

Hauora Kotahitanga

Maori health experiences as models for co-operative co-existence between indigenous and non-indigenous peoples

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ABSTRACT

The complexities for Maori in creating health and disability organisations based on their traditional knowledge and practices, when the institutions and systems they are dealing with for health developments are non-Maori, are part of the broader phenomenon of contemporary indigenous knowledge based developments. This thesis examines the relationships forming between the worlds of Maori and non-Maori peoples through hauora Maori. The purpose of this study is to examine Maori experiences of the development and delivery of indigenous knowledge based hauora Maori models, and to consider these experiences conceptually as models for kotahitanga (co-operative co-existence) between indigenous and non-indigenous peoples.

The five hauora Maori organisations studied were created during the 1990s to implement matakura (Maori knowledge) through tikanga (Maori methodologies), and were inclusive of non-Maori, both as service providers and service receivers. The experiences of the five case study organisations are considered within the historical, political, policy and health sectoral contexts that influence Maori health development.

The research methods are grounded in matakura Maori through an approach called *Kareretanga*, developed for this study and based on traditional forms of knowledge gathering and dissemination. *Kareretanga* characterises and frames the experiences of hauora Maori practitioners, Maori and non-Maori, in developing and delivering hauora Maori. The matakura of Maori scholars guides the study methodology which focuses on three debates from the indigenous health development literature: indigeneity; constructive engagement between indigenous and non-indigenous peoples; and, matakura for health developments.

The findings illustrate multiple hauora Maori initiatives for community development that are conceptualised as models for kotahitanga between indigenous and non-indigenous peoples. The experiences of the hauora Maori organisations studied have been conceptualised in this study as multiple examples of kotahitanga between Maori and non-Maori peoples; based on living together differently through indigeneity-based hauora Maori organisations. The research concluded that ensuring the inclusion of indigenous knowledge in contemporary health developments not only underpins indigenous

sustainability and resilience, it also provides indigenous peoples with a platform to participate in national and global developments in ways that can build the sustainability and resilience of indigenous and non-indigenous peoples together.

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NOTE: This thesis does not use macrons on Maori words to be respectful of the iwi and case study organisations studied who, at the time of the study, did not use macrons in their communications, documentation, websites, models (see Appendices for examples of case study organisation documents prepared for external audiences).

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GLOSSARY

Aotearoa	A Maori name for New Zealand
Aroha	Compassion, empathy, joy
Awhi	Support, assist, help
Atua/atua	God/gods
Hapu	sub- tribe; pregnancy
Hauora	Health, wellbeing, spirit of life
Hinengaro	Mental well being
Hui	Meeting, gathering
Iwi	Nation, tribe, peoples
Kaiarahi	Leader (at Te Roopu Taurima)
Kaiawhina	Community support workers
Kaimahi	Worker, staff member
Kaitautoko	Supporter, advocate
Kaitiaki	Leader, guardian
Kaiwhakahaere	Service coordinator (at Te Roopu Taurima)
Kapa haka	Ritual Song and dance associated with Maori identity
Karakia	Prayer, invocations, religious blessing
Karere	Person that is a Talking newspaper
Kaumatua	Elders (male or female)
Kaunihera	Council
Kaupapa	Sacred principle, agenda, purpose
Kaupapa Maori	Maori standards, philosophy
Kawa	Marae protocol; protocols
Kawanatanga	Governance
Kete	Basket
Koha	Gift, donation
Kohanga Reo	Maori language pre-school
Korero	Discussion, talk
Korowai	Cloak
Kotahitanga	For this study: co-operative co-existence based on living together differently
Kowhaiwhai	Painted scroll ornamentation

Kuia	Elder (female)
Mahi	Work
Mana kotahitanga	Strength in numbers
Mana whakahaere	Chief executive officer
Mana	The spiritual power that creates, produces and restores tapu; it is also authority, prestige, honour bestowed by atua of people
Mana whenua	Customary authority of and over land
Manaaki	Show respect or kindness to, care for, look out for
Manaakitanga	Taking responsibility for the care of others
Manuhiri	Visitors, guests
Maoritanga	Maori culture, practices and beliefs
Marae	Traditional Maori meeting place
Maru	Under the protection of
Matauranga Maori	Maori cultural knowledge
Maunga	Mountain
Mauri	Essence of life
Mihi	Speech, greeting
Moana	Sea
Mohio	Know, understand, realise
Mohiotanga	Knowing, understanding, comprehension
Mokopuna	Grandchild, younger generation, descendant, (also used by Te Roopu Taurima for patient)
Motu	Country, Land, island
Multi-tribal	Multiple tribes operating as a loose collective
Pakeha	Non-Maori New Zealanders
Pan-tribal	Multiple tribes operating as a cohesive collective
Paremata Maori	Maori Parliament
Pono	Integrity of relationships.
Powhiri	Welcome, greeting
Pumau	Fixed, constant, permanent
Rangatahi	Youth
Rangatira	Chief/Leader, revered
Rangatira Hauora	Chief/Leader of wellbeing, Chief /Leader of health
Rangatiratanga	Chieftainship, own authority
Ratonga	Service

Reo	Language, speech
Rohe	Region, tribal district
Rongoa Maori	Maori medicines
Roopu	Group, party of people
Runanga	Council
Runanga a iwi	Tribal council
Taha Maori	Dimensions of Maori
Taha wairua	Spirituality
Take	Issue, claim
Tangata	Man, human being
Tangata whenua	Person or peoples of a given place
Tangihanga	Funeral rituals
Taniko	Weaving
Taonga	Precious belongings; tangible and intangible
Tapu	Sacredness (intrinsic, and relational).
Tauira Poutama	Te Roopu Taurima name for Workers Handbook
Tauiwi	Non-Maori
Taurahere	Maori living in the area who do not whakapapa to local iwi
Tautoko	Support, agree
Te ao	World, dimension
Te ao Maori	Maori world, dimension
Te ao Turoa	Environment
Te Oranga Pumau	Te Roopu Taurima name for Mokopuna Care Plan
Te Reo	The language
Tika	Tika can be defined as the principle concerned with the right ordering of relationships, among atua, tangata and whenua, the right response to those relationships and the right exercise of mana.
Tikanga	Customary rights, duties, principles, customs, procedures
Tikanga Maori	Maori methodologies
Tinana	Physical wellbeing
Tino rangatiratanga	Unqualified chieftainship, paramount authority
Tohunga	Expert; Maori healer
Tukutuku	Traditional decorative panels
Tumanako	Hope
Tumuaki	Head, principle

Tupuna, tipuna	Ancestor
Turangawaewae	Standing place, one's land
Waiata	Song, chant
Wairua	Spiritual essence, spiritual wellbeing
Wairuatanga	Spiritual realm
Waka	Canoe
Wananga	Place of learning
Whaanau ora/whanau ora	Family wellbeing
Whaanau/whanau	Family
Whaea	Female elder
Whakahaere	Someone who leads
Whakairo	To carve
Whakapapa	Genealogical links
Whakapono	Belief, faith
Whakatau	Process of being a part of
Whakatauki	Proverb
Whanau	Family
Whanaungatanga (PaTate)	Whanaungatanga encapsulates the tikanga of tapu, mana, and their expression through the principles of tika, pono and aroha. Tapu can be broken down into three perspectives. Firstly there is the intrinsic tapu or sacredness of being. Secondly there is the tapu/sacredness of relationships between atua, tangata and whenua. Thirdly there are tapu or sacredness as relating to tapu/restrictions. Mana is the spiritual power that creates, produces and restores tapu. Tika can be defined as the principle concerned with the right ordering of relationships, among atua, tangata and whenua, the right response to those relationships and the right exercise of mana. Pono is the principle that seeks to reveal reality and to achieve integrity of relationships. Aroha is the principle of expressing empathy, compassion and joy for others in all that we do. Tika, pono and aroha are the principles of action by which we exercise tapu and mana. If one wants to have mana, one must first seek after tapu. To possess tapu one must exercise tika, pono, aroha. (Tate, 1999). Whanaungatanga for this study is an articulation of the ordering of relationships between tangata, whenua, and atua: peoples, lands and gods. Matauranga that becomes tikanga to a person through the teachings of the whanau, hapu, iwi and other Maori scholars can therefore be regarded as one articulation of whanaungatanga
Whangai	Bring up, an adopted person

Whare	Home, house
Whenua	Land, placenta
ACCESS PHO	Higher level of funding than INTERIM PHO
CHE	Crown Health Enterprise
CPMIP	Criminal Procedure Mentally Impaired Persons Act 2003
DHB	District Health Board
general practitioner	general practitioner
HFA	Health Funding Authority
HHS	Hospital and Health Service
IDCC&R Act	Intellectual Disability Compulsory Care and Rehabilitation Act 2003
IPA	Independent Practitioner Association
MAPO	Maori Authority Purchasing Organisation
NGO	Non-government organisation
RHA	Regional Health Authority
RIDCA	Regional Intellectual Disability Care Agency
RIDSAS	Residential Intellectual Disability Secure Accommodation Service
TRI-MAPO	Collective name for the three MAPO created under the North Health MAPO strategy 1995

Chapter One

INTRODUCTION

1.1 Introduction to this thesis

The purpose of this study is to examine Maori experiences of the development and delivery of indigenous knowledge based Maori health (hauora) models, and to consider the experiences and the hauora models conceptually as models for co-operative co-existence (kotahitanga) between indigenous and non-indigenous peoples.

The world of Maori 'te ao Maori' inhabits a space that includes the worlds of other peoples. The inevitable tensions that arise when two or more peoples inhabit the same space are multi-faceted and require multiple strategies for resolution. Indigeneity has been conceptualised within this study as a way through which to explore the co-operative co-existence between 'te ao Maori', and the worlds of non-Maori. The complexity of the relationships required to integrate the worldviews of two or more peoples into one societal format is being played out uniquely in communities throughout the world. This thesis examines the relationships forming between the worlds of Maori and non-Maori peoples through Hauora Maori models. The Hauora Maori models were created by the case study organisations to implement matauranga (Maori knowledge) through tikanga (Maori methodologies). The Maori who created the Hauora Maori models in this study created organisations and services that were inclusive of non-Maori, both as service providers and service receivers.

The methodology and methods of this study are grounded in te ao Maori. In the methodology chapter, the matauranga of three Maori scholars, Durie, Maaka and Marsden, are re-interpreted to guide an indigeneity-based approach to undertaking this research. The three indigenous health development debates this study addresses are indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and matauranga indigenous knowledge for health development.

The study is based on case studies of five Maori health and disability organisations – hauora Maori organisations. Three are Maori health providers, one is a Maori residential service provider for intellectually disabled people, and one is a Maori health and disability service purchasing organisation. All five organisations were chosen because they are in the tribal region of Ngati Whatua, to which the researcher has a whakapapa

relationship. The rationale for the choice of the study organisations and tribal region is explained more fully at 3.5, but briefly it was to ensure my personal alignment with the kaupapa of my iwi and tupuna.

The experiences of the hauora Maori organisations studied have been conceptualised in this study as multiple examples of community co-operative co-existence. They are experiences of kotahitanga between Maori and non-Maori peoples based on living together differently through indigeneity-based hauora Maori.

The chapter begins by outlining the research questions and the research methods. The researcher's positionality is discussed, and debates from the health development literature that underpin this study are identified. *Kareretanga*, the research approach based on traditional forms of knowledge gathering and dissemination developed for this study is then introduced. The thesis parameters and thesis contribution are discussed, and the chapter concludes with an outline of the thesis and chapters.

1.2 Research Question

The main research question is:

How can Maori experiences of developing and delivering hauora models be conceptualised as models for kotahitanga between indigenous and non-indigenous peoples?

Other research questions are:

- What, broadly, were Maori experiences of health developments between 1840 and 1990?
- What were the experiences of Maori in developing and delivering publicly funded health models (hauora models) from the 1990s?
- What matakā (Maori knowledge) were used to develop hauora models from the 1990s?
- What tikanga (Maori methodologies) were used to deliver hauora models from the 1990s?

- Why did Maori take an indigeneity approach to constructive engagements with non-Maori to develop and deliver publicly funded Maori health models from the 1990s?

1.3 Introduction to research methods

My positionality as the researcher for this study begins with my Ngati Whatua whakapapa, which explains my relationship to the Ngati Whatua lands in which this study takes place, and it also explains my personal place as a Maori within te ao Maori, but also as a non-Maori within te ao non-Maori. My positionality as the researcher is discussed more substantively at 3.3.1 and 3.5. This study focuses on the intersection between these two worlds, so my situation as a person who has been raised by families from both worlds, created a personal positionality for myself within this study of seeking to understand kotahitanga between indigenous and non-indigenous peoples and worlds.

Chapter 2, Literature and Maturanga Maori, explores contemporary issues and debates in the indigenous health development literature, and in particular the proposal that constructive engagements between indigenous and non-indigenous peoples should be indigeneity-based. It also explores how engagements might be considered ‘constructive’. A key debate in the health development literature explored in this chapter is how indigenous knowledge and practices are being, or should be, included in health developments.

Guided by the ideas of Durie (2005) and Maaka & Fleras (2005), indigeneity for this study is explained in the methodology as the indigenous knowledge systems that are considered to be where maturanga Maori knowledge intersects with non-Maori communities through tikanga Maori methodologies. For this study, indigeneity is conceptualised as tikanga Maori methodologies (as an indigenous knowledge system for health developments).

Guided by Maaka & Fleras (2005) ideas, constructive engagement for this study is explained in the methodology chapter as being where indigenous peoples constructively engage with non-indigenous peoples using hauora Maori (which are organisations and services based on maturanga and tikanga Maori). Hauora Maori then becomes a constructive engagement that results in kotahitanga between Maori and non-Maori

peoples. For this study, constructive engagement is conceptualised as indigenous and non-indigenous peoples living together differently through Hauora Maori.

Guided by Marsden's (2003) ideas, matakura for this study is explained as the Maori knowledge that has been combined with hauora Maori to create the tikanga Maori methodologies for health development. Marsden's teachings on how matakura becomes mohio (known) by the people who are imbued with the matakura, is used to identify the matakura that are being delivered through the hauora Maori tikanga. Tikanga, in this study, were delivered by Maori and non-Maori practitioners of hauora Maori. The ability of these hauora Maori practitioners to apply the organisational matakura was dependent upon their mohiotanga of the matakura of the organisational tikanga. This study was designed to understand what matakura were active in the organisation through observation of hauora Maori Practitioners, rather than looking solely at what organisations were documenting as their preferred matakura. For this study, matakura is conceptualised as matakura for health development.

To summarise, a re-interpretation of Marsden's idea of mohiotanga identifies **what** matakura was used to create the service delivery models of the five hauora Maori organisations. A re-interpretation of Durie's idea of indigeneity identifies **how** indigeneity was practiced by the hauora Maori organisations through their tikanga Maori methodologies in their service delivery models. A re-interpretation of Maaka's ideas of indigeneity-based constructive engagement identifies **why** the constructive engagements that resulted in each organisations unique service delivery model might be considered as models for kotahitanga between indigenous and non-indigenous peoples.

An indigenised research method has been developed for this study called *Kareretanga*. This seeks to understand and explain how people create and deliver communications that assist their audience to understand complex Maori knowledge and practices that are being delivered or received by Maori and non-Maori. *Kareretanga* is an articulation of a long tradition of relationality between whanau, hapu and iwi in te ao Maori with te ao non-Maori. The research approach is influenced by the ideas and teachings of the Maori scholar Pa Henare Tate (1999) on whanaungatanga, which have also influenced four of the case study organisations. Whanaungatanga, as taught by Pa Tate (1999) encapsulates the tikanga of tapu, mana, and their expression through the principles of tika, pono and aroha. Tapu, he explained, can be broken down into three perspectives. Firstly there is

the intrinsic tapu or sacredness of being. Secondly there is the tapu/sacredness of relationships between atua, tangata and whenua. Thirdly there are tapu or sacredness as relating to tapu/restrictions. Mana is the spiritual power that creates, produces and restores tapu. Tika can be defined as the principle concerned with the right ordering of relationships, among atua, tangata and whenua, the right response to those relationships and the right exercise of mana. Pono is the principle that seeks to reveal reality and to achieve integrity of relationships. Aroha is the principle of expressing empathy, compassion and joy for others in all that we do. Tika, pono and aroha are the principles of action by which we exercise tapu and mana. If one wants to have mana, Pa Tate (1999) teaches, one must first seek after tapu. To possess tapu one must exercise tika, pono, aroha (Tate, 1999).

Whanaungatanga for this study is an articulation of the ordering of relationships between tangata, whenua, and atua: peoples, lands and gods. Matauranga that becomes tikanga to a person through the teachings of the whanau, hapu, iwi and other Maori scholars can therefore be regarded as one articulation of whanaungatanga. Whanaungatanga for this study frames explanations of the relationships with whanau, hapu and iwi for the research process, whilst *Kareretanga* is applied to provide an analytical tool for explaining the relationships and the implications of the relationships that were studied.

1.4 Thesis Parameters

The study was influenced by a wide range of literature including indigenous development, indigenous health, indigenous knowledge, indigenous politics, indigenous health policy, indigeneity, indigenism, Maori development, Maori health, Maori knowledge, Maori politics, Maori health policy, rongoa Maori, Maori history, traditional healing, human rights, identity, and citizenship, through to materials from the fields of community health, primary health, mental health, health purchasing, intellectual disability, health politics and policy, politics and policy, and health law.

The research studies Maori experiences of their health developments; it does not examine the experiences of the public sector, the health sector, or the Crown, state and governments, except where those experiences augment explanations of the Maori experiences studied. The thesis explores health models created by Maori to deliver publicly funded health services in the community; it does not examine Maori publicly

funded health services attached to hospitals. The Maori models examined were limited to those developed and delivered by Maori organisations whose governance structures consisted of more than 50% Maori, and whose kaupapa was inclusive of non-Maori staff and patients.

In line with the whakapapa connections to the people and organisations collaborating with the research, the ethics proposed for the study were discussed with kaumatua and kuia of the iwi and case study organisations, thesis supervisors, and University of Auckland ethics advisors. Discussions with University of Auckland ethics advisors continued during the research process. At the beginning of the study Professor Sir Hugh Kawharu, as one of my supervisor, advised that because of the whakapapa relationships I had with the people and organisations concerned, ethics approval through a kaupapa Maori process rather than a formalised University process would be more robust. This was also the position of the University of Auckland ethics committee. The whanaungatanga approach explained in Chapter 3 was the result of these ethics considerations by the roopu of the study.

1.5 Thesis Contribution

This inquiry, whilst it rests within the context of Maori health developments in New Zealand, is explored within the context of indigenous health development research globally. Gaps in the literature that are a result of the disenfranchisement of indigenous knowledge in health research have been highlighted by Maori academics in respect to Maori experiences (Cunningham & Stanley, 2003; Durie, 2005). The drive by indigenous peoples for inclusion of their traditional knowledge and practices within political, policy, and academic developments dominates the contemporary literature on indigenous development (Maaka & Fleras, 2005, 2006; Marsden, 2003; Smith, 1999; Viergever, 1999; Walker, 2004), as well as the literature on indigenous health developments (Cunningham & Stanley, 2003; Reading, et al., 2003).

This thesis is a contribution to indigenous health developments and literature, and in particular provides indigenous (Maori) knowledge for, and of, indigeneity (Maori) based health developments. The study explores the ideas of Maori scholars such as Marsden, Durie, and Maaka, in the context of the experiences of Maori peoples, who in crafting their unique health models to implement their traditional health knowledge and practices,

worked with and for non-indigenous peoples. The contribution of this thesis to indigenous and non-indigenous scholars, students, health practitioners, political and policy practitioners, and health consumers, is to provide a window into Maori experiences of their involvement in health developments. These experiences are presented in te reo Pakeha and contextualised within the political and policy dynamic of New Zealand health developments so that they are accessible to non-Maori audiences. These experiences are grounded in mātāuranga Māori, both in the way they are studied and the way they are explained, so that they provide one Maori worldview of the developments that occurred and what might be learned from them.

It is common for research and literature on Maori health to focus on the experiences of Maori and/or the benefits to Maori. This research includes a focus on experiences of both Maori and non-Maori within Maori organisations, and the benefits for both Maori and non-Maori of these Maori organisations practices of delivering not just to Maori, but to all New Zealanders. In effect it focuses not on organisations involved in ‘by Maori for Maori’ service delivery, but on those that are delivering ‘by Maori for all’ services. This thesis is also a contribution to the literature on what health and wellbeing initiatives Maori in New Zealand have created to be of benefit to, and for the benefit of, non-Maori New Zealanders.

1.6 Thesis Outline

The thesis is in four parts. The first part examines contemporary issues and debates in the indigenous health development, and the Maori health development literature, in Chapter 2. Chapter 3 then combines this knowledge with the expert knowledge of three Maori scholars in mātāuranga, indigeneity, and constructive engagements, to create a mātāuranga Māori grounded inquiry framework for this research. Part one consists of Chapters 1, 2 and 3.

The second part begins at Chapter 4 with an historical review of Maori experiences of health developments between 1840 and 1990. Maori believe we walk backwards into the future taking the knowledge of our tupuna with us, so it is important to begin this study by acknowledging our tupuna and their achievements, and to be guided by their experiences. The purpose of this historical review is to find kotahitanga themes, or themes that typify the constructive engagements that occurred between Maori and non-

Maori for health developments in this early colonisation period. These historical themes are then used as guides for the information and knowledge collection and consideration in the Maori health organisation case studies. Chapter 5 takes a detailed look at the politics of an indigeneity-based approach to Maori health developments between 1980 and 2008. The purpose of this chapter is to provide a context for the politicisation of Maori identity within Maori health developments in this period. This context is essential background information for understanding the experiences of the case study Maori health organisations in Chapters 7 and 8. Chapter 6 is an indigeneity-based policy analysis of the mātāuranga found in Crown health policies in the period in which the Maori health case study organisations were proposed, created and implemented; the 1980s to 2003. Part two consists of Chapters 4, 5 & 6.

The third part consists of the case studies at Chapters 7 and 8. Chapter 7 is a case study of the Ngāti Whatua Maori health purchasing organisation, and begins with an introduction to the Ngāti Whatua iwi. It then explains the operationalisation of the MAPO constructive engagements, initially with the Crown (the MAPO strategy), next with the Northern Regional Health Authority (the MAPO organisation), and finally with the Crown (the Kotahitanga Proposal). Chapter 8 is the case studies of the four provider organisations; two mana whenua and two non-mana whenua and explains how the organisations were created, some of the challenges they faced, and some of the constructive engagements that were central to their mātāuranga based, or indigeneity-based, relationships with Maori and non-Maori peoples of their communities. The conceptualisation of organisational and community kotahitanga models from the knowledge and information considered in Chapters 7 and 8 is in Chapter 9.

The fourth part of this thesis consists of two chapters; Chapter 10 is a general discussion of the study. It draws together the knowledge explored throughout the study of Maori experiences of the development and delivery of hauora Maori models, and considers them as conceptual models for co-operative co-existence between indigenous and non-indigenous peoples. The knowledge and experiences from the study of development and delivery of hauora Maori models are considered as conceptual models for co-operative co-existence at the organisational level. These are summarised as the hauora kotahitanga micro-models of the study; hauora kotahitanga – organisational. The knowledge and experiences from the study of development and delivery of hauora Maori models are then

considered as conceptual models for ‘co-operative co-existence at the community level, and summarised as the hauora kotahitanga meso-models; hauora kotahitanga - community. The tupuna themes that are conceptualised in Chapter 2 are combined with the findings from Chapters 7, 8 and 9 to conceptualise models for co-operative co-existence based on hauora Maori experiences across the Ngati Whatua Tihi Ora region. These are conceptualised as models for kotahitanga at the regional level. These are summarised as macro-level hauora kotahitanga models; hauora kotahitanga – tribal and tupuna.

Chapter 11 concludes the study by pulling the threads of the key debates from the indigenous health development literature that were addressed in this study together: indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and indigenous knowledge for health development. It discusses some of the international implications of the research, and some future aspirations for continued discussions on the experiences and findings from this study.

Chapter Two

LITERATURE & MATAURANGA MAORI

“The concept “indigenous peoples”, developed principally within Western traditions of scholarship and legal reform, has nurtured the revival of “traditional” identities ... It has been taken control of by its living subjects – reverse engineered, rearticulated, and put to use as a tool of liberation” (Niezen, 2003)

2.1 Introduction

This chapter explores contemporary issues and debates in the indigenous health development literature, and in particular the proposal that constructive engagements between indigenous and non-indigenous peoples should be indigeneity-based. It also explores how engagements might be considered ‘constructive’. A key debate in the health development literature explored in this chapter is how indigenous knowledge and practices are being, or should be, included in health developments.

In the first part of this chapter, three debates that influence indigenous and Maori health developments are explored: indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and indigenous knowledge for health development. In the final part of this chapter, these three debates are considered through the matauranga of three Maori scholars. Durie’s and Maaka’s matauranga for indigeneity and Marsden’s for matauranga and mohiotanga are considered. The matauranga of Maaka is considered, through the Maaka and Fleras (2005) proposal, for constructive engagement between indigenous and non-indigenous peoples towards co-operative co-existence based on living together differently. The matauranga of these three Maori scholars are introduced in this chapter as starting points for this study’s research proposal, and are used to guide the construction of the research methods in the next chapter.

2.2 Indigeneity

There is evidence that shows indigenous peoples have worse health indicators and inequalities in health compared with non-indigenous populations (Stephens, et al., 2006). A challenge for countries with indigenous populations is how to get indigenous health up to the same level of health as other peoples in their country, using publicly funded services. The equity argument is premised on the need for health systems to apply extra resources to bring indigenous peoples up to the same level of health status as other citizenry, as opposed to the equality argument which is that indigenous peoples are afforded the same opportunity to access public health services as other citizenry with no extra resources (Signal, et al., 2007). A lack of equity for indigenous peoples in health resources is being challenged on the basis that it denies their human rights, indigenous

rights, and rights to participate within societal developments (Smylie, Anderson, Ratima, Crengle, & Anderson, 2006). However, for some countries, there is a problem with recognising populations as 'indigenous' for health developments, based on concerns that recognition of 'indigenous' health rights could lead to further demands for more extensive 'indigenous' rights (Ohenjo, et al., 2006).

The term 'indigenous' has been used globally since at least 1903 (Hall, 1903), but has become more common since the 1980s as part of human rights debates (Niezen, 2003). Contemporaneously, the term 'indigenous' has taken on a more globalised meaning with debates on the framing of a definition for 'indigenous people or peoples' reaching a crescendo during the establishment of the United Nations Permanent Forum on Indigenous Issues in 2000 (Niezen, 2006). The United Nations definition eventually agreed to was "indigenous peoples" rather than indigenous people and the full definition is as follows:

Indigenous peoples are the inheritors and practitioners of unique cultures and ways of relating to other people and to the environment. Indigenous peoples have retained social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live. Despite their cultural differences, the various groups of indigenous peoples around the world share common problems related to the protection of their rights as distinct peoples (United Nations, 2007).

On 13 September 2007, the General Assembly of the United Nations adopted the Declaration on the Rights of Indigenous Peoples. There are a number of clauses which are specific to indigenous rights to health developments. Article 21 explains the right to improvement of health; Article 23 explains the right to develop, determine and administer health programmes through their own institutions; Article 24 explains the right to traditional medicines and health practices, and access without discrimination to all health and social services, and to the highest attainable standard of health; and, Article 29 explains the right to protection of environment, and for maintaining and restoring the health of indigenous peoples (United Nations, 2007).

The UN Declaration in 2007 established globally acknowledged rights for indigenous peoples that included rights to health and wellbeing. Maori have been recognised as the indigenous peoples of New Zealand by Crown, state, political, and health systems since 1852, when separate health policies and funding for 'the natives', as Maori were then

called, were established.¹ Maori means ‘ordinary’ in the language of the indigenous peoples of New Zealand, as they did not have a collective term for themselves (Cunningham & Stanley, 2003). The indigenous peoples of New Zealand, America, Canada and Australia all define themselves traditionally through their family and tribal, or group, affiliations rather than having one particular identifying term; they are peoples, rather than a people (Niezen, 2006). New Zealand signed the United Nations Declaration for the Rights of Indigenous Peoples in 2010.

How indigeneity has been defined in health research is of particular interest in this study. Indigeneity has been defined in indigenous health research as “a complex socialpolitical form of identity, which might or might not be recognised” (Montenegro & Stephens, 2006, p. 1859). It is also defined as how indigenous peoples assert indigenous identity for the purposes of sustainability and survival (Bartlett, 2007). In a study to identify indigenous peoples for health research, the conclusion was that the identification of indigenous peoples should be left to the indigenous peoples themselves (Bartlett, 2007); however, the following definition from Cobo was recommended by the World Health Organisation:

Indigenous communities, Peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories or parts of them (Cobo, 2001).²

How indigenous peoples are identified in research has become intrinsically linked with issues concerning the politicisation of indigenous identity, often referred to as the politics of indigeneity (Maaka & Fleras, 2005), and also referred to as indigenism (Niezen, 2003). Indigeneity is underpinned by the historical exclusion of indigenous peoples from participating in the constitutional or political processes in the lands in which they live, but it is also underpinned by indigenous peoples’ efforts to constructively engage with and within the political systems, even in situations where their “neighbours” are often also their “oppressors” (Daes, 1993). Therefore, indigeneity may also be understood as being an expression of both indigenous resistance and transformation (O’Sullivan, 2007).

¹ For more detail on this period, refer to Chapter 4.

² Note that Daes has used an earlier Cobo definition for indigenous in her 1993 paper. She referred to Jose R. Martinez Cobo Final Report: Study on the problem of discrimination against indigenous populations, vol V, at 29, U.N. Doc. E/CN.4/Sub.2, U.N. Sales no. E86.XIV.3 (1986).

The complexities of indigeneity-based constructive engagements for indigenous health developments are one of the key debates in contemporary indigenous health development literature. Indigenous identity is intrinsically linked to the ability of indigenous peoples to practice their traditional knowledge, and to live by their own worldviews (Durie, 2005). A key goal of indigenous peoples for their development is to be self-determining (Maaka & Fleras, 2005). Indigeneity may be conceptualised in a number of different ways, but the two concepts that underpin this thesis research are those of Maaka and Fleras, and Durie. Maaka and Fleras (2005) propose indigeneity as a principle and practice for indigenous and Crown constructive engagements, and Durie proposes indigeneity as “a system of knowledge based on a state of fusion between indigenous peoples and their accustomed environments” (p. 137). When indigenous peoples engage with non-indigenous peoples on issues of indigenous identity, those engagements would be regarded as constructive if their indigenous identity, their traditional knowledge, and their worldviews were the basis of the engagements (Durie, 2005; Maaka & Fleras, 2005).

2.3 Constructive engagement for co-operative co-existence between indigenous and non-indigenous peoples based on living together differently

The complexities for indigenous communities of creating indigenous knowledge-based developments through engagements with institutions, systems and structures that are often held responsible for indigenous disenfranchisement is problematic (Daes, 1993; Stavenhagen, 2007). These complexities are being canvassed in the indigenous health development literature and have resulted in calls for countries to become more constructive in their engagements with indigenous peoples. Research has provided evidence of inadequate government responses to indigenous health issues (Anderson, et al., 2006; Ring & Brown, 2003; Montenegro & Stephens, 2006), as well as evidence that indigenous populations who have their health resources partially or totally controlled by governments in which they do not have a controlling interest, have poorer health status and outcomes than all other peoples in their regions (Anderson, et al., 2006; Montenegro & Stephens, 2006; Smylie, et al., 2006). An engagement would therefore be regarded as constructive between a government and indigenous peoples where the indigenous

peoples had some controlling interest in health resources (Anderson, et al., 2006; Montenegro & Stephens, 2006; Smylie, et al., 2006; Stephens, et al., 2006).

The United Nations Permanent Forum on Indigenous Issues has under its history section on its website, an introduction titled ‘a brief history of indigenous peoples and the international systems’ (United Nations, 2006). This introduction talks about two indigenous leaders who undertook to represent indigenous issues to the League of Nations in the 1920s; Haudenosaunee Chief Deskaheh in 1923/24, and the Maori leader T Wiremu Ratana in 1925 (United Nations, 2006). Both were denied speaking rights, but are nonetheless regarded as the original pioneers for indigenous issues to be part of the international systems at the United Nations.

The Maori leader Ratana, who visited the League of Nations, was also a traditional Maori healer. Therefore, evidence exists that a Maori health leader was seeking to bring indigenous issues to an international forum as early as 1925, over eighty years before the United Nations Declaration on the Rights of Indigenous Peoples. Ratana established a Maori-managed hospital in New Zealand, which was staffed by state-trained Maori nurses in the 1920s. Ratana’s role in Maori health leadership is further discussed in chapter 4, suffice to say here that he drew together the elements of Maori knowledge systems, successfully fused them with state health development initiatives such as state-nursing training, and then attempted to draw this Maori knowledge and experience onto the global platform for indigenous rights, which in 1925 was represented by the League of Nations.

To bring this study into the contemporary academic context, the indigenous knowledge of Maori scholar Roger Maaka, who has with Fleras examined indigeneity-based constructive engagements between indigenous peoples in Canada and New Zealand, with the Crown, is considered. ‘The Politics of Indigeneity’ (Maaka & Fleras, 2005) builds on their earlier scholarship for indigenous and non-indigenous constructive engagements (Maaka & Fleras, 1997, 2000; Fleras, 2000), and proposes a blueprint for future constructive engagements that places “indigeneity as principle and practice as a basis for living together differently” (2005, p. 284).

Their constitutional blueprint is proposed as a way of breaking the constitutional impasse that exists between indigenous Maori and the Crown, and uses indigeneity as a model for

exploring the notion of a constitutional space in which both peoples can live together differently (Maaka & Fleras 2005, p. 207). Their ideas are based on examining current models of co-operative co-existence between Maori and the Crown. One of their examples is the Waitangi Tribunal, which is a model for negotiating a balanced approach to Treaty of Waitangi grievances between the Crown and Maori. Maaka and Fleras (2005) see the challenges of future Maori development as underpinned by the unique nature of their Treaty of Waitangi with the Crown. The Crown has dominated the creation and implementation of the knowledge systems with which this relationship is maintained, namely through governance and judicial structures. This has resulted in only limited recognition of Maori knowledge systems in law and policy. However, Maaka and Fleras (2005) do see the potential for a 'constructive engagement' between Maori and the Crown to occur, based on positive relations that have occurred in the contemporary period of Treaty settlements, and in particular through the Waitangi Tribunal.

The Waitangi Tribunal was established within New Zealand political, legislative and social systems which are based on British Crown colonial rule. While Maaka and Fleras (2005) see the Tribunal as providing a unique model for constructive engagement between Maori and the Crown, Alfred (2006), an indigenous academic from Canada, questions the viability of Crown based colonial systems for addressing indigenous issues. Alfred (2006) considers the tensions that occur between indigenous peoples and British Crown colonial rule where that rule is based on adversarial, state-controlling, mechanisms of society. Alfred (2006) contends the indigenous peoples in Canada have a history of consensus based, rather than adversarial based social order, and such different positions of social order mean there is an inherent tension underpinning engagements between the two. The British Crown political and social frameworks since 1840 in New Zealand have consistently retained the adversarial, state-controlled mechanisms which the British Crown has collectively imposed across their colonial dominions, as is discussed in the Canadian context by Alfred (2006) and in the New Zealand context by Walker (2004), Cox (1993), and Hill (2004). The electoral system in 21st century New Zealand is still adversarial, as is the judicial system, and the parliamentary system.³

³See Miller, R. (1997, 2003, 2010)

When Maori signed a Treaty with the British Crown at Waitangi in 1840, there was no reference to the potential for adversarial systems to be introduced and or imposed. Te Tiriti o Waitangi, the Maori language version of the Treaty, was a blueprint for a consensus based approach to societal development in which the worldview of each peoples would not dominate or impose on the other; and where Maori were given primacy within their environments to pursue self-determination.⁴ However, what occurred was the wholesale imposition of British Crown socio-political practices onto New Zealand society from 1840 onwards and this has resulted in multiple Maori grievances which have been considered for re-dress through the Waitangi Tribunal since 1975. However, in the early 20th century, there was one example of Maori and the New Zealand government constructively engaging to create models for co-operative co-existence based on living together differently. An Act of parliament in 1900 briefly facilitated limited self-government to Maori for community health developments. Chapter 4 explores some historical Maori constructive engagements with non-Maori for health developments, including this example.

Indigenous autonomy is regarded as key to indigenous development (Niezen, 2003; Stavenhagen, 2007), as is upholding indigenous peoples rights to be autonomous in the definition and control of their health developments (Montenegro & Stephens, 2006; Stavenhagen, 2007; Stephens, et al., 2006; United Nations, 2007). Indigenous autonomy in the definition and control of their health developments would be a ‘constructive’ engagement. The ability for indigenous peoples to apply their traditional knowledge in health developments would also qualify as ‘constructive’ engagement because the indigenous worldviews then become an underpinning facet of future developments, something that is a reality some countries in the Latin American and Caribbean region where some indigenous peoples have had their indigenous health knowledge protected constitutionally (Montenegro & Stephens, 2006).

Constructive engagements for indigenous health developments may be defined as where indigenous-owned health processes and systems are made possible by the Crown or state (Montenegro & Stephens, 2006; Ohenjo, et al., 2006; Smylie, et al., 2006; Stephens, et al., 2006). Constructive engagements for indigenous health developments are explained in the indigenous health development literature as the inclusion by governments and

⁴ For more information on the Treaty of Waitangi see Kawharu (1989,1992), Belgrave (2005), Walker (2004)

policy makers of indigenous knowledge systems, processes, worldviews, and methodologies within health developments (Anderson, et al., 2006; Bhopal, 2006; Cunningham & Stanley, 2003; Durie, 2003; Montenegro & Stephens, 2006; Ohenjo, et al., 2006; Ring & Brown, 2003).

2.4 Indigenous Knowledge

A key indigenous health development debate is how indigenous communities themselves might ensure the efficacy of their traditional knowledge in underpinning community sustainability (Anderson, et al., 2006; Cunningham & Stanley, 2003; Durie, 2003; Montenegro & Stephens, 2006; Ohenjo, et al., 2006; Reading, et al., 2003; Ring & Brown, 2003; Stephens, et al., 2006). What Maori communities were seeking to achieve through their indigenous health developments from the 1990s has been the subject of recent studies (Anderson, et al., 2006; Cunningham & Stanley, 2003; Durie, 2003, 2005; Ring & Brown, 2003). Key works which identify and explain Maori traditional knowledge and practices include, Lavoie (2005) who has examined the tensions between indigenous aspirations for autonomy and health contracting mechanisms in Canada, Australia and New Zealand. Kiro (2001) has examined Maori health policy and practice in the 1990s under the Northern Regional Health Authority. Ratima (2001) characterized Maori health promotion using Maori traditional knowledge as a frame of analysis. Boulton (2005) has used Maori traditional knowledge as a frame for understanding the complexities, for Maori, of implementing mental health contracts within Maori communities, and through Maori practices. Tomlins-Jahnke (2005) has used an indigenous research paradigm based on Maori philosophical traditions to shape an approach to understanding the characteristics of tribal provider services.

This study continues the indigeneity-based approach to Maori health research taken by these scholars through a study of indigenous knowledge based Maori health developments. The study of indigenous peoples and their worlds can be undertaken in two ways. Either the study can be undertaken from within the world of the indigenous peoples, or it can be undertaken from outside of the world of the indigenous peoples looking inwards. This study is from within the world of Maori. The research process is based on Maori knowledge systems. Maori knowledge systems are also part of what is being studied. Maori knowledge systems are part of the global phenomena of indigenous

knowledge systems. In the contemporary indigenous development literature, indigenous knowledge systems are characterised as a collective category for the individual knowledge systems of indigenous peoples (Barnhardt & Kawagley, 2005; Battiste & Semegani, 2002; Durie, 2005). Battiste sees indigenous knowledge as a benchmark for eurocentric theory:

As a concept, Indigenous knowledge benchmarks the limitations of eurocentric theory—its methodology, evidence, and conclusions— reconceptualises the resilience and self-reliance of Indigenous peoples, and underscores the importance of their own philosophies, heritages, and educational processes. Indigenous knowledge fills the ethical and knowledge gaps in eurocentric education, research, and scholarship (Battiste & Semegani, 2002, p. 5).

Other indigenous researchers work towards framing ways in which ‘native and western’ knowledge systems (Barnhardt & Kawagley, 2005) can co-operatively co-exist (Maaka & Fleras, 2005). They are working on models of how to live together differently (Maaka & Fleras, 2005), and are using indigenous knowledge as the basis for their co-operative co-existence models. One model of co-operative co-existence that identifies and brings together Alaskan native knowledge systems and western scientific knowledge systems for teaching science is conceptualised by Barnhardt and Kawagley (2005, p. 16) and is depicted as two intersecting circles, one with ‘western science’ and the other with ‘traditional native knowledge systems’; where they intersect ‘common ground’ is represented.

This Alaskan model differs somewhat from the models examined in this current study in that the Alaskan model is an example of indigenous knowledge being translated into an English language context, whereas the Maori models examined for this study have expressed their indigenous knowledge in te reo Maori, in their own language. Therefore the co-operative co-existence models explored in this thesis are based on living together differently through mātāuranga Maori in te reo Maori.

Maori view development in constructive terms, and look to future conceptualisations of indigenous knowledge pragmatically. Durie proposes that the validity of indigenous knowledge as a vibrant part of future indigenous developments should not be confined to historical interpretations, or conceptualisations, as this reduces capacity for innovation and denies the authenticity of the contemporary experience (Durie, 2005).

Worldviews are the established knowledge systems through which societies develop (Barnhardt & Kawagley, 2005; Durie, 2005; Marsden, 1975, 2003). Maori knowledge systems had evolved independently of extensive external influence due to the geographic isolation of their lands (Marsden, 1975, 2003; Marsden & Henare, 1992). In 1840, New Zealand was established through the Treaty of Waitangi as a society that would evolve based on two views of the world, 'Te Ao Maori' and British Crown socio-political systems. British Crown socio-political systems had evolved within the territorial domain of what is now known as Europe, and are often characterised as eurocentric (Barnhardt & Kawagley, 2005; Henry & Pene, 1996; Walker, 2004; Walker & Amoamo, 1987). Te Ao Maori worldviews dominated the lands of New Zealand until 1840, but following colonisation British Crown socio-political systems became dominant as British systems of governance, law and order became more firmly established.

Maori worldviews are based on Maori knowledge systems (Marsden, 2003) which have evolved through debate, consensus and practice within communal structures, i.e. iwi, hapu and whanau. The locus of power remains within communities who choose to live together and to develop communal structures (Walker, 2003; Durie, 2001). Maori communities developed their own kaupapa and tikanga; their own rules of engagement for intra and inter community engagement. Maori Marsden, an expert in matauranga, defines kaupapa as foundational rules and principles, and tikanga as customs and traditions developed over generations that become proven methods and are integrated into societal "...standards, values, attitudes and beliefs" (Marsden & Henare, 1992, p. 17). Tikanga, Marsden explains were defined by the relationship between Maori, Mother Earth and were thus integral to the "... spiritual and social values of Maori culture ..." (Marsden & Henare, 1992, p. 19). Traditionally, pre-colonisation tensions between neighbouring communities were often progressed through debates, inter-marriage, and occasionally wars (Walker, 2004). There was no state mechanism centralizing power and control. There was no social mechanism for the denigration of other communities (Walker, 2004).

The matauranga on which communities evolved was itself imbued with life force and spirituality, as Durie explains:

...the basis for knowledge creation is the dynamic relationships that arise from the interaction of people with the environment, generations with each other, and social and physical relationships. Relationships form the substrate for indigenous

knowledge, and the three most distinguishing features of indigenous knowledge are said to be that it is a product of a dynamic system, it is an integral part of the physical and social environment of communities, and it is a collective good. Mātauranga Māori, Māori knowledge, is based on similar understandings; it recognises the interrelatedness of all things, draws on observations from the natural environment, and is imbued with a life force (mauri) and a spirituality (tapu) (2005, p. 138).

Durie explains Māori worldviews created the Māori system of knowledge, or mātauranga Māori, and this is the foundation for the distinctive indigeneity of Māori that now exists:

Two sets of understandings: a set of beliefs to guide human behaviour: ‘tikanga’ (or custom) and a system of tenure that recognised the rights of particular groups in specific localities (mana whenua). ... The evolution of tikanga, based on a system of knowledge now widely called ‘mātauranga Māori’, laid the foundations for a distinctive type of indigeneity, elements of which have survived as customary lore and practice in modern times (2005, p. 9).

Mātauranga Māori is fundamental to the identity and existence of Māori as people and communities in contemporary society, and as the discussion above shows, mātauranga is not necessarily translatable into the eurocentric term of ‘knowledge’ because mātauranga is regarded as having a life force of its own. One of the fundamental issues this research is interested in addressing is how to take something that is essentially regarded as an elemental life force and graft it effectively onto eurocentric structures, systems and processes of health. Mātauranga Māori is not uniform, standardised and is not easy to simplify, and this is being recognised in contemporary New Zealand health research, as was highlighted in this 1985 report by the New Zealand National Research Advisory Council:

The purpose of Māori research should be to identify and make available knowledge of the Māori world, Māori perspectives and perceptions, Māori cultural values and attitudes, in areas which are seen as significant in Māori terms. It cannot be assumed that there is a uniform Māori view on things (Stokes, 1985, p. 6).

Stokes (1985) proposed the importance of making “... available the knowledge of the Māori world ... in areas which are seen as significant in Māori terms” (p. 6). However, one of the key challenges for Māori in making Māori knowledge of the Māori world available through New Zealand health policies and developments is how to conceptualise Māori knowledge for non-Māori audiences.

An example of this challenge is below, with a sample of some of the numerous matauranga for hauora that were presented by Maori to non-Maori in the 1980s. The first example was communicated at a presentation at the launch of a Decade of Maori Health in 1984; a meeting of Maori health experts, and the political, policy and practice leaders of New Zealand health systems including the Department of Health. The second was communicated through an academic journal in 1985. The third was communicated by a team of Maori experts in conjunction with a Royal Commission on Social Policy in 1987-1988. They were examining how to create pathways for New Zealand social development, which included health. The fourth was communicated in 1988 by the first Standing Committee for Maori health. They advised the Department of Health on ways to include Maori knowledge in health developments, and to improve Maori health generally.

These Maori expressions show some of the unique ways, and complexities of, communicating matauranga for hauora:

- Pere (1984) describes Maori health for the wellbeing of the family as “Te Wheke”, or an octopus with the head and body as the family, waiora as the eyes of the octopus, and the eight tentacles as: wairuatanga (spirituality), tinana (physical or body), hinengaro (mental), whanaungatanga (family), mana ake (uniqueness), mauri (vitality), ha-a-koro-ma-a-kui-ma (inspiration from the ancestors), whatumanawa (emotions).
- Durie (1985) describes Maori wellbeing as the four sides of a whare (house) in “Te Whare Tapa Wha”: taha wairua (spirituality), taha hinengaro (mental), taha tinana (physical, body), taha whanau (family).
- The Royal Commission on Social Policy (1988) explains Maori wellbeing containing four pillars “Nga Pou Mana”: whanaungatanga (family cohesion), taonga tuku iho (cultural inheritance), te ao turoa (the environment), turangawaewae (security).
- The Standing Committee on Maori Health in 1988 proposed a “Rangatira” framework of themes for Maori health development which included: rangatiratanga, tikanga Maori and kaupapa Maori, awatea – Maori development, and aukati – prevention/promotion. (Cunningham & Durie, 2001).

These examples show that in the 1980s there were a broad variety of matauranga guiding New Zealand health developments; therefore a distinct indigenous knowledge system was operating. Maori health development, however, does not operate in a vacuum. It is part of the overall New Zealand mix of indigenous or Maori development.

Durie defines the three principles of Maori health development as Maori health perspectives, Maori leadership, and dedicated Maori services. These augment three broader Maori development principles: integrated development; tikanga Maori; and self-determination (Durie, 2001, p. 257). These elements of Maori health development were considered by Maori in two national hui with the Crown: the Hui Whakaoranga in 1984 (Department of Health, 1984) and the Te Ara Ahu Whakamua Hui in 1994 (Ministry of Maori Development, 1994). The two hui bracketed ‘a decade of Maori health development’ and remained focused on a primary goal of ‘by Maori for Maori’ health developments, through retention and promotion of Maori identity and autonomy. Whilst the 1984 Hui focussed on Maori self-determination through ‘Maori-Crown’ developments, the 1994 Hui also focussed on hauora Maori initiatives as indigenous knowledge systems that could contribute to global health developments (Ministry of Maori Development, 1994); so Maori were seeking to move their health engagements onto a global platform that would be independent of the Crown, and to share their matauranga globally.

Durie (2003) defines Maori development after colonisation as having five distinct phases: ‘the recovery 1900 to 1925,’ characterised by a tension between two schools of thought within Maoridom, one focussed on embracing British Crown socio-political systems, and one focussed on Maori autonomy (p. 87-88); ‘rural development 1925 to 1950,’ characterised by a Maori-state bond formed through Maori loyalty, political assistance and state dependency (p. 89-90); ‘urbanisation 1950-1975,’ characterised by Maori loss of identity through urbanisation in neighbourhoods where they became an underclass with severed links to their traditional lifestyles (p. 90-91); ‘Te Tiriti 1975-2000,’ characterised by developments dominated by Treaty formalisation and free market economic policies (p. 92-91); ‘Maori development 2000-2025,’ which Durie believes will be characterised by Maori capacity for the “...development of Te Ao Maori, the Maori world” (p. 95-96). These phases are reflective of the experiences of Maori in hauora that are discussed in Chapters 4, 7 and 8. Certainly the ‘Te Tiriti 1975-2000’ (p.

92-91) phase aligns with the experiences of Maori at the two health hui in 1984 and 1994 (Department of Health, 1984; Ministry of Maori Development, 1994).

At the 1984 Hui Maori discussed their Tiriti based rights to rangatiratanga and how this could be best achieved by the Crown in health developments. At the 1994 Hui a key goal became Maori hauora models to inspire the world (Ministry of Maori Development, 1994). This aligns with Durie's proposal for a post-2000 phase where "...development of Te Ao Maori, the Maori world" (p. 95-96) would dominate, as Maori sharing their hauora models globally could be achieved completely independently of their Crown relationship. But it was also a signal that Maori wished to share their matauranga for health developments globally and distinctly separately from New Zealand and Crown interactions with global networks. This had similarities with Ratana's 1925 journey to the League of Nations to broker a global relationship that would potentially be independent of the Maori relationship with the New Zealand government of the British Crown.

The journey to the integration and implementation of Maori knowledge systems and practices within New Zealand political and policy systems has been an area of high contestability between Maori and the Crown since 1840. The early 1990s saw significant growth in the numbers of publicly funded Maori health organisations, from around 30 in 1990 to 286 by 2005⁵ and these developments are discussed in Chapters 4 and 5. Late 20th century moves through organisations such as the United Nations to have countries with indigenous populations provide adequate political and policy protections for their indigenous populations to survive and develop, on the terms set down by the indigenous populations themselves, has added weight to the pressure on governments to include matauranga Maori within New Zealand socio-political and economic developments. The United Nations Declaration on the Rights of Indigenous Peoples 2007, signed by New Zealand in 2010, puts an even greater emphasis on New Zealand to ensure matauranga Maori are one of the key drivers, if not the key driver, to ongoing New Zealand development.

2.5 Matauranga, Hauora and Research

Much of the discussion in this chapter has been influenced by the indigenous (Maori) knowledge, or matauranga Maori of numerous Maori scholars. Many of the scholarly

⁵ See Ministry of Health, 2000, p.1; Ministry of Health, 2003, Ch5, p10; Ministry of Health, 2005b, p.150

works referenced in this chapter are authored or co-authored by Maori scholars. There are three in particular, Durie, Marsden and Maaka, whose ideas have been influential on both Maori and indigenous development and, in the case of Durie and Marsden on indigenous hauora developments. Hauora is used here rather than ‘indigenous health’ because as a matauranga, hauora encompasses many aspects of human development and wellbeing including health, whanau contexts (which include many things such as whakapapa, tribal connections and responsibilities, community connections and responsibilities), medicines, traditional understandings and practices of healing, spiritual elements of healing and wellbeing, environmental elements of healing and wellbeing, and there are many other aspects.

Trying to adequately explain the matauranga of hauora would take an expert in the subject potentially all of their life, so this brief sentence above is inadequate. Yet what it speaks to is the profound depth and extent of knowledge held by experts like Marsden, who was recognised by Maori as a receptacle of the knowledge of te ao Maori and worked, amongst other things, to clarify the connections between te ao Maori and New Zealand social policy; and Durie, who is recognised by Maori as a receptacle of the knowledge of hauora and who works towards clarifying the connections between hauora Maori and New Zealand health and medical systems.

The methodology used in this chapter, and in this rest of this study, draws on the matauranga and teachings of these three Maori scholars who have all contributed in different ways to the fields of Maori health development, indigeneity, and matauranga Maori. It is scholars of these three fields, and scholars from the field of indigenous health developments that have informed this study. However, to undertake a study of Maori health development, indigeneity for health development, and matauranga as indigenous knowledge for health development, it is appropriate to use the matauranga of Maori scholars to inform the research methods as much as possible.

Mason Durie is a globally respected scholar of Maori and indigenous health developments (Durie, 2001, 2003, 2005). It is Durie’s explanation of indigeneity that is used in this study as a guide for characterising ‘indigeneity-based’ health developments. Durie explains indigeneity as “a system of knowledge based on a state of fusion between indigenous peoples and their accustomed environments” (2005, p. 137). Figure 1 below illustrates Indigeneity Based Maori Health Developments for this study through a re-

interpretation of Durie’s explanation of indigeneity. At the top of Figure 1, Durie’s definition of indigeneity (2005, p.137) shows that where there is a state of fusion between Maori, as indigenous peoples, and their accustomed environments as indigenous peoples, a system of knowledge is created; indigeneity.

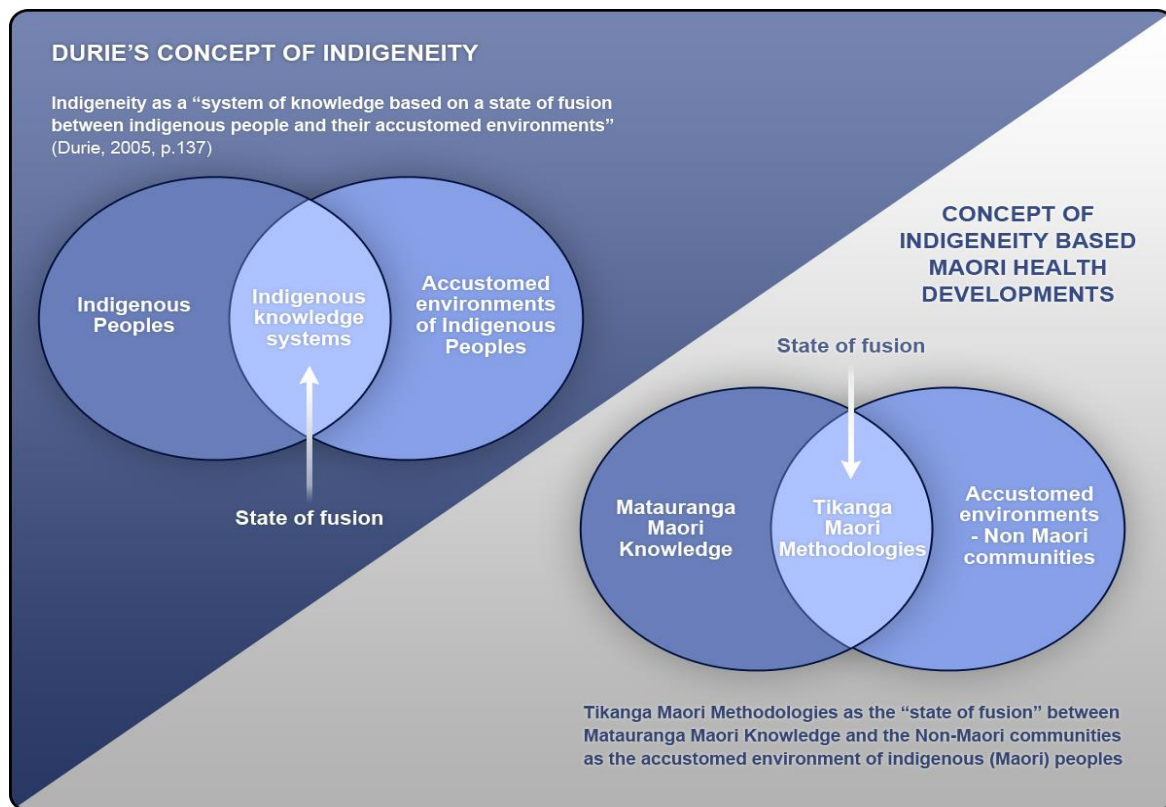


Figure 1: Conceptualising Indigeneity Based Maori Health Developments

At the bottom of the diagram is a conceptual model for Indigeneity Based Maori Health Developments. Maori peoples create a state of fusion between matauranga for hauora and non-Maori communities. The indigenous knowledge systems, or indigeneity-based knowledge systems, that result from this state of fusion in this model are called ‘tikanga Maori methodologies’.

Durie’s concept of indigeneity (2005, p.137) has been re-interpreted for this inquiry to frame ‘how’ indigeneity was practiced by Maori through the tikanga Maori methodologies used by Maori to create a “state of fusion” between “a system of knowledge”, in this case matauranga Maori knowledge, and “their accustomed environments”, in this case non-Maori communities. For this study, indigeneity is conceptualised as tikanga Maori methodologies (as an indigenous knowledge system for health developments).

Having defined ‘Indigeneity Based Maori Health Developments’ for this study, the next definition required for this study is ‘Indigeneity-based Constructive Engagements for Hauora Maori Co-operative Co-existence’. Constructive engagements between indigenous and non-indigenous peoples could be interpreted as those deemed constructive by the indigenous peoples, or deemed constructive by the non-indigenous peoples, or deemed constructive by both the indigenous and non-indigenous peoples concerned. For this study ‘constructive engagements’ are interpreted as those deemed constructive by the indigenous peoples of this study; Maori. Maaka and Fleras’ (2005) concept of indigeneity-based constructive engagements is based also predominantly on what indigenous peoples deem constructive. For this reason, their concept is used to frame ‘why’ the constructive engagements examined in this study occurred, and why they are considered ‘constructive’. Specifically, the Maaka and Fleras concept is used to identify why the constructive engagements that resulted in hauora Maori models might also provide models for co-operative co-existence between indigenous and non-indigenous peoples through living together differently. For the purpose of this study, the Maaka and Fleras (2005) concept of constructive engagement at the constitutional level between sovereign western states and sovereign indigenous populations is going to be applied to constructive engagements between indigenous and non-indigenous peoples at the community level. This research proposes that constructive engagement for co-operative co-existence can be driven as successfully from a community level, as Maaka and Fleras have argued could occur at a constitutional level.

Figure 2 below illustrates ‘Indigeneity-based Constructive Engagements for Hauora Maori Co-operative Co-existence’ for this study which is a re-interpretation of Maaka and Fleras explanation of co-operative co-existence between indigenous and non-indigenous peoples. In Figure 2, the top of the diagram presents Maaka and Fleras (2005) ideas of co-operative co-existence. They show that where indigenous and non-indigenous peoples constructively engage, they live together differently, and co-operative co-existence is achieved.

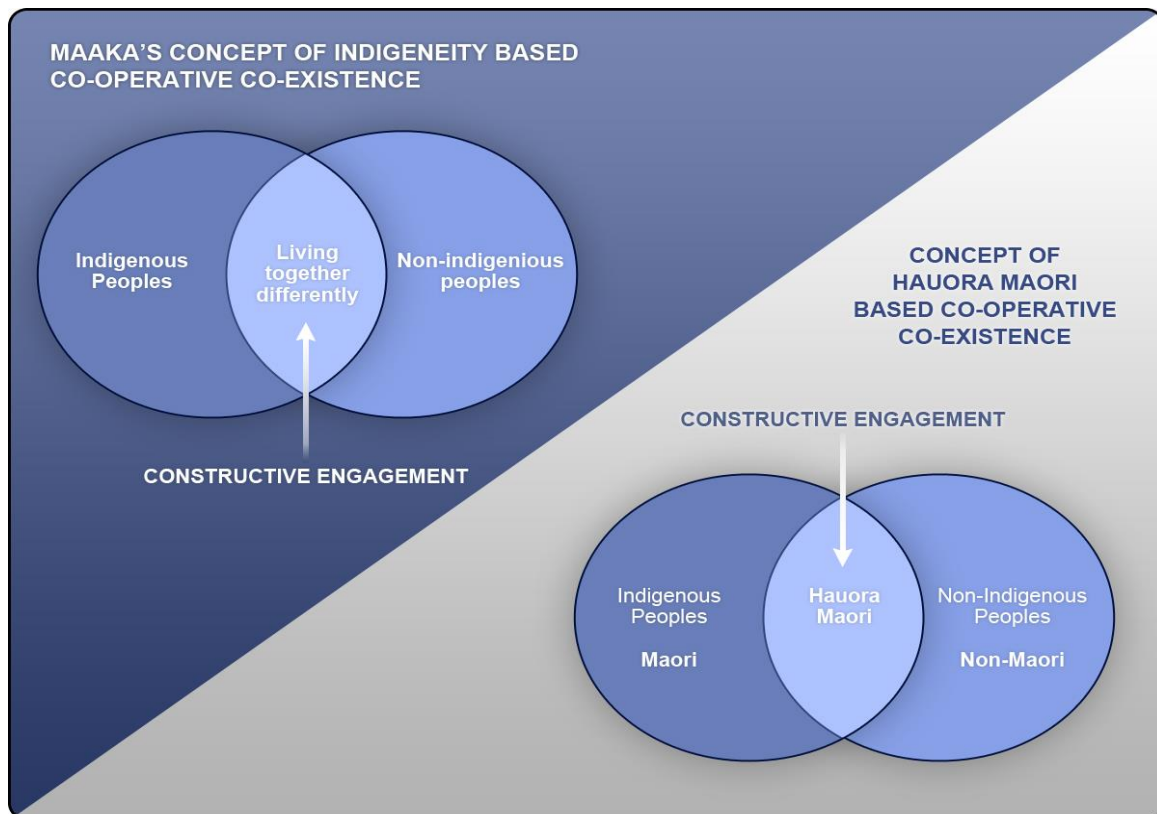


Figure 2: Conceptualising Indigeneity-based Constructive Engagements for Hauora Maori Co-operative Co-existence

At the bottom of the figure, Hauora Maori Based Co-Operative Co-existence proposes that where Maori constructively engage through their indigeneity-based hauora Maori with non-indigenous peoples, hauora Maori based co-operative co-existence occurs. Therefore, non-Maori choose to live differently with Maori through the matauranga and tikanga of the hauora Maori services. Maaka and Fleras concept of constructive engagement for co-operative co-existence (2005) has been re-interpreted for this inquiry to frame 'why' the constructive engagements of hauora Maori studied might be considered as models for kotahitanga between Maori and non-Maori. For this study, constructive engagement through living together differently is conceptualised as occurring through Hauora Maori.

There are five case study organisations. Four are provider organisations. One is a health purchasing organisation. There is one other aspect of analysis that Maaka and Fleras (2005) offer which will be used in evaluating the purchasing organisation only. This is the simple framework for evaluating four levels of Sovereignty/Models of self-determining authority (2005, p.52). Maaka and Fleras propose that indigenous self-determination is generally found along a continuum where statehood represents legal sovereignty, nationhood represents de-facto sovereignty without the right to secede,

community represents functional sovereignty through local autonomy, and institutional represents nominal sovereignty or in name only sovereignty (2005, p.52). This framework is used in the analysis of the health purchasing organisation only because the MAPO organisation was the only case study organisation that had a Treaty of Waitangi iwi based relationship with the health funder.

The final frame of the inquiry is to explain what Maori elements underpin the constructive engagements studied, and the teachings of Maori Marsden (2003) guide this study of indigenous knowledge, or 'matauranga'. Maori peoples have their own perception of their world, how it is ordered, and the relationships that exist between the spiritual world, the natural world, and peoples (Marsden, 1975, 2003; Marsden & Henare, 1992). This Maori world is contemporaneously referred to as 'Te Ao Maori' (Durie, 2005). Marsden explains there is a difference between 'knowledge' and 'knowing' in Te Ao Maori. "Knowledge (matauranga) is different from knowing (mohio)" Marsden (2003) explains. "Knowledge belongs to the head and knowing belongs to the heart. When a person understands both in the mind and in the spirit, then it is said that the person truly 'knows' (mohio)" (Marsden, 2003, p.79). Another way of explaining mohio would be to say that you know something so essentially that it is known at a cellular level (i.e. every cell in your body) and therefore it has become inherent in your behaviours. Marsden's (2003) ideas are re-interpreted in this study to assist in understanding and explaining what matauranga informed the tikanga Maori methodologies of the hauora Maori organisations, and how, through delivery of the tikanga Maori methodologies the matauranga became mohiotanga for peoples delivering hauora Maori services. In Figure 3 below, Marsden's ideas (2003) at the top of Figure 3 show how the matauranga can combine with mind and spirit to become mohio.

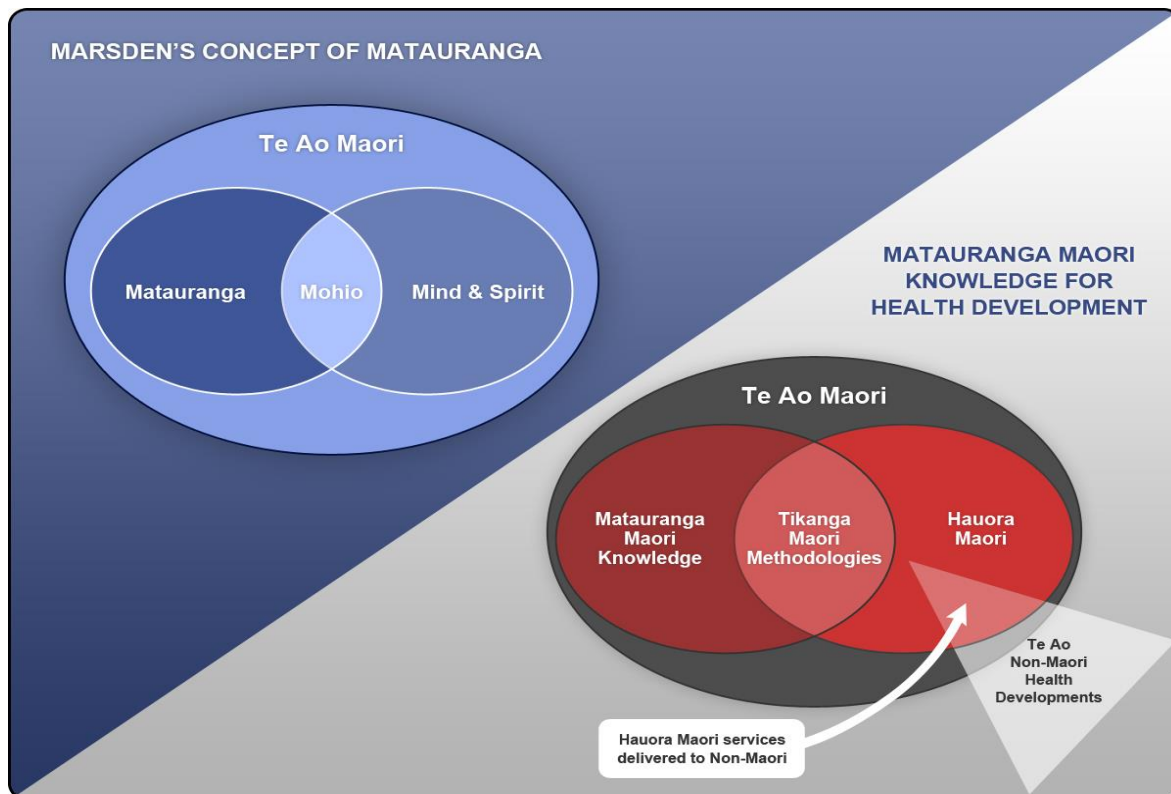


Figure 3: Conceptualising matoranga Maori knowledge for health development

The bottom part of the Figure 3 re-interprets Marsden's (2003) ideas to show how Maori might combine their matoranga with hauora Maori to create tikanga Maori methodologies for health developments. The tikanga Maori methodologies are what are used by Maori and non-Maori to deliver the matoranga-based hauora services. This study researches practitioners of hauora Maori. Practitioners are doctors, nurses, receptionists, community support workers, cleaners, child carers, counsellors; literally anyone who has contact with service receivers and community members accessing the hauora Maori services. The tikanga Maori methodologies of the hauora Maori organisations are applications of the organisational matoranga Maori. The hauora Maori practitioners apply the organisational matoranga Maori through the tikanga Maori methodologies that are their service delivery practices. The ability of the hauora Maori practitioners, who may be non-Maori, to apply the organisational matoranga is dependent upon how they understand and practice the tikanga Maori; in other words their mohiotanga of the matoranga of the organisational tikanga. For this study, matoranga is conceptualised as matoranga for health development.

To summarise, the methodology and methods for this study have been influenced by the matoranga of many Maori scholars, including Marsden, Durie and Maaka. As an indigeneity-based study, this research has re-interpreted the matoranga of these Maori

scholars to inform the inquiry. Figure 4 below is a summary of what has been discussed in this Maturanga, Hauora and Research section. It is presented as a Maturanga Maori Inquiry Frame for studying Indigeneity-based Hauora Kotahitanga models. This inquiry frame informs the thesis methods, which are explained in the next chapter.

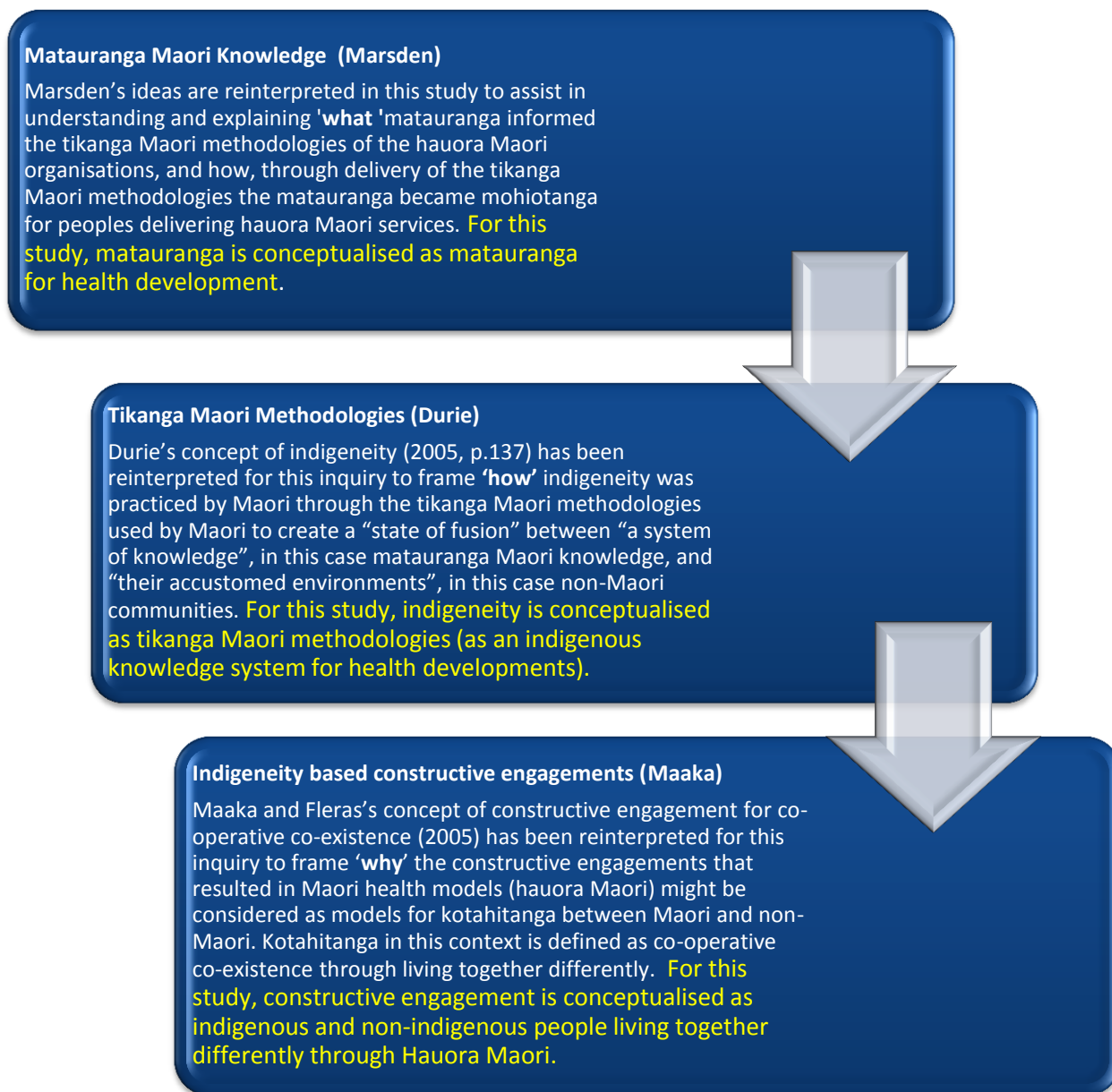


Figure 4: Maturanga Maori Inquiry Frame for studying Indigeneity-based Hauora Kotahitanga models

Figure 4 shows how the maturanga of three Maori scholars has been re-interpreted as an inquiry frame for this study which explores the proposal that constructive engagements between indigenous and non-indigenous peoples should be indigeneity-based; how constructive engagements between indigenous and non-indigenous peoples might be

considered ‘constructive’; and how indigenous knowledge and practices are being, or should be, included in health developments.

This study identifies the mātāuranga of the hauora Māori organisations through understanding and explaining the mohiotanga of the hauora practitioners. To understand and explain the mohiotanga of the hauora practitioners, their collective explanations through stories told at hui of their experiences are studied. At Māori hui a speaker might talk about an experience they have had, and then reflect on experiences that other people they know have had that are similar. Often the speaker will reflect on experiences of tupuna or other well-known historical figures that were similar. In this way, through the art of oral transmission or storytelling, these inter-generational and cross-community understandings and explanations of knowledge and experiences permeate most Māori hui. Traditional story-telling, or experience sharing, is one of the fundamental learning elements within Te ao Māori because traditionally, mātāuranga is transmitted orally. Māori did not have a written language prior to colonisation.

My tribal elders and other whanau, hapu and iwi have told me many stories of the Karere, who were described as talking newspapers who visited the Māori villages. The people would gather to hear the Karere speak. The Karere was an expert at purposefully crafting stories imbued with mātāuranga that could resonate for each audience member within each village visited. Each person in the audience would hear the same story, but for each person the message or level of understanding of the depth of the story, would be different. In this way the different layers of the story would resonate differently with each audience member, some would interpret facets of the story one way, and others would not note that particular detail. The Karere was skilled at delivering mātāuranga orally within the socio-cultural-political moment of each tribal group. In contemporary times the skill of knowledge dissemination undertaken orally is often generically called story-telling, even by Māori during hui. For this study, a research approach based on gathering information and knowledge from traditional Māori story-telling situations has been designed to acknowledge this traditional form of knowledge gathering and dissemination.

The stories gathered for this research are those of hauora Māori practitioners explaining their mohiotanga for the mātāuranga they are delivering through the tikanga of hauora Māori organisations. The hauora Māori practitioners are both Māori and non-Māori, and

they are telling their stories to internal and external audiences associated with their hauora Maori organisations. I have called this research approach *Kareretanga* to respect the legacy and mātāuranga of the Karere. *Kareretanga* is presented in the methods at Chapter 3.

The three debates from the literature that will be studied are indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and mātāuranga as indigenous knowledge for health development.

2.6 Summary

This study proposes that constructive engagements between indigenous and non-indigenous peoples should be indigeneity-based, so this chapter began with a study of the literature on indigeneity, and indigenous identity in health research. It then explored debates and issues in the indigenous development and indigenous health development literature to ascertain how constructive engagements between indigenous and non-indigenous peoples might be considered ‘constructive’ by indigenous peoples, and how indigenous knowledge and practices are being, or should be, included in health developments.

This chapter began by discussing indigeneity and the politicisation of indigenous identity through both historical and contemporary experiences. Conceptualising indigeneity for health research was shown to be a complex question with many and contested definitions. The United Nations has defined indigenous people as peoples (Niezen, 2006), and in New Zealand after the signing of the United Nations Declaration on Indigenous Rights (2007) in 2010, the debates linger over whether Maori are ‘people’ or ‘peoples’. Certainly in policy and literature in New Zealand, as has been shown in this chapter, the term ‘Maori’ is used interchangeably with ‘indigenous’ in a way that characterises them as a ‘people’ and this can cause tensions as Maori peoples may object to being homogenised or unified, particularly by governments, media and non-Maori. However, there is no plural word for Maori in the Maori language – it is both singular and plural. Maori have the right to self-identify and in choosing their identity there are many who link to family and blood ties, just as those who choose to link to community or

other group ties. For this research the term Maori is used as both an individual and group identifier.

In the contemporary period research into indigenous health developments globally have focussed on indigenous sustainability and resilience, and have resulted in global calls for more attention by researchers into indigenous knowledge and practices for health development. How indigenous knowledge and practices are best explained to non-indigenous audiences, particularly governments, policy makers and health systems, is an important part of this progressive research paradigm. Indigenous knowledge is an evolving societal mechanism that within the context of indigeneity becomes a socio-indigenous paradigm with its attendant discourses. Within this socio-indigenous paradigm, for Maori health developments in the 1980s the discourse was dominated by health developments within the context indigenous rights gains, whereas in the 1990s the debates focussed on how indigeneity could be expressed within and through health developments. Inherent in this focus was expectation of preferably fundamental, but at least incremental, movement by the Crown towards more positive support of Maori development aspirations. The exponential growth from the early 2000s of indigenous health development discourses globally, was driven in part by some centralisation of indigenous issues taking place when the United Nations established a permanent forum on indigenous issues. There has been an appreciable increase in political, social, and academic debates about hauora Maori from the 1990s, and there have been a number of multi-indigenous collaborations on cross-country health research projects and publications which have been inclusive of indigenous scholars and leaders. Global indigenous rights and health discourses have resulted in increased external pressures on New Zealand governments to include Maori knowledge and practices within New Zealand developments at the turn of the 21st century.

Within indigenous health development discourses, indigeneity is often a complex form of socio-indigenous transformation because health is a social policy area in which most societal members have an interest. This means that for many governments, states, and non-indigenous peoples, health is the most likely place for them to engage with indigeneity-based issues. Health is also an area of social policy where, for many indigenous peoples globally, engagements with the state may have resulted in some measure of indigeneity-based response. Globally, indigenous health developments range

along a continuum from ‘no engagement’ with indigeneity-based issues, to ‘full autonomy’ for indigenous peoples to use publicly funded resources. Engagements between indigenous peoples and the publicly funded health services in one small town may vary significantly along the continuum. In a study of Latin America and the Caribbean, indigenous peoples ranged from fully independent, having totally withdrawn from engaging with publicly funded health services in some places, to indigenous peoples in other areas having had their rights to indigenous traditional health constitutionalised (Montenegro & Stephens, 2006). There are a multitude of indigenous experiences of indigenous health developments, and there are a complex range of interpretations of what constitutes an indigeneity-based development, response, engagement, and outcome.

Maaka and Fleras (2005) propose indigeneity as a principle and practice for constructive engagements between indigenous peoples and the Crown. This study proposes that indigeneity is also a principle and practice for constructive engagements between indigenous and non-indigenous peoples, and agrees with Durie’s proposition that indigeneity is “a system of knowledge based on a state of fusion between indigenous peoples and their accustomed environments” (2005, p. 137). This study of indigenous health developments will incorporate their ideas of indigeneity-based constructive engagements into the study methods and discussion.

Contemporary indigenous health literature is often a mix of the results of scientific or clinical trial outcomes along with some discussion on the complexities of indigeneity-based health developments. A key debate in contemporary indigenous health literature is how governments, policy makers, and the health sector, can engage more constructively not only with indigenous peoples, but also with indigenous knowledge and practices. Alfred (2006) has explored the tensions between consensus based indigenous socio-political systems and the adversarial based socio-political systems that are characteristic of Crown systems in Canada and New Zealand. While the adversarial nature of New Zealand socio-political systems has been explored in this chapter, one aspect of the health relationships between Maori and the Crown should not be overlooked: health systems tend to be less adversarial than other social policy systems, perhaps because bartering over whether a person gets the resources to live through a health crisis is a fairly unacceptable practice in both Maori and non-Maori communities. The ability for

the Crown and Maori to engage more constructively for health developments, than perhaps would be the case in other policy fields such as justice, or economic development, may also point to why actual and proposed constructive engagements between Crown, state, policy makers and the health sector are so extensively canvassed in the literature.

Maaka and Fleras (2005) ideas of how constructive engagement between indigenous and non-indigenous peoples at the constitutional level can result in co-operative co-existence is re-interpreted in this chapter as a way for studying how hauora Maori might result in co-operative co-existence at the community level, rather than constitutional level. This study looks at relationships between peoples in communities as a pathway to constructive engagements that may have less systemic tensions than those constitutional level engagements used as exemplars by Maaka and Fleras (2005).

The indigenous health development literature highlights the scarcity of research and publications pertaining to the knowledge-based resilience and sustainability practices of indigenous communities. While studies could focus on how countries, nations, states, health systems could be inclusive of indigenous knowledge for health developments, this study takes a different approach. It interprets the matauranga of a Maori scholar about matauranga and mohiotanga. It then utilises this matauranga to create a research approach that assists in understanding and explaining what matauranga informed the tikanga of the hauora Maori organisations, but more importantly, how the people delivering the matauranga explained to an English language audience how they understood and delivered matauranga through the organisational tikanga. The study seeks to understand how non-Maori as well as Maori understood and delivered matauranga through the organisational tikanga.

This study is therefore, in itself a form of constructive engagement between hauora Maori practitioners (Maori and non-Maori) and Maori and non-Maori peoples who are interested in understanding how hauora Maori experiences can be conceptualised as models for kotahitanga between indigenous and non-indigenous peoples.

Chapter Three

THESIS METHODS

“Now, concerning knowledge, this is something we collect. One listens to stories and explanations and gathers these things into one’s basket so that it may be full. One gathers together these things from priests and experts who have partaken of ‘the food of the three baskets’ (sacred knowledge). Your task is to gather together these treasures into your basket”. (Marsden, 2003)

3.1 Introduction to Thesis Methods

The chapter begins by outlining the research questions and the research methods. The researcher's positionality is discussed, and debates from the health development literature that underpin this study are identified. *Kareretanga*, the research approach based on traditional forms of knowledge gathering and dissemination developed for this study is then introduced. The thesis parameters and thesis contribution are discussed, and the chapter concludes with an outline of the thesis and chapters.

As the previous chapter stated, this study is in itself a form of constructive engagement between hauora Maori practitioners (Maori and non-Maori) and Maori and non-Maori peoples who are interested in understanding how hauora Maori experiences can be conceptualised as models for kotahitanga between indigenous and non-indigenous peoples.

The study is based on case studies of five Maori health and disability organisations – hauora Maori organisations. Three are Maori health providers, one is a Maori residential service provider for intellectually disabled people, and one is a Maori health and disability service purchasing organisation. The five organisations are located in the tribal region of Ngati Whatua and were chosen to ensure alignment with the kaupapa of my iwi and tupuna. A fuller explanation of the choice of organisations and tribal region can be found at 3.5.

The frames for this research are based on my positionality as a researcher. These are: my personal Maori/British indigeneity lens created by my Ngati Whatua whakapapa; the matauranga Maori basis of indigeneity theories as explained by Maori scholars; the matauranga of the Maori communities I am part of through my Ngati Whatua whakapapa; and the matauranga of the Maori communities I am part of as a researcher.

From an interpersonal perspective, my research frames were formed through the strong family and professional relationships that I had within the study region, as well as within all of the case study organisations. How my whakapapa strengthened and limited my research is discussed in more detail at 3.3.1 and 3.5. The study is my way of bringing the two worlds, indigenous and non-indigenous, into one space; a dissertation based on

living together differently, in the English language for te ao non-Maori, and an indigeneity-based study grounded in mātāuranga Māori for te ao Māori.

In Chapter 2, the mātāuranga of three Māori scholars, Durie, Maaka and Marsden, were discussed and re-interpreted for this study as ways for understanding mātāuranga and tikanga for indigeneity-based constructive engagements between indigenous and non-indigenous peoples. In this chapter, these re-interpretations are configured as thesis methods to assist in discussions of the three indigenous health development debates which are a focus of this study: indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and mātāuranga as indigenous knowledge for health development.

The research methods and design are grounded in mātāuranga Māori, and for this study which takes place in the mana whenua of Ngāti Whatua, the guidance of Ngāti Whatua kaumatua, kuia and whakatauki are the starting point for the methods design. The approach of the research is also grounded in mātāuranga Māori, through an interpretation for this study of whanaungatanga as an explanatory frame for how the research relationships will be approached, and to explain how the ordering of relationships between whanau, hapu and iwi for te ao Māori and non-Māori would be achieved for the study.

The research approach has concentrated on placing mātāuranga Māori at the centre of the research design. To achieve this, a composite of the mātāuranga of whanaungatanga learned from iwi and the scholars of other iwi Māori, has been developed as an indigenised research approach. The whanaungatanga approach for this study is an interpretation of the knowledge and understanding gleaned of whanaungatanga over many years of working within Māori organisations, and also through whanau, hapu and iwi discussions about whanaungatanga. The overall purpose of the whanaungatanga approach is to protect the mana and tapu of all whanau, hapu and iwi involved with this research. A version of indigenous research has also been developed for this study which draws on traditional forms of Māori knowledge transmission; Māori story-telling at hui.

The methods developed for this study are also grounded in mātāuranga Māori and called *Kareretanga* to acknowledge the role of the Karere, or talking newspapers; people who walked the news from village to village in the Māori world before the Māori language

became a written form. Maori traditionally transmit and disseminate information, knowledge and experiences orally, and *Kareretanga* is designed acknowledge this dynamic. *Kareretanga* is both research method and a way of explaining the relationships and the implications of the relationships that were studied. The Karere were discussed in Chapter 2, and *Kareretanga* is discussed later in this chapter. This chapter concludes by outlining the limitations of this study, and summarising the thesis methods.

3.2 Ngati Whatua matauranga as Research Design

This study takes a ‘Maori-centred’ approach to health research, following Durie’s (1996) ideas which propose that Maori research undertaken in Maori communities should be cognisant of Maori worldviews and methods, and focused on achieving outcomes pertinent to, or identified by the community of study. The research design for this study incorporates Durie’s (1996) ideas of having Maori as central to the research purpose and process by acknowledging the mana whenua of the Ngati Whatua peoples, on whose lands this study takes place.

After taking advice from Ngati Whatua kaumatua prior to beginning the research design, another way of ensuring the matauranga and tikanga of Maori are central to the research approach is by using the Maori tradition of whakatauki to set and explain boundaries for the study relationships. Whakatauki are proverbs which explain tribal boundaries for relationships. Each tribe has their own whakatauki, and often these are sayings or proverbs from tupuna and tribal leaders that have been handed down from generation to generation. Whakatauki often outline the meanings of tribal matauranga, usually along with the tikanga with which the matauranga should be practiced. Whakatauki are also one traditional Maori method for guiding resolution of relationship problems, particularly those between people or peoples. There are also many commonly known matauranga that all tribes recognise or have versions of. Ngati Whatua are resolute in their whakatauki, many of which are of ancient origin, and are still practiced rigorously. The whakatauki the Ngati Whatua iwi use for hauora were documented for the kaimahi at Te Ha o te Oranga and Tihi Ora MAPO by the Ngati Whatua kaumatua Te Pania Kingi, and were consistently implemented by the Chairperson of Te Runanga o Ngati Whatua and Tihi Ora MAPO during the study period, Tom Parore. These Ngati Whatua whakatauki for hauora are discussed in Chapter 7.

The Ngati Whatua hauora whakatauki *Kia mau ki te mana o te whanau, te hapu me te iwi, The mana and tapu of other iwi or hapu must also be observed* (Te Ha o Te Oranga, 2000b), was used as the overarching whakatauki for the forming of relationships with the case study organisations of this study. This whakatauki was adhered to by this study, under the guidance of Te Pania Kingi, Tom Parore, and the Ngati Whatua Rangatira Hauora Professor Sir Hugh Kawharu. Through this whakatauki, this study is grounded in the mana whenua consideration that the mana and tapu of other iwi, in this case the mana and tapu of the hauora Maori organisations studied, ‘must be observed’. In this way the whakatauki requirements that the mana and tapu of other iwi or hapu, in this case the urban community provider Te Puna Hauora, and the intellectual disability community provider Te Roopu Taurima o Manukau, are also being observed, alongside the Ngati Whatua hapu provider Ngati Whatua o Orakei Health Clinic, which is not affiliated to Te Runanga of Ngati Whatua. The mana whenua organisations studied are the Ngati Whatua iwi provider Te Ha o te Oranga, the iwi purchaser Tihi Ora MAPO, both of which are affiliated to Te Runanga o Ngati Whatua.

The teachings and writings of Maori Marsden are used to guide the matauranga Maori elements of the research. To be authentically Ngati Whatua focussed, this research begins with the guidance of Ngati Whatua tupuna and kaumatua. Takiwairua Marsden, my late grandfather, was intrinsically involved with the spiritual and formal aspects of the hauora developments within the Ngati Whatua tribal region as an Ngati Whatua kaumatua, and as an Anglican priest. As a member of his whanau I accompanied him to many hui. Much of what I learned from him and other whanau, hapu and iwi members forms the basis of my study of matauranga of this thesis. However it is my grandfather’s late brother, great Uncle Maori, whose teachings have been posthumously published. Therefore it is to Uncle Maori I have looked for written evidence to support this academic pursuit of explaining the role of matauranga in kotahitanga experiences of hauora Maori organisations and communities. A lot of what I learned from my grandfather about matauranga is congruent with the now published teachings of his brother. Where the written work of great Uncle Maori is quoted in this study, it is often a way of consolidating and explaining matauranga Maori I have acquired from many whanau, hapu and iwi connections.

There is a Maori whakatauki that is regularly used in both te reo Maori *Kia whakatomuri te haere ki mua*, and in English, *Maori walk backwards into the future bringing their past with them*. This broadly means that the knowledge and experience of the tupuna must be drawn into the present and not left behind. We must constantly reflect on the experiences and wisdom of our tupuna if we are to achieve anything in our present. Although this is a contemporary study of hauora Maori, it is necessary to comply with this whakatauki if this study is to have any credibility with Maori audiences. Maori health and medical leadership in New Zealand society is often talked about at hui as being a source of great pride for Maori, particularly when they talk at hui of the historical feats of the Maori parliamentary medical doctors in the early 1900s, Sir Maui Pomare and Sir Peter Buck, and the Maori traditional healer and leader Ratana. To leave reference to them out of this study would again weaken its credibility with Maori audiences. To adhere to this whakatauki, some experiences of Maori in health developments from the late 1800s are discussed in Chapter 4, and are considered comparatively with the contemporary findings of this study in Chapter 10. In this way the knowledge and experiences of tupuna Maori are connected with contemporary Maori experiences to draw some conclusions about hauora Maori kotahitanga.

In addition to including the matauranga of Ngati Whatua and of tupuna into the research design as explained above, *Whanaungatanga* as is taught by Pa Henare Tate (1999) is re-interpreted, along with teachings on whanaungatanga from whanau, hapu and iwi. Whanaungatanga for this study is an articulation of the ordering of relationships between tangata, whenua, and atua: peoples, lands and gods. Matauranga that becomes tikanga to a person through the teachings of the whanau, hapu, iwi and other Maori scholars can therefore be regarded as one articulation of whanaungatanga.

In summary, the matauranga of whanau, hapu and iwi; the matauranga of Ngati Whatua as expressed by kaumatua and Te Runanga o Ngati Whatua; the matauranga of tupuna Maori; and the matauranga of Maori scholars, were all considered, incorporated and re-interpreted in the design of this matauranga Maori grounded study into hauora Maori kotahitanga.

3.3 Whanaungatanga as Research Approach

The interpretation of whanaungatanga as a research approach is informed by the matauranga, kaupapa and tikanga of whanau, hapu, iwi, kaumatua and kuia, and Maori scholars. It is also informed by one of the most respected teachers of whanaungatanga, Pa Henare Tate (1999); whose teachings have been used by several of the Maori health organisations studied to underpin their service delivery models. A brief summary of Pa Tate's teachings of *Whanaungatanga* is below:

Whanaungatanga encapsulates the tikanga of tapu, mana, and their expression through the principles of tika, pono and aroha. Tapu can be broken down into three perspectives. Firstly there is the intrinsic tapu or sacredness of being, secondly there is the tapu/sacredness of relationships between atua, tangata and whenua, and thirdly there are tapu or sacredness as relating to tapu/restrictions. Mana is the spiritual power that creates, produces and restores tapu. Tika can be defined as the principle concerned with the right ordering of relationships, among atua, tangata and whenua, the right response to those relationships and the right exercise of mana. Pono is the principle that seeks to reveal reality and to achieve integrity of relationships. Aroha is the principle of expressing empathy, compassion and joy for others in all that we do. Tika, pono and aroha are the principles of action by which we exercise tapu and mana. If one wants to have mana, one must first seek after tapu. To possess tapu one must exercise tika, pono, aroha (Tate, 1999).

Four of the Maori health organisations studied in this research have re-interpreted Pa Tate's (1999) teachings on *whanaungatanga* for use within their kaupapa and tikanga, so using an interpretation of whanaungatanga as the research approach is appropriate for study with their organisations. Each of the organisations studied have their own interpretation of whanaungatanga, so the research relationships with them are based on their interpretation of whanaungatanga. The whanaungatanga approach adopted for research within Te Roopu Taurima o Manukau, the one organisation that does not use Pa Tate's version of whanaungatanga, was based instead upon their tikanga of rangatiratanga, as articulated in their best practice model Whariki Whakaruruhau (see Appendix 4). In this way the kaupapa and tikanga of Te Roopu Taurima remained paramount in the research process, through the whanaungatanga approach of understanding as a researcher how to appropriately apply their rangatiratanga approach.

The interpretation of whanaungatanga adopted for this study is contributing to the correct ordering of relationships between gods, earth and peoples through ensuring relationships with other people are achieved the right way, with integrity and compassion, for them.

3.3.1 Whakapapa

My positionality as the researcher for this study begins with my whakapapa, which explains my relationship to the Ngati Whatua lands in which this study takes place, and it also explains my personal place as a Maori within te ao Maori, but also as a non-Maori within te ao non-Maori. This study focuses on the intersection between these two worlds, so my situation as a person who has been raised by families from both worlds, created a personal positionality for myself within this study of seeking to understand kotahitanga between indigenous and non-indigenous peoples and worlds.

One of the first things a Maori must do on formal occasions is stand and speak their whakapapa. This underpins their presence and ongoing participation in the proceedings. Maori don't ask a person 'who are you'? Rather they ask 'where are you from'? My response to a question of where I am from would be that I am of the Ngati Whatua peoples, through the Te Uri o Hau whakapapa line, that my maunga (mountain) is the Toka Toka, my moana (sea/ocean) is the Kaipara and my marae (home meeting house) is Otamatea. I was raised in an urban suburb of Auckland, and spent all school holidays until I was 13 back on my tribal lands working as a flounder fisher, living traditionally off the land, and caring for and spending time with members of my whanau, hapu and iwi. My father is from the Wirral, which is across the Mersey from Liverpool in England and I have spent considerable time living in the northern hemisphere between the ages of 19 and 35. I identify as both Maori and British. Who I have become as a researcher is a reflection of my personal interest in the political dynamics of ethnic conflict, which professionally I have pursued through many years of experiences external to New Zealand. I have worked as a photojournalist in ethnic conflict situations, some of which have resolved into war, in the northern hemisphere. I have also worked on a number of projects for resolving political or policy based ethnic conflict situations in both the northern and southern hemispheres. I have been a student of the politics and media of ethnic conflict and international relations in the northern and southern hemispheres.

The frames for this research are: my personal Maori/British indigeneity lens created by my whakapapa; the matauranga Maori basis of indigeneity theories as explained by

Maori scholars; the matauranga of the Maori communities I am part of through whakapapa; and the matauranga of the Maori communities I am part of as a researcher. From an interpersonal perspective, my research frames for this research were formed through the strong family and professional relationships that I had within the study region, as well as within all of the case study organisations. As this study is my whanaungatanga contribution to Ngati Whatua aspirations for sustainable development, I have taken care to be guided by kaumatua and kuia of Ngati Whatua as to how to appropriately undertake this research within our tribal region. There are two primary considerations that have been impressed upon me by kaumatua and kuia: Ngati Whatua are mana whenua; and, Ngati Whatua have a manaakitanga responsibility for other iwi in their mana whenua rohe. This means even though people are not from their tribe, if they are on Ngati Whatua mana whenua lands, Ngati Whatua has the responsibility to extend care, consideration and resourcing to them as good hosts. What I have been taught is that a mana whenua iwi is measured in some ways by their ability to provide manaakitanga to others on their mana whenua; in other words the mana of the whenua is upheld through the manaaki of non-mana whenua peoples, by the mana whenua. The mana whenua relationship between peoples, land and gods is therefore one of the most sacred for a tribe, and their expression of manaakitanga on their mana whenua is essential to their mana.

My whakapapa both strengthened my ability to form the relationships required for the research, but also created one of the main limitations of my research which was that as I am Ngati Whatua it was not possible to regard my presence at many of the hui I attended as ‘an impartial observer’, even in situations where I was specifically observing for my research process and not actively participating.

3.3.2 Tikanga – approach to research

The tikanga for this research are created to protect the mana and tapu of all peoples involved in the research. The tikanga approach focuses on the accountability of this study to whanau, hapu and iwi. The research relationships were guided by the principles of tika, pono and aroha (Tate, 1999), which was interpreted in this study as doing something the correct way by the organisations expectations, with integrity and empathy. The research relationships were also guided by the Ngati Whatua whakatauki that *Kia mau ki te mana o te whanau, te hapu me te iwi* - the mana and tapu of all participants was to be

observed (Te Ha o te Oranga, 2000b), which was interpreted in this study as the dignity and sacredness of all participants and their families, and their patients and their families, and their colleagues and their families, was to be observed. This study was guided by these considerations because they are the basis of relationships within and between the peoples and organisations of the study region.

The research approach is underpinned by whanaungatanga, in particular as taught by Pa Henare Tate (1999) because his teachings were included in various forms by Tihi Ora and Te Ha o te Oranga (example at Appendix 2), Orakei Health Clinic (example at Appendix 1), Te Puna Hauora (example at Appendix 3). In this way the mana and tapu of the mana whenua and the non-mana whenua case study organisations was upheld through some alignment of whanaungatanga between the research approach of this study, and the kaupapa and tikanga of the case study organisations.

This tikanga approach was congruent with the case study organisations tikanga, even where whanaungatanga was not being directly practiced. In the case of Te Roopu Taurima, the practice of whanaungatanga fitted with their overall processes, even though it was not a specific tikanga of the organisation, so the whanaungatanga approach to this research was deemed appropriate by Te Roopu Taurima also. Te Roopu Taurima practice, through their Whariki Whakaruruhau model (see Appendix 4) that the rangatiratanga of the staff, mokopuna, their whanau, hapu, and iwi are paramount. I have applied this as meaning staff, mokopuna and whanau, authority to self-determination was sacrosanct, and the application of mana, tapu, tika, pono and aroha to the overall tikanga of individual and familial rangatiratanga meant I was compliant with Te Roopu Taurima kaupapa. In practice this meant as a researcher I complied with each organisations internal practices for behaviour, relationships with people, and relationships with sources of knowledge. Or to put it in Maori terms, I practiced whanaungatanga as my personal tool for complying with each organisations kaupapa and tikanga.

3.3.3 He tangata, he tangata –peoples of the study

The overall whakatauki that guides Te Runanga o Ngati Whatua guided the choice of peoples for this study because they were chosen in conjunction with the advice of Ngati Whatua kaumatua, kuia and health leaders. *He aha te mea nui – he tangata, he tangata, he tangata, What is important – it is people, it is people, it is people.* The peoples identified for this study were those associated with the Maori health and disability

organisations created in the mid to late 1990s in the Ngati Whatua mana whenua region, and their communities. These organisations were chosen in part because this study is of kotahitanga between indigenous and non-indigenous peoples, and these organisations were inclusive of non-indigenous peoples. The case study organisations are all located within the Ngati Whatua health sub-region, which was established by agreement in 1995 between the Ngati Whatua peoples and the Northern Regional Health Authority, a government health authority. The reason for focusing on researching Maori health developments in the Ngati Whatua health sub-region was because two rangatira, Tom Parore from Te Runanga o Ngati Whatua and Professor Sir Hugh Kawharu from Ngati Whatua Orakei, had asked me to research Ngati Whatua experiences of hauora as a contribution to understanding and explaining Ngati Whatua contemporary sustainability.

The mana whenua⁶ case study organisations chosen for the study were:

- Tihi Ora MAPO, the Ngati Whatua Runanga health co-purchasing organisation, covering the region from Auckland to Whangarei. Based in central Auckland. This case study organisation differs from the other case studies because it is a health and disability purchasing organisation, where the others are all service provider organisations.
- Te Ha o te Oranga, the Ngati Whatua Runanga health service delivery organisation, originally a rurally based health promotion service, but later delivering urban and regional services, including a residential rehabilitation facility for Maori youth with mental health, alcohol/drug issues. Based at Auckland, Wellsford and Dargaville with satellites in a number of rural villages in the region.
- Ngati Whatua Orakei Health Clinic, an Ngati Whatua urban community primary health and social service organisation based near the Auckland central business district.

The non-mana whenua case study organisations chosen for the study were:

- Te Puna Hauora, an urban community primary health and social service organisation. Based at Awataha Marae in the North Shore suburb of Auckland.

⁶ See Chapter 7 for maps of the mana whenua region

- Te Roopu Taurima o Manukau, a pan-tribal intellectual disability residential rehabilitation service. Head office in South Auckland; where throughout New Zealand.

My study focussed on understanding both Maori and non-Maori experiences in these organisations, and the study focussed on ensuring that the stories/experiences being collected were from a broad range of participants in the organisations. The study examines Maori experiences of developing and delivering hauora Maori to conceptualise models for kotahitanga between indigenous and non-indigenous peoples, so the study was designed to ensure that the experiences of people from all walks of life, and from all levels of responsibility within the hauora Maori organisation, were considered equally. Therefore a cleaners experience was to be considered equally with a medical specialists experience for instance. A Maori practitioners experience was to be considered equally with a non-Maori persons experience for instance. In practice this was congruent with the hui approach of the organisations studied which was generally inclusive of attendance and participation of all people from the organisation. Therefore, my pre-defined research method of inclusivity of experiences of all peoples of the organisation was attainable in the research process, because it was already a normal part of the organisational practices within the case study organisations. This provided the basis for my being able to listen to and understand how an organisation was practicing community relations through organisational hui, because hui generally included most of the staff and interactions/dialogue with the public weren't just being driven by organisational leaders or managers; everyone participated.

3.3.4 Indigenised case study approach

The case study approach was chosen for this study of five Maori health organisations because the case study approach is suited to studying relationships and how these relationships interconnect to systems; in this circumstance health and community systems.

Yin explains a case study approach as suitable for one where multiple sources of evidence are used “...an empirical inquiry that investigates contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence is used (Yin, 1994, p. 23)”. In this study, the case study approach was appropriate for this study because it

allowed a focus on relationships and how these relationships interconnect to create or connect to systems; the researcher had no control over the environment in which the study took place; the evidence was collected from a variety of sources including observation of governance, management, operational, community, and clinical, training, development, hui and programmes; and that evidence was collected from internal organisational documents and archival record including organisational management files, databases, video, recorded oral histories, websites, presentations prepared by the indigenous case study organisations for external people and organisations (for instance local schools, international visitors).

Of the four case study designs identified by Yin (1994), the most suitable for this study was the multiple-case study. The multiple-case study facilitates comparison between multiple communities based on the elements that the communities themselves felt were essential to the health developments. The use of multiple cases strengthened the results by allowing comparisons between the experiences. In this research, mātāuranga and tikanga are the elements Māori health organisations indicated were essential to the developing hauora Māori models. Hauora Māori leaders felt it was mātāuranga and tikanga which distinguished hauora Māori services from being just another medical, health, or disability service.

There are three approaches case studies can take, a descriptive approach, an exploratory approach or an explanatory approach (Yin, 1994). An explanatory approach was chosen because it suited explanations of the complex nature of the Māori-with-Māori experiences, and Māori-with-Crown experiences that then shaped, or were causal of, the Māori-with-non-Māori experiences being examined. The explanatory approach was also adopted into the methods through taking a traditional Māori story-telling approach to collection of the mātāuranga and tikanga experiences studied. The Māori story-telling approach is called for the purposes of this study *Kareretanga*, and is explained later in this chapter.

There was a significant limitation in using a case study approach within an indigeneity-based research process, in that a generalised case study approach does not adequately allow for researcher reflection of, and augmentation of, the complex nature of mātāuranga and tikanga of each case study organisation. This study focussed on how to gather and explain the richest forms of knowledge and information about experiences

from inside the Maori world of Maori health developments, as well as the richest forms of knowledge and information about how the Maori world of health developments engages with the non-Maori world of health developments. To resolve this conundrum, traditional academic case study approaches, as explained by Yin (1994; 2010), are combined with both the whanaungatanga based research approach, and the *Kareretanga* research method from this study, to modify and interpret the traditional academic approach to case studies into an indigenised case study approach.

Yin's (1994) idea that case studies facilitate an empirical inquiry where boundaries between phenomenon and context are not clearly evident, was combined with the indigenised case study approaches so that the contexts of health development and Maori development for the Maori health organisations could be explained from both te ao Maori and te ao non-Maori perspectives. An indigenised case study approach was useful because the research was within contemporary Maori communities who had formed around health development, yet the participants and stakeholders were often inextricably linked to other Maori communities in ways that impacted on the development and delivery of health models.

Yin's (1994) ideas of using multiple sources of evidence underpinned the *Kareretanga* approach, which was to triangulate sources of evidence including oral knowledge, hui, traditional practices, internal documents, external documents, indigenous participants, non-indigenous participants, health and medical participants, non health and medical participants, hauora experts and non-hauora experts. An indigenised case study approach was useful because the evidence was collected from a variety of traditional knowledge sources which included hui observations as well as participation of the researcher in traditional practices of the indigenous case study organisations and their communities.

Therefore, my research positionality as an Ngati Whatua person researching Ngati Whatua experiences, phenomenon and contexts, shaped my research approach. For instance, much of the information and knowledge for consideration was collected through my participation at hui of the case study organisations. The majority of these hui were open to the public, and under Yin (1994) ideas of evidence sourcing, could be regarded as direct observations. However Ngati Whatua tikanga means that if you have had a formal welcome into the hui by the elders or leaders of the hui, then you are traditionally regarded a participant rather than an observer. Your place at the hui,

traditionally, is either as 'mana whenua' which means you are of the people who tribally have authority over the lands where the hui is being held, or else you are manuhiri, or a guest, in which case you are bound by the rules of engagement set down by mana whenua for manuhiri (Walker, 2004).

The research was therefore conducted with Yin's (1994) ideas around 'participant-observation' as firm guidance, but in the process of the research it became apparent that this western or eurocentric dimensionality was not aligning well with Ngati Whatua expectations of mana whenua. The Ngati Whatua expectation of "you are here so you might as well manage a tea towel" means that as you are participating in the hui, you might as well contribute in whatever way possible, which would include at the very least helping with the dishes after the meal. Maori tradition denotes that a guest does not become part of the proceedings of a hui until after a meal has been shared with them; so helping in the kitchen would denote that you are committed to the kaupapa, or purpose, of the proceedings by virtue of your relationship as whanau or friend. This meant that that 'participant' vs. 'observer' aspect of my research needed to be broadly interpreted to fit with hui participants expectations of me during the research process.

An indigenised approach also allowed for rich data from a number of Maori experiences to be compared. The characteristics of this indigenised case study approach were: firstly, that the kaupapa and tikanga of the mana whenua iwi were paramount in the formulation of the research. This provided alignment for this study with an indigeneity-based research responsibility to mana whenua. Secondly, that the kaupapa and tikanga of the Maori health organisations studied were considered in the design of the research case studies. This provided alignment with this study's indigeneity-based research responsibility for rangatiratanga and manaakitanga. Thirdly, that the elements used for comparison between the case study organisations were aligned with the expectations for Maori health developments of the mana whenua iwi, the Maori health organisations and their communities, and aligned with experiences of tupuna in Maori health developments. This provided for this study alignment with an indigeneity-based research responsibility for whanaungatanga.

3.4 **Kareretanga** as research method

Kareretanga is an articulation of how to bring te ao Maori and te ao non-Maori together. I use the term *Kareretanga* as a way of acknowledging how members of my whanau, hapu and iwi have explained to me that one of my roles in life is to sit between te ao Maori and te ao non-Maori, and to try to find ways to make each understand and appreciate the other. I have been described by whanau, hapu and iwi as a ‘Karere’ or simply put, a person who provides a communications conduit for constructive engagement between Maori and non-Maori people and organisations. I have taken this concept of myself as a communications conduit between the two worlds, and have connected it to a method as a way to explore and explain how people express their experiences, sometimes orally, other times in images or in writing, and through many other forms of communication, so that a world their audience may be unfamiliar with might become more accessible. *Kareretanga* in this study looks at how people create and deliver communications that assist their audience to understand complex Maori knowledge and practices that are being delivered or received by Maori and non-Maori. *Kareretanga* is my articulation of what I see as a long tradition of relationality between whanau, hapu and iwi in te ao Maori with te ao non-Maori. Whanaungatanga for this study frames explanations of the relationships with whanau, hapu and iwi for the research process, whilst *Kareretanga* frames explanations through research outputs, from a Maori perspective, of the relationships and the implications of the relationships studied.

To ensure the rich data of multiple inter-personal and inter-organisational relations could be gathered and cross-referenced, evidence was collected from a number of different sources within whanau, hapu, iwi and organisational relationships occurring between te ao Maori and te ao non-Maori in the hauora Maori case study organisations. In this way evidence, which included orally transmitted information, could be verified by multiple sources and cross-referenced. This was important because Maori has only been a written language since British colonisation in the 1800s, and the tradition of oral knowledge transmission still dominates Maori socio-political-community practices in the present day. Yin (1994) identifies several sources of evidence that can be combined to create a multiple source study: physical artefacts, documentation, archival records, interviews, direct observations, and participant-observation. The two employed in this study were participant-observation to gather information from case study organisations, and

documentation to gather information from case study organisations, health funding and purchasing organisations, and public policy, documents and literature.

For this study, hui were an important way of gathering rich observational information, knowledge and explanations of matauranga and tikanga for hauora Maori service delivery. As an example, the speaker uses both Maori and English language to explain the whakapapa and whanaungatanga of the matauranga and tikanga under discussion to a Maori and non-Maori audience. This would contextualise the hauora model for them in a much more complex way than if it were just presented as a health service delivery model to achieve a specific health output or outcome. Therefore, in Maori terms, hui can provide a person with a vast body of knowledge and experiences of the particular matauranga and tikanga. The next time someone who was in that audience thinks of that organisation and their hauora model, they could recall the wealth and knowledge of experiences shared with them at the hui; so each phrase, for instance ‘whanau ora at Te Puna Hauora’ or ‘whaanau ora at Orakei’ would mean something quite unique rather than just translating the words into ‘whanau’ meaning family and ‘ora’ meaning wellbeing.

Other examples of using *Kareretanga* in practice for this study included my being at tangi and exploring the interactions of the hauora community in that setting; particularly because questions of hauora would often arise in these settings with some emphasis on the hauora workers providing responses to queries/issues the whole marae was discussing (for instance in cases of youth suicide). Exploring interactions at hui between hauora communities and non-Maori health organisations who were creating joint organisational models, memorandum of understanding, joint services, or finding ways to live in the same community together were other examples of *Kareretanga* in practice. Of the numerous hui that I participated in for the collection of knowledge and information data, the ones that had the most clarity in explaining matauranga and tikanga to non-Maori, and how this would be implemented for and by their organisations within their communities, were the training and development sessions for new staff, and the presentations to external guests. These were the richest forms for knowledge and information data collection because they were often prepared for a mix of indigenous and non-indigenous participants. The hui also often included an historical narrative of both the aspirations and development pathways of the communities concerned, and this gave a

broader context in which to understand community experiences. A mix of oral knowledge and visual presentation provided stronger explanatory data than would have been possible from documentary review alone.

The *Kareretanga* approach provided a way to more realistically identify the progression of the organisational matakā and tikanga than just relying on data from documentation. Documentation is one dimensional and misses the nuances of real time service practices and experiences. The actual dialogue of the practitioners and communities was therefore richer in a way that it was more focussed on what was happening now, how it was happening, and what was being planned to happen next. Often times the multiple dialogues that took place through hui would become reflected latterly in even more refined documentation; in other words their matakā and tikanga explanations became more succinct and explicit over time and reflective of expanded experiences.

Kareretanga was also employed as a frame for feeding back experiences and findings to the research community collaborators. Where I was explaining feedback to a Maori audience, I would also include the feedback presentation that had been used for non-Maori audiences and vice versa, so that people from either world could experience the differences and similarities between what te ao Maori participants and te ao non-Maori participants were asking about, or finding interesting about the research process, findings and outcomes. For instance, te ao non-Maori participants were fascinated by the role of kaumatua and kuia, where te ao Maori participants normalised the practice of including kaumatua and kuia in processes and organisations and didn't initially see why that was so intriguing for te ao non-Maori participants. For an example of *Kareretanga* based feedback, see Appendix 9.

Feedback was a continuous process which began at the same time as the case study hui observations from 2003. Often a copy of the information I was collecting would be requested by the meeting organisers or participants as notes to the meeting I was attending. As I would often be drawing diagrams to augment the text I was writing (for instance I might draw a diagram to explain a set of relationships apparent during a hui discussing matakā and tikanga), the diagrams would often be requested by hui participants and some were subsequently used by the organisations and other community members for their own purposes (see Appendices 8 & 9 for examples). Once the analysis

of the materials was complete, presentations of selected elements were made to people from the case study organisations who had asked to see where the study was at or for feedback on particular elements of the research. These feedback presentations were taking place regularly from 2003 through to 2010 as different peoples from the organisation or communities would ask for different information from the study.

Feedback to individuals and groups continued to provide additional insights and material for the research. Feedback was usually face-to-face, which was in keeping with Maori traditions of *kanohi ki te kanohi*; that face to face interactions have more substance than other forms of interactions. Sometimes organisations would request feedback in written form (see Appendix 9 ‘Tumeke’ as an example). The CEO of this case study organisation had asked me to be a part time HR manager for a few months during my PhD research with them, which I thought was mainly about my contributing something useful back to their community – but I latterly discovered it was because she really wanted me to live and breathe the organisation before I ‘analysed’ them as a researcher. While I was focussing on indigenising my academic research process, many participants from my case study organisations were focussing on ensuring the authenticity of the experiences I was having with them and their communities - because they really wanted to share the reality of their worldviews and experiences with readers of this study. My role as a *Karere* has been to bring the authenticity of their experiences, through the quagmire of academic research processes, and to provide a way for the reader to understand *kotahitanga* in *hauora* Maori, which is in essence a practiced reality for the non-Maori and Maori peoples of the *hauora* Maori organisations studied, as I think the chapter ‘Tumeke’ in the *Te Roopu Taurima* 10 year celebration book shows. How *Kareretanga* was applied in this research is explained below.

3.4.1 Research Steps

3.4.1.1 Knowledge and Information collection

My research interests include exploring and explaining how ethnic conflict is resolved in New Zealand. Theories from the fields of indigeneity, community health, political philosophy, identity politics, Maori development, development, anthropology, and sociology, have shaped my understandings of what is emerging as a distinct field of indigeneity-based inquiry, and the theorising of indigeneity. The most challenging aspect of the evolving theory of indigeneity is the placing of traditional indigenous

knowledge into the mix alongside western traditions of knowledge. To use a common western proverb to good effect: of the indigenous or the western schools of thought, which is the chicken and which is the egg?

For this study, the master knowledge system guiding the research is matauranga Maori. Theories of indigeneity incorporated into this thesis are focussed on how Maori scholars interpret, through matauranga based explanations, Maori/British or Maori/Crown or Maori/Pakeha relationships, and their ideas of constructive engagement to achieve kotahitanga between the two distinctive worlds.

This is a complex piece of research, so for ease of understanding, the research process is going to be introduced in three parts. The first part looks at the literature reviewed, the second part looks at the public policy documentation reviewed, and the third part looks at the case study materials collected, reviewed and considered. See Kareretanga – thematic analysis frames at Appendix 7 for a diagram of the review process.

3.4.1.2 Literature Review method

The scope of the literature reviewed is in two parts. Firstly contemporary indigenous health development and Maori health development literature was reviewed to gain an overview of contemporary issues and debates emerging nationally and globally. Following this review, my supervisor Sir Hugh Kawharu suggested that I look to see if there were any patterns emerging from my contemporary review that were repetitive of Maori health development experiences from the early colonial period. The literature and knowledge collection process needed to consider how to ‘walk the experience of the tupuna into the future’ through alignments with the contemporary experience I was studying. The second part of the literature reviewed was Maori health development initiatives that had occurred in the late 18th and early 19th centuries. The main objective of this second review was to make sure the knowledge and experiences of the tupuna Maori for hauora remained a vital part of this contemporary research. The goal of this review was therefore to see if there were themes from historical Maori experiences of health development that could be used to frame or analyse my contemporary research.

The search method used was to firstly look at Maori authored academic literature on health and development, including books, journal articles, masters and PhD dissertations and theses, and grey literature where available, including from Maori health hui. The

goal of this search was to look for what the authors were most focussed on discovering and explaining about Maori health developments. Assistance for this part of the process was sought from a Maori librarian who was an expert in searching Maori literature. Anahera Morehu assisted in creating numerous database searches, with the search criteria continuously re-evaluated and broadened to gather as much relevant data as possible.

On reviewing the Maori authored literature, a key focus for Maori health developments that kept recurring was how matauranga was being, or could be used, to inform tikanga. This set the first goal of the study: to identify and explain successes and barriers to success of using matauranga to inform tikanga. Relevant pages were copied, highlighted and filed. They were read firstly for a general understanding. They were then read a second time in conjunction with other searched literature. They were then thematically categorised to the three debates that were emerging after the second reading of all literature; indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and matauranga as indigenous knowledge for health development.

The second search method was to search for contemporary academic literature on Maori and/or indigenous health development. The search criteria were: 'Maori health', 'indigenous health', and 'aboriginal health'. As well as books, journals and other publications from the 1980s to 2006, conference papers, and notes from hui on these topics were also considered. There was a significant amount of grey literature, particularly government documents and reports that were considered. The goal of this search was to look for gaps in Maori and indigenous health development that were identifiable in the literature. For this search, in addition to the assistance of the Maori subject librarian at the University of Auckland, the assistance of a Maori with expertise as a health and medical subject librarian based at the University of Auckland medical school library was sought. Jacob Powell assisted in creating a number of searches of national and international databases for any relevant publications. Relevant pages were copied, highlighted and filed. They were read firstly for a general understanding. They were then read a second time in conjunction with other searched literature. They were then analysed specifically for relevant data related to the three debates that were emerging after the second reading of all literature.

On synthesizing the literature reviewed from the both searches, an overriding gap in the literature that was identified was explaining the lack of inclusion of indigenous knowledge and practices within indigenous health developments and related literature. The third search method was to search historical and contemporary literature discussing Maori health developments from 1840 to 1980. For this historical review, the questions I focused on to organise and structure my knowledge and information data were: the politics of early Maori health - what were some of the underlying issues where Maori gained kotahitanga traction; the policy of early Maori health – was there early indigenous health policy; the Maori leaders of early Maori health – who were they and what did they achieve towards kotahitanga with non-Maori; early Maori health practices – what were they and what did they achieve in terms of kotahitanga with non-Maori.

This review included looking at the parliamentary debates from the late 1800s and early 1900s. These were reviewed with the goal of understanding parliamentary attitudes to Maori health development, and to explore the participation of Maori members of parliament in Maori health developments in parliamentary debates. Copies were made of pages where ‘Maori’ was mentioned, highlighted the relevant passages, then sorted for comments by Maori, comments by non-Maori, and marked them ‘positive’ ‘negative’ or ‘neutral’. Proceedings of the Maori/Crown hui from the 1800s and early 1900s were also reviewed, for instance the 1860 Kohimarama Conference (Browne, 1860), with the goal of understanding how Maori/Crown relations were evolving from the mid-19th century in the Ngati Whatua tribal region that I was studying. Again, these were copied, and relevant sections where Maori were trying to explain matauranga or tikanga to non-Maori participants were highlighted, and where Maori health was mentioned these passages were highlighted. Again these were sorted as ‘positive’ ‘negative’ and ‘neutral’. This information did not require much sorting; in the end there was only a moderate amount that related specifically to health development to be reviewed.

While this process did not result in a lot of information, the actual process itself was highly intensive because a lot of the literature I was reading was in te reo Maori, so I had to not only try to consider what it meant in the English language, but my supervisor Sir Hugh Kawharu was insistent that I considered what it meant in the time in which it was written. Sir Hugh Kawharu, for instance, had me read the proceedings of the 1860 Kohimaramara conference in both English and Maori and he then had me write 6,000

words for him on what I discerned were not only the differences between the way the discussions had been presented in writing, but also 6,000 words on trying to discern what the subtleties being inferred by the Maori orators were of the use of English knowledge, for instance biblical knowledge, in the discussions. I also spent days just sitting on the floor in the University of Auckland library reading any words uttered by Maori MPs in the late 1800s and early 1900s, and making notes to try to understand the way in which they were being treated by non-Maori MPs, but also how Maori MP and Maori expectations were being received and treated by non-Maori MPs in ongoing debates. Sir Hugh would discuss my findings after each literature search with me, and if he felt I needed more focus he would set a 6,000 word assignment on a particular aspect he felt was essential to my really understanding the literature I was reviewing. We would then debate my findings, and I would be required to substantiate my opinions. At the time Sir Hugh insisted this was his ‘Oxford’ tutoring practice. I have subsequently considered it may also have been his expectation, as a Maori leader, that scholars of Maori knowledge treat substantively with the available materials to respect the efforts of the tupuna. Possibly Sir Hugh wanted also to ensure that I complied with what seems to be one of the favourite Ngati Whatua whakatauki used by our kaumatua and kuia for us younger ones of ‘*whaka iti*’, so in other words to humble myself and not put myself above the experiences of others by not considering them before myself. The knowledge and information from this review was then used to augment the historical discussions in Chapter 4, and synthesised to contribute to the overall discussions of kotahitanga in Chapter 10.

I also reviewed a number of books, websites and grey literature, by Maori and non-Maori authors and commentators, with the goal of understanding how the role of early Maori leaders involved in Maori health and Maori development were perceived, both historically and contemporarily. I reviewed books and articles exploring Maori socio-political developments, to further understand the context for Maori health developments between 1840 and 1980. I spent time in the rare books and papers collections at University of Auckland, manually searching for where any Maori health development initiatives or leaders were mentioned. Relevant information was copied, highlighted, and then put into a document to create a linear format I was putting together for clarity of how issues developed over time. Again this information did not require much sorting; in the end there was only a moderate amount of information to be reviewed once it had been

distilled for relevance. However, it was very time consuming reading as much as possible just in case there was a mention of something relevant to the study.

The historical literature reviewed has resulted in the addition of a chapter to the thesis that had not been part of the original thesis/study plan. In order to get a linear sense of how the political systems and health policy systems evolved in terms of post-1840 Maori experiences, a large amount of literature needed to be consulted with, reviewed, and cross referenced. There were fragments of information all over the place. I was astounded at how complex it was, at the time, to find substantive amounts of relevant information in any one publication. This motivated me to bring the information together in one chapter that could provide both a timeline of the experiences and a discussion of Maori experiences of political development and Maori health developments from early colonisation (see Chapter 4).

As per the advice of my supervisor Sir Hugh Kawharu, one of the goals of this literature review was to look for historical patterns similar to those I had found with the first two contemporary literature searches. There were three patterns that emerged, which when synthesised were developed as tupuna macro-frames to inform the overall kotahitanga analysis (see Chapter 10). These tupuna macro-frames were: i) rangatira hauora, the impacts on health developments of Maori leaders and leadership; (ii) community initiatives, how communities created initiatives for health developments; and (iii) the role of Maori nurses in health developments.

3.4.1.3 Public Health Policy Documents Review

The scope of the search for the New Zealand health systems and policy documents reviewed was to find anything that mentioned Maori health from 1980s to 2003 (a list of the selected policy documents that were sourced from the case study organisations archives and reviewed is at Appendix 5), other policy documents reviewed and referred to are referenced in the bibliography. The first step of the public health policy search was to do online database searches through the Auckland University library. Where the policy document was available online, it was saved electronically and reviewed electronically. A number of the documents reviewed were not available online and were sourced through a number of physical locations which included: the Auckland public library, the Wellington public library, the University of Auckland libraries, the Victoria University library, the Ngati Whatua Runanga public policy document holdings, the

Ministry of Health in Auckland and Wellington, the Ministry of Maori Development in Auckland and Wellington. A number of public health policy documents being used by the Maori health organisations studied provided a source for copying some of the more obscure public health policy documents that were hard to track down. Where possible a copy of the document was obtained, a hard copy, an electronic copy, or a scanned copy. Where this was not possible, a photocopy of the relevant pages was taken. At the time of this study, many of the documents required for review from the 1980s were difficult to source, for instance reports that influenced particular public health policies.

The first reading of the public health policy documents looked for mātāuranga and tikanga written in te reo Māori and highlighted these. The second reading of the public health policy documents looked for mātāuranga and tikanga written in English and highlighted these. The third reading of the public health policy documents looked for where Māori people/models/mātāuranga/tikanga were being quoted or used in the health policies, and these were highlighted. The first analysis used a table to identify which mātāuranga/tikanga seemed dominant/accepted/repeated in the health policy documents.

The Māori health development literature from the 1970s to 2002 identified in the literature reviewed in Chapter 2 was then re-reviewed to search specifically for mentions of Māori and health policy to understand Māori constructive engagements with the political and health sectors towards mātāuranga based health policy developments. The second analysis of the public health policy documents reviewed searched particularly for discussions of successes, and barriers to success, of using mātāuranga to inform tikanga in health policy and health development. The Māori health development literature from Chapter 2 was then re-reviewed to search particularly for discussions of successes, and barriers to success, of using mātāuranga to inform tikanga to compare against the public health policy document review.

The final reading of the policy documents was for the public health policy analysis in Chapter 6. In the public health policy documentation studied, the analysis focussed on the mātāuranga of ‘whānau ora’ and ‘rangatiratanga’ in te reo Māori and English (a selection of the documents reviewed are listed in Appendix 5). The terms ‘whānau ora’ and ‘rangatiratanga’, and terms similar to them in both English language and te reo Māori were identified in public health policy documents from 1990 to 2003. The data collection was split into two time periods, (i) 1990s and (ii) 2000s, to reflect the pre-*He*

Korowai Oranga period, and the *He Korowai Oranga* (Minister of Health, 2001; King & Turia, 2002) period (from 2000 when the consultation on *He Korowai Oranga* began).

3.4.1.4 How literature and policy documents reviewed informed thematic content analysis for case studies

One purpose of synthesizing the information collected in the literature and policy documents reviewed was to create a thematic frame for the case study analysis that was to follow. In the thematic content analysis (Patton, 1990; Yin, 1994), knowledge and information from literature and policy documents was organised under broad themes to find patterns emerging.

The broad themes for the first literature reviewed were: the politics of early Maori health - what were some of the underlying issues where Maori gained kotahitanga traction; the policy of early Maori health – was there early indigenous health policy; the Maori leaders of early Maori health – who were they and what did they achieve towards kotahitanga with non-Maori; early Maori health practices – what were they and what did they achieve in terms of kotahitanga with non-Maori.

The broad themes for the second literature reviewed were to analyse the parliamentary debates from the late 1800s and early 1900s to understand parliamentary attitudes to Maori health development and to understand the participation of Maori members of parliament in Maori health developments in parliamentary debates. Proceedings of the Maori/Crown hui from the 1800s and early 1900s were analysed to understand how Maori/Crown relations were evolving from the mid-19th century in the Ngati Whatua tribal region. The role of early Maori leaders involved in Maori health and Maori development and how they were perceived, both historically and contemporarily, was explored. Maori socio-political developments were explored to further understand the context for Maori health developments between 1840 and 1980.

The patterns emerging from analysis of these broad themes were then synthesized into two thematic content frames for the case study. The first frame reviewed the information collected about discussions of successes, and barriers to success, of using mātāuranga to inform tikanga. The second frame reviewed the information collected in line with the tupuna frames from Chapter 2, which were: i) rangatira hauora, the impacts on health developments of Maori leaders and leadership; (ii) community initiatives, how

communities created initiatives for health developments; and (iii) the role of Maori nurses in health developments.

The broad themes for the review of the public health policy documents that have been adapted into thematic content frames for the case study were: Identify and analyse Mātauranga/Tikanga being expressed in te reo Māori; Identify and analyse Mātauranga/Tikanga being expressed in English; Identify and analyse which Māori people/models/ mātauranga/ tikanga they are quoting/using; Identify and analyse which mātauranga or tikanga seems dominant/accepted/repeated.

Once the theme 'identify and analyse which mātauranga or tikanga seems dominant/accepted/repeated' was identified, a further analysis of the public health policy documents for the presence of the mātauranga of rangatiratanga and whānau ora was undertaken. This was once again a comparative analysis of the pre-He Korowai Oranga (King & Turia, 2002) period of the 1990s, and the He Korowai Oranga period from 2000. The results of this analysis are discussed in Chapter 6.

3.4.1.5 Case study document review – mid to late 1990s

The first step of the case study knowledge and information data collection was an 'organisational inception and creation period' document review. All available internal documents of the case study organisations from the mid-1990s to the late 1990's were reviewed to identify *Kareretanga* themes. For the case study organisational inception and creation period documentary review, the *Kareretanga* themes used to organise the knowledge and information data were: identify mātauranga/tikanga in te reo; identify mātauranga/tikanga expressed in English; which Māori people/models/mātauranga/tikanga are they quoting using; which mātauranga or tikanga seems dominant/accepted/repeated; look particularly for discussions of successes, and barriers to success, of using mātauranga to inform tikanga. For this document review of internal documents, I requested the organisations allow me to see and work with documents that they felt substantively expressed their mātauranga and tikanga in this period. The documents reviewed included: strategic, management and operational planning; training and development documents; presentation documents; public relations material including websites, brochures, information in waiting rooms, correspondence with other community groups; media releases; contract reports, correspondence, databases, management systems, best practice models, Requests for Proposal. The documents were

reviewed to collect information and knowledge data to assist in identifying successes and barriers to using matauranga to inform tikanga. Documents were analysed straight from the correspondence files by copying and collating relevant data onto a separate 'Summary Table Period 1' document. A full copy of one or more documents that could be used as an exemplar of the data being collected (for instance best practice models) was then requested from the organisation and placed with the 'Summary Table Period 1' document. A list of selected case study documents reviewed is at Appendix 5.

3.4.1.6 Case study document review – 2000 to 2003

The second step of the case study knowledge and information data collection was an 'organisational implementation period' document analysis. All available internal documents from case study organisations from 2000 to 2003 were analysed to identify *Kareretanga* themes. In the case study 'organisational implementation period' documentary review, the *Kareretanga* process was identical to the 'organisational inception' review, as discussed above. Documents were analysed straight from the correspondence files by copying and collating relevant data onto a separate 'Summary Table Period 2' document. A full copy of one or more documents that could be used as an exemplar of the data being collected (for instance best practice models) was then requested from the organisation and placed with the 'Summary Table Period 2' document. A list of selected case study documents reviewed is at Appendix 5.

At this point the earlier analysis of the 'organisational inception and creation period' from the 'Summary Table Period 1' documentation was reviewed and cross-referenced with the 'Summary Table Period 2' document for emerging themes, and checks for omissions were made.

3.4.1.7 Case study hui and Observational Review: (1) Hui review 1993 to 2003; (2) Hui observations 2003 to 2006; Case Study document review 2003 to 2009

A selected list of case study hui and observations can be found at Appendix 6. For the case study hui and observational review (see Chapter 9), first the *Kareretanga* themes (see Appendix 7 – Thematic Analysis Frame Case Study) emerging from the 1999 to 2003 hui knowledge and information data were tabulated, then compared with the documentary data that had been tabulated from the same period onto a 'Observation and Document Comparison Table 1999 to 2003'. Then observational knowledge and information data was collected from the 2003 to 2006 hui. Then relevant documentary

data from 2003 to 2009 was collected. Documents were analysed straight from the correspondence files by copying and collating relevant data onto a separate 'Summary Table Period 3' document. A full copy of one or more documents that could be used as an exemplar of the data being collected (for instance best practice models) was then requested from the organisation and placed with the 'Summary Table Period 3' document. *Kareretanga* themes (see Appendix 7 – Thematic Analysis Frame Case Study) emerging from the 2003 to 2006 hui knowledge and information data were tabulated, then compared with the documentary data that had been tabulated from 2003 to 2009 onto a 'Hui observation and Document Comparison Table 2003 to 2009'.

As the later observational knowledge and information data was collected, the earlier data historical, documentary and observational data was reviewed, other emerging themes were noted, and checks for omissions were made (see *Kareretanga* Thematic Analysis frames at Appendix 7 for a diagram of the review process).

First the *Kareretanga* themes emerging from the 1999 to 2003 hui knowledge and information data were compared with the documentary data from the same period. Then from 2003 key informants at an executive and governance level of the case study organisations were interviewed. However the knowledge and information data collected in the interviews was seeming to be more aspirational than practice driven, so the decision was made in 2003 to collect the bulk of the observational research knowledge and information primarily by listening to how various peoples from the organisation representing various clinical, non-clinical, support, allied health, as well as multiple ethnic and cultural backgrounds, explained their knowledge and experiences of mautauranga and tikanga of the organisations hauora Maori models. The idea was to ensure that there was a good mix of Maori service delivery (for instance Rongoa Maori practitioners) with traditional medical service delivery (for instance general practitioners), and the ability for the receptionists experiences to be considered equally with for instance social workers experiences. This meant that the experiences of people at all levels of the organisation were able to be cross-referenced and generalised for each of the organisations.

In most of the organisations, at least half of the people of the organisation studied were observed and considered on multiple occasions. The organisations ranged in size from around 10 staff to around 400 staff. The *Kareretanga* approach involved attending hui for

each organisation over at least a two year period so that comparisons of the matakā and tikanga in practice and for veracity were possible. For Tihi Ora, Orakei, Te Puna Hauora and Te Ha (the purchaser and primary provider organisations created in the mid-1990s) notes from 1999 planning hui that I had facilitated for the organisations were also used. For Te Roopu Taurima, notes from my attendance at board meetings from 2004 were also referred to. The majority of the hui observations for all case study organisations took place between 2003 and 2006.

Examples of the information gathered under the *Kareretanga* approach, through participant-observation include: kaumatua and kuia explanations to new staff and board members of the matakā and tikanga of their hauora Māori models; management presentations to inter-sectoral agencies involved in the organisations service delivery or co-management of service consumers; management and board presentations to iwi, health funders, social policy funders, government representatives; staff discussions of services to new staff in training; and kaimahi of the organisations presenting at health conferences.

Notes were either taken in shorthand or typed directly onto a laptop. The knowledge and information data was then tabulated under several themes. I have included at Appendix 7 the research process and thematic analysis frame. Appendix 8 is an example of hui observation notes.

3.4.1.8 Beginning the case study analysis

Coding and analysis of documentary and observational data was done manually. All organisations allowed access to internal documents for analysis with the proviso that patient and organisational confidentiality was maintained. The coding frame used for the case study organisation internal documents can be found at Appendix 7, *Kareretanga – Thematic Analysis Frames*. The first analysis focussed on which matakā or tikanga seemed to be dominant/accepted/repeated in the documents. The second analysis focused on discussions of successes, and barriers to success, of using matakā to inform tikanga that were present in the documents reviewed. The third analysis focussed on the themes from the tupuna macro-frames and looked for alignments with i) rangatira hauora, the impacts on health developments of Māori leaders and leadership; (ii) community initiatives, how community's created initiatives for health developments; and (iii) the role of Māori nurses in health developments.

The observational notes were, as soon as possible after the hui, summarised and integrated into each individual case study organisation folder, see example at Appendix 8. At times diagrams/pictures were created to capture the dynamics of the relationships unfolding and issues discussed that could prove pertinent to the study. Some of these diagrams/pictures were subsequently used by the case study organisations (for instance Appendix 3, Te Puna Hauora Organisational Model 1). The case study organisation folders were then compared on a regular basis for newly evolving themes, and to check for omissions or improvements that could be made to the process.

3.4.1.9 Knowledge and information analysis

The primary process used to analyse the knowledge and information data was thematic content analysis (Patton, 1990; Yin, 1994) in which data was organised under broad themes and then as patterns emerged through integrating and analysing the ‘early’ data, they could be tested against the ‘later’ data. See Appendix 7 for a diagram of research process and analysis themes.

The research used multiple methods for collecting knowledge and information data. Data was collected from observations and interactions at hui of the case study organisations and communities (a selected list of hui observations is at Appendix 6). It was also collected from study organisational documentation dated mainly mid-1990s to 2009 for the case study analysis (a selected list of case study documentation is at Appendix 5). Further data was collected from health policy documentation between 1990 and 2003 for the policy review (a selected list of policy documentation used by the case study organisations and also in the policy analysis is at Appendix 5).

The literature review of indigenous health development and Maori health development in Chapter 2 focussed on the presence of, or perceived barriers to the presence of indigenous knowledge for health development, within the literature. The historical review in Chapter 4 identified broad kotahitanga themes emerging from early colonisations experiences of health developments. In Chapter 6 the public health policies of the 1990s through to 2003 were reviewed to identify and compare the presence of the matauranga of rangatiratanga and whanau ora between the 1990s and the 2000s policy documents.

The case study analysis compared the kotahitanga themes emerging from the knowledge and information from hui held between 1999 to 2003, case study organisational documentary data available from the 1990s to 2009, and knowledge and information collected from hui observations between 2003 and 2006 (see Chapters 7, 8 & 9).

The knowledge and information data from both the *Kareretanga* notes taken at hui, and the knowledge and information data from the case study organisational documentation was analysed and then synthesised into tables of case study themes (the thematic frame is at Appendix 7 and an example of case study hui observations is at Appendix 8). The first analysis of the *Kareretanga* notes taken at hui and the case study documents considered the case study theme of ‘matauranga and tikanga that was expressed in te reo Maori’, and the second analysis considered the case study theme of ‘matauranga and tikanga in English’. The third analysis of the *Kareretanga* notes taken at hui and the case study documents considered the case study theme of ‘which Maori people/models/matauranga/tikanga were being used or quoted’. The fourth analysis of the *Kareretanga* notes taken at hui and the case study documents considered case study theme of ‘which matauranga or tikanga seemed to be dominant/accepted/repeated in the documents’. The fifth analysis of the *Kareretanga* notes taken at hui and the case study documents considered the themes from the tupuna macro-frames of i) rangatira hauora, the impacts on health developments of Maori leaders and leadership; (ii) community initiatives, how community’s created initiatives for health developments; and (iii) the role of Maori nurses in health developments.

This method of knowledge and information analysis aligns with methodological triangulation, which is the use of multiple methods to study a problem (Patton, 1990) and thereby strengthen the validity of the results. Data triangulation, which is when data is collected through different people and at different times and places (Berg, 2001) was also incorporated into the case study research design to ensure the validity of this knowledge and information analysis. Triangulation through collecting data from different sources and through different methods (Yin, 2010) was also incorporated into the case study research design, and into the knowledge and information analysis, to authenticate the reporting of the events studied.

A selected list of case study hui and observations is at Appendix 6. A table showing the research process and thematic analysis frame for *Kareretanga* is at Appendix 7, an

example of a hui observational analysis, notes and analysis is at Appendix 8, and an example of case study feedback is at Appendix 9. The organisational analysis of this knowledge and information is reported in Chapters 7 & 8; the case study chapters. The cross-analysis and synthesis of this knowledge and information is reported as ‘conceptualising kotahitanga models’ in Chapter 9. In Chapter 10 ‘hauora kotahitanga models’ are conceptualised.

3.4.1.10 Synthesising the knowledge and information

To synthesise the knowledge and information collected, I firstly created three files (one electronic and one physical for each debate) in which to collate information relevant to the three research debates of indigeneity for health development, matauranga for health development and constructive engagement for health development. I had an electronic and a physical filing system for each of the case study organisations, and their information was sorted into the *Kareretanga* thematic categories in Appendix 7. There was an electronic and physical file for the Summary Tables – Periods 1 to 3; and an electronic and physical file for the Observational Comparison Table.

In synthesising the knowledge and information collected and considered, there were three levels of synthesis I was interested in achieving: organisational, community, tribal. The organisational synthesis speaks to how the members of the organisation interacted. The health sectoral synthesis speaks to the relationships between the peoples of the case study organisations and the peoples of the health sector. The community synthesis speaks to the organisational-health sector interactions that facilitated the community relationships. The tribal synthesis speaks to the Ngati Whatua-with-Maori and non-Maori peoples, communities, and organisational relationships, and how these were realised through the kotahitanga models explored in the organisational, health sectoral and community syntheses. Three files of summary data for organisational synthesis, community synthesis and tribal synthesis were created electronically to facilitate transfer of information between the data and the study reports.

I was using information from document analysis, and knowledge and information that was from hui review and observations. The knowledge and information was constantly revisited and reflected upon as the research process rolled out. The first organisations ‘case studied’, Tihi Ora and Te Puna Hauora, provided a strong basis for understanding how to conduct the later research with Orakei, Te Ha and Te Roopu Taurima. As the

latter research was undertaken, the earlier organisations researched were revisited to re-check information and knowledge previously collected, and to see whether the information and knowledge was still consistent with organisational practices by different people at the later period in the organisations life.

To begin with, I looked firstly to literature about Maori health developments, historical and contemporary. This did not take long. There isn't much of it. What I did find was a number of Maori health commentators and researchers who were contributing to regional and international studies of indigenous health developments, so I began reading the international research on indigenous health developments. I kept revisiting this international, as well as national, research on indigenous health developments throughout my study period through continued database searches, and continuously re-evaluated the progress of my studies in terms of the information and knowledge from this evolving field of inquiry. The synthesis of the information I had collected throughout my case studies was the final step of my research process and therefore most influenced by trends I was seeing in the international literature.

Chapter 9, the organisational synthesis, draws the threads of the organisational matakā, tikanga and constructive engagements from Chapters 7 and 8 together and conceptualises these as hauora kotahitanga models. Chapter 10, the organisational, community, and tribal syntheses, firstly summarises the findings of the case study research into the matakā Maori that was used to develop the publicly funded health models. The tikanga Maori that were used to deliver the matakā Maori through the publicly funded Maori health models from the case study research then are summarised at the micro-level as 'hauora kotahitanga - organisational'. Maori experiences at the community level of the development and delivery of hauora Maori health models are then considered as meso-level conceptual models for 'hauora kotahitanga - community' or co-operative co-existence between indigenous and non-indigenous peoples. Models for co-operative co-existence based on hauora Maori experiences in the Ngāti Whātua rohe and tupuna experiences from Chapter 4 are then explored as macro-level conceptual models for 'hauora kotahitanga – tribal & tupuna'.

Chapter 11 concludes the thesis by responding to the overall question and proposing future potential uses for this research in kotahitanga and hauora developments, and in co-operative co-existence between indigenous and non-indigenous peoples.

3.5 Limitations of the study

In undertaking any study, there are always limitations and challenges to what it is possible to achieve. One example of a limitation to my study identified by some of my non-Maori research advisors, and often debated, was why I had chosen to restrict the study to my own tribal region. To any indigenous person that question is akin to ‘why are two legs more useful than one’, so it was challenging to formulate a response that would both satisfy non-Maori perplexity and not cause Maori perplexity upon reading this. My response to this question is explained in more detail below. This example shows what is in essence one of the main limitations of this study, that I am writing for a Maori and a non-Maori audience, and that even though I am both a Maori and a non-Maori, sometimes I found it difficult to explain the Maori world to the satisfaction of non-Maori research advisors and conversely the non-Maori world to the satisfaction of Maori research advisors, during this study.

One thing I have discovered through ten years of academic lecturing on indigenous issues is that non-indigenous audiences are eager to gain more understanding of the perspectives and understandings of indigenous peoples and issues, and conversely indigenous audiences are eager to gain more understanding of the perspectives and understandings of why non-indigenous peoples view/treat indigenous knowledge and issues in particular ways. Trying to address both audiences in the one lecture often presents a near insurmountable challenge. I was hoping that in researching and writing for this study I would find a cohesive way of achieving this. The study was an attempt at bringing the two worlds, indigenous and non-indigenous, into one space; a dissertation based on living together differently, in the English language for te ao non-Maori, and an indigeneity-based study grounded in matauranga Maori for te ao Maori.

The first limitations I will address here are the tribal and Maori limitations, and the next I will address were some of the personal limitations and constraints I chose or experienced. The final constraint discussed is locating regional and localised findings within globalised debates on indigenous health developments.

Maori and Tribal limitations: One limitation of this research is that I was studying with my own tribe mainly on their lands, and so the mana whenua considerations take precedence over my activities as a researcher. In practice this could have proven to be an

advantage when dealing with the Ngati Whatua organisations, and conversely resulted in possible disadvantages when dealing with non-Ngati Whatua organisations. In reality all participants were eager to assist a local Maori person in her research project, and eager for hauora Maori research to be available for future Maori health developments, so the potential limitations did not eventuate.

There were approximately 200 Maori health organisations nationwide at the time this study was undertaken. By limiting the selection of case studies to the Ngati Whatua region only, and to five of the six hauora Maori organisations in the region, I made the active decision not to seek generalisable findings or representative coverage for hauora Maori nationally, but rather to sacrifice generalisability to focus on a more in-depth analysis and explanation of organisational, community and tribal experiences and findings. One reason for doing this was because I could see there were significant regional variations occurring in Maori health developments in the study period, and I was interested to have in-depth knowledge and information from one region that could potentially be augmented with studies done by other researchers in other regions at a future date. I also aligned with my tribal leaders' preference, which was to have research on our tribal lands undertaken by a tribal member. In aligning with my tribe's preference, I did want to tacitly respect the possibility of other tribes choosing to have their own tribal members research their health experiences; so I excluded other tribes' mana whenua experiences from my study. This exclusion did limit the scope of the study in terms of missing the greater diversity of hauora Maori experiences that may have occurred in other tribal regions, and in urban Maori affiliated organisations.

The five case study organisations in the Ngati Whatua region were chosen because they fell directly under the North Health defined sub-region for Maori health assigned to Ngati Whatua from 1995 (Ngati Whatua & Northern Regional Health Authority, 1995a, 1995b; Walker, 1996, p. 3). It is the relationships between Maori and non-Maori that evolved through Maori health developments from this Ngati Whatua-North Health 1995 initiated relationship that are the subject of this study. There were a number of Maori organisations within the North Health region. Within the traditional Ngati Whatua tribal boundaries the health funder had created Maori health organisations under Tainui (in the south of Ngati Whatua rohe) and under Tai Tokerau (in the north of Ngati Whatua rohe). I considered but rejected including case studies from these two other MAPO regions.

The rejection was because of tribal tensions that could have occurred during comparisons of matauranga, tikanga, and political relations might have resulted in offence to Ngati Whatua mana; or worse, as I am Ngati Whatua, to the mana of other iwi.

As discussed previously, it could also have been deemed impolite for someone from Ngati Whatua to come and study what another iwi was doing when they might well prefer to have one of their own iwi members do their study. This was the situation with two of the potential case study organisations in the Ngati Whatua region, Waipareira Health, which is an urban Maori community provider, and Hapai Te Hauora. One of the Waipareira Health whanau members had recently completed an MA thesis on the experiences of Waipareira Health, so to have included them in the study may have been seen as impugning their mana when they had already chosen to be researched by one of their own community members. This was also the situation with Hapai Te Hauora, a public health organisation co-governed with Ngati Whatua by Waipareira Health, and Tainui MAPO. There were only four Maori primary care providers, one Maori intellectual disability provider, and one Maori health and disability purchasing organisation in the Tihi Ora MAPO sub-region in the case study period. Apart from Waipareira Health, the other four provider organisations were included in the study, as were the Maori intellectual disability provider and the Maori health and disability purchasing organisation.

There were several interesting characteristics of the Ngati Whatua tribal region that made it attractive for a localised study. It contains New Zealand's largest city which is home to a quarter of the total population of the country. It contains a large rural Maori population (predominantly Ngati Whatua peoples). It has the largest urban population of Maori (it is predominantly non-Ngati Whatua with peoples from most other New Zealand tribes present). It has examples of Maori health provider organisations that are affiliated to Ngati Whatua, and others who are not. In some regions in New Zealand there are only tribal-affiliated providers. This mix of Maori peoples and tribal affiliations provides a panacea to the limitation of studying just one tribal area – by looking at both tribal affiliated and non-tribally affiliated organisations it was possible to consider the findings regionally.

Most importantly, 'For Maori by Maori' health developments are a characteristic of Maori health developments from the 1990s, particularly in rural areas with defined Maori

populations. However, this study explores a broader context of Maori health developments where the indigenous and non-indigenous communities are highly integrated.

An important differentiation for this study from many other hauora Maori studies is that it examines 'by Maori' rather than 'for Maori' developments. The case study organisations studied were chosen specifically because they were inclusive of non-Maori organisational members and service receivers. This aspect of the study was easier to achieve by studying the tribal region that has the most ethnically diverse population in the country; Ngati Whatua.

Personal limitations: One of my initial constraints was I chose to only look at the knowledge underpinning the practices, rather than measuring or quantifying practice. I wasn't measuring this as being more Maori than that, or this person's practice as being more Maori than that. Some of the tensions of non-Maori working with Maori practices, particularly as expressed by Maori, were therefore not recorded, examined or explained. This is a limitation to my research that I would now, as a more confident Maori researcher, be able to more adequately resolve to provide more focused information and knowledge of this interesting aspect of Maori health development. The study was an interpretive way of sourcing communicative information and was designed not to be too tightly controlled or measurable. The interpretive approach gets closer to the aspects the study was researching, because the cultural meanings studies are fluid and contextual, and therefore not easily measurable or quantifiable.

Another of my personal initial constraints I had to resolve is that as a Maori we tend to traditionally get our knowledge primarily from elders and leaders about matakā and tikanga. I needed to step through this personal constraint and move towards finding ways to listen to and understand the experiences of both Maori and non-Maori who were delivering the services, but who weren't Maori elders or leaders. Using thematic frames to organise the knowledge and information helped me remove the potential of giving higher credence to contributions from managers, Maori, or elders than those from other participants.

By choosing to aggregate data by organisational, health sectoral, community and tribal relationships, individual experiences of people working in Maori health were not

explained in detail. This constraint protected the individual but also minimised some of the individual journeys of hauora Maori practitioners. However, inclusion of such material would have involved quite a different ethical and study approach.

In terms of hui observations, although I was technically focussing on matauranga, tikanga, service models and responding to specific study questions, because I often used shorthand to take notes I would often have quite full information from the meeting which I would then extract the information and knowledge pertinent to my thesis from, generally the same day or within the same couple of days. If I was direct typing notes, because I type fast, many of my notes of hui were typed verbatim (one ear listening and typing, and one ear listening and pondering). Hence an organisation would often ask to have a copy of my notes from the meeting because they would be more detailed than they had themselves. Therefore I had to be careful to remove my personalised hui observations from the original notes before they were given to the organisation (often the same day or next day). This made collection of information a bit more complex than it would have been had I been doing direct hui observations because I felt constrained in my ability to put too personalised observations in about the characters and characteristics of meetings into my notes as they were, through agreement with the organisations, available for their use.

The use of recording instruments might have restricted the confidence of the people giving the presentations, or joining the discussions at hui, hence the decision not to use them. However, the material was my own observation of the proceedings, and therefore there were several levels of interpretations that were taking place as I listened to, noted down, and occasionally drew diagrams for the study. Often more than one person from a hauora Maori organisation would be talking on the same subject, so the notes might be summarised and annotated as each consecutive speaker expounded on the particular subject. The note taking was fluid and contextual in line with the hui styles, and to allow for the difference in cultural meanings that could occur through different presenters in the same hui talking on the same subject.

Note taking was both a flexible and unobtrusive way to observe and collect and collate information and knowledge. It also gave me a valid excuse not to participate in hui where I wanted to be able to observe as much as possible. I would scribble furiously on my pad and cry out “I’m getting this down for my thesis, I’m getting this down for my

thesis” whenever I was asked a question at a hui I was observing, and eventually people recognised I was in ‘thesis zone’ and I was able to cloak myself into some level of invisibility and get into observer mode.

However, as previously discussed, my position as an insider meant that while there was ease of access to the information that would assist my research, this could result in an expectation by the case study organisation that I would share my professional skills towards contributing to some aspect of the organisations development. This was very challenging. Jumping between being mana whenua, an observational researcher, and providing professional input all in one situation was sometimes quite disconcerting. However, this multi-layering of roles and responsibilities is part of the dynamic of whanaungatanga, so these added challenges were appropriate to the indigeneity basis of the research program and processes I had chosen to undertake, and the relationships that underpinned the research.

Competitive confidentiality limitations: A limitation to use of knowledge and information contained in the internal organisational documentation that I had was the competitive environment for funding between Maori health organisations that had evolved through the way the health sector funding operated in the 1990s (more fully explained in Chapter 5). The Maori health organisations did not want to lose the competitive advantage they had gained through developing their unique service delivery models as required by the health funders to retain their contracts; contracts which were often rolled over on an annual basis and therefore did not provide much security for the organisations. This lack of certainty about the organisations continued existence caused by these public health funding practices meant the organisations were, even in the mid-2000s, highly sensitive to their information being shared. I was careful to establish with each organisation which document I could list as having been referred to, and which models and information they were happy to have replicated/provided in my thesis document. In practice the documents reviewed contained repetitions of the matauranga and tikanga, and the service delivery models, and changes to these over time were reflected in multiple documents. While I reviewed a large number of documents, because I was looking for specifically the matauranga, tikanga, and models, there were in fact a number of documents that were examples of that particular period of time I was looking at and to use. In practice one of the reference documents was generally chosen

as an exemplar to be copied for the study, which is why there is a list of selected documents studied at Appendix 5, rather than a list of all documents studied.

Te ao Maori/te ao non-Maori limitations: An important objective of the research proposal was to bridge the gap in the literature where there is a dearth of knowledge on what Maori have created for the benefit of non-Maori. This meant taking quite a different approach when undertaking the actual study – part of the time I needed to consider the knowledge and information from a Maori perspective, then I needed to flip and consider the knowledge and information from a non-Maori perspective. I was focussed on listening to, reading for, and trying to understand what Maori participants may have felt they were doing to benefit non-Maori, but I was also listening to what non-Maori participants felt they were doing to benefit matauranga Maori based health developments. I then had to consider ways of writing my findings with one foot in both camps, so to speak, Maori and non-Maori. My personal research practice was therefore one example of a kotahitanga approach to Maori health developments as I alternated between my Maori and non-Maori perspective of the information and knowledge gathered and disseminated.

Local to global segue limitations: One of the constraints of my research that was reflected in numerous discussions with a number of my thesis advisors was how to translate my study of one tribal area into findings that were reflective of, and coherent for, global indigenous health developments and literature. Segueing between the local and the global was, I felt, essential to having my study contribute to theories of indigeneity and practices of indigeneity-based research. It would be very good about now to say ‘this is how I addressed and resolved this constraint’. The truth is I am probably not going to adequately resolve this constraint until I have had a few years to mull back over what I have studied, and to consider it more dynamically within indigenous developments (academic and otherwise). With a career that has included documenting potential solutions strategies for ethnic conflict, I would also like to use the local-global indigenous segue as the starting sequence for how this study might usefully contribute indigenous ideas to ethnic conflict solutions debates, and that has certainly been a nagging driver at the back of this research process that I have forced to take a very back seat to the indigenous drivers.

The easiest way I could find to create the local-global segue was to focus the various syntheses to progress from micro to macro considerations; so begin with organisational move to community then to tribal. From there, the final step was to conceptualise these synthesised ideas into global possibilities. Obviously, jumping directly from tribal and into international discussions, without hopping onto the logical step of tribal-to-national-to-international discussions may be seen as an unfortunate, possibly unforgivable, gap that I have created by my leap to internationalising my findings. However, I have followed the lead of my esteemed colleagues who have authored the research discussed in the indigenous health development literature in Chapter 2, where the various authors have examined local or regional indigenous experiences and have then proposed global solutions to the gaps in indigenous health developments identified. Yes, they do also propose national solutions in a number of instances. However, one of the key facets of global solution exemplified or discussed almost universally in the indigenous health development literature is the inclusion of indigenous knowledge within nationally and publically funded indigenous health developments, and the recognition of the primacy of indigenous knowledge in global indigenous health developments.

This study explains some local ideas that could potentially contribute to international solutions for indigenous health developments; logically implying that these would equally be viable as nationalised solutions where indigenous and non-indigenous peoples co-exist.

3.6 Summary – Thesis methods

The methods for this study have been designed purely to fulfil the expectations of my kaumatua and kuia; that Maori knowledge and practices be used. To accomplish this focus on Maori methods within an academic field of inquiry, I have augmented the ideas of four Maori scholars into my research. Maori Marsden (2003), Mason Durie (2005), and Roger Maaka's (2005) ideas inform my research methodology. I have based my research approach on the ideas and teachings of the Maori scholar Pa Henare Tate, whose ideas and teachings on whanaungatanga have informed the matauranga and tikanga of three of the mana whenua, and one of the non-mana whenua, case study organisations that I have collaborated with to produce this research. I have created an indigenized research method for this study that I have called *Kareretanga*. *Kareretanga*

acknowledges, characterizes and frames how I was taught to understand and how I have chosen to explain the whakapapa and whanaungatanga of matauranga and tikanga. I have used whanaungatanga in this study to explain how the ordering of relationships between whanau, hapu and iwi for te ao Maori and non-Maori was achieved for the study, whilst *Kareretanga* was created to provide an analytical tool for explaining the relationships and the implications of the relationships that were studied.

Chapter Four

WALKING IN THE FOOTSTEPS OF OUR TUPUNA

4.1 Introduction

Whakatauki are an important element of the whanaungatanga research approach discussed in Chapter 3. As part of the Maturanga Maori Research Design at Chapter 3, point 3.2, one of the main design elements of this study was to incorporate the Maori whakatauki *Kia whakatomuri te haere Whakamua* which says that Maori walk backwards into the future. To incorporate this whakatauki, the focus of Chapter 4 is to explore and understand the experiences of tupuna Maori in health developments in the early colonisation period, and to draw them into the present.

This chapter explains some of the experiences of Maori in constructively engaging with non-Maori for hauora post 1840 through until the 1990s, when the policy analysis and case study research takes place. This chapter has been created to give the reader a sense of walking backwards through time as well as an understanding that the hauora kotahitanga experiences that will be studied in later chapters have whakapapa and whanaungatanga connections with tupuna experiences. To acknowledge the hauora kotahitanga initiatives of our tupuna, the experiences in this chapter are conceptualized as historical themes which are then considered as ‘tupuna themes’ along with contemporary findings from the case studies in the final chapters of this study, as a way of connecting past with present and drawing some conclusions about hauora kotahitanga.

The chapter begins with a discussion of Maori political disenfranchisement through British Crown colonisation processes; it explores Maori indigeneity as a tool of political differentiation. It then discusses indigeneity-based approaches to Maori health developments in this early colonisation period. Maori constructively engaging with non-Maori for health developments is then explored through discussion of a number of tupuna hauora kotahitanga initiatives, such as donating resources for hospital services, electing Maori trained as medical doctors to parliament, Maori communities working together to send and support girls to undertake public health training to become nurses. Some of the early Rangatira Hauora, or Maori leaders who are acknowledged for their contributions to hauora, are discussed. The role of some of these Rangatira Hauora in creating New Zealand’s first indigenous health policy in 1900 is also discussed. To ensure there isn’t an unusual gap between these early tupuna experiences of hauora, and the actual study period of the 1990s in the later chapter, Maori constructive engagements

from the 1930s until the 1990s is briefly discussed as firstly an assimilation period, then latterly a Maori health renaissance period to give a sense of continuity. However, when Maori talk at hauora hui about positive experiences of constructive engagement between Maori and non-Maori for hauora historically, it is the early 1900s experiences and leaders discussed in this chapter that are the most talked about, and the most referred to, so I have focused in this chapter on exploring them.

This chapter concludes by drawing some of the experiences of the tupuna into kotahitanga themes which are used to guide the overall study process, and to augment the overall study discussions of hauora kotahitanga.

4.2 Maori political disenfranchisement - indigeneity

There is no single definition for the term ‘indigenous’. The United Nations cites two definitions in its report ‘Guidelines on Indigenous Peoples’ Issues’ (United Nations Development Group, 2008). Firstly, Martinez Cobo’s 1983 definition of pre-invasion, pre-colonial communities, peoples and nations:

“Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing in those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal systems” (United Nations, 1983).

The second is from the ILO 1989 Convention No. 169 article 1, subsection 2 definition:

“Peoples who are regarded as indigenous on account of their descent from the populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonization or the establishment of present State boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural and political institutions” (ILO, 2003).

These two attempts to define indigenous peoples, which summarise over two and a half decades of global debates, indicate two characteristics of indigenous peoples. Firstly, a distinct relationship with lands, and secondly, particular cultural systems on the lands identified by indigenous peoples as their territories or regions.

The term indigenous is contentious for many of the world's peoples because of a perceived symbiosis in the discourse between the terms 'indigenous and colonisation'. As an example, the report of the African Commission on Human and Peoples' Rights (2005) Working Group on Indigenous Populations/Communities, adopted by the Commission in 2005, discusses the problem of definition at length. The problem of an inherent connection between the colonisation of lands and the identification of particular peoples as indigenous is discussed:

“...the main argument that has always been preferred is that all Africans are indigenous to Africa. Definitely all Africans are indigenous as compared to the European colonialists who left all of black Africa in a subordinate position that was in many respects similar to the position of indigenous peoples elsewhere. However, if the concept of indigenous is exclusively linked with a colonial situation, it leaves us without a suitable concept for analysing the internal structural relationships of inequality that have persisted from colonial dominance” (African Commission, 2005).

The above report is referring in part to peoples who do not currently affiliate with a particular nation state; nation states that are tacitly acknowledged as colonial structures that have interfered with the nomadic and tribal practices of many peoples. Examples are the San peoples of Southern Africa, the Tuareg and Berbers of the Northern African regions and deserts. These peoples do not live within one particular nation's borders, so they don't have a particular nation state with which to constructively engage for 'indigenous' rights and responsibilities. Conversely, nation states have the ability to ignore these people's rights by saying their nations are not the primary territories on which these nomadic peoples reside.

Maori are recognised by the United Nations as the indigenous peoples of New Zealand. Maori are the peoples of New Zealand, but they did not choose the name New Zealand. Therefore, if the British had not colonised New Zealand, it might not be called New Zealand, and Maori might not have become collectively referred to as 'Maori'. If, as the African Commission report argues above, “... the concept of indigenous is exclusively linked with a colonial situation” Maori without colonisation may have not have chosen to identify themselves as 'indigenous'. However, colonisation by the British did occur on Maori lands and Crown political and policy practices towards Maori are now inextricably linked to Maori identity as indigenous in New Zealand - Maori indigeneity.

The beginnings of these relations with the British Crown began with a Treaty signed at Waitangi in 1840. Prior to 1800 Maori primarily lived in large, family-related groups who were leaders on and of their own lands. In 1831 a number of the Maori tribes began working towards a Declaration of Independence, which was signed in 1835 and formed the basis for constructive engagements with external countries on political issues, and also formed the basis of the relationships from 1840 with the British Crown (Walker, 2004). The 1840 Treaty of Waitangi with the British Crown offered Maori the right to British citizenship, and to share systems for protection and lawmaking in New Zealand with Maori (Kawharu, 1989, 1992, 2005). There are several versions of the Treaty, in both the Maori and English languages. New Zealand governments have traditionally used an English language version, to which Maori have objected since 1840 (Kawharu, 1989). Walker describes the Maori version of the Treaty as:

- Under Article 1, the Maori chiefs ceded *kawanatanga* (governance) of New Zealand to the British Crown.
- The Crown, in exchange for *kawanatanga*, guaranteed under Article 2 the *tino rangatiratanga* (sovereignty) of the chiefs over their lands, forests, fisheries and treasured possessions.
- Under Article 3 the Crown guaranteed Maori all the rights and privileges of British citizenship” (Walker, 2001).

Despite the Article 3 guarantee under the Treaty of Waitangi that Maori would have all the rights and privileges of British citizenship, there is evidence that the British Crown purposefully established a differentiated citizenship for indigenous peoples, including Maori, within its Crown dominion during the 1800s. While this study is about Maori, it is notable that the political and policy situation for other indigenous populations within the British dominions indicates sustained effort by the British to differentiate indigenous identity, citizenship and ability to function in the lands they were colonising (Maaka & Fleras, 2005; Alfred, 2006; Walker, 2004). In New Zealand between 1850 and 1865 four Acts were specifically designed to create differentiated citizenship for Maori through the establishment of separate judicial systems and land rights for Maori. They were the Native District Regulation Act (1858), the Native Circuit Courts Act (1858), the Native Territorial Rights Act (1858), and the Native Land Act (1865). The 1867 Native Representation Act established separate electoral systems for Maori and non-Maori.

All of these political practices, government practices, and legislation resulted in differentiated citizenship for the indigenous peoples of New Zealand and this situation continues to today. This is important because citizenship is regarded as a formative part of a person's political identity (Kymlicka & Norman, 1994), and Maori chose to pursue their right to equity in citizenship through seeking to participate in the political activities of early New Zealand governments, despite legislative impediments to forestall such participation (Cox, 1993).

Marshall's seminal work on "Citizenship and Social Class" (Marshall, 1950, 1965) describes English civil rights as forming during the 18th century, with political rights in the 19th century. New Zealand followed the English system for British Crown migrants, but not for Maori citizens. Civil rights under New Zealand citizenship were nominally extended to Maori in the 19th century, but political rights such as electoral participation were not fully extended to Maori until late in the 20th century, in 1975, a century after they were extended to non-Maori in New Zealand. Crown imposed differentiated citizenship has become the historical basis of Maori-Crown relationships in New Zealand. The inequitable position of Maori having political rights extended to them a century after non-Maori citizens is also one example of how a lesser citizenship for Maori has become the historical basis of Maori and non-Maori tensions in New Zealand.⁷ The Crown did not choose to 'constructively' engage with Maori through Maori knowledge, practices and worldviews. British knowledge, practices and worldviews were the tools the Crown unilaterally chose for engagements with Maori from 1840.

For Maori, finding ways to live together differently with non-Maori through their *matauranga* and *tikanga* was extremely challenging in light of the unilateral way in which the British Crown introduced and implemented policy and legislation from the 1840s. In 1846 the British Crown introduced the New Zealand Government Act and in 1852 the Constitution Act to establish the new governance systems. Effectively, all British Crown law and governance practices were put in place within these two Acts, and this created an instant differentiation of citizenship for Maori. Maori were excluded from decision making around both the introduction of the Acts, and decisions around what form of governance systems would be used to develop the new Treaty relationship.

⁷ For Maori differentiated citizenship also see Havemann (1999), Young (1999), Spoonley, Macpherson, & Pearson (2004)

Maori were also excluded from access to the same political rights of electoral participation as other New Zealanders until 1975. In 1867 separate governance systems were established in New Zealand for Maori through the Native Representation Act, which restricted Maori to electoral participation in Maori only electorates and prevented them from participating in the general electorate. This prevented full Maori electoral participation in the general electorates until 1975. From 1853, Maori could technically vote – but they had to be male, over 21 and land owners or leasers. This excluded all but 100 of the 5,849 in the Maori electorate, because their land was communally owned and they did not have individual titles (which qualified you to vote).

Parliament was also designed to exclude Maori from equitable access to political representation. There were four Maori seats established in Parliament in 1867, compared with a total of 72 European seats (Elections New Zealand, 2010). Walker places the Maori population at this time at 56,049, against Pakeha 171,009, giving a potential 20 seat entitlement to Maori which would have “been dangerous to the balance of Pakeha power in the House...” (Walker, 1984). The Maori seats were supposed to be temporary, but they became permanent in 1876. The four Maori electorates, three in the North Island and one in the South Island, were contested through a separate Maori electoral roll and Maori members of parliament were elected to the house from 1868. Sir Apirana Ngata, a Maori member of parliament between 1905 and 1943, wrote an explanation of the Treaty of Waitangi in 1922. He describes Maori parliamentary representation as primarily having been created as a way for the New Zealand government to restrict Maori political authority:

The Maori people have their own special representatives in Parliament, elected only by the Maori people. The reasons for this special provision were twofold: Maori had their own peculiarities. Maori people were ignorant of most things pertaining to the Pakeha way of life in those days. My own opinion, however, is that the reason for the four Maori Members was the fear on the part of the Pakeha that as Maori and Pakeha populations in these islands were very much on a parity, if the Maori people were given the right to vote with the Europeans, there was a possibility many more Maori Members would be elected to Parliament (Ngata, 1922).

Election for Maori seats by secret ballot was not introduced until 1937, 67 years after it had been introduced in the non-Maori seats, thus further endorsing the differentiation for Maori. Maori electoral rolls were also not introduced until 1948-49, 81 years after the first election and 97 years after European electoral rolls were introduced in 1852. Maori

were not allowed to stand as candidates in European seats until 1967. In 1975 Maori were given the right to choose between voting in the Maori or general electorates. The next major development in Maori electoral rights was not until 1993 when the new electoral act allowed for the number of Maori seats to be changed dependent upon the number of Maori registered in the Maori electorate. At the first MMP election in 1996 the Maori seats were increased to five, and in 2002 there were seven. In 2008, seven out of one hundred and twenty seats in parliament were reserved for the Maori electorates. Maori in 2008, therefore, remain as politically disenfranchised as they were in 1868.

Maori did make an attempt to constructively engage with Parliamentary systems, through living together differently, by choosing to regularly speak in te reo Maori in parliament from the 1800s. The first Maori Members of Parliament elected to the New Zealand parliament in 1868 were Frederick Nene Russell, Mete Kingi Te Rangi Paetahi, Tareha Te Moananui and John Patterson. Tareha Te Moananui was the first Maori MP to ever speak in parliament and his speech was in the Maori language, thus endorsing Maori determination to live together differently, through bringing their knowledge systems into the parliamentary systems.

As well as trying to participate in the new governance and political systems the British were unilaterally introducing, Maori continued attempting to constructively engage with the Crown after the signing of the Treaty of Waitangi in 1840 through meetings to plan measures for co-existing co-operatively. There were a number of hui in the 1860s and 1870s between Maori and the Crown which were attended by substantial numbers of Maori chiefs, including the 1860 Kohimarama conference in Auckland, which was attended by over 200 chiefs and the British Crown representative, and the 1877 Omahu, Hawke's Bay hui attended by a similar number of chiefs. In 1879 a pan-tribal hui took place at Orakei in Auckland, attended by government officials and in 1882 and 1884 deputations of Maori chiefs travelled to Britain to discuss the Maori relationship through the Treaty of Waitangi directly with the British Crown. With Maori finding little Crown commitment towards upholding the Treaty of Waitangi, the Kotahitanga movement began working towards a separate Maori Parliament in 1888, and this was established in 1892⁸.

⁸ Please see Cox, 1993 for more discussion on this period

In 1894 Hone Heke was elected to the Northern Maori seat under the banner of Te Kotahitanga, in essence the first Maori political party. He put forward the Native Rights Bill seeking devolution of power for Maori to the Maori parliament. The bill was defeated when the Pakeha, or non-Maori, members of parliament refused to debate the bill by walking out of the house (NZ Parliamentary Debates, 1894; Walker, 1984). Mr Stevens, a member of the legislature referred during the debate to Maori as ‘race of savages’:

...and he (Mr Stevens) was speaking now in order that the native people might know what his opinion was as a member of the Legislature. It was this: that the native people had been well and fairly and properly treated – infinitely better than any other race of savages who had ever lived under the British Crown (NZ Parliamentary Debates, 1894, p. 563).

The bill was re-submitted in 1896 and again defeated. The Maori parliament met with the New Zealand Prime Minister in 1897 to discuss the issue, but no further progress was made. Maori had spent the first sixty years of colonisation working towards finding ways of living together differently, culminating in their model for a separate parliament that could have worked in concert with the British Crown model for New Zealand governance.

In actuality, what the government was attempting to do was eradicate the Maori culture, and one of the critical ways this was done was by the government enforcing a policy that people with more than 50% non-Maori blood being regarded as “European” by forcibly being placed in European electorates under the electoral system. In 1867 further subordination of Maori culture was ratified in the Native School Act banning the use of Maori language in schools.

The British Crown had shown in the late 1800s that it would implement policy specifically to undermine the knowledge systems of indigenous peoples within its colonies, and would challenge and undermine attempts by Maori to create their own models of development within the colonising environment. The historical differentiation of political identity, political rights, and citizenship that has been imposed publicly onto Maori well into the late 20th century underpins the attitudes of the Crown and non-Maori to Maori development (Durie, 2005). Constructive engagements between the Crown and non-Maori with Maori are therefore based upon the differentiated indigenous identity for Maori that has evolved in the development of New Zealand society (Maaka & Fleras,

2005). Any constructive engagements between Maori and non-Maori are predicated upon the long history and experiences of differentiated indigenous identity of Maori peoples in New Zealand.

4.3 An indigeneity-based approach to Maori health developments begins in the 19th century

There is significant disparity in the literature as to the number of Maori in New Zealand at the time of colonisation in the 19th century as no accurate records of this period exist. The literature suggests that Maori in this period were a stable and growing population (Durie, 1998). Lange records that Maori acknowledge they were 'numerous, healthy and long lived' prior to colonisation and that the observations of many visitors to New Zealand in the early 1800s agree with this opinion (Lange, 1999). There is no written history of health practices for the period before colonisation began in the 19th and early 20th centuries. However, it is 'known that health care issues and practices were of vital importance in this period' (Lange, 1999, p. 25-28) to Maori and that there was 'an awareness of basic anatomy, an understanding of physiological principles, recognition of the health properties of flora' (Durie, 1998, p. 15)

The colonisers had brought illnesses to which the Maori had not been previously exposed and in the late 18th and early 19th centuries massive epidemics occurred wherever colonisers encountered Maori. There were outbreaks of influenza in 1790 and 1810, and during the 1820s to 1830s there were influenza, measles, tuberculosis, and smallpox epidemics (Walker, 1990). James Pope, an inspector of Native Schools in the late 1800s has written of large numbers of Maori deaths in that period in villages such as Ahipara, Kaiapoi, and Tauranga and all over New Zealand (Pope, 1844). There are numerous stories of entire villages being wiped out.

Despite tense relations between Maori and the Crown throughout the 1800s, there were some efforts by political authorities to create infrastructural supports for Maori health issues. From 1846, for example, Governor Grey organised four hospitals catering mainly for Maori (Gauld, 2001). However some of these hospitals were closed or handed over to military or provincial authorities from the 1860s, and other health services for Maori were also reduced from this period (Ward, 1973). British Crown colonial policies that created hospitals accessible by Maori alongside non-Maori in New Plymouth,

Wellington, Auckland and Wanganui, were seen as highly unusual when compared to policies towards the exclusion of indigenous peoples in other British Crown colonies at the time (Nicolson, 1988).

The first health legislation under the post-Treaty colony was the 1872 Public Health Act. From 1852 to 1876 provincial governments controlled the health system, particularly hospitals, but the 1876 Public Health Act gave control to central government. The government created policy directed specifically to Maori health through the New Zealand Constitution Act, 1852, which provided a Civil Lists budgeted amount of seven thousand pounds, which was predominantly spent on Maori health. The Native Purposes Appropriation Act accounted for this funding from 1862 and a ministerial portfolio for Native Affairs was created in 1863, with an Under-Secretary of Native Affairs appointed in 1865 and a Native Department established in 1866. The health policies for Maori in this period were reflective of Crown impetus towards both integrative policy measures, through the development of mixed hospitals, and specialist measures, through the directed funding for Maori health (Dow, 1999; Lange, 1999; Maclean, 1964).

Colonisation brought with it government actions which created a strong impetus from the mid-1800s to alienate Maori from their own healthcare practices as they felt Maori were destined for ‘extermination’ (Pope, 1884, p. 1). Maori seemed destined to extinction in the late 1800s, with a parliamentarian commenting in 1900 that the Maori survivors would be so few they should just assimilate with the European culture, that their culture should be consigned to history as footprints on the sands of time: “Raise [Maori] upon the breast of the great tide of civilization and cast them upon a shore whereon they would leave footprints on the sands of time” (Fraser, 1900, p. 203).

One of the first pieces of Native specific health legislation was the Tohunga Suppression Act of 1907 which made the practices of their most venerated wellness professionals illegal, and forced Maori to use only British methods of healthcare (Durie, 1998; Lange, 1999). Lange describes tohunga as ‘intimately involved in all aspects of community life’ and states that they were the ‘tribal repository of astronomical, mythological, genealogical, historical and legal knowledge’. They are also acknowledged as the healers of the community with their work in this area being ‘one of the most important areas of expertise associated with the tohunga’ (Lange, 1999, p. 12). Tohunga are described by Durie as being in a dual leadership role with the rangatira of the community

(Durie, 1998). Tohunga had multi-faceted roles premised on their individual knowledge and skills being combined with the knowledge and skills of their community (tribal community and tohunga community). As such they had the trust and respect of their tribes to lead progression, development and evolution of healthcare practices for their tribes.

The de-legitimizing of the Tohunga at such an essential time in the destruction of Maori communities and ways of life had a significant effect on not only Maori health and wellbeing, but also on their identity as a cultural and political community. The Tohunga Suppression Act 1907 undermined the traditional hierarchical structures within the tribes and made it illegal for Maori to choose their own leaders. While Maori continued to try to follow their traditional practices with the Tohunga, the overwhelming police and military violence towards any Maori breaching regulations or legislation that occurred in this period did in many ways negate challenges to state authority that might otherwise have occurred (Walker, 2004). There were certainly pockets of resistance that are famous, Parihaka and Urewera being two extreme examples – both communities were brutalised by police and military interventions by the New Zealand government (Walker, 2004). In trying to resist challenges to their traditions, there was a key disadvantage for Maori compared to many other indigenous populations like the Canadian or American First Nations peoples; Maori did not have ‘homelands’ or ‘reservations’ or lands where they might have been able to practice their community traditions quietly away from the Crown authorities. Maori lands were being alienated and settled by non-Maori; there was little possibility of privacy or places to live without near constant overt and covert oversight by non-Maori.

The imposition of British healthcare methods onto the Maori peoples began very early in colonisation, however it would be fair to say that a number of people involved in this imposition genuinely felt they were providing the best and most helpful response to Maori at the time. Unfortunately, the unexpected consequences of the imposition of healthcare practices, by even genuinely altruistic people, often resulted in yet more destruction of Maori communities and self-sufficiency. An example of this is a booklet that was produced for the Native Schools in 1884 by James Pope, the Inspector of Schools. Maori children attended government run Native Schools and in these schools they were taught to reject traditional Maori healthcare practices. They were also taught

to go home and train the rest of their families to reject traditional Maori healthcare practices. This seriously eroded the autonomy and traditional practices of Maori families and communities. The booklet offers much advice to specifically steer Maori away from Maori healthcare practices and towards British healthcare methods:

If the Maoris will take to the best European customs, they will live and do very well ...But, if the Maori keep to his own old ways ...he will be sure to die out (Pope, 1884, p. 34).

The booklet also contains negative comments implying Maori ways were inferior to that of the colonisers:

When two different races of men have to live together, the race that, through any cause, is more ignorant, weaker in numbers and poorer than the other must learn the good customs of the stronger people or else it is sure to die out (Pope, 1844).

Thus children were being taught to reject their families and tribes' own practices and teachings, which had the consequence of undermining the family unit and destroying extended whanau, hapu and iwi authority.

The dis-establishment of Maori leadership, de-legitimizing of Maori Health practitioners, denigration of Maori healthcare practices, and destruction of Maori communities, families and homes, severely impugned Maori ability to provide traditional tribal and health care practices to their people. Despite this, Maori found ways to constructively engage with non-Maori for health development, including the donation of resources for hospital services, sending Maori trained as medical doctors to represent Maori in parliament and to participate in parliament initiated health developments, sending Maori to be trained as nurses to work with Maori and non-Maori communities, creating a number of community health initiatives that were for the benefit of non-Maori also, and proactively participating in the implementation of Crown Maori health policy. The period 1840 to 1900 has been likened to a 'near genocide' by Durie, who proposes 1900 as being the year one of the most dramatic health turnarounds the world has ever seen for indigenous peoples occurred, with the negative dive in Maori mortality and morbidity somewhat arrested from this point (Durie, 1984, 1998). It was from around 1900 that Maori ideas for constructively engaging with non-Maori on health initiatives gained resonance at both political and community levels.

4.4 Maori constructively engage with non-Maori for health developments

4.4.1 Maori donate resources for hospital services

From the beginning of the Treaty based relationship the British Crown leadership negotiated with Maori that they would receive the benefits of health services as part of their Treaty relationship; further, these political leaders convinced many tribes to part with valuable lands at little or no cost in order to provide the land and resources for hospital and health services that Maori would be able to access along with non-Maori; Governor Gore Browne confirmed this as a long term government policy in 1857 (Waitangi Tribunal, 2002). In the Ngati Whatua region, which is the focus of the later case studies of this thesis, there is evidence that Ngati Whatua sold land cheaply to ensure the founding of hospitals and services that would benefit both Maori and non-Maori (Waitangi Tribunal, 2002). By donating lands and resources to facilitate these developments, which included donation of lands from which an ongoing income could be applied to health and medical service provision, Maori proactively involved themselves in these developments.

There is no data which confirms whether Maori felt they would have the ongoing right to utilize their traditional knowledge within these services and hospitals, nor is there data which shows the British Crown told Maori that their traditional knowledge would be excluded from these services. What is known is that Maori challenged the British Crown application of the Treaty where it denied Maori autonomy over their knowledge and development throughout the 1800s, so it is safe to assume Maori would have expected their traditional knowledge and autonomy not to have been excluded from co-operatively established health systems and services. Maori constructively engaged with the Crown to provided resources to establish medical systems and services for the benefit of Maori and non-Maori peoples very early in the Maori-Crown Treaty partnership, as the above 1857 evidence from Governor Gore Brown shows. This can be conceptualised as tupuna Maori co-operative co-existence models for medical and health services with the Crown for the benefit of Maori and non-Maori communities.

4.4.2 Maori electorates send medical doctors to parliament

Another way Maori chose to constructively engage with the Crown through the Treaty partnership was through electoral and parliamentary institutions. Maori who served as members of parliament often took on roles and responsibilities for the betterment of all peoples, not just Maori, but many also tried to proactively improve the constructive engagements between Maori and the parliament. Sir James Carroll was Minister of Native Affairs between 1899 and 1912, and Acting Prime Minister for periods of time between 1909 and 1911 (Alexander, 1966; Dow, 1999). Although he was of Maori descent, Carroll had been elected to a European seat (Alexander, 1966). He remained in parliament until 1919 and was the last Maori to hold a general electorate seat until 1975 (Dow, 1999). Sir James Carroll was the Minister who ushered The Maori Councils Act through in 1900, the only Act of Parliament in the history of New Zealand to give Maori a form of self-government for health.

Buck, Pomare and Ngata, all of whom were elected into Maori electorate seats were members of the 'Young Maori Party' which 'sought to reform Maori social structures and to change Maori attitudes to health' (Cox, 1993, p. 89). As the first Maori to graduate as a medical doctor, Sir Maui Pomare trained in the United States, graduating in 1899. He was appointed 'Health Commissioner for the Natives throughout the colony' in 1901. In 1904 Te Rangi Hiroa/Sir Peter Buck graduated as a medical doctor and was appointed Maori Health Officer. Te Rangi Hiroa/Sir Peter Buck was elected to Parliament in 1909 with Sir Maui Pomare following him in 1911. Sir Maui Pomare became the first Maori to be appointed Minister of Health, a position he held between 1923 and 1926. Sir Apirana Ngata, who was the first Maori to complete a degree at a New Zealand University (1893 BA and 1896 LLB), was elected to parliament in 1905 and remained there until 1943.

The ability of the four Maori electorate members of parliament to influence a significantly larger parliament on issues of Maori development was a challenging endeavour. However, the example of Maori MPs, including Carroll in a European seat, to collaboratively work towards long term health developments based on Maori self-government did show some results. The Maori Councils Act 1900 created limited self-government for Maori in community health, in particular through the creation of a Maori Hygiene division of the Health Department which was active until the early 1920s,

facilitating government funding for around 200 local Maori health committees⁹ until 1931. These initiatives were not long lived enough to ensure matauranga based Maori health developments could become a substantive part of New Zealand health developments, but they are discussed in more detail at 4.4.5.

Maori elected members to parliament who had been trained in European universities in law (Ngata) and medicine (Pomare and Buck) so that they had representatives who were Maori, but could also function within European systems. Maori focussed on finding ways to constructively engage with the electoral and parliamentary systems as a pathway to co-operative co-existence within the evolving political, policy and health systems of New Zealand in the 19th and early 20th centuries. However, as the example of the first Maori parliamentary speech showed by it having been delivered in te reo Maori, matauranga and tikanga were paramount for Maori co-operative co-existence with the Crown.

4.4.3 Maori Nurses

Another way Maori chose to constructively engage with non-Maori and the Crown in the late 19th century was to have Maori girls undertake state-training as nurses. This combined the matauranga that the girls would have from learned from their whanau, hapu and iwi together with European training in medical and healthcare. The idea of finding places for Maori girls to join state-training programs in public hospitals had originally been mooted at the Students Association Conference of Te Aute College in December 1897. A paper recommending scholarships be put in place for the training of Maori girls as nurses was titled “Maori Girls and Nursing” and presented by Hamiora Hei (Hei, 1897). Apirana Ngata was a Te Aute College old boy, and also presented a paper at the 1897 conference where the scholarships for Maori nurses were discussed and became a keen proponent of the idea. Pomare and Te Rangi Hiroa also became advocates for Maori girls to train as nurses during their time as Members of Parliament.

By 1898 there were two Maori girls on scholarships to train as nurses at Napier hospital (McKegg, 1991, p. 63). In 1903 there were three Maori girls training as nurses and in 1905 Wellington and Napier hospitals had one Maori probationer each (McKegg, 1991). The Nurse Registration Act 1901 required three years training plus the passing of a state exam for qualification as a nurse. Unfortunately many hospitals were reluctant to take

⁹The Maori Councils Act and these experiences are discussed in more detail at 4.4.5

Maori girls as nursing probationers, meaning they could not get the experience to qualify to sit the exam. This kept the numbers of Maori nurses low. Subsequently a certificate in nursing was established and facilitated more Maori girls into training.¹⁰

In July 1908 the first Maori woman passed the state nursing exam. Her name was Akenihi Hei and she was the sister of Haimona Hei who had presented the paper on Maori Girls and Nursing in 1897 at Te Aute College. Akenihi laid the foundation for other Maori nurses to follow her career path and in 1911 Nurse Maude Mataira passed the state exam and was put in charge of a nursing station at Otamatea (McKegg, 1991, p. 30), which is the ‘matua or parent’ marae of Ngati Whatua. In 1911 the Health Department established the Native Health Nursing Service. From 1931 the separation of Maori nursing from non-Maori nursing was disestablished, with Maori nurses becoming part of the District Health Nursing services (McKegg, 1991).

Whilst Maori nurses were sent primarily to service Maori communities, in practice in rural areas they would also often end up treating non-Maori patients. In this way, a Maori initiative to get girls trained as nurses proved beneficial to non-Maori community members, in particular in rural areas. Maori training as nurses can be conceptualised as a tupuna model for state-Maori co-operative co-existence through the fusion of matauranga with state nursing training. This then led to Maori nurse treatments of non-Maori patients, which can be conceptualised as a tupuna model for co-operative co-existence between Maori and non-Maori communities.

4.4.4 Tupuna hauora kotahitanga – three historical community-based examples

This section discusses three examples from the early to mid 20th century of tupuna Maori hauora initiatives for community-based constructive engagements. A model for co-operative co-existence between indigenous and non-indigenous mothers with new babies was the Maori Women’s Institute which was initially established in the Bay of Plenty from 1929 and in 1937 became the Women’s Health League Inc. at Tunohopu Marae in Rotorua.¹¹ One of the stated aims of the early Maori Women’s Health Leagues was to bring together Maori and non-Maori women in communities to focus on issues of family and child health. They were undermined in later years, when the Maori Women’s

¹⁰ For more information see McKegg (1991)

¹¹ For further information see: White (1988), Kingi (1991)

Welfare Leagues were created by government in an attempt to bring the extensive voluntary resources of Maori women from groups like the Women's Health League under more government control. The Women's Health League had created what can be conceptualised a model for constructive engagement between Maori and non-Maori mothers in the newly establishing rural communities in a period of prolific growth of colonial arrivals. Maori women were able to share their local and traditional knowledge with newly arriving immigrants as a way of establishing good relationships within newly forming communities.

A Maori health leader, the faith healer Wiremu Ratana, brought together Maori from many iwi in the 1920s to create hauora initiatives for the wellbeing of peoples, which then was transformed in the 1930s into political initiatives to constructively engage with the state towards improved social policy. From the early 1920s a Maori-run hospital was set up on the grounds of Ratana Pa, called Whare Marama, and serviced by state trained Maori nurses (Hagger, 2003). Ratana Pa became the geographical focus of a pan-tribal movement that would, during 1929-30, collect 30,000 signatures for a petition to the Crown to have the Maori language version of the Treaty of Waitangi ratified (instead of the English translation). The population figures for that time indicate this number of signatories to the petition was around 50% of the Maori population; this suggests that a substantial proportion of the Maori adult population were involved in this effort (Henderson, 1963). This powerful organisations influence on health and wellbeing, which was pan-tribal in nature, continued through until the late 1930s, when it was superseded by the political aspirations of the organisation to agitate for change at the government level by fielding their own members to contest the Maori electorates for seats in parliament. The Ratana movement contested the Maori electorates from 1922 and Ratana politicians entered parliament from 1931 (Hagger, 2003). Ratana politicians maintained a firm hold on the majority of Maori parliamentary seats for many years in association with the Labour political party, focussing on their time in parliament to improve social policy for Maori wellbeing. It is to date, the most lengthy Maori and non-Maori constructive engagement for a parliamentary partnership in New Zealand history.

Whilst the Ratana movement was pan-tribal, an example of tribal specific initiatives that resulted in positive outcomes using matauranga and tikanga Maori were those undertaken by Waikato Chieftainess Te Puea. Her initiatives are recognised in achieving significant

improvement in Maori health status throughout the Waikato region (King, 2003). One Te Puea initiative was in response to the smallpox epidemic of 1913. Te Puea established Maori health services in communities so that isolation of patients could take place within their own communities. She created makeshift, open air camps by the riverside in Ngaruawahia, which proved highly successful (King, 2003). In 1940 she established a community house for Maori to stay in whilst accessing Waikato hospital. She also organized for an isolation hut for tuberculosis to be built at Turangawaewae in the Waikato. In 1943 she established a marae based primary health clinic at Ngaruawahia with a non-Maori female general practitioner visiting between one and two afternoons a week through until 1946 (King, 2003), and by 1945 was operating a Maori village committee in conjunction with the government health department (Lange, 2005). The health of the Waikato peoples was profoundly improved through her initiatives and she became a strong advocate for Maori health development nationally (Durie, 1984).

Both Ratana and Te Puea had worked towards amalgamating their traditional knowledge of healing and wellbeing with services delivered by state trained nurses and doctors. Whare Marama, the hospital at Ratana Pa, was staffed by trained Maori nurses, and the health clinic in Ngaruawahia established by Te Puea was staffed by a non-Maori female general practitioner. In this way both Ratana and Te Puea were constructively engaging with the state health services to show that matauranga and tikanga Maori based health initiatives could be successfully fused to state health practices for the benefit of both patients and staff.

4.4.5 New Zealand's first Indigenous (Maori) Health Policy

The period from 1900 to 1930 encompasses the first Maori and Crown efforts towards what can be regarded as co-operative co-existence based on living together differently. New Zealand's first indigenous health policy came into being through the enactment of the Maori Councils Act 1900, giving Maori limited self-government for health developments in their communities. The Native Minister Sir James Carroll, himself of Maori descent, introduced the 1900 Maori Council Bill to parliament for the purpose of establishing a level of local self-government for Maori and to provide them with “a more general and universal power in the affairs of the country” (Carroll, 1900, p. 204). Its purpose was also to assist Maori in gaining some control over their social development. Carroll stated its purpose was:

...for the establishment ... of some simple machinery of local self-government, by means of which such Maori inhabitants may be enabled to frame for themselves such rules and regulations on matters of local concernment or relating to their social economy as may appear best adapted to their own special wants (Carroll, 1900, p. 201).

The Maori Councils Bill and Maori Lands Administration Bill were debated on consecutive days. The Maori Lands Administration Bill had spent three months under consideration and in consultation with “Representatives of the Native race” (Walker, 1990, p. 205). It was noted by a non-Maori MP that Europeans would have majority power under the Native Lands Bill but that “... under the Maori Councils Bill the Natives will have the greatest say” (Rigg, 1900, p. 269).

By the second reading of the Maori Councils Bill on October the 15th, it was being described as a virtual “Native Local Self-government Bill” (Cadman, 1990, p. 271), and the first time in New Zealand’s colonial history that Maori were being given “the right of governing themselves” (Bonar, 1900, p. 267). The Bill was passed on October 15, 1900 as “...an experiment...” of twelve months duration (Cadman, 1990).

The Maori Councils Act 1900 created Maori Health Committees to have the same responsibilities for local governance of health and hygiene issues as the newly created Public Health Boards under the Public Health Act 1900. Both the Maori Health Committees and Public Health Boards were responsible to the Public Health Minister. Maori health was bounced between several different departments in the early 1900s. Maori health became the responsibility of the Department of Health between 1900 and 1909, when it was transferred to the Native Department (Dow, 1999). By 1909 the Maori Councils had taken over some of the functions of the Health Department, including health and hygiene management in Maori communities (Dow, 1999). In 1916 legislative amendment saw Maori Councils become Crown-appointed entities (Hill, 2004). In 1921 Te Rangi Hiroa became Director of the new Maori Hygiene Division of the Department of Health. Under Te Rangi Hiroa/ leadership, the Maori Council networks were reinvigorated through the creating of Maori Health Council Districts (Hill, 2004). In 1922 the responsibility for Maori health was reassigned back to the health department

(Hill, 2004). In 1927 Ellison, another Maori medical doctor succeeded Te Rangi Hiroa as head of the Maori Hygiene division, until it was closed in 1931.¹²

By 1923 there was a Maori division of the Health Department, 20 Maori councils and more than 250 village committees in Maori communities (Lange, 2005), there were Maori Health Councils reporting to a Minister in Charge of Maori Councils, and the Minister of Health was a Maori trained in medicine. In 1930, this grand impetus towards Maori self-government through Maori Councils effectively ended with the closure of the Maori Hygiene division (Hill, 2004). The divisions closure was seen as the outcome of the government moving away from recognising the need to include Maori values and leadership in health policy (Lange, 1999) and moving instead towards integrating Maori into the evolving public health systems. This is particularly apparent following the passing of the 1938 Social Security Act, which provided in and out patient hospital services which were inclusive of Maori (Gauld, 2001).

The impetus for the Maori Councils Act was seen by some as a way of undermining Maori aspirations for their own parliament, and the lack of financial impetus towards Maori Council Act initiatives is taken by some as confirming this.¹³ However, Hill looks at how Maori aspirations for rangatiratanga were not quashed by the failure of the implementation of the 1900 Maori Councils Act:

Interpretations which see the 1900 experiment as having been initially motivated by an urge to meet Maori aspirations, and then as having fallen short in the execution of policy, miss the key dynamic of history. In doing so they inadvertently denigrate the strength of indigenous resistance to what remained a policy goal of full assimilation. The interesting story is how the Crown, with all its coercive and appropriative power, and with the help of sites of collaboration, failed to crush aspirations for rangatiratanga (Hill, 2004, p. 55).

Maori health committees were recognised by Maori as giving them the opportunity to create health infrastructures based on Maori values (Durie, 1984; Hill, 2004). Dow (1999) also provides retrospective evidence that Maori felt the Maori Councils Act had been created to carry out the spirit of the Treaty.

The government drive towards differentiated Maori health policy and practice, and the ability for Maori to create their own knowledge based health developments, existed for

¹² For more information on this period see Cox (1993), Dow (1999), Lange (1999, 2005)

¹³ For a more detailed analysis of Maori political evolution in this period, see Cox (1993).

almost thirty years, between 1900 and 1930. The model of indigenous health policy under the Maori Councils Act 1900 flourished, in terms of numbers of committees and Maori involvement, yet was less than well-resourced by the Health department and Native department, both of which had governance roles throughout this period. One of the most significant outcomes of the policy in terms of a government level co-operative co-existence model was the creation of the Maori Hygiene Division, effectively a model whereby Maori knowledge systems and British Crown developed health systems could co-exist co-operatively. This ended with the unilateral closure of the Division by the government in 1930 (Hill, 2004), and coincided with the end of Maui Pomare and Te Rangi Hiroa influence within the parliamentary domain of Maori health development.

In examining the development of health services for Maori between 1840 and 1940, and the limited self-determination for Maori in health that ended in 1938 with the Social Security Act, Dow explains how Maori were then moved into a period of assimilative policy which was to last until the 1990s:

...the health benefits ushered in by the 1938 Social Security Act marked the end of the subsidised doctors who had served many Maori communities since the mid nineteenth century. This legislation also removed the financial impediments which had hindered the integration of hospital services for Maori and Europeans. This is arguably a more important watershed than 1900, the year which saw the inception of the Department of Public Health and the passage of the Maori Councils Act (Dow, 1999, p. 11).

Maori Councils continued to function through until 1945, but without the Maori oversight that had been possible under the Maori Hygiene Division. The 1945 Maori Social Economic Advancement Act repealed the Maori Councils Act 1900 and "...all existing Maori Councils and komiti marae were abolished, bringing 45 years of this manifestation of Crown-sanctioned Maori autonomy to an end" (Lange, 2005, p.52).

This period of assimilation of health into national health developments has resulted in a scarcity of literature and information on Maori specific health developments between 1945 and the 1980s. The main authors and their findings are discussed in the next section.

4.5 Maori health assimilated

The post-1930 period was a time when Maori values and leadership were de-activated and “where Maori health was incorporated in to public health and hospitals policy and something was done *to* Maori” rather than Maori being able to participate in the development and delivery of health and hospitals policy (Cunningham & Durie, 2001; Lange, 1999). Durie (1994) describes it as a time when Maori were no longer welcomed as active members of the health delivery system. Maori differentiated services and policies were no longer government policy. Williams (2007) describes 1931 to 1975 as a 45 year period in which Maori were subsumed:

...Maori health needs and services were increasingly integrated into general health policy as the state expanded its control and direction of the national health system ... and information and activities specific to Maori were subsumed in the larger national picture (Williams, 2007, p. 19).

Poor Maori health came once again to government attention with the 1960 Hunn Report (Hunn, 1961), which highlighted inadequate government responses to increasingly poor Maori health status, and then again in the early 1970s when significantly higher poor Maori health outcomes were again reported (Rose, 1972). Research into Maori health undertaken in the 1970s highlighted very poor health status for Maori, but framed this as the fault of lifestyle choices of Maori rather than looking at any health system or political system issues that may have been causing Maori health decline (Rose, 1972).

While Maori health status and Maori issues were being negatively highlighted in various reports in at this time, for Maori the 1970s were dominated by increased Maori activism around indigeneity issues. Grievances around Treaty of Waitangi breaches and concern about Maori-Crown relations began to boil over into the public domain and began negatively impacting Maori and non-Maori relations. It was a period when Maori sought proactively to reaffirm the inclusion of matauranga and tikanga Maori in socio-political developments for New Zealand. Maori leaders met with Crown representatives. Young Maori challenged practices that were de-meaning to Maori through increased public activism.

In the early 1970s young Maori, activists and academics, came together to form Nga Tamatoa, a group focused on strengthening the political identity of Maori. They protested at Waitangi Day commemorations and lobbied for the Maori language to be

taught in schools. Their activism, together with the work of many other Maori leading up to the 1970s, saw the Treaty of Waitangi legislated into an Act in 1975, with the subsequent establishment of the Waitangi Tribunal to hear and report on Maori grievances, and to recommend resolutions to Maori and the Crown (Walker, 2004). The post-1970s Maori identity reaffirmation and cultural renaissance saw the rise of the Kohanga Reo movement. These Maori language pre-schools were initially created and funded by Maori organisations such as Nga Tamatoa, and without government funding which would have required compliance with government education standards, they were able to evolve based solely on matauranga and tikanga Maori. Kohanga Reo were a strong signal to government that Maori were committed to rangatiratanga or self-determination around key policy areas, and that they were capable of creating and delivering their own policy initiatives (Walker, 2004).

The 1970s was also a period when Maori tribal and political leaders met with Crown representatives towards resolving historical grievances between Maori and the Crown. Constructive engagements between the two were facilitated by the participation of Maori leaders in the creation of the Waitangi Tribunal. Maori political and tribal leaders worked through the 1970s with the Crown on issues of social policy and community improvements for Maori, so there were traditional leadership initiatives occurring as much as there were activist initiatives occurring in this period. The kohanga reo movement was fronted by a number of significant Maori tribal and political leaders, inasmuch as it was also driven by young Maori activists.

By the early 1980s Maori health development was shaping up to be a key policy area where both Maori and the Crown looked to constructively engage and reduce the divergence between Maori and non-Maori in social policy that had dominated socio-cultural developments of the 1970s.

4.6 Maori health renaissance

Maori community health development initiatives, similar to the ones begun in the early 1900s by Ratana, Te Puea and the Women's Institutes, began once again to develop in small communities from the mid-1970s as Maori again looked to their own communities to create services that would address declining Maori health status on Maori terms. The 1975 Raukawa initiative, for example, was a project focusing on the health and wellbeing

of the Raukawa people. It was based on Maori development philosophies of whanaungatanga, wairuatanga, whakapapa and te reo (Mantell, 1984). In another example, a clinic was set up on the local school grounds at Ruatoki in 1977, using community health funds from beer and tobacco taxes. In its first year of operation it examined 300 children. Similar clinics were established in the Central North Island forest area at Minginui and also at Te Teko in 1980, with plans in place by the local communities of Te Kaha, Waimana, Cape Runaway and Raukokore to develop similar services in the 1980s (O'Brien, 1984).

The Eru Pomare reports on Maori health between 1955 and 1975 (Pomare, 1980; Pomare & De Boer, 1988), were highly critical of Maori mortality and morbidity statistics. The 1980s saw increased activism by Maori towards the Crown for political and policy focus to be placed on improving Maori health. The Hui Whakaoranga, a Maori health development hui hosted by the Department of Health in 1984 was a response to these concerns. In 1984 Te Oranganui Iwi Health was created in the Whanganui region to deliver primary and community health initiatives, and in 1986 government funding was secured for the purpose of developing their services. There were also marae-based health centres delivering services at Waahi and Tumahaurangi Marae in Rotorua in the 1980s (Pomare & De Boer, 1988). Tacit in these 'Maori' developments was the recognition by Maori that their efforts were being regarded by some non-Maori as 'separatist' developments. However, Maori health leaders such as Durie, moved to reassure New Zealanders that the goal was not 'to be separate', as inferred by the term separatism, but rather to advance Maori health aspirations, in particular and relevant Maori ways (Durie, 1984):

New Zealand with its impeccable reputation for race relations has got parallel developments and there is some fear ... Non-Maori are expressing this fear that we are developing a type of separatism. ... In the short term, these movements may certainly look like a separatist development. In the long term, I think they will enable Maori people to take their place as New Zealanders, as healthy New Zealanders and in the field of health that will enable them to take their place, as equals, and as partners (Durie, 1984, p. 12).

Two national meetings held in 1984 between Maori and the Crown are significant in terms of Maori presenting their strategies for health development and articulating their expectations of the Crown. One, the Hui Taumata (Durie, 1998), focussed on Maori economic development while the other, the Hui Whakaoranga (Department of Health,

1984), focussed specifically on Maori health development. The Hui Taumata identified health sector barriers to Maori participation in governance and management, as well as a lack of recognition of Maori concepts of wellbeing, as being barriers to Maori health development (Durie, 1998, p. 73). The Hui Whakaoranga focussed on proposals for improved government impetus towards the inclusion of Maori concepts of wellbeing, and the development of Maori community-based health initiatives. There were recommendations from Hui Whakaoranga participants to the health sector that Maori models of health care in existence, based on the health priorities relevant to the people of the marae they were based in, were the best ways forward for both Maori community development and health status improvement (Mantell, 1984; Pomare & De Boer, 1988). Pomare, an eminent Maori health researcher, also proposed in 1988 that “community initiatives based as much on traditional Maori values as on contemporary modern health education” be further developed (Pomare & De Boer, 1988).

The Hui Whakaoranga emphasised Maori values as *taonga tikanga* and *whanaungatanga* was explained as an element of relationships:

Whanaungatanga is the element that provides the strength, warmth, support and understanding in family and kinship relationships (Department of Health, 1984, p. 18).

Similarly, the Hui Taumata emphasized three key principles: integrated development, *tikanga Maori*, and self-determination. These are explained by Durie (2001) in terms of how they were pertinent to Maori health development. Integrated development he saw as policy developed that recognises a “Maori philosophical base” with a “framework centered on a Maori worldview”. *Tikanga Maori*, he explains, can be where Maori values are incorporated into policy and health services, where “Maori custom and tradition can be lived as part of contemporary existence”. Self-determination, Durie adds, is *tino rangatiratanga* or autonomy and “is about taking control of those resources and activities that impact on Maori lives ... and doing so in a way that strengthens personal and collective identity” (Durie, 2001, p. 255).

By the late 1980s the Department of Health was considering ways to address Maori health more effectively and created the first Standing Committee on Maori Health. They recommended to the Department of Health in 1988 that publicly funded Maori health services be created by Maori (Standing Committee on Maori Health, 1988). The

Standing Committee on Maori Health was replaced by the Ministerial Advisory Committee on Maori Health from 1989. With the establishment of the Iwi Transition Agency in 1989, to facilitate greater Maori control over publicly funded social policy developments such as Maori health services, Maori were on the point of becoming "... potentially masters of their development destiny" (Kawharu, 1992, p. 29). The incoming National government dis-established the Iwi Transition Agency in 1990 halting this particular constructive engagement between Crown and Iwi.

What is important about the 1980s Maori and their health development aspirations was that Rangatira Hauora came together to define baseline Maori expectations of the Crown for health developments and identified with the Department of Health where both parties could constructively engage towards future developments. Rangatira Hauora made it clear in the two 1984 hui, and through the Standing Committee on Maori Health from 1988, that matauranga and tikanga Maori was of paramount importance for all future publicly funded Maori health developments. By the end of the 1980s the creation of a new Iwi Transition Agency by the government was being seen by Maori as one mechanism for implementing social policy developments, for instance the creation of Maori health and social services. When the incoming National government disestablished the Iwi Transition Agency, and repealed the Iwi Runanga Act 1990, it began discussions with Rangatira Hauora as to how the Maori health development impetus from the 1980s could continue into the 1990s. The Minister of Health proposed, in 1991, that Maori could create publicly funded health organisations based on Maori values and priorities:

The establishment of Maori healthcare plans would enable Maori people to transfer their share of healthcare resources to organisations of their choice. These would act as agents to purchase access to comprehensive care. These organisations could recognise Maori values and cater for the specific needs and priorities of Maori people (Upton, 1991, p. 70).

The Crown indicated willingness to allow Maori to separate out their share of publicly funded health resources to create models based on their knowledge and practices, but also that Maori could separate out their share of publicly funded health resources in order to purchase services from other health providers that they deemed acceptable for Maori people. This statement from the Minister of Health seemed to align with expectations for Maori health development that Maori had expressed to the Crown throughout the 1980s.

It appeared at the beginning of the 1990s that the Minister of Health had agreed to constructively engage with Maori on the basis of Rangatira Hauora publicly funded health development expectations. It also appeared that Maori would be able to create publicly funded matauranga and tikanga Maori health services for their communities. For Maori, the development and delivery of 'by Maori' health services was an important feature of their development aspirations.

4.7 Summary

The purpose of this chapter was to discuss experiences for Maori of indigeneity, and attempts to constructively engage with non-Maori through matauranga Maori and hauora Maori. The first section explains how from 1840 Maori were differentiated by the British Crown in terms of their political participation in the electoral system, in terms of legislation, and in terms of judicial processes. This differentiation resulted in an indigenized form of citizenship and political identity for Maori, which formed the historical basis of engagements between Maori and the Crown, Maori and the state, Maori and non-Maori. Maori engagements with non-Maori are framed as indigeneity-based engagements in this study because elements of this indigenized form of citizenship and political identity for Maori remain current. Indigeneity is therefore an appropriate basis for analysis of any historical and contemporary engagements between Maori and non-Maori. Indigeneity, as it relates to health developments in global indigenous health research, was discussed in Chapter 3.

This chapter provides evidence that Maori pro-actively and vigorously pursued political, policy, social, economic and community developments, based upon their sharing and practicing matauranga Maori with non-Maori, from 1840. Evidence of Maori trying to constructively engage with the Crown throughout the mid to late 1800s, through multiple meetings held by large groups of Maori chiefs with Crown representatives in both New Zealand and Britain were discussed. Examples of Maori constructively engaging with non-Maori through Maori community health initiatives, as well as through Maori initiatives for involvement in parliamentary, political, policy, and health developments were also discussed. Examples of Maori constructively engaging with non-Maori through contributions of resources to develop and deliver health and hospital services are also given. The evidence in this chapter indicates that tupuna Maori viewed

engagements between Maori and non-Maori as constructive if they were matauranga Maori based.

A finding of this chapter was that tupuna Maori were willing to constructively engage to co-operatively co-exist through living together differently with non-Maori. An example of this was Tareha Te Moananui giving the first Maori member of parliament speech in the New Zealand parliament in te reo Maori.

One of the purposes of this chapter was to identify tupuna Maori experiences of hauora that could be walked forward into the future to be used as themes for discussion in the contemporary cases studied. The three tupuna hauora kotahitanga themes identified from this chapter are (i) rangatira hauora, the impacts on health developments of Maori leaders and leadership; (ii) community initiatives, how communities created initiatives for health developments; and (iii) the role of Maori nurses in health developments.

In the 1970s and 1980s Rangatira Hauora pursued matauranga and tikanga Maori health developments through constructive engagements with Crown, government, state, health sectoral and non-Maori representatives. These constructive engagements were conducted in an environment where health research was showing a profoundly disturbing trend in negative Maori mortality and morbidity outcomes (Hunn, 1961; Rose, 1972; Pomare, 1980). In 1984 Rangatira Hauora and the Department of Health at the Hui Whakaoranga constructively engaged to produce a set of matauranga Maori Health Goals for New Zealand. The Department of Health therefore agreed to constructively engage in the pursuit of matauranga Maori health developments from the 1980s; indigeneity-based Maori health developments. In 1991 the Minister of Health announced that Maori could use Department of Health resources to purchase and provide healthcare plans and services based on Maori needs, priorities and values (Upton, 1991). A finding of this chapter is that by 1991 the Crown, through the Minister of Health, had agreed to constructively engage with Maori in developing and delivering matauranga-based Maori health plans, models, and services. This provided a context for Maori and non-Maori to co-operatively co-exist because non-Maori would have the option to access publicly funded matauranga and tikanga Maori health services.

The development of the matauranga Maori health services in the 1990s and early 2000s is the focus of this study, and the political and policy context for the developments from

the 1980s into the early 2000s is the subject of the next two chapters. The overall purpose of these next two chapters is to give a political and policy contextualisation for the case study organisation journeys that are studied from Chapter 7 onwards.

Chapter Five

THE POLITICS OF INDIGENEITY- BASED HEALTH DEVELOPMENTS IN NEW ZEALAND

5.1 Introduction

Chapter 4 discussed how Maori engaged constructively with non-Maori, for and through health developments, in the early colonisation period of the 19th and early 20th centuries, to bring some of these tupuna experiences into the future so that they can be considered alongside the contemporary findings of this study. The main purpose of this chapter is to provide a synopsis of the key political, policy and health sectoral changes that frame the contemporary experiences examined in the case study chapters, and for the discussion of matauranga Maori based public health policy in the next chapter. Continuing with the theme of discussing indigeneity-based health developments, this chapter introduces New Zealand governments between 1980 and 2008, and explains the health sector reforms associated with these governments. These health sector reforms are explained in terms of their impact on Maori health developments in the final section, ‘the politics of indigeneity-based health developments’. New Zealand governments – 1980 to 2008

New Zealand governments in the 1980s were dominated by the two major New Zealand political parties, Labour and National. New Zealand had a first past the post electoral system until 1996, meaning whoever got the majority of the electoral votes formed a single party government. There was a Labour government between 1984 and 1990. In 1990 Labour were defeated by National. In 1993, the National government was returned and a binding referendum on the electoral system introduced a change from first past the post to multi-member proportional representation (MMP) from the 1996 election. MMP is typified by coalitions of political parties forming a government, rather than single party led governments that had characterised the previous century of first past the post governments in New Zealand.¹⁴

In December 1996, the first MMP government was elected, and resulted in a centre-right coalition between the National Party and the New Zealand First Party. The New Zealand First Party won all of the Maori electorates in this election; the first time the Labour party had not won the majority of Maori electorates since the 1930s. Winston Peters, the leader of the New Zealand First Party was appointed to the cabinet positions of Deputy Prime Minister and Treasurer. In November 1997 there was an internal coup in the National Party and the Prime Minister Jim Bolger was replaced by Jenny Shipley. In

¹⁴For more information see (Boston, McLeay, Roberts, & Levine, 1996)

August 1998 the coalition collapsed, and eight of New Zealand First's seventeen members of parliament defected from New Zealand First to prop up the minority National government until the 1999 election.¹⁵

In 1999 the election resulted in a Labour-Alliance centre-left minority coalition, with a confidence and supply agreement with the Green Party. The 2002 election resulted in another Labour minority coalition agreement with the Progressive Coalition, a support agreement with United Future, and a cooperation agreement with the Green Party. The 2005 election resulted in a minority coalition between Labour and the Progressives, with confidence and supply arrangements with New Zealand First, United Future and the Green Party. The 2008 election resulted in a National-led government with confidence and supply agreements with Act, The Maori Party and United Future.

5.2 Health Reforms – 1980 to 2008

In the most significant change to the health sector since 1938, when the Social Security Act had implemented universal free in and out-patient hospital services, the National government introduced the Area Health Board Act in 1983. The Labour government completed the establishment of the Area Health Board structure in 1989 through the Local Government Act (Gauld, 2001). The Area Health Boards were hospital boards that incorporated hospital and population-based and funded health services (Barnett & Barnett, 2001). These reforms also introduced national health goals and managerialist systems (Upton, 1991). In early 1991 the new National government held a taskforce on health reform to outline a radical restructure of the health sector. These reforms were then enacted through the Health & Disability Services Act of 1993.

Prior to the 1993 Act the purchasers were the fourteen Area Health Boards that had been constituted under the Area Health Boards Act (1983) with boards who were partly government appointed, and partly locally elected. In 1993 these were reconstituted into four Regional Health Authorities (RHAs) with government appointed boards, and a more market driven approach through business efficiencies than had previously been the case (Ashton, 1999).

¹⁵For more information see (Miller, 2003)

From 1995 general practitioners were moved into contractual relationships with the RHAs, in the main through the Independent Practitioner Associations (IPA) that general practitioners had formed as professional collectives (Barnett & Barnett, 2005). A small number of 'capitated primary care not for profit' models were being funded by the RHAs in this period, including 185¹⁶ Maori health providers and 2 community governed Union health centres. This was a significant change in terms of primary care provision which had up until this point been based upon a fee-for-service model with government co-payments topping up for each patient directly to the general practitioner (Barnett & Barnett, 2005). From 1995, the fee-for-service model remained, but there was the addition of some not for profit services into primary care provision.

Following the 1996 election, the National-led coalition with the New Zealand First Party implemented a Coalition Agreement on Health (Coalition Agreement, 1996). The Health and Disability Services Act 1993 remained, but there was some winding back of the focus on economic imperatives through to 1999. The only major structural change to the health sector in this period was the transition of the four Regional Health Authorities into one health funding authority in 1997. In 1998 Crown Health Enterprises (CHE) were reconstituted as Hospital and Health Services (HHS); there was a reduced emphasis on producing a profit and a move towards community engagement with governance (Barnett & Barnett, 2005).

The Coalition Agreement specifically referred to supporting Maori health development (Coalition Agreement, 1996), and the funding of the Maori health providers and Maori purchasing organisations continued in this period. The new government struggled to maintain a working the coalition, which collapsed in 1998.

The 1999 election resulted in a Labour Party led coalition with the Alliance Party, and in line with their election party manifesto, where they had focused on population based funding and a return to community control for health, the implementation of health sector reforms began almost immediately. In 2000 the New Zealand Public Health and Disability Act removed the Health Funding Authority and turned 21 of the 23 Hospital and Health Services (HHSs) into District Health Boards (DHBs). The new DHBs were responsible for both purchasing and providing of health and disability services in their geographic area, or districts, based on a 'population based funding formula'. They were

¹⁶ See Ministry of Health 2000, p.1; Ministry of Health, 2003, Ch5, p10; Ministry of Health, 2005b, p.150

responsible for almost all health services, and some disability support services. In addition to these responsibilities, they managed the hospitals in their district, moving away from the purchaser/provider split that had existed under National policies between 1990 and 1999. The DHBs contained a mix of government appointed and community elected members.¹⁷ The 2000 Labour and Alliance government did ensure Maori representation by holding two places for government appointments of Maori on to each DHB (Gauld, 2001). However, the government controlled the Maori appointments, not Maori.

The Labour-led government also reintroduced the idea of national health goals, their initiative from their time in government in 1989. The Labour-led post-2000 reforms included national health goals contained in the New Zealand Health Strategy (Minister of Health, 2000), the Primary Health Care Strategy (Ministry of Health, 2001), and the Maori Health Strategy (King & Turia, 2002). The 2001 Primary Health Care Strategy rolled out the most significant restructuring of primary health care in New Zealand history. The previous decade of health sector changes had focused mainly on restructuring secondary, tertiary, public and pharmaceutical services. The contracts for primary care (mainly general practitioner services) had, prior to 2002, been through individual contracts between for-profit practitioners and whichever health funding regime existed at the time. Independent Practitioner Associations (IPAs) had dominated the 1990s primary care developments. However, through the 1980s and 1990s, a small number of iwi-providers and community-providers had developed organisations that were not for profit, and were based on community governance. This model, sometimes called the ‘third sector provider network’ (Crampton, Hefford, & Foley, 2005) was significantly different to the IPA model in that they were given bulk funding by the Regional Health Authorities, and there was a strong clinical leadership role undertaken by nurses, whereas in the IPA model clinical leadership was concentrated on general practitioner management.

In the case of the Maori health organisations, the bulk funding was effected through funding a particular number of staff and then deciding how many patients could be seen by that number of staff, rather than funding for a population number with the requisite staff then appointed. Lobbying for increases in their bulk funding to reflect increased

¹⁷ See Gauld (2001), Davis & Dew (2004).

numbers of people accessing the service was therefore initially restricted for Maori providers because they were funded on staff numbers, not population or patient numbers.

The new environment of PHOs created not-for-profit organisations to manage the funding of large numbers of general practitioners and allied health professionals (nurses, pharmacists etc.) through the population based funding mechanism. One of the pillars of this reform was the need for community involvement in primary care governance (Crampton, 2005). The rollout of the Primary Health Care Strategy re-constructed the primary services from general practitioner or clinical governance and into primary health organisations with community governance inclusive of clinical, paramedical, and nursing membership. District Health Boards and Primary Health Organisations were required to provide health plans for wellbeing, health promotion, and vulnerable populations. This promoted the concept of a 'whole of community' approach to community specific health challenges, which could then benefit from targeted funding initiatives from the Ministry of Health and other allied ministries with a vested interest in the health challenges. As an example, funding from Ministry of Justice and Ministry of Social Development could be secured in terms of issues to do with drug and alcohol abuse linked to perhaps crime and family violence.

However, on implementation this thrust towards community involvement was watered down by the Ministry of Health (Barnett & Barnett, 2005; Neuwelt & Crampton, 2005). There was significant resistance by general practitioners to the change from for-profit organisations to not-for-profit organisations with non-clinical governance membership. General practitioners argued that governance should be led only by clinicians (Neuwelt & Crampton, 2005). The most critical issue for general practitioners was, however, the policy direction taken by the Minister of Health to underscore that no single provider group could dominate the PHO governance.

The funding mechanism created for the transition into the new PHO environment favoured areas regarded as having high need because of the deprivation scores of their population. A PHO population with over half their members being Maori, Pacific or from low income regions, were deemed high need because poverty and deprivation was being linked to poor health status (Barnett & Barnett, 2005). PHOs with over half their population falling within this high needs category qualified for the 'low cost access' funding formula, and they received a higher level of funding than those PHOs on the

lesser interim funding formula (Barnett & Barnett, 2005). By 2003, 34 PHOs were established, and of these 22 were funded under the 'access' funding formula (Barnett & Barnett, 2005).

The health sector reforms from 2000 saw the Area Health Board initiative, introduced by National in 1983 and further developed by Labour from 1984 to 1989, re-interpreted and re-introduced as 'District Health Boards'. The population based funding systems that had been favoured in the 1980s were now re-interpreted and re-introduced as a population based funding mechanism. The twenty one District Health Boards were governed predominantly by people elected through local body elections, promoting community governed health systems.

5.3 The politics of indigeneity-based health developments – 1980 to 2008

In terms of Maori development, the Department of Health had created a Maori health team, which functioned up until 1987 and fed Maori health initiatives into policy processes (Gauld, 2001). Between 1984 and 1987 the Maori health team implemented the Oranga Maori/Maori Health Project through the Community Health Initiatives Funding Scheme, and other programmes, to support Maori community health development initiatives (Dyall, 1987). In addition to this, a Department of Health funded research report on Maori health research released in 1988 had revealed that Maori health status remained significantly poorer than that of non-Maori in New Zealand (Pomare & De Boer, 1988). The Minister of Maori Affairs released a discussion document in 1988, *He Tirohanga Rangapu* (Wetere, 1998), which called for the devolvement of resources and responsibility for social policy directly to iwi Maori authorities. This was implemented from 1989 under *Te Urupare Rangapu* (Wetere, 1998).

Under the Labour government, the Iwi Runanga Act 1990 established the legislative structure of Maori organisations that the Crown could negotiate contracts with, including social policy delivery contracts. In 1990 the National government created a taskforce to prepare green and white papers to give advice on their proposed health sector reforms (Upton, 1991). Despite previous gains in Maori participation in various public policy sectors such as environmental; resource management; education; an increasing recognition of Maori values, for example the opportunities for Treaty grievances to be

addressed; and cooperation between the health sector and Maori from the 1984 Hui Whakaoranga onwards, Maori were excluded from any governance or leadership presence on the National government taskforce (Upton, 1991). Maori were, like the rest of the public, able to make submissions on the changes.

In 1990 the Department of Health created a Maori Health Policy Unit (Durie, 1994). Under the National government, the Iwi Runanga Act was repealed in 1991, putting health policy firmly back into the general health policy agenda, rather than under a Maori social policy agenda. Te Puni Kokiri, the Ministry of Maori Development reporting to the Minister of Maori Development, was established in 1991 and produced the report '*Ka Awatea*' (Office of the Minister of Maori Affairs, 1991) for Maori development, which included to facilitate achievements in Maori health through facilitating and monitoring other government departments efforts (Office of the Minister of Maori Affairs, 1991). The Department of Health became the Ministry of Health in 1993 and Te Kete Hauora, a Maori division, was established. There were a number of 'Maori' state health policy specialists here, as well as in Te Puni Kokiri which was tasked with monitoring the health sector in terms of Maori health developments from 1991.

Maori in the community began developing healthcare plans in the early 1990s in line with the policy directions signalled by the Minister of Health (Upton, 1991). Newly emerging Maori health organisations had an advantage over existing non-Maori health organisations in this change period because they did not have existing structures in which significant changes to systems would need to be made to comply with new legislation and policies (Gauld, 2001).

In creating an indigeneity-based response to Maori health developments, the state took pains to formally recognise the Crown responsibilities to Maori under their Treaty of Waitangi partnership and this was documented in a number of health policies. The Health and Disability Services Act (1993), which resulted in a radical restructuring of the health sector, had placed little emphasis on Maori health developments or the Treaty relationship. Maori were mentioned briefly in section 8e, on page 21, as being one of the particular communities that might have specific Crown Objectives. However, in 1992 the government acknowledged the Treaty of Waitangi as the founding document of New Zealand in the health policy document *Whaia te ora mo te iwi* (Shipley, 1995b). Maori indigeneity, or political difference, in terms of state health policies, was to permeate all

Maori health policy documents from this point onwards. Maori health policy guidelines were issued in 1995 and 1996 (Shipley, 1995c; 1996), but the four Regional Health Authorities (RHAs) were able to place their own individual interpretations on the guidelines and create their own constructive engagements with Maori in their region.

In the Midlands RHA region, co-purchasing agreements occurred with the establishment of four joint venture boards with thirty five local iwi, but without delegated authority to their committee (Shipley, 1995b). The Central RHA adopted an internal Maori advisory unit, and worked with the fifteen regional iwi to plan services in their areas (Cunningham & Durie, 2005). Additionally they set up a group to work with taurahere in the Wellington area (Williams, 2007). The Southern RHA, where Maori made up only 5% of the population, contracted the local iwi Ngai Tahu, who constructed a network of local committees inclusive of taurahere (Williams, 2007). At the Northern Regional Health Authority, the internal Maori health development division had defined the Maori health problem as being premised on a lack of Maori participation in health policy and service delivery, and proposed a Maori Co-ordinated Care and Co-Purchasing Organisations (MAPO) Strategy which included the only delegated authority to be effected across the four regional health authorities (Maori Health Development Division: Northern Regional Health Authority, 1995).

The MAPO Strategy created Maori organisations to co-purchase health and disability services with the Northern Regional Health Authority (North Health), and to provide Maori expertise for the co-monitoring of newly created Maori health organisations within the region (Maori Health Development Division: Northern Regional Health Authority, 1995). The MAPO were referred to by the Minister of Health in 1995 as “Maori co-ordinated care organisations ... established to assist North Health in purchasing the most effective services to meet the needs and expectations of Maori” (Shipley, 1995b, p. 35). The development of this MAPO strategy is discussed in more detail in Chapter 7.

There were a number of Maori focussed health organisations created in the 1990s throughout New Zealand. An example is Hapai Te Hauora Tapui, a public health service purchasing organisation which was created as a joint venture between Tainui (a collective of Waikato tribes), Ngati Whatua (the mana whenua tribe of the region encompassing Auckland through to Whangarei), and Waipareira Trust (an urban Maori authority based in West Auckland). The role of Hapai Te Hauora Tapui was to purchase

public health services, for instance health promotion services, initially for the Northern Regional Health Authority region, but latterly for the top third of the North Island from Waikato north. These three Maori organisations have historical and contemporary boundary and authority disputes which made this organisational compact challenging to create and implement (National Business Review, 1998). Another example was He Kamaka Oranga, a Maori strategy and policy unit created to give internal advice to Auckland Healthcare, the Crown Health Enterprise overseeing the management of four of Auckland's main hospitals, Auckland, Starship, Greenlane, and National Womens. However, the majority of Maori health organisations created in the early 1990s were community service providers and many of them were rurally based. Services delivered by these organisations often included health promotion; well child checks of children in pre-schools and schools; transporting patients to breast and cervical screening appointments and hospital appointments; homecare support services for people with temporary disabilities caused by medical conditions alcohol and drug counselling, and parenting advice. A number of the services also had nursing services, some had community-based mental health services, some had mental or disability residential services, and some had general practitioner services.¹⁸

By the time of the 1996 reforms, Maori “tino rangatiratanga (Maori control and determination)” had become a tacit part of the 1993 health reform implementation (Gauld, 2001, p. 129). Maori health development directions from within Maoridom had gained the “full support” of government and the health sector (Gauld, 2001, p. 130). This support included recognition of new “organisational forms and recognised principles for development” (Gauld, 2001, p. 130).

By 1998 Maori integrated care organisations (MICO), where a number of organisations would come together to take advantage of economies of scale on administrative, management and purchasing decisions that collectivising their patient populations would provide, were being established throughout the country. Often this was in conjunction with the Health Funding Authority objectives of expanding service delivery organisations into service integration and budget holding organisations. One example was Kaipara Care Providers, with governance members from aged care, palliative care, physiotherapy, Plunket, Barnados, mental health care givers, pharmacists and general practitioners.

¹⁸See Lavoie (2005), Tomlins-Jahnke (2005), Boulton (2005), Kiro (2001).

Kaipara Care was one of the key MICO projects in Northland for Te Runanga o Ngati Whatua. Their focus was on coordinating primary and secondary services with a focus on disease management (Kaipara Care Incorporated, 26th March 2003). Another example, Tui Ora Maori Integration Service Organisation (MISO), linked all Maori health service providers in the Taranaki region (St John, 1998). A third example, the Wellington MICO, made up of five Maori health organisations, integrated 50 health contracts in the Wellington region (St John, 1998).

Maori were able to customize their new organisations to fit the new health legislative and policy requirements from the early 2000s by fulfilling the dual expectations of the reforms, firstly for increased development of primary care to reduce pressure on secondary care services, and secondly of community involvement. A key factor of successful constructive engagements between Maori health organisations and the National governments of the 1990s was the National government drive to shift some health services from state funded institutions into communities (Gauld, 2001). The difference with the constructive engagements between Maori health organisations and the Labour-led governments of the 2000s was the drive to shift not just services, but governance and management into the communities (Neuwelt & Crampton, 2005). Maori health organisations were able to take advantage of both of these governments moves to increase community health participation, particularly as most of the Maori health organisations were not-for-profits and so could align more readily with community responsiveness initiatives.

The 2000s began positively for Maori in the New Zealand health sector. Tariana Turia, a Labour party Maori member who was elected through a Maori electorate seat was appointed Associate Minister of Health with a special focus on Maori health development. Tariana Turia was a Rangatira Hauora from Te Oranganui Iwi Health in the Whanganui region, which in 1986 had become one of the first Maori health provider organisations to get state health funding. Tariana Turia was a key driver for constructive engagement between the government and Maori on a Maori health strategy called *He Korowai Oranga*, and from 2000 the government begun extensive consultation with Maori health leaders on that and other proposed health sectoral changes (Minister of Health, 2001).

The overall impetus of the government towards the inclusion of matauranga occurred not only within *He Korowai Oranga* (King & Turia, 2002), but also in the *New Zealand Health Strategy* (Minister of Health, 2000) which included Mason Durie's model *Te Whare Tapa Wha* (Minister of Health, 2000.p.5) taken from his book *Whaiora* (Durie, 1994). Matauranga Maori was, through the *New Zealand Health Strategy* 2000 (Minister of Health, 2000) included in, and influencing New Zealand health developments. In 2002 the matauranga based public health policy *He Korowai Oranga* (King & Turia, 2002) became an indigeneity-based model for kotahitanga in public health policy, and this is discussed in the next chapter.

Maori health organisations were proactive in trying to extend their contractual relationships with the government for health, into increased devolvement of social policy resources to Maori communities, through the health organisations (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003). Some Maori Health Organisations also voiced a wish "to act as a 'catalyst' for new policy development" (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003, p. 30). However, following the creation of twenty one District Health Boards under the 2000 reforms, to purchase health services and manage hospitals, the Ministry of Health decided to relegate existing Maori governance level relationships through to the District Health Boards, rather than up to the Ministry of Health, as some Maori health organisations would have preferred (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003).

The government held two District Health Board seats for Maori representatives (Gauld, 2001), however these representatives were often chosen by the Crown rather than Maori, and were seen by some Maori as representatives of the Crown rather than Maori. In terms of constructive engagements with the Crown through health, Maori had constructively engaged with the Regional Health Authorities up until 1997, and then with the Health Funding Authority which replaced the RHAs until 2000, followed by District Health Boards from 2000.

Tanui, Tai Tokerau and Ngati Whatua entered discussions with the new Minister of Health from 2000 to continue constructively engaging directly with the Ministry of Health, as had been occurring since the dis-establishment of the health funding authority from 2000. The constructive engagements between the three iwi and the Minister of Health lasted until 2003, when a state funded review of the MAPO, in which all Maori

participants to the review opposed the devolution of MAPO to District Health Boards, was completed with a recommendation that the devolution to District Health Boards take place in 2006 (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003).

During this 2000 to 2003 review process Ngati Whatua health leaders had chosen not to recommend governance level representation at the Auckland District Health Board level. The Ministry of Health decision to appoint a Maori, who was not endorsed by the Ngati Whatua Maori health sector, nor the Ngati Whatua MAPO Rangatira Hauora, nor by the Ngati Whatua tribal leadership onto their board. This meant the Crown had taken the Maori health leadership role for deciding Maori health representation on the District Health Board away from the MAPO and Ngati Whatua during the consultation process. The Crown had broken both the Memorandum of Understanding and Deed of Partnership agreements with Ngati Whatua (Te Runanga o Ngati Whatua & The Northern Regional Health Authority, 1995a&b); they were neither consulted about nor informed of the decision that had been taken by the Ministry of Health.

The impact of the post-2000 elections health sectoral reforms on the Maori health service providers was as damaging as the impact had been on the MAPO. In order to remain organisationally viable within the new requirements that primary care services with general practitioners become Primary Health Organisations (PHO), it was calculated that PHOs need to have at least 20,000 patients enrolled. Most Maori health organisations had less than 5,000 patients, so administratively they would need to form collectives with other Maori or non-Maori primary care service providers. Of concern to Maori health organisations was the relative size of the small Maori versus the larger non-Maori organisations, and the potential for loss of autonomy for the smaller Maori partner organisations. In practice there were a number of problems that occurred between Maori health organisations partnering with non-Maori health organisations to create PHOs, and a lot of the difficulties were played out in the media (New Zealand Doctor, 2005b).

The administrative compliance requirements of forming a PHO had more of a negative impact on the smaller partners to the negotiations because of the extensive resources required to comply with new compliance requirements. For instance the new compliance requirement to have patient data captured in a specific computer format for centralisation of patient registration data at the Ministry of Health meant purchasing new software and hardware. In nearly all instances the Maori health organisations were the smaller in both

organisational resources and patient numbers, in comparison with the larger organisations they were trying to form PHOs with. This meant they were generally unable to have as sophisticated technology as the larger organisations and would lag behind, or have trouble in complying with, the new information and data capture and sharing requirements for organisations to qualify to be a PHO. This would sometimes result in the Maori health organisation holding up the other health organisations they were partnered with to register as a PHO.

Another aspect causing challenges for small Maori health organisations forming PHOs with substantially larger non-Maori health organisations was the difference in governance structures of the organisations (De Raad, New Zealand Maori Health Directorate, & New Zealand Institute of Economic Research, 2003). The majority of the Maori health organisations were not-for-profit and had more community focussed management and board resources, whereas the majority of the non-Maori health organisations were 'for-profit', and had more corporatized management and board resources. This meant governance level negotiations were in an environment where non-Maori organisations often held significantly more power through both resources and number of patients enrolled.

The most significant challenge to PHO collaboration between Maori and non-Maori health organisations was, however, the service delivery mechanisms/models of the organisations. Maori organisations were based on *matauranga* and *tikanga* that were foreign to the non-Maori organisations, whose organisational structures were often not based on cultural factors. The cultural dimensions of Maori organisations were sometimes of less significance to the non-Maori organisations in terms of organisational developments and service delivery (De Raad, et al., 2003).

Maori health organisations began the 2000s with significant expectations of successfully transitioning into the PHO environment which seemed positively skewed towards their organisations already established community relationships. But most Maori health organisations quickly found they were in survival mode because of the challenges of having to build multiple new relationships with so many other health sector and community peoples and organisations (De Raad, et al., 2003, p. 9). Gaining funding in the 1990s had been characterised by the simplicity of relationships between the Maori health organisation and the Maori teams within the health funders, and the resulting

simplicity of contractual arrangements. The new 2000s policy environment not only required multiple relationships within potentially a number of DHBs for both funding and patient collaboration; it also required relationships directly with the Ministry of Health to secure and maintain ongoing Maori provider development funding; a new series of relationships was required with ‘virtual’ DHB teams – teams developed for specific areas with ring-fenced funding such as mental health.

By far, the two most problematic requirements were the forming of a PHO with non-Maori health sectoral players with varying attitudes to Maori development, and the need to speedily and massively expand enrolled population numbers to ensure ongoing funding to run the organisation through the new population based funding mechanism. This was especially problematic for Maori provider organisations who have a very transient population because Maori move around a lot between their tribal areas and urban areas, so there was a lot of casualised patient visits that did not align with the population based funding mechanism requirement for a patient to be enrolled only in one medical centre per quarter of a year to qualify for funding.

Another issue that became apparent and was critical to Maori health organisation survival in this new funding context was that patients with high and complex needs, for instance non-Maori patients diagnosed with a number of chronic disease states, were being dumped, particularly by non-Maori health services who would continue to have that person’s funding for the next quarter, onto Maori health services that would not receive that persons funding for potentially another quarter (Gauld, 2001). Other issues for the Maori health organisations included the negative public attitude of some Independent Practitioner Association (IPAs), which had over 80% of general practitioners as members, towards partnering with Maori health organisations to form PHOs (Meylen, 2004b).

Despite the difficulties discussed above, which became apparent over the first few years of the PHOs, Maori health organisations initially had been eager and had created some of the earliest PHOs in collaboration with non-Maori organisations:

The “official” first wave of PHOs were announced early this week but their funding remains a post election mystery ... This has not stopped a North Auckland collaboration between Te Puna Hauora O Te Raki Paewhenua and IPA Comprehensive Health Services from forging ahead as a PHO anyway. The North Harbour PHO was launched on 27 June, five days ahead of the

Government's D-day and minus ministerial approval or start-up funding ... Mrs King [Minister of Health] says there are many other PHOs developing around the country and there is nothing stopping organisations forming PHOs right now. This enthusiasm [North Harbour PHO launch] was also a score for her against the doubters claiming PHOs will not fly" (Sheddan, 2002).

A number of the challenges faced by Maori health providers in the new PHO environment are addressed in the case study chapters, where the experiences of three Maori health providers and one Maori intellectual disability provider are examined. At the end of the study period, many Maori health provider organisations were still in existence, some as part of larger PHOs, and some as smaller Maori provider organisation PHOs with special Ministry of Health assistance to ensure their survival. Many, however, had not survived the transition.

5.4 Summary

The purpose of this chapter was to provide an outline of the political changes that provided the backdrop for Maori health developments between 1980 and 2008. The most significant challenge to Maori health developments in this period was dealing with the numerous restructurings of the health sector that took place, and this chapter briefly introduces some of the aspects of those changes. More in-depth discussion of the political and policy change impacts on the Maori health organisations can be found in the case study chapters.

In Chapter 6, the political and policy discussion continues through the examination of the two matauranga of rangatiratanga and whanau ora that were encapsulated in the public policy document *He Korowai Oranga The Maori Health Strategy* (King & Turia, 2002). *He Korowai Oranga* is considered in Chapter 6 as a matauranga based hauora kotahitanga model between Maori and the Crown.

Chapter Six

INDIGENEITY BASED HEALTH POLICY

6.1 Introduction

The purpose of Chapter 5 was to continue the thread of discussing political and policy engagements between Maori and the Crown by providing a synopsis of the key political, policy and health sectoral changes that frame the contemporary experiences studied in the case studies in the following chapters.

This chapter is an indigeneity-based policy analysis of the two matauranga that were the purpose of the public policy document *He Korowai Oranga The Maori Health Strategy* (King & Turia, 2002) - rangatiratanga and whanau ora. *He Korowai Oranga* is considered in Chapter 6 as a matauranga based, and therefore indigeneity-based, public health policy. It is also an example of policy based kotahitanga between Maori and the Crown.

We begin by considering the creation of *He Korowai Oranga* (King & Turia, 2002). There are several ways this could be considered, for instance as a policy that was created by the Ministry of Health to improve Maori health, or as a policy that was created by the Ministry of Health and Maori health leaders to encapsulate the strategic objectives for Maori health developments of both parties. Alternatively, it could be regarded as a policy created to encapsulate hauora Maori practices that were already occurring within the health sector, as an acknowledgement or endorsement of Maori health organisations. It is probable that the creation of *He Korowai Oranga* (King & Turia, 2002) reflects all three of these dynamics, and possibly others. *He Korowai Oranga* (King & Turia, 2002) has also contributed to New Zealand societal discussions about Maori, Maori health, and Maori development.

How New Zealanders discuss Maori, and in particular how New Zealand leaders discuss Maori, creates a series of ‘truths’ that result in a societal discourse (Foucault, 1972; 1980) that shapes how Maori are perceived publicly, and by society (Chant, 2009). The lack of indigenous knowledge inherent in societal discourses where indigenous peoples are the minority population has had a negative effect on indigenous development globally (Hall, 2006). The shaping of the New Zealand discourse on Maori health development has included the actions of some New Zealand leaders, in particular those from political, medical and health fields, who present Maori to the public as a “threat to the established

order of society” (Chant, 2009). I have argued elsewhere that this negative discourse about Maori people has resulted in a “cage of development”¹⁹ in which Maori development has been perceived only as development if it is in a westernised or eurocentric format (Chant, 2009).

The exclusion of Maori knowledge, of mātāuranga Māori, in New Zealand societal development discourses, has historically and contemporaneously involved exclusion from the documents which encapsulate New Zealand societal development discourses - public policy documents. The use of mātāuranga Māori in te reo Māori in public health policy documents is therefore, one possible measure of the willingness of the public health sector to constructively engage with Maori through a Maori language and Maori worldviews based discourse. It is also one possible measure of the willingness of the New Zealand societal discourse to be inclusive of mātāuranga Māori.

Therefore the presence of mātāuranga Māori within public health policies is examined in this analysis, rather than the implementation of mātāuranga Māori through health policies. Changing the discourse in public policy towards a more positive inclusiveness of mātāuranga Māori is an important element for kotahitanga to occur between Maori and non-Maori in hauora. This is evidenced by Maori health leaders at the 1994 Decade of Maori Health Hui (Ministry of Maori Development, 1994) making ‘positive images of Maori predominant in the media’ one of the main aims for Maori and the Crown to achieve to improve Maori health. Equally, positive public discourse on mātāuranga Māori based public policy could be seen as an important element for future Maori developments.

The *Kareretanga* approach is applied to this policy analysis because the mātāuranga Māori in the indigenous health policy that are being examined were for the benefit of, and to be delivered by, non-Maori as well as Maori. A re-interpretation of Marsden’s idea of mohiotanga, identifies **what** mātāuranga Māori knowledge was used to create *He Korowai Oranga*. A re-interpretation of Durie’s idea of indigeneity identifies **how** indigeneity was practiced by Maori in creating *He Korowai Oranga* (King & Turia, 2002). Durie’s ideas on indigeneity were also used to guide the creation of an indigeneity-based policy analysis frame used in this chapter. A re-interpretation of Maaka’s ideas of indigeneity-based constructive engagement is adapted to identify **why**

¹⁹ (Watts, 1995 p.66)

the constructive engagements that resulted in the health policy *He Korowai Oranga* (King & Turia, 2002) might be considered as a model for kotahitanga between indigenous and non-indigenous peoples in New Zealand through Maori and the Crown agreeing to live together differently. The re-interpretation of Maaka's idea of an indigeneity-based constructive engagement was also used to guide the synthesis of the indigeneity-based policy analysis, where Maori expectations of policy were examined, with Kingdon's (2003) ideas of how and why policy windows can be used to explain policy change; so Maori knowledge constructively engaged with western knowledge to explain this policy experience.

This chapter is an indigeneity-based policy analysis, which is for the purpose of this research, simply one where the expectations of the indigenous peoples are used as the measure to analyse the policy in question. The analysis looks at the similarities and differences between the matauranga Maori that dominated two specific policy change and health sectoral reform periods that occurred: those occurring in the 1990s, and those occurring in the early 2000s.

The comparison of the matauranga Maori inherent in these two periods, within the context of the political and policy changes taking place between 1990 and 2002 is explained using Kingdon's (2003) ideas on policy windows. Specifically the two types of policy windows that Kingdon proposes: those that open due to 'problems'; and, those that open due to 'political circumstances'. Problems can be of a sudden nature or something that builds up. Political circumstances can be changes in government, changes in public mood, changes in ideologies and are often 'themes' rather than specifically defined problems. 'Alternatives or solutions' come from what he defines as the 'policy stream' and are often pre-packaged, waiting for the problem to occur. These solutions are then 'coupled' by 'entrepreneurs or advocates' to the problem and if the political environment is amenable, the issue may move from the governmental agenda to the 'decision agenda' and public policy change occurs (2003, 165-195).

Kingdon's ideas are useful here because in New Zealand politics Maori issues are often framed in discourse as either a 'problem' for instance, Maori and socio-economic disparity (Durie, 1998; Cunningham, 2005), or as a 'political circumstance' for instance, Maori economic impoverishment as the result of land and asset confiscations by the Crown (Walker, 2004; Durie, 2005). Kingdon's (2003) idea of policy entrepreneurs who

connect policy problems and policy solutions together when a window of opportunity is available is useful in explaining the nuance of Maori working as public health sector employees, who were also perceived as Maori health development entrepreneurs by Maori people and hauora Maori organisations.

Kingdon's (2003) ideas on how policy windows form is used to compare the experiences of these two matauranga in two health policy periods, the 1990s and the first decade of the 2000s. The experiences and activities of hauora Maori organisations and leaders are reflected on to discuss the presence of these two matauranga in public health policies in these two decades that are the study period for the case studies in the following two chapters.

6.2 Matauranga Maori in public health policies from the 1990s

This section investigates the presence of the matauranga in public health policies from the 1990s. The Department of Health document '*Whaia te ora mo te iwi: Strive for the Good Health of the People: Maori health policy objectives of Regional Health Authorities and the Public Health Commission*' (Department of Health, 1992) outlined general policy directions for Maori health. Maori health was identified as one of the four health gain priorities of government in the *1994/95 Policy Guidelines for Maori Health*. The rationale for the priority was to address "New Zealand's relatively poor record and the potential for improvement" (Ministry of Health, 1994b). At the 1994 Te Ara Ahu Whakamua, the Maori Decade Hui, Maori met with representatives from the Ministry of Maori Development and Ministry of Health and expressed the overall Maori health goal as "Tino rangatiratanga – let Maori determine their own futures" (Ministry of Maori Development, 1994, p.7):

Tino rangatiratanga – let Maori determine their own futures: The most powerful and insistent message to come out of the hui was the repeated call for Maori control and Maori management of Maori resources. 'By Maori, for Maori' was a predominant theme. Maori want to be involved in all levels of the policy making process. They want to deliver services (Ministry of Maori Development, 1994, p. 7).

Maori expressed their matauranga Maori in 1994 Te Ara Ahu Whakamua Hui in te reo Maori as "tino rangatiratanga". This matauranga Maori goal was presented by the

Minister of Health, in te reo Pakeha, as a government focus for Maori health development through “... Maori self-determination and management” (Ministry of Health, 1994, p. 3). “Maori self-determination and management” was to be implemented through the Crown Maori health obligations for purchasers to pursue development of Maori health providers, through partnerships, joint ventures, and to work towards Maori purchasing and budget holding (Ministry of Health, 1994, p. 4). The Minister of Maori Affairs furthered this discussion by proposing state policy Maori towards budget holding of health funds and development of managed care organisations (Ministry of Maori Development, 1994, p. 4).

Maori health aspirations that had been proposed at two Maori hui with the Ministry of Health in 1994 were then recognised in the government document *Nga Matatini, Strategic Directions for Maori Health*:

In 1994 two major hui, Te Ara Ahu Whakamua and Hui Whakapumau, provided opportunities for Maori to come together to identify and crystallize a broad vision for Maori health and development. The Ministry of Health regards the proceedings of these hui as a driving force behind future strategies to improve Maori health (Te Kete Hauora, 1995).

The government focus on Maori health developments in this period did not occur in isolation of the economic developments taking place within the health sector through the tacit transition of health services into a health market place. Maori health developments were seen by the government as aligned with improving Maori economic development:

If the Maori economic base can be restored and strengthened, it will create the potential for some Maori groups to emerge in their own right as fully fledged partners in the health and disability sector. More access to capital will enable Maori groups to buy health and disability organisations if they so wish – and these organisations may then contract with RHAs to provide significant levels of services, both for Maori and the wider community. This would give Maori direct influence over the way services are delivered (Shipley, 1995a, p. 37).

The need for Maori to have the ability to develop an economic base in order that they could compete to deliver services in this new health market place was a key government rationale for funding differentiated Maori health developments, although this was carefully worded to be reflective of the policy focus on Maori participation rather than moving Maori from economic dependence to independence (Shipley, 1995a). In 1995 the Minister of Health proposed that Maori health organisations would continue to be

developed as fundamental structures for primary health development; Maori health organisations had become a key part of the governments health development strategies (Shipley, 1995b).

In 1995 the Minister of Health appeared to be committed to indigeneity-based health developments, or differentiated health developments for Maori based on their indigeneity. From 1996 the inclusion of matauranga Maori in the Minister of Health policy guidelines moved more towards the use of te reo Maori and away from the use of te reo Pakeha explanations of matauranga Maori. The 1996/97 Maori health policy guidelines proposed affirmation of the relationship between Maori and the Crown through meeting “the health needs and expectations of Maori ... by ... recognizing the tikanga and mana of iwi in their region ... [and by] ... being aware that Maori and iwi have their own vision of health ...” (Minister of Health, 1996, p. 40). The matauranga Maori of rangatiratanga in te reo Maori was avoided, however, with terms such as “respect for empowerment of people and on their autonomy and participation ... and independence” used instead (Minister of Health, 1996, p. 13).

In the document *Maori Policy Guidelines A Summary 1996/97* the government acknowledged the success of purchasing and services models that operated under kaupapa Maori:

giving priority to successful purchasing and service models which operate under kaupapa Maori ... services provided by Maori for Maori where appropriate (Shipley, 1996, p. 6).

Kaupapa Maori seemed to have been re-interpreted to mean ‘by Maori for Maori’ service provision. The matauranga Maori of whanau was expressed in te reo Maori by the Minister of health “... Maori preference for community-based and marae-based services; whanau as an integral part of the healing process” (Shipley, 1996, p. 6), and the matauranga Maori of whanaungatanga, with a translation into te reo Pakeha, was implemented by North Health from 1995:

Maori preferences for defining primary health care include the necessity to deal with the ‘whole or integral’ Maori person ... This includes **whanaungatanga**, the kinship relationships that mean that no Maori should be treated as an isolated individual (North Health, 1995, p. 16).

By 1996, the government had produced three Maori health guidelines documents which stated that the government recognised the Treaty of Waitangi as New Zealand's founding document (Shipley, 1995c; Minister of Health, 1996; Shipley, 1996). The idea that the Treaty of Waitangi is the founding document of New Zealand remains mired in controversy even into the early 21st century (Belgrave, 2005), so this statement in three government health documents in 1996 is seen as a significant departure from the standard government rhetoric on the place of the Treaty of Waitangi in constitutional debates.

These three Maori health guideline documents (Shipley, 1995c; Minister of Health, 1996; Shipley, 1996) stating that the Treaty of Waitangi was New Zealand's founding document also suggested that 'by Maori for Maori' health services would be resourced by the publicly funded health system, further reinforcing the state position of Maori as indigenous and requiring distinctive treatment. There was also significant recognition of Maori models of health in the Minister of Health's policy guidelines between 1991 and 1996, including those that were based on whanau, whanaungatanga, kaupapa Maori, and te whare tapa wha, to name but a few. Maori themselves, when evaluating the health reforms occurring from the early 1990s, focused on their ability to exercise rangatiratanga as autonomy and constitutional equity first and foremost:

When Maori evaluated what the 1991 health reforms meant for them, uppermost in their minds was a system of autonomous health care based on constitutional equity arising from the Treaty of Waitangi (Laing, 1994, p. 150).

With New Zealand's first coalition government elected in 1996, Maori issues came to prominence because the New Zealand First Party, which had fielded candidates for and had won all five Maori electoral seats, was in a position to choose either the National or Labour parties to form a government. As part of the Coalition Agreement on Health between the National party and New Zealand First party coalition government, the Regional Health Authorities were transitioned into a single health authority. This meant that the relationships formed between Maori health organisations and the Maori teams at the regional health authorities ended. As these teams had been the key drivers of Maori health organisational development between 1993 and 1997, this was regarded by many Maori health organisations studied as a negative outcome of these latest health sector reforms.

In 1997 a Ministry of Health steering group (Ministry of Health, 1997) to oversee health and disability changes, proposed a framework for Maori health development called “the Rangatira Framework” (Cunningham & Durie, 2005, p. 227). This emphasised rangatiratanga, defined as “Treaty of Waitangi; autonomy and self-determination; Maori control of service delivery to Maori” (Cunningham & Durie, 2005, p. 227). ‘Tikanga Maori and kaupapa Maori’, defined as “traditional healing; services based on Maori health and well-being philosophies” was also emphasised (Cooper & Health Funding Authority, 1998). In June 1998 the Maori Health Group of the Health Funding Authority produced their ‘Maori Health Policy’ document which included a “Maori Health Clause” to be put into all contracts with provider organisations (Health Funding Authority, 1998). This required all organisations contracted for services where Maori might be clients to “... demonstrate how the policies and practices of their provider organisation and service delivery shall benefit that Maori clientele” (Cooper & Health Funding Authority, 1998). For the first time in the history of New Zealand, Maori health outcomes were to become contracted outputs required of all publicly funded health services. The Maori Health Clause was due for implementation through the 1999-2000 health provider contracts, but this impetus was halted by a change of government in 1999.

The restructuring of the health sector by the Labour-led government was instituted through the New Zealand Public Health and Disability Act 2000. Provisions in the legislation for Maori and their health development included: to recognise and respect the principles of the Treaty of Waitangi; to ensure Maori are represented on DHB boards and committees; to establish relationships between Maori and DHBs to ensure they participate in and contribute to strategies for Maori health improvement; to protect gains already made and move forward to strengthen Maori provider and workforce development; to improve mainstream service responsiveness to Maori; and to reduce inequalities between the health of Maori and other populations (King & Turia, 2002). The New Zealand Public Health and Disability bill had contained proposals to identify mana whenua in each of the DHB regions, but these were dropped from the final draft (Cunningham & Durie, 2005, p. 227). Despite this, the Act was unique as it was the first time that the Treaty of Waitangi had been incorporated into social policy legislation (Boulton, 2004, p. 36).

In August 2000, during the restructuring of the health sector, the Minister of Health put out a number of press releases discussing the need for the health sector to develop strategic relationships with Maori health organisations, and to continue developmental support of 'Maori' controlled health and disability organisations (King, 2000). What is notable about the set of press releases is that they showed the Minister of Health taking a strong position in terms of the government's expectations of what the health sector should deliver for Maori development. The inclusion of Maori specific provisions in the Act resulted in positive Maori health developments in terms of "Maori inclusion in governance, planning and decision-making roles" (Boulton, 2004, p. 36).

The 2000 New Zealand Health Strategy (Minister of Health, 2000) was indicative of the political impetus of the Labour-led government towards inclusiveness of matauranga Maori in health developments. Durie's Maori health model, 'Te Whare Tapa Wha' (Ministry of Health, 2000, p.5), was highlighted as a model for intersectoral approaches to health within the Health Strategy. What is notable about 'Te Whare Tapa Wha' in the New Zealand Health Strategy (Minister of Health, 2000, p.5) is that it was targeted at all New Zealanders, and not just Maori, so the government was recommending Maori health models, based on matauranga Maori, as a suitable approach for health developments of all New Zealanders. It was presented in the Strategy in te reo Maori with translations into English:

This intersectoral approach is consistent with Maori approaches to maintaining and improving wellbeing. The Whare tapa wha (Durie 1994) Maori health model, which is also known as the four cornerstones of Maori health, describes four dimensions that contribute to wellbeing: te taha wairua (spiritual aspects), te taha hinengaro (mental and emotional aspects), te taha whanau (family and community aspects), and te taha tinana (physical aspects). It is considered that good health depends on the equilibrium of these dimensions (Minister of Health, 2000, p. 5).

This meant that the broader aspects of health sector restructure were tacitly being informed by matauranga Maori, for the benefit of all New Zealanders. Further, in the New Zealand Health Strategy (Minister of Health, 2000), the government outlined its commitment to a Maori Health Strategy. The New Zealand Health Strategy (Minister of Health, 2000) outlined the process that would take place to achieve a differentiated Strategy for the health of Maori, based on Maori health development:

In acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi, the health sector will face expectations that extend beyond just improving Maori health and those which have been included in the New Zealand Public Health and Disability Act. Those expectations will centre around ensuring participation of Maori in decision making on health issues and the delivery of health services and providing opportunities for Maori to meet their aspirations for wellbeing (Minister of Health, 2000, p. 36).

The ideas of Maori health development were, in the main in 2000, presented in te reo Pakeha, the exception being the presentation of Te Whare Tapa Wha in the New Zealand Health Strategy 2000 in which the matauranga Maori was presented along with te reo Pakeha translation.

In the Primary health care strategy document 2001, a differentiated development pathway for Maori health organisations is given. Diagrams from the document of ‘the new primary health care sector’ include Maori development organisations alongside primary health organisations. The diagram also includes separate ‘Maori’ health organisations along with ‘health organisations’, giving Maori assurance that separately publicly funded Maori health developments were to remain a reality within the new government’s policy directions (Ministry of Health, 2001, p. 5).

In terms of Labour-led health sector reforms from 2000, the movement towards community participation was a key focus. Neuwelt and Crampton (2005) have argued that the concept of community participation in health policy was strengthened by the exemplar of how successfully Maori health organisations had garnered not only Maori community support, but also extensive non-Maori community support in the 1990s. Maori were regarded from the 1990s by governments as having rights to participate in health policy as a specific and defined community (Neuwelt & Crampton, 2005). Maori participation in health systems and policies as a defined community was thus pragmatically aligned with the health sectoral changes of the Labour-led government which were focused on facilitating the participation of ‘defined’ communities; Maori health organisations were seen as exemplars for how new PHO communities could be formed (Boulton, 2005).

He Korowai Oranga (King & Turia, 2002) was co-produced by Maori Rangatira Hauora and the government. Based on Maori and government aspirations for Maori health, *He Korowai Oranga* was timely as the newly forming Primary Health Organisations had to,

amongst other requirements for registration, provide a Maori health plan. *He Korowai Oranga* provided a format for Maori to receive health services according to Maori interpretations of wellbeing and service delivery. It was regarded positively by Maori because of its focus on pathways to future developments (Boulton, 2004, p. 36).

The planned implementation of *He Korowai Oranga* (King & Turia, 2002) was signalled through the government document *Whakatataka: Maori Health Action Plan 2002-2005* (Ministry of Health, 2002). This was followed by *Whakatataka Tuarua: Maori Health Action Plan 2006-2011* (Ministry of Health, 2005). *He Korowai Oranga* was presented diagrammatically as ten steps. Of these, only two were matauranga Maori and in te reo Maori. Rangatiratanga was presented as a ‘key thread’ and Whanau Ora as ‘the overall aim’. The two matauranga Maori are examined in more detail below, and in particular their presence within health policy documents from the 1990s in the lead up to *He Korowai Oranga 2002*.

6.2.1 The matauranga Maori ‘Rangatiratanga’ in public health policies from the 1990s

This section investigates the presence of the matauranga rangatiratanga in public health policy documents from the 1990s, through to its application in 2002 within *He Korowai Oranga* (King & Turia, 2002). In 1994 the Minister of Health indicated a focus for health development would be “... Maori self-determination and management” (Ministry of Health, 1994, p. 3). In 1995 the Crown reiterated its commitment to Maori aspirations for tino rangatiratanga in health development as proposed at the 1984 Hui Whakaoranga (Te Kete Hauora, 1995). Tino rangatiratanga had been defined as Maori control and Maori management of Maori resources, ‘By Maori, for Maori’ service delivery, and Maori in policy making processes (Ministry of Health, 1994, p. 7).

By 1995, the Minister of Health was proposing resourcing Maori so that they could facilitate “...Maori groups to emerge in their own right as fully fledged partners in the health and disability sector” (Shipley, 1995b, p. 37). By 1996 the Minister of Health was requiring that the health sector ensure they were “recognizing the tikanga and mana of iwi in their region” (Minister of Health, 1996, p. 40), and also to pursue the “empowerment ... autonomy... independence” of Maori in health developments (Minister of Health, 1996, p. 13). The document *Maori Policy Guidelines A Summary 1996/97* required the health sector to give “... priority to successful purchasing and

service models which operate under kaupapa Maori ... services provided by Maori for Maori where appropriate” (Shipley, 1996, p. 6).

From 2000, with Crown focus on creating a Maori health strategy, rangatiratanga was explained in *He Korowai Oranga* 2002 as driving changes for the health and disability sector:

He Korowai Oranga acknowledges whanau, hapu, iwi and Maori aspirations for rangatiratanga to have control over the direction and shape of their own institutions, communities and development as a people. Involving iwi in decision-making as representatives and as partners ensures that new directions fit with the wider development goals. Continuing Maori provider development and Maori workforce development allows health initiatives to contribute to whanau, hapu, iwi and Maori community initiatives. These aims are in the New Zealand Public Health and Disability Act 2000. The Government has also supported moves to strengthen the capability of Maori communities to develop initiatives that meet their needs across the social, cultural and economic sectors. These initiatives will begin to drive changes for the health and disability sector (King & Turia, 2002, p.7).

Rangatiratanga had been applied in a number of health policy documents in the 1990s and was interpreted into te reo Pakeha for *He Korowai Oranga* as meaning for Maori to ‘direction and shape of their own institutions, communities and development as a people’ (King & Turia, 2002, p.7). Rangatiratanga as matauranga Maori was linked through *He Korowai Oranga* into indigeneity-based public health policy for the early 21st century.

6.2.2 The matauranga Maori ‘Whanau Ora’ in public health policies from the 1990s

This section investigates the presence of the matauranga Whanau Ora in public health policy documents from the 1990s, through into its application within *He Korowai Oranga* 2002 (King & Turia, 2002). There were a number of references to ‘whanau’, but not to ‘whanau ora’ specifically in the 1990s documents. The *1993/94 Policy Guidelines for RHAs and the PHCs* emphasised health care structures based around whanau, hapu and iwi, and also emphasised ‘whanau’ within Te Whare Tapa Wha with (Shipley, 1995c, p. 21). The *Maori Policy Guidelines A Summary 1996/7* referred to “whanau as an integral part of the healing process” (Shipley, 1996).

In 2002 *He Korowai Oranga* referred to ‘whanau ora’ in the following way:

Maori families supported to achieve their maximum health and wellbeing. Whanau (kuia, koroua, pakeke, rangatahi and tamariki) is recognised as the foundation of Maori society. As a principal source of strength, support, security and identity, whanau plays a central role in the wellbeing of Maori individually and collectively. The use of the term whanau in this document is not limited to traditional definitions but recognises the wide diversity of families represented within Maori communities. It is up to each whanau and each individual to define for themselves who their whanau is (King & Turia, 2002).

As ‘whanau ora’ was not a dominant matauranga in health policy documents in the 1990s in the way that rangatiratanga was, the influence of Maori health organisations using ‘whanau ora’ as matauranga Maori, which is explored in the case study chapters, may have been a more significant influence on its becoming the overall aim for *He Korowai Oranga* 2002.

6.2.3 Summary – Matauranga Maori within health policy documents

Matauranga Maori within public health policy documents became increasingly common throughout the 1990s, but was predominantly presented in te reo Pakeha until 1996, after which time matauranga Maori was presented in te reo Maori more often. There was a significant presence of the matauranga of rangatiratanga within health policy documents in the 1990s, in both te reo Maori and te reo Pakeha. This may have been, in part, influenced by the Maori political presence in government through the New Zealand First party/National party Coalition government from 1996. There was less significant presence of the matauranga of whanau ora within health policy documents in the 1990s. The findings of this chapter show that there was a public health policy document pathway to the inclusion of the matauranga of rangatiratanga into *He Korowai Oranga*, but there was not a significant health policy document pathway to the inclusion of the matauranga of whanau ora into *He Korowai Oranga*.

The findings of the case study chapters are that three of the organisations studied, Orakei Health, Te Puna Hauora and Te Ha o te Oranga, gained funding from the Ministry of Health in the 1990s to develop health models, and that the three organisations named ‘whaanau ora’ (Stephens, 1998) as a key matauranga Maori for their health models. Whilst the Ministry of Health may not have highlighted ‘whanau ora’ in their public health policy documents, they were funding a number of Maori initiatives based on

‘whanau ora’ in the 1990s and this may have influenced the use of ‘whanau ora’ in the new health policies created in the health sector reform period from 2000.

6.3 An indigeneity-based policy analysis

This policy analysis looks at the similarities and differences between the matauranga Maori that dominated two specific policy change and health sectoral reform periods, the 1990s, and the early 2000s. Applying Kingdon’s (2003) idea of a policy window to the matauranga Maori in public health policy documents and experiences from 1990, compared with the early 2000s, there appears to be distinct differences in the experiences of rangatiratanga and whanau ora.

The 1990s experience saw rangatiratanga present in both te reo Maori and Pakeha in an increasing number of state health policies through until 1999. State expressions of rangatiratanga were aligned in the public health policy documents with how Maori self-sufficiency could be brokered through health developments. There was less of a focus on rangatiratanga through health developments aligning with Maori aspirations for self-determination. The window of opportunity (Kingdon, 2003) for Maori to create ‘by Maori for Maori’ health organisations that had arrived with the 1993 health sector reforms was primarily driven by Maori ‘policy entrepreneurs’ who were in bureaucratic roles within the regional health authorities.

Maori benefited from the competitive environment that was created under the new health contracting mechanism from 1993, which created a sense of urgency for both health authorities to deliver their Crown objectives and provider organisations to win health contracts. This may have been a causal factor in the significant growth from approximately 25 to 185²⁰ Maori health organisations between 1993 and 1996. Many non-Maori health sector organisations dragged their feet on moving to the new format of health contracting. Maori however were using the new format to begin organisations, so when the Ministry of Health opened their doors in 1993 and were keen to sign on providers to new contracts they found a large queue of Maori potential providers waiting.

In contrast, the 2000s experience saw the dominance of the presence whanau ora in te reo Maori in state health policies, over rangatiratanga. This was particularly evident in *The*

²⁰ See Ministry of Health, 2000,p.1; Ministry of Heath, 2003, Ch5, p10; Ministry of Heath, 2005b, p.150

Korowai Oranga 2002 where rangatiratanga was a key thread, and whanau ora the overall aim of the policy. This focus on whanau ora rather than rangatiratanga aligned with the political focus on community-led health developments, where Maori were seen as part of the health communities as envisaged under the New Zealand Health Strategy, (Minister of Health, 2000) and Primary Health Care Strategy (Ministry of Health, 2001), rather than autonomous from them.

The window of opportunity (Kingdon, 2003) for Maori to implement matauranga Maori through state health policies may well have been driven by the need for Labour-led governments to show their commitment to Maori health development in some way. Any growth in the already significant number of Maori health organisations created in the early 1990s could be viewed by Maori as the Labour-led government just continuing National-led government policies from the 1990s, under which the majority of Maori health organisations had been created. Maori disappointment at the exclusion of the Treaty of Waitangi in the 1993 Health and Disability Act was a key reason it was one of the changes proposed for the health sector reforms from 2000. With the proposal for inclusion of the Treaty in legislation, a window of opportunity opened for Maori to constructively engage with the Crown in creating an indigeneity-based public health policy.

This time the policy entrepreneurs taking advantage of the window were not dominated by Maori in health bureaucracy positions, as had been the case in the 1990s. Predominantly the Maori involved in the reference groups for the health sector reforms from 2000 were from Maori health organisations that had been created in the 1990s (King, 2000). Another interesting factor in the reference groups for the health sector reforms was that there was little involvement of tribal leaders, nor leaders from Treaty of Waitangi negotiating groups. In this way, those Maori who got a seat at the table of health sector reforms tended to be those focused on health development, rather than tribal development. This may have been a key influence in the dominance of the presence of whanau ora over rangatiratanga that typified the policies of the early 2000s, as focus on rangatiratanga was associated in the 1990s with tribally driven Treaty of Waitangi settlements and tribal aspirations for rangatiratanga as autonomy and sovereignty. Whanau Ora could mean family wellbeing which was inclusive of non-Maori, whereas rangatiratanga was perceived as mainly for the benefit of Maori.

6.4 Conclusion—Matauranga Maori based health policy in New Zealand

Constructive engagements between Maori health leaders in the 1980s with the Department of Health, as discussed in Chapter 4, were based on the matauranga of rangatiratanga. This may account for its significant presence in the public health policies and documents of the 1990s. Some of the constructive engagements between Maori health organisations in the 1990s with the Ministry of Health are explored in the case study Chapters 7 and 8. These case studies show that these organisational constructive engagements were based predominantly on the matauranga of whanaungatanga and whanau ora from the mid-1990s. This aligns with Maori health leaders and Maori health provider organisations constructive engagements with the Crown for *He Korowai Oranga* (King & Turia, 2002) that took place between 2000 and 2002, where whanau ora was chosen as the main aim, with rangatiratanga as an essential thread for the new policy. The prevalence of whanau ora as a matauranga of Maori health organisations in the 1990s is most likely the reason for its higher incidence in public health policies from 2000 than other matauranga.

Re-visiting Kingdon's (2003) ideas of policy windows, the policy window that opened for rangatiratanga as a matauranga in health policy documents from the 1990s was driven by the 'problem' of poor Maori health status that had been highlighted through various publications and health reports in the 1980s, as was discussed in Chapters 4 and 5. The policy window that opened for whanau ora as a matauranga in the early 2000s was most likely driven by the 'political circumstance' (Kingdon, 2003) of the new government needing to differentiate its offering to Maori for health development from those of the previous two governments. The previous two governments had created a policy window, based on the problem of poor Maori health status. That policy window had resulted in a significant increase in the number of Maori health provider organisations in the 1990s. It had also resulted in a number of public health policy documents focussed on Maori health developments.

The new government in 2000 tried at first to include the Treaty of Waitangi and other Maori aspirational measures into the health sector reforms they were undertaking at the time, but they faced a public backlash as was discussed in Chapter 5. However, the Maori electorates had moved strongly back in favour of Labour as the majority party of

the new government, having moved en masse from Labour in the previous election, so Labour had a significant ‘political circumstance’ (Kingdon, 2003) in maintaining their Maori electoral base when they opened the ‘policy window’ (Kingdon, 2003) for a matauranga based, indigeneity-based, public health policy to be created for implementation throughout the Maori and non-Maori health sector.

There was consistency of Maori health leadership as well as a consistency of adherence by those leaders to collaboratively agreed Maori goals and aspirations for health developments through the 1970s, 1980s, 1990s and early 2000s. The policy window of the early 1990s resulted for Maori in an extensive and rapid increase in the number of Maori health organisations through the 1990s. For the government, the result of the policy window was their ability to transfer responsibility for well documented poor Maori health status back from the government to Maori leaders and communities.

The policy window of the early 2000s resulted for Maori in matauranga based health policy applicable to, by and for Maori and non-Maori. The policy, *He Korowai Oranga* (King & Turia, 2002), was a strategy for co-operative co-existence based on Maori and non-Maori living together differently through the matauranga of whanau ora (underpinned by rangatiratanga). For the government, the result of the policy window was their ability to not have to engage in ‘Maori for Maori’ health strategies, because Maori health strategies were now focussed through *He Korowai Oranga* on the wellbeing of all whanau, Maori and non-Maori. Health strategies for all New Zealanders could now be homogenised because they were inclusive of matauranga Maori.

He Korowai Oranga (King & Turia, 2002) has been considered as a model for kotahitanga between indigenous and non-indigenous peoples in New Zealand through Maori and the Crown agreeing to live together differently. *He Korowai Oranga* was a matauranga based health policy that was inclusive of non-Maori. Non-Maori could participate in and benefit from matauranga shared by Maori for a public health policy. *He Korowai Oranga* changed the discourse about Maori in New Zealand health developments from being about Maori and their poor health status. Through *He Korowai Oranga*, matauranga Maori became one of the knowledge bases for New Zealand health developments. The discourse in New Zealand public health policy was no longer ‘about’ Maori, it was ‘by Maori.

The next two chapters introduce the Maori health organisations created in the Ngati Whatua iwi rohe from the mid-1990s that are the case studies. This chapter has provided a policy context for the organisations through their creation and development phases from the mid 1990s into the early 2000s. The next two chapters provide some elucidation of the experiences of people associated with the case study organisations during these policy changes, and in particular their ability to express their matauranga through constructive engagements with non-Maori, and sometimes other Maori, through hauora Maori.

Chapter Seven

CASE STUDY- PURCHASER ORGANISATION

7.1 Introduction

In Chapter 2, the mātāuranga of three Māori scholars, Durie, Maaka and Marsden, were discussed and re-interpreted for this study as ways for understanding mātāuranga for indigeneity-based constructive engagements between indigenous and non-indigenous peoples. In Chapter 3, these re-interpretations were configured as thesis methods to assist in discussions of the three indigenous health development debates which are a focus of this study: indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and indigenous knowledge for health development.

This chapter begins, in keeping with the research approach of whanaungatanga, by introducing the mana whenua iwi of the case study. This chapter is about the Māori health co-purchasing organisation (MAPO) that was established between Te Runanga o Ngāti Whatua, as the representative of the Ngāti Whatua iwi, and North Health, as the representative of Crown and public health sector purchasing. This chapter charts the creation and establishment of Tihi Ora MAPO by applying a re-interpretation of Marsden's idea of mohiotanga to understand and explain **what** mātāuranga informed the tikanga Māori methodologies of Tihi Ora MAPO, and how, through the delivery of these tikanga the mātāuranga became mohiotanga for the peoples delivering hauora Māori services. A re-interpretation of Durie's idea of indigeneity is applied to understand and explain **how** indigeneity was practiced by Ngāti Whatua iwi through the implementation of mātāuranga through the tikanga of the Tihi Ora MAPO organisation for health developments with communities. A re-interpretation of Maaka's ideas of indigeneity-based constructive engagement is applied to understand and explain **why** the Tihi Ora hauora model of the MAPO strategy might be considered as a model for kotahitanga between Māori and non-Māori peoples. The discussion of the Tihi Ora MAPO strategy as a hauora Māori model for kotahitanga is continued in Chapters 9 and 10.

The creation and evolution of the Ngāti Whatua MAPO organisation, Tihi Ora, is explained, along with how it functioned through until the government review of the MAPO in 2003. The mātāuranga of Tihi Ora is identified, and the mātāuranga based tikanga service delivery models created by Tihi Ora are discussed in terms of constructive engagements with the Tihi Ora communities. This case study has a

significant difference to the case studies in Chapter 8 because Tihi Ora is a purchasing organisation, so its relationships were about purchasing, and not providing, health and disability services. As part of the MAPO strategy implemented from 1996 by Tihi Ora and North Health, four primary care providers were created under primary care and health promotion services in the mid-1990s and three of these are studied in Chapter 8, along with a residential disability provider organisation established under disability services in the late 1990s.

7.2 Whanaungatanga – te whakapapa o Ngati Whatua iwi

When Maori introduce themselves they speak of their tupuna, the waka they arrived on, their land or rohe boundaries, and their marae or meeting house. The eponymous ancestress of Ngati Whatua is believed to be Te-whatua-kai-marie, the great granddaughter of Rongomai, and Rongomai captained the waka Maahuhu-ki-te-Rangi that brought the Ngati Whatua iwi (Chant, 1999). The traditional Ngati Whatua rohe boundaries are described as: Tamaki ki Maunganui i te Tai Hauauru and Tamaki ki Manaia i te Rawhiti. The northern boundary is: Manaia titiro ki Whatitiri, Whatitiri titiro ki Tutamoe, Tutamoe titiro ki Maunganui. The southern boundary is: Te awa o Tamaki. Marae, whanau and hapu within the maru of these maunga are included within the rohe (Chant, 1999). The Ngati Whatua marae are: Haranui, Puatahi, Reweti, Te Aroha Pa, Te Kia Ora, Nga Tai Whakarongorua, Oruawharo, Otamatea, Parirau, Pouto, Rawhitiroa, Orakei, Te Kiri, Te Kowhai, Te Pouna, Te Whetu Marama, Waihaua, Waiohau, Waiotea, Korokota, Takahiwai, Tirarau, Toetoe, Ahikiwi, Kapehu, Matatina, Naumai, Oturei, Pahinui, Ripia, Taita, Tama Te Uaua, Te Houhanga Waikara, Waikaraka (Chant, 1999).

Figure 5: Ngati Whatua 2005 map of their Tribal Region.



Source: Tihi Ora, 2005. Map of Ngati Whatua tribal rohe

Ngati Whatua tribal identity in the 21st century is linked to the ongoing negotiations with the Crown over mana whenua, or the tribal authority over lands and resources within the region described above. Crown-Maori relations have formed a stronger platform for debate following the 1975 Treaty of Waitangi Act, and the subsequent establishment of the Waitangi Tribunal as an interface between Maori and the Crown on Treaty breaches. Major treaty claims have been presented to the Waitangi Tribunal since the late 1980s.

Ngati Whatua has been described by Kawharu (1995) as a ‘polity’ that sought to protect its rangatiratanga through the signing of the Treaty of Waitangi - a polity that was put into a state of disarray through the Crown’s policy practices. Kawharu explains that the Treaty with the Crown was to protect the rangatiratanga of the polity of Ngati Whatua:

In a longer perspective it was such rangatiratanga that guided Ngati Whatua to Aotearoa a millennium ago, then later from the Far North to Kaipara, and ultimately to sign the Treaty with the Crown. But this was a treaty that would ensure that at least external threat would never arise to destroy Ngati Whatua as a polity. It was a treaty offering protection, above all the exercise of Ngati Whatua rangatiratanga (Kawharu, 1995, p. 4).

The Ngati Whatua region is unique in terms of other tribal regions because it includes New Zealand's largest city, Auckland, which has a population of over one and a half million out of a total country population of four and a half million. Auckland has the largest concentration of urban Maori. The majority of the Maori in Auckland do not have whakapapa to Ngati Whatua. They are Maori from other tribes.

In 1995 Te Runanga o Ngati Whatua, on behalf of Ngati Whatua iwi, formed a Maori health and disability co-purchasing organisation (MAPO) with the Northern Regional Health Authority (North Health) to deliver the MAPO strategy on Ngati Whatua mana whenua lands. This meant that Ngati Whatua iwi became responsible for the co-purchasing of health and disability services for all Maori, including non-Ngati Whatua, in their tribal region in 1995 until 1998, as is discussed in this chapter. The tikanga Maori model of the hauora Maori organisation, Tihi Ora, is the MAPO strategy.

7.3 The MAPO Strategy

The Health and Disability Services Act 1993 created four Regional Health Authorities. In the absence of specificity towards Maori health or the Treaty of Waitangi relationship with Maori in the new Health and Disability Services Act 1993, the Regional Health Authorities were mandated to manage Maori health at their own discretion. The newly created Regional Health Authorities developed structures to implement the new health sector changes. The 1993 Act significantly reformed the health sector, as was discussed in Chapter 5.

The Maori Health Development Division (MHDD) was one of a number of divisions competing internally within the Northern Regional Health Authority (North Health) for Vote Health monies²¹ to distribute to health and disability providers in the North Health region. The MHDD created a unique response to Maori health for the North Health region which they called 'the MAPO Strategy'. They created this strategy as a catalyst for increasing Maori participation in New Zealand health services and policy, and they described it as a "grand strategy":

To reiterate, it is the essential need for greater Maori participation in the public health sector which drives the MAPO strategy. Hence the MAPO – Co-Purchasing strategy. In summary, we could refer to "the grand strategy" as

²¹ 'Vote' health is the New Zealand government term for government monies that are spent on health.

Increased Maori Participation at every level of the public health sector” (Maori Health Development Division: Northern Regional Health Authority, 1995).

The MAPO strategy was regarded as a unique way of using the Treaty of Waitangi as the basis for constructive engagement between Maori and the North Health Board. It was created to focus on constructive engagements in health and disability purchasing through primary health services provision and the enhancement of secondary and tertiary health, and disability provision. It was unique in that the partnership between Maori and Crown was seen as being without precedent in health sectoral relationships up until this point in the Treaty based relations:

The North Health Board has accepted and endorsed the strategy and wants to give it life in the form of a Waitangi Treaty based “health partnership”. **The practice of this partnership is without precedent** [in original] (Maori Health Development Division: Northern Regional Health Authority, 1995, p. 1).

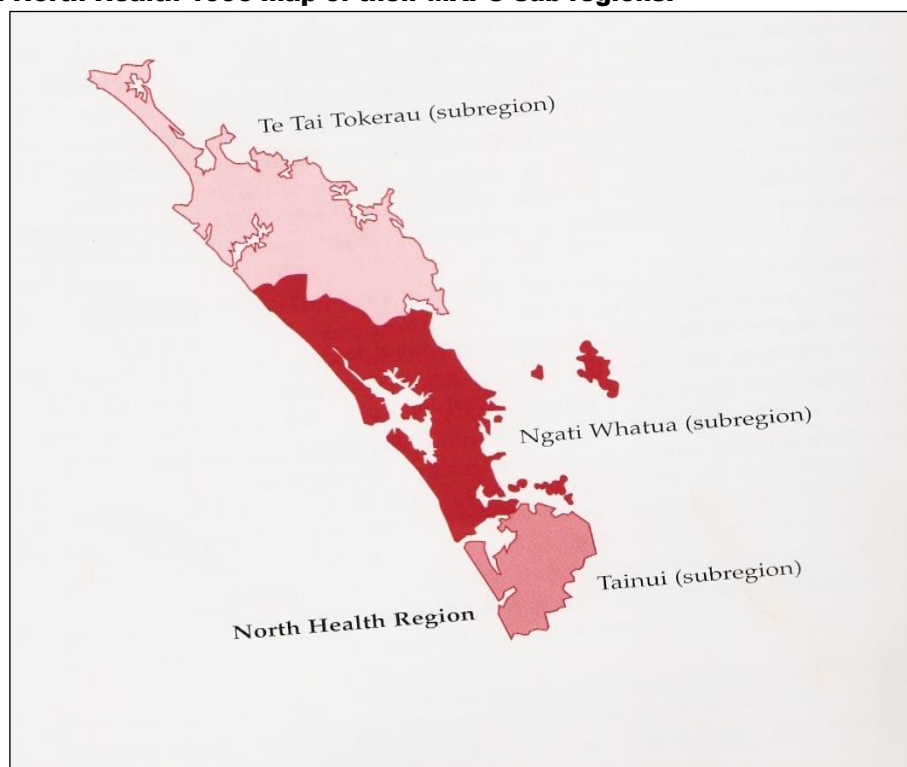
The three strands of the MAPO strategy were expressed by North Health as: “1. MAPO: the development of Maori Purchasing Organisations; 2. Providers: the development of by Maori for Maori providers; 3. Mainstream: to enhance mainstream services such as hospitals by improving their cultural responsiveness” (Maori Health Development Division: Northern Regional Health Authority, 1995, p. 2). It was envisaged that the MAPO teams would work with MHDD towards achieving strands 2, developing Maori providers, and 3, enhancing mainstream services.

The three iwi entities chosen by the MHDD team of North Health to form the MAPO in the North Health region were Tainui Trust Board, Te Runanga o Ngati Whatua and Te Tai Tokerau Trust Board²². As the three MAPO teams developed close working relationships with the MHDD team, they became informally referred to as the ‘tri-MAPO’, particularly when working on projects together. The MAPO were created through a Memorandum of Understanding and Deed of Partnership with North Health that were underpinned by funded contracts from North Health with the iwi entities which provided resources to create, develop, and implement the MAPO strategy. The Te Runanga o Ngati Whatua Deed of Partnership was executed 24 April 1995 (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003). On the 15th December 1995 a number of

²²Raukura Hauora o Tainui Deed of Partnership and Memorandum of Understanding were executed 15 November 1995, and Te Tai Tokerau MAPO Partnership Deed and Agreement for Co-Purchasing Health and Disability Services on 24 October 1996 (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003).

kaumatua and kuia of Te Runanga o Ngati Whatua and the Northern Regional Health Authority, as the Crown health purchasing organisation, signed a Memorandum of Understanding and Deed of Partnership (Ngati Whatua & Northern Regional Health Authority, 1995a, 1995b). Tihi Ora MAPO the organisation was subsequently created by Te Runanga o Ngati Whatua as the first Maori Purchasing Organisation under the North Health Maori Purchasing Organisation (MAPO) Strategy. Tihi Ora's purpose was to co-purchase health and disability services in a region defined by the regional health authority as 'the Ngati Whatua sub-region' (Walker, 1996, p. 3) which can be seen below in the North Health documented map of the three MAPO regions shown below in Figure 6.

Figure 6: North Health 1996 map of their MAPO sub regions.



Source of Map: Walker, Ratana (1996)

North Health offered MAPO a co-purchasing strategy that would give the three iwi entities three levels of constructive engagements with North Health. Firstly a Kaunihera Hauora created a governance level role for the MAPO Rangatira Hauora alongside the North Health Board. Secondly, a management level relationship was formed between the tri-MAPO general managers and the general managers of the various divisions of North Health. Thirdly, an operational relationship was formed between the MAPO operational teams and the North Health operational teams.

The initial focus of the MAPO strategy was to create Maori health purchasing and provider organisations that were “by Maori for Maori” (Maori Health Development Division: Northern Regional Health Authority, 1995, p. 5). The expectation of the Northern Regional Health Authority was that the MAPO strategy would create a “socio-cultural” platform for Maori health development (Maori Health Development Division: Northern Regional Health Authority, 1995, p. 8).

There were four Regional Health Authorities implementing the 1993 Health and Disability Services Act. What made North Health’s response to Maori different, in comparison to the other three Regional Health Authorities, was that they created a governance level relationship between the three iwi and the Crown through the creation of the Te Kaunihera O Nga Rangatira Hauora O Te Raki (the Kaunihera) with the North Health Board. North Health provided the MAPO with delegated authority for Maori health gain; a delegated authority that was not repeated by any other regional health authority. The relevant clauses from the North Health Board that established this delegated authority under the Act are below:

It was agreed that the Board (i) Establish a Committee of the Board, pursuant to Clause 13 of the Second Schedule to the Health and Disability Services Act 1993, comprising all Board members and one representative of each of the Tainui, Ngati-Whatua and Te Tai Tokerau iwi, when a Deed of Partnership has been signed with each iwi.”...”It was agreed that the Board 3 (ii) Delegate to this Committee, pursuant to Clause 14 of the Second Schedule to the Health and Disability Services Act 1993, the HFA Boards powers, duties and functions in relation to Maori health gain (Eruera, Grace, Stewart, Tepania Palmer, & Shea, 1998).

The purpose of this delegated authority, when read in conjunction with the MAPO Strategy documents (Maori Health Development Division: Northern Regional Health Authority, 1995), and read in conjunction with the Memorandum of Understanding and Deeds of Partnership with each MAPO (Ngati Whatua & Northern Regional Health Authority, 1995a, 1995b), was to create a Treaty of Waitangi based partnership of equal responsibility for Maori health gain between iwi Maori and a Crown entity utilising Crown resources. Te Kaunihera O Nga Rangatira Hauora O Te Raki (The Kaunihera) had their inaugural meeting in April 1996. Between 1996 and 2006, the Rangatira Hauora representative of the Ngati Whatua MAPO was Sir Hugh Kawharu, who was Chairperson of Ngati Whatua Orakei Trust Board, of which the Ngati Whatua o Orakei Health clinic is a subsidiary organisation. I observed that Ngati Whatua MAPO chose to

present a consistent face and voice to the various government and non-government actors involved in the development and delivery of the MAPO strategy, and the Ngati Whatua MAPO strategies. This consistency of leadership and representation was a key strategy of Ngati Whatua in their constructive engagements with the Crown for Maori health gain throughout the study period and is reflective of tupuna Maori health leaders such as Pomare and Buck, who were discussed in Chapter 4.

While North Health funded the operational contracts of the MAPO, the MAPO reported directly back to their iwi entities (Te Runanga o Ngati Whatua, Tainui Trust Board and Te Tai Tokerau Trust Board). The respective iwi entities defined and created their own MAPO board. The MAPO were therefore, in effect, primarily responsible back to their iwi entities. However, the iwi entities were responsible back to North Health for the contractual obligations of the MAPO as defined in their operational contracts. This relationship was established through delegated authority from North Health for “express functions, powers and duties in regard to Maori health” (Eruera, Grace, Stewart, Tepania Palmer, & Shea, 1998) to Tainui MAPO (24 May 1995), Ngati Whatua MAPO and Tai Tokerau MAPO (24 April 1995). The rationale for two separate delegations of power, one to the Kaunihera and one to the MAPO was explained as providing a distinction between the governance and operation functions of the MAPO (Cooper & Health Funding Authority, 1998, p. 3; Eruera, et al., 1998, p. 3) .

Other aspects of the MAPO Strategy, for instance the development of Maori health provider organisations and Maori involvement in the mainstream enhancement of secondary and tertiary health services, were not unique to the North Health region. These were also common aspects of Maori health strategies of the three other Regional Health Authorities.

As part of the MAPO strategy, a number of health and disability provider organisations were created. A key difference between provider organisations created under the MAPO Strategy and most other non-Maori primary care providers in the North Health region was that Maori health organisations were bulk funded (Crampton, 2005). I observed that this was positive for the Maori health provider organisations in that they had consistent operating budgets, but negative in that if the responsibilities or numbers of patients proved overwhelming for the resources provided. The funding was for salaries and minimal operating costs for patient treatments. Initially some of the Maori health

provider organisations were only contracted to deliver services to Maori. This meant in practice that Maori whanau members and community members who were non-Maori and who accessed the services were not funded by the state. Some Maori health provider organisations were initially in the invidious position of having self fund the treatment of these non-Maori whanau and community members, or turn them away.

I observed that in the MHDD team, Gwen Te-Pania Palmer was a Maori nurse and Maori health manager who had a significant input into the creation of the primary care providers. At the time of the Maori Health provider organisation creation, Gwen was part of an informal network of ‘Maori Nurses’ that existed throughout New Zealand, and many of the Maori health providers created throughout New Zealand were either created by, led by, or had significant leadership from, Maori nurses from this collective. The Maori nurses collective were very active in the 1980s and 1990s, often inviting international colleagues to their conferences to discuss indigenous ideas for developing primary care and nursing practices.²³ This Maori nurse collaboration was indicative of the informal networks that had remained in place from the time of the first Maori nurses being trained from the early 1900s as was discussed in Chapter 4. The creation of the Maori health organisations from the mid-1990s in the Tihi Ora region was a collaboration between Maori nurses and other Maori who were involved in community and health developments, so is reflective of the tupuna community developments discussed in Chapter 4.

The MAPO and Maori health providers created from 1995 were being developed at speed by the MHDD at North Health, and political changes signalled at the end 1996 after the election indicated there would be health sector changes which might challenge the viability of the MAPO strategy. The period between the 1996 and 1999 elections proved fraught for the MAPO strategy as the legal status of the MAPO organisations, and their delegated authority through the Kaunihera, was highly contentious with the Health Funding Authority that replaced the four regional health authorities (Cooper & Health Funding Authority, 1998, p. 3)²⁴. The Memorandum of Understanding and Deed of Partnership with each of the three MAPO that had been signed in 1995 and 1996 had ‘no fixed term’ and, therefore, the revoking of the relationship between the Transitional Health Authority Regional Health Committees and the Health Funding Authority Board

²³ See www.maorinursescouncil.org.nz/ for more information on Maori Nurses

²⁴ See Chapter 5 for more discussion on the elections and health sector changes in this period

which replaced them from 1996, did not seem to have removed the legal relationship between the MAPO and the Crown health funders (Cooper & Health Funding Authority, 1998, p. 3).

The Kaunihera continued to operate through delegated authority under the Northern Regional Health Committee of Transitional Health Authority until December 1997. The delegated authority was unilaterally revoked in January 1998 by the Health Funding Authority board, and without consultation with the three MAPO, which was in breach of both the Memoranda of Understanding and Deeds of Partnership with the three MAPO. The explanation of the Health Funding Authority for the revoking of the relationship was lack of infrastructural capacity to maintain the regional relationships:

However, when the THA became the Health Funding Authority on 1 January 1998 the HFA structure did not have the “capacity”, in terms of human resource, to deal with former regional type governance relationships. Nor, did it have “capacity” in terms of a national policy position related to relationships with Maori. Accordingly, in January 1998, delegated authorities to all Regional Health Committees of the THA were revoked by the new HFA Board (Cooper & Health Funding Authority, 1998, p. 2).

At the Tri-MAPO Trustees meeting at Waitangi, on 5 February 1998, the Kaunihera expressed their disappointment in the Crown’s unilateral decision to dis-establish the Kaunihera meetings (CEO Tihi Ora, 1998, p. 2). However, also in 1998, Rob Cooper who was a manager at the Health Funding Authority, having previously headed the MHDD team at North Health, acknowledged that a key goal in the MAPO Strategy, which was referred to in the document as a “MAPO policy” rather than a “MAPO strategy”, had been “traditional Maori leadership ... to participate in decision making as health sector leaders” (Cooper & Health Funding Authority, 1998, p. 1). This HFA statement appeared to be out of line with the revoking of the Kaunihera meetings by the HFA. It was perhaps indicative of the tensions occurring between Maori staff and the HFA as they transitioned from the North Health Maori Health Development Division into an HFA that was not as receptive to the MAPO strategy as North Health had previously been. This was a salient example of Maori-Crown relations based on the Treaty of Waitangi being both created, and later undermined, by political and policy changes. It also provides the first case study observation, presented at Vignette 1 below, as an example of the experiences of a Maori ‘policy entrepreneur’ (Kingdon, 2003), Rob Cooper from the Maori Health Development Division of North Health who had then

gone on to be in the Maori team of the Health Funding Authority and who straddled the worlds of the public health sector and Maori development.

Case study observation Vignette 1: In a casual conversation at a hui in the mid 2000s Rob Cooper and I were discussing why sometimes the public health sector was receptive to Maori development aspirations, and sometimes it was not. I remember explaining Kingdon's ideas on policy windows (Kingdon, 2003) to him, and how the window in the 1990s for health organisations to develop was so different to the window in the 2000s that resulted in health policy developments (as was discussed in Chapter 6). His comment was that we needed to figure out how to turn those damned windows into ranchsliders (sliding glass doors).

After the 1999 election the incoming new government, a Labour-led coalition, signalled there would be yet another complete restructuring of the health sector and introduced The New Zealand Public Health and Disability Act 2000. Between 2000 and 2002 the government introduced changes including moving from one health funding authority to twenty-one District Health Boards (DHBs). They also centralised health developments through a number of national health strategies, including: the New Zealand Health Strategy, (Minister of Health, 2000), The Primary Health Care Strategy, (Ministry of Health, 2001), and the *He Korowai Oranga* Maori Health Strategy (King & Turia, 2002). The government began consultation on a Maori Health Strategy through a 2001 discussion document, *He Korowai Oranga* (Minister of Health, 2001). There were nine meetings throughout the country between May 2nd and 25th of 2001 to launch the discussions (Minister of Health, 2001). The document and strategy were finalised in 2002 and implementation under *Whakatataka Maori Health Action Plan* (Ministry of Health, 2002), took place from 2002.²⁵

The tri-MAPO looked to progress the development of their organisation's, service's, and influence over Maori health gain within New Zealand health developments under this new political management from 2000, when they informed the Minister of Health that they represented over 33% of the New Zealand population on Maori health issues (Te Tai Tokerau, Tihi Ora, & Tainui MAPO, 2000). Collectively the tri-MAPO referred to

²⁵See Chapter 5 for more discussion of these events

their organisations in this correspondence as a “MAPO authority”, tacitly re-defining the tri-MAPO as a Maori health funding authority (Te Tai Tokerau, Tihi Ora, & Tainui MAPO, 2000, p. 4). Up until this point they had identified MAPO as partners with regional health authorities; this was the first time they had defined the tri-MAPO as a Maori health funding authority.

In April 2000 Tihi Ora expressed the expectation to the Minister of Health that the demise of the HFA would leave the Ministry of Health as the key partner to the MAPO relationship, and that Te Runanga o Ngati Whatua wanted to have a strategic role in the development of the New Zealand Health Strategy (Minister of Health, 2000), on the basis of their being the “Ngati Whatua Treaty partner” through their Memorandum of Understanding and Deed of Partnership that had been signed with North Health in 1995:

Point 31: agree that in anticipation of the Ngati Whatua Memorandum of Understanding and Deed of Partnership transferring over to the Ministry of Health upon the disestablishment of the HFA, it is appropriate that the Ministry of Health involve its Ngati Whatua Treaty partner in the development of the New Zealand Health Strategy (CEO Tihi Ora, 2000, p. 3).

However, only one seat for one MAPO representative was included in the Sector Reference Group for the New Zealand Health Strategy by the Minister of Health (Minister of Health, 2000, p. 24) rather than one for each of the MAPO. However, the three MAPO had highlighted to the Ministry of Health that they saw the relationship between themselves as individual tribal representatives and the Crown as based on the Treaty of Waitangi, but based on the three MAPO working collectively through “a consensus process” as is shown from their letter to the Crown in 2000, so the Minister of Health may have felt one seat was appropriate:

What is the MAPO Strategy? Put simply, the MAPO Strategy is based upon implementing Te Tiriti O Waitangi partnerships for Maori health gain and development. ... All members participated in a partnered manner with decisions being managed through a consensus process (Te Tai Tokerau, et al., 2000, p. 5).

This correspondence also highlighted to the Minister of Health that the MAPO Strategy had been premised on partnerships with the Crown that were based on the Maori version of the Treaty, Te Tiriti O Waitangi (Te Tai Tokerau, et al., 2000, p. 5). Matauranga Maori had been assured primacy of place in the original developments of the MAPO strategy because the core basis of the relationships that had evolved from the 1995 and

1996 Deeds of Partnerships and Memoranda of Understanding, which had been based on the Maori version of the Treaty. This was at a time when the majority of Crown documents reflected the English language version of the Treaty.²⁶ That this point was highlighted to the Minister of Health by the three MAPO shows that the use of the Maori version of the Treaty was an essential element of the Crown-MAPO constructive engagement that had resulted four years of co-operative co-existence between the parties up until that point. It also highlights that the MAPO wished to see it remain as a core element in future constructive engagements on their mana whenua lands, particularly for the New Zealand Health Strategy (Minister of Health, 2000), which was the focus of this particular correspondence.

In addition to ensuring that the Maori version of the Treaty was paramount in the ensuing constructive engagements between MAPO and the Crown, the MAPO also highlighted to the Minister of Health, in correspondence that had also been sent to the Associate Minister of Health and all Maori members of parliament in April 2000, that the tri-MAPO had plans for ongoing development of relationships with the government services. The tri-MAPO said in a letter that they had:

... always intended that the MAPO strategy would evolve. Evolution was based primarily on the principles of continued quality improvement and expansion to create a seamless delivery of social, economic and cultural services for the overall betterment of Maori” (Te Tai Tokerau, et al., 2000, p. 12).

This evolution, the tri-MAPO hoped, would pave the way for governance through to operational relationships between the three iwi-Maori and the government in other policy areas in addition to health (Te Tai Tokerau, et al., 2000, p. 12). This had also been a key expectation of the MAPO strategy for the Northern Regional Health Authority when it formed the relationships with the MAPO from 1995 (Maori Health Development Division: Northern Regional Health Authority, 1995, p. 8). Had the Crown agreed to expand the MAPO Strategy from 2000 into other policy areas such as employment, education, social services through the original MAPO arrangements which were based on the Maori version of the Treaty, the matauranga and tikanga Maori of these iwi would have been in a stronger position to be part of ongoing policy developments. The tri-MAPO contended the MAPO model was a more successful model for Maori

²⁶See Chapter 4 for more discussion of the Treaty of Waitangi

development than any other strategic model for Maori health and development, and this is why they were calling for the Minister of Health to support it:

The MAPO works. It is successful. It is proven. Maori and non-Maori support it. It is not perfect and it has its critics. However, based upon the collective knowledge and practical experience of the MAPO, we are confident that this strategic model has produced more gains for Maori health and development than any other model. We challenge the Minister to enjoy the benefits to be gained from retention and expansion of the MAPO partnership model in the 'new' health sector (Te Tai Tokerau, et al., 2000, p. 13).

In summary, in the early 2000s there was support by the tri-MAPO for a continued partnership model with government. The tri-MAPO actively consulted with Crown representatives throughout this period. I observed that MAPO clearly articulated representations to government following a MAPO review undertaken in 2003 that the MAPO and their iwi wished to remain in a governance level relationship in the state health funding arena with the government. They did not want their regional Maori health gain relationships relegated to potentially multiple localised relationships with DHBs. The decision of the government was to rescind the MAPO contractual relationship with the Ministry of Health from 1 July 2006, with MAPO relationships delegated to the DHBs (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003, p. 45). The experiences of Ngati Whatua in the development and delivery of their hauora Maori organisation, the MAPO organisation is discussed in the next section.

7.4 The MAPO organisation

This section explores the constructive engagements that occurred between Tihi Ora and the North Health organisations and teams. Te Runanga o Ngati Whatua created a health division called Tihi Ora MAPO to fulfil their responsibilities under the Memorandum of Understanding and Deed of Partnership signed on the 15th of December 1995 with North Health (Ngati Whatua & Northern Regional Health Authority, 1995a, 1995b). Te Runanga o Ngati Whatua underpinned their commitment to Maori health gains with uniquely Ngati Whatua whakatauki. These whakatauki express the matauranga and tikanga Maori of the iwi for their health developments under Tihi Ora MAPO, their health co-purchasing division, and under Te Ha o te Oranga, their health providing division. Whakatauki (i) expresses that services are for non-Maori and non-Ngati Whatua. Whakatauki (ii, iii, and iv) express that services will be imbued with the

matauranga and tikanga Maori of tika, pono, aroha, mana and tapu, with mana and tapu being specifically defined as those of all patients, iwi and hapu:

(i) Kia kotahi te mau o te oranga ki roto i a Ngati Whatua

Health services delivered within Ngati Whatua will be of the same highest standards and applicable to everyone.

(ii) Kia mau ki te tika, te pono me te aroha

Health services delivered by Ngati Whatua will be imbued with the concepts of tika, pono and aroha.

(iii) Kia mau ki te mana te tapu me nga tika o te turoro

The mana and tapu of the patient is to be recognised, including his/her rights

(iv) Kia mau ki te mana o te whanau, te hapu me te iwi*The mana of the whanau is to be recognised especially when dealing with children. This principle requires whanau participation in decision-making and also gives whanau the right to challenge decisions made on their behalf. The mana and tapu of other iwi or hapu must also be observed (Te Ha o te Oranga, 2000b).*

These whakatauki enforce the matauranga and tikanga Maori of Ngati Whatua within service developments and deliveries under the MAPO and Ngati Whatua provider organisations. In addition to whakatauki, Te Runanga o Ngati Whatua created organisational divisions to manage their hauora responsibilities. In the 1998/99 Annual Plan, Te Runanga o Ngati Whatua defined the health structures of the organisation under several responsibility areas. The MAPO is listed, along with a unit called 'Waitangi Tribunal Claims', under the 'rangatira representation portfolio', which is a sub-unit of 'rangatiratanga responsibilities' (Te Runanga o Ngati Whatua, 1998). The provider organisation, Te Ha O te Oranga is listed under the sub unit 'health and lifestyle portfolio' in 'people caring responsibilities' (Te Runanga o Ngati Whatua, 1998). Tihi Ora presented their relationship as part of Te Runanga O Ngati Whatua organisational structure in the 2005 diagram reproduced in Figure7 below:

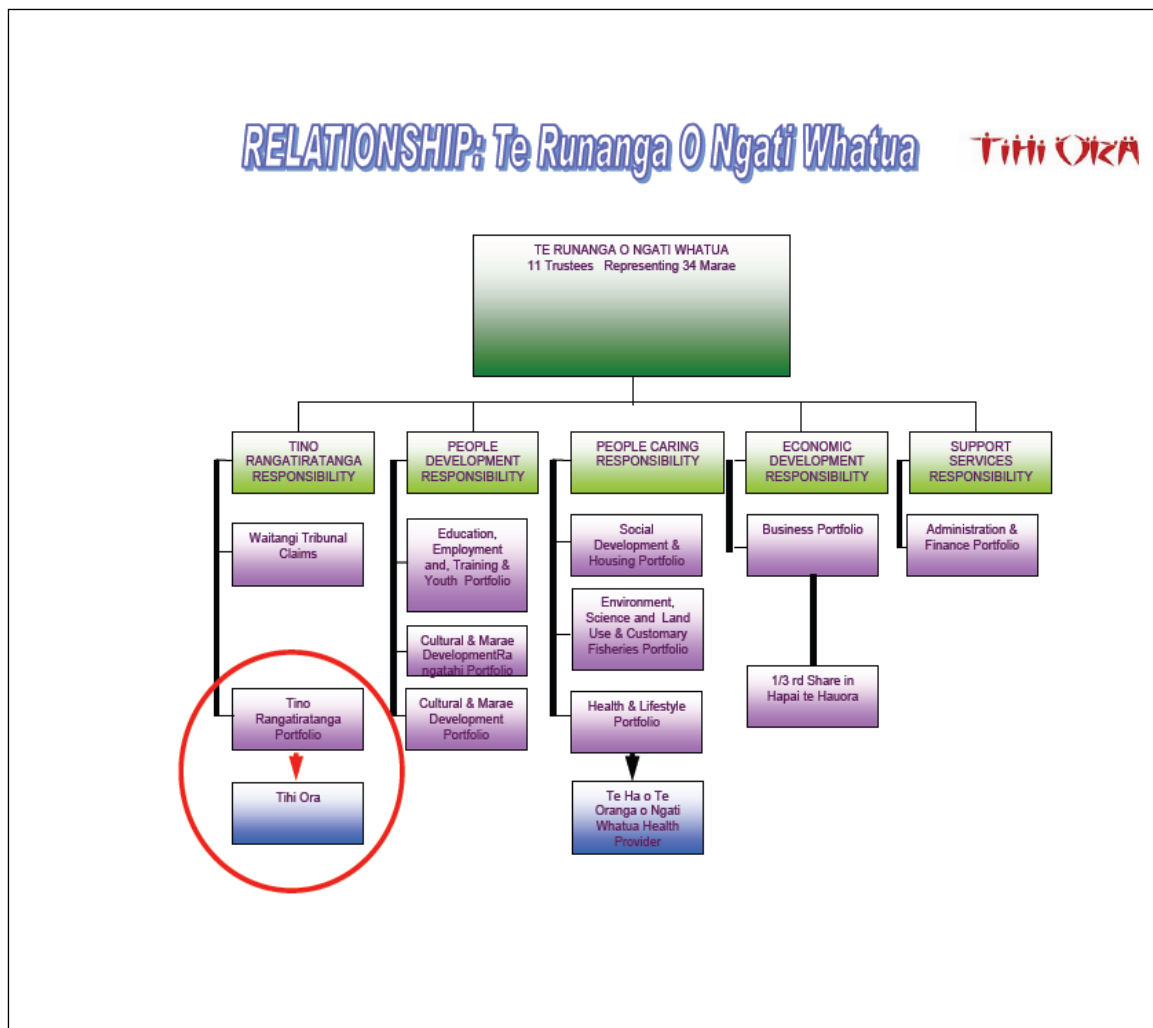


Figure 7: Te Runanga o Ngati Whatua organisational diagram showing Tihi Ora relationship 2005. Source: Tihi Ora, 2005

Tihi Ora is therefore specifically designated by Te Runanga o Ngati Whatua as representing rangatiratanga responsibilities, and rangatira representation. Te Ha o te Oranga was one of four Maori health provider organisations which had purchasing agreements co-signed by North Health and Tihi Ora MAPO, and is discussed in the next chapter. Hapai Te Hauora was a public health provider which was a joint venture between Te Runanga o Ngati Whatua, Te Whanau o Waipareira and Raukura Hauora o Tainui formed on 23rd February 1996. It is not one of the case studies in this study; however this joint venture was of particular interest to Maori health developments because it was governed by an urban health authority and two mana whenua iwi health groups.

Urban Maori health authorities are groups of people that have formed on the basis of their suburban relationships. The joint venture between Te Runanga o Ngati Whatua and Te Whanau o Waipareira was at the time regarded as ground breaking, and was described

in the media as ‘a breakthrough in Maori politics’ because the relationships between the urban organisations and mana whenua iwi in Auckland were regarded as tense at that time (Wharawhara, 1996). Hapai Te Hauora had a number of interesting governance, representation, and service complexities which would make it a very interesting organisation to research. It was excluded from this study because it is governed by Waipareira and Tainui MAPO, both of which were excluded from this study for reasons explained in Chapter 3.

In terms of governance, The Tihi Ora board consisted of the Rangatira Hauora, Sir Hugh Kawharu who was the Chairperson of the Ngati Whatua o Orakei Trust Board, two members from Te Runanga o Ngati Whatua, one of whom was Tom Parore, the Chairperson of Tihi Ora, a representative from the Maori Womens’ Welfare League, and the CEO of Tihi Ora.

A Tihi Ora building was purchased in Auckland in 1996 using establishment funding from North Health. This was significant for Te Runanga o Ngati Whatua because it enabled them to have a base in Auckland which is the main population centre in their region, while their head office remained based in Whangarei at the far north of their region, approximately three hours north of Auckland by car. The Auckland building was located within walking distance of the North Health offices. However, health sectoral changes meant the regional health authority was only a neighbour for around three years. The District Health Boards were subsequently housed on or near hospital sites from the 2000 health sectoral changes discussed in Chapter 5.

Staff for Tihi Ora MAPO were recruited in conjunction with North Health, who had given the tri-MAPO guidelines as to the number of staff to employ, and job descriptions they would fulfil: “Management functions: CEO, Policy Analyst, Project Worker, Admin Person” (Maori Health Development Division: Northern Regional Health Authority, 1995, p. 6). The roles initially recruited for Tihi Ora were a CEO, a receptionist/administrator, a clinical manager and a business manager. The recruitment process was managed by a combination of the MAPO team and the MHDD team at North Health. The initial Tihi Ora Team included one Maori from Ngati Whatua and three, non-Ngati Whatua Maori. One of the team was a psychologist; one held a Bachelor of Social Science (the receptionist) and one had Maori health provider management experience.

I observed that in Tihi Ora Planning meetings in 1999 (Tihi Ora, 1999), the MAPO team canvassed the challenges they had faced in early interactions with North Health and their efforts towards Maori health gain. The MHDD team at North Health was instrumental in developing and implementing both the MAPO strategy and for training and developing the MAPO teams (Tihi Ora 1999a, 1999b). This meant the MAPO team's were expected to spend the majority of their time working alongside the MHDD at North Health and learning the purchasing environment. As well as working alongside MHDD, the tri-MAPO staff had one or two other divisions in North Health to work alongside (Tihi Ora MAPO, 1999b). This involved the new MAPO recruits attending purchasing meetings with the North Health team's, communicating the purchasing team issues back to the tri-MAPO, and then returning to the purchasing teams with tri-MAPO and occasionally individual MAPO responses (Tihi Ora MAPO, 1999a). In effect, due to the smallness of the tri-MAPO team's, one of the tri-MAPO team member's could be representing all three MAPO at any one meeting, for instance with the medical-surgical team responsible for purchasing secondary and tertiary health services, or with the disability support team (Tihi Ora, 1999b).

I observed that from the perspective of Ngati Whatua MAPO staff this provided a number of difficulties (Tihi Ora, 1999b). First, they were required to represent Ngati Whatua MAPO views before they had been adequately trained to do so and also before Ngati Whatua MAPO had promulgated these views into a coherent strategy (Tihi Ora, 1999b). Second, they were expected to represent Ngati Whatua views without being Ngati Whatua (Tihi Ora, 1999b). Third, they were often expected to represent Tainui and Tai Tokerau MAPO and iwi views, often without a clear mandate from those parties to do so (Tihi Ora, 1999a). Their inability at short notice to give quick answers to the North Health team's soon became problematic for both parties (Tihi Ora, 1999a).

Additionally, the melding of knowledge needed so that each staff member could be effective within the North Health purchasing teams included strong financial management skills, legal skills to understand contracting arrangements being discussed, and clinical expertise in the field of the purchasing being undertaken (Tihi Ora, 1999b). MAPO members could move between meetings on heart transplants, paediatric oncology, IT management of patient details, residential support services for drug addicts, and head lice all in the same morning. The ability to be prepared for the plethora of

meetings the MAPO staff needed to take part in was challenging given the small size of the teams and the lack of resources for adequate preparation of responses to North Health team's (Tihi Ora, 1999b).

The MAPO involvement in co-purchasing with North Health very quickly became primarily focused in the contracting of services with Maori providers created by North Health in the MAPO sub-regions. The MHDD had ring-fenced funding from the relevant North Health team's and then created contracts to bulk fund the four Maori primary providers in the Tihi Ora MAPO sub-region. The contracts were then negotiated, signed and monitored by North Health and the relevant MAPO. The bulk funding of Maori health provider organisations proved challenging for the first few years because there were no precedents in place for the contracting of services where there were an uncapped number of patients. The provider organisations were funded initially for a set number of staff rather than on potential patient numbers, and when they were changed to being able to negotiate on patient numbers they were initially only able to present statistics for Maori patients. Non-Maori patients could not be included in their statistics and re-negotiations for contracts (Tihi Ora, 1999).

The risks were very high for the fledgling Maori health organisations, who because they were charging substantially less than non-Maori providers' at the behest of their contract managers (North Health and the MAPO), faced possible infrastructural collapse by potential influxes of patients who were not from the target patient cohort of Maori with high health needs and/or low incomes. Because of their bulk funding, some Maori health organisations had non-Maori people arriving demanding services on the basis that because their funding was similar to public hospital services they had to provide free health services to anyone who presented themselves (Tihi Ora, 1999).

The MAPO were also created to provide focus on mainstream enhancement of the Crown Health Enterprises (CHEs), particularly the aspects affecting Maori health service delivery. The CHEs within the Ngati Whatua MAPO region included Waitakere Hospital, North Shore Hospital, Starship (the national children's hospital), Greenlane (the national heart hospital), National Womens (gynaecological and obstetrics), and Auckland hospital. In practice, however, providing a focus on mainstream enhancements within CHEs was more difficult to accomplish because of the lack of power over the

contracting process with CHEs held by MHDD and because of the fragmented nature of the decision making processes in each of the hospitals (Kiro, 2001).

One aspect of Tihi Ora development that caused problems was resourcing (Tihi Ora, 1999a). While only funded for three staff plus one administrator, Tihi Ora was expected to develop and monitor four Maori primary health care providers' that covered a very large geographic area stretching from the Tamaki River in south Auckland to Whangarei in the north. It also had responsibilities for a regional public health provider, a strategic policy unit based in the corporate office of the four main central Auckland hospitals', and various other Maori health allied provider organisations.

The team was also expected to work with the eight North Health team's on purchasing, contracting and monitoring as well as spending at least half of each week with the MHDD team in either training or processing MHDD work. Additionally, the team was required to develop and monitor mainstream enhancements (such as signage in Maori language, Maori speaking support teams for patients and staff) for six major hospitals' (Tihi Ora, 1999b).

In respect of internal tribal responsibilities, Tihi Ora, a division of Te Runanga o Ngati Whatua was expected to consult and inform Ngati Whatua iwi on health policy, health development, health services and specific health status within the Ngati Whatua region through advice to the Tihi Ora board and to Te Runanga o Ngati Whatua (Tihi Ora, 1999a).

The roles of Tihi Ora and the other two MAPO were significantly changed by the demise of the Regional Health Authorities, and in particular the loss of the North Health Maori Health Development Division from 1996. The move from regional health funding to a single Health Funding Authority meant that regional expressions of Maori health development, such as the MAPO strategy and organisations', became part of a broader mix of Maori health development responses that nationally became the responsibility of the single Health Funding Authority from 1997. In 2000 this governance level relationship changed again with the move to a District Health Board model under the New Zealand Health Strategy 2000, with the objective for Maori development being to move responsibility for the MAPO from the Health Funding Authority and into District

Health Board governance relationships.²⁷ From 2000 Ngati Whatua began planning their response to the new health sectoral reforms, and these were eventually articulated as a Kotahitanga Proposal to the Crown in 2002. This proposal for constructive engagement with the Crown is discussed in the next section.

7.5 Ngati Whatua Kotahitanga Proposal

This section explores Te Runanga o Ngati Whatua constructive engagement's with the Crown through Tihi Ora MAPO in the early 2000s. In 2002 the Runanga communicated with the Crown and the Minister of Health that they expected to be a full partner with government concerning all policy, not just health policy that might be created in the Ngati Whatua region by the Crown. The document also stated that they wished to be involved in resource allocations and policy decisions affecting 'Maori' in their region, and not just Ngati Whatua Maori:

Our vision is to work in partnership with government, to be a full participant in resource allocation and policy decisions affecting Maori in the rohe, to achieve Kotahitanga for Ngati Whatua. The Runanga is ready to play a role that is in alignment with current government policy: the whole of government approach, improved relationships with iwi, and local solutions for local problems ... The Runanga seeks a robust Treaty-based relationship of equals and endorses the relationship principles included in the "Statement of Government Intentions for an Improved Community – Government Relationship" in so far as they support our Kotahitanga approach (Te Runanga o Ngati Whatua, 2002, p. 3).

The Runanga was proposing to extend their MAPO partnership to all government policy areas, as part of their intentions to pursue "Improved Community-Government Relationship" (Te Runanga o Ngati Whatua, 2002). The Runanga were defining themselves as a distinct community with a Crown relationship based upon the Treaty that could be applied through a community-government relationship. The terminology used in this document by the Runanga to the government was reflective of the newly elected Labour-led government focus on community participation²⁸. I observed that the Runanga had Maori stakeholder support for pursuing a 'community-government' relationship in terms of Maori representation in health and Maori health development, as can be seen from the community consultation discussed in the independent report on Tihi Ora MAPO which had been commissioned by the Ministry of Health:

²⁷ See Chapter 5 for more discussion of the politics of indigeneity-based health developments in this period

²⁸ See New Zealand Health Strategy (Minister of Health, 2000)

Similar to the responses from other MAPO stakeholders, the need to continue current MAPO functions in the sector was a strong theme from nearly all those Tihi Ora MAPO stakeholders interviewed. Interviewees identified this as particularly critical in terms of continuing support for iwi developmental objectives and building on current gains. Similar to other MAPO stakeholders, interviews noted the need for an independent Maori 'voice' contributing to and monitoring the activities and performance of the DHB in meeting Treaty and Maori health requirements (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003, p. 41).

I observed that the stakeholders' clearly indicated a preference to the Labour-led government for iwi-focused or Maori focused representation with the Ministry of Health for Maori health issues and development. They also expressed that independent Maori representation within government health was essential for monitoring Crown performance in Treaty requirements.

The Tihi Ora stakeholders' opinion that retaining 'independent Maori' health services was essential, were reflected in a national poll of Maori, which asked whether they supported or opposed specialist Maori health service. Taken in February of 2004, the public polls of Maori found 78.7% supported specialist Maori health services whilst 62% of non-Maori opposed specialist Maori health services (Taylor, 2004). The majority of Maori supported specialist Maori health services, and the majority of non-Maori did not. The majority of Maori in the public poll support for specialist Maori health services aligned with the MAPO stakeholders' interviewed for the Tihi Ora, Tainui and Tai Tokerau MAPO reviews who supported retaining MAPO, which were one example of the specialist Maori health services in existence at that time.

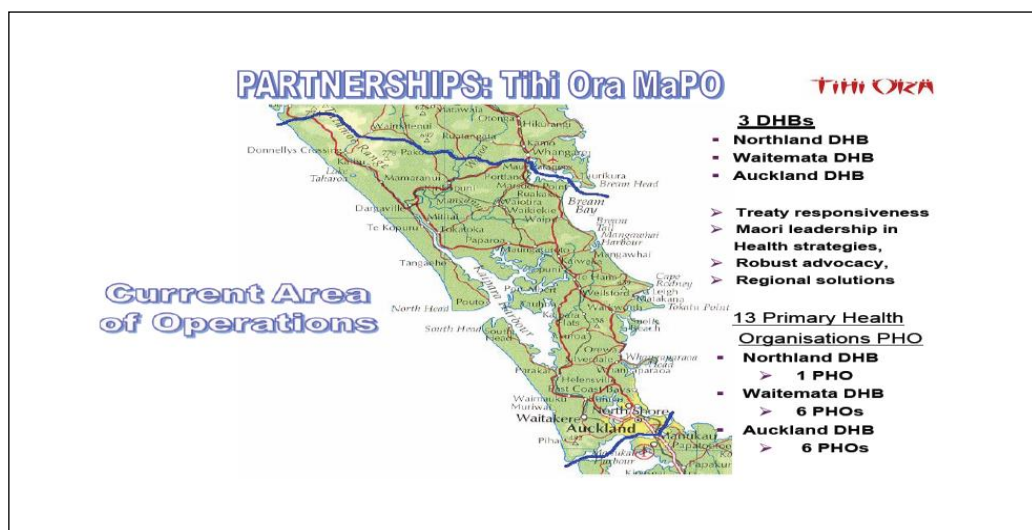


Figure 8: Tihi Ora MAPO diagram showing their 2005 operations, health partnerships and strategic partnership objectives

Tihi Ora survived the transition into the post-MAPO review 2003 environment, and by 2005 had extended their Crown partnership arrangements into constructive engagements with three District Health Boards. They had extended their health responsibilities into constructive engagements with thirteen primary health organisations, as they have represented in Figure 8 above. However, the Crown did not agree to the Kotahitanga Proposal as advocated by Ngati Whatua in 2002, and following the 2003 Ministry of Health review of Tihi Ora MAPO, the Crown did not uphold any of the perspectives, wishes, or expectations of Ngati Whatua, Tihi Ora, stakeholders, communities or iwi Maori. The Crown chose not to constructively engage with Ngati Whatua on the basis of the Kotahitanga Proposal directly as had been requested, instead the relationships for Ngati Whatua in health were delegated to District Health Board and Primary Health Organisation level; the relationships remained localised and regionalised rather than at a national level as had been proposed.

7.6 Matauranga

In this section, the matauranga Maori knowledge underpinning Tihi Ora MAPO development is examined. The three matauranga identified were rangatiratanga, whanaungatanga and kotahitanga, and these were evidenced in many of the organisation's documents and through observations which were synthesised for the explanations in this chapter, and are further discussed in Chapter 9. The first was rangatiratanga, established and developed through the Memorandum of Understanding and Deed of Partnership (Te Runanga o Ngati Whatua & Northern Regional Health Authority, 1995a, 1995b); whanaungatanga, established and developed from 1999 (Tihi Ora, 1999b); and kotahitanga, established and developed from 2002 (Te Runanga o Ngati Whatua, 2002).

Tihi Ora MAPO was driven by the two matauranga Maori of 'rangatiratanga' (Te Runanga o Ngati Whatua, 1998) and 'kotahitanga' (Te Runanga o Ngati Whatua, 2002). Te Runanga o Ngati Whatua aligned their matauranga Maori with Crown health developments through documents sent to the Ministry of Health in te reo Pakeha by presenting themselves as a Treaty partner (CEO Tihi Ora, 2000), Maori health authority (CEO Te Tai Tokerau, et al., 2000), traditional Maori leadership (CEO Te Tai Tokerau, et al., 2000), and their MAPO strategy as a service delivery model for socio-economic-

cultural betterment of Maori (CEO Te Tai Tokerau, et al., 2000). Tihi Ora MAPO was for Te Runanga O Ngati Whatua the embodiment of their hauora matauranga, rangatiratanga and kotahitanga.

7.7 Summary – Tihi Ora MAPO

The MAPO strategy was created by the Northern Regional Health Authority and implemented with the Runanga of Ngati Whatua, Tainui Trust Board, and Tai Tokerau Trust Board from 1995 as part of the North Health's unique response to Maori health developments in their region. Changes to the structuring of health funding authorities through health sectoral and policy changes from 1996 meant that the MAPO strategy was removed as a health policy focus for Maori health development in the MAPO regions, yet the MAPO organisations were maintained with some baseline funding and activity after the demise of the Northern Regional Health Authority that created them. In 2000, with a new incoming Labour led government, the three MAPO, including Tihi Ora, proposed MAPO as the best strategic model for Maori health development between the Ministry of Health and Maori could be achieved through "more planned inter-sectoral work funded and managed by the MAPO ... to create a seamless delivery of social, economic and cultural services for the overall betterment of Maori" (Te Tai Tokerau, et al., 2000). Maori and Crown health funders' had been constructively engaging for health developments through the MAPO organisations since the mid-1990s.

Through the original 1995 MAPO strategy with the Northern Regional Health Authority, a Kaunihera or governance level arrangement for co-purchasing and co-monitoring of health contracts in the North Health region had been established between the Crown, through the North Health Board, and with Maori, through the three MAPO Boards'. The second incarnation of MAPO and Crown relations from 1996 saw a reduction in the impetus for MAPO as key drivers to the governance processes of Maori health developments in their regions with the revoking of the delegated authority to the Kaunihera being unilaterally imposed by the Health Funding Authority in 1998.

The third incarnation of MAPO and Crown relations from 2000 saw an initial role for MAPO in participating in the development of *He Korowai Oranga*, The Maori Health Strategy 2002, but with no re-institution of the Kaunihera or governance level relations

between the Crown and MAPO that had existed in their initial relationship with the North Health board.

MAPO relationships had begun as a regional constructive engagement with North Health from 1995, then had moved to national constructive engagements with the Health Funding Authority from 1998, and had retained national constructive arrangements with the Ministry of Health from 2000 with the restructuring of the Health Funding Authority into District Health Boards. From 2003 the Crown relegated the national constructive arrangements of the MAPO with the Ministry of Health to be moved in 2006 to being with the District Health Boards. From 2006 the MAPO relationships were moved from national to local constructive engagements; a move that was steadfastly opposed by the iwi Maori of the MAPO, and Maori stakeholders in the hauora community who were consulted with for the 2003 review (Kaipuke Consultants Ltd, & PHP Consulting Ltd, 2003).

Te Runanga o Ngati Whatua had initially engaged with the Crown from 1995 to develop the Ngati Whatua MAPO from as part of their ‘rangatiratanga’ strategies (Te Runanga o Ngati Whatua, 1998). By 2000 Te Runanga o Ngati Whatua was expressing to the Minister of Health that through the Memorandum of Understanding with the Crown that created the MAPO they were now expecting to be involved in development of the New Zealand Health Strategy as the “Ngati Whatua Treaty Partner” (CEO Tihi Ora, 2000), and by 2002 were proposing to move the footing of the relationship into the matauranga and tikanga Maori of “kotahitanga” (Te Runanga o Ngati Whatua, 2002).

In Table 1, the three core matauranga of Tihi Ora are summarised. The first was rangatiratanga, established and developed through the Memorandum of Understanding and Deed of Partnership (Te Runanga o Ngati Whatua & Northern Regional Health Authority, 1995a, 1995b); whanaungatanga, established and developed from 1999 (Tihi Ora, 1999b); and kotahitanga, established and developed from 2002 (Te Runanga o Ngati Whatua, 2002).

Organisation	Matauranga Maori of organisation
Tihi Ora	Rangatiratanga, Whanaungatanga, Kotahitanga

Table 1: Matauranga - Tihi Ora

In Table2, is the tikanga Maori of Tihi Ora. What is interesting is that this tikanga was collaboratively established with North Health, but remained the core tikanga for Tihi Ora even after the replacement of North Health with the Health Funding Authority.

Organisation	Tikanga Maori Service Delivery Model
Tihi Ora	MAPO strategy

Table 2: Tikanga – Tihi Ora

This chapter has charted the creation and establishment of Tihi Ora MAPO using Marsden’s idea of mohiotanga to identify **what** matauranga was used to create Tihi Ora MAPO, through explaining the MAPO strategy at 7.3. Durie’s idea of indigeneity was used as a basis for identifying **how** indigeneity was practiced by Ngati Whatua iwi in creating the Tihi Ora MAPO organisation at 7.4. Maaka’s ideas of indigeneity-based constructive engagement was adapted to explain **why** the Ngati Whatua Kotahitanga Proposal might be considered as a model for kotahitanga between indigenous and non-indigenous peoples agreeing to live together differently at 7.5. This discussion of the Ngati Whatua Kotahitanga Proposal is continued in Chapter 9, where conceptualised hauora kotahitanga models for each of the case study organisations studied are presented.

This Tihi Ora chapter has outlined how a Maori purchasing organisation was established between Ngati Whatua iwi and North Health from 1996, and how the MAPO organisation evolved and functioned through until the MAPO review in 2003. As part of the MAPO strategy implemented from 1996 by Tihi Ora, four primary care providers were created. Three of these primary care providers are studied in the next chapter.

Chapter Eight

CASE STUDIES – PROVIDER ORGANISATIONS

8.1 Introduction to case study chapter

In Chapter 7, the Tihi Ora case study outlined how a Maori purchasing organisation was established between Ngati Whatua iwi as the mana whenua iwi, and North Health from 1996. The creation and evolution of the Ngati Whatua MAPO organisation, Tihi Ora, was explained, along with how it functioned through until the government review of the MAPO in 2003. The matauranga of Tihi Ora was identified, and the matauranga based tikanga service delivery model was discussed in terms of constructive engagements with the Tihi Ora communities.

This chapter charts the establishment of four Maori health and disability service provider organisations by applying a re-interpretation of Marsden's idea of mohiotanga to understand and explain **what** matauranga informed the tikanga Maori methodologies of the organisations, and how through delivery of these tikanga the matauranga became mohiotanga for the peoples delivering hauora Maori services. A re-interpretation of Durie's idea of indigeneity is applied to understand and explain **how** indigeneity was practiced by the hauora Maori provider organisations through their implementation of matauranga through the tikanga of the organisations for health developments with communities. A re-interpretation of Maaka's ideas of indigeneity-based constructive engagement is applied to understand and explain **why** the unique hauora Maori models of each of the provider organisations might be considered as models for kotahitanga between Maori and non-Maori peoples.

The provider case study organisations are introduced and their development is discussed within the context of indigeneity-based health developments taking place during multiple health sector and policy reforms in New Zealand in the 1990s and early 2000s. The constructive engagements discussed in this chapter are synthesised from a number of case study examples that were collected. This synthesis was in part to show the breadth of constructive engagements occurring across the case study organisations, and to highlight the uniqueness of hauora Maori organisation and community ways of creating and achieving constructive engagements to facilitate developments. In Chapters 9 and 10, some of these intriguing examples of organisational tikanga in practice are discussed further and conceptualised as models for hauora kotahitanga.

This chapter begins with the Te Puna Hauora case study, which is an overall case study introduction to the political, policy and health sectoral changes which provided pathways and barriers to Maori health organisational development from the 1990s. This particular case study provides a background to issues which were common to all hauora Maori organisations evolving in this period, including the three other case study provider organisations in this chapter. The political, policy and health sectoral issues and contexts discussed in the Te Puna Hauora case study are not re-canvassed in detail in the Te Ha, Orakei or Te Roopu Taurima case studies.

Te Puna Hauora o te Raki Pae Whenua is a primary health and social service organisation based on the North Shore of Auckland, which is an urban environment. The second case study is Te Ha o te Oranga o Ngati Whatua, created in 1997, as one of four Maori community health provider organisations under the Northern Regional Health Authority MAPO Strategy for the Ngati Whatua MAPO. Te Ha operated in both urban and rural settings, but the majority of their primary care services, such as mobile nursing, were rurally based. The third case study is the Ngati Whatua o Orakei Health Clinic, a clinic based on the Ngati Whatua marae complex located in Orakei and near to the central business district of Auckland, New Zealand's largest city. The final case study is Te Roopu Taurima o Manukau, a residential intellectual disability service provider, with residences throughout New Zealand, many in rural areas. Te Roopu Taurima was not created to be a Maori provider organisation at the same time as the other three case studies in this chapter. It was a Maori health organisation that evolved in the late 1990s through the closure of hospitals for intellectually disabled peoples. In the late 1990s the Maori staff and families of Maori patients came together to establish an organisation which would be independent of Spectrum Care - the organisation they had been devolved to with the closure of the hospitals. Te Roopu Taurima had one home based in the Ngati Whatua region, in the rural setting of Glorit, at the time of this study. Although Te Roopu Taurima did not have a contractual relationship with Tihi Ora MAPO, they did have a relationship with both Tihi Ora and Ngati Whatua as part of the Te Roopu Taurima kaupapa of working closely with mana whenua where their service provider homes were based.

The five case study organisations are, a purchaser, two Ngati Whatua affiliated primary services providers, one non-Ngati Whatua affiliated primary service provider, and one

non-Ngati Whatua affiliated intellectual disability service provider. The purchaser, Tihi Ora, was introduced in the previous chapter. In this chapter the four provider organisations are introduced. The experiences of the providers are substantially different to the purchaser organisation, because the purchaser organisation did not deal directly with patients or service receivers. In the next chapter the knowledge and experiences of all five case study organisations from Chapters 7 and 8 will be considered as models for hauora kotahitanga.

8.1.1 An introduction to Te Puna Hauora o te Raki Pae Whenua

In 1995 a Maori primary healthcare provider was created at Awataha Marae, an urban Maori marae in the North Shore suburbs of Auckland city. It was contracted by the Northern Regional Health Authority and Tihi Ora MAPO. Te Puna Hauora o te Raki Pae Whenua (Te Puna Hauora) was one of four Maori primary health organisations created in the Tihi Ora MAPO health sub-region, under the Northern Regional Health Authority MAPO Strategy. The boundaries defined by the health contracts for Te Puna Hauora were “from Hatfields Beach down to bottom of Northshore includes [sic] Hibiscus Coast” (Tihi Ora, 1999c, p. 2). The first contract, valued at approximately \$380,000 per year²⁹, funded the employment of a full time nurse coordinator, a half time doctor, a full time receptionist and a full time community support worker. The concept behind the creation of this Maori organisation was to provide North Shore Maori, which numbered approximately 14,000, with an alternative option to the somewhat expensive private general practitioner clinics locally (which were partly government funded at this time). general practitioner visits locally at the time charged between \$20 and \$45 a visit. Te Puna Hauora charged \$10, but only if the patient said they could afford to pay and the services were free to those under 18 year olds, and over 60 year olds.

The organisation’s kaupapa is “He aha te mea nui – he tangata, he tangata, he tangata What is important – it is people, it is people, it is people. He aha te huarahi – i runga, i te TIKA, te PONO me te AROHA What is the pathway – it is doing what is RIGHT with INTEGRITY and COMPASSION” (Te Puna Hauora, 2001).

Te Puna Hauora had 1400 registered patients in 1997, 3000 by January 1999 and by March 2001 approximately 5000 (Te Puna Hauora, 2001, p. 3). By 2002 there were

²⁹ Supplied by L Marsden, CEO, Te Puna Hauora in telephone conversation, 12 June 2006

5,500 patients with 60% identifying as Maori, and over 600 being under the age of 5 (New Zealand Doctor, 2002). By 2004 52% patients identified as Maori, 60% of the staff identified as Maori, including 9 on the management team and 15 staff members. 92% of the trustees also identified as Maori. By 2005 Te Puna Hauora had over 60 staff and 6000 members (patients). Of these members, 3,500 were under 16 years; over half were Maori, over 1000 were Pacific Islanders and over 1000 were new New Zealanders³⁰ (Te Puna Hauora, 2006). The organisation has grown steadily and in 2005 was one of 81 PHOs in New Zealand, covering 3.8 million New Zealanders (Ministry of Health, 2005).

One of the strategies adopted by Te Puna Hauora was to constructively engage with external services and organisations to have them deliver their services at the Te Puna Hauora clinic buildings to provide a seamless and accessible service for their patients, who they call 'members'. By 2005 these constructive engagements had resulted in goodwill services provided by external organisations such as government organisations, non-government organisations and community groups. Services included adult and child mental health services; psychotherapy and counselling; tamariki ora well-child services; general practitioner service; mobile disease management nursing service; dental service; physiotherapist; obstetrician and midwife service; paediatric outreach from Starship hospital; nutrition classes; exercise classes; first aid training; ear clinic; hearing therapy; diabetes clinic; respiratory clinic; alcohol and drug services; smokefree programmes; homecare support services; work placements for general practitioner trainee interns, house surgeons and registrars; student placements for health; social work and childcare education; and a Certificate in Community Work co-delivered with AUT University. The next two sections look at some of the community and political issues Te Puna Hauora had to manage in the process of their development from the mid-1990s.

8.1.2 Constructive engagement with non-Maori community

This section looks at how Te Puna Hauora and their community collaborated in development of the organisation and services from the mid-1990s. In 1996 the decision was taken to separate the governance of the health centre from the Awataha Marae board and on 11 October 1996 a community board of ten members comprising 50% Te Puna Hauora staff members, and 50% community members, formed an Incorporated Society (Te Ha o Te Oranga & Te Puna Hauora, 2000e, p. 5). The community membership was

³⁰ Te Puna Hauora term for refugees or migrants

open to all residents of the North Shore who demonstrated affinity with the kaupapa (Te Puna Hauora O Te Raki Paewhenua Society Incorporated). The community, through a casting vote by the chairperson, who had to be elected from the community, effectively had control of a Maori health provider board. This was a somewhat radical departure in Maori health organisation development where the norm was for Maori to hold control of management and governance structures, although Maori in governance and management positions have remained at over 50% throughout the research period

In 1999 Te Puna Hauora worked with the community to develop new ideas for dealing with health and wellbeing issues for whanau and the community. The ideas were used to create a service delivery model which would create an environment for progression between issues identified by whanau and services that could be offered by Te Puna Hauora and other key stakeholders. It was envisaged that this model would be particularly useful in whanau crisis situations. Whilst there was no funding for this service to be delivered, the staff began implementing it initially funding the services themselves, using their own staff social club fund. They called their model the Harakeke I-MAP or Individual Management Action Plan Model (see Appendix 3).

How the Harakeke - I-MAP worked from a service delivery perspective was that from the outset the individual or whanau were given as much control of the process as possible. For instance, a whanau who were compulsorily required to have a family group conference with social services, justice representatives, education representatives, mental health representatives and other multiple agencies, would be able to use the Te Puna Hauora premises for this meeting. This way the whanau, even though they may have been forced into the process by external government organisations could begin by welcoming the various representatives to the meeting, offering them cups of tea, and showing them to their seats. This meant the whanau were able to express a degree of independence and control from the outset, leading to a greater sense of wellbeing for the whanau through maintenance of whanau dignity.

The Ministry of Education, ASB Trust and Lotteries Commission funded building works to develop the community programs envisaged through the Harakeke - I-MAP model, including an early childhood education centre on the land behind the health centre. Built to accommodate 50 children, the centre always holds 10 places open to assist families in crisis and in need of urgent childcare assistance. Lyvia Marsden recounted to a journalist

in 2005, how the center had come about because of an experience the staff had early in Te Puna Hauora days:

...a solo mother sick from the flu and exhaustion came to them and fell asleep on the examination table. She had two young preschoolers. Staff, reluctant to wake her, watched after her children so she could sleep. Mrs Marsden says that was the catalyst for her to add an onsite childcare center” (North Shore Times 7 June 2005).

As part of Te Puna Hauora’s community development initiatives, they sought to establish relationships with other health providers in the community, and in 1999 signed a Memorandum of Understanding with Comprehensive Healthcare Services (CHS), an Independent Practitioners Association (New Zealand Doctor, 4 August 1999). I observed that by early 2002 the two organisations were working towards collectively forming a Primary Health Organisation (PHO), under the new Primary Health Care Strategy 2001 launched by the government, as stated by Lyvia Marsden of Te Puna Hauora at the time:

We took a hikoi [march or journey] and planted a flax bush. Now with the possibilities of becoming a PHO with CHS we are prepared to face the risk and take a hikoi of hope” (New Zealand Doctor, 2002).

Te Puna Hauora alignment with the new PHO structures was recognised in the media, and their organisational model was presented as a positive example of the new PHO policy implementation:

A marae on Auckland’s North Shore houses the kind of health service the Government wants to send to us all. From small beginnings, Te Puna Hauora in Northcote has grown into a one-stop shop, with services ranging from general practitioner consultations, diabetes and ear clinics to social workers, health promotion and mental health clinicians. It provides low-cost healthcare for nearly 6000 mainly Maori and Pacific Island patients and a growing Pakeha and new migrant roll (New Zealand Herald, Jun 22 2002).

By 25 June 2002 the North Harbour PHO was ready to be launched as the first PHO in the country, with the media spinning the launch as a political positive for the Minister of Health, who was having trouble convincing the ‘fee for service’ general practitioner practices and Independent Practitioner Associations (IPA) to implement the Primary Healthcare Strategy through forming PHOs:

The “official” first wave of PHOs were announced early this week but their funding remains a post-election mystery.... This has not stopped a North

Auckland collaboration between Te Puna Hauora O Te Raki Paewhenua and IPA Comprehensive Health Services from forging ahead as a PHO anyway. The North Harbour PHO was launched on 27 June, five days ahead of the Government's D-day and minus ministerial approval or start-up funding.... Mrs King [Minister of Health] says there are many other PHOs developing around the country and there is nothing stopping organisations forming PHOs right now. This enthusiasm [North Harbour PHO launch] was also a score for her against the doubters claiming PHOs will not fly (Sheddan, 2002).

I observed that the North Harbour PHO was immediately attacked by many of the general practitioner practices who made up Comprehensive Healthcare. Many did not want to sign on to the PHO. By June of 2003 only five of the forty-two practices had joined the PHO (Kinninmonth, 2003). One of the critical issues of divergence highlighted by CHS was the new government policy focus on community, which was the underpinning philosophy of Te Puna Hauora o te Raki Pae Whenua and their Harakeke - I-MAP model, but intrinsically out of step with what CHS referred to as 'general practitioners traditional focus':

According to Kinninmonth [CEO of CHS], the general practitioners' traditional focus on caring for "the person who comes in and sits in front of them" is now being extended to the community in which they operate. They are encouraged to keep track of their community's health status and the outcomes of their work, he says ... (Kinninmonth, 2003).

I observed that in November 2003 CHS separated their governance from the North Harbour PHO, through the appointment of one Chair for CHS and another Chair for the PHO (Doctor, 5 November 2003). In the same month ProCare IPA, who had been trying since 2002 to form a PHO under the Waitemata District Health Board, was given the go ahead to form a PHO on the proviso that it would merge with North Harbour PHO in 2005 (Doctor, 8 October 2003); (Doctor, 5 November 2003). Te Puna Hauora were being forced into a PHO relationship with another IPA, ProCare IPA, while at the same time Comprehensive IPA were alluding to significant discomfort with the Te Puna Hauora model of collaborative and equal power sharing governance (Doctor, 5 November 2003).

These pressures were echoed around the country as other Maori health providers struggled to survive in the new PHO environment. In Hawke's Bay the PHO disintegrated in late 2003, when the Maori health provider organisations that were part of the PHO discovered the non-Maori organisation members were behaving inappropriately

with funding. They “...discovered funding for the PHO was not going into an agreed bank account which had signatories from both the Maori provider and general practitioner members of the board. Instead it was going into an IPA account controlled by general practitioner members alone.” (Doctor, 5 November 2003).

The seeming failure of a number of PHO relationships between Maori and general practitioner services was discussed in the media as an inability for Maori providers and general practitioners to get along, with DHBs being accused of exacerbating the problems:

The DHB is accused of attempting to bind together quite disparate groups too quickly, leaving too little time for the Maori providers and general practitioners to build a relationship and understanding of each other (Meylen, 2004b).

Criticisms around the suitability of the PHO system for Maori providers were discussed in an article in Doctor in April 2004 with reference to the tensions with mainstream general practices: “In the landscape of health a river of suspicion runs between mainstream general practice and Maori health providers” (Meylen, 2004a).

Asked to comment for the above article, Te Puna Hauora made the following remarks:

Chief Executive of Te Puna Hauora o te Raki Pae Whenua Lyvia Marsden says she prefers to describe the PHO environment not as difficult but challenging for Maori providers. “I believe that with the Treaty based stuff we need to move on to the restoration stuff and we can only do that if we are part of mainstream [health]. I see that as a healthy way to influence a change to community based care,” Mrs Marsden says. She says the challenge is to move the mainstream away from its focus on self-preservation, finances and career paths, which she acknowledges are legitimate concerns but which currently preoccupy mainstream too much. “We believe it is not about how much money you can get but how well you can collaborate across the community in a sincere manner”, she says (Meylen, 2004a).

One of the concerns for Maori providers involved in PHOs was the often significant size disparity between themselves and their non-Maori provider partners. I observed that in the case of Te Puna Hauora o te Raki Pae Whenua, they had around 5,000 clients, whilst their PHO with Comprehensive IPA listed 52,790 registered patients³¹. However, their governance structure reflected a 50/50 partnership, with half of the board coming from

³¹ Ministry of Health, Table of PHOs by District Health Board region as at 1 April 2005 Source: HealthPAC, Ministry of Health and Primary Health Team, Ministry of Health) <http://www.moh.govt.nz/primaryhealthcare>

Te Puna Hauora and half from Comprehensive IPA. This type of partnership was not unusual at the time, as can be seen in the following analysis of PHO governance structures in 2003 at Table 3 below. Of the five PHOs surveyed, three had equality of governance power (number of board members) between Maori and non-Maori organisations involved. Another interesting aspect of the Maori and non-Maori PHO arrangements in Table 3 below is the lack of a chairperson casting vote for at least half of those studied. These 50/50 partnerships without a chairperson casting vote can be considered as models for hauora kotahitanga because they were based on co-operative co-existence between Maori and non-Maori boards with equal rights in decision making.

Table 3: Comparative analysis of Maori representation within five PHO governance structures in the Tihi Ora and Tai Tokerau MAPO sub-regions May 2003.³²

Waitemata District Health Board PHOs						
Organisational status	Parties to the organisation	Number of Trustees/Directors	Make up of Board	Role of Chair	Quorum	Additional governance/issues
North Harbour PHO Trust (Charitable Trust)	TPH Comprehensive Health Services Ltd	Not less than 4 Not more than 10 trustees	Equal trustee nos from each organisation	Chair to rotate between both organisations	6, 3 from each org	An independent non-voting facilitator/mediator may chair meetings
Waiora Amataga Trust (Incorporated Charitable Trust)	West Auckland Pacific Health Fono Inc Te Whanau o Waipareira Trust Workers Health Care Ltd	Minimum 3, maximum 6	1 from each of the 3 appointing organisations	Chair to rotate between 3 orgs, is elected from existing trustees, and has no casting vote.	3 – 1 from each of the founding organisations	

³²The information has been created through the documents available through the companies' office website at today's date. The analysis consists of two PHO's from the Waitemata DHB and three PHO's from the Northland DHB. For the three PHO's from the Northland DHB, documents from the Companies website were used. For the Tihewa Mauriora Charitable Trust Board incorporation document was used. For the Te Tai Tokerau document of incorporation was not available, so the information for that organisation is taken from the constitution. The Kaipara Care Incorporated information is taken from the document 'alteration to rules' as this society was created a number of years ago and has just been altered to reflect the new PHO environment. For the two PHO's from the Waitemata DHB, incorporation documents have been used.

Northland District Health Board PHOs						
Organisational status	Parties to the organisation	Number of Trustees /Directors	Make up of Board	Role of Chair	Quorum	Additional governance/ issues
Tihewa Mauriora Charitable Trust Board	Te Hau Ora o Kaikohe Charitable Trust (part of Ngati Hine) Broadway Health Management Ltd	Minimum 4 and maximum 7 trustees Original 4 trustees create Board and choose Chair.	Not less than 4 and not more than 5 with the power to co-opt 2 others. 4 elected members, 2 from each organisation, elections 3 yearly Co-opted trustees elected 2 yearly	Independent chairperson co-opted by 4 nominated trustees for a 2 year term. Chair does not have casting vote.	60% of members providing one is chair and others equally represent services providers & Kaikohe community.	
Te Tai Tokerau PHO Ltd (Charitable Company with issued shares)	Te Tai Tokerau Maori Shareholders First Health	No more than 10 and no less than 4 directors Existing directors are appointed by the constitution.	Te Tai Tokerau Maori Shareholders shall have the right to appoint five directors, the remaining five directors to be appointed by First Health. Board appoints Director as Managing Director.	Chair elected from within board, is chair for 12 months and does not have casting vote.	6 directors, comprising at least 3 directors appointed by each shareholder	
Kaipara Care Incorporated Society	Kaipara Care Incorporated Te Runanga o Ngati Whatua	(not clear from document)	Appointments to board annually : Dargaville Medical Centre x 3 Te Runanga O Ngati Whatua x 2 Kaipara Community Trust x 2 Te Ha o te Oranga o Ngati Whatua x 1 Pharmacists x 1 Primary healthcare nurses & nurse practitioners x 1 Allied health providers x 1 Northland DHB x 1	(not clear from document)	Any 7	Any future increase to the Board size will maintain or increase the current proportion of Maori representation.

The North Harbour PHO, comprising Te Puna Hauora and Comprehensive Health Services, with equal trustees from each organisation and a rotating chair may have been the catalyst for such positive Maori representation within governance arrangements,

given that they were the first PHO and also the amount of media coverage their PHO launch and implementation garnered.

Despite the challenges presented by the new PHO organisational requirements, Te Puna Hauora continued to get positive media attention. In June 2004 Te Puna Hauora was one of four organisations named in the National Business Review ‘search for New Zealand’s most exciting companies’ when their focus turned to the health services sector.

Te Puna Hauora was said by respondents to provide a “tremendous health service ...” (National Business Review, 2004)

By February 2005 CHS and Te Puna Hauora o te Raki Pae Whenua had signalled to the Waitemata District Health Board that they were looking at separating because of “a lack of shared vision and philosophy (New Zealand Doctor, 2005a).

It was noted at the time of the announcement that it would be the third PHO to separate because of difficulties between Maori and non-Maori organisations:

...be the third [PHO] to have done so because of difficulties cementing a cohesive vision acceptable to both the mainstream general practice partner and their Maori provider or union health partners (New Zealand Doctor, 2005b).

I observed that by 1 July 2005 the two organisations had split and formed their own PHOs with Te Puna PHO having an enrolled population of 5,500, and Harbour PHO was also established on 1 July with an enrolled population of 52,000. Te Puna PHO remained the only ‘access’ funded PHO on the North Shore, with other PHOs’ being funded under ‘interim’ population based funding. The pool of money for ‘access’ funded PHOs was significantly higher than for ‘interim’ funded PHOs and was based on the needs of the population through a formula and deprivation index. Te Puna Hauora PHO had separate governance to Te Puna Hauora provider organisation. The PHO had two representatives from Te Puna Hauora o te Raki Pae Whenua, one from Tihi Ora MAPO, one general practitioner and one from a community group.

I observed that in October of 2005 Windsor Medical Centre exited Harbour PHO and joined Te Puna PHO. The commonalities between the population groups of both Windsor and Te Puna were behind the decision, even though Windsor remained on ‘interim funding formula’. This means there was no financial benefit to Windsor in the decision:

Dr Chan says a common ground between Asian migrants and Maori is behind his decision to switch PHOs. Te Puna PHOs substantial Maori population shares issues with his 3500 enrolled population, of which 85 per cent are Asian he says ... Dr Chan and Te Puna's seven other general practitioners share a similar patient-focused ideology, Te Puna PHO chief executive Lyvia Marsden says. Te Puna PHO, which serves a population of 5500 and is access funded, has long been worried about the welfare of Asians in the community and their inequitable access to healthcare services, Mrs Marsden says (New Zealand Doctor, 2005a).

By April 2006, the six PHOs in the Waitemata DHB formed a coalition because of concerns around the lack of proper collaboration, consultation and inclusion in planning around implementation of the primary care strategy. The six PHOs were Health West, Waiora (Union Health and Waipareira Trust amalgam), Harbour, ProCare Network North, Coast to Coast (Te Ha o te Oranga o Ngati Whatua and twelve general practitioners from a Wellsford medical centre), and Te Puna Hauora o te Raki Pae Whenua. I observed that of the six PHOs at April 2006, four of the CEO's were nurses, five were women and three were Maori.

8.1.3 Constructive engagement with health funders, the state, the Crown

This section looks at how the Te Puna Hauora organisation and community managed some of the political issues impacting on their development. One of the most significant risk factors to the development of the organisation was political change and the inherent changes to health policies and practices that could arise from these political changes. In 1996, within a few months of starting the organisation, there were elections and the first coalition government under the new electoral reforms was elected. There wasn't a clear winner between the two major parties and a smaller political party, New Zealand First, negotiated for several weeks between the two parties before agreeing to create a coalition government with the National party, who had been the sole party government previously. In terms of health sector reforms, the new government reconstituted the four Regional Health Authorities that had been created by the National party government in 1993 into one health funding authority (HFA).

The Maori health development division of the Northern Regional Health Authority, which had been instrumental in the creation and development of Te Puna Hauora, no longer existed and was no longer there to facilitate the contract negotiation process between providers like Te Puna Hauora and the health authority purchasing teams. This

meant Te Puna Hauora, and the other Maori providers, needed to establish new relationships with the new funder, and to move from being reactive and accepting of contracts that had been facilitated by MHDD, to actually personally negotiating for contracts themselves. They also need to ensure their ongoing financial survival and viability. There was much confusion in the health sector during these transitions and a number of unusual contracting situations arose for the Maori health providers organisations. An example of one of the changes that occurred for Te Puna Hauora in this policy transition period was the rollover of the mental health community support contract: Whanau Iwi Support.

Under North Health, the Whanau Iwi Support contract had been deliverable in the region between Devonport and Orewa (part of urban Auckland and roughly forty minutes drive) Monday to Fridays, from 8.30am to 5pm. The new contract arrived from the new Health Funding Authority (HFA) with the region changed to Devonport to Wellsford, which added a region which ended approximately one hour's drive from the previously contracted boundary. Not only was the new region rural, it was also a region that the Te Puna Hauora had not delivered services to before, therefore the staff were unfamiliar with the geographic territory, and unfamiliar with the hospital and teams who would be referring the patients into Te Puna Hauora services. The previous Whanau Iwi Support contract was for five days a week, during working hours; the new contract was seven days a week, with twenty-four hours a day coverage. The funding for this new contract remained at the same amount as had been paid for the previous five day contract. Additionally, the contract had arrived by mail after its own start date. It took the organisation several days of phone calls to track down the responsible parties at the HFA and to have the contract re-written. In the meantime the staff of the organisation had to cover the hours and patients, even though there was no additional funding for this extensively expanded service delivery. More importantly, there had been no process outlined for a clinical handover of patients.

The 1997 to 1999 period resulted in no funding to increase services at Te Puna Hauora by the health purchaser, and no focused efforts on the part of the health funder to promote continued development of the provider. The period was one of consolidation for Te Puna Hauora, as purchaser funding and service levels were maintained. This was regarded as positive by the organisation because it gave them time away from intensive

contact with the government health authorities; time which they used to focus on consulting with the local community around needs assessments and aspirations for future growth and development of the organisation. The result of this community focus was the creation of a community driven model of service delivery, which was then integrated firstly through restructuring the organisation to best underpin the model, and then it was into the community through service delivery. The organisation then approached other community funding organisations and charities and was able to get assistance to further develop and their service delivery model more widely. The model was called Harakeke - I-MAP and is at Appendix 3.

In 1999 there was another election and the incoming Labour coalition government indicated there would be a complete restructuring of the health sector. In 2000 the New Zealand Public Health and Disability Act removed the Health Funding Authority and created twenty-one District Health Boards (DHBs); Te Puna Hauora had to begin dealing with their third funding process and team in five years.

As early as February 2000, the Maori Development Ministry of the Government, Te Puni Kokiri, was indicating that the newly elected DHBs could be detrimental to the significant advances made in Maori health purchasing and service delivery since the 1990s. This concern was borne out by Te Puna Hauora who highlighted concerns around the District Health Board relationship in their strategic plan for the 2001-2002 year:

Consultation from the District Health Board has not clarified their future direction. Waitemata Healths provider/purchaser role creates uncertainty around parameters between primary and secondary health service delivery. Lack of consultation regarding doubling up or overlapping community contracts on the part of Waitemata Health nurtures an unhealthy environment of mistrust and uncertainty. This will inevitably lead to a breakdown of the integrated quality services that had previously been gained for Maori consumers in the North Harbour region through support of 'for Maori by Maori' providers (Te Puna Hauora, 2000 , p. 6).

I observed that the 'integrated quality services' referred to above by Te Puna Hauora, took the form of a best practice model for service delivery that was created in 1999 by the organisation, and subsequently used to inform the government health and policy community about the Te Puna Hauora o te Raki Pae Whenua rationale for Maori and Primary health care development. The I-MAP model won the supreme award for

innovation in the Ministry of Health awards for Maori providers in 2004 and is discussed in more detail in the next section.

The rollout of the PHO policy by the Ministry of Health promoted Maori involvement in governance of PHOs with statements like the following one from the Ministry of Health: “PHOs must demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community” (Ministry of Health, 2004). Shared governance with Maori for PHOs was also expressed by a number of DHBs in their policies, an example of which is the Northland District Health Board statement from 2003:

Governance

We expect that the governance structure will meet the following requirements:

- Maori representation which reflects Treaty of Waitangi principles. This means real power sharing which requires 50% influence in decision making. This does not necessarily mean equal number of Maori and non Maori people on the board, It does mean that when consensus can not be reached around the board table, and a vote is required, both Maori and non-Maori have equal weight.

The following are examples of Maori participation governance models that PHOs may wish to use depending on the legal structure that is chosen.

- Pro-rata representation based on number of enrolled Maori clients
- Treaty of Waitangi Model: 50% of the governing body is Maori
- Iwi model: each iwi with mana whenua status is afforded representation
- Provider based system: Maori health providers nominate representation
- 2 members on board (on the basis of leadership and participation in local Maori affairs). Partnership with an iwi consortium (ie representation + partnership)

(Northland District Health Board, 2003)

In the lead up to this policy push for Maori involvement in governance, Te Puna Hauora had hosted a number of political, health sectoral, government and non-governmental leaders and showed how as a Maori health provider organisation they had created an integrated community, social and healthcare model. Te Puna Hauora Harakeke - I-MAP model of service delivery and organisational structure had been requested by the key government organisations working towards Maori health and Maori Development policy from 1999. It had had been brought to government attention from 2000 when the concept was part of the Maori Provider Development Scheme proposal to the Health

Funding Authority in June 2000, and a proposal to the Community Funding Association in May 2000. In August 2000 it was the basis for a joint application between Te Ha o te Oranga (another Maori health provider) and Te Puna Hauora to the Health Funding Authority to bring their services together to seamlessly deliver Harakeke - I-MAP services from the North Shore of Auckland, across to Helensville at South Kaipara, then up through to south Whangarei for the region between the east and west coasts; across the majority of the Ngati Whatua rohe.

All of the key government organisations who were participating in creating the Maori Health Strategy and the Primary Healthcare Strategy had copies of the Harakeke - I-MAP model. Further, I observed that presentations of the model were made to the Prime Minister and Associate Minister of Health (at their request) and Te Puni Kokiri, The Ministry of Maori Development by Te Puna Hauora in the 2000-2001 periods. The model was regarded as innovative and was already having positive outcomes for whanau accessing the service, as is evidenced by the case studies in Appendix 3. These case studies were created by the staff of the organisation to explain their services to new staff and external organisations. Many staff and community members attended the hui with the Prime Minister and Associate Minister of Health. In a talk given to the Te Puna Hauora community on 16 March 2006 the then Minister of Health, Pete Hodgson spoke of how the I-MAPO was one of models that had been influential on the government as they created the Primary health care strategy from 2000 and the PHOs.³³

The Primary Health Care Strategy discussion document was released in February 2001 for discussion and published in 2002 as part of the implementation plan for the New Zealand Public Health & Disability Act 2000. What Te Puna Hauora had inadvertently created through the Harakeke - I-MAP and its inherent relationships with their community, was in numerous aspects similar to the Primary Health Organisations that were going to be implemented under the Primary Health Care strategy. The New Zealand Primary Health Care Strategy was based in part on the 1978 Alma-Ata Declaration:

... the definition of primary health care outlined in the strategy was taken directly from the Alma-Ata Declaration (WHO & UNICEF 1978). The 1978 declaration had proposed comprehensive primary health care, with community participation at all levels, as the key strategy to improve global health (Neuwelt, 2004, p. 195).

³³ The Minister of Health, 16 March 2006, at a speech given at Te Puna Hauora o te Raki Pae Whenua

The essence of the differentiation between Te Puna Hauora and other health organisations prior to PHOs was in the governance requirements for Primary Health Organisations as expressed by the Ministry of Health in 2001:

1. PHOs must demonstrate that their communities, iwi and consumers are involved in their governing processes and that the PHO is responsive to its community.
2. PHOs must demonstrate how all their providers and practitioners can influence the organisations decision-making. (Ministry of Health, 2004)

The PHO strategy was underpinned by an expectation of community involvement at governance level. Te Puna Hauora had already taken that a step further. Through the creation of a community-focused constitution and governance structures on the 11th October 1996, as well as creating the Harakeke - I-MAP strategy in 1999, Te Puna Hauora had created an organisation which typified the style of primary health care that WHO and UNICEF had outlined in the declaration, and that was to become the underpinning notion of the Primary Health Care Strategy in 2002:

The Declaration on Primary Health Care [WHO & UNICEF] was a radical statement that added a socio-political perspective to the definition of health and to the purpose of health services. It highlighted the importance of community participation in health-care planning and delivery, by redefining health as a human rights issue and participation in health planning as a democratic principle. The intent to shift control from health professionals and bureaucrats to communities was clearly implied in the tone and content of the Declaration (Neuwelt & Crampton, 2005, p. 195).

I observed that when the Prime Minister, Helen Clark, visited Te Puna Hauora in 2001, the problem of delivering the Harakeke - I-MAP through multiple contracts was discussed. The diagram at Figure 9 in the next section was used to explain the administrative and clinical challenges of juggling a patient through multiple contracts. The Prime Ministers response to the Te Puna Hauora community at the meeting was to indicate the Harakeke - I-MAP style of service delivery was exactly what they were hoping to achieve through the Primary Health Organisations, and that funding the wrap-around style of service the I-MAP delivered through one contract would be a health priority for her government in the longer term.

Te Puna Hauora were successfully engaging with the non-Maori community from the mid-1990s and this constructive engagement with non-Maori was extended and magnified with the health sector changes from 2000. A combination of Maori pro-

activity and political and policy changes resulted in significant pathways for Maori health leaders to participate in, and contribute to decisions on health sectoral reforms such as the Primary Healthcare Strategy for the benefit of not only Maori health gain, but also non-Maori health gain.

8.1.4 Constructive engagement with the ‘Maori health’ workforce and community

The two defining characteristics of Te Puna Hauora that have underpinned constructive engagements with non-Maori community, and with political and health authorities have been their organisation model, and their workforce development model, both based on their Harakeke - I-MAP model (see Appendix 3).

A challenge faced by the differentiated funding mechanism that had been created in the mid-1990s for the Maori health providers was how to create a clinical team of Maori clinicians. Because the Maori health providers were bulk funded, they were unable to negotiate to earn higher contracted amounts to pay competitive salaries for clinicians as their skill sets and experience increased. The Maori health providers could get extra funding for extra training of clinicians; but they couldn't get extra money to pay the higher salaries once these clinicians had completed their training. The clinical team originally started in the 1990s with a number of Maori doctors and nurses on the team, who went on to further training through the organisation. The extra training was a challenge for the organisation, for instance they had two Maori nurses off on full time training for a year each, so while they had two funded nurses on payroll – these nurses were unavailable to deliver services for a significant proportion of the time. Once the clinicians had completed often expensive and extensive further training, they were often ‘head hunted’ by non-Maori organisations for much higher salaries than it was possible for Te Puna Hauora to match.

I observed that this meant Te Puna Hauora often had significant numbers of staff out training and a high turnover of staff into other health related organisations. Of course this had some benefits, with collaborative relationships through ex-staff members within other health related organisations often assisting with Harakeke - I-MAP whanau. Consistency of service development and delivery remained challenging from a clinical perspective however. Within all other teams (non-clinical), the focus of having predominantly Maori staff was achieved, with a lower staff turnover.

I observed that a critical element of Harakeke - I-MAP was the kaumatua and kuia team who guided the board, and worked ‘hands on’ with the management, staff, and with whanau accessing the services. For instance, the kaumatua and kuia could develop programmes to assist whanau accessing the services to understand their whakapapa or aspects of their Maori culture that the clinical, mental health, or social work teams had recommended might assist in improving the wellbeing of this whanau. Having kaumatua and kuia working directly with the whanau ensured matauranga and tikanga Maori of the organisation was a key driver in service development and delivery. The kaumatua and kuia also began each day with karakia and waiata in the meeting room that all staff and any whanau on the premises were welcome to attend. This allowed staff to connect with the matauranga and tikanga Maori of the organisation each morning before beginning whanau interactions. This was particularly highlighted as a positive aspect of the organisational culture by non-Maori staff.

The first model of training in matauranga for Maori health undertaken by the staff was ‘Whaanau Ora’ (see Appendix 1), the model created by Lewis Stephens at Ngati Whatua o Orakei Health Clinic. The second model of matauranga for Maori health training undertaken by the staff was ‘Whanaungatanga’ (see Appendix 3), the model created by Pa Henare Tate at Te Hiku o te Ika Trust. With Pa Tate’s (1999) permission, the basis of his teaching was documented and used for the organisation in their first strategic plan, and remained the foundation of their strategic planning and organisational practices throughout the research period.

I observed that the staff were encouraged to move through various roles in the organisation and often their development was augmented through liaison or work with health professionals external to the organisation. Several staff members moved into management or supervisory roles over the period of their employment, including one whose first role was as a receptionist, and one who left a job as a pharmacy assistant to become a community support worker then manager of the social services team. Many staff trained on the job, and gained new skills over a period of years, during the development and delivery of the Harakeke - I-MAP service.

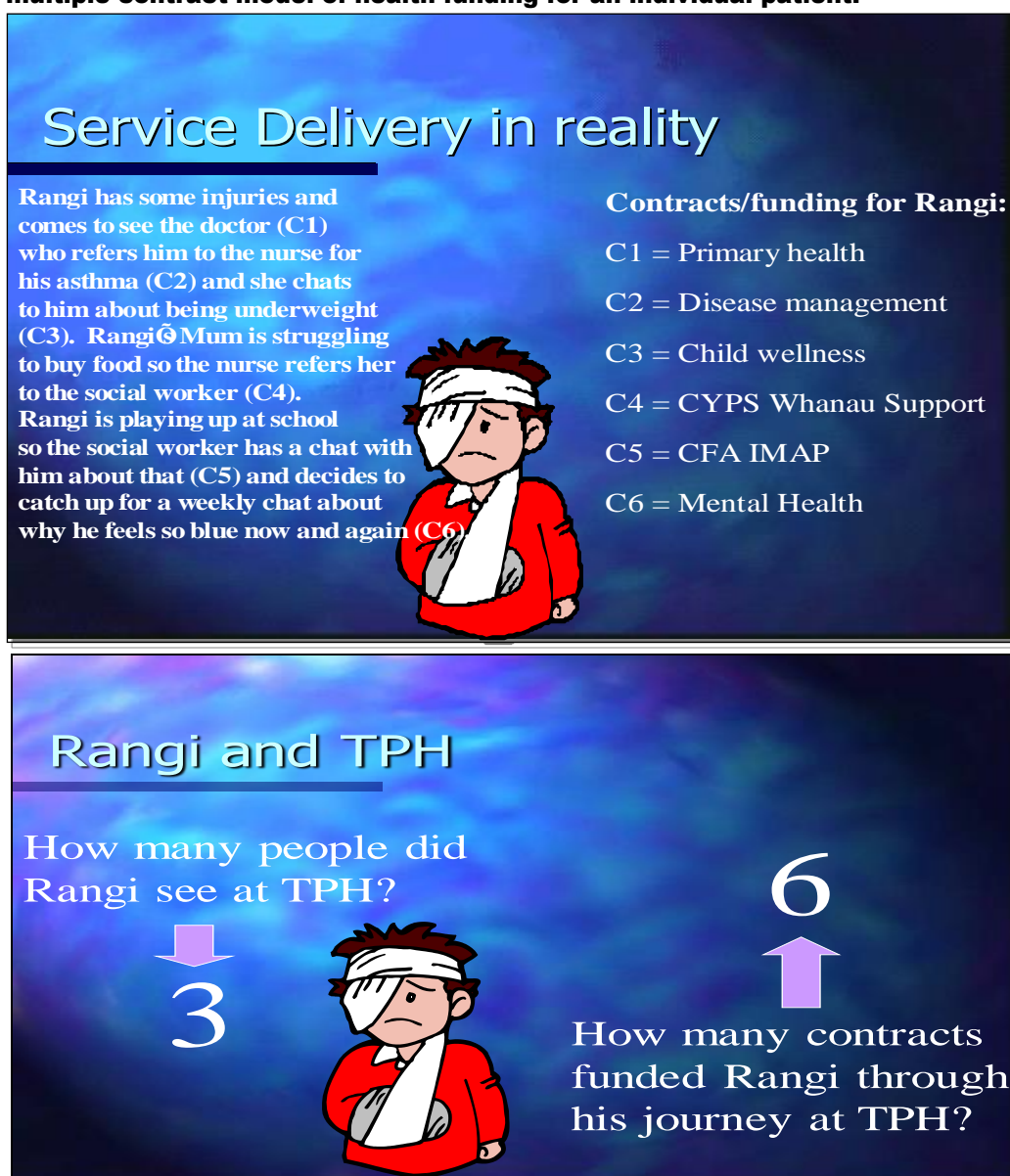
In line with the development of the Harakeke - I-MAP, I observed that staff were asked to identify their skills, experience and aspirations. With the assistance of a consultant they then created their own job descriptions, competencies and performance appraisal

systems. They also developed their own individual training action plans and the organisation sought funding/resources in order for them to undertake training. As an example, two staff members who were Maori nurses undertook post-graduate study in mobile disease management nursing, which was full time for a year.

From a workforce development perspective, I observed that individual training plans created by the team members for themselves included training through degrees at the University of Auckland and Massey University; management training through the Employment Manufacturers Association, the Institute of Management, the Institute of Directors, as well as Ministry of Health funded courses. In addition, training modules for staff were developed specifically to underpin the Harakeke - I-MAP competencies (see Appendix 3). The Leadership & Personal Development module evolved out of a recognition that the three areas highlighted in the module were key to staff being successful within the organisation. I observed that the whanaungatanga aspect was of particular importance to the staff because it placed staff not only within the matauranga and tikanga Maori of the organisation, but also within the context of Maori health development occurring in the wider community of New Zealand.

By May 2002, 120 people and their whanau had accessed the Harakeke - I-MAP programme, with the average length of assistance between 4-6 weeks ('Maori health providers look to healthier future' New Zealand Doctor. 8 May 2002). I observed that one of the key skill sets that needed to be established by the organisation in the period from 2000 onwards was contract negotiation and management to facilitate the high volume of low value contracts the organisation was taking on to fund the I-MAP delivery. Contracts to deliver various aspects of the Harakeke - I-MAP were funded through organisations such as Child Youth and Family Services, Community Funding Agency, the local DHB team, a national virtual DHB team, the Ministry of Health, Accident Compensation Corporation, and the Ministry of Maori Development-Te Puni Kokiri. This in effect created contract monitoring and reporting requirements that were excessive in comparison to the services delivered. An example of how this contracting process impacted on service delivery, and on staff interactions and reporting, is given below at Figure 9. 'Rangi' is not based on a particular person, and these slides formed part of presentations to external audiences to explain the challenges of multiple contracts for the staff of the organisation:

Figure 9: Te Puna Hauora internal presentation diagram of the challenges caused by the multiple-contract model of health funding for an individual patient.



The contract reporting in this example included three staff members reporting on six contracts, for a single visit of one person. I observed that whilst the contract reporting was an onerous task, the actual funding by multiple organisations had a positive outcome in that many sectors of the community had the opportunity to participate in the Harakeke - I-MAP evolution. This was regarded as a positive way of developing community and non-governmental organisational participation and involvement. It was also expected that the service delivery model would provide a framework for the collaborative efforts of multiple participants seeking to assist an individual or whanau crisis. However, the pressure on staff to comply with the reporting requirements of many different

organisations and contracts provided more time constraint challenges than they would have faced had they been working as nurses, for instance, in a non-Maori for-profit primary health care provider organisation.

Te Puna Hauora began life in a converted room of the new marae at Awataha on Auckland's North Shore. Within four years it had grown into a new purpose built building capable of providing social and ancillary services to conjunction with the health services, had added a purpose built building for a childcare centre for fifty children, and was being visited by the Prime Minister and Ministers of Health of New Zealand, and the United States Secretary of State for Health under Bill Clinton during the APEC visit year, because it was regarded as one of the foremost models for Maori health development in the country.

In 2004 the Ministry of Health and other Maori health providers declared Te Puna Hauora the winning 'Whanau Kaupapa' and the 'Supreme Award winner in the Whanau Ora Awards' (see Appendix 3). In the same year they were named as 'one of New Zealand's most exciting companies' in New Zealand's foremost business publication, The National Business Review ('A Healthy Prognosis' The National Business Review. 25 June 2004). Within ten years Te Puna Hauora's membership had grown to 10,000 Maori and non-Maori peoples. I observed that they had also shared their Harakeke - I-MAP model, developed in conjunction with their community, with indigenous health organisations globally, some of whom sent their staff to work for a while at Te Puna Hauora to learn how to implement it and to create similar models based on their own matauranga and tikanga back in their own countries.

These three examples of constructive engagements between Te Puna Hauora and Maori and non-Maori peoples and organisations have provided an introduction into how the organisation developed. The knowledge and experiences explained above are used in the next chapter to conceptualise Te Puna Hauora kotahitanga models. In the next section, the matauranga of Te Puna Hauora that underpinned the experiences discussed above, are identified.

8.1.5 Matauranga – Te Puna Hauora

The matauranga Maori knowledge underpinning Te Puna Hauora o te Raki Pae Whenua development was Whanaungatanga and Whaanau Ora, as was evidenced in many of the

organisation's documents, including the following examples (see Appendix 5): Te Puna Hauora Harakeke - I-MAP, 2005; Te Puna Hauora Kaupapa, Tikanga and Kawa Model – Whanaungatanga 2004; Te Puna Hauora Organisational Model, 2005; Te Puna Hauora Philosophy of Care and Service – Strategic Goals of the Organisation, 2000; Te Puna Hauora Staff Training and Development Model, 2005); and, The Harakeke - I-MAP as an integrative model for social and health wellbeing, 2005).

Alignments with the matauranga Maori knowledge of other Maori health organisations in the Ngati Whatua health sub-region included: '*Whaanau Ora*' by Lewis Stephens (1998) and Ngati Whatua o Orakei Health Clinic (see Appendix 1).

The matauranga based tikanga service delivery model of Te Puna Hauora was the Harakeke I-MAP model (see Appendix 3). The matauranga and tikanga of Te Puna Hauora o te Raki Pae Whenua are presented in Tables 6 and 7 with the other case study organisations in the conclusion of this chapter.

8.1.6 Summary – Te Puna Hauora o te Raki Pae Whenua

There were three key constructive engagements occurring for Te Puna Hauora over the study period: (1) With Non-Maori community members, in terms of development of the clinic into an Incorporated Society and then into a Primary Health Organisation; (2) With the Health funders/State & Crown, in terms of presenting matauranga and tikanga Maori models for community based service delivery. (3) With the 'Maori health' workforce and community, in terms of creating organisational models and workforce development models to fulfil the expectations of both workforce and community who were a mix of Maori and non-Maori peoples.

Te Puna Hauora was one of the early primary healthcare providers created under the Maori provider development scheme of the North Health MAPO Strategy. Their I-MAP model gained them much political, health sectoral and media attention through the late 1990s and into the mid-2000s. Therefore some of the information available from review of the organisation's documents, and from observational analysis, was able to be cross referenced with government documents and media publications. For this reason the experiences of Te Puna Hauora during political and health sectoral changes are used in this study as an exemplar for the similar experiences of the other Maori health organisations that make up the case study organisations.

The main characteristics Te Puna Hauora shared with Te Ha o te Oranga and Ngati Whatua Orakei Health Clinic included bulk funding in the 1990s, interim versus access funding in the 2000s, how to attach more community and social wellbeing services to medical-service only contracts in the 1990s, how to create and deliver PHOs' alongside non-Maori organisations in the 2000s, and how to be inclusive of non-Maori community members. Some of these issues are canvassed in the next case studies, but the broader political and policy contexts underpinning these issues are not canvassed in as much detail in the next case studies as they were in this one.

In Chapter 9 three Te Puna Hauora models for hauora kotahitanga, based on some of the information, knowledge and experiences discussed in this chapter, are conceptualised as a Mana Tauwiwi model, a Te Tohu Kahukura model, and a Mana Kaitautoko model.

8.2 An introduction to the Te Ha o te Oranga o Ngati Whatua case study

Te Ha o te Oranga o Ngati Whatua was created by Te Runanga o Ngati Whatua to be the iwi health provider of health services in the Ngati Whatua tribal region under the MAPO strategy with the Northern Regional Health Authority from 1 May 1997 (Te Ha o Te Oranga, 2000e, p. 28). Te Ha o te Oranga o Ngati Whatua began service delivery with a different focus to the other Maori health organisations in the Ngati Whatua health sub-region because it was the only one of the four health service providers created under the MAPO strategy that was a division of Te Runanga o Ngati Whatua. Te Runanga o Ngati Whatua described Te Ha as a 'health provision unit':

The Runanga also has the obligation to enhance the health and well being of its people and to this end has created a designated health provision unit which it has named *Te Ha o te Oranga o Ngati Whatua* (Te Runanga o Ngati Whatua & Procure Health Limited, 1998, p. 1).

By 2000 Te Ha services included mobile disease management nursing, mobile nursing service, mobile breast-screening service, whanau ora, Accident Compensation Corporation car-seat promotion, Whetu Ora - a residential mental health service, Hep.B programme, alcohol and drug rehabilitation programme, tamariki ora well-child nurse service, home-care support service (Te Ha o te Oranga, 2000c).

I observed that from an internal perspective, the organisational model for Te Ha o te Oranga differs from non-Maori services in their region by having kaumatua and kuia, or a council of elders, as a connection between governance, management, staff and external peoples on matauranga and tikanga issues (Te Ha o te Oranga, 2000e). Legislative requirements for the management of public monies requires a statutorily recognised board in a format applicable to public service management, and this was created through the Te Ha o te Oranga Board, reporting back to Te Runanga o Ngati Whatua.

I observed that Ngati Whatua requirements for the management of community health and wellbeing issues required a council of elders, created through the inclusion of kaumatua and kuia at a governance level with the Te Ha Board from which they could be highly influential in terms of management, operations, and most particularly the public relations of the organisation with the community. Kaumatua and kuia attended hui with staff members of the organisation in marae, and at community meetings, with health sector and Ministry of Health representatives. They oversaw, in particular, the spiritual and cultural elements required to ensure meetings took place in a way that was appropriate to the kaupapa and tikanga of the peoples concerned. They were involved in everything from strategic planning to interviewing and training new staff.

I observed that the Ngati Whatua kaupapa, tikanga and kawa were the dominant organisational knowledge because Te Ha o te Oranga was a division of Te Runanga o Ngati Whatua (see Chapter 7). For this reason Te Ha staff were required to be well versed in Tikanga, Taha Maori and Ngati Whatua protocols (Te Ha o te Oranga, 1999b). In the induction training for new Te Ha o te Oranga staff, it was made clear that any Te Ha representation to an external party was in effect a representation on behalf of Te Runanga o Ngati Whatua, which was why all staff of Te Ha directly reported to Te Runanga o Ngati Whatua (Te Ha o te Oranga, 1999b).

Two critical issues affected the development of Te Ha o te Oranga from 1997 as a provider organisation. The first was that the service delivery boundaries assigned by North Heath did not align with Ngati Whatua tribal boundaries and so the organisation spent much time agitating with North Health to have this resolved. The second was that Te Ha was the only one out of the four provider organisations that did not have an in-house general practitioner contract. The reason for this was that the population in the rural region where the Te Ha services were based did not warrant another general

practitioner service, particularly a service that could end up competing with or undermining the local rural general practitioner services (Tihi Ora, 1999).

In terms of the boundary issue, Te Ha was caught up in the boundary negotiations occurring between the Te Runanga o Ngati Whatua and North Health, particularly over mana whenua lands in the far north of the region where services were being contracted out by North Health to Maori providers under the Te Tai Tokerau MAPO. North Health had originally contracted Te Ha o te Oranga to deliver services from just north of Wellsford down to just north of Orewa, a sparsely populated rural region (Tihi Ora, 1999c, p. 2). This meant that when the funding moved to population based funding from 2000 Te Ha was significantly disadvantaged in terms of the other Maori health providers in the Tihi Ora region who had larger population catchments to attract patients from, and had general practitioner services. Te Ha made a number of proposals to the health authorities to extend their boundaries so that they could increase their population because by 2000 they only had 3,200 registered patients (Te Ha o te Oranga, 2000c). In 2000 Te Ha o te Oranga sent a proposal to the health authority to extend its mobile nursing contract boundaries from between Paparoa and Dargaville to include Hadfield's beach to Helensville to Paparoa as well. The potential population for the service then would increase from 3,022 to 19,878 (Te Ha o te Oranga, 2000d).

At this time they were already delivering a regional breast screening service beyond the North Health-Ngati Whatua Tihi Ora MAPO region. The breast screening services were delivered from Mercer to Cape Reinga, approximately the top 1/3rd of the North Island of New Zealand (Te Ha o Te Oranga, 2000e). From 2000 Te Ha o Te Oranga claimed their health service delivery region as "Otahuhu to Whangarei" or from South Auckland to three hours by car north of Auckland to Whangarei (Te Ha o Te Oranga, 2000e, p. 2). From 1999 they had been defining their role as "to oversee the ongoing coordination, delivery and growth of health services within the Ngati Whatua rohe and the approximately 100,000 Maori who reside therein" (Te Ha o te Oranga, 1999b, slide 2), which meant in effect they were aligning themselves as the mana whenua service provider alongside the boundaries that had been agreed for the mana whenua service purchaser (Tihi Ora).

The region they were describing in this 1999 document had been split into four distinct Maori health organisation areas by North Health under the 1995 MAPO strategy (Tihi

Ora, 1999c) and each quarter contracted a newly created Maori health provider to work alongside Tihi Ora MAPO: Te Puna Hauora on the North Shore of Auckland, Waipareira in the West of Auckland, Orakei in Central Auckland, and Te Ha in the rural region to the north of Auckland. So this re-definition of Te Ha of their boundary had the potential to be seen as controversial by the other three Maori health providers, whose boundaries for service delivery they were effectively challenging. In addition to seeking to extend the geographic and population opportunities for health service delivery to Maori, Te Ha o te Oranga were also actively pursuing opportunities for health service delivery to non-Maori, by offering “a ‘kaupapa Maori’ service which they described as culturally inclusive”:

We offer a ‘kaupapa Maori’ service which is culturally inclusive. We make every effort to train and employ people from as many ethnic minority groups living in Te Ha as possible to offer consumer choice. We will continue to research and introduce policies that meet the expectations of cultures, Maori and otherwise (Te Ha o te Oranga, 2000a, p. 2).

I observed that the second critical issue encountered by Te Ha was that they alone of all the Tihi Ora providers did not have a general practitioner contract. Te Ha o te Oranga patients were seen by general practitioners affiliated to non-Maori health provider practices in the region in which they delivered their services. This meant Te Ha was unable to achieve the integration of health services with matauranga and tikanga that had been possible for the three other provider organisations who were able to provide general practitioner, nursing and community and social services to patients all under the one organisational kaupapa (Tihi Ora, 1999). This was a significant drawback to the development of Te Has in comparison to the other Maori health providers created at the same time as them. With the other Maori health providers having contracted general practitioners as part of their services, they had a better business case for attracting other allied health services to work with them, and more opportunity to win other health, social and community contracts because the historical funding relationships general practitioner services already held with government organisations gave them credibility with the funders.

I observed that there were also geographic challenges presented by being the only rural provider out of the four Maori health primary providers in the North Health Ngati Whatua health sub-region. For instance, there were long distances to cover in terms of

delivery of homecare support services, and no network coverage for mobile phones or computers in many of the rural areas where the staff ran outreach clinics (Tihi Ora, 1999). Other Tihi Ora MAPO providers had general practitioner and urban based services and so were able to learn from comparisons between their collective experiences of service development and delivery. Te Ha, as the only rural provider, did not have a cohort of providers with similar issues to collaborate with on issues affecting their service development and delivery.

I observed that the lack of a general practitioner contract was particularly problematic with the health sector transition of primary care providers into the Primary Health Organisation model from 2000. The PHO model was based on registration of patients for general practitioner services, so the three other Tihi Ora provider organisations, Te Puna, Orakei and Waipareira were able to align more easily with these health sectoral challenges. Te Ha o te Oranga, however, became strategically misaligned with this new primary health organisation policy focussed on general practitioner and nurse led services, and as a Labour-led coalition was in government for the following eight years, there was little possibility of using health sectoral changes to find other ways to grow. I observed that the result for Te Ha o te Oranga was little by way of opportunity for growth and development of their services and systems, and significant challenges to their being able to maintain organisational viability in a PHO environment without their own general practitioner service.

I observed that an alliance with Te Puna Hauora to co-implement the Te Puna Harakeke - I-MAP model from 2000 created a seamless service delivery mechanism between the two adjoining regions of the two providers, but the on-going lack of a general practitioner contract caused clinical oversight complications in terms of effective model implementation. The situation was eventually progressed through Te Ha joining with the local general practitioner providers to form the Coast to Coast PHO in 2003, and Te Ha nurses worked with the local general practitioner mobile doctor/nurse service to hold rural clinics in isolated villages in the region like Tinopai (Coast to Coast PHO, 2003). Te Ha o te Oranga, as the mana whenua provider organisation was able to achieve two constructive engagements, one with a non-Maori health provider, and one with other Maori health providers. These constructive engagements reinforced their mana whenua

position in terms of the overall Te Runanga o Ngati Whatua matauranga of rangatiratanga.

8.2.1 Constructive engagement with non-Maori health provider organisations

I observed that one of the most interesting aspects of Te Ha o te Oranga is the difference in the constructive engagements that have been possible for Te Runanga o Ngati Whatua to make with non-Maori and non-governmental organisations as a provider, particularly when they are compared with the Crown and governmental constructive engagements of Tihi Ora, as a purchaser, in the previous chapter. Tihi Ora Crown and governmental constructive engagements were dominated by Crown interpretations of the Treaty and unilateral decisions by the Ministry of Health on disestablishing constructive engagement models such as the Kaunihera Council. However, Te Runanga o Ngati Whatua has been able to form a number of relationships on behalf of Te Ha o te Oranga with other primary health care service providers in the Ngati Whatua region. These relationships are examples of constructive engagements with community groups, rather than with Crown representatives. What is interesting is how Te Runanga o Ngati Whatua defined their matauranga and tikanga Maori to non-Maori who are not the Crown, through constructive engagements by Te Ha o te Oranga.

I observed that in their negotiations with ProCare, a very large Independent Practitioner Association in the greater Auckland region, Te Runanga underpinned the Memorandum of Understanding with the Maori language version of the Treaty of Waitangi (which is the version that was signed by Maori), Te Tiriti o Waitangi, and included a clause on the mana whenua of Ngati Whatua over their region, through the relationship formed through the Maori language version of the Treaty. This, in effect, meant that a non-Maori organisation was constructively engaging with Ngati Whatua on the basis of the Maori language version of the Treaty, where the Crown predominantly had used the English language version of the Treaty since 1840. A non-Maori health organisation was therefore willing to constructively engage with Maori, on Maori terms, resulting in a model for co-operative co-existence. Te Runanga o Ngati Whatua, through Te Ha o te Oranga constructively engaged as mana whenua with a non-Maori health organisation to co-operatively co-exist through their matauranga of rangatiratanga.

8.2.2 Constructive engagement with other Maori health provider organisations

The previous example was of a constructive engagement with a non-Maori health organisation. In this example, the constructive engagement example is with the other Maori health provider organisations in the Tihi Ora region. The relationship Te Runanga o Ngati Whatua held as health purchaser, through Tihi Ora, with the four Tihi Ora designated Maori health organisations: Orakei, Te Ha o te Oranga, Te Puna Hauora o te Raki Pae Whenua, and te Whanau o Waipareira, caused tension within the MAPO health systems (Te Ha o te Oranga o Ngati Whatua, 1999). Under the purchaser/provider split that had been introduced through the 1993 health sectoral changes (Barnett, 2005), providers of health services were supposed to compete against each other for delivery contracts, with the purchasing organisation awarding the contracts and deciding their values.

A Maori organisation, in this case Te Runanga o Ngati Whatua, which controlled both a purchaser, in this case Tihi Ora, and a provider organisation, in this case Te Ha o te Oranga, created concern for the other Maori providers who were supposed to be competing for scarce health resources against each other, Te Puna Hauora, Orakei and Waipareira. Te Ha sought to minimise the risk of inter-Maori provider organisational tensions that may have arisen from the perception that Te Ha had more likelihood of getting more provider funding from Tihi Ora than the other providers, by instituting a series of meetings with Ngati Whatua o Orakei Health Clinic and Te Puna Hauora beginning in January 1999 (Te Ha o te Oranga, 2000c; Te Ha o te Oranga o Ngati Whatua, 1999). The idea of the meetings was to move towards creating a Ngati Whatua Maori Integrated Care Organisation (MICO), with joint management, administration and coordination functions between a number of provider organisations, to find economies of scale, and to develop best practice models together (Te Ha o te Oranga, 2000b; Te Ha o te Oranga o Ngati Whatua, 1999). I observed that after two meetings between the three CEOs of Te Ha as the Ngati Whatua provider, Orakei as a Ngati Whatua hapu provider, and Te Puna whose Chair and CEO both had whakapapa to Ngati Whatua, an invitation was sent to Waipareira to join the third meeting of the proposed MICO, and an agreement in principle was reached between the four provider CEOs (Te Ha o te Oranga o Ngati Whatua, 1999).

I observed that the MICO proposal by the four CEOs' and their organisations was stymied by the refusal of Te Runanga o Ngati Whatua to participate, effectively withdrawing Te Ha and Tihi Ora from the process that had been begun by the Te Ha CEO. No reason or explanation was offered by the Runanga. The impetus for constructive engagement between the four Maori health providers, which may have resulted in a single organisational structure robust enough to survive the transition to PHOs that occurred with the health sectoral changes from 2000 was lost and was never reinvigorated (Te Ha o te Oranga, 1999). The sudden death of the Te Ha CEO a few months later left the proposal without an internal champion at Te Ha or to the Runanga. Waipareira, Te Ha and Orakei all struggled to remain financially and structurally viable in the post-2000 period. Te Puna Hauora remained financially viable but was initially structurally challenged by the new PHO environment.

The MICO model may have alleviated some of these issues, because the minimum number of registrations required to be a viable PHO was 20,000 and between the four Maori health organisations it may have been possible to get close to that number. The CEO of Te Ha, Hinekehu Hohaia was a Maori Nurse who had worked as the Clinical Manager of Tihi Ora before moving over to Te Ha, so her relationships with the other providers were a key aspect in getting their respective CEOs to come together to form a working alliance. If Hinekehu had lived, there is a possibility with the changes occurring from 2000 she may have been able to move the constructive engagements between the Maori health organisations in the Tihi Ora rohe into longer term collaborations. Nonetheless, this was a good example of how a mana whenua organisation could undertake their rangatiratanga responsibility to manaaki the non-mana whenua organisations. In other words, as mana whenua Ngati Whatua practiced manaaki, or host responsibility for the care and wellbeing of the non-mana whenua organisations, as part of their rangatiratanga responsibilities.

However I observed that one outcome of this alliance was that Te Ha partnered with Te Puna Hauora to deliver the I-MAP, which was underpinned by Pa Henare Tate's (1999) teachings on the matauranga of whanaungatanga, and Lewis Stephen's (1998) matauranga of Whaanau Ora. Ngati Whatua Orakei had a Kia Tu Kia Puawai Orakei model that was underpinned by Pa Tate's (1999) teachings on Whanaungatanga and the Orakei Health Whanaau Ora model. Following the 1999 MICO meetings there was an

alignment in the matauranga being delivered across three quarters of the Tihi Ora MAPO sub-region.

In the next section, the matauranga of Te Ha o te Oranga are identified and explained. In Chapter 9 the experiences, knowledge and information from these constructive engagement examples are considered as conceptual models for hauora kotahitanga.

8.2.3 Matauranga – Te Ha o te Oranga

The Te Ha o te Oranga matauranga of rangatiratanga, whanaungatanga and Whaanau Ora are present in a number of organisational documents, including: The Te Ha o te Oranga Induction Program (Te Ha o te Oranga, 1999b); The Kaupapa, Tikanga and Kawa of Ngati Whatua (Te Ha o te Oranga, 2000b); the Te Ha o te Oranga Harakeke - I-MAP Model Strategy (Te Ha o te Oranga, 1999a). Rangatiratanga was a matauranga for the organisation, through Te Runanga o Ngati Whatua as their parent organisation.

Alignments with the matauranga Maori knowledge of other Maori health organisations in the Ngati Whatua health sub-region include: the alignment with the Te Puna Hauora Harakeke I-MAP model from 2000, which was underpinned by the matauranga Whanaungatanga by Pa Henare Tate (1999) and Whaanau Ora by Lewis Stephens (1998) and Ngati Whatua o Orakei Health Clinic.

The matauranga based tikanga service delivery model of Te Ha o te Oranga was the Harakeke I-MAP model (Te Ha o te Oranga, 1999a). The matauranga and tikanga of Te Ha o te Oranga are presented in Tables 4 and 5 with the other case study organisations in the conclusion of this chapter.

8.2.4 Summary – Te Ha o te Oranga

Te Ha o te Oranga, with the dual challenges of a large rural service delivery area with a low population, and not having a general practitioner contract, still managed to constructively engage in for organisation-to-organisation relationships on behalf of Te Runanga o Ngati Whatua. One particular achievement was engaging with non-Maori health providers on the basis of the matauranga of Ngati Whatua. Another achievement was engaging with non-Maori health providers on the Maori version of the Treaty of Waitangi. Te Ha were also instrumental, along with Orakei Health and Te Puna Hauora, in ensuring there was some consistency of matauranga Maori delivered in three quarters

of the hauora services in the Ngati Whatua health sub-region, with all three organisations implementing Lewis Stephen's (1998) '*Whaanau Ora*' from Orakei, and Pa Henare Tate's (1999) '*whanaungatanga*' through the Te Puna Hauora Harakeke - I-MAP, and this version of '*whanaungatanga*' also present in the kaupapa, tikanga and kawa of Te Ha (Te Ha o te Oranga, 2000b) from 2000 and Tihi Ora from 1999 (Tihi Ora, 1999d).

There were two key constructive engagements occurring for Te Ha o te Oranga over the study period: (1) With non-Maori health provider organisations, in terms of Treaty of Waitangi vs. Tiriti or Waitangi based relations; (2) With Tihi Ora Maori health provider organisations, in terms of developing a collaborative approach to Maori health service provision and delivery.

In Chapter 9 two Te Ha o te Oranga models for hauora kotahitanga, based on some of the information, knowledge and experiences discussed in this chapter, are conceptualised as a Manawhenua model, and as a Manaaki model.

8.3 An introduction to the Ngati Whatua o Orakei Health Clinic case study

Ngati Whatua o Orakei Health Clinic services were developed at the same time as Te Puna Hauora, so the socio-political challenges presented by state health developments that were discussed in the Te Puna Hauora case study are identical to those experienced by Orakei Health. Rather than explaining in detail the similar Orakei experiences with the health system, this section instead focuses on the Orakei experiences of development of their health services based on matakura Maori knowledge and tikanga Maori methodologies.

Ngati Whatua o Orakei Health Clinic (Orakei Health) is a subsidiary of Ngati Whatua o Orakei Maori Trust Board (Ngati Whatua o Orakei Health Clinic, 2000a). Orakei Health is one of four main Maori health organisations in the Tihi Ora MAPO region with catchment boundaries defined as:

Orakei North, Kohimarama West and East, St Heliers, Glendowie, Glen Innes North, West and East, Pt England, Tamaki, Panmure Basin, Hamlin, Ferndale, Meadowbank North, Grafton and Freemans Bay (Tihi Ora, 1999c, p. 2).

The health authority boundaries for Orakei Health do not correspond with the Ngati Whatua o Orakei Maori Trust Board boundaries. Socio-politically, Te Runanga o Ngati Whatua is mandated by Ngati Whatua peoples to represent all the marae within Ngati Whatua rohe, including Orakei marae. However, Ngati Whatua Orakei has their own status through their Trust Board. From this perspective they have similar legal standing on indigeneity and political issues with the Crown as Te Runanga o Ngati Whatua (Ngati Whatua o Orakei Corporate, 1999). North Health approached Te Runanga o Ngati Whatua to set up Tihi Ora MAPO, and the Rangatira Hauora appointed by Tihi Ora MAPO to be the representative on Te Kaunihera O Nga Rangatira Hauora O Te Raki (the Kaunihera) with the North Health board was the Chairperson of the Orakei Trust Board, Sir Hugh Kawharu.

In 1996, the Orakei Health target Maori population to register for services was 1000 Maori who were living close to where the clinic was based on Takaparawhau, with a further 7000 living in the broader east Auckland region (Stephens & Ngati Whatua o Orakei Health Clinic, 1998). The services, however, were designed to be delivered inclusively to all cultures and during 1998 the organisation saw an appreciable growth in the number of Indians, Asians and Pacific Islanders accessing the services (Stephens & Ngati Whatua o Orakei Health Clinic, 1998). The members of a large retirement village, built on the Orakei marae grounds for Maori and non-Maori, also became users of the services. Orakei Health noted that the population of the clinic is “very parochial and is very proud of their community” (Stephens & Ngati Whatua o Orakei Health Clinic, 1998).

8.3.1 Constructive engagement with the community

Orakei Health clinic describes their establishment as being partially to meet the aspirations of Maori, and partially to address government initiatives towards Maori health disparities (Ngati Whatua o Orakei Health Clinic, 2000a). The key priority of the health clinic was to combine cultural practices and professionalism with healthcare (Ngati Whatua o Orakei Health Clinic, 2000a). Orakei Health services delivered include: primary care services, counselling, health education, immunization, community nursing, tamariki ora (well- child checks), dental education, mental health prevention, ear clinics, aukati kai paipa smoking cessation programme, rangatahi (youth) services,

Kuia/Kaumatua (services for the 60+), and a diabetes clinic (Ngati Whatua o Orakei Health Clinic, 2000a; Stephens & Ngati Whatua o Orakei Health Clinic, 1998).

Kaupapa Maori philosophies were identified as critical to organisational management and service delivery, with a focus on creation of lifestyles (Ngati Whatua o Orakei Health Clinic, 2000c):

- Creating lifestyles for others requires the community to see the need and then generate services accordingly. This will provide the impetus for increased health as opposed to services being imposed on others;
- We have a responsibility as whanaau specialists to guide and train whanaau in accessing the health system to create lifestyle changes (Ngati Whatua o Orakei Health Clinic, 2000c).

The organisational model is based on a mission statement based on lifestyles:

Mission statement: Our vision is to build a service that will **reinvent health** for Maori through the **creation of lifestyles** that will have **Maori health second to none** (Ngati Whatua o Orakei Health Clinic, 2000c, p. 2).

The organisational model for the creation of lifestyles for Maori within the region created eight areas of focus for health development: membership so that whanau or members would have a sense of ownership of the clinic and results (Ngati Whatua o Orakei Health Clinic, 1999b), expansion of services into Glen Innes to particularly target the Pacific Island population (Stephens & Ngati Whatua o Orakei Health Clinic, 1998), Kaumatua/Kuia services, creation of a renal dialysis service and expansion of diabetes clinics, and the creation of a Maori health insurance company (Ngati Whatua o Orakei Health Clinic, 2000c).

One of the main objectives of the organisation was to “Develop a cultural model of holistic health to improve the health outcomes for Maori”, with the goal being to “establish a whanau ora strategy where primary health needs are taken care of within the whanau”, so that “each whanau incorporates a lifestyle health focus (Ngati Whatua o Orakei Health Clinic, 2000c). Lewis Stepehns for Orakei Health created a service delivery model to encapsulate their organisational objectives called ‘Whaanau Ora’, Tikanga from within. (See Appendix 1) The model was envisaged as being not only a model of empowerment to the community, but also from the community, and was inclusive of non-Maori:

A key aspect for the success of this model is that it is applicable to the whole community and not just Maori. It is a model of empowerment from within the community (Stephens & Ngati Whatua o Orakei Health Clinic, 1998, p. 8).

Patients were to be identified as whaanau members, rather than patients (Ngati Whatua o Orakei Health Clinic, 1999b), and a model of empowerment was interpreted as being to “empower whanau members with skills to access health pathways” (Ngati Whatua o Orakei Health Clinic, 1999b, slide 5).

I observed that the elements of the ‘Whaanau Ora’ model were then put into the organisation’s health programmes, along with other Maori knowledge models to facilitate community empowerment. One example of this is the Ngati Whatua Orakei Kia Tu Kia Puawai model (see Appendix 1). This community mental health prevention programme drew together Pa Henare Tate’s (1999) *whanaungatanga*; Mason Durie’s (1994) *Te Whare Tapa Wha*, which had been used in the Health Funding Authority 1999 document Kia Tu Kia Puawai; as well as Orakei Health’s own ‘Whaanau Ora’ (see Appendix 1).

I observed that Orakei Health’s community empowerment model was evident in their response to the government query as to what outcomes could be expected from a Kia Tu Kia Puawai project being undertaken by the community; the outcomes were to be created by the community, not prescribed by the clinic:

Given the nature of this project, it has not been possible to give detailed outcomes. The project is to be developed and implemented by the hapu and therefore is in the infancy of its creation process. The establishment of reporting parameters has been avoided in order that a prescriptive methodology is not imposed on the hapu prior to its having its consultation and development process. It is therefore suggested that the Manager of the pilot project reports on a monthly basis, both internally and to the HFA, and that in the initial stages of the project this reporting take the form of an informative qualitative report on each of the 7 major goals. As pilot projects are approved and progressed by the hapu, outcomes will be attached and these can then be articulated into qualitative and quantitative reporting measures in consultation with the HFA (Ngati Whatua o Orakei Health Clinic, 1999a, p. 2).

I observed that the outcomes for the project were not defined by Orakei Health; instead they were creating a model whereby the community could create the outcomes themselves. Orakei Health were effectively trying to convince the Ministry of Health that a “state-determined model for self sufficiency” would be re-moulded so that an

“indigenous-determined model for indigenous self-determination” (Maaka & Fleras, 2005, p. 293) could be the outcome. Interestingly however, Orakei Health proposed their model of Whaanau Ora for the wellbeing of non-indigenous members of their community as well. Orakei Health were empowering their broader Maori and non-Maori community towards self-determination through providing a pathway for them to navigate, consider and utilise state health resources for personally defined interpretations of improved wellbeing; so self-determination of wellbeing. Self-determination, on these terms, appears to have been less about indigenous rights and more about indigenous methods providing pathways to community empowerment.

8.3.2 Constructive engagement with health authorities, the state, the Crown

A critical issue for Orakei Health development was the significant number of health sectoral changes throughout the 1990s, which were seen as taking a negative toll on Maori health initiatives and developments, and their frustrations showed in a 1998 document below:

We consider it imperative to identify practical structures and technologies to keep abreast of the changes in the current health system. Each time change occurs in the health sector, Maori health seems to take a dive and then stabilises until the next change. Usually this occurs with changes in government policy (Stephens & Ngati Whatua o Orakei Health Clinic, 1998, p. 15).

This frustration with health sectoral changes was borne out in a 2000 review of the Orakei Health services when they found one of the key barriers to Maori participation and service development for Orakei Health was the governments contracting policies for Maori health development:

...the duplication of contracts given to other Maori health agencies and Auckland Healthcare has each vying for the same clients. The outcomes are often confusion for the clients and workers (Ngati Whatua o Orakei Health Clinic, 2000a, p. 1).

I observed that Orakei Health realised that their clinical and organisational development was dependent upon government policy for Maori health development, and the contracting practices of the health authorities. In the competition for the highly populated and urbanized environment of Auckland, Orakei Health was facing competition from Te Ha o te Oranga of Ngati Whatua, Te Whanau o Waipareira, and numerous other Maori health provider organisations created in South Auckland under the

Tainui MAPO Strategy in the 1990s (Ngati Whatua o Orakei Health Clinic, 2000a). In the change from 2000 to health funding based on population size and dynamics, the Maori health providers, who were very small in comparison to the large Auckland IPA of ProCare, began to look to ways to increase their enrolments, which often meant moving services into suburbs with a higher population density. In addition to the Maori health providers, there were also a number of Pacific health providers being established during this period. Orakei Health, with its base in central Auckland on its marae with a nearby population of around 1,000 Maori, was not in a good position to maintain growth within the new funding regime. They formed an alliance with Healthcare Aotearoa, as one way of mitigating the onerous management and administration challenges of the health sectoral changes on small provider organisations. The focus for the early 2000s thus became one of creating alliances and consolidating services in order to survive.

8.3.3 Matauranga - Ngati Whatua o Orakei Health Clinic

The matauranga Maori knowledge underpinning Orakei Health development was *Whanaau Ora* by Lewis Stephens (1988) of Ngati Whatua o Orakei Health Clinic (see Appendix 1).

Alignments with the matauranga Maori knowledge of other Maori health organisations in the Ngati Whatua health sub-region included: *Whanaungatanga* by Pa Henare Tate and (as conceptualised Te Puna Hauora o te Raki Pae Whenua and underpinning Orakei services delivered at Te Puna Hauora – initially the Smoking Cessation Program Auahi Kore).

The matauranga based tikanga service delivery model of Orakei Health was the Whaanau Ora model (see Appendix 1). The matauranga and tikanga of Orakei Health are presented in Tables 4 and 5 with the other case study organisations in the conclusion of this chapter.

8.3.4 Summary – Ngati Whatua o Orakei Health Clinic

Orakei Health is based on Orakei marae, a Ngati Whatua hapu or sub-tribe community living on a few acres of land returned by the Crown in the 1980s, close to the central business district of Auckland. As such they are surrounded by an extensive non-Maori urban population. The establishment of the health clinic provided a vehicle for building co-operative co-existence between the Ngati Whatua peoples based at Orakei, and the

urban population in the vicinity. The Orakei clinic, like the Te Puna Hauora, also provided a reason for non-Marae affiliated peoples of both Orakei and Awataha marae respectively to come onto the marae grounds and become familiar with the communities there. Orakei Health, like Te Puna Hauora, noted a significant number of ‘new’ New Zealanders, from a number of different ethnic communities opting to register with their services rather than nearby non-Maori health providers.

The primary matauranga for Orakei Health was Whaanau Ora towards community empowerment. The most significant challenge to Orakei Health for their development was the number of changes to the health funding and health policy environments, and the overlapping nature of health funder contracts given to a number of health provider service organisations in and immediately around the vicinity of Orakei Health throughout the 1990s and into the early 2000s. Despite these challenges, Orakei Health held very firmly to their matauranga and tikanga Maori, as will be seen in the two constructive engagements discussed in chapter 9, both of which were based on community empowerment, rather than organisational development.

There were two key constructive engagements occurring for Orakei Health over the study period: (1) With the community, in terms of facilitating health system collaboration with families (rather than families having health systems dictate their healthcare); (2) With health authorities, Crown and State, in terms of developing alliances towards collaborative approaches to health service provision and delivery.

In Chapter 9 two Ngati Whatua o Orakei Health Clinic models for hauora kotahitanga, based on some of the information, knowledge and experiences discussed in this chapter, are conceptualised as a Whaanau Ora model, and as a Kia Tu Kia Puawai Orakei model.

8.4 An introduction to Te Roopu Taurima o Manukau intellectual residential rehabilitation organisation RIDSAS case study

Te Roopu Taurima has been included as a case study organisation because it was not an organisation created under the MAPO strategy, and because it was an ‘intellectual disability’ service provider rather than a ‘health’ service provider. Te Roopu Taurima was not contracted to a MAPO, but had met with the MAPO teams in the regions in

which they delivered services. Te Roopu Taurima has been included so that the experiences of an organisation delivering services in the Ngati Whatua region, but not contracted to the MAPO, can be considered. Te Roopu Taurima has a whare in Glorit, in the South Kaipara area of the Ngati Whatua region. The Chairperson of Te Roopu Taurima at the time of the study, John Marsden, was Ngati Whatua. Two of the kaumatua and kuia, Whero and Kathy Nahi, as well as a Training and Development manager, and an HR manager, at the time of the study were also Ngati Whatua.

In 1990, Tui Tenari, a Maori nurse from Mangere Hospital and Mangere St Johns Home for people with intellectual disabilities, worked to establish “culturally appropriate services” for the Maori and Pacific Island peoples who were about to be deinstitutionalised under a health sector review which was closing hospitals for the intellectually disabled (Tenari, 2009, p. 22). The whanau of the Maori patients were consulted throughout the country, and all agreed they wanted services “that acknowledged that their whanau member was Maori” (Tenari, 2009, p. 22). The first whare opened for Maori services was in 1991 and by 2009 there were 49 whare in the service, throughout New Zealand, with 205 mokopuna³⁴, and 460 kaimahi³⁵ (Tenari, 2009, p. 22).

This case study has been placed last in this case study chapter because it is the organisation that uses te reo Maori the most; hence the reader will be exposed to more te reo in this case study than in the previous ones. This was done on purpose – to allow the reader who is not familiar with te reo to slowly come to a level of comfort through the other case studies with their sprinkling of te reo, before getting to this case study and hopefully reading both English and te reo with confidence. In Appendix 9 there is an example of case study feedback which includes a chapter I was invited to contribute to Te Roopu Taurima o Manukau as a reflection of my time with them. The CEO had agreed to my doing the case study with them, but only if I would work 20 hours a week helping them put their human resources systems in place. This case study was undertaken as a combination of work and observations in 2005.

³⁴ Mokopuna is the organisational term for a patient

³⁵ Kaimahi is the organisational term for a staff member

8.4.1 Constructive engagement with health authorities, the state, the Crown

The organisation became a charitable trust in 1992 with John Marsden of Ngati Whatua the original Chairperson. In 1998 the organisation applied to the health funding authority for funding to become a Maori health provider contracted to the Ministry of Health for services to Maori intellectually disabled people. Up until this point the Maori services that had devolved out of the hospitals had been delivered under Spectrum Care Trust. Gwen Te Pania Palmer, a Maori Nurse, who had previously been a manager at the Maori Health Development Division of North Health and was now with the Health Funding Authority, assisted Te Roopu Taurima in gaining Maori Provider Development Scheme funds to create the Te Roopu Taurima o Manukau Trust organisation, and on 1 November 1999 the trust began its independent journey. I observed that subsequently, Tui Tenari negotiated with Health Funding Authority disability team to secure a contract for service that would include the kaupapa Maori of the trust, and have a contractual provision for the tikanga Maori of the organisation to be implemented (Tenari, 2009).

I observed that by 2009 the organisation held ten contracts, the majority with the Ministry of Health for residential and Regional Intellectual Disability Supported Accommodation (RIDSAS) services. The RIDSAS services, the focus of this study, were developed to implement services under The Intellectual Disability Compulsory Care and Rehabilitation Act 2003 (IDCC&R Act), and to a lesser, but related extent, the Criminal Procedure Mentally Impaired Persons Act 2003 (CPMIP). The services were developed to provide residential rehabilitation for mokopuna with ‘high complex needs’ and some with “severe challenging behaviours and who could not be placed elsewhere” (Muller, 2009, p. 106). During the consultation process with the Maori community in the early 1990s, it was made clear what whanau and the community wanted for their own people:

They wanted the intellectually disabled to know that they belonged to an iwi; they belonged to a hapu; they belonged to a whanau; they belonged to a marae; they belonged to the land, that they and their tupuna were born in. And they belonged to the rivers, to the hills, and to the mountains. They had whanau who wanted to participate in their lives and include them in theirs. It was promised to whanau that this would be done. Te Roopu Taurima would provide a service, loosely termed at the time as ‘kaupapa Maori services incorporating tikanga Maori (Tenari, 2009, p. 22).

I observed that although the organisation was created to be a Kaupapa Maori Service for Maori by Maori under the board direction of Te Titiro Whakamua (Te Roopu Taurima o Manukau, 2006, p. 28), in practice there are both non-Maori kaimahi and mokopuna. The Te Roopu Taurima tikanga based model for RIDSAS has become so highly regarded by the industry that it has been adopted by non-Maori service providers. The focus of the organisation is the rangatiratanga of all of the people who are integrated into the service, patients, staff, communities, and their whanau. The organisation's whakatauki is:

Rangatiratanga mo tatou katoa irunga i nga tikanga o tena o tena o tena. Self-determination for everyone under the auspices of each individual person's right, regardless of disability, gender or race (Te Roopu Taurima o Manukau, 2006).

The organisation expects all staff to assist patients in achieving their 'rangatiratanga'; expectations which effectively imbue the organisation with matauranga Maori knowledge and tikanga Maori methodologies:

All Maori people with a disability receiving support from Te Roopu Taurima O Manukau are entitled to an environment which supports the development of their Rangatiratanga, acknowledges their whakapapa, respects their tribal kawa, and supports the use of Te Reo. All service areas and its Kaimahi are expected to strive toward meeting the following: Pursues the achievement of Rangatiratanga; Participates in, and develops Iwi networking and Maori development; Implements Maori Tikanga in daily lives and systems; Understands and practices Whanaungatanga; Communicates in writing and orally in Te Reo Maori; Demonstrates in-depth knowledge of Tikanga Maori; Recognises and respects kawa of different Iwi (Te Roopu Taurima o Manukau, 2006).

I observed that the challenge for the organisation was always going to be, in a service such as RIDSAS, was how to implement tikanga. One of the people charged with achieving this within Te Roopu Taurima RIDSAS service was Justin Matangi (Muller, 2009, p. 105) who explains their journey in his own words as:

It was not foreseen that mokopuna subject to the IDCC&R Act would gain positive momentum while under a restrictive legislative regime, but now we have young men and women engaged in cultural activities that ooze 'rangatiratanga'. From mau rakau to whakairo and daring to romance with kapa haka, these few initiatives have gained momentum in positive ways. Alas, all was 'not cool' in the garden of RIDSAS. We first had to fertilise the somewhat stubborn section of the orchard that is 'whanaungatanga' (building relationships, camaraderie, common grounds, friendships and understandings). It was this 'hua' (fruit) that permitted mokopuna to view their world through differing prisms of light (Matangi, 2009, p. 120).

The systems and processes of the organisation were originally specifically designed as a tikanga Maori model called Whariki Whakaruruhau:

A performance appraisal system was developed and named tauira poutama, as well as a governing document whariki whakaruruhau which incorporated three patterns interwoven. One pattern was for mokopuna, one pattern for the kaimahi and one for the roopu. Tikanga was written and interwoven into the whariki whakaruruhau. It was developed to monitor the quality of services (Tenari, 2009, p. 25).

The constructive engagement I observed with most interest was two roles that had been developed within the organisation to facilitate tikanga Maori. These roles were within the RIDSAS service whare; the houses where the mokopuna under the RIDSAS service lived. One of the roles was 'Kaiarahi' and they were trained in 'high complex needs' supervision, and would provide assistance across the various whare so that there was consistency of intervention management for kaimahi and mokopuna. This specialised role developed specifically for the RIDSAS service has now become a recognised component of the organisation's collective employment agreements.

I observed that, as can be seen from the description of tikanga within the RIDSAS services above, many aspects of matauranga Maori were used to develop a sense of rangatiratanga for the mokopuna. Kapa haka, which is the process of learning Maori knowledge through performance of intricately ritualised waiata or chants and co-ordinated movements, is practiced to implement matauranga and tikanga. A key challenge in terms of implementing matauranga through tikanga methods such as kapa haka within an organisation such as Te Roopu Taurima is the training, development, and retention of a skilled workforce, particularly with the added complexities of managing mokopuna entering the RIDSAS service. Te Roopu Taurima do not believe in locking people up or locking people in, so mokopuna who are under compulsory care orders and must be supervised at all times, are literally supervised at all times. In many non-Maori organisations with people under compulsory care orders, locking them up or in is one method of service delivery.

I observed that the challenges of adopting a full time supervision model for the RIDSAS mokopuna included creating models for training, assessing and developing the kaimahi who would work with the mokopuna. The critical issues to be balanced in the training and development include: matauranga and tikanga Maori of the organisation, matauranga

and tikanga Maori of the mokopuna, health and wellbeing needs of the mokopuna, social and training or employment needs of the mokopuna, living and residential needs of the mokopuna, health and safety of the mokopuna and kaimahi. On top of this they needed to be conversant with the judicial requirements of the compulsory care orders in terms of moving with the mokopuna outside of the whare.

To address these training and development needs, several modules of training were developed which could be taken throughout the employment experience of the kaimahi. The first three modules were compulsory, with the first delivered as a training induction of several days duration into the organisation, the second assessed on the job, and the third, also taking several days to complete a follow up to induction training. Several modules were created to train kaimahi so that they could progress through promotional levels within the organisation.

I observed that the matauranga and tikanga of the organisation required that the rangatiratanga of the mokopuna, kaimahi and roopu be given primary importance. By enhancing the kaimahi rangatiratanga within the roopu through effective training and development, they would have enhanced abilities to facilitate the rangatiratanga of the mokopuna and the roopu. With these internal dynamics of rangatiratanga addressed, the kaimahi then were part of the roopu as they constructively engaged with iwi Maori to ensure the rangatiratanga of the communities in which Te Roopu Taurima whare were to be located was also understood and implemented where appropriate. Weaving these threads together were two roles created specifically to implement Whariki Whakaruruhau - 'korowai aroha', and 'whaea manaaki', which are explained in more detail below and in Chapter 9.

8.4.2 Constructive engagement with iwi Maori and non-Maori

One of the most intriguing elements of Te Roopu Taurima kaupapa and tikanga that I observed was that when they open a new whare in a new town, the kaumatua, kuia, management, and kaimahi, travel en masse to the locality and meet with the marae, iwi and Maori organisations in that locality, laying down or placing of the 'take' or issue to be discussed as the potential establishment of a new whare in the locality. They also explained that the kaupapa and tikanga of Te Roopu Taurima was that the kaupapa and tikanga of the local iwi and marae be paramount for constructive engagements between Te Roopu Taurima and the local people and marae.

In 2005, new whare were to be opened in Kaitaia, which is the northern most town in New Zealand. Te Roopu Taurima met with the local marae, iwi and Maori organisations over several months. What I observed that the kaumatua, kuia, and management said to the local people in these meetings was that some of their mokopuna who had whakapapa into the local region had expressed a wish to move closer to their homelands, and that Te Roopu Taurima were committed to developing their services through establishing whare where mokopuna could reintegrate with their iwi, marae, and spend more time with their whanau.

I observed that Kaumatua and kuia from the localities of Kaikohe/Kaitaia, and the Waikato region, became part of Korowai Aroha to facilitate this integration, and where possible the kaimahi were also employed locally, or were long term kaimahi who wished to move from the Auckland services closer to their whanau, iwi and marae. Some of the challenges for Te Roopu Taurima of moving mokopuna back into their family localities are best described by whanau of the mokopuna. Haare Waiomio is here talking about his adult son Edward, who was in a Te Roopu Taurima home in Auckland, and Te Roopu Taurima were proposing to move him to a new home in Te Tai Tokerau, in the north where his whanau are from:

There was reluctance to have Edward back in Te Tai Tokerau as most of Edward's whanau at Matawaia would give him sweets, chocolates and coffee, which was no good for his cellulitis ...[then reflecting on after Edward moved back] ... There has been a big change in Edward, he is much happier and is active at the marae in Matawaia. I recall a time Edward saw a whakairo of a man poking his tongue out. So Edward imitated the whakairo ... that's how I know Edward is fine. Edward is learning te reo Maori and goes to the marae a lot now (Waiomio, 2009, p. 130).

Te Roopu Taurima RIDSAS services are accessed by people who have been referred by the RIDCA into their services. In the Tai Tokerau, Ron Bowmar is an Intensive Service Co-ordinator for Access Ability. This is his experience of Te Roopu Taurima as recounted for the 10 year celebration, and note his use of the Te Roopu Taurima term 'roopu kaimahi':

Te Tai Tokerau service is for clients who are at the end of their rehabilitation, and who are preparing to move back into the community ... we have had a number of successful transfers back home ... I don't know of any of the people who have left the Te Tai Tokerau service who have returned into RIDCA. This of course is the aim of the far north service, and again speaks volumes for the care and

support that these people have received, who have been rehabilitated to the degree that they make successful transitions back into the community. ... The best aspect of this service is that the people of Te Tai Tokerau RIDSAS are at the centre of their own programs. Together, the roopu kaimahi work so well with the individual person and whanau, that everyone appreciates the efforts of each other” (Bowmar, 2009, p. 116).

I observed that Te Roopu Taurima was recognised by non-Maori organisations as providing good services, as the Bowmar quote above shows. Towards the end of this case study research in 2006, Te Roopu Taurima were approached by the Ministry of Health to deliver their RIDSAS services in the South Island to mainly non-Maori mokopuna; a service which they now provide. The Manager of the South Island service explains in her recollection of the set-up of the service that the first task in 2007 prior to set up was to meet with and gain the support of Ngai Tahu, the local iwi (Todd, 2009, p. 125). Todd describes this Te Roopu Taurima venture as ‘Kaupapa in mainstream’:

... often mokopuna enter the service frightened and angry individuals who have little to look forward to. To look at the smiles and excitement on their faces as time goes by and to hear their stories about the activities they have taken part in; to see the pride on their faces when they show you their latest achievement; ensures that we all stay true to the kaupapa of our service (Todd, 2009, p. 124).

Zane McDonald, one of the mokopuna in the South Island service explains his experience of Te Roopu Taurima:

Since being at Te Roopu Taurima I have won two awards. The first at the recognition hui for ‘Most Outstanding Mokopuna’ and also one at the garden competition for ‘Most Outstanding Mokopuna’. I got these awards and prizes because of my stone carving and how hard I work at them. I have a talent in carving and have made lots of stone carvings, One is in the office in reception. I am very proud of this ... I like living at Te Roopu Taurima because its good fun and I don’t get in trouble anymore with the cops (McDonald, 2009, p. 136).

I observed that the Ministry of Health were therefore funding a Maori organisation to deliver kaupapa Maori services in the South Island to predominantly non-Maori patients within a predominantly non-Maori community, through predominantly non-Maori staff. The success of the kaupapa Maori model in being able to be applied within a predominantly non-Maori community has seen the service in the South Island expanded to four whare in 2009 (Todd, 2009). The organisation’s matauranga and tikanga was therefore able to be used by non-Maori staff for non-Maori mokopuna in a way that led

to significant and speedy growth of their services in the South Island within two years of their establishment.

8.4.3 Matauranga - Te Roopu Taurima o Manukau

The matauranga Maori knowledge underpinning Te Roopu Taurima o Manukau development was Rangatiratanga as explained in their tikanga model Whariki Whakaruruhau by (see Appendix 4). The organisation interprets 'rangatiratanga' in the organisation's whakatauki for the mokopuna (patients), for kaimahi (staff), and for the roopu (organisation) as:

Rangatiratanga for mokopuna to develop and achieve independence. No matter how severe the disability is, or how small the task that they learn to do for themselves, they can develop their rangatiratanga. Rangatiratanga for kaimahi, means assisting staff and educating them to have skills to develop a career pathway, by means of completing a certificate, diploma or degree course. Rangatiratanga for the roopu is to grow, to be viable so that people who contract to us have confidence in our ability to provide a quality service. We ensure that what we promised whanau, years ago, we will honour it and continue to provide a Maori service (Te Roopu Taurima, 2009).

The matauranga based tikanga service delivery model of Te Roopu Taurima o Manukau was the Whariki Whakaruruhau (see Appendix 4). The organisation is supported by a network of kaumatua and kuia called Korowai Aroha, which translates as a 'cloak that embraces us with love and support' (Hona, 2009, p.55). The primary document guiding the services of Korowai Aroha is Nga Ratonga Tikanga Maori. The secretary to Korowai Aroha describes it as:

This blueprint gave guidelines for incorporating tikanga Maori within the services of the roopu. It is simple, yet has universal application. It supported and respected each individual's kawa, history and beliefs. Korowai Aroha were the kaitiaki of these tikanga guidelines, its monitoring and adherence. Nga Ratonga Tikanga Maori is still used as the founding document for implementation and conduct of tikanga Maori (Hona, 2009).

The matauranga and tikanga of Te Roopu Taurima o Manukau are presented in Tables 4 and 5 with the other case study organisations in the conclusion of this chapter.

8.4.4 Summary – Te Roopu Taurima o Manukau

Te Roopu Taurima has succeeded in becoming both a respected industry provider, and a respected Maori organisation. They have managed to fuse matauranga and tikanga

Maori, not only into the fabric of the organisation, but also into the home environments created for the mokopuna in the whare, and into the mixed Maori and non-Maori communities in which there are Te Roopu Taurima whare.

Their model is somewhat different to the other organisations studied in this thesis because they have a residential model that also requires elements responsive to Ministry of Justice compliance under the IDCC&R and CPMIP 2003 Acts; they have successfully fused matauranga and tikanga Maori within New Zealand health, disability and justice systems, and within Maori and non-Maori communities the length and breadth of New Zealand. Their primary matauranga was rangatiratanga as ‘self-determination for everyone’.

There were two key constructive engagements occurring for Te Roopu Taurima o Manukau over the study period: 1) With health authorities, Crown and State, in terms of developing collaborative approaches to criminal justice/intellectual disability service provision and delivery; (2) With iwi Maori and non-Maori, in terms of facilitating services in multiples communities to be cognisant of, and where practicable, to be based as much as possible upon the local kaupapa and tikanga.

In Chapter 9 a Te Roopu Taurima model for hauora kotahitanga, based on some of the information, knowledges and experiences discussed in this chapter, is conceptualised as a Korowai Manaaki model.

8.5 Conclusion – Case Study Chapter

One of the aims of this case study chapter was to show how health sectoral and policy changes affected the operationalisation of Maori health provider organisations. Rather than do this in an in-depth manner with all of the case study organisations, the first case study organisation, Te Puna Hauora, was more broadly examined so that the dynamics and challenges to Maori of operationalising one Maori health provider organisation within a decade of radical changes to the health sector could contextualise the health environment in which the other case study organisations were also developing and operating.

The purpose of this chapter was also to examine the matauranga and tikanga of the organisations, and to explore some of the constructive engagements facilitated by the

individual case study organisations. Some of the constructive engagements of the case study organisations are discussed in more depth in the following chapter.

To conclude the examination of matauranga and tikanga for the case study organisations, there was consistency and overlap between the provider organisations in terms of their expressed and practiced matauranga. This consistency was irrespective of whether the organisation was an Ngati Whatua aligned organisation or not. This indicates there was some universality of matauranga between the hauora organisations.

Organisation	Matauranga Maori of organisation
Te Puna Hauora	Whanaungatanga, Whaanau Ora
Te Ha o te Oranga	Whanaau Ora, Whanaungatanga, Rangatiratanga
Ngati Whatua Orakei Health	Whanaau Ora, Whanaungatanga
Te Roopu Taurima	Rangatiratanga

Table 4: Matauranga Maori of Provider organisations

The tikanga of the organisations were each unique to their communities and the services that evolved. There were a number of reasons that Te Puna Hauora and Te Ha o te Oranga were using the same tikanga model, firstly they had some significant crossovers in governance and management members, and secondly they co-delivered some services.

Organisation	Tikanga Maori Service Delivery Model
Te Puna Hauora	Harakeke - I-MAP
Te Ha o te Oranga	Harakeke - I-MAP
Ngati Whatua Orakei Health	Whaanau Ora
Te Roopu Taurima	Whariki Whakaruruhau

Table 5: Tikanga Maori (service delivery models) of Provider organisations

The constructive engagements discussed in this chapter were only some of the ones observed or discussed in the organisations during the case study period. There were many more that were recorded. The examples chosen for this chapter each provided some insight into how each organisation was constructively engaged with their communities, and how this was influencing their development as an organisation. Although all of the organisations were dealing with similar issues, and often similar external people; in their construction of their engagements they had quite unique responses to these issues and people. This organisational and community uniqueness of tikanga, even though there were similarities across the organisations in terms of matauranga, has provided a number of intriguing examples of tikanga that can conceptualised as models for kotahitanga. These are developed and explained in more depth in the next chapter.

Chapter Nine

CONCEPTUALISING KOTA HITANGA MODELS

9.1 Introduction

In Chapter 7, the Tihi Ora case study outlined how a Maori purchasing organisation was established between Ngati Whatua iwi as the mana whenua iwi, and North Health from 1996. The creation and evolution of the Ngati Whatua MAPO organisation, Tihi Ora, was explained, along with how it functioned through until the government review of the MAPO in 2003. The matauranga of Tihi Ora was identified, and the matauranga based tikanga service delivery models created by Tihi Ora were discussed in terms of constructive engagements with the Tihi Ora communities. As part of the MAPO strategy implemented from 1996 by Tihi Ora and North Health, four primary care providers were created and these were studied in Chapter 8.

In Chapter 8, the provider case study organisations were introduced and their development was discussed within the context of indigeneity-based health developments occurring during multiple health sector and policy reforms in New Zealand in the 1990s and early 2000s. The matauranga of each organisation was identified, and the matauranga based tikanga service delivery models created by each of the organisations were discussed in terms of how each organisation constructively engaged with their communities. The constructive engagements discussed in Chapter 8 were synthesised from a number of case study examples that were collected. This synthesis was in part to show the breadth of constructive engagements occurring across the case study organisations, and to highlight the uniqueness of hauora Maori organisation and community ways of creating and achieving constructive engagements to facilitate developments.

The purpose of Chapter 9 is to conceptualise models for kotahitanga through synthesis of the information and knowledge gathered about the matauranga and tikanga of each of the case study organisations. The organisational matauranga have become mohiotanga through the tikanga of these organisations, and these conceptual models are an interpretation of these experiences as models for hauora kotahitanga.

What is interesting about many of these conceptual models is that they reflect practices which often seem to be such a normal part of te ao Maori for the people in the case study

organisations that they don't even explain, describe, include, or reflect upon them when considering their service delivery or organisational models.

The chapter begins with Tihi Ora MAPO, as the mana whenua health purchasing organisation. Then the provider organisations, Te Puna Hauora o te Raki Pae Whenua, Te Ha o te Oranga o Ngati Whatua, Ngati Whatua o Orakei Health Clinic, and Te Roopu Taurima o Manukau are considered.

9.2 Tihi Ora MAPO

9.2.1 Conceptualised hauora kotahitanga models

The Tihi Ora matauranga identified in Chapter 7 were rangatiratanga, whanaungatanga, and kotahitanga. The tikanga Maori service delivery model of Tihi Ora was the MAPO Strategy, and this was also discussed in Chapter 7. In this chapter, two hauora kotahitanga models are conceptualised from the information, experiences and knowledge considered from the Tihi Ora MAPO case study. The first is the Kaunihera model based on the matauranga of rangatiratanga, and the second is the Ngati Whatua Kotahitanga model based on the matauranga of Ngati Whatua kotahitanga.

9.2.1.1 Kaunihera Model

The Kaunihera is a conceptualised model of the constructive engagements that occurred with North Health. The experiences of Tihi Ora MAPO that resulted in this conceptualising of a Kaunihera model are described in chapter seven. To briefly summarise, each of the three MAPO were invited to appoint three Rangatira Hauora to join board members of the Northern Regional Health Authority in providing a Kaunihera, which was basically a governance council, for Maori health issues arising through MAPO and North Health activities. The Kaunihera, consisting of the Rangatira Hauora of the three MAPO survived the demise of North Health in 1996 and, without its North Health partners, evolved to continue providing governance level advice to the State health funder organisations that superseded North Health and the Crown until 1998 when it was unilaterally disestablished by the Crown.

The Kaunihera Model is evaluated here using Maaka and Fleras (2005, p. 52) simple framework for evaluating four levels of Sovereignty/Models of self-determining authority. This framework is used in the analysis of the Kaunihera and Kotahitanga

Proposal models only, and not the provider organisation models in this thesis because the MAPO organisation was the only case study organisation that had a Treaty of Waitangi iwi based relationship with the health funder.

Maaka and Fleras propose that indigenous self-determination is generally found along a continuum where statehood represents legal sovereignty, nationhood represents de-facto sovereignty without the right to secede, community represents functional sovereignty through local autonomy, and institutional represents nominal sovereignty or in name only sovereignty (2005, p.52).

The Kaunihera had delegated authority to a board that contained representatives from the three MAPO, and representatives from the Northern Regional Health Authority (Eruea, Grace, Stewart, Tepania Palmer, & Shea, 1998). The Kaunihera placed the iwi three MAPO into an 'institutional sovereignty' level relationship with the Crown. However, the Health Funding Authority in 1998 described the MAPO as having had a 'regional type governance relationship' (Cooper & Health Funding Authority, 1998, p. 2). I concluded that the Kaunihera could also be interpreted as in a 'community sovereignty' level relationship with the Crown on the Maaka & Fleras scale (2005, p. 52) based on hui observations including the one presented below.

In 2000 the Crown proposed to hold two positions open for Maori representatives on the newly created District Health Boards. Had the Ngati Whatua MAPO been one of the two Maori representatives under this arrangement, it might have continued the Ngati Whatua MAPO 'institutional and community sovereignty' with the Crown. However, with Ngati Whatua only potentially holding one or two board positions on a large board, the Rangatira Hauora did not see this as being as effective as the 50% decision making ability they had held previously with the Kaunihera. The decision was made by Ngati Whatua to continue to negotiate for a continued 50/50 governance relationship with the Crown for Maori health developments and the offer for positions on the board were not accepted by the iwi who proposed further consultation and negotiation. The Crown subsequently unilaterally appointed a Maori of Ngati Whatua descent to the board without consulting with the iwi, as is indicated below in the case study observation.

Case study observation Vignette 2: When District Health Boards (DHBs) were set up in the early 2000s the Crown indicated they would hold two positions for Maori representation on each of the DHBs. The Rangatira Hauora of Ngati Whatua was called by an individual of Ngati Whatua descent who told him that he had been appointed to the DHB as a Maori representative. The Rangatira Hauora called Te Runanga o Ngati Whatua and established that this appointment had not been at the instigation of the Runanga or Tihi Ora.

The Rangatira Hauora said he had two options, firstly not to assist the individual on the basis that the Crown had ignored the processes established through the Kaunihera arrangement, or secondly, to assist the individual on the basis that they had whakapapa to Ngati Whatua and were an unfortunate victim of Crown machinations rather than an individual seeking to undermine their own iwi. The Rangatira Hauora chose the latter option. But, as he commented at the time, it was yet another example of the Crown trampling over the mana of the iwi, and compromising the iwi right to choose their representation. He also, somewhat humorously, indicated that when there were transgressions from the Ngati Whatua side on hauora issues to do with the Crown he did not hesitate to pull the person or people concerned onto the marae to re-explain and correct processes with them, but that the Crown was such a nebulous actor it was impossible to find the individuals responsible for such transgressions on the part of the Crown and it was therefore impossible to pull them into the marae for a good telling off.

9.2.1.2 Ngati Whatua Kotahitanga Proposal Model

The Ngati Whatua Kotahitanga Proposal is a conceptualised model of the constructive engagements that occurred with the Crown. The experiences of Tihi Ora MAPO that resulted in conceptualising this Ngati Whatua Kotahitanga Proposal model are described in Chapter 7. Runanga o Ngati Whatua pursued a ‘kotahitanga proposal’ with the Crown through their health strategies (see Chapter 7). They defined themselves through their MAPO relationship as: “the” treaty partner for particular government ministries (Cooper & Health Funding Authority, 1998, p. 2). They also communicated to the Crown, state and health sector that the MAPO model was the preferred strategic model for Ngati Whatua Maori health and development for peoples within the region of Ngati Whatua

(Te Tai Tokerau, et al., 2000, p. 13). They also defined the MAPO as a Maori health authority (Te Tai Tokerau, Tihi Ora, & Tainui MAPO, 2000, p. 4), which, if treated like other New Zealand health authorities could have presumed delegated authority for implementation of health policy, and management of health resources.

I concluded that through their Kotahitanga Proposal, Ngati Whatua was seeking to achieve what Maaka and Fleras call an “indigenous-determined model for self-determination” (2005, p. 293). However, the initial initiative that established the MAPO Strategy was created by the Northern Regional Health Authority, so the relationship that existed could be interpreted under the Maaka and Fleras description as more reflective of a “state-determined model for self sufficiency” (2005, p. 293). This conclusion is based on hui observations, an example of which is below:

Case study observation Vignette 3: I attended a hui at Tihi Ora in 2002 where their proposal for Kotahitanga with the Crown was discussed with whanau, hapu, iwi just before the document was sent to the Crown. The one statement that really resonated positively with the participants and that came in for much positive discussion is produced below because it is a succinct summary of the Ngati Whatua Kotahitanga Proposal approach:

Our vision is to work in partnership with government, to be a full participant in resource allocation and policy decisions affecting Maori in the rohe, to achieve Kotahitanga for Ngati Whatua. The Runanga is ready to play a role that is in alignment with current government policy: the whole of government approach, improved relationships with iwi, and local solutions for local problems ... The Runanga seeks a robust Treaty-based relationship of equals and endorses the relationship principles included in the “Statement of Government Intentions for an Improved Community – Government Relationship” in so far as they support our Kotahitanga approach (Te Runanga o Ngati Whatua, 2002, p. 3).

The participants at the meeting all agreed that the position that was being taken by Te Runanga o Ngati Whatua was appropriate to a Treaty-based relationship of equals. It was also seen as the next logical step in relations with the Crown for the MAPO given that the current government were pushing for community participation and responsibility.

Once again, using the Maaka and Fleras (2005) simple framework for evaluating four levels of Sovereignty/Models of self-determining authority, the partnership model of Tihi Ora was based on an ‘institutional and community’ level of sovereignty (see the Kaunihera Model above). With their Kotahitanga Proposal, Te Runanga o Ngati Whatua were attempting to move towards a ‘community’ level of sovereignty as they were seeking equal responsibility for resourcing and decisions over all Maori in their region, not just Ngati Whatua Maori, but they were also proposing an “indigenous-determined model for self-determination” rather than a “state-determined model for self sufficiency” (Maaka & Fleras, 2005, p. 293).

From 2003, after the MAPO Review (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003), the Ministry of Health indicated it would be delegating all MAPO relationships to District Health Boards, effectively placing MAPO relationships into a fragmented form of ‘institutional and community’ sovereignty (Maaka & Fleras, 2005, p.52) because there was more than one DHB on Ngati Whatua mana whenua lands.

9.2.2 Tihi Ora MAPO Summary

As discussed previously, Maaka and Fleras simple framework for evaluating four levels of Sovereignty/Models of self-determining authority (2005, p.52) has been used for this case study organisation only because it is important to explain how the matauranga of rangatira (representation) and rangatiratanga (responsibilities) was treated by Ngati Whatua iwi and treated by the Crown partners in these constructive engagements for health developments. Ngati Whatua is the mana whenua iwi, so the matauranga of rangatira and rangatiratanga is considered in light of how Tihi Ora MAPO was used by the Ngati Whatua iwi to constructively engage as rangatira with the Crown for hauora Maori.

Te Runanga o Ngati Whatua, from the beginning of the MAPO strategy development, created Tihi Ora MAPO to fulfil the Ngati Whatua matauranga of rangatira and rangatiratanga. None of the other case study organisations have been used by the mana whenua iwi in this manner for constructive engagements with the Crown, so it would be inappropriate to evaluate them using this particular framework. Therefore only one of the case study organisations, Tihi Ora, is being evaluated using this framework.

Ngati Whatua matauranga Maori of rangatira and rangatiratanga for the MAPO prior to 2000 can be aligned with an ‘institutional’ (Maaka & Fleras, 2005, p. 293) based self-determination proposal, whereas the matauranga of kotahitanga from 2000 can be seen as moving towards a self-determination ‘community’ (Maaka & Fleras, 2005, p. 293) based sovereignty proposal, where both Te Runanga o Ngati Whatua and the Crown would have equal sovereignty in the Te Runanga o Ngati Whatua region for hauora for all Maori, including non-Ngati Whatua. Te Runanga o Ngati Whatua consistently maintained that any constructive engagements through their tikanga MAPO strategy would be based on the matauranga Ngati Whatua.

Te Runanga o Ngati Whatua proposed to co-operatively co-exist through living together differently as two sovereigns (Rangatira) in partnership (kotahitanga).

9.3 Te Puna Hauora o te Raki Pae Whenua

The Te Puna Hauora matauranga identified in Chapter 8 were whanaungatanga and Whaanau Ora. The tikanga Maori service delivery model of Te Puna Hauora was the I-MAP model, and this was also discussed in Chapter 8. In this chapter, three hauora kotahitanga models are conceptualised from the information, knowledge and experiences considered from the Te Puna Hauora case study. The first conceptualised model is ‘Mana Tauwi’, based on multicultural-social-integration with the non-Maori community, the second conceptualised model is ‘Te Tohu Kahukura’ based on best practice for Whanau Ora policy through integration with non-Maori community and organisation ideas and initiatives, and the third conceptualised model is ‘Mana Kaitautoko’ based on workforce and community enhancement through spiritual-philosophical integration by kaumatua and kuia networks.

9.3.1 Conceptualised hauora kotahitanga models

9.3.1.1 *Mana Tauwi Model*

The Mana Tauwi is a conceptualised model of the constructive engagements that occurred with the non-Maori community using the organisation’s Harakeke I-MAP service delivery model as a social-multicultural integrative tool. The knowledge, information and experiences of Te Puna Hauora that resulted in this conceptualising of a Mana Tauwi model are described in Chapter 8. One of the elements of Te Puna Hauora

that was often discussed in the community and organisation was the number of newly arrived New Zealanders who chose to integrate with the health and wellbeing services of Te Puna Hauora.

From 2008 Te Puna Hauora has had kaupapa Maori Asian services being delivered to the North Shore community. I concluded through hui observations that this example was reflective of the growing cultural mix that is part of Auckland's development, and shows how a Maori health development model may also be a model for co-operative co-existence between multi-cultural non-Maori peoples at the community level. There are a number of experiences used by Te Puna Hauora practitioners to explain their services to visitors and new staff that reflect this concept of a Mana Tauwiwi model. Some of these experiences, which I heard on numerous occasions during the case study hui observations' are repeated below.

Case study observation Vignette 4: *One often told story is of a family group from a war torn country who had been members of Te Puna Hauora for a while. One day while they were leaving Te Puna Hauora after an appointment, they came across a newly arrived to New Zealand family group from their old country. The two groups were the same family, and each had up until that point thought the other group had disappeared/perished in the conflict, so the reunion was highly emotional and within sight of a number of Te Puna Hauora staff. I heard this experience recounted a number of times and each time the majority of the participants of the hui were in tears. Often participants would speak about having previously seen issues of war/conflict in the media and not having related to them, but now that they actually shared a community with people who had lived through these experiences they were finding these conflicts and their associated cultural issues were impacting on a much more personal level with them.*

Another story told, mainly at training hui for new staff, was of a non-Maori practitioner taking a night time call out for a mental health issue to a rural area and after a long drive through unfamiliar countryside arriving at the top of the driveway to be greeted by a man holding a gun (he was a farmer so this wasn't unusual in the NZ countryside, but a gun was disconcerting for this urban raised practitioner – particularly in the pitch black dark of a dusty rural road with no street lighting). Quite overwhelmed with fright by this point, the practitioner arrived down the driveway and met with the whanau concerned who were quite certain the mental health issue of the patient was a spiritual rather than a physical issue, so the practitioner had to call for appropriate assistance and support for the spiritual aspects from other colleagues more experienced with such matters.

The story was told from the perspective of a successful outcome for the whanau concerned, and a positive learning experience for the practitioner concerned. I heard this experience recounted a number of times over the years of the study and each time, no matter who was telling it, the participants of the training meeting ended up on the floor in stitches of laughter. This experience became informally referred to by some staff as 'the gun and ghost' callout.

Both experiences were, in my opinion, used regularly because they showed how the mana of tauwiwi can be upheld even if the practitioner is not 100% certain of the issues, background issues, or the cultural dynamics of the interactions taking place. The use of story-telling to help visitors and new staff understand that all situations can have unusual elements, and to show how applying matoranga and tikanga can lead to positive outcomes for all participants was a key part of how the services of Te Puna Hauora developed. Face-to-face story-telling as the focus of the organisation's communication proved useful in providing a basis for social interaction between people, and a basis for cultural interactions between people and organisational participants such as clinical teams.

The I- MAP model was based on the matoranga of whanaungatanga and given that the organisation had over a quarter of its members coming from the refugee and migrant community, and a significant number of Pacifica members, along with around half of its members being from the Maori community, the I-MAP has provided an integrative model for both social and health wellbeing of communities based on multiculturalism, which is conceptualised here as the Mana Tauwiwi model.

9.3.1.2 Te Tohu Kahukura Model

The Te Tohu Kahukura is a conceptualised model of the constructive engagements that occurred with the health funders, the state, the Crown and communities using the organisation's Harakeke I-MAP service delivery model as a Whanau Ora policy tool. The knowledge, information and experiences of Te Puna Hauora that resulted in this conceptualising of a Te Tohu Kahukura³⁶ model are described in Chapter 8.

By 2004, Te Puna Hauora had been delivering their I-MAP model for five years. The Ministry of Health launched the Whanau Ora Awards so that Maori health services could come together and share knowledge and experiences, and celebrate successes under the broad umbrella of Whanau Ora, as the policy aim of *He Korowai Oranga* (King & Turia, 2002). The Ministry of Health awarded Te Puna Hauora the Supreme Award, Te Tohu Kahukura, for their Harakeke - I-MAP model which won as best Whanau Ora programme.

³⁶For media release on Te Tohu Kahukura award, see Appendix 3.

At the inaugural Whanau Ora Awards in 2004, the attending Maori health providers voted for Te Puna Hauora and Ngati Porou Hauora as the best Maori providers in the country, jointly awarding them the Matarau Supreme Award. This was reported in the NZ Doctor magazine:

What the judges said Te Puna Hauora o te Raki Pae Whenua Chosen [sic] because it demonstrated strong leadership, has a strong consumer focus, offers a wide range of services, has a whanau model of case management, embraces new immigrants and operates a PHO and governance model with strong Treaty and community orientation (NZ Doctor, 17 March, 2004).

I concluded through hui observations was that what the organisation had created was a model that was able to facilitate services for whanau in their community through integrating services contributed by government, non-government and community organisations, as well as training and development programmes for medical students, nurses, community carers, informal carers, and other clinical and health allied students and professionals. It is an example of a co-operative co-existence model between Te Puna Hauora as a Maori health provider, and other non-Maori and Maori organisations who chose to integrate their services with Te Puna Hauora for the benefit of the community members. Each of these other organisations constructively engaged with Te Puna Hauora to co-operatively co-exist on the basis of the Te Puna Hauora matauranga and tikanga for community best practice of Whanau Ora (King & Turia, 2002) policy.

9.3.1.3 Mana Kaitautoko Model

The Mana Kaitautoko is a conceptualised model of the constructive engagements that occurred with the workforce and community using the organisation's Harakeke I-MAP model as a spiritual-philosophical workforce and community enhancement tool as led by kaumatua kuia. The information, knowledge and experiences of Te Puna Hauora that resulted in this conceptualising of a Mana Kaitautoko model are described in Chapter 8. This model focuses on how the kaumatua and kuia practiced the matauranga and tikanga of the organisation to enhance the workforce and community of Te Puna Hauora. One of the most important factors in the consistency of service development and delivery for Te Puna Hauora was the role of their kaumatua and kuia. Their mana kaitautoko was integrated within the governance, management and operational structures of the organisation, and most importantly into every relationship between people inside, through and outside of the organisation. Their influence was particularly noticeable with

non-Maori staff members, who through the kaumatua and kuia had consistent access to support with the matauranga that underpinned the organisational tikanga.

One of the ways the kaumatua and kuia have held the organisational structure together is by having karakia and waiata at the beginning of every working day. This allows all staff to optionally attend a daily ritualised form of engagement with the te ao Maori, and the matauranga and tikanga of the organisation. In addition to providing the internal stabilisers for the matauranga and tikanga, the kaumatua and kuia practice the matauranga and tikanga in the community. Te Puna Hauora delivers services in the community, in schools, in pre-schools, in hospitals, at marae, at tertiary institutions; and in many other community based situations including people's homes. The kaumatua and kuia were available to assist in all of these situations through providing matauranga and tikanga guidance and practice. Obviously one of their skills was being able to imbue the situation with the matauranga and tikanga of Te Puna Hauora whatever the age, culture or needs of the people they were meeting with.

I concluded through hui observations that the kaumatua and kuia services were available to all Maori and non-Maori peoples accessing Te Puna Hauora services; this shows how a Maori health model may work well as a spiritual-philosophical model for constructive engagement at the community level. To explain what spiritual-philosophy based enhancement meant in practice, there are several case study hui observations are included below:

Case study observation Vignette 5: There are a number of small observations I made which might seem quite normal practice to Maori reading this, but will highlight for non-Maori some of the aspects of kaumatua and kuia within Te Puna Hauora that led me to conceptualise the Mana Kaitautoko Model. One example is when one of the kaumatua planted large vegetable gardens at the clinic, with the objective of getting staff and patients more involved in growing and using more vegetables. There were a number of benefits of this – strengthening linkages with Papatuanuku the earth mother, fitness and time outdoors gardening, eating more healthily by having plenty of vegetables available, eating more cost effectively by growing your own, having someone you could get planting and growing vegetable advice from.

Another example was when two of the kuia from the Awataha marae who had grown close to the staff when the clinic was previously based in offices near the Awataha marae kitchens and dining room where the kuia spent most of their time. When the clinic staff moved into new premises across the paddock from the marae, the kuia asked to do the cleaning of the clinic and premises, and when I asked them why they said it was because it was one way of keeping in touch with everyone on a daily basis. So they came in each day in the late afternoon before everyone left for the day so they could chat as they dusted and pottered about, much as you would in a normal family home.

What I noted with interest was how often they were asked for advice by staff on community and tikanga issues, and also how the staff organised their schedules to be in the office in the afternoons when the kuia arrived, which created a strong team ethic about spending time together and at their desks and chatting about the challenges of their days in an informal manner – because they were telling the stories to the kuia, but everyone else would chime in with thoughts and advice. I noted how these kuia were always included in hui and celebrations as respected community members. I noted how respectfully the kuia were treated as they were cleaning; it was always as though the staff felt their grandparents were around and cleaning up after them as a special treat – rather than there being any tone of condescension.

The kaumatua and kuia were doing things like gardens and cleaning, and at the same time they were treated with the deference generally seen for a chairperson of a multinational organisation. This created an organisational environment in which every person, Maori and non-Maori, in the organisation experienced the role of a kaumatua and kuia – so they were imbued with a more philosophical understanding of the role of kaumatua and kuia in a community or home setting than would have been possible if for instance a non-Maori member of staff had read a pamphlet on the ‘role of a kaumatua and kuia’ before inviting them to come out on a medical callout.

In another example, one of the kaumatua questioned me during my research, he said, 'dear, I've been asked to officiate at a ceremony for matariki'. 'But what is it they want the dawn ceremony for?' he asked, 'Matariki is just when we plant the potatoes'. I explained that it seemed to me that the Maori kids were a bit jealous that the Chinese kids who had a New Year celebration, so they wanted a celebration of their own and chose matariki to be the newly created Maori New Year. 'Oh', he said and wandered away looking somewhat perplexed. Anyway, he and many other kaumatua and kuia chose to support the new initiative coming from the young people and he ended up helping out a number of groups with their matariki celebrations. I thought it was a nice example of how the generations were able to come together through a health organisation for a community initiative that was being driven by youth. The kaumatua was able to imbue the proceedings with the correct amount of formal ritual and integrate Maori spiritual elements into community events that were for Maori and non-Maori, thereby providing an integrative spiritual-philosophical modelling of matauranga Maori for the community.

In another example, there was a young school aged child who was having many challenges. Their pakeha mother thought it could be because the young person was a Maori, and had an absent Maori father. So she asked the doctor for assistance, and the I-MAP team decided it might be a good idea for this child to spend time with kaumatua and kuia. So this young person began spending a few afternoons after school with kaumatua and kuia at the clinic to learn about being Maori by watching the kaumatua and kuia being Maori with the staff and children at the attached childcare centre. This significantly improved the mental health and social wellbeing of this young person.

The Mana Kaitautoko model as conceptualised above shows the community and workforce enhancement nature of spiritual-philosophical practices of kaumatua and kuia with both the Te Puna Hauora workforce, and the Te Puna Hauora community of service receivers. The kaumatua and kuia integrated spiritual-philosophical practices of Maori into the workforce and community by just doing what came naturally to them when practicing whanaungatanga and Whaanau Ora. They taught whanaungatanga and

Whaanau Ora by practicing whanaungatanga and Whaanau Ora. They enhanced the workforce and community of Te Puna Hauora through imbuing them with Whanaungatanga and Whaanau Ora. This knowledge and these experiences are conceptualised here as a spiritual-philosophical based workforce and community enhancement model called the Mana Kaitautoko Model.

9.3.2 Te Puna Hauora Summary

Te Puna Hauora matauranga and tikanga Maori have been practiced through their Harakeke - I-MAP model for service delivery and organisational design, organisational behaviour, and organisational development. The Harakeke - I-MAP encapsulates Te Puna Hauora interpretations of the matauranga of *whaanau ora* by Lewis Stephens and *whanaungatanga* by Pa Henare Tate (1999).

Three distinct features of the Te Puna Hauora matauranga and tikanga Maori that have been conceptualised as hauora kotahitanga models are: multiculturalism, best practice for Whanau Ora policy, and kaumatua kuia led workforce and community enhancement.

The Harakeke - I-MAP model is being utilized by numerous refugee and migrant groups as a socio-cultural model for broader community participation. In this way the Te Puna Hauora community has established a basis for living together differently through multiculturalism, as was evidenced by the establishment of kaupapa Maori Asian health services. In this way a tikanga Maori methodology evolved of Harakeke - I-MAP as a 'Mana Tauwi' social-cultural integrative model based on multiculturalism.

The Harakeke - I-MAP model is also the basis for co-operative co-existence between Te Puna Hauora community, health funders, the state, the Crown, and other communities towards strengthening communities. This is particularly evidenced by the integration of government, non-government, and other community ideas, initiatives, and services into the Harakeke - I-MAP service delivery model. In this way a tikanga Maori methodology has evolved from Harakeke - I-MAP as a 'Te Tohu Kahukura' model of best practice for Whanau Ora policy.

The Harakeke - I-MAP model became a 'Mana Kaitautoko' kaumatua kuia led workforce and community enhancement model, in particular because of the kaumatua and kuia networks underpinning the matauranga and tikanga of Te Puna Hauora within both the

organisation and the community. The integration of the spiritual-philosophical underpinnings of the matakā and tikanga of Te Puna Hauora within the community and workforce was accomplished in a number of ways by kaumātua and kuia through karakia, waiata, and celebrations of key Māori events such as matariki with the broader community. In this way the kaumātua and kuia led the tikanga Māori methodology of Harakeke - I-MAP as a workforce and community enhancement model through the implementation of its underpinning matakā; Whanaungatanga and Whānau Ora.

Te Puna Hauora proposed kotahitanga with others through their tikanga I-MAP model based on their matakā of whanaungatanga and whānau ora.

9.4 Te Ha o te Oranga o Ngati Whatua

The Te Ha o te Oranga matakā identified in Chapter 8 were rangatiratanga, whanaungatanga, and whānau ora. The tikanga Māori service delivery model of Te Ha o te Oranga was the I-MAP model, and this was also discussed in Chapter 8. In this chapter, two hauora kotahitanga models are conceptualised from the information, knowledge and experiences considered from the Te Ha o Te Oranga case study. The first is the Manawhenua model with non-Māori organisations, and the second is the Manaaki model with Māori organisations.

9.4.1 Conceptualised hauora kotahitanga models

9.4.1.1 *Manawhenua Model*

The Manawhenua is a conceptualised model of the constructive engagements that occurred with non-Māori health organisations based on Te Tiriti o Waitangi. The experiences of Te Ha o te Oranga that resulted in this conceptualising of a Manawhenua model are described in Chapter 8. In a Memorandum of Understanding establishing relationships between ProCare Health, a large IPA in the Auckland region, Te Runanga o Ngati Whatua emphasised the matakā manawhenua:

The Runanga has the core obligation of preserving the special historical, cultural and spiritual relationship of the people of Ngati Whatua within its tribal rohe/region which includes Tamaki Makaurau. This is enshrined in the concept of *manawhenua* (Te Runanga o Ngati Whatua & Procare Health Limited, 1998, p. 1).

In the same document, Te Runanga o Ngati Whatua defines their relationship with this non-Maori health organisation as being based on Aotearoa, rather than the Crown interpretation of New Zealand. It also defines the relationship as being based on Te Tiriti o Waitangi, rather than the Crown interpretation of the English language version of the Treaty. It also explicitly highlights the relationship between Tino Rangatiratanga and Kawanatanga in the Maori version of the Treaty, which are key contested elements between the English and Maori versions of the Treaty:

Both parties acknowledge the founding role in *Aotearoa* of *Te Tiriti o Waitangi* and the relationship between *Tino Rangatiratanga* and *Kawanatanga* (Te Runanga o Ngati Whatua & Procure Health Limited, 1998, p. 2).

Maori contend they retained their tino rangatiratanga, or sovereignty, but ceded kawanatanga, or governance, to the British Crown in the Maori version (Walker, 2001). By having this non-Maori health organisation agree to this clause in the Memorandum of Understanding, Te Runanga o Ngati Whatua was getting them to agree to upholding the Maori interpretation of how co-operative co-existence between Maori and non-Maori peoples should have been practiced from 1840. This non-Maori health organisation, through this agreement, showed they were more willing than the Crown to constructively engage with Maori on Maori terms, and to co-operatively co-exist with matauranga and tikanga Maori as the basis of their constructive engagements. Rangatiratanga through Te Tiriti o Waitangi was a dominant matauranga in this constructive engagement model.

9.4.1.2 Manaaki Model

The Manaaki is a conceptualised model of the constructive engagements that were facilitated by Te Ha o te Oranga with the other Maori primary health provider organisations in the Tihi Ora region. The experiences of Te Ha o te Oranga that resulted in this conceptualising of a Manaaki model are described in Chapter 8. As was explained in Chapter 8, Te Ha began a collaborative process with the other three Maori health provider organisations, Te Puna Hauora, Orakei and Waipareira. The idea was to create a MICO, or a Maori integrated care organisation.

The purpose of the MICO was to streamline and rationalise the management, administration and resourcing costs of the four provider organisations but unifying their systems and practices. While the CEOs of all four providers were willing to progress the Te Ha MICO initiative, Te Runanga o Ngati Whatua decided they did not wish to

proceed with the idea, so the initiative was stymied. However, I concluded through observations that there was still quite a strong collaboration occurring between Te Ha and Te Puna Hauora and this continued on past the MICO initiative when the two organisations agreed to both deliver the Te Puna Hauora tikanga model, I-MAP,

In August 2000, and identifying itself as a “manawhenua mandated health and social services body,” Te Ha o te Oranga sought funding for a two year project to implement the Te Puna Hauora Harakeke - I-MAP model within the Te Ha region (Te Ha o te Oranga, 1999a, slides 1-6; 2000b, p. 1). This collaboration between Te Puna and Te Ha was proposed to ensure consistency of service delivery throughout a significant proportion of the Tihi Ora region. Additionally, the proposal was based on strengthening governance and management relationships between the two organisations, including combined training and development of staff (Te Ha o te Oranga, 1999a, slides 1 and 6). As the Te Puna Hauora Harakeke - I-MAP model was underpinned by the ‘Whaanau Ora’ (see Appendix 1) model that was created by Lewis Stephens and was being implemented through Orakei Health, this project to implement Harakeke - I-MAP in the Te Ha region meant that three of the four Tihi Ora providers were now aligned through the matauranga and tikanga Maori of ‘Whaanau Ora’. Additionally, Te Puna Hauora, Te Ha and Orakei Health were also already aligned through their conceptualisation of Pa Henare Tate’s (1999) *whanaungatanga* ideas (see Appendices 2 & 3) as a matauranga for their tikanga Maori models.

Case study observation Vignette 6: When Hinekehu Hohaia, a non-Ngati Whatua manager of Te Ha had suggested creating a MICO in 1999, she had managed to pull together the support of all of the provider managers in the Ngati Whatua rohe because all the managers could see the potential strength in having one management and administration unit between them. The problem with the initiative came with the governance level not of Te Ha, but of Te Runanga o Ngati Whatua, where there was hesitancy about the potentiality of compromising to \their rangatiratanga over their provider and purchaser organisations. This seemed to be more about their concern around political and policy changes occurring nationally at the time, rather than concern about provider interactions.

However, the relationships formed between the organisations through the MICO discussions that had taken place provided a platform for a more networking to occur in the following years between boards, managers, and staff of the provider organisations. One example of this was the dinner hui that was held between the board and management members of Te Ha and Te Puna Hauora in July 2004 – where ensuring kaupapa and tikanga were consistent across both organisations was a key focus, and in October/November 2004 the staff of the organisations attended Whanaungatanga training courses together and began more actively sharing experiences/knowledge across the two organisations. This included having staff members from Te Ha working with Te Puna staff and patients, and vice versa. The platform for the two organisations coming closer together was the teachings of Pa Henare Tate through his whanaungatanga courses – which gave Maori and non-Maori and Ngati Whatua and non-Ngati Whatua kaimahi a common set of matauranga to establish their personal and working relationships through. The tacit agreement of the governance members of Te Ha and Te Puna to the joint whanaungatanga training taking place, as well as the Tihi Ora endorsement of the funding request for the training by the two organisations, shows an integrated approach across the Ngati Whatua hauora community towards finding commonality of service delivery and staff training and development approaches.

9.4.2 Te Ha Summary

Te Ha o te Oranga matakura and tikanga have been practiced through their implementing the Te Puna Hauora Harakeke - I-MAP model for service delivery. The Harakeke - I-MAP encapsulates Te Puna Hauora interpretations of the matakura and tikanga Maori of *whaanau ora* by Lewis Stephens (1998) and *whanaungatanga* by Pa Henare Tate (1999).

Two distinct features of the Te Ha o te Oranga matakura and tikanga Maori that have been conceptualised as Hauora Kotahitanga models are: Manawhenua and Manaaki.

In the Manawhenua Model, Te Runanga o Ngati Whatua established a relationship for Te Ha o te Oranga with the non-Maori health organisation ProCare. The memorandum of understanding negotiated between the two organisations was based upon the matakura of Ngati Whatua manawhenua and on the Maori language version of the Treaty explicitly protecting Maori rangatiratanga. In this way a tikanga Maori methodology for manawhenua evolved into a constructive engagement model based upon non-Maori health organisations recognising the rangatiratanga of Maori as encapsulated in the Maori language version of Te Tiriti o Waitangi.

In the Manaaki Model, Te Ha o te Oranga brought together the three other Maori health provider organisations in the Tihi Ora region with the purpose of establishing closer working relationships. Eventually, three of the four provider organisations, plus the health purchasing organisation were aligned in their matakura approaches through the application of the Harakeke - I-MAP by Te Ha and Te Puna, and the application of Kia Tu Kia Puawai by Orakei, all three of which included Pa Henare Tate's (1999) *whanaungatanga*, and Lewis Stephen's (1998) *Whaanau Ora*. In this way a tikanga Maori methodology for manaaki was established as a co-operative co-existence model between the three Maori health providers, and one Maori health purchasing organisation.

Te Ha o te Oranga proposed kotahitanga with others through their tikanga I-MAP model based on their matakura of rangatiratanga, whanaungatanga and whanaau ora.

9.5 Ngati Whatua o Orakei Health Clinic

The matauranga of whaanau ora and whanaungatanga as practiced through the Ngati Whatua o Orakei Health clinic Whaanau Ora tikanga Maori service delivery model were discussed in Chapter 8, and are discussed here in more detail including case study observational examples. In this chapter, two hauora kotahitanga models are conceptualised from the information, knowledge and experiences considered from the Ngati Whatua o Orakei Health Clinic case study. The first conceptualised model is ‘Whaanau Ora’ as Maori and non-Maori community empowerment for health pathways, the second conceptualised model is ‘Kia Tu Kia Puawai Orakei’ as Maori community empowerment for public health sector initiatives.

9.5.1 Conceptualised hauora kotahitanga models

9.5.1.1 *Whaanau Ora Model*

The Whaanau Ora is a conceptualised model of the constructive engagements that occurred with the Maori and non-Maori community using the organisation’s Whaanau Ora service delivery model as a community empowerment for health pathways tool. The experiences of Orakei Health that resulted in this conceptualising of a Whaanau Ora model are described in Chapter 8. The overriding objective of the organisation’s ‘Whaanau Ora’ model was to “empower whanau members with skills to access health pathways” (Ngati Whatua o Orakei Health Clinic, 1999b, slide 5).

The model empowered people to self-determine their health development based on having been given the knowledge and skills to negotiate health pathways. This is very different from the “traditional independent general practitioner” (Kinninmonth, 2003) health practice whereby the general practitioner controls the health knowledge and negotiates the health pathways for the patients. The ‘Whaanau Ora’ model creates an opportunity for people accessing Orakei Health services to self-determine their health development through open access to the knowledge and skills contained at Orakei Health services.

Kaupapa Maori was the primary driver of the organisational development strategies, even where clinical contracts required a specific compliance with the usual general practitioner practice requirements of best practice guidelines of professional bodies:

... to obtain an accreditation certificate of best practice compliance and participation in development of Kaupapa Maori Best practice protocols (Ngati Whatua o Orakei Health Clinic, 2000c, p. 4).

The Kaupapa Maori of the organisation was their Whaanau Ora model. The compliance requirements of operational contracts from health authorities were presented as secondary to Kaupapa Maori philosophies by Orakei Health in their organisational management planning terms (Ngati Whatua o Orakei Health Clinic, 2000c), however the health authority compliance requirements were interpreted by Orakei Health as being aligned with Kaupapa Maori:

In order to comply with Health Funding Authority contractual requirements for all 'by Maori for Maori' services provided by Ngati Whatua o Orakei Health clinical, recognition of the following priorities is implemented through the Kaupapa of the organisation and the delivery of all services. (a) Maori participation with Strategic, governance, Management and Service Delivery planning, implementation and review functions; (b) Maori as a Government Health Gain priority area; (c) the 8 Maori Health priority areas: asthma, diabetes, smoking cessation, injury prevention, hearing, immunisation, mental health, oral health; (d) the HFA Maori Health Policy and Strategies, and clause 3 "Maori Health Priority in the Standard Contract for Services; and (e) Maori specific quality specifications, monitoring requirements and service specific requirements" (Ngati Whatua O Orakei Health Clinic, 2000b, p. 20).

This meant the organisation felt its focus on Whaanau Ora was aligning with the apparent Kaupapa Maori focus of the Health Funding Authority (HFA) and this was organisationally sound practice to ensure their ongoing funding from HFA.

In 1998 the organisation had undertaken a review of their services which found that the service was highly rated by consumers because it was 'Maori based' and because the clinic had a Maori general practitioner (Stephens & Ngati Whatua o Orakei Health Clinic, 1998, 9.15). I concluded through observations that the community, including non-Maori, was supporting Orakei Health focus on community empowerment through Kaupapa Maori and their Whaanau Ora model. There were many examples of this community empowerment in practice, and some observations of this are included below:

Case study observation Vignette 7: There were a lot of teenagers in the local community attending a local high school. One of the initiatives from Orakei Health Clinic was to bring a successful sportswoman on as a coordinator for sports initiatives that could include these young people in afterschool activities and have them become more familiar and confident of the organisation and the services available. This was a highly successful idea. The young people had a sports mentor, they had activities they could take part in for free, and they were participating in sporting, outdoor and fitness activities. This community has a high prevalence of diabetes, so this initiative was crucial to empowering young people to understand and take part in healthy lifestyle initiatives. This service segued well into other programs delivered by the clinic, such as the smoking cessation program – which could also be useful for the extended families of the young people.

9.5.1.2 Kia Tu Kia Puawai Orakei Model

The Kia Tu Kia Puawai is a conceptualised model of the constructive engagements that occurred with health authorities, the state, the Crown to create a community empowerment for public health sector initiatives model. The experiences of Orakei Health that resulted in this conceptualising of a Kia Tu Kia Puawai Orakei model are described in Chapter 8. Despite the highly competitive environment for health contracting, Orakei Health took a stand against the Ministry of Health ‘Kia Tu Kia Puawai’ project format of a request for proposal.

Their challenge was based on their concern that community empowerment would be removed by the request for proposal process if Orakei Health management were to unilaterally decide the outcomes for the community, agree them with the funder, and then impose them on the population. This was because the Ministry of Health request for proposal format required the outcomes of the programme to be identified prior to funding approval. A number of organisations were competing to get Kia Tu Kia Puawai funding for their community projects, so there was pressure on all of them to identify the outcomes the government was going to get for its money to help to win the contract.

Orakei Health called consultation hui with their community, explained the Kia Tu Kia Puawai request for proposal, and took the feedback from their community back to the

Ministry of Health along with the community concerns. Orakei Health took the stance on behalf of their community that if the outcomes were pre-determined, the community would not have the opportunity to drive the project; it would instead be driven by the health clinic and the health funder. As the Kia Tu Kia Puawai project was about mental health prevention, Orakei Health believed that their matauranga and tikanga Whaanau Ora underpinned the community rights to not be disenfranchised by a mental health program imposed upon them. They proposed that if Kia Tu Kia Puawai was going to succeed as a strand of Whaanau Ora, then the community needed to be empowered to define mental health and explore prevention strategies as part of a Kia Tu Kia Puawai funded activity.

At a meeting at Auckland Airport with the Ministry of Health panel deciding the contracts, which also included the other Maori health organisations competing for this funding, the kaumatua and kuia of Ngati Whatua Orakei stood and explained their position. Orakei Health's community empowerment for public health sector initiatives model resulted in a proposal for Kia Tu Kia Puawai that was intrinsically out of line with the health contracting environment which funded contracts on the basis of pre-defined health outputs and outcomes. The kaumatua kuia had come to support the Orakei Health team to challenge the Ministry of Health to accept their Kia Tu Kia Puawai proposal without outputs or outcomes. They were awarded the contract. In the year that followed, Orakei Health could see significant alignment between their Kia Tu Kia Puawai model and the New Zealand Health Strategy (Minister of Health, 2000) which announced a new government impetus towards community based health developments.

I concluded through observations that this was one of the key challenges for Orakei Health community when presenting innovative models within a complex health sectoral change environment; sometimes the right window of opportunity for the model to be funded did not occur at the same time as the community impetus. In this case, the project was funded even though it was out of step with the funding contracts at the end of 1999. It would, however, have been less of a challenge to win that funding under the new community focussed funding from late 2000. There are some observations of this process for Kia Tu Kia Puawai Orakei discussed below:

Case study observation Vignette 8: *The first hui I attended was interesting because some of the people challenged my right to be at the community hui, because I wasn't part of the community. Ngati Whatua iwi is made up of 34 marae and a number of hapu (Chant, 1999). I am from Otamatea marae in the north of the rohe, often called the matua or parent marae. My hapu, Te Uri O Hau, is located mainly around the northern Kaipara harbour, whereas the Orakei peoples are from the central business district of Auckland through to the southern Kaipara harbour. However, one of the other hui participants, whom I didn't know, got up and did my whakapapa linking me through to them in a way that meant I was accepted for being there, but not accepted for taking part in decisions. When I whispered to the kuia next to me to find out how on earth this person who did my whakapapa knew who I was, I was told there are people in all iwi who are receptacles of knowledge, for instance the whakapapa of the iwi. They are like walking oral encyclopaedia of the iwi. At a different hui at Otamatea marae I did get to hear one of these 'walking oral encyclopaedia' chant the whakapapa of the iwi from many, many, many generations ago down all the way to the numerous small children at the hui. Both times were equally profound for me.*

The people at the first Orakei hui expressed an unwillingness to participate/engage with government funding/programs like mental health prevention (Kia Tu Kia Puawai) because they felt they were always being pegged as a problem that needed resolving and that this impugned their mana. This was expressed consistently as a key issue for participation/engagement with health and social wellbeing services at all hui I participated in with all of the provider organisations in the Tihi Ora region. Even where those services were ultimately being managed and delivered by people from their own iwi, or people chosen by their own iwi. This was an expression of the deep hurt that this particular hapu felt at successive land confiscations that had occurred at what is infamously known in the literature as 'Bastion Point'.

One Bastion Point story that was told was of a church group arriving with a significant koha, or donation/gift, towards building regeneration happening on Bastion Point. The group were told that if they were bringing the koha for the building work, it was too much; and if they were bringing the koha for the hurt they

had visited historically on the iwi, it was too little. The iwi were emphasising/endorsing/explaining that they would rather refuse money than impugn the mana of the iwi. It was this sentiment that the people of Orakei, and in particular the kaumatua and kuia who fronted the Kia Tu Kia Puawai negotiations with the Ministry of Health themselves rather than let their health managers do it, insisted be dominant in the relationship going forward. Kia Tu Kia Puawai might be seen by the Ministry of Health as a mental health prevention program, but Ngati Whatua Orakei people were not going to accept it unless it was agreed that they and the Ministry of Health would be working together towards community empowerment.

The Ministry of Health did accept this Ngati Whatua Orakei challenge at the hui the Ministry had called, which was held at Auckland Airport in a meeting room. I could see the Ministry participants were incredibly humbled and moved by the dignity of the presentation of the Ngati Whatua Orakei people. I do also remember reflecting at the time that the Ministry of Health, rather than visiting the various iwi who were bringing Kia Tu Kia Puawai proposals to them on their own marae, had made them all come to an airport meeting room and had set it up so that the Ministry people were sitting in tables in a horseshoe shape, while the Maori participants had seats set back against the walls of the room and had to stand in the middle of the room in front of everyone while they presented their proposal. It was akin to the adversarial environments of a court room or a commission of inquiry – and as an observer I didn't think the dignity of the Maori participants was considered even in the room. It would have been a much stronger process for the Maori participants had they been able to meet with the Ministry of Health at their own health clinics, and on their own marae

9.5.2 Ngati Whatua o Orakei Health Clinic Summary

The Whaanau Ora model for community empowerment was developed and delivered on the basis of Orakei Health matauranga and tikanga Maori, which encapsulates both Whaanau Ora, and Ngati Whatua Orakei Health interpretations of the matauranga of 'whanaungatanga' by Pa Henare Tate (1999) (see Appendix 1).

Two distinct features of Ngati Whatua Orakei Health matakārangā and tikanga Māori that have been conceptualised as hauora kotahitanga models are: Whaanau Ora as a Kaupapa Māori model for community empowerment for health pathways, and Kia Tu Kia Puawai Orakei as a community empowerment for public health sector initiatives model.

Whaanau Ora evolved as a model for implementing community empowerment into the service delivery methods of a number of different health contracts at Orakei Health, including health promotion, general practitioner services and mental health prevention programmes. Whaanau Ora ensured that the community and not the health funders were driving the development of the services; and that the community, and not the health workers, were driving the delivery of the services. In this way community members were able to establish processes for living together differently with both the health funders, and the health workers. Thus a tikanga Māori methodology, Whaanau Ora, evolved as a kaupapa Māori model for community empowerment.

Kia Tu Kia Puawai Orakei evolved initially as a health funder model for implementing mental health prevention programs into the community. Orakei Health took the health funder proposal and re-engineered it into community mental health prevention empowerment model. The health funder was keen to see outputs and outcomes attached to the funding before allowing the contract to commence. The community, however, insisted that they receive the contract to explore potential interventions, outputs and outcomes and that unless they could drive the process from within the community, as opposed to the health funder model of a top down approach of a contract with targeted outcomes pre-prepared for the community, they would not engage with the project. This was a gutsy move in a highly competitive health funding and contracting environment in which their health services were vulnerable through a potential lack of access to publicly funded health resources. The health funder agreed to constructively engage with the community on the basis that the contract would be written at the completion, rather than the beginning of the process, and Kia Tu Kia Puawai as a tikanga Māori methodology evolved in the Orakei community as a community empowerment model for constructive engagement with external peoples and organisations, based on community defined kaupapa and tikanga.

Ngati Whatua Orakei proposed kotahitanga with others through their tikanga Whaanau Ora model based on their matakārangā of whaanau ora.

9.6 Te Roopu Taurima o Manukau

The matauranga Maori knowledge underpinning Te Roopu Taurima o Manukau development was rangatiratanga, as was evidenced in many of the organisation's documents. The matauranga of rangatiratanga as practiced through their Whariki Whakaruruhau tikanga Maori service delivery model was discussed in Chapter 8, and is discussed here in more detail including case study observational examples. In this chapter, one hauora kotahitanga model is conceptualised from the information, knowledge and experiences considered from the Te Roopu Taurima o Manukau case study. The conceptualised model is 'Korowai Manaaki' for mokopuna empowerment.

9.6.1 Conceptualised hauora kotahitanga models

9.6.1.1 Korowai Manaaki Model

The Korowai Manaaki is a conceptualised model of the constructive engagements that occurred with the roopu and communities. The experiences of Te Roopu Taurima o Manukau that resulted in this conceptualising of a Korowai Manaaki model are described in Chapter 8. In addition to the role of Korowai Aroha as the kaitiaki of the tikanga Maori of the organisation, described above in the matauranga Maori section, the other role created for RIDSAS was 'whaea manaaki', a role that was not contracted for, so was completely unique to the Te Roopu Taurima organisation. Korowai Aroha played a vital role in the whare: they knew all of the mokopuna as if they were their own grandchildren, and spent a significant amount of time with them. In addition to the kaumatua and kuia of Korowai Aroha, the RIDSAS service 'whaea manaaki' for each whare ensured the kaupapa, tikanga, and kawa of each of the mokopuna was appropriately applied when they welcomed whanau or manuhiri into the mokopuna whare, or when the mokopuna were taken to visit their whanau, hapu, iwi homes or marae.

The entire whare of a mokopuna would often attend a tangi or celebratory function at a marae associated with mokopuna from their whare, and the 'whaea manaaki' would assist the mokopuna with following the kaupapa, tikanga and kawa of the places where some of them were manuhiri. In this way the organisation was able to ensure the rangatiratanga of each mokopuna in each whare, by having a kaimahi specifically designated to achieve this fusion of the mokopuna indigeneity within their 'accustomed

environment' of a kaupapa Maori intellectual disability residential service. I concluded through observations that one of the important elements of the Korowai Manaaki model is that the organisation focuses on the rangatiratanga of the mokopuna, of the kaimahi, and of the whanau of the mokopuna and kaimahi. In this way the organisation is empowering the mokopuna to confidently achieve their rangatiratanga by empowering the kaimahi and whanau who are part of the mokopuna world to confidently achieve their own rangatiratanga.

I concluded through hui observations that the relationships that underpin the living and working contexts of all people at Te Roopu Taurima are all imbued with the matauranga of rangatiratanga for each of them and their whanau. Examples from hui observations are below

Case study observation Vignette 9: An experience at one of the recruitment hui sticks out in my mind as encompassing the tikanga experience at Te Roopu Taurima. One of the potential applicants arrived with his extended whanau for the hui. The applicants and their whanau and support people were welcomed in with a powhiri. The recruitment hui was in the evening, nonetheless a significant number of staff and management team members were at the hui to welcome the manuhiri. After the powhiri the staff and management took turns explaining the whakapapa of the organisation and peoples who made up the organisation (mokopuna, kaimahi, whanau). Then staff and management explained their roles, their experiences of the mokopuna and organisation, and in particular, how they practiced being a kaupapa and tikanga Maori organisation and why that made them different to the other intellectual disability residential services in New Zealand.

The potential applicants and their whanau were invited to make comments and ask questions. One young man stood and said that he had a young family of his own, and had also brought along the older members of his whanau. They knew there was a Te Roopu Taurima whare in the rural region in which they lived and the young man was hoping to get a role in that home. After participating at the hui he could now see how a career pathway within the organisation might be possible for someone like him, without qualifications and experience. His whanau indicated that the Te Roopu whare had a good reputation in the community, and that the

application of the local iwi kaupapa and tikanga in the whare had made their whanau happy to bring their young man along to support his application and to support the kaupapa of the organisation. They had followed Maori protocol by consulting with their own tribal kaumatua and kuia before coming to the recruitment hui, and their kaumatua and kuia had referred them to kaumatua and kuia within Te Roopu who had whakapapa connections to the young man and his whanau so that they could also provide him and his family with support and assistance.

The young man and his whanau made it clear that it was being able to be Maori in his employment, and being able to be Maori in ways that were important to his whanau personally, that prompted his application. Most importantly the young man and his whanau said they now not only understood why the kaupapa and tikanga of the mokopuna was paramount in the whare, but also how they now felt he could not go wrong as a young worker implementing kaupapa and tikanga because the organisational models and practices put such strong support around the kaimahi of the organisation. The presence of the Te Roopu Taurima kaumatua and kuia within the organisation was perceived by them as being the key point in protecting and developing their young man in the work environment.

Another observation was from a non-Maori manager in the organisation when reflecting on the experiences of non-Maori mokopuna and their whanau. The non-Maori manager said that the whanau of the non-Maori mokopuna not only loved that their person was included 100% in all things Maori happening in the whare and organisation, but also that many of the whanau felt it was a wonderful way for them as whanau of the mokopuna to be part of and participate in the Maori world. A number of non-Maori whanau expressed a deep sense of belonging to Te Roopu Taurima through their being able to participate in Maori practices such as hui and tangi and being consistently made to feel part of the whanau rather than manuhiri by Maori associated with Te Roopu Taurima. I also saw this in community interactions. One of the whare in a rural town (Tokoroa) had an elderly mokopuna whose health needs meant they would benefit a particular mechanised bed that the health system was unwilling to fund. The non-Maori neighbours of the whare

began fund raising locally in the neighbourhood and were able to put together the money to buy the bed.

Even though this organisation was the most 'steeped in te ao Maori' of all the case study organisations, there was still a significant and positive impact on the organisation by many non-Maori who recognised the value of the services and efforts of the kaimahi for their mokopuna and who chose to support and participate in these efforts.

Many miles away in the far north, on a visit to a Kaitia house, one of the young Maori kaimahi had taken an older mokopuna to his home for Sunday roast with his wife and young children on his day off. I saw this many times in this organisation. Kaimahi making the mokopuna part of their whanau and the spending their days off welcoming mokopuna into their whanau activities. Most of the kaimahi were paid not much above minimum wage because the funding for intellectual disability is so low in New Zealand. Given that the service is 7 days a week, 24 hours a day and these kaimahi can be rostered on at any time – I really felt it was for most of them a calling rather than a job and that the majority of the staff really 'walked the talk' in terms of the matauranga and tikanga of the organisation even when they weren't on duty.

9.6.2 Te Roopu Taurima o Manukau Summary

Te Roopu Taurima o Manukau matauranga and tikanga Maori have been practiced through whariki whakaruruhau model for service, organisational, and community development. This is underpinned by Korowai Aroha and their application of Nga Ratonga Tikanga Maori for service, organisational, and community peoples. The underpinning matauranga and tikanga of Te Roopu Taurima is rangatiratanga for mokopuna, kaimahi, and roopu.

Two distinct features of Te Roopu Taurima matauranga and tikanga Maori that have been conceptualised as hauora kotahitanga models are: korowai aroha, and whaea manaaki – together they have been conceptualised as a 'korowai manaaki' model. Korowai Aroha are the kaumatua and kuia who korowai the matauranga and tikanga of the mokopuna, the kaimahi, the roopu and their communities. Whaea manaaki are the

whaea who support the matauranga and tikanga of the mokopuna in their whare and communities.

The overall concept of this integration of rangatiratanga of mokopuna, kaimahi, and roopu, and how it was practiced by Te Roopu Taurima, as shown by the RIDSAS example in this chapter, is an example of Maori Marsden's explanation of how 'matauranga' becomes 'mohio', "Knowledge (matauranga) is different from knowing (mohio) ... knowledge belongs to the head and knowing belongs to the heart. When a person understands both in the mind and in the spirit, then it is said that the person truly 'knows' (mohio)" (Marsden, 2003, p.79)

In this way Te Roopu Taurima o Manukau established a basis for living together differently as communities through acknowledging the rangatiratanga of the mokopuna, kaimahi, and roopu of Te Roopu Taurima, through their matauranga and tikanga. Te Roopu Taurima evolved a tikanga Maori methodology which can be considered a Korowai Manaaki model for roopu and communities.

Te Roopu Taurima o Manukau proposed kotahitanga with others through their tikanga Whariki Whakaruruhau model based on their matauranga of rangatiratanga.

9.7 Conclusions – case study organisations

The purpose of this chapter was to 'conceptualise' how case study organisations practice tikanga by using information and knowledge from the case study research to model kotahitanga. The organisational matauranga have become mohiotanga through the tikanga of these organisations, and these conceptual models are one interpretation of how the experiences of matauranga based tikanga for hauora Maori can be conceptualised as models for kotahitanga.

In the Tihi Ora section, the two conceptual models have been evaluated differently to the models from the other organisations. This is because Tihi Ora was a purchasing organisation, and the other case study organisations were provider organisations. Te Runanga o Ngati Whatua, the iwi mandated Ngati Whatua organisation that Tihi Ora is a division of, considered this relationship with the Crown to be part of their rangatiratanga responsibility. For this reason the evaluation tool that has been applied to the two Tihi Ora models is a 'levels of sovereignty/self-determination' tool created by Maaka and

Fleras (2005, p.52). Only the health purchasing organisation was evaluated using this tool because Tihi Ora MAPO had a Treaty of Waitangi based iwi-Crown relationship as the basis of their organisational structure. The provider organisations did not. Although only one of the case study organisations is being evaluated using this framework, it may be that the findings from the evaluation in this study may prove useful for future evaluations of models of self-determination proposed by Te Runanga o Ngati Whatua, and so this was another reason for doing this evaluation. What the two models showed, in terms of the sovereignty evaluation was that Te Runanga o Ngati Whatua consistently maintained that constructive engagements through the MAPO strategy with North Health, and with the Crown for health and other policy areas, would be based on the matauranga and tikanga of Ngati Whatua. Te Runanga o Ngati Whatua proposed to co-operatively co-exist through living together differently as two sovereigns (Rangatira) in partnership (kotahitanga) with the Crown. The two features of the Tihi Ora matauranga and tikanga Maori that have been conceptualised as hauora kotahitanga models are: Kaunihera as rangatiratanga for health systems model, and Ngati Whatua Kotahitanga Proposal as rangatiratanga for Crown model.

Three distinct features of the Te Puna Hauora matauranga and tikanga Maori that have been conceptualised as hauora kotahitanga models are: multiculturalism, best practice for Whanau Ora policy, and kaumatua kuia led workforce and community enhancement. Two distinct features of the Te Ha o te Oranga matauranga and tikanga Maori that have been conceptualised as hauora kotahitanga are: manawhenua based on Te Tiriti o Waitangi and manaaki for a Maori integrated care organisation. Two distinct features of Ngati Whatua Orakei Health matauranga and tikanga Maori that have been conceptualised as hauora kotahitanga models are: Whaanau Ora as a community empowerment for health pathways model, and Kia Tu Kia Puawai Orakei as a community empowerment for public health sector initiatives model. There were two distinct features of Te Roopu Taurima matauranga and tikanga Maori that have been conceptualised as hauora kotahitanga models are: korowai aroha, and whaea manaaki as a korowai manaaki for mokopuna and whanau, and kaimahi and whanau, empowerment. These are discussed in more detail in each case study organisation summary in this chapter, and are detailed in the Tables below.

In Table 6, there are two conceptualised kotahitanga models used to explain Tihi Ora constructive engagement with, firstly health funders, and secondly with the Crown. These models are explained in detail in Chapter 7, but the background to these models evolving is found in this chapter.

Organisation	Conceptual Hauora Kotahitanga Model
Tihi Ora	Kaunihera as rangatiratanga for health systems model
Tihi Ora	Ngati Whatua Kotahitanga Proposal as rangatiratanga for Crown model

Table 6: Conceptualised Hauora Kotahitanga Models - Tihi Ora

The constructive engagement models that were conceptualised for each of the case study provider organisations in Table 7 are by no means an exhaustive list. Rather, the models have been conceptualized to show some of the diversity of constructive engagements that epitomize hauora Maori developments.

Organisation	Conceptual Constructive engagement Model
Te Puna Hauora	Mana Tauwiwi as a social-cultural integrative model based on multiculturalism
Te Puna Hauora	Te Tohu Kahukura as best practice for Whanau Ora policy model
Te Puna Hauora	Mana Kaitautoko as kaumatua kuia led workforce and community model
Te Ha o te Oranga	Manawhenua based on Te Tiriti o Waitangi model
Te Ha o te Oranga	Manaaki for a Maori integrated care organisation model
Ngati Whatua Orakei Health	Whaanau Ora community empowerment for health pathways model
Ngati Whatua Orakei Health	Kia Tu Kia Puawai Orakei community empowerment for public health sector initiatives model
Te Roopu Taurima	Korowai Manaaki mokopuna and whanau, and kaimahi and whanau, empowerment model

Table 7: Conceptualising Hauora Kotahitanga Models – Provider Organisations

Chapter 10 is a general discussion of the findings of this study into hauora kotahitanga, and the models that have been created through synthesis of the knowledge and information gathered and considered for this study. In Chapter 10, one final synthesis of knowledge and information gathered and considered for this study is undertaken. The findings from the tupuna in Chapter 4 are combined with the findings from Chapters 7, 8 and 9 to consider hauora kotahitanga models that combine the tupuna themes with the experiences and knowledge of hauora Maori and hauora kotahitanga across the Ngati Whatua Tihi Ora region. These ‘tribal & tupuna’ hauora kotahitanga models are an example of Maori walking backwards into the future bringing the knowledge and experiences of the tupuna with them. These macro-level models are a reflection of the kotahitanga connection between ancestral and contemporary Maori people, knowledge and practices.

Chapter Ten

GENERAL DISCUSSION

10.1 Introduction

The purpose of Chapter 9 was to conceptualise models for kotahitanga through synthesis of the information and knowledge gathered about the matauranga and tikanga of each of the case study organisations. The organisational matauranga have become mohiotanga through the tikanga of these organisations, and these conceptual models are an interpretation of their experiences as models for hauora kotahitanga.

Chapter 10 is a general discussion of the research and findings. The research has reviewed the literature for experiences of Maori health developments between 1840 and 1990, and has researched using documentary and observational analysis the experiences of Maori in development and delivery of hauora models from the 1990s to 2008 in the Tihi Ora MAPO region. The research examined the presence of the matauranga of rangatiratanga and whanau ora in New Zealand health policies between the 1990s and 2003, and the findings of this indigeneity-based public health policy analysis are summarised in this chapter.

At 10.2, knowledge and experiences from the study of development and delivery of hauora Maori models are considered as conceptual models for co-operative co-existence at the organisational level. These are summarised as the hauora kotahitanga micro-models of the study; hauora kotahitanga – organisational.

At 10.3, knowledge and experiences from the study of development and delivery of hauora Maori models are then considered as conceptual models for co-operative co-existence at the community level. These are summarised as the hauora kotahitanga meso-models of the study; hauora kotahitanga - community.

At 10.4, the tupuna themes that were conceptualised in Chapter 4 are combined with the findings from Chapters 7, 8 and 9 to conceptualise models for co-operative co-existence based on hauora Maori experiences across the Ngati Whatua Tihi Ora region. These are conceptualised as models for kotahitanga at the regional level. These are summarised as macro-level hauora kotahitanga models; hauora kotahitanga – tribal and tupuna.

Chapter 11 concludes the study by pulling the threads of the key debates from the indigenous health development literature that were addressed in this study together:

indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and indigenous knowledge for health development to respond to the overall thesis question: How can Maori experiences of developing and delivering hauora models be conceptualised as models for kotahitanga between indigenous and non-indigenous peoples?

10.2 Micro-level Hauora Kotahitanga– Organisational models

10.2.1 Summary: Matauranga Maori Knowledge

This section answers the question what matauranga (Maori knowledge) were used to develop hauora models from the 1990s?

As was discussed in Chapters 2 and 3, the matauranga Maori knowledge used to develop the publicly funded health models from the 1990s were examined through identifying the matauranga that evolved into tikanga Maori methodologies that were then implemented through hauora Maori models. The idea of examining how ‘knowledge’ becomes ‘known’ was prompted by Marsden’s teachings on ‘matauranga’ and ‘mohio’ (Marsden, 2003, p.79). Marsden’s (2003) ideas are re-interpreted in this study to assist in understanding and explaining what matauranga informed the tikanga Maori methodologies of the hauora Maori organisations, and how, through delivery of the tikanga Maori methodologies the matauranga became mohiotanga for peoples delivering hauora Maori services. In Figure 10 below, Marsden’s ideas (2003) at the top show how the matauranga can combine with mind and spirit to become mohio.

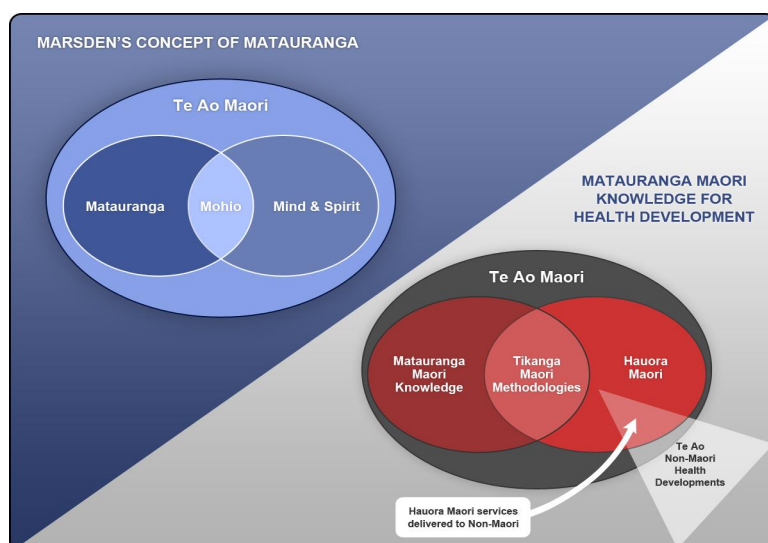


Figure 10: Conceptualising matauranga Maori knowledge for health development

The bottom part of Figure 10 re-interprets Marsden's (2003) ideas to show how Maori might combine their matakura with hauora Maori to create tikanga Maori methodologies for health developments. The tikanga Maori methodologies are what are used by Maori and non-Maori to deliver the matakura-based hauora services. This study researches practitioners of hauora Maori. Practitioners are doctors, nurses, receptionists, community support workers, cleaners, child carers, counsellors; literally anyone who has contact with service receivers and community members accessing the hauora Maori services. The tikanga Maori methodologies of the hauora Maori organisations are applications of the organisational matakura Maori. The hauora Maori practitioners apply the organisational matakura Maori through the tikanga Maori methodologies that are their service delivery practices. The ability of the hauora Maori practitioners, who may be non-Maori, to apply the organisational matakura is dependent upon how they understand and practice the tikanga Maori; in other words their mohiotanga of the matakura of the organisational tikanga. For this study, matakura is conceptualised as matakura for health development.

From the 1990s a key matakura Maori for the case study organisation Tihi Ora was rangatiratanga; for Te Puna Hauora it was Whanaungatanga and Whaanau Ora; for Te Ha it was whanaungatanga and whanaau ora; for Orakei Health it was whaanau ora; and for Te Roopu Taurima it was rangatiratanga. The organisational matakura are summarised in Table 8 below.

Organisation	Tikanga Maori Service Delivery Model	Matakura underpinning model
Tihi Ora	MAPO strategy	Rangatiratanga, Whanaungatanga, Kotahitanga
Te Puna Hauora	Harakeke - I-MAP	Whanaungatanga, Whaanau Ora
Te Ha o te Oranga	Harakeke - I-MAP	Whanaungatanga, Whaanau Ora, Rangatiratanga
Ngati Whatua Orakei Health	Whaanau Ora	Whanaungatanga, Whaanau Ora,
Te Ha o te Oranga	Whariki Whakaruruhau	Rangatiratanga
Table 8: Hauora kotahitanga – micro-models		

As was discussed in Chapter 4, rangatiratanga was the matakura used as the basis for constructive engagements by Maori for health developments with the Crown through the Hui Whakaoranga and Hui Taumata in 1984, and rangatiratanga underpinned the recommendations of the Standing Committee on Maori Health of the Department of

Health in 1988. Maori health leaders consistently emphasised rangatiratanga as the matauranga for constructive engagements between Maori and the Crown for health developments in the 1980s. The study illustrated that rangatiratanga was present for as a matauranga in the 1990s for some of the Maori health organisations studied. The study established rangatiratanga was consistently present in public health policy in the 1990s.

The study illustrated that the majority of the Maori health organisations studied were sharing their service delivery models with the Crown through health sectoral interactions in the 1990s, and that whanaungatanga and whanau ora were matauranga in many of these models. The study revealed that whanau ora and whanaungatanga were present as matauranga in the 1990s for most of the Maori health organisations studied. The study established that whanau ora and whanaungatanga were not consistently present in public health policy in the 1990s. Between 2000 and 2002 the countrywide process of Crown and Maori consultation for the creation of *He Korowai Oranga 2002* resulted in Whanau Ora becoming the overall matauranga and the overall aim for this policy. This study established Whanau Ora was consistently present as a matauranga in public health policy from the early 2000s.

The matauranga Maori examined in this research through the studies illustrated two characteristics, firstly the same matauranga appear across a number of the organisations, and secondly the matauranga of the case study organisations are similar in nature to those appearing in public health policies in the period. This study has revealed that matauranga Maori were a distinct indigenous knowledge system for both Maori and health developments in the 1990s

10.2.2 Summary: Indigeneity-based Tikanga Maori Service Delivery Models

This section answers the question what tikanga (Maori methodologies) were used to deliver matauranga based hauora Maori models from the 1990s?

Durie's explanation of indigeneity has been re-interpreted to guide characterising of 'indigeneity-based' health developments. Durie explains indigeneity as "a system of knowledge based on a state of fusion between indigenous peoples and their accustomed environments" (2005, p. 137). Durie's concept of indigeneity (2005, p.137) has been re-interpreted to explain 'how' indigeneity was practiced by Maori through the tikanga

Maori methodologies used by Maori to create a “state of fusion” between “a system of knowledge”, in this case matakura Maori knowledge, and “their accustomed environments”, in this case non-Maori communities. This was discussed in the methodology in Chapter 2, and in the methods at Chapter 3.

Figure 11 below illustrates indigeneity-based Maori health developments for this study through a re-definition of Durie’s explanation of indigeneity. At the top of Figure 11, Durie’s definition of indigeneity (2005, p.137) shows that where there is a state of fusion between Maori, as indigenous peoples, and their accustomed environments as indigenous peoples, a system of knowledge is created - indigeneity.

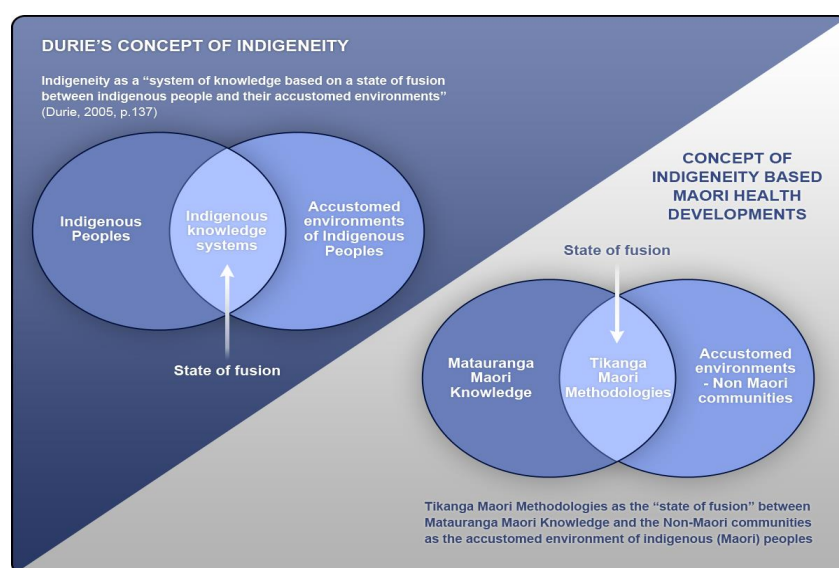


Figure 11: Conceptualising indigeneity-based Maori health developments

At the bottom of Figure 11 is a conceptual model for Indigeneity-based Maori Health Developments. Maori peoples create a state of fusion between matakura for hauora and non-Maori communities. The indigenous knowledge systems, or indigeneity-based knowledge systems, that result from this state of fusion in this model are called ‘tikanga Maori methodologies’.

This research explored two types of tikanga Maori methodologies. The first are the tikanga Maori methodologies the Maori health organisations created, named and delivered that were discussed in Chapters 7 and 8. The second are the tikanga Maori methodologies that are conceptualised as models for constructive engagements, based on the experiences of the Maori health organisations examined in this study and discussed in Chapter 9.

The tikanga Maori health models created by the five Maori health organisations are all focussed on service delivery based on matauranga and tikanga Maori. All four Maori health service provider organisations deliver to Maori and non-Maori patients/consumers/members/whanau/mokopuna. All five Maori health organisations employ Maori and non-Maori staff. Te Ha, Te Puna and Orakei share similar matauranga and tikanga Maori in their service delivery models, as has been discussed previously, including *whanaungatanga* by Pa Henare Tate (1999) and *Whaanau Ora* by Lewis Stephens (1998).

The service delivery models created by the organisations had significant cross-over of the matauranga Maori underpinning their development and delivery, as can be seen in Table 8 repeated below:

Organisation	Tikanga Maori Service Delivery Model	Matauranga underpinning model	Maori
Tihi Ora	MAPO strategy	Rangatiratanga, Whanaungatanga, Kotahitanga	
Te Puna Hauora	Harakeke - I-MAP	Whanaungatanga, Whaanau Ora	
Te Ha o te Oranga	Harakeke - I-MAP	Whanaungatanga, Whaanau Ora, Rangatiratanga	
Ngati Whatua Orakei Health	Whaanau Ora	Whanaungatanga, Whaanau Ora,	
Te Ha o te Oranga	Whariki Whakaruruhau	Rangatiratanga	
Table 9: Hauora kotahitanga – micro-models			

These models are examined in the case study chapters. What is notable is that whanau ora and rangatiratanga as the two dominant matauranga Maori within *He Korowai Oranga 2002*, were also present in these tikanga Maori service delivery models that were created in the 1990s. The four organisations created under North Health's MAPO strategy; Tihi Ora, Te Puna Hauora, Te Ha and Orakei Health, were all underpinned by one common matauranga, whanaungatanga. The application of rangatiratanga for Tihi Ora was connected with the manawhenua of the iwi, whereas the application of rangatiratanga by Te Roopu Taurima was connected with the people of the organisation. See the case study chapters for more discussion of these models.

10.3 Meso-level Hauora Kotahitanga– Community models

This section draws together Maori experiences of the development and delivery of hauora Maori models and considers them as conceptual models for co-operative co-existence between indigenous and non-indigenous peoples.

10.3.1 Summary: Indigeneity-based constructive engagements

The concept of indigeneity-based co-operative co-existence for this study was developed using the ideas of Maaka and Fleras (2005) who proposed a blueprint for indigenous peoples living together differently, by using examples of how Maori and Canadian indigenous peoples were already living together differently under the Crown in Canada and New Zealand. Their proposal includes ideas of how current constructive engagements between the two, for example the Waitangi Tribunal as a constructive engagement mechanism between Maori and Crown for resolving Treaty grievances, could be used as models for co-operative co-existence at the constitutional level based on indigeneity. For the purpose of this study, the Maaka and Fleras (2005) concept of constructive engagement at the constitutional level between sovereign western states and sovereign indigenous populations was applied to constructive engagements between indigenous and non-indigenous peoples at the community level. This research proposes that constructive engagement for co-operative co-existence can be driven as successfully from a community level, as Maaka and Fleras have argued it can be from a constitutional level.

In Figure 12 below, the top of the diagram presents Maaka and Fleras (2005) ideas of co-operative co-existence. They show that where indigenous and non-indigenous peoples constructively engage, they live together differently, and co-operative co-existence is achieved.

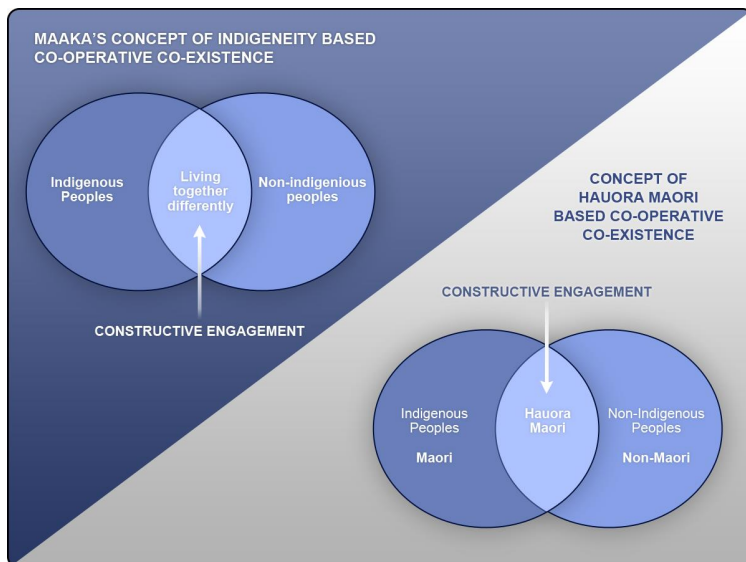


Figure 12: Conceptualising hauora Maori based co-operative co-existence

At the bottom of Figure 12, Hauora Maori Based co-Operative co-existence proposes that where Maori constructively engage through their indigeneity-based hauora Maori with non-indigenous peoples, hauora Maori based co-operative co-existence occurs. Therefore, non-Maori choose to live differently with Maori through the matakura and tikanga of the hauora Maori services. The interpretation of the Maaka and Fleras concept of constructive engagement for co-operative co-existence (2005) developed for this study frames 'why' the constructive engagements of hauora Maori studied might be considered as models for kotahitanga between Maori and non-Maori.

The hauora Maori based health models studied were created from the 1990s, and were publicly funded health initiatives based on Maori indigeneity. Maori were funded by the health funders because they were Maori. Maori were funded by the health funders to produce models of health service delivery based on their traditional knowledge and practices. Therefore these publicly funded health initiatives were based on Maori indigeneity. The reality of service development and delivery for these Maori health organisations and their hauora Maori models was that non-Maori opted to be involved in development and delivery of the models, and non-Maori opted to be involved as service users of the models. Non-Maori were willing to constructively engage as service providers and service users on the basis of matakura and tikanga Maori based service delivery; they opted to participate with indigeneity-based health developments.

10.3.2 Summary: Hauora Kotahitanga - community

In addition to the service delivery models created by the organisations themselves, as presented in Table 8 above, the case study organisations constructive engagement activities resulted in a number of co-operative co-existence practices. These constructive engagements have been conceptualised in Chapter 9 as kotahitanga models, and are summarised in Table 9 below. These models are discussed in more detail in the case study Chapters 7 and 8, and the case study analysis at Chapters 9.

Organisation	Hauora kotahitanga meso-models	Kotahitanga with:
Tihi Ora	Kaunihera as rangatiratanga for health systems model	With health funders
Tihi Ora	Kotahitanga as rangatiratanga for Crown model	With Crown
Te Puna Hauora	Mana Tauwi as a social-cultural integrative model based on multiculturalism model	With non-Maori people and communities
Te Puna Hauora	Te Tohu Kahukura as best practice for Whanau Ora policy model	With health sector, allied health organisations
Te Puna Hauora	Mana Kaitautoko model for kaumatua kuia led workforce and community enhancement	With internal workforce and broader community
Te Ha o te Oranga	Manawhenua based on Te Tiriti o Waitangi model	With non-Maori health providers
Te Ha o te Oranga	Manaaki model for a Maori integrated care organisation	With Maori health providers
Ngati Whatua Orakei Health	Whaanau Ora community empowerment for health pathways model	Between community with health clinic and health sector
Ngati Whatua Orakei Health	Kia Tu Kia Puawai Orakei community empowerment for public health sector initiatives model	Between community with health clinic and health funder
Te Roopu Taurima	Korowai Manaaki model for mokopuna and whanau, and kaimahi and whanau, empowerment	Between people from organisation, and other communities
Table 10: Hauora kotahitanga – meso-models		

The importance of these models is that they are the expression of each community's unique way of expressing and achieving matauranga and tikanga based services and relationships. There were many and complex constructive engagements that were observed in each of the organisations, and there were some similarities in how each organisation individually factored these constructive engagements into their organisational developments and practices. The Te Puna Hauora models are reflective of

their multi-cultural community and sizeable workforce. The Te Ha models are reflective of their mana whenua provider status. The Orakei models are reflective of the geographical placement of the community which is in the centre of the largest city in New Zealand. The Te Roopu Taurima model is reflective of it being the largest Maori intellectual disability organisation, the largest Maori intellectual disability employer, as well as delivering services throughout New Zealand.

10.4 Macro-level Hauora Kotahitanga– Tribal & Tupuna models

At the interface between matauranga Maori knowledge and tikanga Maori methodologies in the Maori health examples studied, are the people who developed and delivered the services. ‘Te ao Maori’ within and by these Hauora Maori organisations was defined by the people who interpreted and practiced matauranga and tikanga both within and for their broader communities. The ability for a community to co-operatively co-exist can only form where the will of the people exists to constructively engage with one another. Maori people shared their matauranga Maori knowledge and tikanga Maori methodologies with their broader communities, inclusive of non-indigenous peoples, through the Maori health organisations and models they developed and delivered.

In addition to the co-operative co-existence models developed and delivered by the Maori health organisations discussed as micro-level organisational hauora kotahitanga models above, there were co-operative co-existence experiences at the community level that were conceptualised as meso-level hauora kotahitanga models. These micro-level and meso-level models were identified and conceptualised through the information, knowledge and experiences from the case studies.

In this section the case study information, knowledge and experiences are considered with the information, knowledge and experiences of the Tupuna discussed in Chapter 4. The conceptual models from this combined consideration are defined here as macro-level ‘tribal & tupuna’ models. These are models of collectivised experiences across the Ngati Whatua tribal region – so they are a reflection of all of the case study organisations that have been considered. This section considers some of the intriguing regional elements that collectively have alignment with the experiences of the tupuna. The ‘rangatira’ model aligned the experiences of the historical Maori health leaders discussed in Chapter

4 with the experiences of some of the Maori health leaders in the case study organisations across the Ngati Whatua rohe. The ‘kaimahi’ model aligns the experiences of Maori kaimahi in some of the case studies with the historical community health initiatives discussed in Chapter 4. The ‘Maori nurse’ model aligns the experiences of the Maori nurses’ history from Chapter 4 with Maori nurses from the case studies.

These models draw the whanaungatanga relationships of this study together by bringing past and present experiences of matauranga and hauora Maori together to be respectful of both the mana whenua experiences and the tupuna experiences.

10.4.1 The Rangatira model

The Ngati Whatua health sub-region developments resulted in a governance and management network, conceptualised here as ‘the Rangatira model’, that was characterised by the significant cross-over of people in governance and management positions between the case study organisations. This integration was combined with the consistency and longevity of the Maori concerned within their governance and management roles. Of the seven people discussed below, four were Ngati Whatua: Tom Parore, Sir Hugh Kawharu, Liz Mitchelson, and John Marsden.

The Chairperson of Te Runanga o Ngati Whatua, Tom Parore, was also the Chairperson of Tihi Ora MAPO. The Rangatira Hauora of the Tihi Ora MAPO board, Sir Hugh Kawharu, was also the Chairperson of Ngati Whatua o Orakei Trust Board, of which Ngati Whatua o Orakei Health Clinic was a subsidiary. The Chairperson of Te Ha o te Oranga, John Marsden, was also the Chairperson of Te Puna Hauora and Te Roopu Taurima. Liz Mitchelson was on the Te Ha o te Oranga and Ngati Whatua Orakei boards.

The Ngati Whatua health sub-region management leadership was also highly integrated between the case study organisations. Kerry Hiini, the original manager of Ngati Whatua o Orakei Health Clinic, became a manager at Tihi Ora MAPO. Lewis Stephens, the clinical manager of Tihi Ora MAPO, became the manager of Ngati Whatua o Orakei Health Clinic. Hinekehu Hohaia, the clinical manager of Tihi Ora MAPO, became the manager of Te Ha o te Oranga. John Marsden, the chairperson of Te Ha, Te Puna, and Te Roopu, became manager of Te Ha and then Te Puna.

Governance and management commonalities between the various health organisations in the Ngati Whatua health sub-region were augmented by the extensive implementation of collective matakā knowledge and tikanga Māori methodologies, made possible through the consistencies of, in particular, Ngati Whatua peoples within governance and senior management roles. This is a small, highly integrated management and governance network. The kaimahi across the organisations, however, numbered in their hundreds and were from a variety of cultural and professional backgrounds. Nonetheless the drive of the kaimahi to ensure matakā Māori knowledge and tikanga Māori methodologies were implemented through their health models was also key to the creation of co-operative co-existence models for Māori and non-Māori peoples within their communities. This was possible because of the ‘rangatira model’ or leadership model, which promoted consistency of leadership, which in turn promoted consistency of application of matakā and tikanga Māori. This ‘rangatira model’ can be broadly aligned to the experiences and practices of Māori health leaders like Buck, Pomare, Ratana and Te Puea in the early 1900s, as discussed in Chapter 4. Kotahitanga in both of these rangatira examples were premised on the confidence in the Māori leaders of the matakā and tikanga based hauora Māori initiatives - confidence held by Māori and non-Māori peoples involved.

10.4.2 The Kaimahi model

New directions in health development often occur at the political and policy level of government, and then work their way down into the health systems through implementation. Two of the hauora models created in the 1990s grew from staff social club initiatives, one within a Māori organisation, Te Puna Hauora, and one that began within a non-Māori organisation where the staff then separated from the non-Māori organisation to form a Māori organisation, Te Roopu Taurima. In this way, the kaimahi drove aspects of the matakā Māori knowledge and tikanga Māori methodologies from the community up and into the organisations development.

The first example is Te Puna Hauora. Their Harakeke - I-MAP model was initially a staff and community initiative to constructively engage with and define the community needs, particularly for whānau in crisis situations. They came up with a plan, but were frustrated by the time it was taking to deal with bureaucracy and red tape to get funding in order to deliver their ideas. They decided to use their social club fund to cover the

costs of delivering the service. The whanau outcomes through the new service delivery were compelling, with case studies of positive whanau outcomes presented to external organisations to seek funding to develop the services into a coherent delivery model. A number of external organisations all gave small amounts of money to pursue the development of a community based model. This was problematic however for the staff of Te Puna Hauora because the reporting mechanisms required for a large number of small value contracts meant that little of the money was able to be used on actual service delivery.

However, the community integrative nature of the model was able to be evidenced by the involvement of a large number of community funding organisations in getting the model produced into a fundable format over a period of years at the beginning of the I-MAP journey. The large number of small funding contracts to get this service started provided a greater range of constructive engagements with other community organisations than would have been possible through one funder. This was an unexpected bonus of the need to function through lots of small funding amounts. The variety of constructive engagements that were undertaken to organise funding, resourcing and assistance for the new service resulted in NGOs and community organisations such as Housing New Zealand, the Budgeting Service, and legal aide services, delivering workshops and services on a regular basis at the Te Puna Hauora building for whanau who were in what was eventually called the Harakeke - I-MAP service. Effectively, a one-stop-shop for health and social needs evolved out of the multiple-agency approach that had in part been facilitated by the search for funds to run the kaimahi initiated service.

The health funding authority did not have a contracting mechanism for such a combination of 'social' services with health services, which was one of the defining elements of the Te Puna Hauora Harakeke - I-MAP model. Funding for health services did not generally include social interventions under the Health Funding Authority in the 1990s. There were some health promotion contracts being delivered through Maori health organisations under public health funding at this point, but the Harakeke - I-MAP model did not fit well either with these contracts, or with the primary health contracts already being delivered at Te Puna Hauora. The first funding to come from the Ministry of Health was through the Maori Provider Development Scheme. Te Puna Hauora was initially only able to get funding to 'create a best practice model', funding. However

because the funding to ‘create a best practice model’ was in effect being used on service delivery, the staff and the community came together to ensure that that contract requirements of producing and documenting a model were achieved. One of the whanau participants of the Harakeke - I-MAP service, a person who had arrived under the UN refugee program from an African country, volunteered to assist in the desk-top publishing of diagrams and graphics to go with the presentation accompanying the model. His case study diagrams of the I-MAP process are at Appendix 3, and were used to present the model to the Ministry of Health and the Ministry of Maori Development when Te Puna Hauora sought their assistance in further developing the services. They were also used to present the model to the New Zealand Prime Minister and Associate Minister of Health in 2001.

The result of this collaborative effort between the staff, whanau and community of the service, and health and community development organisations, was a model for co-operative co-existence. A model was designed by the ‘workers and patients’, or kaimahi and whanau. It was then integrated and further developed by the ‘management and community’ or kaimahi and whanau. It was latterly funded by state health and social service agencies, and community donations and resources.

The second example of a Maori-driven self-determination model being transitioned into a community-driven self-determination model comes from the staff social club of Mangere Hospital and Mangere St John’s home services. One third of the patients of these services were Maori (Tenari, 2009). From the 1990s government policy moved towards community, rather than institutional care, for people with intellectual disabilities, and Mangere Hospital and Mangere St John’s services were devolved out into the community to Spectrum Care.

The Maori staff social club of Mangere Hospital and Mangere St John’s home services had a strong focus on facilitating tikanga Maori knowledge amongst the staff, who formed a kapa haka group, and learned waiata, karakia, and taniko weaving, under the guidance of kaumatua kuia (Tenari, 2009). This evolved into Maori services for the patients being set up for Mangere Hospital and Mangere St John’s, by participants from the Maori staff social club. When Tuila Tenari was asked to investigate how appropriate services for Maori could be created in the devolution process to the community, she and the Maori team followed tikanga and consulted the whanau, hapu and iwi of the patients

(Tenari, 2009). The results of these constructive engagements with the Maori intellectual disability community, and the corporate bodies for intellectual disability services management in New Zealand, was that the Maori staff social club Te Roopu Taurima o Manukau was established as a charitable trust to facilitate Maori intellectual disability service development: services that would be driven by board members who included whanau of the peoples living in the services (Stacey, 2009; Tenari, 2009).

Both the Te Puna Hauora and Te Roopu Taurima examples illustrate similarities with the Maori initiatives for community health undertaken in the early 1900s by the Maori Womens Institutes, and the services created by Te Puea and at the Ratana hospital as discussed in Chapter 4. They were initiatives that evolved through the impetus of Maori health workers to develop and deliver ‘by Maori for Maori’ programmes, and evolved into ‘by Maori for all’ programmes developed and delivered by Maori and non-Maori health workers. They are conceptualised here as a ‘Kaimahi Model’. Both Kaimahi models discussed were characterised by kotahitanga initiatives that were being initiated through the goodwill of the kaimahi of the organisation, rather than the leaders or managers. These examples illustrate that the mohiotanga of the kaimahi of the organisation can resolve and guide the tikanga for kotahitanga with the community. Kotahitanga in both of these kaimahi and community examples were premised on kaimahi and community members choosing to put the most vulnerable members of their communities at the forefront of their efforts, even where a large part of the work required was delivered on an unpaid basis by the people concerned; manaakitanga in Maori and goodwill in English.

10.4.3 The Maori Nurse model

One of the elements of Maori health developments of the early 1900s was the creation by Maori of a Maori nurse training scheme, which was implemented through state nursing training from 1898 and a Native Health Nursing Service established by the Department of Health in 1911. Almost a century later, Maori nurses were intrinsic to the creation and development of both the MAPO and Maori health case study organisations in the 1990s. The original member of the Maori health development division, the team that created the MAPO Strategy at North Health, was Gwen Te-Pania Palmer who was also a Maori nurse. Gwen was instrumental in setting up the three MAPO and all of their providers throughout the North Health region. In 1997 when the Regional Health Authorities

became the single Health Funding Authority, she remained in a senior management position within the Maori health team, through until the new government was formed in 2000. Gwen's guiding hand was on the MAPO strategy from inception in the early 1990s and implementation through to 2000 and at the end of this study Gwen was a Maori appointment on the Waitemata District Health Board, and involved in a number of government Maori health policy forum.

Another Maori nurse, Hinekehu Hohaia, as the clinical manager of the Ngati Whatua MAPO in the mid-1990s was responsible for creating the clinical management models for the MAPO organisation, and for overseeing the veracity of the Maori health provider clinical contracts in the Ngati Whatua MAPO region. She went on to become the head of the Ngati Whatua service provider organisation, Te Ha o te Oranga o Ngati Whatua, extending its localised contracting services into a regional service delivery model, particularly focused on health promotion, mobile nurses, public health and breast-screening. The linking of the purchasing and providing leadership models for Ngati Whatua that took place through the work of Hinekehu created the impetus for significant growth of the provider organisation, and for a closer working relationship between the four primary care providers in the Ngati Whatua rohe. Another Maori Nurse, Liz Mitchelson, was on the boards of Te Ha o te Oranga, and Ngati Whatua o Orakei Health Clinic.

The role of Maori Nurses in establishing the provider at Awataha Marae was one of the critical elements of early Te Puna Hauora organisational creation. Gwen Te-Pania Palmer from North Health worked to create the original contract and assisted in the recruitment of Lyvia Marsden, who had been a district nurse, practice nurse, and Maori nurse representative on the North Shore for many years, into the Nurse Manager role. Hinekehu Hohaia from Tihi Ora then used her nursing management knowledge to assist with Te Puna Hauora development of contracts and services in the late 1990s. The role of Gwen and Hinekehu was to represent Maori health developments within the health funder, and Tihi Ora MAPO, whilst the role of Lyvia was to represent Maori health developments within the North Shore community. One of the characteristics of the primary health contracts negotiated by Gwen and Hinekehu for Maori health providers, and instigated and implemented by Te Puna Hauora, is that all whanau attending a general practitioner clinic are given a comprehensive nursing assessment prior to seeing a

general practitioner. The nurse management structure of both the organisational development and the clinical management of the patients was not a characteristic of a non-Maori general practitioner service at that time. The Maori health organisations evolving in the 1990s faced a dearth of Maori trained as general practitioners, but there were a number of Maori trained as nurses, which was one strategic rationale for a nurse-dominated management and service delivery model

Te Roopu Taurima o Manukau was created through the vision of Tuila Tenari, also a Maori Nurse, who trained under the Maori nursing program at Auckland and Greenlane Hospitals with Lyvia Marsden. Tuila provided the clinical and tikanga interface for constructive engagements to take place between the Maori intellectual disability community, and the corporate and government organisations controlling intellectual disability service development and delivery. As a member of the Maori Nursing Council, Tuila joined Gwen Te Pania Palmer and Lyvia Marsden in meetings throughout the 1980s, 1990s and 2000s which in part focussed on the strategising of Maori health developments. It was this relationship with Gwen Te Pania Palmer, and through her the North Health Maori Health Development Division which facilitated Te Roopu Taurima applying to the Ministry of Health for funding under the Maori Provider Development Scheme to create an organisational structure so that Te Roopu Taurima could become independent of Spectrum Care and create a tikanga Maori based service. The Maori Health Development Division then assisted Te Roopu Taurima to negotiate a service delivery contract that was cognisant of tikanga Maori; this was the first time in New Zealand's history that a disability contract had included tikanga Maori.

As explored in Chapter 4, the journey to Maori Nursing that that began in New Zealand in 1898 resulted in Maori nurses becoming an important part of Maori health developments in the rohe of Ngati Whatua from the 1990s. Maude Mataira graduated in 1911 and then managed the nursing station at Otamatea (McKegg, 1991:30-75). In the final decade of the 20th century the Maori nursing journey was being continued in the Ngati Whatua rohe by Maori nurses including Gwen Te Pania Palmer, Hinekehu Hohaia, Liz Mitchelson, Lyvia Marsden and Tuila Tenari. For the nurses at the end of the 20th century, there existed a political and policy environment in which they could model services and organisations on matauranga Maori knowledge and tikanga Maori methodologies equitably with their nursing knowledge.

Kotahitanga through hauora Maori was in part an expression of, and result of, the mohiotanga of both te ao Maori, and the world of medical health, held by these Maori nurses who led many of the hauora Maori developments in the case study organisations.

10.4.4 Summary: Ngati Whatua & Hauora Kotahitanga

There are two aspects of the micro, meso and macro level analysis undertaken in this chapter that are focussed on here. The first is the shared experiences of the contemporary and historical hauora Maori people and organisations. The second is the experiences of Ngati Whatua iwi. In this way this summary aligns with the whanaungatanga aspect of the Kareretanga methods used in this study and discussed in Chapter 3. The experiences of the tupuna from Chapter 4 provide the tupuna frame. The broader experiences that have occurred in the Ngati Whatua rohe for hauora Maori that have been discussed in Chapters 7, 8 and 9 provide the mana whenua frame; the Ngati Whatua frame. Together these frames have provided a way to have a more in-depth discussion of some of the key characteristics that underpinned hauora Maori developments within the case study organisations, and therefore within the Ngati Whatua rohe. The key characteristics are that the Rangatira model showed consistency of leadership supported consistency of tikanga, that the kaimahi model showed Maori health developments can be driven up from the grass roots, and that the Maori nurses model showed that the efforts of the early Maori nurses to blend being Maori with practicing nursing knowledge has led to Maori nurses contemporaneously blending matakura and nursing knowledge equitably.

The key characteristics of these three macro-level models are outlined in Table 10 below.

Tribal & Tupuna Models	Key characteristic
Rangatira Model	Cross over and consistency between people in governance and management leads to cross over and consistency in matauranga and tikanga between Maori health organisations
Kaimahi Model	Kaimahi in Maori health organisations creating initiatives to drive aspects of the matauranga Maori knowledge and tikanga Maori methodologies from the community up and into the organisations development.
Maori Nurse Model	Maori Nurse managers modelling services and organisations on matauranga Maori knowledge and tikanga Maori methodologies equitably with their nursing knowledge

Table 11: Macro-level Hauora Kotahitanga models

The key characteristics of the three tribal & tupuna hauora kotahitanga models from the late 1990s were conceptualised using characteristics they shared with tupuna experiences from the late 19th and early 20th century experiences discussed in Chapter 4. These models are one example of how Maori ‘walk backwards into the future’ bringing with them the knowledge and experiences, the matauranga and tikanga, of their tupuna. These shared characteristics are outlined in Table 11 below:

Tribal & Tupuna models	Key characteristic of Ngati Whatua Hauora Kotahitanga model	Shared characteristics with early colonisation period experiences of Maori health leaders from Chapter 4
Rangatira Model	Cross over and consistency between people in governance and management leads to cross over and consistency in matauranga and tikanga between Maori health organisations	Buck and Pomare in government and community Maori health developments. Te Puea and Ratana in Maori community health developments.
Kaimahi Model	Kaimahi in Maori health organisations creating initiatives to drive aspects of the matauranga and tikanga from the community up and into the organisations development.	Maori women’s institutes. Initiatives driven through Ratana health participants result in Ratana supporters electing members of parliament to work on social policy developments.
Maori Nurse Model	Maori Nurse managers modelling services and organisations on matauranga Maori knowledge and tikanga Maori methodologies equitably with their nursing knowledge	Hei, Buck, Pomare, Ngata initiatives for Maori nurse training from 1898. Ratana and Whare Marama (Maori hospital staffed by Maori nurses).

Table 12: Macro-level Hauora Kotahitanga Models – incorporating tribal and tupuna characteristics

Three constructive engagements occurred in the course of Maori efforts to develop Maori models for community wellbeing in the Ngati Whatua health sub-region from the 1990s. The first was the constructive engagement taking place between the state health sector and the Ngati Whatua Maori health sub-region. The second was the constructive engagement taking place between the Maori people and Maori health provider organisations who were contributors to the Ngati Whatua Maori health sub-region. The third was the constructive engagement between the people and organisations of the Ngati Whatua Maori health sub-region, and the communities who benefitted from their services. Collectively, these three constructive engagements resulted in a model for co-operative co-existence in community wellbeing between the Ngati Whatua Maori health sub-region, the state, the health sector, iwi Maori, Maori, and non-Maori peoples. This was important to Te Runanga o Ngati Whatua iwi because it contributed to their kaupapa of rangatiratanga (leadership, authority and self-determination), manawhenua and manaakitanga (responsibility for their lands and peoples on their lands), through a kotahitanga (co-operative co-existence) approach.

The first of the constructive engagements, between the state health sector and the Ngati Whatua Maori health sub-region was the Northern Regional Health Authority MAPO Strategy, implemented in 1996. This constructive engagement was characterised by formal meetings and a legal relationship formalised through Memorandum of Understanding, Deed of Partnership, and delegated authority from the North Health Board to both the Tihi Ora MAPO organisation, and the Kaunihera Council.

The second constructive engagement, between Maori people and Maori health provider organisations who were contributors to the Ngati Whatua Maori health sub-region, was initially fraught with the tension created by the health systems in the 1990s. The health systems had been created to be a competitive contracting environment, which meant Maori people who were creating the new Maori health providers and organisations were required by the health system to compete amongst each other. Maori practices of collaboration, particularly through whanaungatanga, eventually overcame the state directed imperatives for competitive tension, and the Maori people and organisations who were contributors to the Ngati Whatua Maori health sub-region began to meet informally, to share knowledge and experiences, and eventually began utilising each other's Maori knowledge systems. In the case study organisations, Tihi Ora, Te Ha, Te

Puna and Orakei Health all implemented the *whanaungatanga* Maori knowledge system by Pa Tate, and Orakei Health, Te Puna Hauora, and Te Ha implemented the *Whaanau Ora* Maori knowledge system by Lewis Stephens. Orakei and Te Roopu Taurima both indicated use of *Te Whare Tapa Wha* Maori knowledge system by Mason Durie. Te Puna and Te Ha both implemented the Harakeke - I-MAP model, which was underpinned by the *Whanaungatanga* (Tate, 1999) and *Whaanau Ora* (Stephens, 1998) knowledge systems. Another significant factor in collaboration between these people and organisations were the people who were in the Ngati Whatua Maori health sub-region governance and management roles across a number of the organisations at various times during service development and delivery.

The third constructive engagement, between the people and organisations of the Ngati Whatua Maori health sub-region, and the communities who benefitted from their services, was facilitated through the implementation of models, such as the Te Puna Harakeke - I-MAP, and the Orakei Health 'Whaanau Ora'. These models facilitated constructive engagement from the community and into the organisations in ways that meant the community had as much power in the creation, development and delivery processes of the organisation, as the people managing and governing the organisations. These constructive engagements explained above are tabulated below in Table 12:

<i>Constructive Engagement 1</i> Ngati Whatua & State (Rangatiratanga)	<i>Constructive Engagement 2</i> Ngati Whatua & Maori (Manawhenua)	<i>Constructive Engagement 3</i> Ngati Whatua & Non-Maori (Manaakitanga)
Between Ngati Whatua AND the the state health sector	Between Ngati Whatua AND Maori people and Maori health provider organisations who were contributors to the Ngati Whatua Maori health sub- region	Between Ngati Whatua AND People and organisations of the Ngati Whatua Maori health sub- region
Initial constructive engagement between Ngati Whatua and North Health through Memorandum of Understanding and Deed of Partnership (1995/1996) leads to MAPO Strategy (1995/96)	Constructive engagement between the Maori health organisations on the basis of rangatiratanga and collaborative management and governance practices	Constructive engagement from the community facilitated through models such as Harakeke - I-MAP and Whaanau Ora
Table 13: Ngati Whatua constructive engagements for kotahitanga (hauora)		

Collectively, these three constructive engagements resulted in a conceptualised model for kotahitanga in community wellbeing between the Ngati Whatua Maori health sub-region, the state, the health sector, iwi Maori, Maori, and non-Maori peoples. This conceptualised model for ‘kotahitanga approach for community wellbeing’ is depicted below at Figure 13.

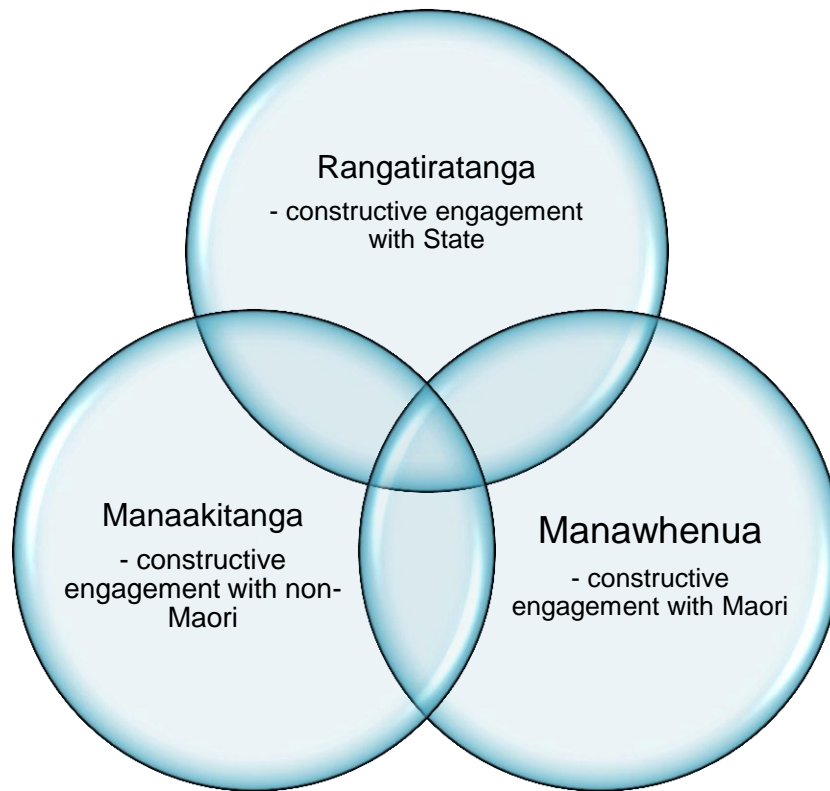


Figure 13: Conceptualising the ‘Kotahitanga Approach for Community Wellbeing’

Figure 13 also reflects a kaupapa of Te Runanga o Ngati Whatua iwi, which was to apply their rangatiratanga (leadership, authority and self-determination), and manawhenua and manaakitanga (responsibility for their lands and peoples on their lands) through a kotahitanga (co-operative co-existence) approach.

10.5 Summary: Indigeneity-based public health policy

In Chapter 4 Maori political and policy aspirations for Maori health development between 1840 and 1990 was discussed, and in Chapters 5 and 6 the political and policy dynamic in which Maori health developments occurred from 1980 was discussed in detail. As discussed in Chapter 4, when meeting with public health officials at the Hui Whakaoranga in 1984 and the Maori Health Decade Hui in 1994, Maori health leaders made it clear they wanted to participate in health policy and services, and they wanted that participation to be based on Maori world views. Chapter 6 proposed that public health policy that is created with Maori, and is based on matakauranga Maori and presented in te reo Maori, would be regarded as a ‘constructive engagement’ between Maori and the Crown and public health sector. In Chapter 6 the 2002 health policy document, *He Korowai Oranga* (King & Turia, 2002) was considered as a model for kotahitanga

between Maori and the Crown, and the two matauranga it contained, rangatiratanga and whanau ora, were studied to document their presence in health policies in the 1990s and 2000s.

The study in Chapter 6 had three main conclusions. Firstly, that rangatiratanga had been a matauranga used often in public policy documents throughout the 1990s, but that whanau ora had not. Whanau ora had however been used often in Maori health organisation documents sent to the Ministry of Health mainly from the mid-1990s, and many of the Maori health organisations met with or consulted with the political and health sectoral leaders between 2000 and 2002 to create *He Korowai Oranga*. The interpretation of matauranga used in this policy evaluation was based on the interpretation developed in this study of Marsden's (2003) ideas on matauranga and mohiotanga, where Maori combine matauranga with hauora Maori to create tikanga Maori methodologies. This is explained in Figure 10 at 10.2.1 in this chapter. The study revealed that the matauranga of whanau ora in *He Korowai Oranga* 2002 had alignments with the matauranga applied from the 1990s by a number of the hauora Maori organisations studied. The first finding was that whanau ora as a matauranga appeared to have been driven by the Maori health organisations and their communities onto the policy agenda through both their service delivery practices, and their policy consultation processes.

The second finding was that as *He Korowai Oranga* (King & Turia, 2002) had as its overall aim the matauranga Maori 'whanau ora' in te reo Maori, it was in effect a matauranga Maori based health policy, and therefore could be considered to be an indigeneity-based public health policy. The interpretation of 'indigeneity-based' used in this policy evaluation was based on the idea that where Maori knowledge intersects with Maori accustomed environments of non-Maori communities, indigenous knowledge systems can be found and these are called tikanga Maori methodologies for this study as depicted in Figure 11 at 10.2.2 in this chapter. In terms of the matauranga of whanau ora intersecting with the accustomed environment of public policy, *He Korowai Oranga* (King & Turia, 2002) can be considered as an indigeneity-based health policy.

For the third finding, the idea of co-operative co-existence as depicted at Figure 12 in 10.3.1 in this chapter is applied. The interpretation developed in this study of Maaka and Fleras (2005) co-operative co-existence idea, proposes that where indigenous and non-

indigenous peoples constructively engage through indigenous mātāuranga and tikanga based hauora Māori, co-operative co-existence between indigenous and non-indigenous peoples occurs. In terms of Māori and the Crown having constructively engaged to create the policy strategy *He Korowai Oranga* (King & Turia, 2002), ‘rangatiratanga’ and ‘whānau ora’ as indigenous mātāuranga and tikanga was used so this policy strategy can be considered as one example of kotahitanga between Māori and the Crown, and Māori and non-Māori, in New Zealand.

10.6 Conclusion – General Discussion

In this chapter, the knowledge and experiences studied were considered and synthesised into hauora kotahitanga models at three levels: at the micro-level were the organisational models, the meso-level were the community models, and the macro-level tribal and tupuna models. Firstly the mātāuranga and tikanga of the hauora Māori organisations studied in Chapters 7 and 8 were summarised as hauora kotahitanga micro-models. The hauora kotahitanga at the community level that were conceptualised in Chapter 9 were then summarised as meso-models. Finally, the findings of tupuna themes from Chapter 4 were combined with the experiences and information considered in Chapters 7, 8 and 9 to conceptualise three macro-level tribal and tupuna models. The implications of these macro-level models for Ngāti Whatua was then considered in terms of Ngāti Whatua iwi kaupapa, which was to apply their rangatiratanga (leadership, authority and self-determination) and manawhenua and manaakitanga (responsibility for their lands and peoples on their lands) through a kotahitanga (co-operative co-existence) approach.

The indigeneity-based policy analysis from Chapter 6 was also summarised by evaluating the findings with the study frames of mātāuranga as indigenous knowledge for health development, indigeneity for health development and indigeneity-based co-operative co-existence for health development, as introduced in Chapter 2.

Experiences of Kotahitanga between indigenous and non-indigenous peoples, in this study, have been found to have two main characteristics. Firstly, they are underpinned by public policy that is based on mātāuranga as indigenous knowledge; indigeneity-based public policy. Secondly, they are grounded in te ao Māori, which in this study has been characterised as ‘a kotahitanga approach for community wellbeing’ through mana

whenua, rangatiratanga, and manaakitanga. Grounding in te ao Maori facilitates and strengthens matauranga based tikanga for hauora Maori community development.

Chapter Eleven

CONCLUSIONS

11.1 Introduction

The purpose of this study was to examine Maori experiences of the development and delivery of indigenous knowledge based hauora Maori models, and to consider the experiences and the hauora models conceptually as models for co-operative co-existence (kotahitanga) between indigenous and non-indigenous peoples.. The purpose of this chapter is to draw the elements of this study together into some conclusions which may act as signposts for continued discussions and studies.

This thesis examines the relationships forming between the worlds of Maori and non-Maori peoples through Hauora Maori models. The Maori who created the Hauora Maori models in this study facilitated non-Maori peoples to be able to deliver matauranga and tikanga based hauora Maori models; and they facilitated non-Maori peoples to receive matauranga and tikanga based hauora Maori services. There are many unique Hauora Maori models for constructive engagements that were reflected upon through examining the experiences of the five Maori created hauora Maori organisations in this study. The experiences of the hauora Maori organisations studied have been conceptualised in this study as multiple examples of kotahitanga. They are experiences of kotahitanga between Maori and non-Maori peoples based on living together differently through indigeneity-based hauora Maori.

This research has explored the relationships between Maori and non-Maori peoples through hauora Maori in one tribal region, yet the study has only been able to touch in very basic terms on the complexities of the Maori and Maori relationships, and the Maori and non-Maori relationships that characterise the experiences studied. However, it is hoped that by having findings from an in-depth study of one tribal region, this study will provide useful knowledge and information for comparison with studies from other tribal regions, nationally and internationally, in the future.

The methodology and methods of this study are grounded in te ao Maori. In the methodology chapter, the matauranga of three Maori scholars, Durie, Maaka and Marsden, were discussed and re-interpreted to guide an indigeneity-based approach to undertaking this research. The three indigenous health development debates this study addresses are indigeneity for health development, constructive engagement between

indigenous and non-indigenous peoples for health development, and matauranga indigenous knowledge for health development.

Guided by Durie's (2005) and Maaka & Fleras (2005) ideas, indigeneity for this study is explained in the methodology as the indigenous knowledge systems that are considered to be where matauranga Maori knowledge intersects with non-Maori communities through tikanga Maori methodologies. For this study, indigeneity is conceptualised as tikanga Maori methodologies (as an indigenous knowledge system for health developments).

Guided by Maaka & Fleras (2005) ideas, constructive engagement for this study is explained in the methodology chapter as being where indigenous peoples constructively engage with non-indigenous peoples using hauora Maori (which are organisations and services based on matauranga and tikanga Maori). Hauora Maori then becomes a constructive engagement through living together differently that results in kotahitanga between Maori and non-Maori peoples. For this study, constructive engagement is conceptualised as indigenous and non-indigenous peoples living together differently through Hauora Maori.

Guided by Marsden's (2003) ideas, matauranga for this study is explained as the Maori knowledge that has been combined with hauora Maori to create the tikanga Maori methodologies for health development. Marsden's teachings on how matauranga becomes mohio by the people who are imbued with the matauranga, is used to identify the matauranga that are being delivered through the hauora Maori tikanga. Tikanga, in this study, were delivered by Maori and non-Maori practitioners of hauora Maori. The ability of these hauora Maori practitioners to apply the organisational matauranga was dependent upon their mohiotanga of the matauranga of the organisational tikanga. This inquiry was designed to understand what matauranga were active in the organisation through observation of hauora Maori Practitioners, rather than looking solely at what organisations were documenting as their preferred matauranga. For this study, matauranga is conceptualised as matauranga for health development.

In Chapter 10, the knowledge and experiences of the hauora Maori practitioners and organisations studied were considered and synthesised into conceptualised hauora kotahitanga models at three levels: at the micro-level were the 'organisational' models, at

the meso-level were the ‘community’ models, and at the macro-level were the ‘tribal & tupuna’ models. The matauranga and tikanga of the hauora Maori organisations studied in Chapters 7 and 8 were summarised as hauora kotahitanga micro-models at the organisational level. The hauora kotahitanga that were conceptualised in Chapter 9 were then summarised as meso-models at the community level. The findings of tupuna themes from Chapter 4 were combined with the experiences and information considered in Chapters 7, 8 and 9 to conceptualise three macro-models at the tribal & tupuna level.

The macro models were then considered in relation to a kaupapa of the Ngati Whatua peoples, which were in part expressed in their Kotahitanga Proposal (Te Runanga o Ngati Whatua, 2002). To summarise, Ngati Whatua kaupapa was to apply their rangatiratanga (leadership, authority and self-determination) and mana whenua and manaakitanga (responsibility for their lands and peoples on their lands) through a kotahitanga approach. Chapter 10 concluded with a summary of the indigeneity-based public health policy analysis of *He Korowai Oranga* (King & Turia, 2002) from Chapter 6. In this summary the findings from Chapter 6 were evaluated with the frames of the study identified in Chapter 2 through indigenous health development debates and literature: matauranga, indigeneity and indigeneity-based co-operative co-existence.

This chapter is in two parts. In the first part of this chapter, the three contemporary debates from the indigenous health development literature that have guided this study are discussed in light of the findings, and what contributions this study makes to these debates. The three debates explored were, firstly the proposal that constructive engagements between indigenous and non-indigenous peoples should be indigeneity-based; secondly, how constructive engagements between indigenous and non-indigenous peoples might be considered ‘constructive’; and finally how indigenous knowledge and practices are being, or should be, included in health developments. The second part of this chapter discusses the contribution that Kareretanga, as an indigenous research method, has made to this study and could make to the indigenous health development literature and debates. The final part of this chapter concludes the discussion on the contribution this study of Kotahitanga makes to the indigenous health development literature and debates.

11.2 Indigenous Health Development Debates

11.2.1 Indigeneity

The first debate engaged with was ‘indigeneity’. There are many complex ways of explaining and defining indigeneity; it is an evolving phenomenon with global implications and influences. A population is only indigenous if there is a non-indigenous population present; this is confirmed by the Cobo (2001) and the United Nations (United Nations, 2007) definitions of indigenous. The contemporary literature, however, makes it clear that there is much complexity in defining, explaining, and understanding the terms ‘indigenous’ (Daes, 1993; Cobo, 2001; Niezen, 2003; United Nations, 2007), and ‘indigeneity’ (Durie, 2005; Maaka & Fleras, 2005; O’Sullivan, 2007) within the social, political, economic, environmental, spiritual domains in which engagements between indigenous with non-indigenous peoples take place. As a simple explanation, indigeneity can be viewed as both collision and collaboration between indigenous identity as expressed by indigenous peoples themselves, and indigenous identity as expressed by non-indigenous peoples.

Defining indigeneity for this research was guided by many indigenous and non-indigenous scholars, but primarily by the teachings of Maori scholars Durie (2005), and Maaka (2005). Indigeneity for this study is defined as ‘matauranga Maori based tikanga Maori methodologies in hauora Maori developments for and with non-Maori peoples and communities’. What this examination has highlighted in terms of indigeneity, is that Maori chose to create health services based on their traditional knowledge, and to offer their traditional knowledge based services through and with non-Maori. For Maori in the case study organisations, their indigeneity-based approach was their matauranga and tikanga Maori based hauora services and organisations. Non-Maori people could choose to deliver or receive these services. These non-Maori were choosing to engage with indigeneity-based organisations and services. The ‘indigeneity’ aspect was the ‘tikanga’, or the Maori service elements, which the non-Maori people chose to deliver or receive. These non-Maori people chose to engage with te ao Maori, through the matauranga of Maori. They were engaging in an indigeneity-based relationship with the Maori peoples involved. Maori and non-Maori people studied were willing to co-operatively co-exist through living together differently based on Maori indigeneity through hauora Maori.

The debates on indigeneity in relation to global health developments are intertwined with debates on indigenous rights to autonomy, and their ability to be self-determining (Niezen, 2003; Durie, 2005; Smylie, et al., 2006; Montenegro & Stephens, 2006; Stavenhagen, 2007). These debates have become more prominent at the beginning of the 21st century with the establishment of a permanent forum on Indigenous Rights at the United Nations in 2000, and the 2007 Declaration on the Rights of Indigenous Peoples (United Nations, 2007). Research and literature on indigenous health developments is dominated by evidence of a lack of equity in health status between indigenous and non-indigenous peoples globally, and the concurrent lack of indigenous health and human rights that have caused this inequitable situation (Ring & Brown, 2003; Anderson, et al., 2006; Montenegro & Stephens, 2006; Smylie, et al., 2006; Stephens, et al., 2006; Signal, et al., 2007). Although one of the driving debates of indigenous health currently is the global phenomenon of disproportionately negative health status for indigenous peoples, this study has not addressed the health status of Maori. This thesis has not examined whether there has been an improvement in the health status of Maori since the hauora Maori organisations and services came into being. It has not looked at whether there has been an improvement in the health status of Maori through the constructive engagements between Maori and non-Maori that have characterised the experiences of the hauora Maori people and organisations.

What has been illustrated and that can contribute to this debate is that there were numerous examples of Maori choosing to have ‘by Maori for Maori’ health services, in the early 1900s as was discussed in Chapter 4, and throughout the 1970s, 1980s, 1990s and early 2000s, as was discussed in Chapters 4, 7 and 8. Another facet of this debate that was illustrated was that the Maori studied did expect to have autonomy and to be self-determining for their health services, and that this has been consistently expressed by the Maori studied to government institutions. The continued expression of this expectation to government institutions for over a century is evidence that Maori did not feel government institutions had achieved this expectation.

There is evidence that Maori have retained the essence of their traditional knowledge and practices despite the trauma of colonisation processes that were not protective of Maori rights to their own identity, knowledge, practices and worldviews. Te Runanga o Ngati Whatua was able to apply Ngati Whatua matakura and tikanga to public health sector

developments across the Ngati Whatua tribal region, and therefore to achieve some aspects of self-determination between 1995 and 1998, as was discussed in Chapter 7. To summarise this experience briefly, the Northern Regional Health Authority Board recognised the authority of Te Runanga o Ngati Whatua to control and define what indigeneity meant and how it would be practiced through public health and disability services in the Ngati Whatua tribal region between 1995 and 1998; Te Runanga o Ngati Whatua were able to control and define what indigeneity meant for health in their tribal lands without interference from the Crown for this period. The Crown unilaterally wrested back control of this aspect of indigeneity-based purchasing, providing and monitoring of public health and disability services from Te Runanga o Ngati Whatua in 1998 (Cooper & Health Funding Authority, 1998, p. 2), over continued Ngati Whatua objections (CEO Tihi Ora, 1998, p. 2).

The evidence indicates that the Maori people and organisations studied in the Ngati Whatua region continued to demand of the Crown the right to self-determination in matters of hauora (Kaipuke Consultants Ltd & PHP Consulting Ltd, 2003, p. 41); demands which remained ignored by the Crown. This lack of responsiveness of the Crown to Maori self-determination in hauora may be tempered by the lack of political power wielded by Maori, who make up only 15% of the population. Separate Maori health services were proving publicly unpopular with non-Maori in the early 2000s, as a poll in 2004 indicated. The public poll revealed that the majority of Maori polled supported “specialist Maori health services” while the majority of non-Maori polled did not (Taylor, 2004). The evidence has illustrated that the Crown remained unresponsive to Maori definitions of, and requirements for, self-determination in hauora that were communicated to them by study participants in multiple situations, through multiple contacts with Crown, public health sector, and government representatives, throughout the 1990s and early 2000s.

The evidence also revealed numerous constructive engagements by the Maori studied occurred with the Crown, public health sector, government, and non-Maori to inform, to educate, to explain, and to share matauranga and tikanga Maori for health developments throughout the study period. As was discussed in Chapters 5 and 6, financial assistance from governments from the early 1990s enabled Maori to create and develop hauora Maori organisations, and an indigeneity-based health policy was co-produced by Maori

health leaders and the Minister of Health in 2002 (King & Turia, 2002), yet the overall health sectoral reforms throughout the late 1990s and early 2000s undermined the veracity of the hauora Maori organisations studied. Each reform contained challenges that often required a defensive position by the hauora Maori organisations studied, towards the government and health sector, to protect their matauranga and tikanga. As evidence presented in Chapters 7 and 8 discussed, this reduced the capacity of most of the organisations studied to practice and deliver traditional knowledge.

The findings illustrated that the Maori organisations and peoples studied were able to articulate what indigeneity meant to them, and were able to construct mechanisms based on protecting their indigenous knowledge and practices through which to constructively engage with non-Maori organisations and peoples. The evidence indicated that indigeneity, based on Maori self-determination for hauora, was in the main achieved between Maori and non-Maori peoples in this study, but not consistently achieved between Maori and the Crown, governments, and public health sector. Indigeneity-based kotahitanga through hauora Maori was achieved at the community, but less so at the constitutional, governance and political levels of New Zealand society.

However, after this research was completed, there was one example of indigeneity-based kotahitanga through hauora Maori being achieved at the constitutional, governance and political levels of New Zealand society. In 2010 the first matauranga Maori based, therefore indigeneity-based, cabinet position in government was established through the appointment of a Minister for Whanau Ora. This is an exemplar of Maori health developments and leaders achieving indigeneity-based resilience through changing the political landscape to reflect indigenous knowledge and practices in the indigenous language.

For Maori in the case study organisations, improving indigenous health rights in their communities went hand in hand with building more productive relationships with non-Maori members of their communities. This research suggests that Maori were suddenly in a situation from the mid-1990s through creating the Maori health organisations where they had resources to share with the other community members. Maori initially had the opportunity to restrict access to their health services to Maori service users only, however many Maori health organisations chose to provide services for non-Maori peoples families also. Many refugees and migrants joined Maori health organisations because

they felt a sense of welcome and belonging within their new communities through accessing the family based services and relationships that were part of the Maori services, as evidence in the case studies of Te Ha o te Oranga, Orakei Health Clinic and Te Puna Hauora explained. O'Sullivan (2007) explains indigeneity as both a form of 'resistance' and 'transformation'. Maori experiences of health developments from the 1990s show they were able to 'resist' the subjugation of Maori identity in their communities by sharing their matakau and tikanga services with non-Maori. In this way the Maori world became more accessible to non-Maori, thereby reflecting both resistance and transformation of indigenous identity simultaneously in the community. Indigeneity-based Maori health services reflected transformation of indigenous knowledge into a base for multi-cultural resilience in community developments.

11.2.2 Constructive engagements between indigenous and non-indigenous peoples

The contemporary literature on indigenous health developments proposes engagements with indigenous peoples for health might be considered constructive where: indigenous peoples have a controlling interest in health resources (Anderson, et al., 2006; Montenegro & Stephens, 2006; Smylie, et al., 2006; Stephens, et al., 2006) and indigenous peoples have autonomy to define and control health developments (Montenegro & Stephens, 2006; Stavenhagen, 2006; Stephens, et al., 2006; United Nations, 2007). They might also be considered constructive where indigenous peoples have protection of indigenous health knowledge constitutionally (Montenegro & Stephens, 2006), and indigenous peoples knowledge, worldviews and methods are included within local, regional, national and global health developments (Anderson, et al., 2006; Bhopal, 2006; Cunningham & Stanley, 2003; Durie, 2003; Montenegro & Stephens, 2006; Ohenjo, et al., 2006; Ring & Brown, 2003). Many of these debates have now been reflected in the rights now protected through the various articles of the United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007), and in particular in the four articles that specifically mentioned health, Articles 21, 23, 24 and 29, and that were discussed in Chapter 2. This study has adopted an approach which was proposed by Maaka and Fleras as a way to broker an indigeneity-based constitutional space where Maori and the Crown could live together differently (2005, p. 207; p.284). Their approach was applied not at the constitutional level in this study, but at the community level. New Zealand became a signatory to the United Nations Declaration on

the Rights of Indigenous Peoples in 2010, so the constructive engagements at the community level which have been studied here may provide some useful examples for what may become an exponential growth in constructive engagements between Maori and the Crown, as well as Maori and non-Maori, in the post United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007) period.

What the findings suggest is that where Maori had a ‘controlling interest’ (Anderson, et al., 2006; Montenegro & Stephens, 2006; Smylie, et al., 2006; Stephens, et al., 2006) in health resources, as occurred with the Tihi Ora MAPO organisation discussed in Chapter 7, that the Maori involved considered the engagement with the publicly funded health authorities to be constructive. The evidence suggests that where Maori were able to include their ‘indigenous knowledge, worldviews and methods’ within their local and regional health developments’ (Anderson, et al., 2006; Bhopal, 2006; Cunningham & Stanley, 2003; Durie, 2003; Montenegro & Stephens, 2006; Ohenjo, et al., 2006; Ring & Brown, 2003), as was the case with the five hauora Maori organisations studied and discussed in Chapters 7 and 8, the Maori involved were able to effect constructive engagements with non-Maori through indigeneity-based hauora Maori organisations and services.

What the evidence has also revealed, through the complexities investigated in the case studies, is that Maori and non-Maori communities have unique ways of deciding how to constructively engage with each other. It has illustrated that the matauranga that Maori in this study chose to share as part of their engagements with their non-Maori community resulted in tikanga that were unique to the particular situations of each of their communities. The findings have revealed that the Maori involved in the hauora Maori organisations in the early 2000s who were consulted for *He Korowai Oranga* (King & Turia, 2002) as the matauranga Maori based health strategy co-produced by the Crown and Maori, chose to focus on whanau ora as an overall aim for that health strategy. One of the reasons for having whanau ora as the overall aim discussed by Maori at hui during the two years of consultation on *He Korowai Oranga* (Minister of Health, 2001) was that ‘whanau’ literally translated means ‘family’ and so no one could be excluded from the policy. The matauranga of whanau is automatically inclusive of non-Maori peoples. The policy was being created to be inclusive of non-Maori, yet also to acknowledge that many Maori whanau have members from a number of different cultures.

Whanau ora for *He Korowai Oranga* (King & Turia, 2002) was a matauranga to strengthen the health and wellbeing of all families and peoples in New Zealand, not just Maori. Yet each of the organisations in this study did not start calling their tikanga Maori methodologies whanau ora after *He Korowai Oranga* was produced in 2002; they chose to retain their unique community-based models and methods. Hauora Maori organisations throughout New Zealand had been able to be involved in the creation of *He Korowai Oranga* from 2000, so were mainly supportive of the *He Korowai Oranga* policy, and the whanau ora aim. The hauora Maori organisations in this study were aligning their services with *He Korowai Oranga* and whanau ora from 2002, yet they retained their own unique tikanga. They each maintained their own unique hauora Maori models through which non-Maori peoples could constructively engage on an indigeneity-basis with them, yet they delivered and practiced what had been agreed as a nationwide initiative of Whanau ora for *He Korowai Oranga*. In this way, whanau ora for *He Korowai Oranga* became a matauranga, or a philosophy for Maori knowledge-based wellbeing from 2002. Whanau ora for *He Korowai Oranga* 2002 was a co-operative co-existence model for Maori and non-Maori peoples, created through constructive engagement between hauora Maori representatives and the Crown (through the Minister of Health). It was distinctive because it was an all-of-country policy platform for kotahitanga.

11.2.3 Indigenous Knowledge & Practices/Matauranga & Tikanga Maori

There are two indigenous knowledge debates in the indigenous health development literature that this research contributes to; understanding efficacy of traditional knowledge for indigenous sustainability, and understanding indigenous knowledge systems. A discussion that dominates the indigenous health development literature is the dearth of available research and literature into how indigenous communities themselves, through self-determination in health developments, might ensure the efficacy of their traditional knowledge in underpinning community sustainability (Anderson, et al., 2006; Cunningham & Stanley, 2003; Durie, 2003; Montenegro & Stephens, 2006; Ohenjo, et al., 2006; Reading, et al., 2003; Ring & Brown, 2003; Stephens, et al., 2006). The findings illustrate that one way the Maori community have chosen to ensure the efficacy of their traditional knowledge was through sharing their traditional knowledge for use in public health policy. In Chapter 4, Maori constructive engagements with the government

and the public health sector in the 1980s were discussed, while those in the 1990s and early 2000s were discussed in Chapter 5. One of the primary goals of these constructive engagements for Maori was for their traditional knowledge to be included in New Zealand health policies and practices (Pomare, 1980; Department of Health, 1984; Murchie, E, 1984; Mantell, 1984; Pere, 1984; Marsden, 1986; Maori Health Committee, 1987; Maori Health Committee & O'Brien, P 1988; Pomare, E & De Boer, G, 1988; Ministerial Advisory Committee on Maori Health et al., 1990; Maori Studies, 1991; Ministry of Maori Development, 1994; Pomare, 1995).

The policy analysis in Chapter 6 highlighted how these Maori constructive engagements with governments and public health sector through the 1980s and 1990s resulted in indigeneity-based public health policy in 2002. *He Korowai Oranga* (King & Turia, 2002) was studied in Chapter 6 as an example of Maori and the Crown (through the Minister of Health) agreeing to co-operatively co-exist by living together differently through an indigeneity-based public health policy. What was notable about *He Korowai Oranga* was not only that it was delivered by hauora Maori organisations for the benefit of non-Maori as well as Maori, but that it was also available for use by non-Maori health services and organisations. Maori had shared their matauranga hauora Maori for the use of, and benefit of, non-Maori peoples. Maori ensured the efficacy of their traditional knowledge by making it available for the use of, and benefit of, non-Maori peoples. As *He Korowai Oranga* was also available online, Maori were able to ensure the efficacy of their traditional knowledge by making it available for the use of, and benefit of, any person globally who wished to access it online.

At a conference for Indigenous Peoples hosted by the Okanagan peoples in Canada in 2002, just as I was beginning these studies, I was questioned by a number of indigenous peoples from different tribes and countries as to how Maori had managed to get the government to agree to produce an indigenous knowledge based policy. They asked whether it would be acceptable for them to use the indigenous knowledge premise of *He Korowai Oranga* in their negotiations with their own health funders and other non-indigenous political contacts, to which I said yes, of course. The ideas of the hauora Maori organisations studied had been shared for the purposes of developing *He Korowai Oranga*, and during the 2000s some of the case study organisations did host international indigenous health practitioners as interns to understand both hauora Maori organisations

and hauora Maori in public policy. In 2008 I was back at an indigenous peoples conference in Canada, this one focussed on health, and a number of people came to tell me how they had subsequent to 2002 used *He Korowai Oranga* to broker more positive relations with their health funders and other state and federal government organisations for and through their own indigenous knowledge. The general consensus was that the external non-indigenous contacts had felt comfortable negotiating around inclusion of indigenous knowledge into health developments because Maori and the New Zealand government had revealed through *He Korowai Oranga* that this was possible.

Another way the Maori case study organisations ensured the efficacy of their traditional knowledge in underpinning community sustainability was by attracting peoples from multi-cultural heritages to their matakā and tikanga Maori organisations and services. In the case studies of Te Ha o te Oranga, Te Puna Hauora and Orakei Health, evidence was presented of their commitment to constructively engaging with non-Maori New Zealanders with multicultural identities. Te Ha offered a culturally inclusive kaupapa Maori service and actively sought to employ people from “ethnic minority groups” (Te Ha o te Oranga, 2000a, p. 2). Te Puna Hauora combined with local Asian general practitioner practice to offer services for Asian patients from 2005 (New Zealand Doctor, 2005a). Orakei Health focussed on being culturally inclusive and in 1998 documented their appreciable growth in Indian, Asian and Pacific Island peoples accessing their services (Stephens & Ngati Whatua o Orakei Health Clinic, 1998). The findings illustrated that an indigeneity-based approach to health developments based on matakā and tikanga Maori was viable for the sustainability of inclusiveness of multi-cultural and multi-ethnic communities in hauora developments in the study period.

When discussing traditional indigenous knowledge in the indigenous health development literature, indigenous knowledge systems are discussed as a way of collectivising the complexity of the many and unique traditional knowledge of indigenous peoples (Barnhardt & Kawagley, 2005; Battiste & Semegani, 2002; Durie, 2005). What this study discussed in Chapters 9 and 10 was that the five case study organisations had significant alignment in the matakā that underpinned their organisational development and practices, and more importantly their hauora Maori community development and practices. The matakā of these organisations could collectively be regarded, therefore, as ‘an indigenous knowledge system’ for hauora Maori in the Ngati

Whatua tribal region. However, this study also indicated in Chapter 10 that despite a collectivised ‘indigenous knowledge system’, for their matauranga, the tikanga Maori to deliver the matauranga were uniquely interpreted by each of the organisations; therefore the tikanga were considered to be unique, while the matauranga were considered to be collectivised.

What the study did not consider was how matauranga and tikanga were practiced in other hauora Maori organisations and communities outside of the tribal region of Ngati Whatua. There were around 200 Maori health organisations in New Zealand at the time this research took place. The Northern Regional Health Authority approach to creating three tribal MAPO from 1995 had given a more distinctly tribal focus to health developments in their region, than in the other health authority regions. This implication of tribal involvement in the Maori health developments in the Ngati Whatua region continued after the demise of the Regional Health Authorities in 1997, but this level of tribal involvement was not common in the situation of other Maori health organisations evolving in the late 1990s and early 2000s. This was one of the reasons for limiting this study to this tribal region, rather than undertaking a larger and more comparative analysis from other parts of the country. This focus on one tribal region was undertaken to give a more fine grained analysis of the relationships that had evolved at the community level, within the frame of the Ngati Whatua mana whenua involvement in the health developments studied. However, what the evidence has revealed is that the Maori studied did integrate traditional Maori knowledge into health developments to be shared nationally and internationally, thus ensuring the contemporary efficacy of their traditional knowledge.

11.2.4 Summary – Indigenous Health Development Debates

There are a number of conclusions we can draw from this research. In terms of ‘indigeneity’, the findings revealed that there were Maori who chose to create matauranga based hauora services from the 1990s when the opportunity arose. The hauora Maori services were created by Maori who were expressing their indigenous identity through their service creation and delivery; the services created were indigeneity-based. The indigenous identity of the hauora Maori organisation was considered to be unique in that each of the organisations studied applied matauranga that was similar to one or more of the other organisations studied, yet the tikanga Maori of

each organisations service delivery was completely unique. This was the situation even where two organisations had the same tikanga model. Another conclusion that we can draw is that the Maori who created the hauora Maori services studied were willing to share their matauranga, tikanga and other hauora service resources with non-Maori peoples, but only on the basis of matauranga and tikanga Maori; thus Maori offered indigeneity-based engagements with non-Maori peoples. In terms of 'constructive engagement' this evidence has revealed that if, rather than looking at a constitutional space between Maori and the Crown as Maaka and Fleras have proposed (2005), we instead look at how a community space was brokered between Maori and non-Maori peoples through hauora Maori, we might find many ways of achieving co-operative co-existence that are community, rather than Crown or constitutionally driven.

During the 1990s, Maori were discussing the potentiality of hauora Maori becoming a socio-indigenous platform for sharing and enhancing Maori identity with non-Maori in New Zealand and globally. Where the 1980s had been dominated by Maori efforts towards self-determination in hauora, in the 1990s Maori focused on sharing hauora globally. In 1984 at the Hui Whakaoranga, Maori constructively engaged with the Crown to express expectations of fulfilment of their indigenous rights to self-determination for health developments through more Crown support (Department of Health, 1984). In 1994 at the Hui Te Ara Ahu Whakamua, Maori constructively engaged with the Crown to express expectations of continuing to be able to define their indigeneity through health developments (Ministry of Maori Development, 1994). By 1994 Maori at the Hui Te Ara Whakamua were talking about using hauora Maori to provide positive images of Maori for the media to improve public perceptions of Maori. They were talking about sharing their matauranga and tikanga hauora to inspire health developments globally. Both of these aspirations became future goals set at this Hui Te Ara Whakamua (Ministry of Maori Development, 1994). Therefore hauora Maori was by the mid-1990s perceived by Maori as a co-operative co-existence model for living together differently based on Maori indigeneity; locally, nationally, and globally.

11.3 Kareretanga as Kotahitanga between Maori research and western academic research output

To create this indigeneity-based research project, the research process began within te ao Maori, but the goal was to produce an English-language doctoral research thesis within a western-academic institution. In Chapter 2 the Karere, or people who were talking newspapers and moved between Maori villages prior to the Maori language becoming a written form in the early colonisation period, were discussed. To acknowledge the Maori tradition of walking backwards into the future, and so ensuring experiences from ancestors are brought into the present, the experiences of the Karere have been used as a basis for creating the research methods. The Karere were recognised as experts in the philosophical debates of te ao Maori, as they travelled from village to village orally transmitting knowledge, and engaging in debates on issues of importance. This research focuses on building pathways between te ao Maori and non-Maori worlds in the research process, in as much as it studies the pathways that are being built through hauora Maori.

The pathways in hauora Maori studied included the oral transmission of knowledge by the hauora Maori practitioners – oral transmission that was inclusive of non-Maori practitioners. The research process focussed on discerning and distilling the orally transmitted knowledge of at least half of the hauora Maori practitioners in each organisation, and then triangulating that oral knowledge with written communications by their organisations. Essentially the research process focussed on listening to and reading how the hauora Maori practitioners communicated their organisational matakā and tikanga to others. The simplistic term of ‘storytelling’ was used in Chapter 3, the methods chapter, to explain how Kareretanga was designed as a method to gather, collate, consider, distil, and discern the knowledge and practices of the hauora Maori practitioners and hauora Maori organisations of this study. Hopefully by now, at the end of this thesis, the reader will understand that the term ‘storytelling’ was the best way of providing a basic interpretation for what was in fact a quite complex insider journey into researching and communicating experiences of peoples from te ao Maori and te ao non-Maori trying to figure out how best to function together.

Kareretanga in this study looks at how people create and deliver communications that assist their audience to understand complex Maori knowledge and practices that are being delivered or received by Maori and non-Maori. *Kareretanga* is my articulation of

what I see as a long tradition of relationality between whanau, hapu and iwi in te ao Maori with te ao non-Maori. Whanaungatanga for this study frames explanations of the relationships with whanau, hapu and iwi for the research process, whilst *Kareretanga* frames explanations through research outputs, from a Maori perspective, of the relationships and the implications of the relationships studied.

What *Kareretanga* contributes to the indigeneity debates in the indigenous health development literature is one idea of how an indigeneity-based approach to academic community health research might be achieved. This indigeneity-based approach has placed the ‘autonomy’ and ‘self-determination’ of the Maori who are the research subjects, at the centre of the research plan and process. This was accomplished in a number of, hopefully subtle ways, in the study and this dissertation. Firstly, as Ngati Whatua were the mana whenua peoples of the region studied, their proposal for ‘kotahitanga through hauora’ was considered in forming the research proposal and methods, see Chapter 3; in engaging with the case study organisations, knowledge and information, see Chapter 7; and in considering the findings, see Chapter 10. At the beginning of the research process Ngati Whatua kaumatua were consulted with to ensure the research would comply with Ngati Whatua kaupapa. The kaumatua outlined and explained which Ngati Whatua whakatauki should be used to guide the study, and how the whakatauki should be applied during the research. In this way the mana, the authority, of Ngati Whatua as mana whenua was upheld before and during the study. The whakatauki, and their application in this research, are in Chapter 3. The Ngati Whatua health purchasing organisation Tihi Ora MAPO was presented as the first case study, and this research included my understanding of some of the history of Ngati Whatua iwi, so Ngati Whatua as mana whenua were respected by being the first case study considered.

In the findings and general discussion in Chapter 10, the experiences studied across the organisations in the mana whenua region were juxtaposed with knowledge and information gleaned from historical experiences of Maori in hauora discussed in Chapter 4 to characterise some macro-themes for hauora Maori for Ngati Whatua. In this way the research considered the Ngati Whatua self-determined kotahitanga proposal for hauora against the findings, as a way to make a contribution to the mana whenua hosts of the research.

Kareretanga as a research method was achieved through whanaungatanga as a research approach. Whanaungatanga is a widely used matauranga Maori for ordering of relationships between people, gods and the earth. In this study it was re-interpreted as a way to explain my insider position as a Maori researcher undertaking research in their own mana whenua region. It also facilitated the attendant Maori or indigenous responsibilities associated with the researcher being mana whenua but also researching with non-mana whenua organisations and peoples, on mana whenua lands. The contribution of Kareretanga through whanaungatanga to the indigenous health development literature is that it documents one indigenous researcher's steps and rationales to undertaking indigeneity-based health research, and outlines the methods used for ensuring the indigenous autonomy, self-determination and knowledge of the peoples studied were respected through accepted traditional knowledge and practices of relationship ordering; whanaungatanga.

There were many different routes to constructive engagement by each of the organisations that were studied. There were, however, some commonalities and particular interfaces that were consistently observed as being important to participants' confidence in delivery of matauranga and tikanga through hauora Maori in all communities studied. These were interfaces that involved guidance by kaumatua and kuia in matauranga and tikanga to communities. What was interesting was that it didn't matter what culture the participants were from, what age or level of knowledge and experience the participants had in te ao Maori, or what level of knowledge of experience the participants had in health service delivery or hauora Maori; when kaumatua and kuia were involved or referred to there was consistently across the organisations a more substantive confidence and contentment displayed by the participant's involved in all facets of the organisational matauranga and tikanga. The findings have revealed that one way for kotahitanga to be considered viable is for kaumatua and kuia involvement in the related processes.

11.4 Kotahitanga – future implications and applications

Iwi: There are a number of implications for potential iwi use of this research. This study is one example of how an iwi might evaluate the implications of the depth and breadth of social policy occurring on their mana whenua lands, including that not under their direct

control, as either complying with or impugning their kaupapa. It is also an example of how an iwi might evaluate the consistency of social policy interventions occurring on their mana whenua lands, including that not under their direct control, to be used to strategically guide non-mana whenua organisations into more confidently complying with iwi kaupapa. It is also an example of how an iwi might evaluate the depth and breadth of community initiatives occurring on their mana whenua lands, including that not under their direct control, to be used to strategically guide community groups into more confidently applying iwi kaupapa.

Community: There are a number of implications for potential community use of this research. For community workers, it gives one example of how to use whanaungatanga personally if they are seeking to interface with Maori communities. For proponents of community development, it gives multiple examples of how and why indigenous knowledge and self-determination initiatives can provide a substantive basis for constructive engagements at the community level with both Maori and other cultural peoples in the community. An example of this might be including aspects of this research on a community website that has just been launched through Te Puni Kokiri, the Ministry of Maori Development, to share experiences of ‘whanau ora’ through He Korowai Oranga.

Policy: There are a number of implications for potential policy use of this research. For policy workers, it gives one example of how to use whanaungatanga personally if they are seeking to interface with Maori communities. For the policy community, it gives multiple examples of where if the policy can be based on the self-determination, traditional knowledge and cultural aspirations of the community; community engagement has the potential to be substantive, and sustainable. For policy leaders, it illustrates that indigeneity-based approaches to policy development, including the inclusion of traditional knowledge and experiences, and indigenous leadership, can lead to collaborative policy creation and implementation, at local, regional, national and global levels. An example of this is some current research I am working on with a team towards getting policy changed for child solvent abuse interventions. The study team have used the methods from this study in the first phase of the consultation with community and practitioners, and have decided to continue to use it in the second phase of the research process.

Kotahitanga and future research: There are a number of different ways this study of kotahitanga can be applied to future global comparative research that could continue the discussions from this research. A broader study of more hauora Maori organisations, and possibly other indigeneity-based health organisations in other countries, to test for similarities and differences against these experiences and findings could continue the contribution to the debates around indigeneity for health development, constructive engagement between indigenous and non-indigenous peoples for health development, and mātāuranga as indigenous knowledge for health development in the indigenous health development debates. A comparative analysis of the traditional indigenous knowledge from other countries indigeneity-based policy initiatives could continue the contribution to the debates around indigeneity-based health policies. The role and contribution of Maori nurses in indigenous health developments, with perhaps a comparative study on the role and contribution of other indigenous nurses from other countries could continue the contribution to debates around indigenous knowledge. The role and contribution of Maori health leaders in indigenous health developments, with perhaps a comparative study on the role and contribution of other indigenous health leaders from other countries could continue the contribution to debates around indigenous knowledge.

This research has given insight into indigeneity-based kotahitanga but we still haven't seen the non-indigenous aspects of the indigenous and non-indigenous constructive engagements. There are two pathways for continued studies into the aspects of kotahitanga studied here that would augment this study. One pathway would be a more finely grained examination of experiential relationships at the community level, rather than at this organisational level that has been the focus of this current study. The different light this would shed is that where this current work has studied processes and structures through case studies of hauora Maori organisations, research at the community level on the significance of socio-indigenous platforms, such as hauora Maori, for multi-cultural community development would be one way of addressing the non-indigenous aspects of this kotahitanga study. This could contribute to not only debates around indigenous health developments, but also debates on multi-cultural health and social developments in New Zealand. The other pathway would be a more finely grained investigation of experiential relationships at the worker level, rather than at the organisational level. The different light this would shed onto this study of kotahitanga is

the workforce development aspects of both community development, organisational development, and health sectoral development that kotahitanga can bring to discussions of New Zealand development, and indigenous health development.

In conclusion, this research has illustrated that there are numerous ways of including indigenous knowledge in both indigenous developments, and developments that are inclusive of indigenous knowledge. This study has also reflected upon the role of non-indigenous peoples in constructively engaging with indigeneity-based developments for the benefit of indigenous and non-indigenous peoples. It may well be that the incremental changes being wrought by numerous small community-led initiatives towards co-operative co-existence between indigenous and non-indigenous peoples can become exemplars for world developments that are more inclusive of, and reflective of, indigenous peoples and their knowledges. Ensuring the efficacy of indigenous knowledge in contemporary times not only underpins indigenous sustainability and resilience, it also provides indigenous peoples with a platform to participate in national and global developments in ways that can build the efficacy, sustainability and resilience of indigenous and non-indigenous peoples together.

APPENDIX 1: NGATI WHATUA O ORAKEI HEALTH CLINIC MODELS

Source: Ngati Whatua o Orakei Health Clinic. 24 November 1999. Kia te Kia Puawai. 46 pages. Kia Tu Kia Puawai model pp: 34-46



The *whanaungatanga* concepts of Ngati Whatua o Orakei will be articulated by the *hapu* in their modeling process. The following explanations come from the Te Hiku o te Ika Trust *Whanaungatanga*³⁷ model and are used here for contextualisation purposes only. The traditional concepts of *whanaungatanga* embody *tapu*, *mana*, *tika*, *pono* and *aroha*. *Tapu* and *mana* are two cultural tikanga intrinsic to Ngati Whatua.

Tapu can be broken down into three perspectives. Firstly there is the intrinsic *tapu* or sacredness of being, for instance '*te tapu i te atua*' (the *tapu*/sacredness of god/s), '*te tapu i te tangata*' (the *tapu*/sacredness of people), '*te tapu i te whenua*' (the *tapu*/sacredness of earth). The underlying principle here is that all living things (birds, rocks, tress etc) have an intrinsic sacredness.

Secondly, there is the *tapu*/sacredness of relationships between *atua*, *tangata* and *whenua*. Therefore the intrinsic sacredness of both a person and the earth must be acknowledged and respected in any relationship between them. Many believe that the relationship between people and earth is validated through the relationship between people and god/s. A person breaching the relationship with the earth via abuse i.e. burying toxic waste; is in effect also breaching their relationship with *atua* as well as *whenua*.

Thirdly there are *tapu* or sacredness as relating to *tapu*/restrictions. These restrictions support and enforce the intrinsic *tapu* and relationship *tapu*. An example of this kind of *tapu* would be '*rahui*'. *Rahui* is a limit or ban on use of a particular resource, which is put in place either to protect the resource or people. For instance, in the case of a drowning a *rahui* will be put in place over the water concerned to protect the sacredness of the person drowned, the sea itself and people who may take sustenance from it. A *rahui* is also used where a resource is becoming depleted and needs to be protected, for instance banning fishing in an area where the numbers are dwindling dangerously, or rotation farming of crops.

Mana is the spiritual power that creates, produces and restores *tapu*. It can be expressed in a number of ways including: *Mana-whakahaere*: the spiritual power and authority of people to order and determine their own lives according to *tika*, *pono* and *aroha*. *Mana-tuku*: is the spiritual power and authority of those with *tapu* and *mana* to share of themselves and their resources with others. *Manaaki* is the act of sharing; *aroha* is the principle under-pinning *mana-tuku*.

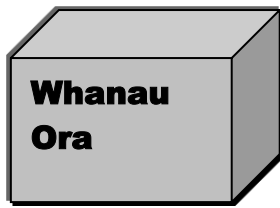
³⁷ Source: Transcription from Te Hiku o te Ika Trust course on Whanaungatanga 8-9 September 1999.

Mana is also authority, prestige, honour bestowed by *atua* of people upon individuals or representatives. If one wants to have *mana*, one must first seek after *tapu*. To possess *tapu* one must exercise *tika*, *pono*, and *aroha*.

Tika can be defined as the principle concerned with the right ordering of relationships, among *atua*, *tangata* and *whenua*, the right response to those relationships and the right exercise of *mana*. In other words the right way to do things. *Pono* is the principle that seeks to reveal reality and to achieve integrity of relationships. In other words it calls for honesty and integrity in all that we do. *Aroha* is the principle of expressing empathy, compassion and joy for others in all that we do.

Tika, *pono* and *aroha* are the principles of action by which we exercise *tapu* and *mana*.

These Ngati Whatua values underpin Ngati Whatua *tikanga* and *kaupapa*. They are applied naturally to all social, political, economic and environmental initiatives and issues of the tribe.



**Whaanau Ora
Tikanga From Within
(Lewis Stephen)**

- It has been the observation of the writer and feedback from consultations that many health services are imposed on those who appear to need it the most.
- Health services are provided by those in authority and power without really empowering the development of Maori.
- Much lip service is given to the health needs of Maori.
- Health initiatives appear to be having little or mixed effects in producing quality healthy outcomes.
- Maori seem to be more and more dependent on others for the standards of health.
- One could say that the status of Maori health is on the dole.
- The dignity of the whaanau to resolve issues of the community appears to be less and less.
- We are relying more and more on others to provide the initiatives for better health when the power to enable or provide the means for quality health lies within the Tikanga Maori and how the whaanau implement or live that tikanga.

From the writers perspective the whaanau has the power to reestablish themselves to gain the quality of health other New Zealanders enjoy.

The following is one view of empowering the whaanau. This is the foundation of the blueprint. Within the models there are traditional aspects mixed with modern. Whaanau ora is an attempt to bridge the disparities of health by utilising what is traditional with modern realities.

The model overviews the whaanau being at the center of influence within society. The collective due to modern times maybe a group of household within the community as opposed to the traditional definition. The arrows indicate the direction of empowerment of the whaanau to access services within themselves and the community. The model is an attempt to place the power and control back on the whaanau. Any other model will place other in control and thus lose the dignity and mana of group in other word being on a spiritual dole waiting for handouts to make us whole.

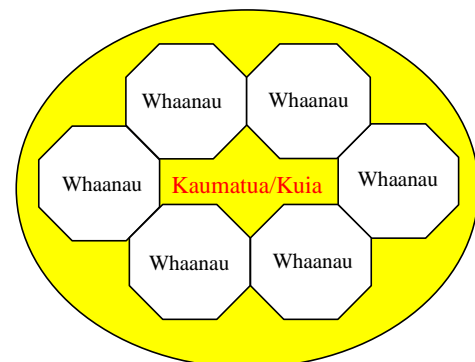
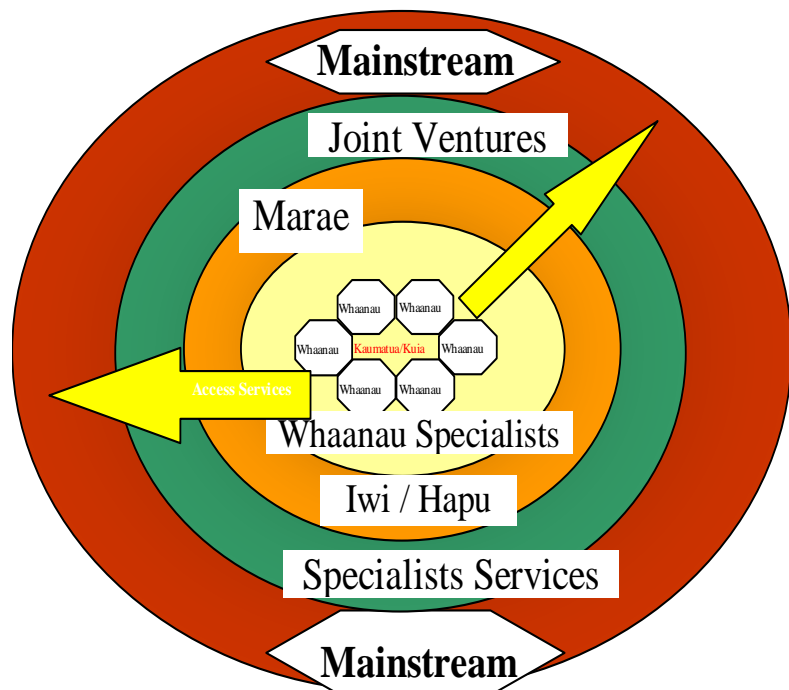
This model allows a community to draw upon the skills and resources that currently exist within its own people. The strength from such a community will allow a foundation for groups of whaanau / and or households, to maximise efforts by securing resources that improve wellness.

THE INNER CIRCLE

The inner circle is a collective of participating whaanau or households. These groups are lead by a Kaiwhaka Ngawari, Kaumatua and Kuia. These leaders have the mana and respect of those involved leading the development of the whaanau.

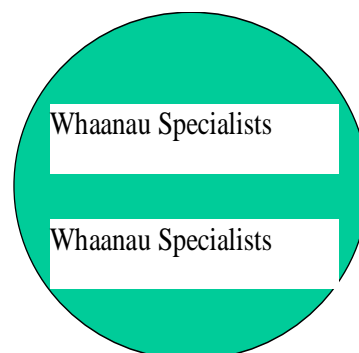
Each group has at least one or two model whaanau or household that can add value to the whole.

Whaanau Ora



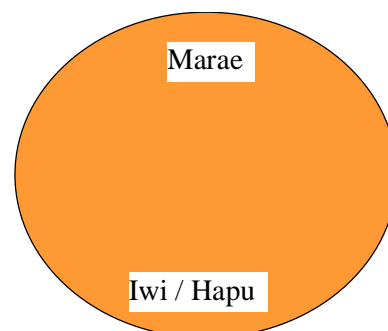
The whaanau specialists are professionals who are members of or who can be accessed by whaanau and can add value through their current expertise. They might include social workers, employment specialists, psychologists, business owners and teachers etc.

Their role would be to provide guidance and specialist knowledge on subjects required that will enable the whaanau to greater well-being.



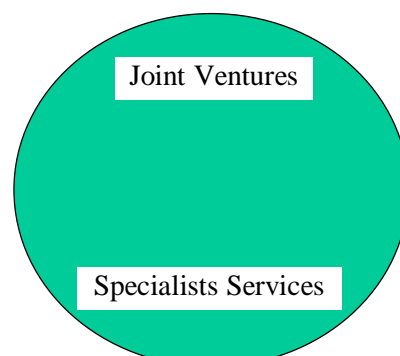
IWI RESOURCES

The Iwi, Hapu, or Marae provide resources if necessary to the inner circle and the whaanau specialists for assistance in the well-being of all concerned. They also provide a sense of identity, support for empowerment and access pathways to the outer circle who provide public services.



SPECIALIST SERVICES

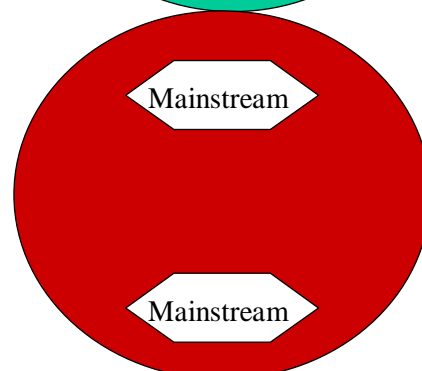
The specialists circle provide the specialists services to the whaanau collectives. For example, provision of suicide prevention, Mental health services, social services etc. these contracts are negotiated by North Health and CHE with community or mainstream providers of health services



MAINSTREAM SERVICES

Mainstream provides the acute health services to all consumers. The key for Maori is to encourage service delivery that will allow Maori the choice of service delivered in a Maori model or a mainstream model.

In summary, this concept helps facilitate the empowerment of the whaanau. It provides the foundation to deal with the imposition that occurs from many health initiatives and thus ultimately fail. Further more, the provision of the control over ones life and well-being is placed back in the hands of the whaanau where it belongs in an effort to enjoy the level of health other New Zealanders have.



APPENDIX 2: TE HA O TE ORANGA MODELS

Ngati Whatua Kaupapa, Tikanga and Kawa

Source: (Tihi Ora, 1999c)

HAUORA NGATI WHATUA

Ngati Whatua culture is based on its *kaupapa*, *tikanga* and *kawa* and expressed through values such as *tapu*, *mana*, *tika*, *pono* and *aroha*. The ability to express Ngati Whatua culture has been impugned through dis-enfranchisement caused by colonisation, and this has reduced their ability to pursue sustainable development. The restoration of tribal *rangatiratanga* through *tapu*, *mana*, *tika*, *pono* and *aroha*, will lead naturally to a positive outcome on programmes of Ngati Whatua sustainable development. The tribe have taken a number of steps towards restoration of their culture and traditional lifestyles. We can look to current examples of sustainable development initiatives in the Ngati Whatua *rohe* in health, to see ‘where Ngati Whatua have been’ and ‘where Ngati Whatua are now’.

The health status of Maori in general is acknowledged as being low due to a number of socio-economic and environmental factors, many of which have their root causes in the dis-enfranchisement caused by colonisation. One of the initiatives the Crown has taken is to fund some portions of Maori health directly to see whether Maori, using their own *kaupapa*, *tikanga* and *kawa*, can have a more positive effect than general health practices. The Crown have formed a relationship with Ngati Whatua through *Te Runanga o Ngati Whatua* to co-purchase a portion of health services for Maori in the Ngati Whatua *rohe*.

Under the ‘health’ arm of the *Te Runanga o Ngati Whatua* there exist two entities. One is ‘Tihi Ora’ which operates as a co-purchaser of health with the Crown, the other is ‘Te Ha o te Oranga’ which is a Maori provider of health services in Ngati Whatua. There are several other Maori Health providers in the Ngati Whatua *rohe* including Ngati Whatua ki Orakei Health Clinic, a *hapu* based health service in central Auckland; Te Puna Hauora o te Raki Pae Whenua, an urban Maori health service on the North Shore of Auckland; and Waipareira Health, an urban Maori health service in West Auckland. These providers, along with Te Ha o te Oranga, must seek guidance and funding through Tihi Ora, and Ngati Whatua, through governance of Tihi Ora, has a *manaaki tanga* responsibility to seek best results for these providers and their consumers.

Ngati Whatua *kaupapa* based initiatives are being developed and expanded into broader areas of health and disability services and into models and frameworks that will be sustainable and successful for Ngati Whatua and the people who live in their *rohe* in the future. These *kaupapa* health services form part of a broader move by Ngati Whatua

towards sustainable development. They can be viewed as an holistic approach to not only health outcomes, but also the development of skills and expertise of Maori workers and businesses, and therefore to the overall skills and expertise of Ngati Whatua as an *iwi*.

HAUORA NGATI WHATUA TIKANGA

Ngati Whatua *havemana whenua* or people of the land status, and as such have a *manaaki tanga* or responsibility to take care of all other people in their *rohe*. This *manaaki tanga* articulated in the Ngati Whatua *tikanga*:

KIA KOTAHI TE MAU O TE ORANGA KI ROTO I A NGATI WHATUA

Health services delivered within Ngati Whatua will be of the same highest standards **and applicable to everyone.**

The underpinning Ngati Whatua values for health services are articulated in the following Ngati Whatua health *tikanga* which apply across the *rohe*:

KIA MAU KI TE TIKA, TE PONO ME TE AROHA

Health services delivered by Ngati Whatua will be imbued with the concepts of tika, pono and aroha.

KIA MAU KI TE MANA TE TAPU ME NGA TIKA O TE TURORO

The mana and tapu of the patient is to be recognised, including his/her rights

Acknowledgement of the health issue from a collective perspective as it affects not only the individual, but also their entire family is acknowledged.

So too is the importance of the *mana* and *tapu* of other *iwi* in the following Ngati Whatua health *tikanga*:

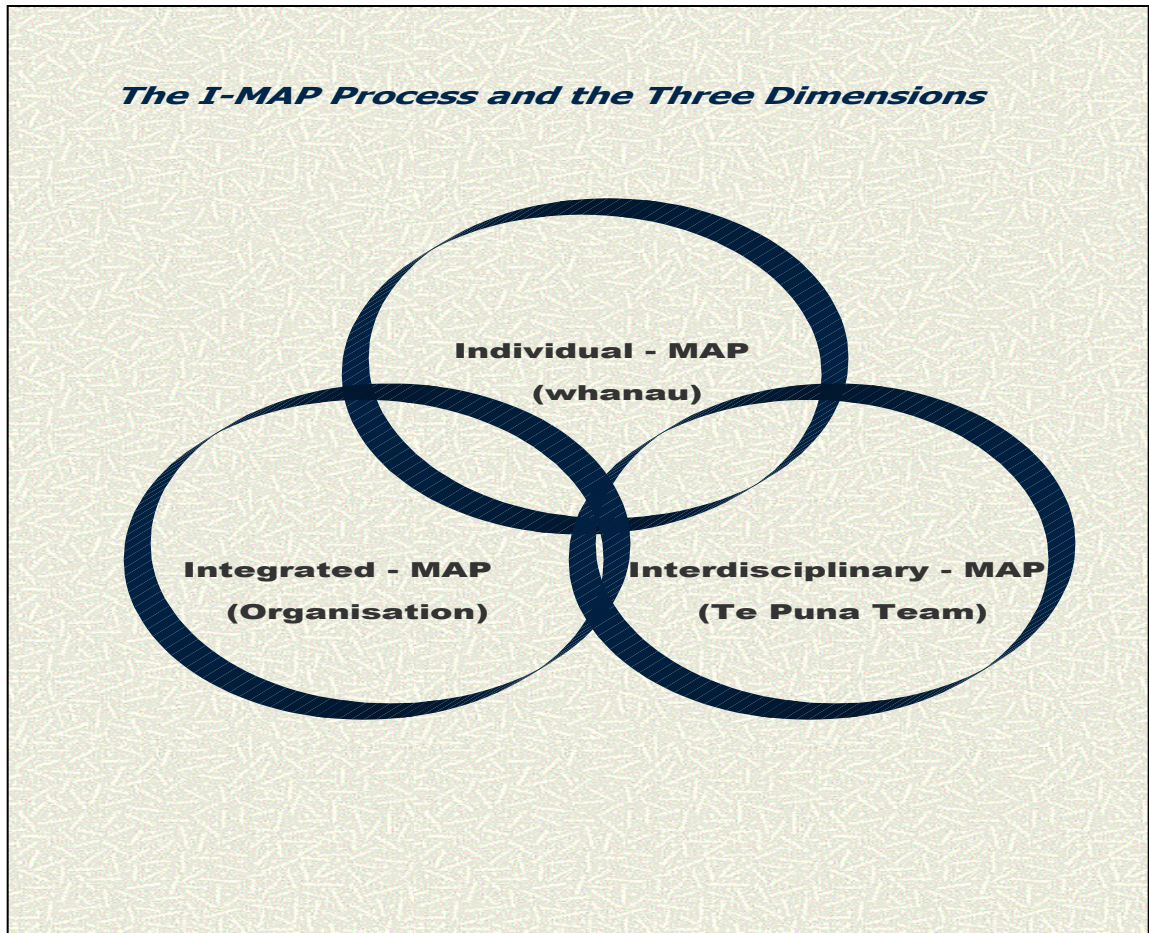
KIA MAU KI TE MANA O TE WHANAU, TE HAPU ME TE IWI

The mana of the whanau is to be recognised especially when dealing with children. This principle requires whanau participation in decision-making and also gives whanau the right to challenge decisions made on their behalf. The mana and tapu of other *iwi* or hapu must also be observed.

APPENDIX 3:TE PUNA HAUORA O TE RAKI PAE WHENUA MODELS

Organisational Model 1: Te Puna Hauora I-MAP

Source: Te Puna Hauora o te Raki Pae Whenua, documents for web, January 2005



The organisation describes their Harakeke-IMAP model as: “Our Kaupapa Maori model of delivery is encapsulated in our Harakeke-IMAP model. This model when practiced within it’s true spirit, both generic and kaupapa Maori, is the korowai which encompasses the individual, whanau, hapu and iwi. It focuses and brings alive the whakatauki which we have heard mai rano. It is the heartbeat of Maori development when practiced in partnership with different groups biculturally, multiculturally, intersectorally, intra-sectorally, intra-physically.

The concept of the Harakeke or heart of the flax is that the whanau/individual and Te Puna Hauora service providers work towards the outcome of total wellbeing for the whanau/individual. This is ideologically aligned with the weaver weaving the flax into the shape they want. In the Te Puna Hauora process the weaver is the whanau/individual and Te Puna Hauora provides guidance on the weaving process.

Organisational Model 2: Te Puna Hauora Kaupapa, Tikanga and Kawa Model - Whanaungatanga

Source: Te Puna Hauora Strategic Plan 2004

TABLE 1 - WHANAUNGATANGA:

The following explanations for *tapu*, *mana*, *tika*, *pono* and *aroha*, are scribed from a 1999 hui conducted by Pa Henare Tate in *whanaungatanga*:

Te Puna Hauora *kaupapa*, *tikanga* and *kawa* are embodied in the traditional concept of *whanaungatanga*. *Whanaungatanga* encapsulates the *tikanga* of *tapu*, *mana*, and their expression through the principles of *tika*, *pono* and *aroha*.

Tapu can be broken down into three perspectives. Firstly there is the intrinsic *tapu* or sacredness of being, for instance ‘*te tapu i te atua*’ (the *tapu*/sacredness of god/s), ‘*te tapu i te tangata*’ (the *tapu*/sacredness of people), ‘*te tapu i te whenua*’ (the *tapu*/sacredness of earth). The underlying principle here is that all living things (birds, rocks, trees etc) have an intrinsic sacredness.

Secondly, there is the *tapu*/sacredness of relationships between *atua*, *tangata* and *whenua*. Therefore the intrinsic sacredness of both a person and the earth must be acknowledged and respected in any relationship between them. Many believe that the relationship between people and earth is validated through the relationship between people and god/s. A person breaching the relationship with the earth via abuse i.e. burying toxic waste, is in effect also breaching their relationship with *atua* as well as *whenua*.

Thirdly there are *tapu* or sacredness as relating to *tapu*/restrictions. These restrictions support and enforce the intrinsic *tapu* and relationship *tapu*. An example of this kind of *tapu* would be ‘*rahui*’. *Rahui* is a limit or ban on use of a particular resource which is put in place either to protect the resource or to protect people.

Mana is the spiritual power that creates, produces and restores *tapu*. It can be expressed in a number of ways including: *Mana-whakahaere* is the spiritual power and authority of people to order and determine their own lives according to *tika*, *pono* and *aroha*. *Mana-tuku* is the spiritual power and authority of those with *tapu* and *mana* to share of themselves and their resources with others. *Aroha* is the principle under-pinning *mana-tuku*. *Manaaki* is the act of sharing. *Mana* is also authority, prestige, honour bestowed by *atua* of people upon individuals or representatives.

Tika can be defined as the principle concerned with the right ordering of relationships, among *atua*, *tangata* and *whenua*, the right response to those relationships and the right exercise of *mana*. In other words the right way to do things. **Pono** is the principle that seeks to reveal reality and to achieve integrity of relationships. In other words it calls for honesty and integrity in all that we do.

Aroha is the principle of expressing empathy, compassion and joy for others in all that we do.

Tika, **pono** and **aroha** are the principles of action by which we exercise *tapu* and *mana*. If one wants to have *mana*, one must first seek after *tapu*. To possess *tapu* one must exercise *tika*, *pono*, *aroha*.

Organisational Model 3: The I-MAP as an integrative model for social and health wellbeing



The Supreme Award - Te Tohu Kahukura – press release Ministry of Health

Te Puna Hauora (Waitemata)

The winning Whānau Kaupapa and the Supreme Award winner in the Whānau Ora Awards can be found on Auckland's North Shore located at Te Puna Hauora. Te Puna Hauora has been built on this project which was the development of a kaupapa Maori model of delivery – Te Puna Hauora's Harakeke - I MAP model.

The Harakeke – I MAP model is an impressively documented Best Practice model where the heart of the flax is the individual and whānau who weave the flax into the shape they want for their health and wellbeing. Around the individual and whānau is the Te Puna Hauora team who work with them to help set priorities for their health and social needs. And beyond the Te Puna Hauora team are the external organisations who might also be called upon as part of the integrated management plan.

In this model the 'I's have it. I is for Individual management. I is for Interdisciplinary management. I is for Integrated management.

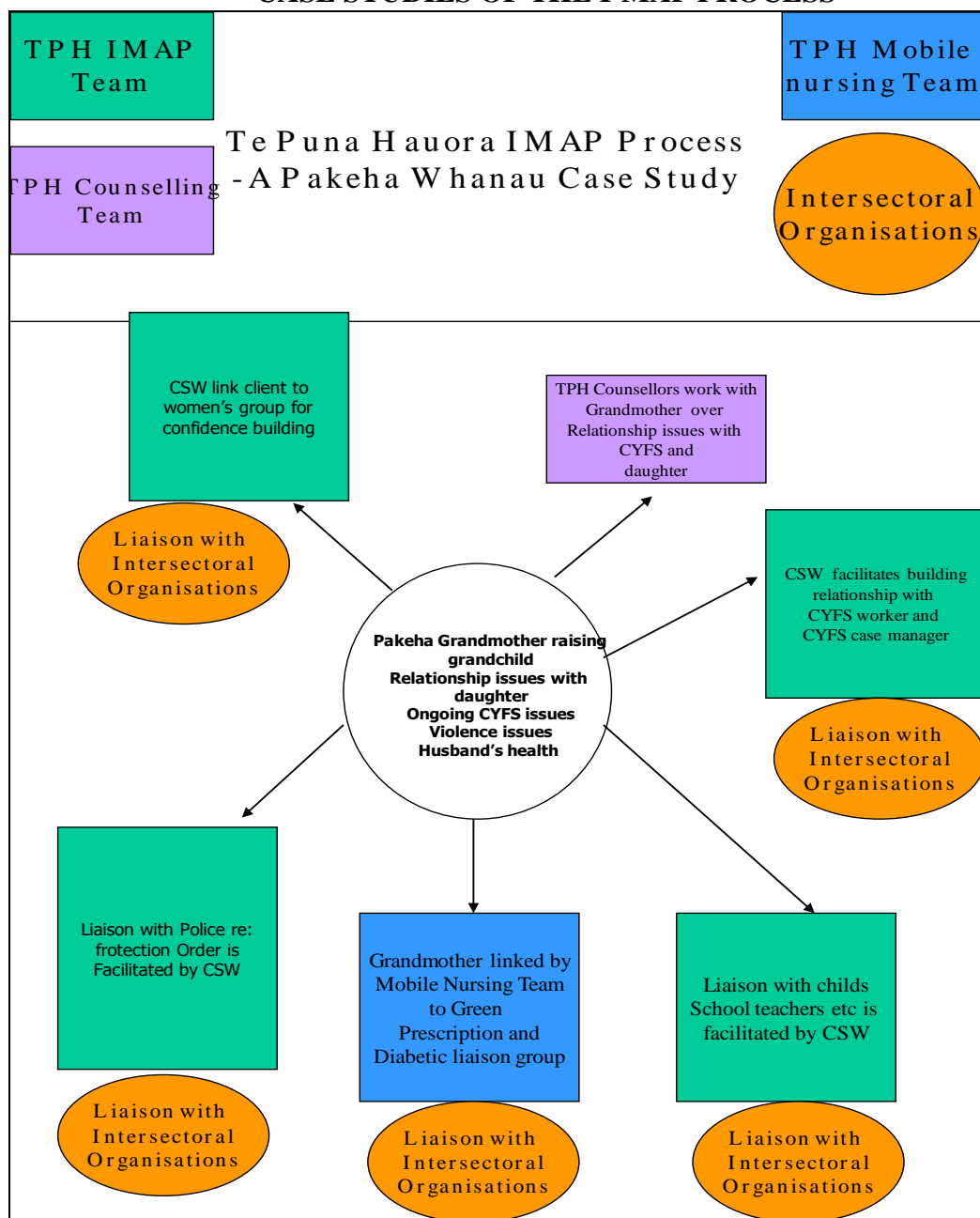
Harakeke I MAP gives individuals and whānau the ability to 'Map' their own plan toward health and well-being, putting them at the centre of the organisational kaupapa.

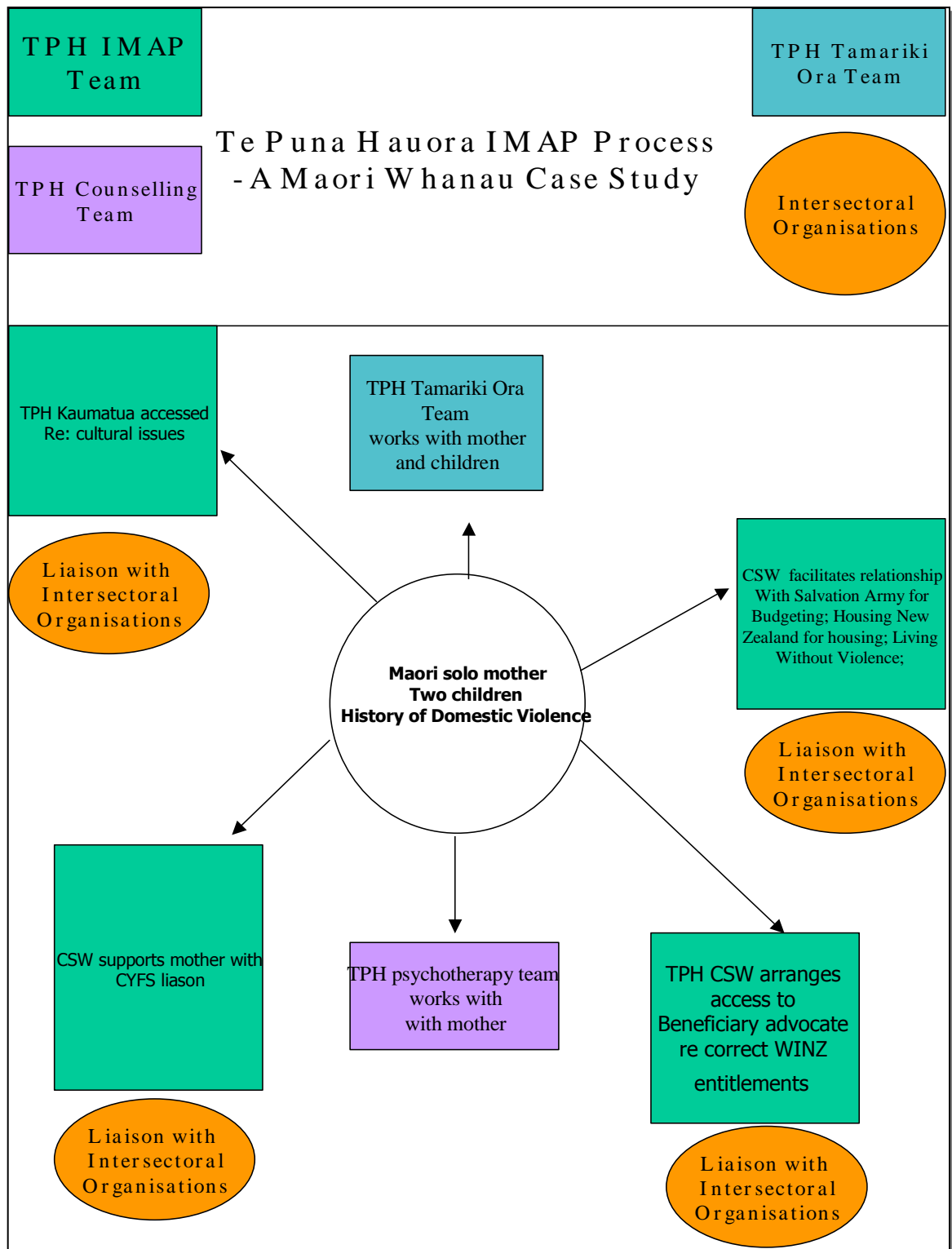
There is a fourth I in this winning whānau ora model which not part of the model but it is the 'I' that sums it all up.

I for innovation. Innovative steps for example like rent free reception and accommodation for lawyers, doctors, dentists and budget advisors and the child care facilities for staff and clients alike. For the judges the I's did it, as did the very simple goal of the Harakeke I MAP which is to see clients exit the service confident in their ability to self manage social and health issues.

Source: www.maorihealth.govt.nz– [Te Puna Hauora](#)

CASE STUDIES OF THE I-MAP PROCESS





APPENDIX 4: TE ROOPU TAURIMA O MANUKAU

Organisational Model 1: Te Whariki Whakaruruhau O Te Roopu Taurima O Manukau Framework

Te Whariki Whakaruruhau Te Roopu Taurima O Manukau model of service that interweaves:	
<u>Raranga</u>	<u>Results</u>
Mokopuna and Whanau (Focus)	Satisfaction Independence Choice
Kaimahi (Staff)	Career Development Remuneration Recognition
Roopu (Organisational Requirements)	Sustainability Innovative In Demand

Te Whariki Whakaruruhau O Te Roopu Taurima O Manukau Framework

(abridged) © Te Roopu Taurima O Manukau 2000

Te Whariki Whakaruruhau O Te Roopu Taurima O Manukau - the weaving of flax to form a mat of relationships, strengths, pathways and collectiveness.

Te Whariki Whakaruruhau O Te Roopu Taurima O Manukau is an innovative model that incorporates Maori and “mainstream” concepts that covers the core business of the Trust. The frame work provides a matrix process model, by which the Trust sets:

1. expectations and standards,
2. identifies processes,
3. incorporates specific legislation
4. develops and implements plans
5. and monitors results.

It is a model of support and guidance that protects embraces and interweaves past present and future. The matrix assesses the needs, development and improvement areas from three raranga (strands) that support the matrix.

Each is as important as the other and all are aspiring towards Tino Rangatiratanga.

The construct of the strands is kept alive by the quality cycle and ensures quality is a natural integration of all supports and services.

The quality of one strand could not exist without the others.

Te Whariki Whakaruruhau is our tool to ensure linkages, identify strategies for development and improvement and provide the Roopu with a service delivery model that results in the needs of Mokopuna/Whanau, Kaimahi and the contracting agency to be met.

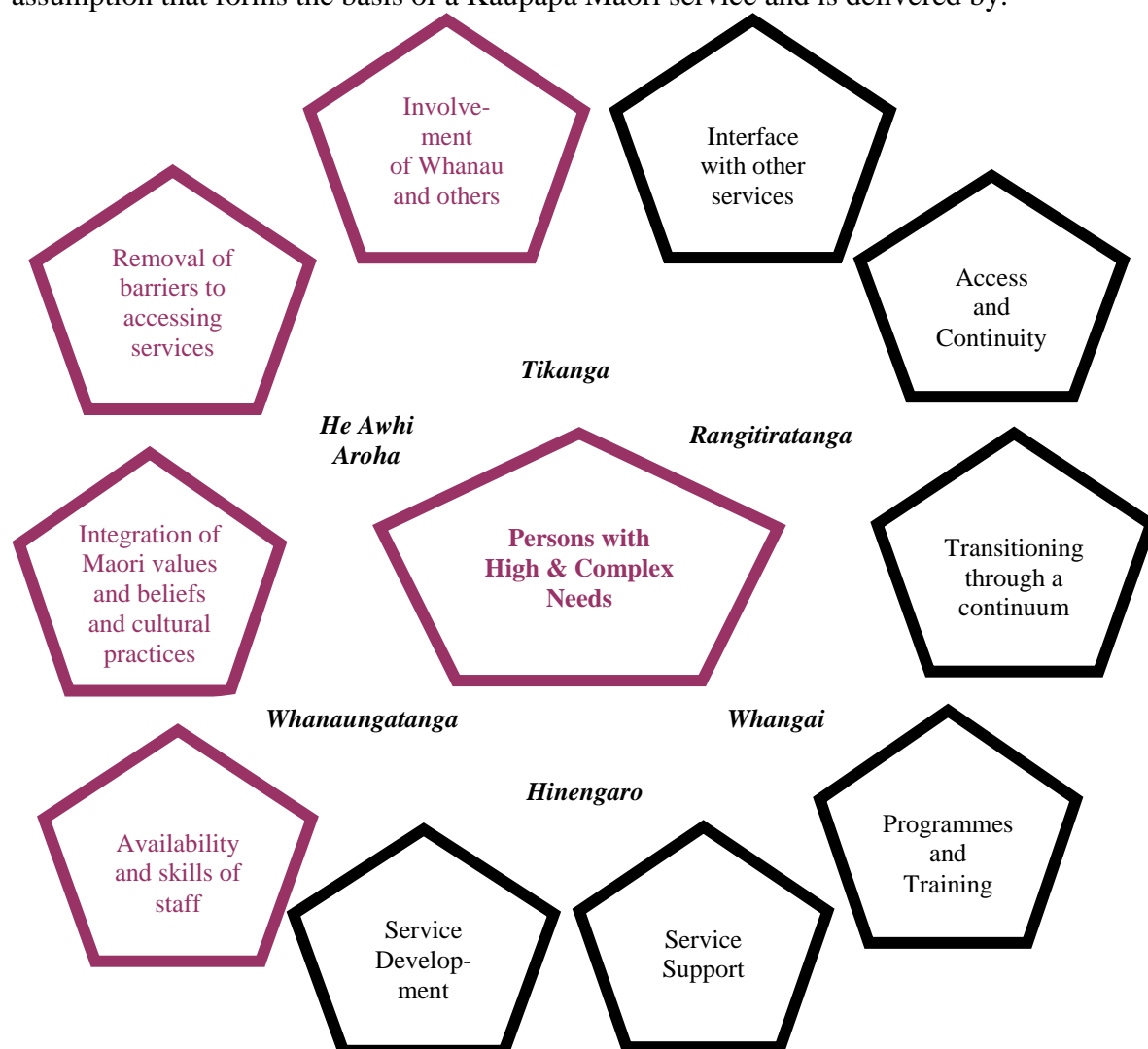
Services are delivered through a process of identifying and meeting individual and collective needs of Mokopuna and Whanau.

The task of Te Roopu Taurima is to ensure Mokopuna feel that they belong somewhere and can do things for themselves, so that they can exercise self direction and enjoy independence but not experience abandonment.

- **our Tikanga Maori processes are translated into the appropriate process for each individual's ethnic origin.**

Organisational Model 2: Te Roopu Taurima: RIDSAS High Complex Needs Kaupapa Maori Model

The focus remains on the individual with belonging as the essence and underlying assumption that forms the basis of a Kaupapa Maori service and is delivered by:



APPENDIX 5: SELECTED LIST OF CASE STUDY DOCUMENTS REVIEWED

For all case study organisations I was given access to correspondence, contract and request for proposal files dating from the beginning of the organisation through to the mid-2000s. Because of the significant number of the documents accessed, they have not all been listed here. The documents listed below were the ones I asked permission to copy for use in the thesis data collection process because they held significant tracts of information that would prove useful in the triangulation process. The policy documents listed at the end were used because they were policy documents that the case study organisations were using internally.

Tihi Ora MAPO Selected List of Internal Documents Reviewed		
Date	Organisation &/Or Author	Doc
		Smith, S P. Ngati Whatua Traditions. Journal of the Polynesian Society 1911. Vol.20 No 78.
		Tuhaere, Paora. A Historical Narrative concerning the Conquest of Kaipara and Tamaki by Ngatiwhatua. Journal of the Polynesian Society 1923, 32-229
1995	Walker, Ratana	Maori in the North Health Region: An analysis of health information . 27 pages. Auckland: Northern Regional Health Authority.
1995, Sep	Walker, Ratana	'Maori in the North Health Central Subregion, Ngati Whatua: baseline information for strategic planning. Auckland: Northern Regional Health Authority.
1995, June 27	Maori Health Development Division	MAPO Draft Discussion Document 27 th of June 1995. Auckland: Northern Regional Health Authority.
1995, 24 April	Te Runanga o Ngati Whatua, & Northern Regional Health Authority	Deed of Partnership Agreement for Identifying and Purchasing Health and Disability Support Services for Maori in the Ngati Whatua Tribal rohe.
1995, 15 December	Te Runanga o Ngati Whatua, & Northern Regional Health Authority	Memorandum of Understanding between Te Runanga o Ngati Whatua and the Northern Regional Health Authority: Agreement for Identifying and Purchasing Health and Disability Support Services for Maori in the Ngati Whatua tribal rohe.

1996	Walker, Ratana	Subregion, Ngāti Whatua : baseline information for strategic planning = Ngā Māori Kei roto i te hauora i roto o Tāmaki Makaurua [i.e. makaurau] ara Ngāti Whatua. Auckland, [N.Z.] : North Health Ngati
July 1995 – April 1998	Tihi Ora	Tihi Ora Top Health Review
1998, March 9	CEO, Tihi Ora	Briefing Papers Tihi Ora Directors Meeting with National Director Maori Health at North Health 9 March 1998
1998, 29 Sept.	Rob Cooper, Health Funding Authority	Memo To Tri-MAPO, Sally Wilkinson, Bridget Allen
1998, 17 Nov	MAPO CEO's- Taura Eruera, Joeline Grace, Lynette Stewart. Senior Maori Development Manager, Maori Health – wen Tepania Palmer. Service Strategy Maori Health – Sharon Shea.	Report to HFA/MAPO Forum Members, Hauora Rangatira, HFA Board, Rob Cooper, Pio Jacobs. Subject: HFA and MAPO governance relationship.
1998/99	Te Runanga o Ngati Whatua	Annual Plan. 9pages.
1998	Waitangi Tribunal	Te Whanau o Waipareira Report WAI414 (discusses relationship with Ngati Whatua as mana whenua in relation to health and social services).=
1998	Health Funding Authority	National Strategic Plan for Maori Health, 1998-2001, Unpublished, 20-43.
1999	Sharon Shea, Strategic Projects Manager, Tai Tokerau MAPO Trust, Whangarei, New Zealand,	Strategic Health Care Policy & Development for the Indigenous Peoples of Aotearoa/New Zealand (document presentation for Scotland)
1999, Jun & Jul	Tihi Ora	Notes from internal meetings to prepare Tihi Ora Operational Plans
1999, Jun & Jul	Tihi Ora	Notes from internal meetings to prepare Tihi Ora Workforce Development Plan.
1999, Jun & Jul	Tihi Ora	Notes from internal meetings to prepare Tihi Ora Maori Provider Development Plan
1999, September	Tihi Ora	Tihi Ora Demographic & Provider Analysis. 9 pages.
1999	Tihi Ora	Tihi Ora Strategic Plan 1999-2001.
1999	Chant, Lisa,	<i>Ngati Whatua: A Cultural Context</i> in Sustainable Maori Development in Ngati Whatua. (Unpublished paper: James Henare Maori Research Centre, The University of Auckland). 21 pages.

2000, 1 Jan	Tihi Ora	Human Resource Manual. 34 pages.
2000	Cooper R.	The role of the Health Funding Authority in Maori health development. Pacific Health Dialog 7 (1):101-6
2000, 17 Feb	Tihi Ora	Briefing paper on sector developments and potential strategies for Maori participation. 61 pages.
2000, 3 March	Tom Parore, Chairman, Tihi Ora	Letter to Hon. Annette King. Subject: Meeting last Saturday at Dargaville.
2000, 13 March	Tihi Ora	Position Paper on Health Sector Developments within the Ngati Whatua Rohe
2000, 27 March	John Marsden, Chairperson Te Ha o te Oranga	Memo to Sir Hugh Kawharu. Subject: Providers's perspective of ideal relationships. 2 pages.
2000, 8 March	Kim Workman	Paper to Minister of Health entitled 'Health & Disability Sector Changes and their implementation – The impact on Maori Health Development'. 17 pages.
2000, April	CEO, Tihi Ora	Letter to Minister of health re: Tihi Ora's response to the cabinet papers embargoed until 4pm on 7 th April, 2000. Dated 10 April 2000.
2000, April 10	CEO, Tihi Ora	Letter to Minister of health re: Tihi Ora's response to the cabinet papers embargoed until 4pm on 7 th April, 2000
2000, April	CEOs Te Tai Tokerau, Tihi Ora, and Tainui MAPO	Health Sector Strategic Position Paper. 13 pages.
2001 May 9	Te Runanga o Ngati Whatua & Waitemata District Health Board	Memorandum of Understanding between Te Runanga o Ngati Whatua and Waitemata District Health Board. 10 pages.
2001, June 24	Kere Cookson-Ua, CEO Tihi Ora	Memo to Cindy Kiro, cc; Graeme Edmond re: an overview of Tihi Ora's strategy for effective engagement between ADHB and Ngati Whatua
2001 (no further date info given)	Co-signed by ADHB & TRONW	Memorandum of Understanding between Auckland District Health Board an Te Runanga o Ngati Whatua. 10 pages.
2002	Waitangi Tribunal	Interim Report on the Auckland Hospital Endowments Claim Wai 261. Wellington.
2002, Feb	Te Runanga o Ngati Whatua	Treaty Policy Framework DRAFT COPY
February 2002	Te Runanga O Ngati Whatua	Kotahitanga The Ngati Whatua Proposition
17 Jul	Lisa Chant	Letter of thanks to Tom Parore & Alan

2002		Pivac for meeting in Whangarei to discuss Hauora Maori, a note explaining transfer from masters to PhD.
2002 September	Maori Health Directorate, Ministry of Health	Review of Maori Co-Purchasing Organisations and Terms of Reference
2002 September 6	Northland District Health Board & Te Runanga o Ngati Whatua	Memorandum of Understanding between Northland District Health Board and Te Runanga o Ngati Whatua. 12 pages.
2003,Sept 10	CEO	Board Papers – Tihi Ora
2003 December	Kaipuke Consultants Ltd and PHP Consulting Ltd. Published by MOH	MAPO Review 2003 Final Report
2004 August	Tihi Ora MAPO	Consultation Review Report: Mapo Consultation June-July 2004. 6 pages.
May 2004	Tihi Ora	MAPO Review Consultation Plan: MAPO Review: Consultation of Contract Transfer. 7 pages.
July 2004	Auckland District Health Board	Draft Maori Health Action Plan Te Aratakinā A Pathway Forward 2004-2007. 5 pages.
14 Dec 2006	Tihi Ora MAPO	Stakeholder powerpoint presentation: Tihi Ora MAPO A FAIR SHARE OF HEALTH CARE <i>Kia Orite Te Tiaki O Te Hauora</i> ELIMINATE HEALTH DISPARITIES
6 July 2007	Tihi Ora MAPO	Tihi Ora Presentation WDHB CPHAC July 2007.ppt
2009	Auckland DHB	“Primary Health Care Plan for Auckland City - 2008-2020” Auckland City: Auckland District Health Board.

Te Puna Hauora o te Raki Pae Whenua Selected List of Internal Documents Reviewed		
Date	Organisation &/Or Author	Document
	Te Puna Hauora O Te Raki Paewhenua Society Incorporated.	Constitution and Rules of Te Puna Hauora O Te Raki Paewhenua Society Incorporated (AK/827896)
2 June 2000	Te Puna Hauora	Tamariki Ora plan, Reporting model for Te Puna Rangatahi, Review - behavioural model.
9 June 2000	Te Puna Hauora	Te Puna Rangatahi Report for HFA.
17 Nov 2000	Te Puna Hauora	Te Puna Hauora, ASB Funding Proposal.
2000	Te Puna Hauora & Te Ha o te Oranga	Te Puna Hauora and Te Ha o Te Oranga joint application for (06) Family/Whanau Networkers; (07) Community Support Workers; (09) Alcohol and Drug services Community Based Treatment Kaupapa Maori.
2000	Te Puna Hauora	Te Puna Hauora Strategic Plan 1999-2001. 21 pages.
2000	Te Puna Hauora	Te Puna Hauora Strategic Plan 2001-2002
2000	Te Puna Hauora	Te Puna Hauora Philosophy of Care and Service – Strategic Goals of the Organisation
2000, 2 June	Te Puna Hauora	Tamariki Ora Plan: Reporting Model for Te Puna Rangatahi: Review of Behavioural Model
2000, 9 June	Te Puna Hauora	Te Puna Rangatahi Report for Health Funding Authority
2000, 17 Nov	Te Puna Hauora	Te Puna Hauora ASB Funding Proposal.
2001, 11 May	Te Puna Hauora	Te Puna Hauora ASB Funding Proposal. Te Puni Kokiri MPDS & Capacity Building 2001 Plan.
11 May 2001	Te Puna Hauora	Te Puna Hauora , Te Puni Kokiri MPDS & Capacity Building 2001 Plan
2003, 19 Nov	MoH & DHB MPDS Manager	Maori Provider Development Scheme 2003/2004 MOH & DHB Assessment Form. Provider: Te Puna Hauora o te Raki Pae Whenua. 9 pages.
2003	Ministry of Health	Te Puna Hauora o Te Raki Pae Whenua Society Inc. Contract 421303/286477/00. PA2-Infrastructure Support. WD1-Workforce Development. BP1-Accreditation/Quality Assurance. 24 pages.
2004, 17 March	Te Puna Hauora Internal Document	ISO Health & Safety compliance training (full day training and notes)
2004, 17 March	Te Puna Hauora Internal Document	ISO Health & Safety compliance h&s and hazard identification scan (training and notes)
2004, 14 April	Te Puna Hauora Internal Document	ISO Audit Training (full day training and notes)
2004, Jan -	Te Puna Hauora	MPDS 2003/2004 – January to June 2004 Plan.

June	Internal Document	
2004, Jul 8	B. Little, ISO9001:2000; ICL No: 0420831	Surveillance Report for Te Puna Hauora o te Raki Pae Whenua ICL No: 040831 (visit 1 Jul 2004). 9 pages.
2004, 9 Jul	Lisa Chant	To: Kaumatua & Kuia; Board Members; Management Team members of Te Ha o te Oranga & Te Puna Hauora. Subject: Hui 9 Jul 2004 – Hauora Maori (notes of responses from meeting)
11 June 2004	C Duley, TPH	MPDS 2003/2004 July 2004 Report. 44 pages.
2004, Jul 19	H Beazley, TPH	MPDS 2004/2005 application to Te Kete Hauora. 42 pages.
1 Oct 2004	Te Kete Hauora	Letter confirming MPDS 2004/2005. 2 pages.
16 Nov 2004	Te Puna Hauora	October 2004 Report on Maori Provider Development Scheme 2003/2004 for Maori Health Group, Health Funding Authority. 24 pages.
2004	Te Puna Hauora	Te Puna Hauora Kaupapa, Tikanga and Kawa Model – Whanaungatanga
2005	Te Puna Hauora	Te Puna Hauora Harakeke - I-MAP
2005	Te Puna Hauora	Te Puna Hauora Organisational Model
2005	Te Puna Hauora	Te Puna Hauora Staff Training and Development Model
2005	Te Puna Hauora	The Harakeke - I-MAP as an integrative model for social and health wellbeing

Te Ha o te Oranga o Ngati Whatua Selected List of Internal Documents Reviewed

Date	Organisation &/Or Author	Document
1998	Te Ha o te Oranga	Te Ha o te Oranga Business Plan 1998
1998, Nov	Te Runanga o Ngati Whatua, & Procure Health Limited	Memorandum of Understanding between Te Runanga o Ngati Whatua and Procure Health Limited. 3 pages.
1999, 4 Jan	Te Ha o te Oranga	Internal Memorandum on Ngati Whatua Maori Integrated Care Organisation. 1 page.
1999, 30 Mar	Te Ha o te Oranga	Notes from Korowai (proposed Ngati Whatua MICO) Hui (Te Puna Hauora, Te Ha, Orakei, Waipareira). 5 pages.
1999, 7 Jan	Te Ha o te Oranga	Te Ha o te Oranga Induction Programme. 11 slides.
29 April 1999	Te Runanga o Ngati Whatua	Te Runanga o Ngati Whatua/Te Ha o te Oranga Schedule for Auckland Healthcare/Department of Justice Post Mortem Contract
1999, 15 Nov	Te Ha o te Oranga	Te Ha I-MAP Model Strategy presentation to Te Puni Kokiri. 6 slides.
3 March 2000	Te Ha o te Oranga	Te Ha o te Oranga o Ngati Whatua Business Plan 2002/2003. 44 pages.
3 March 2000	Te Ha o te Oranga	<i>Te Ha o te Oranga Review</i>
30 April 2000	Te Ha o te Oranga	Document review and recommended changes to organisational Policies /Procedures/Employment

		Contracts/Job Descriptions/Competencies manuals
30 April 2000	Te Ha o te Oranga	Review Implementation Plan
2000	Te Ha o te Oranga	Te Ha o Te Oranga o Ngati Whatua Organistion Structure, 2000
2000, 13 Aug	Te Ha o te Oranga	ACC request for proposal for supply of home based rehabilitation services. 10 pages.
2000, April	Te Ha o te Oranga	Ngati Whatua Kaupapa, Tikanga and Kawa. 3 pages.
2000, 30 Mar	Te Ha o te Oranga	Te Ha o te Oranga Overview
2000, 3	Te Ha o te Oranga	Te Ha o te Oranga, – Mobile Community Nursing Service Proposed Exentension [sic] of coverage area. 3 pages.
2000	Te Ha o te Oranga and Te Puna Hauora	Te Puna Hauora and Te Ha o Te Oranga joint application for (06) Family/Whanau Networkers; (07) Community Support Workers; (09) Alcohol and Drug services Community Based Treatment Kaupapa Maori.
2000	Te Ha o te Oranga o Ngati Whatua	Internal Memorandum on Ngati Whatua Maori Integrated Care Organisation. 2 pages.
2000, 2 Nov	Te Ha o te Oranga	Te Ha Proposal for Te Puni Kokiri. 1 page.
2003	North Rodney PHO	Draft Strategic Plan and Overview 2003-2005. 20 pages.
2003	North Rodney PHO	Draft Maori Health Plan 2003-2005. 14 pages.
2003	Coast to Coast PHO	Internal documents file on meetings and developments between Te Ha o te Oranga, Coast to Coast Providers and Waitemata DHB
26 Mar 2003	Kaipara Care Incorporated	Agenda and Papers for Extraordinary General Meeting
2003	Kaipuke Consultants Ltd, & PHP Consulting Ltd	<i>MAPO Review 2003 Final Report.</i>
2003	Northland District Health Board	<i>Review of PHO Candidate Business Plans, Review Criteria & Evidence Sought</i>
Ngati Whatua o Orakei Health Clinic Selected List of Internal Documents Reviewed		
Date	Organisation &/Or Author	Document
1998, 6 Nov	Stephens, L., & Ngati Whatua o Orakei Health Clinic	Ruapotaka health application. 25 pages.
25 May 1999	Ngati Whatua o Orakei Health Clinic	Orakei Recruitment Manual
10/10/99	Kawharu, IH	Evidence to the Waitangi Tribunal for WAI6744 & WAI312.

1999, 28 Oct	Ngati Whatua o Orakei Health Clinic	Te Ao Marama. 19 slides.
9/11/99	Ngati Whatua o Orakei Health Clinic	Renal Dialysis Strategy Recommendation
24/11/99	Ngati Whatua o Orakei Health Clinic	Draft Kia Tu Kia Puawai document. 46 pages.
7/12/99	Ngati Whatua o Orakei Health Clinic	Letter to Cathy Holland, HFA: Subject: Answers to specific Health Funding Authority queries on Ngati Whatua O Orakei Kia Tu Kia Puawai. 5 pages.
7/12/99	Ngati Whatua Orakei Corporate	Business Plan for Ngati Whatua o Orakei – Kia Tu Kia Puawai
9/12/1999	Ngati Whatua o Orakei Health Clinic	Ngati Whatua o Orakei Hapu Health Strategy Model - Prioritisation and Implementation.
9/12/1999	Ngati Whatua o Orakei Health Clinic	Ngati Whatua o Orakei Hapu Health Strategy Model - Goals, Objectives & Tasks
December 1999	Ngati Whatua Orakei Health Clinic	Notes from Kia Tu Kia Puawai Community hui at Orakei Marae, Oct - Dec 1999. 7 pages.
1999, 13 Dec	Ngati Whatua Orakei Corporate	Addendum to the Business Plan for Ngati Whatua o Orakei - Kia Tu Kia Puawai application. 13 pages
14 Dece 1999	Wackrow & Co	Draft agreement Kia Tu Kia Puawai. Letter. 3 pages.
3/4/2000	Ngati Whatua Orakei Corporate	Ngati Whatua o Orakei Kia Tu Kia Puawai . 46 pages.
2000	Ngati Whatua o Orakei Health Clinic	Strategic Overview, Ngati Whatua Orakei Health Clinic ‘Creating Healthy Lifestyles’
2000	Ngati Whatua o Orakei Health Clinic	Strategic Overview 2000-2001 – Powerpoint presentation
2000	Ngati Whatua o Orakei Health Clinic	Ruapotaka Health Services Proposal
2000, June 30	Ngati Whatua o Orakei Health Clinic	Service Plan for Aukati Kai Paipa 2000. 20 pages.
2000, 15 Feb	Ngati Whatua o Orakei Health Clinic	Strategic Overview. 8 pages.
2000, 25 Mar	Ngati Whatua o Orakei Health Clinic	Proposal for Comprehensive Health Services - Whare Rapuora. 2 pages.
26 June 2000	Ngati Whatua o Orakei Health Clinic	Ngati Whatua Orakei, Auahi Kore Quality Plan
9/6/2001	Ngati Whatua o Orakei Health Clinic	KIA TU KIA PUAWAI, Stand Tall With Confidence,
Te Roopu Taurima O Manukau Selected List of Internal Documents Reviewed		
Date	Organisation &/Or Author	Document
20 Nov 2006	Te Roopu Taurima o Manukau	Te Huirhanga Rihari Letter to: Annette Brown Contract Analyst, Disability Services Directorate re:

		REQUEST FOR TENDER for a Regional Residential Intellectual Disability Supported Accommodation (RIDSAS), Upper South Island and West Coast
21 Dec 2006	Te Roopu Taurima o Manukau	REQUEST FOR TENDER for a Regional Residential Intellectual Disability Supported Accommodation (RIDSAS), Upper South Island and West Coast
2009	Hona, M	Te Korowai Aroha <i>E Kore A Muri E Hokia</i> : Te Roopu Taurima o Manukau Trust.
2009	Todd, S	Kaupapa in mainstream <i>E Kore A Muri E Hokia</i> : Te Roopu Taurima o Manukau Trust.
2009	Waiomio, H	He iti te korero, he nui te whakaaro <i>E Kore A Muri E Hokia</i> : Te Roopu Taurima o Manukau Trust.
2005	Te Roopu Taurima o Manukau, HR Manager	Notes from 2005 meetings in Kaitia region for opening of new whare
2006		Request for Tender for a Regional Residential Intellectual Disability Supported Accommodation (RIDSAS), Upper South Island and West Coast to Disability Directorate.
2009	McDonald, Z.	It's cool <i>E Kore A Muri E Hokia</i> . Te Roopu Taurima o Manukau Trust.
2009	Matangi, J.	What I know <i>E Kore A Muri E Hokia</i> : Te Roopu Taurima o Manukau Trust.
2009	Muller, P.	A RIDSAS journey <i>E Kore A Muri E Hokia</i> : Te Roopu Taurima o Manukau Trust
2009	Tenari, T.	Nga korero o te Mana Whakahaere <i>E Kore A Muri E Hokia</i> : Produced by Te Roopu Taurima o Manukau Trust.

Selected List of Media reviewed
<i>New Zealand Doctor</i> , (4 Aug 1995) : p.10-11 0114-1422 : Ill. Gifford, Adam (and others) {Maori health}
<i>Kia Hiwa Ra : National Maori Newspaper</i> , (Jun 1995) : p.3112 80cm 1170-9804 Te Kete Hauora
Wharawhara, R 'Health contract reflects shifts in Maori Politics' <i>New Zealand Herald</i> . 24 Feb 1996.
The National Business Review 13 Sep 1996, Page 49 NEWS <u>By STEPHEN WARD</u> Maori health 'bureaucracy' attacked
WAIKATO TIMES, 28 MAY 1999, Edition 1, Page 3. By: NATHAN Te Anga Urban Maori allege funds discrimination
New Zealand Doctor - 15 Sep 1999; p.11 News <u>Daryl McIntosh</u> MDOs in development (Health Funding Authority begins contract negotiations to transform Maori ICOs in first step of contract which will see them become a Maori Development Organisation, MDO)
Mana, Apr 2000 : Page 56+ Maori health; Public administration "We have come too far, not to go further. we have done too much, not to do more" Sir James Henare
Press Release: <u>New Zealand Government</u> 19-05-2000 17: 09 Turia - fairer sharing of health dollars
Sheddan, Amanda. <i>Ethnic bias in heart surgery investigated</i> <i>New Zealand Doctor</i> , 19 June 2000.
Press Release: <u>New Zealand Government</u> 01-08-2000 17:42 Health partnership between Maori and Crown
'Tapu Misa article in <i>New Zealand Herald</i> , 27 March 2002, 'Sick Maori face of subtle racism'
'Maori health providers look to healthier future' <i>New Zealand Doctor</i> . 8 May 2002
NZPA 'New Zealand: New Health Boards Have Greater Mix of Minority Groups. 23 Aug 2000
'A tough pill to swallow' <i>New Zealand Herald</i> . Jun 22 2002.
'PHO funding still a mystery' <i>New Zealand Doctor</i> . 3 July 2002.
Hugh Kinninmonth of Comprehensive Healthcare IPA quoted in 'Govt policy endangers the traditional independent general practitioner' <i>The Independent</i> , 4 June 2003
Newsbriefs' <i>Doctor</i> . 5 November 2003
'Stalemate continues for ProCare PHO'. <i>Doctor</i> . 8 October 2003& 'ProCare gets go ahead' <i>Doctor</i> . 5 November 2003
Taylor, K. 'Poll: Maori equal, special' <i>New Zealand Herald</i> . 28 February 2004.
Meylen, G. 'PHO forged under pressure ruptures' in <i>Doctor</i> , 25 February 2004 pg 3
Meylen, G 'Are PHOs the answer for Maori providers?' <i>Doctor</i> . 7 April 2004.
'A Healthy Prognosis' <i>The National Business Review</i> . 25 June 2004
Hugh Kinninmonth of CHS interviewed in 'North Harbour PHO imports troubleshooter' <i>New Zealand Doctor</i> 9 March 2005
'North Harbour PHO facing breakdown' <i>New Zealand Doctor</i> . 9 February 2005.
'general practitioner shifts PHOs with Asian patients in mind. <i>New Zealand Doctor</i> . 21 September 2005

Selected List of Government Documents Reviewed (this is not a complete list of government documents reviewed. These documents were all sourced from the case study organisations and were being used by or referred to by them, so they have been included as case study organisation documents sourced)

- Controller and Auditor-General. 2006. *Report of the Controller and Auditor-General on The Treasury: Capability to recognise and respond to issues for Maori*. Wellington.
- Department of Social Welfare, Information and Analysis Group. 1999. *Social Environment Scan*. Wellington: Department of Social Welfare.
- Health Funding Authority. 1998. *A demographic profile from the 1996 census*. Auckland. Health Funding Authority
- Health Funding Authority. 1 September 1998. Draft Business Plan for the Maori Health Group "Taitikawai" Rohe 1998/1999. Unpublished document
- Health Funding Authority. June 1998. *HFA Maori Health Policy*. Unpublished document
- Health Funding Authority. *National Business Plan for the Maori Health Group 1998-1999*. Unpublished document.
- National Health Committee. 2002. Improving Maori Health Policy.
- New Zealand Department of Health and Te Puni Kokiri. 1993. *Whaia te ora mo te iwi: Strive for the good health of the people: Maori health policy objectives of regional health authorities and the Public Health Commission*. Wellington: Department of Health.
- New Zealand Department of Health, 1984. *Hui Whakaoranga: Maori Health Planning Workshop* Hoani Waititi Marae 19-22 March 1984. Department of Health, Wellington.
- New Zealand Department of Public Health. 2002. NZDep2001 Index of Deprivation. Wellington: Wellington School of Medicine and Health Sciences.
- New Zealand Institute of Economic Research. 2003. *PHOs and Maori health: Implications of PHO policy for Maori health policy objectives: Report to Maori Health Directorate, Ministry of Health*. Unpublished document.
- New Zealand Health Funding Authority. 1998. *A guide to Maori providers and Maori personnel in the health sector*. Health Funding Authority, Auckland
- New Zealand Health Funding Authority. 1998a. *Health Funding Authority Maori Health Policy full version*. New Zealand Health Funding Authority, Wellington
- New Zealand Health Funding Authority. 1998b. *Te Hauora Maori, Directory of Maori Health Providers in the Lower North Island and the Nelson/Marlborough Region*. Tu Ake Productions, Dunedin
- New Zealand Health Funding Authority. 1999. *Te Hauora Maori, Directory of Maori Health Providers in the South Island excluding Nelson/Marlborough*. Tu Ake Productions, Dunedin
- New Zealand Ministry of Health. 1989. *New Zealand Health Charter*.

New Zealand Ministry of Health. 1994. 1994/95 Policy Guidelines for Maori health/Nga Aratohu Kaupapahere Hauora Maori. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 1995a. 1995/96 Policy Guidelines for Maori health, Nga Aratohu Kaupapahere Hauora Maori. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 1995b. Co-ordinated Care for Maori - Issues for Development. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health, Te Kete Hauora. 1995c. Nga matatini: Strategic directions for Maori health: A discussion document. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 1996a. 1996/97 Policy Guidelines for Maori health, Nga Aratohu Kaupapahere Hauora Maori. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 1996b. Policy Guidelines for Regional Health Authorities 1996/97. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 1997. An introduction to the Maori provider development scheme. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 1998. Progress on Health Outcome Targets: The state of the public health in New Zealand 1998. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 1999a. Our Health, Our Future. Hauora Pakari, Koiora Roa: The health of New Zealanders 1999. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 1999b. Taking the Pulse: The 1996/97 New Zealand Health Survey. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2001a. He Korowai Oranga, Maori Health Strategy: Discussion Document. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. Minister for Disability Issues. 2001b. New Zealand Disability Strategy: Making a world of difference: Whakanui Oranga. New Zealand Ministry of Health, Wellington.

New Zealand Ministry of Health. 2001c. Service specification, Maori Development Organisation (MDO). New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2001d. The primary health care strategy. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health, Wellington New Zealand Ministry of Health. 2002a. A guide for establishing Primary Health Organisations. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2002b. He Korowai Oranga, Maori Health Strategy. New

Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2002c. Whakatataka: Mori Health Action Plan 2002-2005. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2002c. Reducing Inequalities in Health. Wellington: New Zealand Ministry of Health.

New Zealand Ministry of Health. 2003a. *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau: A strategic framework*. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2003b. *Achieving Health for all People*. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2004. Primary Health Care Strategy, Services to improved access (SIA) funding. Ministry of Health, Wellington

New Zealand Ministry of Health. 2005a. Developing a Monitoring Framework and Strategic Research Agenda for He Korowai Oranga: Summary of submissions. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2005b. Strategic Research Agenda for He Korowai Oranga. New Zealand Ministry of Health, Wellington

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New Zealand Ministry of Health, 2005. Decades of disparity. II, Socioeconomic mortality trends in New Zealand, 1981-1999. Wellington, N.Z: Ministry of Health.

National Health Committee. 2005d. Decision-Making about New Health Interventions: A report to the New Zealand Minister of Health. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2006a. Whakatataka Tuarua: Maori Health Action Plan 2006–2011, Discussion Document. New Zealand Ministry of Health, Wellington

New Zealand Ministry of Health. 2006b. Primary Health Care Strategy Implementation Work Programme, 2006–2010. The Next Steps. New Zealand Ministry of Health, Wellington

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- New Zealand Ministry of Social Development. 2004. The Social Report: Indicators of social well-being in New Zealand. Wellington: Ministry of Social Development. URL: <http://www.socialreport.msd.govt.nz/>
- New Zealand National Advisory Committee on Health and Disability. 1998. The Social, Cultural and Economic Determinants of Health in New Zealand: Action to improve health. Wellington: National Advisory Committee on Health and Disability.
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- New Zealand National Health Committee on Health and Disability. 2002. Tena te ngaru whati, tena te ngaru puku, there is a wave that breaks, there is a wave that swells: A framework to improve Maori health policy. National Health Committee on Health and Disability, Wellington
- New Zealand National Health Committee. 1988. The Social, Cultural and Economic Determinants of Health: Action to improve health. Wellington: National Advisory Committee on Health and Disability.
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- New Zealand Te Puni Kōkiri. 2000. Maori Provider Views of Government Funding, Key issues from the literature and interviews. Wellington
- New Zealand Transitional Health Authority Maori Health Groups. 1997. Te Tipunga, Transitional Health Authority Maori Provider Development Strategic Plan 1997 and beyond, version I. Transitional Health Authority Maori Health Groups, Wellington
- New Zealand Treasury. 2001. Guidelines for contracting with non-government organisations for services sought by the Crown. New Zealand Treasury, Wellington
- New Zealand Waitangi Tribunal. 1998. Whanau o Waipareira Report. Legislation Direct, Wellington Ngati Kahungunu Iwi Inc. 2003. Maori Health Plan for Hawke's Bay 2003-2005. Ngati Kahungunu Iwi Inc., Hastings
- NGO\MOH Health and Disability Forum. 2004. Primary Health Organisations and NGOs working together to improve health outcomes: opportunities and issues, Report to Key Stakeholders on the NGO\MOH Health and Disability Forum held in Wellington on 19 March 2004. Ministry of Health, Wellington, NZ
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Te Puni Kokiri. 2000. *Maori Provider Views of Government Funding: key issues from the literature and interviews*. Wellington: Te Puni Kokiri, Ministry of Maori Development.

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APPENDIX 6: SELECTED LIST OF CASE STUDY HUI & OBSERVATIONS

The data collection at hui took place over several years. A number of observations were at sensitive hui, such as tangi (for instance there were a number at Orakei where the health clinic and marae are on the same grounds), and these are not listed below. The hui listed below are actual examples of the types of hui attended for collection of data, but are not an exhaustive list because it would be very large and repetitive. For instance, the Te Roopu Taurima applicants powhiri and inductions hui listed below are representative of 3 of each a month (so, 6 a month) attended for the period of six months (approximately 36).

Date	Organisation/Observation
20/11 to 21/12/06	<i>Te Roopu Taurima</i> - REQUEST FOR TENDER for a Regional Residential Intellectual Disability Supported Accommodation (RIDSAS), Upper South Island and West Coast. Hui with staff/management involved in tender process.
5-8/7/05	<i>Te Roopu Taurima</i> : Staff induction, Tai Tokerau (Michelle & Bob facilitating at Kaitaia motel – approx 20 attendees)
29-30/6/05	<i>Te Roopu Taurima</i> : Staff induction, Auckland (Michelle & Bob facilitating at Hamilton venue – approx. 25 attendees)
22-27/6/05	<i>Te Roopu Taurima</i> : Staff induction, Waikato (Michelle & Bob facilitating at Auckland office – approx. 25 attendees)
22/6/05	<i>Te Roopu Taurima</i> : Community/whanau powhiri for applicants, Tai Tokerau region (held at Kaikohe head office – approx. 30 attendees)
14/6/05	<i>Te Roopu Taurima</i> : Community/whanau powhiri for applicants, Waikato region (held at Hamilton head office – approx. 40 attendees)
7/6/05	<i>Te Roopu Taurima</i> : Community/whanau powhiri for applicants, Auckland region (held at Manukau head office – approx. 60 attendees)
26/5/05	<i>Te Roopu Taurima</i> : Three organisations visited to discuss new Kaitaia homes opening were - Te Runanga o te Rarawa at Te Oranga, Kaitaia (service delivery arm of Te Runanga o te Rarawa). Te Whare Wananga O Muriwhenua – Te Aupouri Maori Trust Board: Pukepoto Road, Kaitaia. Te hau Ora O Te Hiku O Te Ika, Te Roopu Whitiara.
2004	<i>Te Roopu Taurima</i> : Attendance at monthly board meetings.
2004, 4-5 Nov	<i>Te Puna Hauora & Te Ha o te Oranga</i> : Dynamics of Whanaungatanga L2 course at TPH (includes week before planning and week after evaluation).
2004, 25-26 Oct; 1-3 Nov	<i>Te Puna Hauora</i> : Awards celebrations planning and followup
2004, 6-8/Oct & 28-29 Oct	<i>Te Puna Hauora & Te Ha o te Oranga</i> : Dynamics of Whanaungatanga L1 course @ Naumai marae (includes week

	before planning and week after evaluation.
11/10/2004	<i>Te Puna Hauora:</i> MOH, Tihi Ora, TPH Mgmt, Waitemata DHB Maori Health Manager (@ MOH) re: MPDS 04/05
2004, 9 Jul	<i>Te Puna Hauora; Te Ha o te Oranga</i> Hauora Maori hui at Puriri Park Orewa with kaumatua, kuia, governance members, management members of both organisations (total 39 people).
June-July 2004	<i>Tihi Ora MAPO</i> MAPO Review Consultation hui (Orakei Marae, Aug 3; Te Puna Hauora , Jul 28th; Te Ha at Wellsford Community Centre, Jul 20th.)
19 March 2004	NGO\MOH Health and Disability Forum. 2004. Primary Health Organisations and NGOs working together to improve health outcomes: opportunities and issues, Report to Key Stakeholders on the NGO\MOH Health and Disability Forum held in Wellington on 19 March 2004. Ministry of Health, Wellington, NZ. (Staff from Tihi Ora, Orakei, Te Puna Hauora, Te Ha, Te Roopu Taurima present)
28/5/04 – 10/6/04	<i>Te Puna Hauora:</i> MPDS 03/04; 04/05; MOH Integration (held at Te Puna Hauora, various hui with clinical team/IMAP team/social work team/management team)
11 September 2003	<i>Tihi Ora MAPO; Te Puna Hauora; Te Ha o te Oranga; Orakei</i> Tihi Ora MAPO organised Maori provider hui.
2 July 2003	<i>Waitemata DHB @ Waitakere Marae</i> MAPO/MOH Provider hui re: Maori Health Plans. (80+ participants, (Staff from Tihi Ora, Orakei, Te Puna Hauora, Te Ha present))
19 March 2003	<i>Te Ha:</i> Performance Management workshop. Held at Te Ha, Wellsford. Attended by staff, kaumatua and kuia, management (approx 20 people).
June 2003	<i>Te Ha:</i> Mentoring/coaching workshops. Held at Te Ha, Wellsford. Attended by staff, kaumatua and kuia, management (approx 20 people).
March – Oct 2003	<i>Te Ha:</i> Coast to Coast PHO interim – start 1 Jul 2003; announced as access 1 Oct 2003. Various hui with providers, community members – Auckland, Warkworth, Wellsford, Dargaville.
February 2003 (week of 5 Feb – includes powhiri at Orakei	<i>Orakei/Te Puna Hauora:</i> Boston Uni to Orakei Marae. Boston Uni students interested in community services/social work/nursing internships/careers discuss services with Orakei

and follow up meetings)	staff, and Te Puna Hauora staff.
June 2002	<i>Tihi Ora/Te Ha:</i> Meeting with Te Runanga o Ngati Whatua (Tom Parore, Chair of Tihi Ora; Alan Pivac, CEO TRONW) to discuss my proposed research for PhD.
2000, 7 April	<i>Tihi Ora:</i> Hui with key stakeholders, Tihi Ora providers, to discuss Tihi Ora's response to the cabinet papers embargoed until 4pm on 7 th April, 2000. (Staff from Orakei, Te Puna Hauora, Te Ha present)
1999, Oct-Dec	<i>Orakei:</i> Kia Tu Kia Puawai hui (several) –Orakei provider staff, Orakei social services staff, Orakei community (maximum 30 people at any one hui)
1999, June - July	<i>Tihi Ora:</i> Strategic, Business and Operating Planning workshops attended by staff, management, governance, and community members of Tihi Ora (maximum 15 people at any one hui).
1999, 30 March	<i>Te Ha:</i> Korowai - Ngati Whatua MICO proposal hui. Held at Te Puna Hauora, Auckland. Attended by governance, management and staff of Te Puna Hauora, Te Ha, Orakei, and Waipareira.

APPENDIX 7:
KARERETANGA – RESEARCH
PROCESS AND THEMATIC ANALYSIS
FRAMES

Kareretanga – Case Study Research Process

	Title	Process
Pre-steps	Literature Review Historical Review Policy Analysis	(see methods chapter)
Step 1	Summary Table - Period 1	Case study organisational documents mid to late 1990s
Step 2	Summary Table – Period 2	Case study organisational documents 2000 to 2003
Step 3	Hui Knowledge and Information	1999-2003
Step 4	Observational Comparison Table 1999-2003	Summary Tables Periods 1 & 2; and Hui Knowledge and Information
Step 5	Obervational knowledge and information	Data collected at hui 2003-2006
Step 6	Summary Table – Period 3	Case study organisational documents 2003 to 2009
Step 7	Observational Comparison Table 2003-2009	Data collected at hui 2003-2006 and Case study organisational documents 2003 to 2009
Step 8	Synthesis 1	Debates Indigeneity Matauranga Constructive Engagement through Hauora Maori
Step 9	Synthesis 2	Kotahitanga Organisational Community Tribal

Kareretanga – Analysis Frames

ANALYSIS FRAME – LITERATURE REVIEW

ANALYSIS FRAME – LITERATURE REVIEW				
LITERATURE	Identify what authors and health commentators were most focussed on discovering and explaining about maori health developments	Look for gaps in Maori and indigenous health development that were identifiable in the literature	The Maori leaders of early Maori health – who were they and what did they achieve? (kotahitanga themes?)	Early Maori health practices – what were they and what did they achieve? (kotahitanga themes?)
HISTORICAL ANALYSIS PART 1	The politics of early Maori health - what were some of the underlying issues where Maori gained traction? (kotahitanga themes?)	The policy of early Maori health – was there indigenous health policy? (kotahitanga themes?)	The Maori leaders of early Maori health – who were they and what did they achieve? (kotahitanga themes?)	Early Maori health practices – what were they and what did they achieve? (kotahitanga themes?)
HISTORICAL ANALYSIS PART 2	Analyse the parliamentary debates from the late 1800s and early 1900s to understand parliamentary attitudes to maori health development. Analyse the parliamentary debates from the late 1800s and early 1900s to understand the participation of maori members of parliament in maori health developments in parliamentary debates.	Analyse proceedings of the maori/crown hui from the 1800s and early 1900s to understand how maori/crown relations were evolving from the mid-19th century in the ngati whatua tribal region.	Explore the role of early maori leaders involved in maori health and maori development: how they were perceived, both historically and contemporarily.	Explain Maori socio-political developments, to further understand the context for Maori health developments between 1840 and 1980
<p>Synthesis of literature review for thematic analysis of case study organisations is:</p> <p>Analyse discussions of successes, and barriers to success, of using matauranga to inform tikanga</p> <p>Tupuna macro-frames are: i) rangatira hauora, the impacts on health developments of Maori leaders and leadership; (ii) community initiatives, how communities created initiatives for health developments; and (iii) the role of Maori nurses in health developments.</p>				

ANALYSIS FRAME – POLICY DOCUMENT REVIEW				
POLICY DOCUMENT ANALYSIS	Identify & analyse Mātauranga/ Tikanga In Te Reo	Identify & analyse Mātauranga/Tikanga expressed in English	Identify & analyse which Māori people/models/ mātauranga/ tikanga are they quoting/using?	Identify & analyse which mātauranga or tikanga seems dominant/accepted repeated
<p>Synthesis of policy analysis for thematic analysis of case study organisations is:</p> <p>Identify & analyse Mātauranga/ Tikanga In Te Reo</p> <p>Identify & analyse Mātauranga/Tikanga expressed in English</p> <p>Identify & analyse which Māori people/models/ mātauranga/ tikanga are they quoting/using?</p> <p>Identify & analyse which mātauranga or tikanga seems dominant/accepted repeated</p>				

THEMATIC ANALYSIS FRAME – CASE STUDY				
CASE STUDY DOCUMENT ANALYSIS 1	IDENTIFY & ANALYSE MATAURANGA/ TIKANGA IN TE REO	IDENTIFY & ANALYSE MATAURANGA/TIKANGA EXPRESSED IN ENGLISH	IDENTIFY & ANALYSE WHICH MAORI PEOPLE/MODELS/ MATAURANGA/ TIKANGA ARE THEY QUOTING/USING?	IDENTIFY AND ANALYSE WHICH MATAURANGA OR TIKANGA SEEMS DOMINANT/ACCEPTED REPEATED
CASE STUDY DOCUMENT ANALYSIS 2	<p>ANALYSE DISCUSSIONS OF SUCCESSES, AND BARRIERS TO SUCCESS, OF USING MATAURANGA TO INFORM TIKANGA</p> <p>tupuna macro-frames – analyse for: i) rangatira hauora, the impacts on health developments of Māori leaders and leadership; (ii) community initiatives, how communities created initiatives for health developments; and (iii) the role of Māori nurses in health developments.</p>			
HUI & OBSERVATIONAL ANALYSIS 1	IDENTIFY AND ANALYSE MATAURANGA/ TIKANGA BEING EXPRESSED IN TE REO	IDENTIFY AND ANALYSE MATAURANGA/TIKANGA BEING EXPRESSED IN ENGLISH	IDENTIFY AND ANALYSE WHICH MAORI PEOPLE/MODELS/ MATAURANGA/ TIKANGA ARE THEY QUOTING/USING?	IDENTIFY AND ANALYSE WHICH MATAURANGA OR TIKANGA SEEMS DOMINANT/ACCEPTED REPEATED
HUI & OBSERVATIONAL ANALYSIS 2	<p>ANALYSE DISCUSSIONS OF SUCCESSES, AND BARRIERS TO SUCCESS, OF USING MATAURANGA TO INFORM TIKANGA</p> <p>tupuna macro-frames – analyse for: i) rangatira hauora, the impacts on health developments of Māori leaders and leadership; (ii) community initiatives, how communities created initiatives for health developments; and (iii) the role of Māori nurses in health developments.</p>			

APPENDIX 8: EXAMPLE OF CASE STUDY HUI & OBSERVATION NOTES

Appendix 8 – Hui Notes example

Org: Te Roopu Taurima o Manukau

Date: 26 May 2005

Purpose of Hui: To introduce the idea of Te Roopu Taurima establishing whare for mokopuna in Kaitiaia

Hui participants (ext orgs):

Hui 1 = Te Runanga o Te Rarawa @ Te Oranga (Cnr Matthews Ave & Melba St) – approx. 25 people at hui.

Hui 2 = Te Whare Wananga O Muriwhenua & Te Aupouri Maori Trust Board (Pukepoto Road) – approx. 40 people at hui.

Hui 3 = Te hau Ora O Te Hiku O Te Ika, Te Roopu Whitiara (beside hospital) – approx 25 people at hui.

Mihi and whakatau at all orgs focused on kaupapa, tikanga and whakapapa of their alignments. Trtom spent some time during each mihi focussing on the whakapapa of the mokopuna coming back – all are local – this made a significant difference to the peoples of the mana whenua orgs – in particular the kaumatua/kuia in one org where staff were initially hesitant to be supportive but once the kaumatua/kuia were positive

Concern from ext. Orgs. As to where their kaupapa and tikanga will fit in the integration of trtom into community. Two orgs in particular focussed on this. When trtom explained the kaupapa and tikanga (k&t) of the mokopuna is paramount in the whare, and the k&t of the mana whenua on their whenua is paramount ... all three orgs were relieved and/or impressed ... the two health orgs in particular were intrigued and then very positive about this way of managing k&t issues

Concern expressed from ext. orgs re: recent integration of Maori mental health services into community which did not go as well as possible ... all were won over by staff members who manage whare at trtom talking about how they set up and integrate new whare – hearing from the horses mouths rather than the trtom management worked really well with the community members as well – I got a real sense they were really comfortable once they had heard a kaimahi explain how and why they did things ... I think the passion and humility of her explanation was seen as more substantive than the ‘management speak’

One of the orgs is passionate about creating a certificate in some form of Maori health training as they have had one of their whanau with expertise in training return home to live – so they want to network her skills, trtoms training needs, the orgs iwi development aspirations into collaborative development pathway between local iwi and trtom

All three orgs really positive about the idea of rangatiratanga for the mokopuna AND their whanau being the basis of service delivery AND they like the rangatiratanga for kaimahi AND whanau being the basis of employment in their rohe ... none of them saw any potential for conflicts with their K&T

Local Maori orgs have been working hard to get services from Whangarei transferred into the local community because the travel to the hospital is too far, and the services are culturally inappropriate. Clear they see trtom’s arrival as giving them added impetus for service and policy focus towards decentralising health and medical services to kaitiaia. Maori health services trying to maintain services at the closed local hospital by pulling some back from Whangarei bit by bit.

**HUI & OBSERVATIONAL ANALYSIS
– TE ROOPU TAURIMA 26 MAY 2005**

	MATAURANGA/ TIKANGA IN TE REO	MATAURANGA/TIKANGA EXPRESSED IN ENGLISH	WHICH MAORI PEOPLE/MODELS/ MATAURANGA/ TIKANGA ARE THEY QUOTING/USING?	WHICH MATAURANGA OR TIKANGA SEEMS DOMINANT/ACCEPTED REPEATED
	TRTOM: RANGATIRATANGA OF THE MANA WHENUA (PEOPLE BEING VISITED) WAS EMPHASISED		TRTOM: RANGATIRATANGA OF THE MANA WHENUA (PEOPLE BEING VISITED) WAS EMPHASISED	HOSTS: RANGATIRATANGA OF THE MANA WHENUA (PEOPLE BEING VISITED) WAS ACCEPTED BY HOSTS
	TRTOM: RANGATIRATANGA OF THE MOKOPUNA RETURNING WAS EMPHASISED		TRTOM: RANGATIRATANGA OF THE MOKOPUNA RETURNING WAS EMPHASISED	HOSTS: RANGATIRATANGA OF THE MOKOPUNA RETURNING WAS ACCEPTED BY HOSTS
	TRTOM: RANGATIRATANGA OF THE KAIMAHI WAS EMPHASISED			HOSTS: RANGATIRATANGA OF THE KAIMAHI WAS ACCEPTED BY HOSTS

CASE STUDY OBSERVATIONS CONTINUED

discussions of successes, and barriers to success, of using matauranga to inform tikanga

HOSTS:

Trtom spent some time during each mihi focussing on the whakapapa of the mokopuna coming back – all are local – this made a significant difference to the peoples of the mana whenua orgs – in particular the kaumatua/kuia in one org where staff were initially hesitant to be supportive but once the kaumatua/kuia were positive

Concern expressed from ext. orgs re: recent integration of Maori mental health services into community which did not go as well as possible ... all were won over by staff members who manage where at trtom talking about how they set up and integrate new where – hearing from the horses mouths rather than the trtom management worked really well with the community members as well – I got a real sense they were really comfortable once they had heard a kaimahi explain how and why they did things ... I think the passion and humility of her explanation was seen as more substantive than the ‘management speak’

All three orgs really positive about the idea of rangatiratanga for the mokopuna AND their whanau being the basis of service delivery AND they like the rangatiratanga for kaimahi AND whanau being the basis of employment in their rohe ... none of them saw any potential for conflicts with their K&T

When trtom explained the kaupapa and tikanga (k&t) of the mokopuna is paramount in the where, and the k&t of the mana whenua on their whenua is paramount ... all three orgs were relieved and/or impressed ... the two health orgs in particular were intrigued and then very positive about this way of managing k&t issues
they see trtom’s arrival as giving them added impetus for service and policy focus towards decentralising health and medical services to Kaitaia.

APPENDIX 9: EXAMPLE OF CASE STUDY FEEDBACK

E KORE A MURI E HOKIA

There is no turning back, We can only go forward



...continue to develop career pathways with many staff going on to positions such as kaitiaki, kaitiwhakare, administrators, and intensive service managers.

Although our pay rates and conditions of employment are similar in nature to other employers within our industry, our organisation provides a lot of unique employee benefits. Our tangihanga insurance program, life cover and health insurance have been specially designed to assist our kaimahi and their whānau. This has helped Te Raupe Taurima O Manukau Trust in retaining staff; in fact our retention levels are higher than most employers in our industry.

A quality based approach to developing the skills of our kaimahi is vitally important as they meet the changing needs of our mokopuna. It goes without saying that our mokopuna are at the very centre of our being. Without the skills, dedication and commitment of our kaimahi our mokopuna lives would not be filled with the opportunities that currently exist.

I am proud of the achievements that our kaimahi have made over the past ten years. Along with the rest of the human resource team we look forward to providing new initiatives that will further enhance the capability of our kaimahi.

Lisa Chant Tumeke

One of the first things that struck me when I arrived at Te Raupe Taurima in 2005 was that I couldn't tell who were the mokopuna and who were the kaimahi. There was such a sense of whānau in the office, everyone respected equally. I had no idea who the managers were, and I (much to the amusement of many of the staff) had absolutely no idea which islands anyone came from: Māori, Tongan, Samoan, Rarotongan, Niuean. It was all so seamless, this functioning as a whānau, that the usual ego of seniority or position or tribal warfare for cultural supremacy

“In ten years since becoming an independent organisation the thing that has had the most impact from a human resource perspective, has been the massive growth in our staffing numbers.”





that often takes place within an organisational structure was beautifully absent (most of the time!).

The first thing I was made to do as a new kaimahi was go out to meet the mokopuna; visiting the homes around the motor; and of course to meet with my new fellow kaimahi and the whanau of mokopuna and kaimahi who form the greater whanau that is the heart of Te Roopu Taurima. Of course, as with all things Maori, this is the true training and testing ground for whether you have anything useful to contribute to your new whanau. What I remember most about those visits were the vibrancy of the personalities of the mokopuna; the depth of commitment of the kaimahi and their whanau; and the incredible sense of feeling completely at home every time I walked into one of these houses that I had never been in before. I remember that most of the older mokopuna spoke in Maori to me and were in fits of laughter at my terrible grammar and syntax. I managed to improve my reo greatly through their constant attentions.



There is one old whaea who, every time she saw me, cracked up laughing and would tell everyone in hearing range that I got 'cat' and 'dog' completely mixed up when I first talked to her ... thankfully she only speaks Maori, so only those who understood her story in Maori laughed at me (all the time!).

My role was to come in and try to continue the great work of the previous HR manager, just temporarily whilst they wowed him back into the fold, which they eventually succeeded in doing. I am sure, like all other Te Roopu Taurima kaimahi/whanau - he will be back forever. It was probably the simplest job I have ever undertaken in that the pride and commitment of the kaimahi in the homes meant there was very little for me to contribute. Their documented systems and processes were second to none in terms of other organisations I have worked with; and it was clear that the teams in the homes had spent a lot of out of work time preparing their documents; and personalising them to the houses, so that the documents would blend with the homes, rather than making the

...ones look like a building site full of regulations.

I distinctly remember walking into my first health and safety management meeting at the Orahua office, and being completely stunned at the huge numbers of people involved in OSH within the organisation; and then being completely humbled as I, with the degree and lots of work experience in the field of OSH internationally; suddenly understood how simple these processes and procedures can be if they are in the hands of people who really care about their mahi and their mokopuna. The stories of these managers' experiences were beyond hilarious – at every meeting. I introduced a few paper systems into what was essentially a well functioning oral system. But the stories in the meetings remained oral and contained the hilarity of frustration that can occur with highly unusual work environments, like that of Te Roopu Taurima. The one story that kept recurring was kaimahi being injured in showering patients because they didn't like wearing the OSH issued gumboots. They would fill up with water and make their feet wrinkle, and their movements sluggish! Those stories would have us literally rolling on the floor holding our sides, before we took a deep breath and documented and investigated it all properly, of course.

The payroll team deserves special mention because, my goodness, what an interesting journey they had. Moving from a paper system to a computerised system is always a nightmare. This one had lings! Mainly because of the unbelievably large distances the paperwork had to travel from (particularly the rural where); and the number of people who had to contribute to that paperwork before it could travel for processing. There was also significant distrust in-house that this damn computer system would actually work, and people just seemed to LOVE that paper system and were VERY unwilling to give it up.

I would throw my hands in the air and disappear into a dark corner hyperventilating come payroll day every week – but not our payroll people (and, of course, the supervisors and managers from all over the motu). The lovely Cynthia would smile and carry on, trying to achieve through insurmountable odds at times. Pira Cherrington would walk through, doing that calm wise old man walk and exuding an aura of "all will be well" ... and at particularly fraught times the kaumatua and kula would exit their office on the other side of the building and "korowai arua" the payroll team. Magically, all of the efforts of the regions, the kaumatua and kula, and the payroll team paid off and the payroll system got better and better as time went along.

The organisation had one of the most phenomenal short term growth phases I had ever seen, moving from less than a hundred to almost four hundred staff in the blink of an eye. Not only was the payroll team struggling to manage, the HR systems were struggling to keep up with the radical changes in employment policy the governments had introduced in 1991, 1996 and 2000. The 2000 changes had reintroduced the union systems, so not only did the organisation need to integrate new HR systems post-2000, they also needed to integrate aspects of the re-unionising environment.

Three collective employment agreements in three different regions; you HAVE to be kidding I thought. This is going to be SO UGLY. Everything I had learned at university and through previous work experiences was that as a manager I needed to – "watch out for the unions". Well, I had to quickly UN-learn everything. Every single union person I met with, both in-house and externally, was so committed to the kaupapa of Te Roopu Taurima that it was just a dream to work with them. The union negotiations were characterised by really well thought out ideas that would result in progressive outcomes in the environment for the mokopuna, for the kaimahi AND for the organisation. Generally only the kaimahi are the focus in union negotiations. Very unusual model. Best I've seen. Don't get me wrong, MAN were there some creative ways people tried to get out of trouble for employment transgressions. THOSE stories would make a great book (look out you lot, you think 'Sex & the City' is funny?). I think I can now safely say I HAVE HEARD EVERYTHING!

The training and development systems were absolutely beautiful to behold. Michelle Nahi, an exceptional trainer and very committed whanau member, delivered induction training and follow up programs for new kaimahi in Auckland, Hamilton, and the far north when needed. The numbers of staff in the organisation meant she was on a continuous circuit, constantly evaluating and giving confidence to new and not so new kaimahi as they progressed through the organisation. She was giving several training sessions every week – it was totally hard out! There was constant laughter emanating from the training rooms, and as the trainings wore on, you could literally see the sense of dignity and commitment from the trainees and kaimahi growing day by day, particularly when other kaimahi came and shared their experiences and knowledge with the trainees. One of the challenges, we discovered, was that the high level of literacy required of the training systems was out of step with the skillsets of some of the trainees – so Michelle set to recreating them using a lot of pictures to emphasise her storytelling style of teaching.



This worked so well, there was an eagerness from the trainees, and Michelle was able to stand by herself in a room and recreate the journey of the organisation; the mokoopuna, the kaimahi and the whānau Te Roopu Taurima, over several days and in a way that meant when the trainees headed out to be kaimahi they had the whakapapa firmly embedded front of brain. The supervisors and managers in the whare also re-worked their systems to assist kaimahi with these literacy issues, and to ensure the goals for mokoopuna reports, treatment plans and documentation were achievable by all kaimahi.

I got to do a little of the training in the far north, when new Kaitiaki and Kaiakohe whare were opened. I know I loved the training. I know I LOVED the local wines (perhaps a little too much)... I have memories of middle of the night conversations on park benches in Kaitiaki that are only matched by similar memories of similar nights in London ... just safer in Kaitiaki as I recall. And I remember I did not love those damned Manganuka rivers and turns where, even when I was driving myself, I would be so carsick I would



have to stop and throw up (thank you Maria Blane for eventually pointing out to me that there was a coast road that didn't twist like ballyhoo). My abiding memory of the Kaitiaki experience is meeting with the local iwi, and the way the roopu whānau explained the journey of the organisation, and more importantly the journey of the mokoopuna, back to the far north. I remember how those organisations, community, whānau, hapu and iwi got on board with the kaupapa and everyone worked together to make the experience for the mokoopuna as good as it should be. I remember that I wanted to stay up there and did my best to avoid heading back to Auckland every time I was there. I applied for the position of gardener in one of the whare, but unfortunately they saw through me (didn't know what a rake was – for some reason THAT was a problem?).

The kaimahi in Kaitiaki, Kaiakohe, as much as the kaimahi in Otorohanga and Tokoroa, were so far from base that they had to rely on each other and on the community for support. I was stunned at the stories of community support and involvement that came

out of the relationships the kaimahi were able to establish and build. I think it was in Tokoroa where the next door neighbours had fundraised for a substantive bed for one of the mokopuna; wow! I remember turning up to the Kaikohe whare on the hill and there was a kaimahi, with his wife and kids, on his day off, coming to drop back a mokopuna they had taken to their home for dinner and to stay the night. I've been around the world dozens of times, but man I'd never seen that before. It wasn't a job, it was a way of life for him – amazing people those kaimahi. Now I lecture at a university – in Maori community development, and I get to tell these stories about how the mokopuna and kaimahi manauaki the mauri of Maori – and even the non-Maori get it when they hear these stories. Tūmāke Te Roopu Taurima, you've had ten years of operation, and mai ra ano, mauri ora.

“It wasn't a job, it was a way of life for him – amazing people those kaimahi.”



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