalisation", as justifying the inequalities of "ascribed birth hierarchy" rather than pointing to democratic equality and citizenship. She asserts that government policy, institutional positions and their practices deal with people as members of the "re-created tribal group" rather than as citizens. Such approach, according to Rata (2005), leads to demands for group rights based upon "original-kind group", rather than the contractual association of individuals, which is an essential feature of democracy. It seems Rata (2005) is suggesting that both the Tiriti o Waitangi and the Declaration of Rights for Indigenous People (UN, 2007) are not valid and should not be upheld. If Rata is making such a suggestion, then she appears to be claiming that Māori are not entitled to any type of 'rights' as the indigenous

people of Aotearoa New Zealand. With this in mind it would seem that Rata would also support continuation of the failed approach of 'one size fits all' when planning for the likes of health, education, housing and employment.

Rata (2005) also asserts that policy based on racial lines rather than egalitarian is "autocratic", and that racial divisions, embedded into culture by government funding policies are precarious. Rata (2005) also claims the bi-cultural, Māori-Pakeha movement in New Zealand has been a mistake and that it is "subverting democracy", "erecting ethnic boundaries between Māori and non-Māori" and promoting a "cultural elite" within Māoridom. My question to Rata, and writers that support further subservience would be "have we not had a cultural elite in Aotearoa New Zealand for the last 150 years and if so, why does she believe Māori should continue to accept they are second class citizens and therefore accept being treated as such?"

Openshaw and Rata (2006) ask whether given the current range and diversity of views about the meaning of the Te Tiriti o Waitangi, should one view only be promoted as the correct one? Openshaw and Rata (2006) state:

the extent of uncritical self-representation and academic orthodoxy found many of the new professional degrees, which include a Tiriti component means that the "acceptable" view rapidly becomes unchallengeable doctrine because it is essentially the Crown's view.
(p. 10)

The writer would expect, based on Openshaw and Rata's (2006, p. 10) premise, a health paradigm that reflects a Crown supported correct version of te Tiriti o Waitangi, and health polices reflecting a Māori health paradigm.

Reducing disparities

In 2000 the then Prime Minister Hon. Helen Clarke (as cited in Humpage & Fleras, 2001) delivered a speech on the budget acknowledging the Labour-led Government's strong emphasis on reducing disparities between Māori and other New Zealanders by stating:

First, it is a simple issue of social justice. Second, for Māori it is a Treaty issue. Third, for all New Zealanders it is important that the growing proportion of our population which is Māori and Pacific Island peoples not be locked into the economic and social disadvantage, because, if they are, our whole community is going to be very much poorer for it. (p. 38).

Health disparities in Aotearoa New Zealand remain (Howden-Chapman & Tobias 2000; Ministry of Health 1999a; Pomare 1995; Statistics New Zealand 2006; Te Puni Kokiri 2000). Unfortunately it would seem that the then Prime Minister Hon. Helen Clarke and her Labour led-government's commitment, in 2000, to 'unlocking' Māori and Pacific peoples' economic and social disadvantage was never achieved and consequently Māori and Pacific peoples' disparities continue.

Based on the last 150 years of colonising legislation and policy, and no evidence of health equity for Māori, it is timely to consider other options for the development, implementation and review of Māori health policy. Māori must assume a more prominent role in governing Māori health, which will also reflect a Tiriti o Waitangi partnership. A Māori driven policy is likely to have views more representative from Māori communities. Māori could also assume a level of accountability alongside the Ministry of Health and remain accountable for policy development, its implementation, and subsequent evaluation and auditing of policy effectiveness.

If the above suggestions are to be implemented, significant changes would be required to health policy development and implementation processes. The health workforce would also require training on understanding a Māori world view and how to work with Māori communities.

Why address Māori health?

Māori health status is impacted by environmental and socio-economic elements. Māori health equity is being undermined by lack of education qualifications, low-income, benefit dependence, labour-intense employment, poor standard of living, and little access to healthcare. Government sectors (e.g. housing, health, education employment) operate in silos and therefore lack inter-sector service coordination in response to Māori communities, which contributes to statistics revealing disenfranchised indigenous people (Statistics New Zealand, 2013). The lack of inter-sector co-ordination also means Māori, as well as non-Māori, have to restate their individual circumstance to numerous government agencies whereas collaboration between such agencies could prevent this.

Allowing Māori health to remain in a poor state will lead to major problems in the economy. By 2026, the Ministry of Health (2010) suggest the Māori population will grow by 21 per cent, while the non-Māori population is predicted to grow only by 11 per cent. Māori will be the predominant workforce by 2026, and therefore Māori will require training and up-skilling to meet the expected demand. Māori will require increased capability to increase and strengthen their cultural capital and social capital to enhance Māori growth, development and prosperity. Failing to support Māori capacity will impact on the economy to the extent it may not generate enough revenue to fund public services (e.g. health, education, housing, corrections, social welfare). In the meantime, the State is welcoming increasing numbers of skilled off-shore personnel into the country, which is detrimental to not only Māori but non-Māori, because this results in loss of jobs, less income and increased poverty, ill-health and crime. Consequently, more Māori people are benefit-dependent and reside in lower socio-economic communities.

High Māori representation in ill-health statistics suggest modifications are required in the health and disability system's paradigm and governance structures including its legislation, policy, purchasing of services and compliance reporting frameworks. The current mainstream health framework encapsulates silo structures (e.g. Ministry of Health), silo based purchasing practices, silo-focused compliance reporting (e.g. services delivered within a specified contract time – 15

minute contact) and are directed at the individual rather than whānau/families, hapū and/or iwi. Māori health models offer a holistic and therefore a more comprehensive, collaborative service response in meeting health needs (Hauora Waikato, 2011).

Socio-economic elements

Socio-economic elements contribute to a cycle of deprivation and create barriers and therefore undermine an improved Māori health status (Strickett & Barnes, 2012). Whether these elements are inherited by our parents, and their parents, and their parent's parents or whether we as individuals start the cycle fresh, the outcome to the cycle of deprivation will remain the same (i.e. the impact of problem gambling on Māori women and their children) (Hauora Waikato Group, 2005).

Within the education sector, high truancy, engagement and retention rates of Māori students remains a concern. For instance, in 2009 the percentage of Māori year 9 and 10 students who were frequent truants was more than double that of non-Māori students. Furthermore the number of Māori students who leave school with NCEA level 2 or higher is only one seventh of our non-Māori counterparts. And those entering into university with a NCEA Level 4 (within 2 years of leaving school) is just over half of that of non-Māori students (Ministry of Education, 2013). The lack of education qualifications can lead Māori to a pathway of low socio-economic conditions (i.e. poor housing with sub-standard living conditions, cold homes, no insulation and no heating). Such elements undermine optimal health. Low-income can be a result of poor education for Māori, who are unable to purchase the necessities of life or enjoy a healthy lifestyle. Low incomes also mean delays to seeking medical attention, which leads to Māori children becoming sick and staying sick for longer; thus education around health lifestyles is often misunderstood. Furthermore, Māori are over-represented in the criminal justice system (Department of Corrections, 2007). Such disparities would suggest once again government policy has failed to achieve its objective (i.e. 'Closing the Gaps' (as cited in Comer, 2008)), which was intended to close an increasing gap between Māori and non-Māori (e.g. economic, social, educational and health indicators).

Māori approach to health

It is important that a Māori approach to health is understood by all within the health and disability system. Those at all levels including the governance, management, operational personnel and staff involved in policy development, and implementation and review. Acceptance is required by government decision-makers that there is more to treating an individual than just how they present with their mental state. People's lives have many facets and that's what makes them unique – their spirituality, culture, family, and the environment including their community and home they reside in (Durie, 2005). All are important in understanding them and supporting them to be empowered so they can manage their own life.

Māori models of health

Rangimarie Rose Pere offers 'Te Wheke' or 'The Octopus' model of health as another interpretation of holistic Māori health (Pere, 1991). Te Wheke represents whānau, hapū or iwi, with each of the eight tentacles considered a dimension of selfhood: wairua; mana ake, mauri, whanaungatanga, tinana, hinengaro, whatumanawa, ha a koro ma a kuia ma. Each tentacle overlaps and interlinks to represent interconnectedness. The model suggests an individual's health is connected with and inseparable from the health of whānau, hapū and iwi.

Both 'Whare Tapa Wha' and 'Te Wheke' are models that encapsulate the indigenous definition of health, valuing the social, emotional and cultural wellbeing of a complete society (i.e., whānau, hapū and iwi).

The Ministry of Health acknowledges both models on their website (Ministry of Health, 2012) but cultural aspects and interventions (i.e. karakia, whakawhanaungatanga etc.) are not included in their data collection system. Such approaches could be interpreted as the Crown not perceiving 'cultural' dimensions as legitimate in assessing and intervening to address whānau/family needs. Furthermore, the Ministry of Health (2013) appears to focus on collecting statistics on the number of face to face contacts made, travel time, administration time, and even frequency of 'did not attend' to be able to report on:

- 1) what services were provided;
- 2) who is providing the services; and,
- 3) what outcomes were achieved?

Collating such data does not inform the provider or the funder if the service provided was of a high quality, or whether the intervention contributed to the patient making positive lifestyle improvements. Likewise, the Ministry of Health neglected to acknowledge traditional Māori practices such as whakawhanaungatanga, mihimihi, karakia, te reo Māori, waiata, and whānau hui. Kaumatua and Whaea involvement in supporting interventions are also not acknowledged even though anecdotal evidence from some of those interviewed in this study suggest traditional Māori practices contribute to positive health and wellbeing outcomes. Durie (2001) acknowledges the relevance of these traditional Māori interventions and others including rongoa, tikanga Māori, and whānau or extended family in strengthening the delivery of responsive mental health services. It may be that traditional Māori practices (e.g. karakia, tikanga, whakapapa) could be delivered in conjunction with mainstream treatments so that a comprehensive best practice approach is utilised to deliver responsive services to Māori. Durie (2001) acknowledges whakapapa as providing a valuable structure for how Māori organise, manage, position and contest relationships. Whakapapa also provides a means to store, learn and transmit and inscribe Māori knowledge. In relation to Māori knowledge, Smith (1997) states:

Kaupapa Māori strategies question the right of Pakeha to dominate and exclude Māori preferred interests in education, and asserts the validity of Māori knowledge, language, custom and practice, and its right to continue to flourish in the land of its origin, as the tangata whenua (indigenous) culture. (p. 273)

The value of Kaupapa Māori embedded models such as Te Wheke and Whare Tapa Wha are that they evolve through listening to whānau/families, hapū and Iwi and are therefore guided by respondents' needs rather than being framed around funding and compliance reporting. These models commit to promoting holistic approaches that understand and value the importance of tikanga within their

interventions and practices. They recognise the importance of cultural beliefs and values, and inter-connected relationships (e.g. whānau/whanaungatanga) as well as their physical, emotional and spiritual wellbeing. Such interventions are likely to enhance health treatment and rehabilitation for Māori communities; thus enhancing the nation's wellbeing.

Who best to deliver health services to Māori?

Māori non-government organisations attempt to deliver health services based on similar models (i.e. Te Whare Tapa Wha – Durie 2001; Te Wheke, Pere, 1991). These providers are constrained however by the funder's (i.e. District Health Board, and the Ministry of Health) stipulations rather than the assessed needs of whānau, hapū and iwi. Despite such requirements, Māori live in a complex and ever-changing social and economic environment. Māori health needs do not conveniently slot into the functions of one policy or one set of service specifications, because they overlap and interact with each other, which is reflected in Māori models of health (e.g. Whare Tapa Wha, and Te Wheke) (Hauora Waikato, 2011). If health services are to be delivered to Māori then they need to respond to their health needs otherwise the status quo of health disparities will continue.

In brief, no one agency is likely to be able to address all needs of whānau, hapū or iwi (Durie, 2005; Hauora Waikato, 2011; Matheson 2004; Ministry of Health 2001, 2002, 2010, 2011; National Health Committee, 2002; Te Kete Hauora 2010; Te Puni Kokiri 2010; and United Nations, 2007). The Ministry of Health continues to release its reports suggesting improvements are occurring in Māori health, but Māori health still remains behind the health of non-Māori. Its policies have not achieved equity for Māori, are not fostering Māori development, and appear to be contributing to prolonged State dependency (Statistics New Zealand, 2013). In view of such phenomenon it seems timely to not only consider an alternative to mainstream driven policy, but to examine Māori driven health policy to secure health equity. It is timely to consider also an integrated coordinated approach to policy development and implementation that reflects Māori health models, which will meet Māori health needs. Implementation of Māori driven policies that reflect the complexity of Māori communities appears

necessary to support a more effective, efficient and responsive service for Māori (Hauora Waikato, 2011).

Māori models of health are touted as important in the introduction sections of Ministry of Health contracts, but they remain absent in the government's health governance structures, operational administration and compliance requirements (Ministry of Health, 2011). Immediate equity in Māori health is unlikely because of current mainstream health policy and infrastructure (i.e. Ministry of Health), silo-based service delivery, and Māori assuming an advisory role only. It is therefore likely, consistent with Matheson's (2004) observations, that my female children and moko will die nearly ten years earlier than their non-Māori counterparts.

In sum, I have briefly discussed the United Nations Declaration of rights for indigenous people and its application within Aotearoa as a country who eventually supported the Declaration. I have established that the current Health and Disability system, its governance, administration, legislation and policy, and compliance and monitoring expectations are not reflective of the Declaration and nor are they improving Māori health status. Māori remain over-represented in ill-health statistics and are dying earlier than non-Māori. For positive health improvements for Māori, it is judicious that the Government support a Māori driven model that will eliminate barriers to improving Māori health. Barriers for Māori in health, which cause disparities, are caused by political barriers. Political decisions in sectors such as education, housing and social development present socio-economic barriers have a similar impact on Māori. Furthermore, it is prudent for the Government to consider eliminating barriers so that positive health gains are achieved for Māori.

Harcourt (2000) suggests that a 'barrier-based' approach to marketing can provide a unique way to achieve success. The idea of marketing is not to make service users 'buy' products and services, but rather to eliminate the things that keep them from 'buying'. The barrier-based approach applied in a service-purchasing framework supports the provider to offer solutions to service users so they have ease of access, and assures the purchaser of success – improving health gains.

With this in mind, a Māori mental health provider applied Harcourt's (2000) approach to eliminating barriers to their services for Māori and non-Māori, which has resulted in increasing access to services, improving not only individual and whānau wellbeing but has also empowered whānau to manage their lives. Other successful Māori driven initiatives are now considered.

Māori-led initiatives for Te Reo Māori (Māori language)

Kohanga Reo (Total immersion in Māori language family programme from birth to six years)

The decline of the Māori language after the 1980s was the result of it being replaced with English in schools, and also as a consequence of the urban movement whereby rural Māori relocated to urban settings in search of employment. Consequently, the urban movement created a disconnection between young Māori and their elders, whakapapa (genealogy) was lost, connection to their whenua (land) was lost, and their ability to learn their ancestral language, cultural protocols, values and beliefs was also lost (Ministry for Culture and Heritage, 2013).

The loss of te Reo Māori was coupled with the demise of the culture; hence Māori elders agreed that a revival was necessary (Te Kohanga Reo National Trust, 2013). In 1982, as part of the Kohanga Reo movement, ("language nest") the first kohanga was opened which immersed infants in Te Ao Māori (the Māori world) through to primary school entrance. The immersion embedded, from a very young age, ancestral principles, tikanga (customs and traditions) and beliefs and the hope of planting the seed of Māori knowledge for not only those children but for them to teach their children and the generations that followed. The Māori Language Act (1987) came into force declaring the Māori language as an 'official' language and allowing the use of the language in official settings.

Te Reo Māori has been revitalised through the "Kohanga Reo Movement which lead to a string of schooling and education interventions including the growth of kura kaupapa (Māori language immersion schools), undertaken by Māori people themselves" (Smith, 2003, p. 7). Kohanga Reo is now flourishing with an estimated 60,000 'graduates' (Te Kohanga Reo National Trust, 2013).

The revitalisation of Te Reo Māori is a positive Māori led initiative because te reo is being learnt and spoken by Māori and non-Māori (Shaskey, 2013). The value of the Māori language and its role in sustaining Māori culture is important. In addition it is increasing Māori capacity, capability, social and cultural capital, which is apparent in Rose Pere's (1999) quote below:

There is one truly great treasure among us Māori, no matter which tribe, sub-tribe, or family, and that is our chiefly language. The language which came from Rangiatea, the highest heaven of the far-flung heavens, down to earth, was planted here and thereafter since it was first uncovered in the soil, it was grown, it was cherished, it was nurtured, it was cared for, it grew. Then from its growth, it gradually spread its sweet scent to every corner of the universe of the ancients. This chiefly language has its own spirit of inherent wisdom, it is communication of the abstract, in order that outsiders might not understand its hidden depths. The problem at this time is there are many Māori who do not know its depths, or the breadth of the language. (p. 3 - 10)

Pere (1991) also states:

Language is the life line and sustenance of a culture. It provides the tentacles that can enable a child to link up with everything in his or her world. It is one of the most important forms of empowerment that a child can have. Language is not only a form of communication but it helps transmit the values and beliefs of a people. (p. 9)

Te Ataarangi (name given for a language learning model)

Another Māori-led initiative to sustain te reo Māori was that introduced by Kateraina Mataira (Te Ataarangi, 2013). This was a borrowed model which utilised specialised teaching materials such as cuisenaire rods, sound colour charts, word charts and fidel charts as a language technique and placed emphasis on the autonomy of the learner (Gattengo, 1963). Kateraina Mataira was intrigued by this model and adapted the method to teach te reo Māori renaming the model 'Te Ataarangi'. Te Ataarangi provides opportunity for the student to be actively involved and the teacher silent. Again this method immerses learners in to an

environment where Māori language, tikanga and values are primary. Kateraina Mataira's Te Ataarangi method is another initiative, like Kohanga Reo that has witnessed a growth in the number of Māori speaking or learning to speak their language. Te Ataarangi has supported more than 50,000 people to speak Māori (Te Ataarangi, 2013). Both the Kohanga Reo movement and Te Ataarangi support an increase in Māori capacity and capability as well as the social and cultural capital supporting Māori to grow, develop and prosper as Māori.

Both initiatives have produced positive outcomes for Māori. In 1994 responsibility for Kohanga Reo was moved from the Department of Māori affairs to the Ministry of Education. This movement brought with it 'barriers' similar to that of the health sector, whereby providers were faced with government determined service delivery and compliance reporting frameworks (Te Kohanga Reo National Trust, 2013). Although we have achieved 'by Māori for Māori' services, like health, we are now striving for tino rangitiratanga (self-governance) - Māori models evolving and driven from the community rather than ideology from the Government of the day.

Despite the success of initiatives like Kohanga Reo and Te Ataarangi models contribution to Kura Kaupapa growth within Aotearoa, barriers still exist to improve Māori health including: education, access, funding, policy, cultural appropriateness of a service, broad structural barriers, 'universalism' structural barriers and age restriction (Baxter, 2002). Ellison-Loschmann and Pearce (2005) also state:

non-genetic explanations for differences in health between Māoris and non-Māoris can be grouped into 4 major areas focusing on socioeconomic factors, lifestyle factors, access to health care, and discrimination. These explanations are not mutually exclusive, but it is useful to consider them separately while bearing in mind that they are inextricably linked. (p. 613)

What could work better for Māori?

Māori respond better to services delivered by Māori (Durie, 1997). One way to circumvent barriers to health gains is to build indigenous capacity, capability, social and cultural capital. Indigenous people need to have the skills, expertise and be informed, and sit with non-indigenous people when the decisions are made, with equal decision-making power, on where government money will be spent. Honouring the declaration, te Tiriti O Waitangi agreements, and a Māori developed evidenced-based health policy is but a beginning to reduce inequalities.

Devolving government funding to indigenous self-governed authorities, founded on indigenous principles and values, with reduced bureaucracy, is likely to increase productivity and achieve Māori health gains. Providers in consultation with the community would set the objectives, based on indigenous aspirations, and report their achievements to communities. For instance, promoting healthy indigenous lifestyles seems more effective than the out-dated promotions of telling people to “stop smoking”. Unfortunately, it seems there is a wall of silence surrounding indigenous and non-indigenous leaders, with an absence of positive, practical and real-time solutions to reduce the impact of historical legislation and policy that is undermining Māori as a nation.

Compliance reporting

Despite the fact that Māori organisations deliver services to Māori, their day to day practice is still impacted by the Crown’s compliance and reporting requirements (i.e. PRIMHD Reporting) (Ministry of Health, 2009). However, if the Crown were sincere in purchasing services that achieve positive health outcomes one would assume that they would be interested in what interventions were working for Māori. It is important that bureaucrats re-orientate their focus from the number of people through the door, or the number of people who did not attend their appointment, to consider what Māori interventions are achieving positive health gains for Māori and non-Māori whānau/clients (e.g. cultural tikanga, values and beliefs, whanaungatanga, karakia, and/or Te Reo Māori) (Hauora Waikato, 2011).

Māori practices need to be purchased and thus acknowledged and included as legitimate and credible interventions (e.g. karakia, mihi, whanaungatanga (relationships), gender appropriateness, and age appropriateness) (Hauora Waikato, 2011). Kaumatua must be acknowledged as experts, and purchased as such, and non-clinical positions (i.e. support staff without professional registration such as that of a doctor or a registered nurse) would also be purchased as part of acknowledging cultural safety – gender and age appropriate (Hauora Waikato, 2011). Such interventions would be included in the reporting framework.

Finally, the challenge is to determine if a Māori model of delivery could, despite the stringent compliance reporting requirements, contribute positively to improving Māori health status. Māori health models are imbued in tikanga Māori and cultural beliefs, values and acknowledge karakia (prayer), mihi (greetings), whanaungatanga (relationships), gender and age appropriateness, and are therefore focused on responding to the needs of whānau/families. In practice, Māori health models embrace a holistic approach to working with whānau (patients), while also attempting to minimise barriers to access services.

In summary, I have discussed the United Nations' Declaration for Indigenous peoples and the initial hesitation, but eventual agreement by Aotearoa New Zealand Government to commit to supporting the declaration. I have provided two successful Māori driven initiatives which focused on the revival of te reo Māori which produced positive outcomes for te reo Māori speakers in Aotearoa New Zealand, revoked previously enforced legislation, and improved Māori capacity, capability, and social and cultural capital. Contemplation of such examples was important in understanding the features that would improve Māori health.

The following section is part of this literature review and looks deeper into health policy for Māori – its development, intentions and effectiveness.

Analysis of health policy and legislation

A prolonged history of low Māori health status, compared to non-Māori, raises questions about the effectiveness of current legislation and health policy. In this section I will examine the history of health policy, the dispersal of funding and its subsequent impact on Māori. I will examine current national health policy intended to increase Māori health status, how it is developed and implemented, how Māori have participated in its development and implementation, and how effective the policy has been.

History of Health Policy in Aotearoa

From 1852, central and provincial governments provided health care for Māori using erratic dispersal of funding for subsidised medical treatment (Dow, 1999). The civil list payments, an initiative implemented by Governor George Grey, was part of the civil list budget where funding was provided for ‘native purposes’ and earmarked for medical care, pensions, and rations (Dow, 1999). The civil list budget figure of £7,000 for Māori remained unchanged for almost a decade. Governments during 1852-1952 did not review or improve Māori settlement sanitary conditions (Dow, 1999). It is further noted that over this time there was much intentional work done to alienate Māori from land, cultural, whanau – all of which are key determinants of Māori health. Apart from the £7,000 allocated for the civil list budget, no further funding was provided for Māori. “Māori policy was made an imperial responsibility; however the purse strings were controlled by colonial politicians” (Dow, 1999, p. 16). Moreover, Dow (1999) suggests as a result of the New Zealand health system’s ad hoc development during 1840-1940, no one policy or set of standards was implemented nationally.

Dow (1999) described an increase in the pakeha population of New Zealand from 59,000 to 300,000 and a Māori decline from 56,000 to 47,000 as the rationale for the change in ethos and function of the New Zealand hospital system, which was ‘relative equality of treatment’ (Dow, 1999). Unfortunately, Governor George Grey believed unification between Māori and European was simply a case of Māori conforming to European ways (Belgrave, 2012).

Between 1975 and 2001 the health system underwent a series of reforms as a result of growth in hospital expenditure, elected government priority, and redefining of roles and responsibilities (New Zealand Parliament, 2009). The Aotearoa New Zealand government believed its health framework supported a system that benefited all of its constituents. In 1985 the Board of Health Committee on Māori Health recommended that the three articles of te Tiriti o Waitangi should be regarded as the foundation for good health in New Zealand (New Zealand Board of Health, 1987). The Public Health Commission in 1995 also emphasised that any discussion on Māori health must begin with reference to te Tiriti o Waitangi (Dow, 1999).

The Ministry of Health's response to health statistics was to release its Māori Capacity and Capability Plan (Ministry of Health, 2001). The plan sought to build Māori management and workforce capacity, and to strengthen the knowledge and understanding of Māori health. Māori health disparities indicate that more than 150 years of active colonisation and acculturation had undermined Māori health (Howden-Chapman & Tobias 2000; Ministry of Health 1999a; Pomare 1995; Statistics New Zealand 2006; Te Puni Kokiri 2000). Māori education achievements were low which contributed to their disproportionate over representation in unemployment statistics. Māori subsequently required tailored health and education programmes.

In 2002 the National Health Committee (2002, p. 7) released its report "Improving Māori Health", which identified aspects that have assisted, and delayed positive outcomes for Māori policy.

The report identified five "lessons" limiting positive outcomes from Māori health policy: limited implementation of the Treaty of Waitangi within the health sector; no clear framework to underpin Māori health policies; no comprehensive strategy incorporating all necessary Māori health policies; failure to consistently demonstrate responsiveness and leadership by government and its agencies; and in the absence of clear minimum expectations, variability in approaches across regions which in places, have constrained Māori health development.

The National Health Committee's (2002) report also:

... recommended the use of an overarching framework, based on te Tiriti o Waitangi, for Māori strategies and policies. This framework was to apply to policy development, implementation, monitoring and evaluation in all parts and levels of the health sector" (p. 7).

Unfortunately, 11 years after the release of "Improving Māori Health" (National Health Committee, 2002) we have not seen changes in the development of health policy for Māori. Māori continue to be represented by Te Kete Hauora on policy affecting Māori wellbeing. There has been no change to policy being developed 'with' Māori. Harcourt (2000) supports this concern noting that barriers to improving Māori health status include government determining the level of Māori input into developing policies, and the level of acceptance for non-Māori clinicians to not practice from a Māori-world view when dealing with Māori.

It is of concern that te Tiriti o Waitangi principles are included in health policy for Māori but no reference to te Tiriti o Waitangi principles are made in the Ministry of Health's Statement of Intent 2013 to 2016 (Ministry of Health, 2013). The Crown's sincerity toward acknowledging a tangible partnership between Crown and Māori under te Tiriti o Waitangi would be considered legitimate if such reference was recognised in all health reports and frameworks. An overarching framework for Māori health policies and strategies based on te Tiriti o Waitangi has been recommended (National Health Committee, 2002). Such a framework would guide health policy development, and its implementation, as well as monitoring and evaluating all parts of the health sector to achieve health outcomes. No report was located indicating when or if any of the National Health Committee's (2002) recommendations were implemented. To date, Māori remain excluded from a joint governance arrangement over the health and other sectors (e.g. employment, housing, mental health, social services), and are therefore being excluded from tangible governance partnerships across the State sector.

In November, 2002 the Ministry of Health (2002) released He Korowai Oranga Māori Health Strategy. This strategy stated that it “supported tangata whenua-led development resulting in the achievement of tino rangitiratanga and ultimately the promise of a healthy nation” (Ministry of Health (2002, p. iii). This report set out to offer reassurance to Māori whānau, hapū and iwi that they were important, and that te Tiriti o Waitangi was being honored. He Korowai Oranga did acknowledge the Crown’s commitment to te Tiriti o Waitangi principles and the special relationship between Crown and Māori as the foundation for good health in Aotearoa, as recommended by the Board of Health Committee (New Zealand Board of Health, 1987). The report also set out to support Māori-led initiatives as well as a ‘healthy nation’ so it seems logical that effective health policy realign the planning and funding of health and disability services to target tangible positive Māori health outcomes.

Hearing the Māori ‘voice’ through government directorates and agencies such as Te Kete Hauora and Te Puni Kokiri is useful but as discussed earlier they assume advisory roles only. How are Māori able to effectively influence policy if Māori communities do not have the opportunity to contribute at governance level? Furthermore, all contracted health service providers, including Māori services, work within the constraints of government-determined contractual specifications while trying not to compromise their own protocols (e.g. karakia, mihimihi, whanaungatanga, waiata) values and beliefs.

He Korowai Oranga (Ministry of Health, 2002) supports Māori determining their own aspirations and priorities for health and disability. Furthermore the report acknowledges that Māori should be involved in decision-making and service delivery. The strategy intended to provide substance to the principles of te Tiriti o Waitangi by recommending:

- collaboration with other sectors (e.g. Te Puni Kokiri, Iwi and Māori communities and iwi);
- including Māori seats at a governance level; and
- requiring publicly funded hospitals and health care organisations to specify and identify how they intend to meet the needs of Māori.

While the New Zealand Public Health and Disability Act 2000 requires at least two Māori members on each of the Aotearoa New Zealand governments District Health Boards (He Korowai Oranga, 2002), the normal democratic process ensures the Māori voice is heard at the governance level but Crown representatives can ignore such requests.

Following He Korowai Oranga (2002) was the release of Whakatataka: Māori Health Action Plan 2002-2005 (Ministry of Health, 2002). Whakatataka outlines the Government's intent to progress the objectives of He Korowai Oranga within the three year timeframe. The plan acknowledges the responsibility of all involved in the Health and Disability Sector to improve Māori health, while also recognising that the Ministry of Health funds health related programmes. Consequently, "many hospitals have Māori health units that intend to ensure services meet Māori health needs, including service provisions of cultural safety" (Ministry of Health, 2002. p. 20). Within a Māori context it is important that Whānau seeking assistance from hospitals feel 'culturally safe'. 'Gender appropriateness' and 'age appropriateness' or 'kawa whakaruruhau' are regarded as safe cultural practices within Te Ao Māori (Ramsden & Spoonley, 1994). Furthermore, also important for rehabilitation is the ability for whānau to 'culturally identify' that they are Māori and access interventions such as karakia, whanaungatanga, mihimihi, and waiata.

The Māori Capacity and Capability plan (Ministry of Health, 2001) for Māori was recognition by government that Māori health had deteriorated, and that it was the Government's responsibility to work with Māori to restore good health and reduce disparities. Implementation of the following were all acknowledged as necessary to achieve Māori health equity: The Māori Capacity and Capability Plan, (Ministry of Health, 2001); Improving Māori Health (National Health Committee, 2002); He Korowai Oranga (Ministry of Health, 2002); and Whakatataka (Ministry of Health, 2002). Each document acknowledges the special relationship between Māori and the Crown under te Tiriti o Waitangi and the importance of Māori achieving health gains in Aotearoa New Zealand. The Statement of Intent (Ministry of Health, 2013) focuses on improving, promoting and protecting the health of 'New Zealanders'. The Statement of Intent (Ministry of Health 2013) is

the overarching health and disability intentions for government. The Intent document does not mention Māori health as a ‘main health priority’, and while Whānau Ora is acknowledged it is recognised only as ‘other government priority’.

If Māori health is not a priority for the Ministry of Health then it would be better served if it stated this, which would then result, in iwi assuming more responsibility to improve Māori health status. The Ministry of Health assumes responsibility to allocate funding to health and disability initiatives they continue to reserve the right to determine where funding:

- should be spent;
- how it should be spent and what initiatives it will fund;
- will achieve the objectives to accomplish positive outcomes for Māori; and
- will achieve the compliance, monitoring and evaluation framework.

I believe that for far too long Māori policy, and its implementation and review has been driven by political agendas rather than targeting community health needs. Likewise, Harcourt (2002) lists legislative violations of te Tiriti o Waitangi within the first 150 years:

- Native Health Act (1909) Māori could no longer use the ‘whangai’ system for adopting children and Māori could no longer breastfeed;
- The Suppression of the Tohunga Act (1907) – illegalised traditional Māori spiritual and educational practices;
- The advance to settlers Act (1894) – provided low interest rates to settlers for land and purchase development. Māori were excluded until 1930;
- Peace Preservation Bill (1879) – One years hard labour for Māori people who refused to leave their abodes;
- Native Schools Act (1867) – whereby the schools would assist in the process of assimilation; and
- Native Lands Act (1862) – designed to break down Māori communal ownership of land.

The consequences of the te Tiriti o Waitangi breaches continue today resulting in significant disparities between Māori and Pakeha.

Summary

Colonising legislation, health policy and a government driven health and disability system have seen 150 years of low Māori health status. The Board of Health's recommendation that the three articles of the te Tiriti o Waitangi should be regarded as the foundation for good health in New Zealand (New Zealand Board of Health, 1987) and the Public Health Commission's emphasis on this recommendation (Dow, 1999) seem to have been ignored. Māori health policy continues to be imposed via a 'top down' approach, which appears to reflect the Crown's commitment to uphold te Tiriti o Waitangi principles, and its value on a joint Māori and Crown governance partnership arrangement. Instead, Māori representation remains positioned in an advisory Crown directorate and agency. Crown's consultation with Māori seems more of a tick box exercise rather than a sincere attempt to listen to the Māori voice and implement strategies to meet the health needs of Māori communities. Unresponsive health services are contributing to a low Māori health and socio-economic status. Māori health policy will remain ineffective with continued minimal Māori input. Current Ministry of Health contract service specifications and the compliance reporting and subsequent auditing frameworks remain mainstream and seem to restrict attempts to deliver comprehensive holistic services.

A framework focused on improving Māori Health (National Health Committee, 2002); He Korowai Oranga (Ministry of Health, 2002); and Whakatataka (Ministry of Health, 2002) has never been achieved. It is timely to consider a model that recognises one's values, beliefs and tikanga and the importance of whānau, and extended whānau and all aspects of their wellbeing. A model is required where whānau enter one door while the provider works to make sure their holistic needs are met.

The reality is that, in 2014, Māori do not have health equity. Therefore I believe that it is timely to consider alternative approaches to the development, implementation and review of Māori health policy. Māori assuming a greater role in governing Māori health reflects a bona fide te Tiriti o Waitangi partnership. Māori health disparities suggest it is timely for Māori and the Crown to assume joint governance over the health sector including joint responsibility for policy

development, its implementation, auditing of policy effectiveness, and revision of the service purchasing framework.

Te Kete Hauora and Te Puni Kokiri advisory roles require review to increase their ability to influence decisions that will result in tangible health gains for Māori communities. Holding an advisory role means the Māori voice and te Tiriti o Waitangi principles can be ignored, and current statistics remain status quo under an ineffective health and disability structure. The following question must be asked of government representatives – “Is the purpose of Te Kete Hauora and Te Puni Kokiri to ensure the government is well-informed to act on evidence-based Māori health policy or is more about having a process in place whereby Māori can be seen as ‘having input’ while maintaining the status quo?”

In this section I have examined the history of health policy dating back to 1852 and considered the management of Māori and their health to this current day. The political agendas of the present governments, their policies, and the policy intentions have been outlined. Each specific policy created with the intention of improving Māori health status was outlined alongside the Ministry of Health’s Statement of Intent (Ministry of Health, 2013) which is the overarching health document for Aotearoa New Zealand. I have examined how, within the current health and disability system, policy intended for the improvement of Māori health was developed and implemented and how Māori were unable to contribute effectively to these policies. Furthermore it is clear that policies to date have not been effective as disparities between Māori and non-Māori remain to this day.

The following chapter outlines a case study on an organisation that works from a Māori model of service delivery. The model evolved in response to the unmet mental health needs for Māori.

Case Study

This chapter considers a case study of a Māori model of service delivery that was developed and implemented by a Māori organisation that provides mental health services for Māori and non-Māori. Barriers to implementing a Māori health model of delivery are considered. The model's strengths and weaknesses are examined, with recommendations offered to improve the model.

A Māori organisation implementing its own model of care is an example of tino rangatiratanga. As a concept, tino rangatiratanga is desiring self-autonomy and self determination to achieve growth, development and prosperity. Durie's (1997) statement adds weight to my concept by proclaiming "Māori answers to Māori problems" (p. 113).

Māori health disparities will inevitably facilitate the question of whether an indigenous centred paradigm of health – a Māori model of health care – could improve Māori health status. It seems logical therefore that purchasing health and disability services targeting Māori health needs, while embracing Te Ao Māori and Māori diverse realities, is more likely to achieve responsive health services. Likewise, Māori will have improved wellbeing through Māori-led initiatives that embrace indigenous good governance, value Te Ao Māori, and utilise holistic approaches (e.g. Te Whare Tapa Wha) (Durie, 2005). Additionally, Māori led initiatives are likely to increase Māori capacity, capability, social and cultural capital; thus enhancing Māori prosperity (Durie, 2005). Such an approach is likely, in the writer's view, to eliminate access related barriers, and encourage Māori to seek health and disability services that better facilitate their health and wellbeing.

Organisation's Kaupapa principles

The organisation is guided by and operates according to kaupapa principles which reflect a Māori world view. The view emphasises the need for collective responsibility and accountability – and embraces a holistic approach which emphasises partnership and choice. The operating principles were also developed from a hikoi undertaken by organisation founders. The hikoi sought to understand what key stakeholders (Māori communities) considered to be key health

outcomes. From that hikoi, key operating principles emerged. Those principles included (but are not limited to):

- The right to be informed;
- The right to be listened to;
- The right to be treated with respect;
- The right to be believed;
- The right to tell their story once.

The organisation developed and implemented the health model based on its kaupapa principles. It is mandated by an Iwi to provide needs assessment, service co-ordination, and a range of community and inpatient based Kaupapa Māori, bicultural, pan cultural and mainstream treatment services.

Cultural touchstones

The organisation chooses to refer to those that engage their services as ‘whānau’ rather than ‘patient’, ‘client’ or ‘service user.’ The use of the term ‘whānau’ is about providing an experience whereby staff/employees treat ‘whānau’ as they would expect their own whānau to be treated. In support of this practice, the organisation also emphasises the use of ‘the three Rs’: respect for yourself; respect for others; and respect for the whare (house/building they reside).

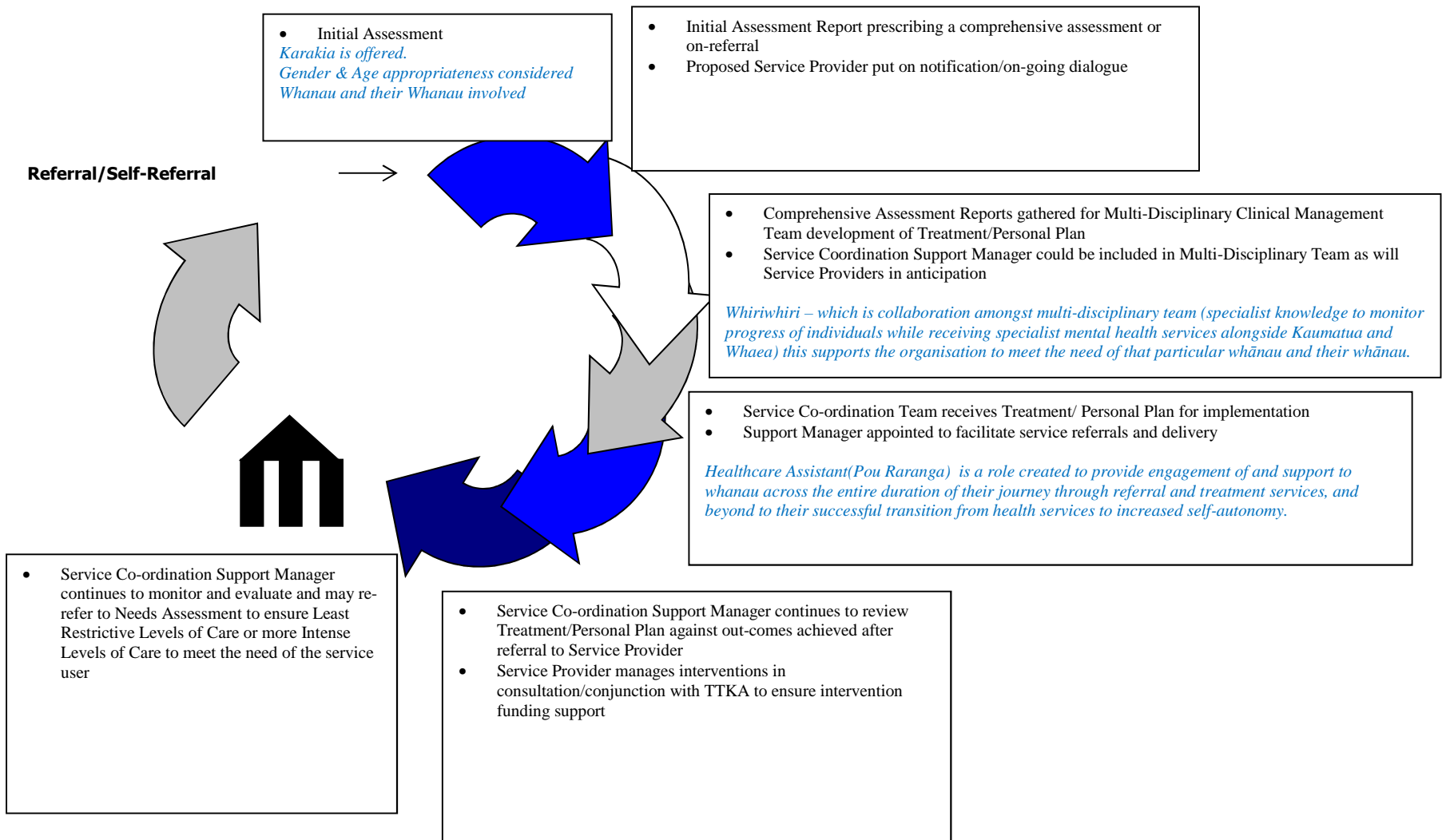
The organisation’s services are based on addressing the health and mental health needs of its whānau. I believe the government’s interpretation of ‘meeting Māori health needs’ varies from a Māori interpretation of meeting Māori health needs. For example, some positions (e.g. Kaumatua and Whaea) are not funded by the government via Ministry of Health contracts. For this Māori provider the support of Kaumatua and Whaea is crucial in supporting the road to recovery for some whānau. For Māori, Kaumatua and Whaea bring with them a certain status that acquires respect. This is useful for some Māori and also non-Māori whānau who are at an escalated state as the presence of Kaumatua or Whaea can support de-escalation. Furthermore, interventions identified as traditional Māori practices (i.e. karakia, mihimihi, whakawhanaungatanga, waiata) which are not accorded the same value in mainstream, as they are in a Māori organisation. The process seen in the ‘Whānau Referral Process’ (Table Two) may seem similar to

other models of practice but it is the inclusion of valued traditional cultural aspects that strengthen the delivery and impact of clinical and cultural services.

Te Awhi

‘Te Awhi’ is the model that was developed and implemented for clinical and cultural Māori mental health service delivery. Meeting whānau needs is what drives the service provision and determines service priority. Below (Table Two) outlines the process of progression for whānau using Te Awhi.

'Te Awhi'



The model evolved following Māori clinicians expressing concern that the mainstream model of care was not meeting the clinical or cultural needs of Māori Whānau (Harcourt, 2000). Māori clinicians were looking for a model that was sensitive to Māori needs, embraced Māori cultural beliefs, values and tikanga, and a Māori centred paradigm that practices and values interventions such as karakia, mihimihi and whanaungatanga. A Māori model based on best clinical and cultural practice was deemed necessary by Māori clinicians to deliver responsive service to whānau, their extended whānau, hapū and iwi, and non-Māori. In short, the clinicians sought a health model that acknowledged clinical risk, celebrated uniqueness and considered latent potential, rather than a mainstream approach, which appears to focus on clinical risk only. In support of such intent, a study completed by (Prasad, 2008) on the provision of health services and accessibility of health services to Māori in the Hawkes Bay, revealed:

The types of services offered to Māori indicated that services provided by Māori by the Private Māori health providers did meet Māori health needs that is it met all the aspects of The Whare Tapa model of health. The mainstream services did not meet all the aspects of the Whare tapa model and cultural appropriateness of the services was being questioned. My findings on accessibility issues indicated that Māori in Hawke's Bay did face accessibility issues and this was mainly due to cultural appropriateness of services (mainly mainstream services), the location of the private Māori health providers, the cost of the health services mainly the non-Māori health providers and lastly capacity issues of the Private Māori health providers. Thus all these accessibility issues arise due to insufficient funding and resources being allocated to Hawke's Bay district health aimed at Māori in the Hawkes Bay. These issues show that it does not fit the health promotional aspects of Te Pae Mahutonga and hinders the important theme of participation. (p. 1)

Nursing Council of New Zealand (2002) describes a model which applies and values 'whakaruruhau' (cultural safety) as:

The effective practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. (p. 7)

Furthermore Nursing Council of New Zealand (2002) states that: "unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual" (p. 7). Unfortunately a mainstream health approach appears to treat an individual's health and wellbeing in isolation; that is examining their health only rather than also valuing whānau, extended whānau and having regard to the influence of an individual's home environment (Durie, 2005; The National Aboriginal Health Strategy, 1989).

'Te Awhi' model of service delivery supports Te Whare Tapa Wha whereby individuals' circumstances are considered not just their mental state but their spiritual appreciation, social circumstances, physical wellbeing, and their environment (i.e. whānau). 'Te Awhi' appreciates these elements as being part of the whānau and extended whānau, and therefore acknowledges that these aspects contribute to living a balanced life.

The organisation supports 'home visits' so the whānau and their immediate whānau and their environment can be considered. The ability for the organisation to complete home visits also eliminates the need (i.e. the barrier) for people to seek access to mental health services. Gender appropriateness, as discussed earlier, is considered non-negotiable in this organisation. It is an iwi mandated obligation and not a Crown funded requirement. Gender and age appropriateness, as discussed earlier in this case study, ensures the whānau and the clinician and/or the support worker feels safe. For instance, it is not appropriate to have a male nurse work with a kotiro (girl) nor is appropriate for a wahine (female) nurse in her 20s to work with a Kaumatua (elder male). Pou Raranga (support workers)

assume the role of providing cultural safety in this organisation, so that whānau are comfortable, and are encouraged to engage with clinicians, which supports their rehabilitation. The organisation believes this also supports with reducing 'access' barriers as whānau feel more comfortable to engage mental health services.

Clinicians are supported to engage in work required to meet the needs of whānau and to ensure they meet best practice requirements of their profession. Clinicians are required to enter all activities completed in a day so that the Ministry of Health, through their reporting schedules, can identify how much time clinicians are spending completing activities such as face to face with whānau, travelling, completing administration work (i.e. case notes) or care co-ordination. These activities are important for statistics but they do not indicate what improvements whānau have made. Furthermore, an absence of information on whānau improvements raises concern for the organisation's management about the rationale for collecting such data, while knowing that having clinicians working with whānau is money better spent.

In sum, the organisation supports whānau and their immediate whānau to facilitate positive lifestyle changes and improve their health, mental health and wellbeing. However I identified that meeting the funder's contractual reporting requirements presents challenges to the organisation while trying to meet its Iwi mandate obligations. The organisation is acknowledged by its funders as a Māori organisation but non-clinical roles such as Kaumatua and Whaea and Pou Raranga are not funded but the inclusion of such traditional cultural interventions in funding and reporting is required to meet the needs of Māori.

The rationale for 'Te Awhi' was to enhance people's quality of life and provide a more flexible system to deliver responsive services to people with mental ill-health and disabilities with minimal disruption to their lives. 'Te Awhi' seeks an improved health status/wellbeing for individuals and their whānau to enable independent living; thus opening the door to further training and education and employment options, and opportunities to participate in community and Marae activities.

Focus interviews - Findings

A research approach identified in chapter two was to complete interviews with no more than 10 participants who are involved in developing and/or delivering health services to Māori. The researcher completed interviews with a total of six participants: one group interview which involved three participants; two individual interviews; and one individual interview completed via email. Face to face interviews were approximately one hour in duration.

Collectively participants have between 80 to 85 years health sector involvement. Participant exposure to national and international health issues has seen them attend international, national and regional conferences and hui (meetings). They had also been involved in national, regional, and local steering committees, contributed to iwi health initiatives, and joined with other health providers, both government and non-government, as part of clinical and non-clinical forums.

My rationale for selecting these participants was because of their involvement at the community level delivering health services to whānau, hapū and iwi. Their perspective was valuable to this research as they offered experiences that are not available in literature, by providing scenarios and identifying barriers or inequities they may encounter day to day working in the current health and disability paradigm.

The researcher was interested in what participants believed was required to improve health services' responsiveness to Māori, including whether they believed Māori models of health could improve current Māori health status. Furthermore, information was sought to understand observable and/or reported benefits to Māori when a Māori health model is guiding they way they work with whānau/families.

For the benefit of the reader, rather than name my interviewees 'x' 'y' and 'z' etc., and keeping in mind my interviewee's right to confidentiality, I decided to allocate them fictional names. I have also decided to format their responses in italics to assist the reader to distinguish participant response from literature quotes.

Māori health status

When asked about their view on Māori health status, participants acknowledged there had been slight increases in numbers of whānau accessing their services. Jane, one of the respondents stated: *“I think there has been a lot of educational promotional drives trying to inform and build awareness in communities.”*

Participants commented that statistics released by the Ministry of Health, and other government agencies, indicated that Māori were still over-represented in ill-health statistics compared to that of non-Māori. Lane, one of the respondents stated:

Well my views about Māori Health status are influenced very much by these statistics that we see coming out of the year from the Ministry of Health and various other government agencies. They indicate that there may be some slight improvement in overall health status for Māori people but if we look at, over the last time, young Māori people generally are represented very much in the statistics which shows that this lack of attendance at school, lack of qualifications, lots of teenage pregnancies or incidents of alcohol and drugs, all of those indicators which would indicate that things are not all that well so there is a big room for improvement.

Ray, another respondent further acknowledges the slight improvement by stating:

Well have we made a difference in the last 20 years? I would have to say yes. It's a small difference and is not bridging the gap you know between Māori and non-Māori. Now why do you think this is? Simply there is a whole lot of reasons. There is health in itself cannot be resolved unless you address, the wider social determinants so all those things go hand in hand and health is one of the components I guess of achieving wellness of our people.

Overall, regardless of the slight improvement with regards to Māori accessing health services earlier, participants agree that further improvement was required to improve Māori health. Improvements would include, but not be limited to: whānau/families linking to services that could address basic health needs like income, employment, warm housing, food, and children being kept in school.

Contributing features to Māori health status

Acculturation of Māori over time (i.e. confiscation of land, loss of te reo and cultural heritage), and a history of socio-economic outcomes (i.e. education, income, occupation, housing) were identified as influencing Māori health status. Ray, one of the respondents commented on the confiscations stating:

I come back to my earlier comment where the consequences of the loss of land, loss of reo, loss of your cultural heritage, loss of the things that our Tupuna took as part of their daily living. All of those things and of course you know the economy and therefore the potential earnings, the power of that loss meant that our people were taken back and occupy the current status.

Jei' view on Māori socio-economic status was:

It is no secret that Māori socio-economic status, particularly those in poverty, impacts health status. Those who live in poor environments experience lower health status than those living in favourable circumstances. We know that health inequalities exist between the poor and affluent for more or less all diseases.

Jei's response is consistent with Strickett and Barnes' (2012) suggestion that socio-economic elements contribute to a cycle of deprivation and create barriers, and therefore undermine an improved Māori health status. Hauora Waikato (2005) also suggests the cycle of deprivation will continue to impact whānau ability to deal with inherent problems. Ellison-Loschmann and Pearce (2005, p. 613) extend participants' statements further by stating:

non-genetic explanations for differences in health between Māoris and non-Māoris can be grouped into 4 major areas focusing on socioeconomic factors, lifestyle factors, access to health care, and discrimination. These explanations are not mutually exclusive, but it is useful to consider them separately while bearing in mind that they are inextricably linked.

Participants agreed the socio-economic status of Māori remains low with poor education, low income, high benefit dependency, which has resulted in a low health status. They agree for change to occur the socio-economic status of Māori needs to improve.

Health and disability structure

Participants were shown a copy of the health and disability structure of Aotearoa (see Appendices). He Korowai Oranga – the Māori Health Strategy (Ministry of Health, 2002) commits to a partnership between Māori iwi and the Crown, with Māori positioned at all levels of the health sector – decision making, development, planning, and delivery. Participants were therefore asked if they believed the current health and disability structure was a good representation of Māori being involved at all levels.

Overall, participants agreed that the structure was not a good representation of the stated commitment to the special relationship between Māori and the Crown (Ministry of Health, 2002). They believed Māori participation at all levels, especially at governance, was absent. Jei stated: *“The structure does not symbolise any form that reflects the Treaty of Waitangi or its associated principles, which the Crown acknowledge is the founding document of Aotearoa, but in reality the government structures reflect and remain dominant culture”*.

Jei’s statement is consistent with Dodd’s (2000, p. 4) view that “Māori self-governing structures are socially constructed hybrids of a colonial past!” Furthermore, participants acknowledged Māori in ‘advisory’ roles had achieved small gains, and agreed that a genuine commitment by the decision makers (i.e. at a governance level) was necessary before Māori health structures could be effective. This is supported by Ray, who stated:

District Health Boards are required to have in place machinery that enable Māori participation – hugely advisory that’s contestable and you know my experience is unless you have genuine commitment of both the board and senior management, again you are pushing up hill.

Ray provided further sustenance to his initial statement by adding:

You can have the government ministers with the best intention even the best policy in the world but if you can’t get traction and what I call ‘blue-management level’ then a lot of that can be diluted and so within the whole environment and I don’t just confine my comments to health, social welfare etc., the bureaucratic silo that separates politics from service delivery.

Ray however did elaborate further on a way forward with regards to a governance approach by stating the following:

What’s missing and I think this is guaranteed to take on increasing prominence particularly as the whānau ora policy starts to really materialise over the next little while and that is the relationship between the Crown and there is evidence you know of growing relationship that is establishing a partnered approach to matters related to the Crown. There’s some examples of that the river clean up you know its half Crown and half Iwi. The whānau ora will have at the political level a structure, a leadership structure based on half iwi and half Crown and I think that is the blue print for the relationship between the Crown, the government and our people via those relationships – partnered leadership structures.

Overall, participants felt the current structure had been unsuccessful in responding to or improving Māori health so structural changes were required. The changes would include real partnerships at all levels of the health structure, including governance level. Both Jei and Ray’s responses are consistent with Durie’s (1998, p. 237) view:

There is no Māori body politic. In its absence, policy making for and on behalf of Māori is assumed by the Crown, with irregular Māori input and, inevitably, increasing Māori discontent. Even policy decisions about Māori resources rest with the State, not Māori. While the key participants are Māori, the accountabilities, reporting lines, and appointment processes lie with the state.

Participants indicated disappointment that Māori were not represented at all levels of the current health and disability structure. Furthermore as te Tiriti o Waitangi partners the structure provided no opportunity for Māori to participate equally (i.e. make decisions around supporting the health needs of Māori).

Te Kete Hauora

Participants were asked about Te Kete Hauora advisory role in the Ministry of Health and whether such role was sufficient to improve Māori health. Participants unanimously agreed that an advisory role was not sufficient to improving Māori health status. Jane, one of the respondents stated:

I think its just tokenism I don't think that it's an advisory group; it depends on how it falls on the ears of those people that are on the other end receiving that. And whilst I was listening to you ask me that question I was thinking about the treaty of Waitangi and our tupuna and how they delivered their interpretation and impression of what they thought in comparison to the ears that it fell on in their misinterpretation. An advisory group is something but again it all depends on who's listening and what they take away from that then how that's infused through to 'on the ground' 'day to day' benefits for Māori.

Jane's view is supported by Jei who stated:

the Ministry of Health, restrict the indigenous voice to assuming an advisory role only and so the Māori voice may be heard but no one in the Ministry needs to consider whether it is a valid or reliable voice or even if note is taken of the korero progressed. The reality is that mainstream believes they know what is best for Māori.

Respondents unanimously agreed that Māori want to be making decisions. This is consistent with Fleras and Spoonley (1999, p. 147) who state “Māori don’t want to be passengers on the bus. We want to be driving the bus with our hands on the steering wheel”.

Participants agreed that the advisory role of Te Kete Hauora has complications because Te Kete Hauora has the ‘power’ of representing all Māori; thus they needed to be in the communities requesting feedback and relaying the same persuasively to the decision maker. Participants queried how Te Kete Hauora, a government born agency, had the right to be the advisors on policy that affected Māori, on behalf of Māori. Concern was expressed about their position as representing the ‘Māori voice’. Jei stated:

I don’t know what iwi gave Te Kete Hauora the authority or the mandate to develop health policy on behalf of Māori. Te Kete Hauora needs to be getting out to the iwi and getting advice from the iwi. Not sure where they have been to date? Who have they spoken to over the last year?

Participants’ concern is consistent with that of Smith (1997, p. 97) who states:

Many Māori elites are appointed to senior positions and they need to remember how they got to the position they are in, how they perform their role and who they are working to benefit. They also need to remember those values and principles that are of significance and forget assimilation of a western ‘corporate’ approach.

Again participants indicated disappointment at the representation provided on behalf of Māori by Te Kete Hauora. They want to see Māori making the decisions but would also like to see a joint Māori and government mandated Māori governance board making these decisions for and on behalf of Māori.

Māori providers' response to Māori health

Participants were asked how effective they thought Māori providers were in responding to the health needs of Māori. Majority of the participants believed Māori providers were critical in supporting their communities whether they were Māori or non-Māori service users. Participants' response is consistent with Durie's (1997) view, who suggests Māori respond better to services delivered by Māori. Also, the majority of participants did state that they believed their 'effectiveness' was restricted because they were of the view that less funding was paid to Māori providers in comparison to provider arm services (i.e. District Health Boards), to provide a similar service. Dale, one of the respondents stated: *"I think we are as effective as those that fund us allow us to be"*. Further, Ray had a similar view by stating: *"I don't think we've yet got the question of equity and that's financial equity resolved"*.

One participant identified the need for further development (i.e. education) by Māori providers so to increase their capability and improve their effectiveness. Lane stated the following:

You know, everybody had the passion, had the aroha, they had the desire to actually go and do things – but that's not enough – you know having the desire to do something needs to be informed by education, it needs to be informed by training. It's one thing to be very interested with the local health person to go and offer advice.....it's a different thing to be a trustee of an NGO. So you would need skills and you need training, and you need people who have got credibility.

Participants identified that Māori health will only improve if their needs are accurately met. For Māori providers to be effective participants believed the government needed to ensure all providers were financially equitable.

Barriers

Participants were asked if they were aware of barriers to delivering successful services. Funding and providers' capability were identified as barriers. Participants identified the barrier of not being offered opportunities by the Ministry of Health to deliver services, which is reflected in Ray's response *"Perhaps the challenge of simply being in the game. This means that there is a greater level of pressure for accountability of Māori providers to deliver. You know you just simply had to be as good as mainstream providers, if not better"*.

Another barrier identified was the Ministry of Health's contractual obligations regarding compliance and monitoring, and funded positions. Jei stated: *"Māori providers are required to deliver on mainstream or Māori contracts, irrespective of the time taken to meet these obligations, otherwise they breach such agreements, which results in formal discussions, and potentially loss of contract"*.

Māori providers use concepts such as karakia, whakawhanaungatanga, waiata, and mihimihi as interventions. Participants were asked whether they believed such interventions assisted the improvement of an individual's wellbeing and whether they believe the Ministry of Health should be collecting such information. Information collected would include data on interventions that are working for Māori, rather than just gathering statistics on people coming through the door being seen face to face. All participants agreed that cultural concepts were vital to engaging with whānau, establishing trust and connecting with them. Participants agreed that these cultural concepts were certainly viewed as important 'interventions' for them. Participants identified these interventions as what distinguished Kaupapa Māori organisations from mainstream organisations. Participants also agreed that these approaches were not only necessary but essential as indicated by Ray one of the respondents:

Just doing a whakapapa or whakawhanaungatanga you know takes a person on a journey in terms of who they are or where they've come from and what's happened for them as a whānau. It will help shed the light on how to manage or support that person in their journey moving forward.

Dale, another respondent supports Jane's comment by stating: *"Since working with the kaupapa we've had a number of whānau with complicated medical conditions that have come in. I think that if we had approached it any differently then we wouldn't have the outcomes we've had"*.

Dale's response strengthens support for assertions that te ao Māori interventions play an important part in supporting positive whānau outcomes. Both Jei and Dale's comments are consistent with Durie's (2001) view who acknowledges the relevance of these traditional Māori interventions, and others (e.g. rongoa, tikanga Māori, and extended whānau) to strengthen the responsiveness of mental health services.

Participants agreed that the inclusion of te ao Māori interventions in the monitoring and compliance reporting requirements would assist the Ministry of Health to realise that these interventions produce positive rehabilitation outcomes leading to improved Māori health status.

Data collation

Participants unanimously agreed that the Ministry of Health needed to collect information on te ao Māori interventions and needed to understand the value of such concepts, and improve Māori health status. One participant believed it was important to have people in the Ministry of Health who understand why te ao Māori concepts are positive interventions. Pax believed it was obvious that Te Kete Hauora had either not informed the Ministry about the value of such concepts and subsequent interventions can help improve Māori health, or the Ministry had chosen to ignore such advice. Furthermore, participants believed there was no value in the current data the Ministry of Health was collecting. Lane, one of the respondents, stated: *"It's a bit of a joke really the information the Crown actually get in monitoring returns that contracted providers have to fill in – it tells you a lot about activity, it tells nothing about actuality such as what has worked and what has not"*

Lane's assertions were reiterated in Pax's comment:

I guess that's the thing that's wrong with the current structure is that we report on throughput but we can do the same as MacDonald's how many come through, that's what we do and that's what we report on. We don't actually report on quality, how we do it.

Lane and Pax's comments are consistent with Hauora Waikato (2011) view, which is that the Ministry consider what Māori interventions are achieving positive health gains for Māori and non-Māori whānau/clients (e.g. cultural tikanga, values and beliefs, whanaungatanga, karakia, and or te reo Māori).

Participants believed it was necessary to provide 'useable' data, data that indicates what works and what does not. The data collected currently is showing the Ministry of Health the service's busyness, how long whānau are in services, where they are coming from and where they are going to. The data does not reveal what has worked for whānau, and how they have or have not rehabilitated when they were within the service. Participants felt the current data collection programme is about practitioners' busyness rather than the service quality or the outcomes achieved for whānau (e.g. choosing a healthy lifestyle). Lane, one of the respondents stated:

Oh yeah, the busier we are, the more they'll think of us and I can put my hand up and say I need more money. Meanwhile being busy means nothing it doesn't mean that we've been effective. We don't have that concern, there's nothing there to say, you know did that programme on sexuality that was delivered in Ngaruawahia – did that have any effect on teenage pregnancy? Did it have any effect on young people who had sexually transmitted diseases? There's nothing about that.

Participants agreed the Ministry of Health needed to review their compliance and reporting requirements so that the information they are collecting is useful. Useful in terms of identifying what works and what does not. Then this would indicate to participants and other Māori providers that whānau rehabilitation is the intended aspiration of the Ministry of Health.

Understanding Māori health models

Participants were asked about their understanding of Māori health models and whether they believed these models were effective. Overall, participants had an understanding of Māori health models and were able to identify Te Whare Tapa Wha, and Te Wheke as commonly known Māori health models. The key component to a Māori health model was identified as being ‘holistic’. Dale, one of the respondents defined ‘holistic’ as: *“It takes on board everything about a person not just as an individual but everything that comes with them”*.

Jane added:

They’re just core humanistic things like you know feeling valued, being able to love and things like that but if you strip it back that’s what people want, at the end of the day, to feel valued, to be able to love and be productive in all sorts of things. That’s what I see with Māori health models it’s just those underlying sort of principles and values of that person first and looking at them within all realms.

Jane and Dale’s responses are consistent with Durie (2005) who suggests people’s lives have many facets that make them unique – their spirituality, culture, family, and the environment they are surrounded by.

Governance of Māori health models

Following discussion on their understanding of Māori health models participants were asked whether the Ministry of Health should retain a governance role of a Māori health model. All participants indicated that the Ministry of Health should not have a governance role over Māori health. Dale, one of the respondents stated: *“I think for me it’s clear evidence that Māori themselves have developed models for Māori health but that’s it, what hasn’t been matched up is the governance around it, so it’s still very much mainstream sort of mentality.”*

Participants consistently agreed that governance of a Māori health model belonged with Māori. Jei reasoned:

Māori health models are the taonga of Māori so they are the responsibility of Māori. Such models were an attempt to explain in a formalised way to everyone how Māori models of health and wellbeing have been and continue to be in practice. The reality is anyone can write what they like and design models they believe will meet the needs of Māori – the truth is that interpretation and delivery is the key to meeting the needs of Māori. This organisation has a mainstream contract with a few Māori words sprinkled here and there to ‘look good’ from a Māori perspective! However we take that contract and interpret from a stance of a Māori world view (Māori are non-static and evolutionary) and the delivery on the contract not only meets the expectation of Māori but exceeds that expectation. However when the auditors, who constantly come to our door, we need to revert our world view to that of the tauīwi contract writers!

This organisation is a break-thought organisation – we think differently – we act on things differently we progress our professional abilities differently – we manage our fiscal portfolios differently but all from a kaupapa of integrity and outcome achievement so for the Ministry of Health to assume governance over a kaupapa Māori health model would place Māori further into a subservient position.

Further feedback from Ray was provided around the ownership issue. He stated:

Simply because it is owned – there is an ownership issue and legal beagle terms, you come with a brand or in this case a model. Probably the best way to kind of describe it, if you go into ‘Te Awa’ (Shopping mall) you know where the Pou is, you go in there and you look up, that is Tainui – you just look up at the ceiling at the roof, it’s all Tainui designed and it’s not anybody else - it is ours by whakapapa and tribal identity.

Respondents unanimously agreed that Māori should remain kaitiaki of Māori health models not only in health but social services, housing, and employment or economic sectors.

The statements made above are consistent with Article 21 in the Declaration of Indigenous Rights (United Nation, 2007) which states:

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions. (p. 6)

This is further supported by Durie (1997) stating:

Māori deliver best on national goals for social and economic advancement if they deliver it themselves under policies of their own choosing. The nation benefits when Māori take responsibility for those matters. For the government it means as a negotiating face to deal with when policies require public expenditure, a face mandated through a Māori owned structure and the resolution of Māori issues through a settled Māori process. (p.112)

Summary

In sum, the participants' contribution to this research has been beneficial. I have heard the views of those working within a Māori provider day to day, on the ground, with Māori whānau under the current health and disability structure. For the purpose of this research I have summarised this analysis in three sections: areas of general agreement; areas where there was a different of perspective; and areas of a specialised perspective.

Areas of general agreement

Participants agreed that the poor health status of Māori was a result of the socio-economic reality that Māori assume (i.e. education, income, and housing). They agreed that Māori health will improve when the government addresses the socio-economic realities, while also amending the current health and disability structure.

Participants agreed that the current health and disability system did not allow Māori providers to operate completely as kaupapa Māori because the Crown, through a mainstream framework, maintain control autonomy, ensure financial dependency, determine the compliance and monitoring reporting. Furthermore the participants agreed the current health and disability structure was evidence that Māori were not present at all levels of the health and disability system and were not involved in strategic decision making. More so, participants agreed that the special relationship between the Crown and iwi Māori did not accurately represent the principles within te Tiriti o Waitangi or the commitment of He Korowai Oranga (Ministry of Health, 2002).

Participants were consistently uncomfortable with Te Kete Hauora – the Māori health directorate’s appointment to provide policy advice to the Minister of Health on behalf of Māori. Participants’ dissatisfaction with Te Kete Hauora was due to the business unit representing government, and is right to voice Māori policy behalf of Māori Further disappointment was expressed by all participants that the role of Te Kete Hauora was advisory only.

Participants felt disadvantaged as a result of restricted opportunity compared to that of the provider arm (i.e. district health board), funding allocation, and the stringent contractual obligations (i.e. compliance and monitoring requirements). Financial inequity amongst providers was identified as a barrier to providing effective services to Māori.

Participants agreed that their cultural values, beliefs and tikanga (i.e. karakia, mihimihi, whakawhanaungatanga) were critical interventions when supporting Māori and non-Māori. Furthermore they believed the collection of such data in the Ministry of Health's compliance and monitoring reporting would be beneficial to understand the value of such interventions. Within their current data collection obligations time taken to engage whānau in such interventions is not collected, nor are reported outcomes.

Furthermore participants agreed working from a Māori health model framework and having a holistic approach when dealing with whānau was important to understand an individual within all realms. Participants agreed Māori are and should retain ownership of Māori models of health.

Areas where there was a difference of perspective

Participants did not disagree on any area discussed. However one participant identified that there needs to be a lot of development amongst Māori providers so that they have the capability, and are fully informed so that they can improve their effectiveness. The importance of education, training and up-skilling of Māori for the benefit of Māori was emphasised.

Specialised Perspectives

One of the participants 'Ray' has held significant roles within the Health sector of Aotearoa. He has been involved in many Māori health initiatives at a national, regional and local level and is very knowledgeable with regards to Aotearoa health history, Māori health history, iwi and Crown relationship history and iwi issues. His perspective on governance management was quite simple - half iwi and half Crown.

Conclusion

Introduction

At the time of printing this research Māori remained disproportionately over represented in all ill health statistics. Māori health models have been acknowledged as legitimate by both Māori and non-Māori (e.g. Ministry of Health, 2013). Te Whare Tapa Whaa (Durie, 2005), and Te Wheke (Pere, 1991) are adopted in day to day practice in health and non-health settings. Te Awhi, was also recognised by interviewees in this study as a legitimate health model. In time, Te Awhi and other Māori models may also gain recognition by the Crown's funders.

Significance of the research

In this research I set out to answer the question 'if a Māori model of health would work better to improve Māori health status?' The question evolved based on my concern that Māori communities continue to be disproportionately over-represented in all ill-health statistics. Unfortunately, these statistics are increasing despite current legislation, health policy, and purchasing frameworks and compliance reporting aimed at improving Māori health status. Barriers to improving Māori health status can be minimised and thus Māori health can improve where Māori models of practice are implemented. Modifications to the service purchasing and also the compliance reporting frameworks are central to acknowledgement of Māori health models.

To commence the research I had to gain insight into my field of enquiry therefore the starting point was to understand what 'health' actually meant. I discovered that non-indigenous, indigenous and Māori 'health' definitions vary and the way Māori believe health is measured also varies. Māori perceive health as the balance of all the realms in life rather than it being an individual's physical and social wellbeing. I then considered the health and disability framework within Aotearoa New Zealand, to understand how reflective the framework was of the United Nations Declaration of Rights for indigenous people, of which the New Zealand government is a member state. I also considered the government's commitment to te Tiriti o Waitangi and Māori as the indigenous people of Aotearoa. As an indigenous people and as te Tiriti o Waitangi partners Māori are entitled to

participate at all levels of health and disability system in matters that affect their rights. What was evident is that Māori are not participating at all levels, including governance, within the health and disability sector. Instead, government formed agencies such as Te Puni Kokiri and business units like Te Kete Hauora that adopt advisory roles to inform the Minister of Health on Māori policy. Māori involved in advisory roles appears to be more of superficial attempt to address Māori health than to hear and act on the Māori voice.

The next stage of the inquiry was to set out the methods I would engage to assist my research. I chose an interpretive qualitative methodological approach, which provided insight into how health policy has impacted Māori, and the possible health gains to be achieved through Māori models. I completed a literature review; literature review of policy and legislation; case study; and interviews (one on one and focus group). I chose this approach, in part because I was a wahine Māori working within a Māori organisation, aware of the importance of cultural interventions and their worth to Māori, but also because I was aware of the barriers that existed for Māori providers within the current health and disability system.

Barriers are prohibiting improvements to Māori health status, which include Māori being unable to contribute effectively, as Tiriti partners, to health policies that affect Māori. Imperative roles, i.e. Kaumatua, Whaea, and Healthcare assistant are not funded, and data on successful traditional cultural interventions (i.e. karakia, mihihimihi, whakawhanaungatanga) are not requested through the government's compliance and reporting framework. Financial inequity to that of the provider arm (i.e. district health board) was identified as a barrier restricting the ability to deliver services that could improve Māori health status. The inclusion of these roles and interventions is required to contribute to meeting Māori health needs. As a result of excluding Māori interventions, Māori providers are presented with challenges when trying to meet the expectation of the funder alongside the expectation of Māori whānau, hapū and iwi.

Differences between participants' views were minimal with the majority of the participants agreeing on most aspects of the interview. One noteworthy difference was the need for increased development amongst Māori providers to enhance capability and capacity so they are fully informed, therefore improving their effectiveness.

Similarities in the findings between interviewees were that the health status that Māori currently occupied was a result of the inability for Māori to appropriately contribute to the health policy for Māori within the current health and disability framework. The socio-economic reality that Māori assume is a contributing factor as well as the ability for Kaupapa Māori organisations trying to work under a Māori model of health without being offered the same opportunities and funding as their, for example, DHB provider arm equals. If Māori providers were able to financially support those roles of importance (i.e. non-clinical roles) and identify reporting specifications that 'make a difference' (i.e. cultural interventions) that are working, and contribute effectively, at all levels of the health and disability system, Māori health status would improve and the special relationship between the Crown and Iwi would be reflected more accurately. A simple perspective offered by one participant with regards to the governance of health and disability system – half Māori and half Crown.

What was evident in the literature, has been the New Zealand government's eventual support of the United Nations Declaration of Rights for Indigenous People, and its acknowledgement of, but slow efforts to address – te Tiriti o Waitangi principles.

I provided two successful Māori driven initiatives which focused on the revival of te reo Māori which produced positive outcomes for te reo Māori speakers in Aotearoa New Zealand, revoked previously enforced legislation, and improved Māori capacity, capability, and social and cultural capital. Contemplation of such examples was important in understanding the features that would contribute to improving Māori health.

The model 'Te Awhi' was an indigenous response to the needs of Māori and was a model that revealed a Māori practice imbued with traditional values and principles. The model takes into consideration all realms of an individual's life because this is what makes them diverse. 'Te Awhi' is a collaborative model offering a 'one door' approach, a model that moves away from 'silo-based' approach but support one point of contact and that person supporting the whanau and their whānau. The model operates effectively in a Māori organisation and therefore it may prove challenging to implement in a mainstream agency. 'Te Awhi' seeks an improved health status/wellbeing for individuals and their whānau to enable independent living.

On a personal note, based on current statistics unless alternative models of practice are implemented Māori health status will not improve and therefore tane Māori will die 8 years earlier, and wahine Māori will die 9 years than their non-Māori counterparts. This is a korero that my tane and I do not feel comfortable to share with our tamariki so as parents we must play our part to contribute to improvements.

Limitations of this research

There have been limitations to this research project. If time permitted, I would have:

- undertaken a more comprehensive piece of work that investigated the health gains achieved by other Māori health models and looked at how these compare to 'Te Awhi', and mainstream models;
- interviewed more personnel involved in delivering and also those who were recipients (i.e. Whanau and extended Whanau) of the model 'Te Awhi';
- interviewed personnel (i.e. senior executive, managers and policy writers) in the Ministry of Health to ascertain their views on the measures they use to assess the effectiveness of health policy.

I would have been able to triangulate the above responses to provide a more conclusive picture of the effectiveness of the health and disability system and health policy in addressing Māori health status. I would also have gained insight

into the Ministry of Health's rationale for not recognising Māori health models, including traditional Māori practices, in their service purchasing and compliance reporting framework.

A further limitation

I am aware that the findings were specific to this study's cohort so it would be difficult to state with a high level of confidence the findings from this study could be generalised to other population groups (i.e. Māori, non-Māori). I would have liked to interview deliverers and receivers about their experiences of 'Te Awhi' across various stages of receiving services.

Future research

Based on the limitations I observed in this thesis, it is timely for future research projects to build on my study to determine how health models, Māori and non-Māori, can be improved to improve Māori health status. Reviewing the relevant legislation, the effectiveness of the health and disability system, and health policy is required to improve the Ministry of Health's effectiveness and responsiveness to Māori health. Recognition of other socio-economic determinants of health, including poverty, is required in health policy. Research is needed to identify opportunities to address how determinants of health can be addressed through delivering health services, or may be via intersectoral collaboration, such as the Whānau Ora initiative.

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Appendices

1. United Nations Charter – Declaration of Indigenous Rights.
2. Copy of the Ministry of Health’s organisational structure (locating Te Kete Hauora)

Appendix One: United Nations Charter – Declaration of Indigenous Rights.

Adopted by General Assembly Resolution 61/295 on 13 September 2007

The General Assembly,

Guided by the purposes and principles of the Charter of the United Nations, and good faith in the fulfilment of the obligations assumed by States in accordance with the Charter,

Affirming that indigenous peoples are equal to all other peoples, while recognizing the right of all peoples to be different, to consider themselves different, and to be respected as such,

Affirming also that all peoples contribute to the diversity and richness of civilizations and cultures, which constitute the common heritage of humankind,

Affirming further that all doctrines, policies and practices based on or advocating superiority of peoples or individuals on the basis of national origin or racial, religious, ethnic or cultural differences are racist, scientifically false, legally invalid, morally condemnable and socially unjust,

Reaffirming that indigenous peoples, in the exercise of their rights, should be free from discrimination of any kind,

Concerned that indigenous peoples have suffered from historic injustices as a result of, inter alia, their colonization and dispossession of their lands, territories and resources, thus preventing them from exercising, in particular, their right to development in accordance with their own needs and interests,

Recognizing the urgent need to respect and promote the inherent rights of indigenous peoples which derive from their political, economic and social structures and from their cultures, spiritual traditions, histories and philosophies, especially their rights to their lands, territories and resources,

Recognizing also the urgent need to respect and promote the rights of indigenous peoples affirmed in treaties, agreements and other constructive arrangements with States,

Welcoming the fact that indigenous peoples are organizing themselves for political, economic, social and cultural enhancement and in order to bring to an end all forms of discrimination and oppression wherever they occur,

Convinced that control by indigenous peoples over developments affecting them and their lands, territories and resources will enable them to maintain and strengthen their institutions, cultures and traditions, and to promote their development in accordance with their aspirations and needs,

Recognizing that respect for indigenous knowledge, cultures and traditional practices contributes to sustainable and equitable development and proper management of the environment,

Emphasizing the contribution of the demilitarization of the lands and territories of indigenous peoples to peace, economic and social progress and development, understanding and friendly relations among nations and peoples of the world,

Recognizing in particular the right of indigenous families and communities to retain shared responsibility for the upbringing, training, education and well-being of their children, consistent with the rights of the child,

Considering that the rights affirmed in treaties, agreements and other constructive arrangements between States and indigenous peoples are, in some situations, matters of international concern, interest, responsibility and character,

Considering also that treaties, agreements and other constructive arrangements, and the relationship they represent, are the basis for a strengthened partnership between indigenous peoples and States,

Acknowledging that the Charter of the United Nations, the International Covenant on Economic, Social and Cultural Rights (2) and the International Covenant on Civil and Political Rights,² as well as the Vienna Declaration and Programme of Action,⁽³⁾ affirm the fundamental importance of the right to self-determination of all peoples, by virtue of which they freely determine their political status and freely pursue their economic, social and cultural development,

Bearing in mind that nothing in this Declaration may be used to deny any peoples their right to self-determination, exercised in conformity with international law,

Convinced that the recognition of the rights of indigenous peoples in this Declaration will enhance harmonious and cooperative relations between the State and indigenous peoples, based on principles of justice, democracy, respect for human rights, non-discrimination and good faith,

Encouraging States to comply with and effectively implement all their obligations as they apply to indigenous peoples under international instruments, in particular those related to human rights, in consultation and cooperation with the peoples concerned,

Emphasizing that the United Nations has an important and continuing role to play in promoting and protecting the rights of indigenous peoples,

Believing that this Declaration is a further important step forward for the recognition, promotion and protection of the rights and freedoms of indigenous peoples and in the development of relevant activities of the United Nations system in this field,

Recognizing and reaffirming that indigenous individuals are entitled without discrimination to all human rights recognized in international law, and that indigenous peoples possess collective rights which are indispensable for their existence, well-being and integral development as peoples,

Recognizing that the situation of indigenous peoples varies from region to region and from country to country and that the significance of national and regional

particularities and various historical and cultural backgrounds should be taken into consideration,

Solemnly proclaims the following United Nations Declaration on the Rights of Indigenous Peoples as a standard of achievement to be pursued in a spirit of partnership and mutual respect:

Article 1

Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration of Human Rights(4) and international human rights law.

Article 2

Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their indigenous origin or identity.

Article 3

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

Article 4

Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions.

Article 5

Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State.

Article 6

Every indigenous individual has the right to a nationality.

Article 7

1. Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person.
2. Indigenous peoples have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group.

Article 8

1. Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture.
2. States shall provide effective mechanisms for prevention of, and redress for:
 - (a) Any action which has the aim or effect of depriving them of their integrity as

- distinct peoples, or of their cultural values or ethnic identities;
- (b) Any action which has the aim or effect of dispossessing them of their lands, territories or resources;
 - (c) Any form of forced population transfer which has the aim or effect of violating or undermining any of their rights;
 - (d) Any form of forced assimilation or integration;
 - (e) Any form of propaganda designed to promote or incite racial or ethnic discrimination directed against them.

Article 9

Indigenous peoples and individuals have the right to belong to an indigenous community or nation, in accordance with the traditions and customs of the community or nation concerned. No discrimination of any kind may arise from the exercise of such a right.

Article 10

Indigenous peoples shall not be forcibly removed from their lands or territories. No relocation shall take place without the free, prior and informed consent of the indigenous peoples concerned and after agreement on just and fair compensation and, where possible, with the option of return.

Article 11

1. Indigenous peoples have the right to practise and revitalize their cultural traditions and customs. This includes the right to maintain, protect and develop the past, present and future manifestations of their cultures, such as archaeological and historical sites, artefacts, designs, ceremonies, technologies and visual and performing arts and literature.
2. States shall provide redress through effective mechanisms, which may include restitution, developed in conjunction with indigenous peoples, with respect to their cultural, intellectual, religious and spiritual property taken without their free, prior and informed consent or in violation of their laws, traditions and customs.

Article 12

1. Indigenous peoples have the right to manifest, practise, develop and teach their spiritual and religious traditions, customs and ceremonies; the right to maintain, protect, and have access in privacy to their religious and cultural sites; the right to the use and control of their ceremonial objects; and the right to the repatriation of their human remains.
2. States shall seek to enable the access and/or repatriation of ceremonial objects and human remains in their possession through fair, transparent and effective mechanisms developed in conjunction with indigenous peoples concerned.

Article 13

1. Indigenous peoples have the right to revitalize, use, develop and transmit to future generations their histories, languages, oral traditions, philosophies, writing systems and literatures, and to designate and retain their own names for communities, places and persons.
2. States shall take effective measures to ensure that this right is protected and also to ensure that indigenous peoples can understand and be understood in political, legal and administrative proceedings, where necessary through the provision of interpretation or by other appropriate means.

Article 14

1. Indigenous peoples have the right to establish and control their educational systems and institutions providing education in their own languages, in a manner appropriate to their cultural methods of teaching and learning.
2. Indigenous individuals, particularly children, have the right to all levels and forms of education of the State without discrimination.
3. States shall, in conjunction with indigenous peoples, take effective measures, in order for indigenous individuals, particularly children, including those living outside their communities, to have access, when possible, to an education in their own culture and provided in their own language.

Article 15

1. Indigenous peoples have the right to the dignity and diversity of their cultures, traditions, histories and aspirations which shall be appropriately reflected in education and public information.
2. States shall take effective measures, in consultation and cooperation with the indigenous peoples concerned, to combat prejudice and eliminate discrimination and to promote tolerance, understanding and good relations among indigenous peoples and all other segments of society.

Article 16

1. Indigenous peoples have the right to establish their own media in their own languages and to have access to all forms of non-indigenous media without discrimination.
2. States shall take effective measures to ensure that State-owned media duly reflect indigenous cultural diversity. States, without prejudice to ensuring full freedom of expression, should encourage privately owned media to adequately reflect indigenous cultural diversity.

Article 17

1. Indigenous individuals and peoples have the right to enjoy fully all rights established under applicable international and domestic labour law.
2. States shall in consultation and cooperation with indigenous peoples take specific measures to protect indigenous children from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development, taking into account their special vulnerability and the importance of education for their empowerment.
3. Indigenous individuals have the right not to be subjected to any discriminatory conditions of labour and, inter alia, employment or salary.

Article 18

Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.

Article 19

States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their

free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

Article 20

1. Indigenous peoples have the right to maintain and develop their political, economic and social systems or institutions, to be secure in the enjoyment of their own means of subsistence and development, and to engage freely in all their traditional and other economic activities.
2. Indigenous peoples deprived of their means of subsistence and development are entitled to just and fair redress.

Article 21

1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.
2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.

Article 22

1. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.
2. States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination.

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 25

Indigenous peoples have the right to maintain and strengthen their distinctive spiritual relationship with their traditionally owned or otherwise occupied and used lands, territories, waters and coastal seas and other resources and to uphold their responsibilities to future generations in this regard.

Article 26

1. Indigenous peoples have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired.
2. Indigenous peoples have the right to own, use, develop and control the lands, territories and resources that they possess by reason of traditional ownership or other traditional occupation or use, as well as those which they have otherwise acquired.
3. States shall give legal recognition and protection to these lands, territories and resources. Such recognition shall be conducted with due respect to the customs, traditions and land tenure systems of the indigenous peoples concerned.

Article 27

States shall establish and implement, in conjunction with indigenous peoples concerned, a fair, independent, impartial, open and transparent process, giving due recognition to indigenous peoples' laws, traditions, customs and land tenure systems, to recognize and adjudicate the rights of indigenous peoples pertaining to their lands, territories and resources, including those which were traditionally owned or otherwise occupied or used. Indigenous peoples shall have the right to participate in this process.

Article 28

1. Indigenous peoples have the right to redress, by means that can include restitution or, when this is not possible, just, fair and equitable compensation, for the lands, territories and resources which they have traditionally owned or otherwise occupied or used, and which have been confiscated, taken, occupied, used or damaged without their free, prior and informed consent.
2. Unless otherwise freely agreed upon by the peoples concerned, compensation shall take the form of lands, territories and resources equal in quality, size and legal status or of monetary compensation or other appropriate redress.

Article 29

1. Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. States shall establish and implement assistance programmes for indigenous peoples for such conservation and protection, without discrimination.
2. States shall take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior and informed consent.
3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

Article 30

1. Military activities shall not take place in the lands or territories of indigenous peoples, unless justified by a relevant public interest or otherwise freely agreed with or requested by the indigenous peoples concerned.
2. States shall undertake effective consultations with the indigenous peoples concerned, through appropriate procedures and in particular through their representative institutions, prior to using their lands or territories for military activities.

Article 31

1. Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions.
2. In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights.

Article 32

1. Indigenous peoples have the right to determine and develop priorities and strategies for the development or use of their lands or territories and other resources.
2. States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free and informed consent prior to the approval of any project affecting their lands or territories and other resources, particularly in connection with the development, utilization or exploitation of mineral, water or other resources.
3. States shall provide effective mechanisms for just and fair redress for any such activities, and appropriate measures shall be taken to mitigate adverse environmental, economic, social, cultural or spiritual impact.

Article 33

1. Indigenous peoples have the right to determine their own identity or membership in accordance with their customs and traditions. This does not impair the right of indigenous individuals to obtain citizenship of the States in which they live.
2. Indigenous peoples have the right to determine the structures and to select the membership of their institutions in accordance with their own procedures.

Article 34

Indigenous peoples have the right to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures, practices and, in the cases where they exist, juridical systems or customs, in accordance with international human rights standards.

Article 35

Indigenous peoples have the right to determine the responsibilities of individuals to their communities.

Article 36

1. Indigenous peoples, in particular those divided by international borders, have the right to maintain and develop contacts, relations and cooperation, including activities for spiritual, cultural, political, economic and social purposes, with their own members as well as other peoples across borders.
2. States, in consultation and cooperation with indigenous peoples, shall take effective measures to facilitate the exercise and ensure the implementation of this right.

Article 37

1. Indigenous peoples have the right to the recognition, observance and enforcement of treaties, agreements and other constructive arrangements concluded with States or their successors and to have States honour and respect such treaties, agreements and other constructive arrangements.

2. Nothing in this Declaration may be interpreted as diminishing or eliminating the rights of indigenous peoples contained in treaties, agreements and other constructive arrangements.

Article 38

States in consultation and cooperation with indigenous peoples, shall take the appropriate measures, including legislative measures, to achieve the ends of this Declaration.

Article 39

Indigenous peoples have the right to have access to financial and technical assistance from States and through international cooperation, for the enjoyment of the rights contained in this Declaration.

Article 40

Indigenous peoples have the right to access to and prompt decision through just and fair procedures for the resolution of conflicts and disputes with States or other parties, as well as to effective remedies for all infringements of their individual and collective rights. Such a decision shall give due consideration to the customs, traditions, rules and legal systems of the indigenous peoples concerned and international human rights.

Article 41

The organs and specialized agencies of the United Nations system and other intergovernmental organizations shall contribute to the full realization of the provisions of this Declaration through the mobilization, inter alia, of financial cooperation and technical assistance. Ways and means of ensuring participation of indigenous peoples on issues affecting them shall be established.

Article 42

The United Nations, its bodies, including the Permanent Forum on Indigenous Issues, and specialized agencies, including at the country level, and States shall promote respect for and full application of the provisions of this Declaration and follow up the effectiveness of this Declaration.

Article 43

The rights recognized herein constitute the minimum standards for the survival, dignity and well-being of the indigenous peoples of the world.

Article 44

All the rights and freedoms recognized herein are equally guaranteed to male and female indigenous individuals.

Article 45

Nothing in this Declaration may be construed as diminishing or extinguishing the rights indigenous peoples have now or may acquire in the future.

Article 46

1. Nothing in this Declaration may be interpreted as implying for any State, people, group or person any right to engage in any activity or to perform any act contrary to the Charter of the United Nations or construed as authorizing or encouraging any action which would dismember or impair, totally or in part, the territorial integrity or political unity of sovereign and independent States.

2. In the exercise of the rights enunciated in the present Declaration, human rights and fundamental freedoms of all shall be respected. The exercise of the rights set forth in this Declaration shall be subject only to such limitations as are determined by law and in accordance with international human rights obligations. Any such limitations shall be non-discriminatory and strictly necessary solely for the purpose of securing due recognition and respect for the rights and freedoms of others and for meeting the just and most compelling requirements of a democratic society.

3. The provisions set forth in this Declaration shall be interpreted in accordance with the principles of justice, democracy, respect for human rights, equality, non-discrimination, good governance and good faith.

(2) See resolution 2200 A (XXI), annex.

(3) A/CONF.157/24 (Part I), chap. III.

(4) Resolution 217 A (III).

Appendix Two: Copy of the Ministry of Health’s organisational structure (locating Te Kete Hauora)

Ministry of Health Organisation Chart

