

The Rise and Rise of Indigenous Policy Entrepreneurs in New Zealand

Lisa Chant

Ngati Whatua iwi

(the 'descendants of the ancestors' tribe)

Political Studies Department
University of Auckland

Refereed paper presented to the Australasian Political Studies Association
Conference

University of Adelaide
29 September – 1 October 2004

Introduction

Indigenous cultures colonized by western societies have long recognized that western healthcare methodologies are detrimental to their wellbeing and survival. Regrettably it is only in recent times that the colonizing societies have also acknowledged that this is so. Research shows (Blakely and Dew, 2004) that there are significant gaps in mortality and morbidity for indigenous cultures against all other ethnies that make up western societies, meaning that for indigenous cultures health policy is of paramount importance in the relationship with the governments of their countries.

The evolution of indigenous health policy in the early 1990's is the most beneficial to have occurred in two centuries of colonization, and resulted in the creation of one hundred and eighty five 'for Maori by Maori' health provider organisations. To analyse this unprecedented success in aligning with the policy domain of the government, the change that occurred is analysed from within the Maori policy context utilizing some of the tools of western policy analysis.

Kingdon's (2003, 71-89) 'Garbage Can' model of the agenda setting process is useful in defining the Maori paradigm of, firstly their own agenda setting process and secondly, how they influence the agenda setting process of government. The analogies used by Kingdon have congruence with Maori mythology and therefore can be used both descriptively and analytically for indigenous audiences. Maori mythology begins with the 'process of continuous creation and recreation. Te Korekore is the realm of potential being, Te Po is the realm of becoming and Te Ao Marama is the realm of being' thus 'the primal energy of potential being proceeds from the infinite realms of Te Korekore through the realms of Te Po into the world of light (Te Ao Marama) to replenish the stuff of the universe as well as to create what is new'.¹ Kingdon's (2003) idea of a 'policy primeval soup' in which all ideas bump around together and re-structure continuously to fit the changing times aligns with this Maori paradigm of order within chaos.

Kingdon (2003, 165-195) outlines two types of policy windows that may occur and allow an issue onto the governmental agenda. Firstly, those that open due to 'problems' and secondly, 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

¹ Maori myth and legend are ... deliberate constructs employed by the ancient seers and sages to encapsulate and condense into easily assimilable forms their view of the World, of ultimate reality and the relationship between the Creator, the universe and man'. Royal, Te Ahukaramu (editor), 2003. *The Woven Universe. Selected Writings of Rev. Maori Marsden*. The Estate of Rev. Maori Marsden pp 21, 55,56

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.

By separating the agenda setting process into three semi-independent streams – the political, the problem and the policy or solution streams – Kingdon's (2003, 90-208) model is congruent with the Maori policy paradigm and assists in the explanation of this paradigm to non-Maori audiences. 'By Maori for Maori' policy has historically evolved in 3 separate streams. The *take* (problem) stream is resolved through the formulation of *tikanga* (policy or solution stream). *Kotahitanga* or unity within the polity of the right conditions to validate the *tikanga* then needs to occur in order for policy change to eventuate. *Take* is the Maori term for a problem or issue requiring resolution. In traditional terms the *take* is dependent upon issues such as how it is defined, by whom and to which audience. It bears a close similarity to Kingdon's 'problem' stream. A *tikanga* is literally 'our way of doing things' and once there is general agreement between stakeholders and participants, it becomes a practice, principle, expression of boundaries – in other words it is the manner in which Maori formulate policy. This can be therefore aligned with Kingdon's notion of a policy or solution stream. *Kotahitanga* is about unification of people or around an issue, and encompasses the domain and environment of the polity concerned. It is therefore, in the broader sense, aligned with Kingdon's 'political stream'.

One of the underpinning themes of this paper is that New Zealand governments, as with other Westminster style governments, are constantly changing their political and policy directions. By contrast Maori political and policy development remains fairly constant and is influenced, but not diverted, by New Zealand political and policy changes mainly due to an overarching *kaupapa* or 'first principle' which, like Kingdon's garbage can, contains the contents of the three streams. This *kaupapa* (first principle) is defined by Maori (Kawharu, 1989; Walker, 1990; Durie, 1998) as *tino rangatiratanga* (self determination). All three streams of our agenda setting process are underpinned by this *kaupapa*, and Maori (Royal 2003, 56-77) would more commonly refer to it as a 'basket of knowledge' and not as a garbage can.

The role of 'coupling the streams' by 'policy entrepreneurs' as defined by Kingdon (Kingdon 2003, 182-183) is useful because there have historically been Maori who have fulfilled this role in what can be defined as the Maori policy domain. These *mana-whakahaere* or people with the authority to explore and manage change specifically in health will be called for the purposes of this paper 'Maori health policy architects'.

The role of Maori health policy architects in connecting the *take* (problem), *kotahitanga* (political) and *tikanga* (policy) streams in a way that effects a 'policy window' of

opportunity is key to our case study, as are Kingdon's ideas on the unpredictability and limited openings of these windows. The term 'policy windows' became important in the early and mid-1990's because Maori wished to know how to create them in other policy domains to effect the same result as that which had been achieved in health policy. It is now common to hear Maori in the policy domain discussing how to turn policy windows into ranch sliders (sliding doors).²

The political environment of profound change through neo-liberal reforms in the 1990's facilitated Maori framing their health policy to government in a manner that was more successful than in the previous two centuries of colonisation. This period provides an enlightening snapshot of indigenous health policy evolution and is significant for two reasons. Firstly, because it established a governance level relationship between Maori and the government that had never existed before in health. This was regarded by the Maori concerned as being the first time government had actively addressed their responsibilities as partners to the Treaty of Waitangi – that responsibility being to share governance of New Zealand with Maori. Secondly it is important because this governance level relationship was an unintended consequence of the policy for government and was a result of policy solutions arriving not from the top down (Ministry of Health to providers) or bottom up (providers to Ministry of Health) but from a group of Maori middle managers within a regional health funding organization. Thus, the policy change sprang from what can loosely be called the middle of a top down, bottom up, policy making hierarchy in a period when top down policy making was the norm.

Maori achieved this evolution through identifying and contextualising the political and policy mechanisms that would best serve to achieve their outcome of *tino rangatiratanga* (self determination) in defining and delivering of health services for Maori. One of the key mechanisms for achieving this outcome was a focused and effective Maori health policy community consisting of Maori participants from a variety of health sector related environments. They recognized that a policy window of opportunity for Maori health to gain traction on the government agenda was occurring through the neo-liberal reforms, and that this in turn could facilitate the coupling of pre-determined solutions for Maori health. It was hoped that success with this coupling would initiate successful outcomes in other policy domains. Health policy, it was hoped, would be a catalyst for a renaissance of *tino rangatiratanga* (self determination) across all government policy areas.

My PhD thesis is also looking at the concept of a Maori health policy community using Sabatier's (1999) work in Advocacy Coalitions and the role of Maori health policy

² Conversation with Erima Henare, 25 June 2004, NZ Network of Indigenous Health Knowledge and Development *Hui*, University of Auckland

architect's is being analysed using the Policy Entrepreneurship Model (Mintrom 1996). In the absence of this broader study, this paper seeks to identify the policy window that occurred and enabled the evolution of Indigenous health policy and Maori health policy architect's throughout the 1990's. Kingdon's concept of the problem, political, and policy streams will be used to contextualise the role of the Maori health policy architects in defining and utilizing a policy window successfully.

What's the problem with Maori?

When Maori are compared with non-Maori New Zealanders in social and economic terms, there is a significant gap between the two population groups. Maori have consistently lower standards of achievement across all indicators. This is a common theme across all indigenous cultures that have been colonized and more especially so in evidence (Walker 1995; Marsden 1987; Brown 1999) about comparative mortality and morbidity statistics.

The current focus for government on poor health status is to construct it as an issue of poverty. Thus Maori health is now linked in with all other people who fall into the government deprivation index category 9 or 10, and Pacific Islanders.³ This is despite clear recent evidence (Blakely 2004) that the health status of wealthy Maori is significantly worse than the poorest non-Maori. The Maori perspective (Reid 1999) of this imbalance is that it is a result of differentiated citizenship for Maori precluding their full participation in society and resulting in poorer social, economic, political and health status. By constructing Maori health in conjunction with Pacific Island and deprivation index 9 and 10, the government disregards the indigenous and colonisation aspects of Maori health status.

Two key issues occurred nationally due to the neo-liberal reforms in the 1990's and signaled a return to the governmental agenda for Maori health. The first was evidence (Marsden 1987; Walker 1995) that the neo-liberal reform period saw a staggering increase in mortality and morbidity statistics for Maori unmatched by any other population group. The second was an increased focus on quantitative measures aligned to health funding and this showed that Maori were accessing free secondary and tertiary services (hospital services) in preference to partial-payment primary services (GPs & nurses). Government had two main concerns with this. Firstly, many Maori were presenting with issues at secondary/tertiary level that could have been resolved/alleviated by the accessing of more cost effective primary services. Secondly, by the time many of these Maori did access the secondary/tertiary services, they were in

³ Ministry of Health, 19 May 2003 Memo by email to Lisa Chant regarding: Services to Improve Access

such a bad state that they were pre-disposed to poor outcomes and the potential to become an ongoing health and social expense to the state.⁴

A pattern has emerged within this study of how Maori identity is constructed in order to fit within the policy dynamic of the time. At times Maori are portrayed by the government and media as 'deserving extra attention for health' and at other times as 'demanding extra attention for health, but being undeserving of it'. Maori health is at times an area of interest and at times anathema from a political and policy perspective. This is an example of Kingdon (2003, 104-105) discussion of issues 'fading' from the agenda.⁵ In the case of Maori and health the process can move quickly from sympathy to empathy to denigration – referred to colloquially as 'Maori-bashing'.⁶ This of course impacts on the way the problem of Maori health is defined, and is premised by the notion that the definition will be controlled by hegemony i.e. the government. In the 1990's period Maori were defined as 'deserving extra attention for health' by government.⁷ International concern about poor Maori health status also impacted on the nation's perception and attitude to Maori, especially with regard to the country's relative position against the other western democracies. The World Health Organisation life expectancy statistics showing poor Maori health status were quoted in a national magazine, the National Business Review on 1 May 1990, with the indication that this was the fault of the Maori themselves, but the responsibility of the country to resolve.

This period was one of massive change and restructuring with the focus on Maori health being only one of a large number of issues hitting the policy agenda at that time. The devolvement of some level of resourcing for health back to Maori was attractive to government in that it would also relieve them of some responsibility for Maori health outcomes. This neatly fitted with the neo-liberal agenda. By focusing resources into developing a relationship between government and themselves through health, Maori saw an opportunity to progress their assertion of rights to *tino rangatiratanga* (self determination).

It wasn't so much 'a' political change that made the time right for the policy change in the example, more it was the speed and number of political changes that were occurring that created the right environment for Maori health policy evolution. Some (Boston et al. 1996, 168) have described the policy context that typified the neo-liberal period as 'rapid, radical policy change'.

⁴ Notes from MAPO training *hui*, week of 27 June 1995

⁵ Kingdon, J 2003, *Agendas, Alternatives, and Public Policies*. 2nd edn., New York, Longman pp104-105

⁶ Tapu Misa article in New Zealand Herald, 27 March 2002, 'Sick Maori face of subtle racism'

⁷ For example Bill English, Minister of Health, quoted in the New Zealand Herald 23/12/96 pg 1 supporting Maori aspirations for providing services to their own

The Political Stream – acronym nirvana

The period from 1990 has seen significant restructuring of the health policy environment within the context of profound political change. The fourth Labour government came to power in 1984 and quickly set about deregulating the economy and restructuring the government through corporatisation and privatization of the public sector. The 1990's heralded the return of National to government and one of their first areas of attention was health. Continuing the neo-liberal reforms, National introduced a Green and White paper in 1991 outlining changes that were to subsequently come into place through the Health and Disability Services Act 1993.⁸

The restructuring of the health environment was significant in that it separated the purchasing mechanism from the providing mechanism and attempted to create a 'market place' for health. A corporate style of governance and management of health purchasing was introduced through four Regional Health Authorities. The Ministry of Health contracted the Regional Health Authorities to purchase and monitor health and disability services. The Regional Health Authorities contracted providers for the delivery of health and disability services, leading to significant growth of non-government providers. This system of contracting out the health system fitted neatly within neo-liberal reforms that had been taking place since 1984.⁹

Concurrent to these health sector changes the New Zealand electorate had voted in a (1993) referendum for a change to the electoral system. The move from First Past the Post to Multi-Member Proportional Representation took place at the 1996 election and resulted in a coalition government between National and New Zealand First. The Health and Disability Services Act 1993 remained, but there was a coalition agreement on health which led to some winding back of the focus on monetary rather than health issues.

Under the 1993 Act, four Regional Health Authorities for purchasing and monitoring were created and there was an element of competition between them for government funding. In 1996 these four Regional Health Authorities were merged into one Health Funding Authority. Under the 1993 Act the twenty three hospitals had been turned into CHE's or Crown Health Enterprises with a corporatised governance and management restructuring resulting in a focus often more on saving money than saving lives. Under the 1996 Coalition Agreement on Health the CHE's were re-formed into HHS's or

⁸ These were described by Martin and Salmond as 'derived from economic analysis grounded in the New Institutional Economics ... imposed on the health sector with little or no consultation. The approach was confrontational and compromising'. Martin, J & Salmond, G (2000) *Policy Making: The 'Messy Reality'* in Davis, P & Ashton (eds) *Health & Public Policy In New Zealand*, Auckland, OUP

⁹ For a more detailed analysis, see Ashton, Toni (2001) *The Influence of Economic Theory* in Davis, P & Ashton, T (eds) *Health and Public Policy in New Zealand* pp 107-124, OUP, Auckland

(Health and Hospital Services). The corporatised model was wound back and the emphasis returned, albeit it mainly in policy speak, to saving lives (but save money if you can too).¹⁰

After the 1999 election Labour in coalition with the Alliance Party immediately indicated a change would be taking place in the health sector. In 2000 the Health and Disability Act removed the Health Funding Authority and turned 21 of the 23 HHS's into DHBs or District Health Boards. The new DHB's were responsible for both purchasing and providing of services in their geographic area based on a 'population based funding formula'. The boards of the DHB's contained a mix of government appointed and community elected members. Under the new Act changes to primary care were effected through the Primary Care Strategy. This was the first reform of the primary sector that had been undertaken, the previous decades changes had focused mainly on secondary, tertiary, public and pharmaceutical. The contracts for Primary Services (mainly GP services) had previously been through individual contracts between practitioners and funders. The new environment created not for profit organisations to manage the funding of large numbers of GPs and allied health professionals (nurses, pharmacists etc) through the population based funding mechanism.

¹⁰ For a more detailed analysis, see Barnett, P & Barnett, R (1999) *Reform and change in health service provision* in Davis, P & Dew, K (eds), *Health and Society in Aotearoa*, OUP, Auckland pp219-234

Table 1: New Zealand Health Politics and Policy 1984 to 2001

Political environment	Health Legislation and Policy	Health Funding	Primary Care	Secondary Care
1984-1990 Fourth Labour Government – neo-liberal reforms	1983 Area Health Boards Act 1983	No change	No change	14 area health boards – partly locally elected and partly govt. appointed
1991 to 1996 National government - neo-liberal reforms continue	1993 <i>National govt.:</i> Health & Disability Services Act 1993)	Four regional health authorities for primary & secondary (govt. appointed boards)	No change	23 crown health enterprises (govt. appointed boards, corporate structure)
1996 - 1999 MMP electoral system introduced National & NZ First coalition National minority government?	1996 - 1998 <i>(National & NZ First coalition agreement on health)</i>	Transitional Health Authority and then the Health Funding Authority established – a single funder nationally. Boards appointed by MOH.	No change	CHE's are transformed into HHS's (health & hospital services 1998). Boards appointed by government
1999 - 2001 Labour & Alliance coalition 2001 – present Labour minority government	2000 <i>Labour & Alliance coalition:</i> NZ Public Health & Disability Act 2000	21 District Health Boards	Primary Health Organisations	21 DHBs

Hauora (wellbeing, health) Maori and the Political Stream

One of the key political factors of influence that Maori have with government is that they form a constituency in their own right. Within this constituency lies the basis for evolution of social movements which will activate on issues of relevance to this constituency. The evolution of social movements by Maori around health is intrinsically linked to the political development of Maori within the historical New Zealand context. Two Maori medical school graduates, Dr Maui Pomare and Dr Peter Buck, became politicians in the first years of the 20th century and focused heavily on Maori health issues in their work. The ability for Maori to coalesce as a constituency is at variance with most other indigenous cultures due to key factors such as two languages (the official one is Maori, but English is the primary language spoken), a country that is small in size and geographically isolated, and one Treaty. In most other indigenous cultures there are mixtures of languages and treaties, also there are often huge geographic challenges.¹¹ This ability to form a constituency underpinned the Maori success in the health policy domain of the 1990's.

The move to an MMP electoral system, signaled by the 1993 referendum, and the realization that Maori were a significant voting block or constituency, had not escaped the notice of political participants. Maori health became a prominent issue for dialogue between political participants and the Maori community.

For the previous two centuries, land had been the main focus of Maori grievances to the government through the relationship created by the Treaty of Waitangi. With the advent of the Waitangi Tribunal in 1975 a forum was created between the government and Maori to resolve land issues. This meant health became the new focus for Maori *hui* (gatherings) and activism nationwide.

Much discussion took place around the failure of western healthcare methodologies imposed on Maori in the previous two centuries to improve Maori health status. This combined with legislation making Maori healthcare practices illegal¹² was deemed at least partially responsible for the widening gap between Maori and non-Maori health status. All *hui* (gatherings) and communications between Maori and the government focused on the need for Maori to be resourced to deliver their own health services to their own. Inherent in this was the recognition of both parties that systemic racism in the health system was an underpinning factor in Maori mortality and morbidity statistics.¹³

¹¹ For instance Turtle Island (US & Canada), Sami Nation (Norway, Sweden, Finland and Russia).

¹² For instance the Tohunga Suppression Act 1907 (Tohunga were experts in many facets of tribal wellbeing, often including traditional healthcare practices)

¹³ An example of this is an article in the Dominion newspaper, 2/8/96, headlined: Maori Mental ills 'ignored' discussing that Maori with mental health issues seemed to be discharged earlier than any other ethnic group.

In 1984 the government had engaged with Maori in two nationwide Hui (gathering). While the *Hui Taumata* launched a 'decade of Maori development', *Hui Te Ara Ahu Whakamua*, facilitated by *Te Puni Kokiri*, the Ministry of Health and the Public Health Commission, is referred to as the 'Maori Health Decade *hui*'.

Maori (Cunningham & Kiro 2000) began planning and developing health plans in this period with the objective of attaching them to new policy changes they expected to be the result of this increased level of consultation between themselves and government.

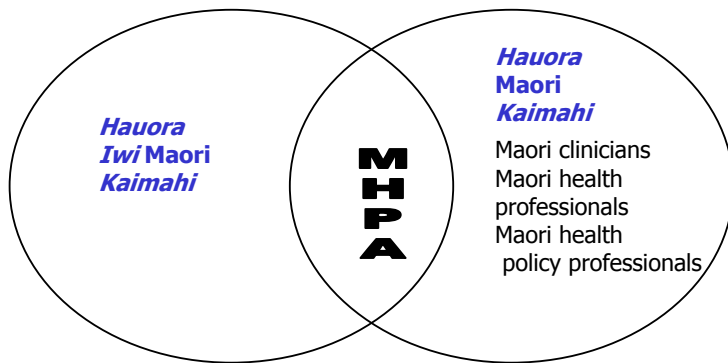
For Maori, in the endless pursuit of reasserting their rights to *tino rangatiratanga* (self determination), health was seen as one of the key areas for commonality of purpose between themselves and the government and therefore one of the best areas to prove *tino rangatiratanga* (self determination) for Maori within modern New Zealand was not only feasible, but desirable.

The problem of poor Maori health status was firmly on the government's agenda and the solutions attached by Maori were more readily accepted than at any other time in the history of colonization. The political stream provided a level of *kotahitanga* (unity of purpose) between Maori and government and with the coupling of this and the problem stream, a policy window for the evolution of indigenous health policy opened in 1993 with the Health and Disability Services Act and the commitment to the special needs of Maori contained in section 8, page 21.

The Policy Stream – Maori Health Policy Architects

There were two key Maori groups engaged in health policy development in this post 1990 period and it is at the juxtaposition of these two groups that we see the emergence of Maori health policy architects.

In the first group were the many *iwi* (tribes) who, especially in the post-Hui (gathering) Taumata and Hui (gathering) Te Ara Ahu Whakamua period, had dedicated resources to health politics, policy and service development. These were often small structures with minimal resources and, thanks to the dedication of Maori leaders and MP's of the early 1900's placing an impetus on getting Maori women trained as nurses, they often had recourse to trained health expertise within their own *iwi* (tribe). Health had become a key planning issue for all *iwi* (tribes) in this period. The second group comprises an amalgam of Maori specializing in health and including, clinicians, health professionals, health policy professionals, lawyers, accountants, researchers, and academics.



It is doubtful that without the political and health policy environment of the 1990's so many Maori health policy architects would have been created and have become such a dominant force in the contemporary health policy environment. The rapid changes meant that the 'Maori Health Policy Community' had no time for fragmentation – they had to coalesce under urgency and provide a response that was not only using the language and terms of the neo-liberal period, but also they needed to be completely on top of all health policy direction changes which were occurring almost on a weekly basis.

One of the key results for this 'Maori health policy community' has been that many of the Maori terms that have been used and re-used by them in political and policy circles have become commonly used within the broader health policy environment, for instance '*hauora*' for health and '*kaimahi* (worker)' for worker, '*whanau*' or '*whai ora*' for patient, 'by Maori for Maori providers'. The 'Maori health policy community' was able not only to create a paradigm of integration within their own community, they were able to reach out and influence the broader New Zealand health context.

While Kingdon (2003, 97) indicates that 'symbols diffuse rapidly' and are not powerful mechanisms within agenda setting, the opposite is true for New Zealand indigenous participants. Symbols are regularly used to reinforce political and policy impetus by Maori, and are often ancient. What is significant is the consistency of recognition and use of these symbols across the numerous tribes that make up the Maori nation. An example of this is the '*korowai*' or feather cloak – which is used symbolically to unite, nurture, protect and give authority to people or peoples. Many of the Maori health service providers who developed from the 1990's chose to use the term '*korowai*' in the names of their organisations. The government indigenous health policy, formulated by Maori and government in 2000, is named '*He Korowai Oranga*' or 'the cloak of wellness' and is described (Ministry of Health 2002, ii) in the inside cover of the booklet thus:

For Maori, this Maori Health Strategy symbolizes the protective cloak and *mana o te tangata* – the cloak that embraces, develops and nurtures the people physically and spiritually. In the weaving, or *raranga*, of a *korowai* there are strands called *whenu* or *aho*. In the strategy these represent all the different people who work together to make Maori healthy – including *whanau* (family), *hapu* (subtribe) and *iwi* (tribe), the health professionals, community workers, providers and hospitals. We need to weave the *whenu/aho* with all the diverse groups and combine these with our resources to form the different patterns of the *korowai*.

This cross-fertilisation of Maori knowledge and expertise, with public policy and health, created a rich environment of learning for Maori health policy architects to flourish within and also validated the Maori perspective in the evolving health policy environment. To contextualise this renaissance of Maori Health Policy Architects, and the re-invigorating of the *tikanga* or policy stream, a fine grained analysis of one Regional Health Authority and its Maori health strategy is used as a story to illustrate my argument.

The MAPO Strategy

The Northern Regional Health Authority (North Health) was one of the four regional health authorities created under the Health and Disability Services Act 1993. The region extends from the southern outskirts of Auckland to the top of the North Island.

In the mid 1990's North Health's interpretation of the Maori health aspects of the Crown Health objectives from the 1993 Act led to the creation of the Maori Purchasing Organisation (MAPO) Strategy. This strategy was significantly different to how other Regional Health Authorities were addressing Crown Health objectives for Maori. The main differences were in the creation of the MAPO as a co-purchasing¹⁴ organization for government health monies and the inclusion of a governance level role for the MAPO with the North Health board. There were three key Maori who came together to create this strategy along with their team and this became known as the 'MAPO strategy or Maori Purchasing Organisation Strategy'.

The neo-liberal environment that created the Regional Health Authorities also gave rise to an environment of contracting out of services, and North health segmented into

¹⁴ Co-purchasing meant deciding with North Health how the funding would be allocated, approving non-government providers, monitoring of government and non-government providers, being co-negotiators and co-signatories to all health and disability contracts (Maori and non-Maori – known as Maori and mainstream) in the relevant subregion.

service teams. At North Health, as well as teams such as primary care, medical/surgical, child and youth, mental health team, disability support there was also a 'Maori Health Development Division (MHDD)'. MHDD were given the task of developing a regional Maori strategy.

The first to come on board was a clinical manager, Gwen Te Pania-Palmer, a Maori nurse with strategic and management expertise who recognised that this new environment was focusing on 'statistical rationales' for funding of services, and quickly linked into the network of Maori clinicians, health professionals and researchers to provide robust evidence for the need for separate Maori health funding and service provision. The second key person to come on board was the Manager of the Maori Health Development Division team, Rob Cooper, who had many years experience and knowledge of what Maori networks were seeking to achieve politically and from a health policy perspective. He was able to meld the Maori aspirations and expectations into a model that was acceptable to the North Health board – known as the MAPO strategy. His expertise gave the board and other Maori involved in the project a high level of confidence in the wisdom of the MAPO strategy and its projected outcomes.

The third team member was a young Maori lawyer, Sharon Shea, who came on board in a contracts role and she discovered a hook in the Health and Disability Service Act which allowed the MAPO strategy to include a health co-purchasing role for the three *iwi* (tribes) MAPO who were being created. She was able to articulate the development of a governance level role for *iwi* (tribes) in the purchasing and monitoring of health and disability services through Memorandum of Understanding and Deeds of Partnership between Maori and the Northern Regional Health Authority that were deemed acceptable by both parties.

The MAPO Strategy

The three prongs of the MAPO strategy were:

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

The purpose of this MAPO co-purchasing strategy (Walker 1995, 3) was:

'to provide opportunities for greater Maori participation in North Health's 'purchasing' and decision making which impact upon Maori health status. This is another way of encouraging greater Maori participation within the health sector.'

The *iwi* (tribal) entities chosen by North Health to form the MAPO were Tainui Trust Board, Te Runanga o Ngati Whatua and Te Tai Tokerau Trust Board. North Health (Walker 1995, 3) sought to:

‘establish partnerships based on the Treaty of Waitangi. Such an orientation resulted in the development of MAPO who were Maori co-purchasing partners with the Board of North Health’.

The MAPO were created through a Memorandum of Understanding and Deed of Partnership between North Health and each of the three *iwi* (tribal) entities. They were regarded by North Health as having *tangata whenua* (indigenous) status in the North Health region.

Each of the new MAPO was given a subregion in which to be involved in co-purchasing arrangements. The geographical boundaries created by North Health (Walker 1995, 3) were somewhat different to traditional *iwi* (tribal) boundaries:

‘reference is made to three sub regions within the North Health region and these are referred to as Tainui (South), Ngati Whatua (mid) and Te Tai Tokerau (North). It should be noted that this is not an attempt to redefine traditional tribal territory. It is simply a means of assisting in a variety of strategies to improve Maori health. These sub regions coincide with the localities selected to include Maori organisations within North Health’s Co-purchasing Strategy.’

North Health gave a pragmatic rationale for the boundary changes. It would align each of the three *iwi* (tribal) MAPO with Crown Health Enterprise (CHE) boundaries and facilitate work with the CHE’s on mainstream enhancements (cultural improvements to the hospital services). The Strategy was seen as being of such importance to the *iwi* (tribes) involved that they were willing to accept these arbitrary boundary changes even though the sacred relationship between their land and their people would be negatively impacted upon.¹⁵ Thus the *take* (problem) stream and the *tikanga* (policy) stream were successfully coupled by the Maori health policy architect concerned.

North Health offered MAPO a co-purchasing strategy that would give the three *iwi* (tribal) entities a relationship at three levels. Firstly they formed a *Kaunihera Hauora* (health council), which created a governance level role for the MAPO *Rangatira Hauora* (health chief) alongside the North Health Board. Secondly a management level relationship was formed between the three MAPO general managers and the general managers of the various divisions of North Health. Thirdly, an operational relationship

¹⁵ 13 March 2002, interview with Tom Parore, Chairperson, Tihi Ora MAPO, Ngati Whatua

was formed between the MAPO operational teams and the North Health operational teams.

The relationship between the Board and *Kaunihera* was outlined in the Memorandum of Understanding. The following is from the Ngati Whatua version:

‘Ngati Whatua will nominate one person to participate with North Health’s Board on a committee of the Board in respect of the purchasing of health and disability services for Maori people. This committee will comprise all the members of the North Health Board and one nominee of each *iwi* (tribe) which has entered into a co-purchasing agreement with North Health’.¹⁶

While North Health funded the operational contracts of the MAPO, the MAPO reported directly back to their *iwi* (tribal) entities (Ngati Whatua Runanga, Tainui Trust Board and Te Tai Tokerau Trust Board), and the *iwi* (tribe) defined and created their MAPO board. However, the *iwi* (tribal) entities were responsible back to North Health for the contractual obligations of the MAPO as defined in their operational contracts.

North Health also funded by Maori for Maori health providers who were responsible in their service contracts back to MAPO and North Health. In this way, the co-purchasing strategy was defined and implemented. Some commentators (Kiro 2001, 208-223) refer to the MAPO strategy as creating a ‘defacto Maori purchasing policy’ and MAPO as ‘Maori Health Authorities’.

The MAPO strategy was a regional solution by the Northern Regional Health Authority to the problem of poor Maori health status, co-defined by Maori and Government. It was created by three key Maori Health Development Division members, or Maori health policy architects, and was supported by another key Maori Health Policy Architect, who sat on the board of North Health. Denese Henare had been involved with Government in high level strategic development of policy for Maori for a number of years and was experienced in getting such strategies accepted and implemented. This *tikanga* (policy) stream successfully coupled with the *take* (problem) stream and fitted well into the neo-liberal political environment.

The strategy created responsibilities for the government in that the legal relationship between North Health and the three *iwi* (tribal) Maori was in effect a legal relationship

¹⁶ Ngati Whatua & North Health Deed of Partnership *Agreement for Identifying and Purchasing Health and Disability Support Services for Maori in the Ngati Whatua Tribal rohe* 1995 p2

between the Crown (government) and the three *iwi* (tribal) Maori. In this way the MHDD and North Health originated the policy for government, as opposed to the hierarchical, top down origination of policy that was the norm in this period.

One of the key outcomes expected by both Maori and government of the MAPO strategy was capacity building of Maori communities around health. As well as support from both groups (Maori and government) for infrastructure and organizational development, there was a focus on workforce development to ensure capacity for participation was underpinned by a skilled and effective workforce.

The MAPO Strategy – Creating Maori Health Policy Architects

By taking young Maori trained in law, accountancy, IT, policy, social sciences, nursing etc and putting them in the MHDD team, into a MAPO team, or into other North Health teams – a workforce development program for Maori Health Policy Architects came into fruition. The focus was training them in all aspects of **Maori** health development.

It was acknowledged that all of these Maori Kaimahi (worker) had several masters to serve and serve well. For instance, the MAPO teams were managed by *iwi* (tribes) and therefore their Maori kaimahi (worker) worked for not only the *iwi* (tribes) managing their MAPO, but also had responsibilities back to their own personal *iwi* (tribes - of which generally people have several). Those working for North Health had not only responsibilities to their North Health teams, but also to the Maori Health Development Division, the three *iwi*-MAPO and their own *iwi* (tribes). The kaimahi (worker) also had a responsibility to the Maori organisations they were working with in conjunction with their roles, often fledgling Maori structures having their first go at setting up and running health and social services within their own communities.

These responsibilities are over and above the generally accepted levels of commitment to an employee. When you are working within your own community on health issues, Maori expect you to be available 24 hours a day, 7 days per week and to act with *tika* (proper procedures), *pono* (integrity) and *aroha* (compassion) at all times. There is a collective responsibility for the wellbeing of the community that underpins any individual role within the Maori health environment that is inescapable.

The workforce development strategy involved planting the feet of the kaimahi (worker) Maori firmly into the *Hauora* Maori domain, whilst supporting them in their mainstream skills development and responsibilities. The balance between being Maori and serving your people and being a worker and serving your team was the key lesson. The projected outcome was balanced, effective and expert Maori Health Policy Architects. In this instance the political, policy and problem streams had created a policy window

which produced an environment conducive to the evolution of 'policy entrepreneurs' who were Maori and focused on health policy.

Conclusion

In discussing the topic of this paper with Maori health policy architects interviewed for my PhD thesis, one of the key themes that is played out is how positive the governments of the 1990's treated the Maori health issues, and how substantive the subsequent gains were. In seeking to explain this change from a policy, as well as a political perspective, Kingdon has proven to be a theorist who has made sense to indigenous audiences, both nationally and internationally. This has provided some validity for non-indigenous policy concepts being used for research in Maori health politics and policy.

In using the approach of three separate streams, this paper seeks to introduce the idea that 3 Maori streams and 3 government streams can join in various forms to create a policy window for indigenous health policy to evolve. Whether this is evidence of a greater understanding of Maori streams by government, or government streams by Maori is unclear. There is the possibility that the policy window that occurred in 1993 may prove to be a one off incident, and that it may be another two centuries before one with similar potential for substantial gains in Maori policy aspirations and expectations occurs.

The key to future success may lie in the ongoing development of a Maori health policy community and Maori health policy architects. There are significant moves within the Maori health domain to not only underpin these developments, but also to network with other indigenous cultures internationally on such issues. Because Maori health networks and health experts existed pre-colonisation, and there were also a few examples such as Drs. Buck and Pomare in the early 20th century, this paper has referred to a 'renaissance of' Maori health policy architects.

The co-purchasing and monitoring relationship created between the three *iwi* Maori and the Northern Regional Health Authority in 1995 was regarded at the time as a 'regional anomaly' and the government, sensing the danger in such a relationship that had appeared from the regions was quick to stymie such aspirations in other *iwi (tribe)* Maori around the country. The legal relationship that existed through the Memorandum of Understanding and Deed of Partnership with the three *iwi (tribe)* Maori was not extinguished by subsequent restructurings and legislative changes, and remains in place today, although the current government is trying through various methods to reassign the relationship from themselves and to the District Health Boards. This ongoing legal relationship between the three *iwi (tribe)*-Maori and the government was an unintended

consequence for the government, but a key expectation of the *iwi (tribe)* Maori and the Maori Health Policy Architects involved in the MAPO strategy.

The management and training of the MAPO and North Health Maori kaimahi (worker) , was a planned outcome for the MHDD, but achieved perhaps more in a piecemeal rather than strategic fashion. There was a more formalized plan for the workforce development of the kaimahi (worker) of the Maori Providers that were created as part of the MAPO strategy and it was during the cross-training between the MAPO and North Health Maori Kaimahi (worker) and the Maori Provider Kaimahi (worker) that many of the young people involved got a sense of their future roles within Maori health being somewhat mapped out, also a sense of belonging to a community of hauora expertise.

Pre-colonisation it was common for the elders of the tribe to identify what roles young people would be trained to fulfill within the tribe. In this regard colonization appears not to have effected too much change to this tradition.

Biobibliography

- Blakely, T & K. Dew. 'Ethnicity, acculturation and health: who's to judge?'. *New Zealand Medical Journal* 2004:117-1188
- Brown, M. 'Policy induced changes in Maori mortality patterns in the New Zealand economic reform period'. *Health Economics* 1999:8(2) 127-136
- Cunningham, C. and C. Kiro. 2000 'Rāpuhia mo te Hauora Māori'. In *Health and Public Policy in New Zealand*, eds. P. Davis and T. Aston. Auckland, Oxford University Press.
- Durie, Mason. 2001. *Mauri Ora: The Dynamics of Maori Health*. Auckland, Oxford University Press.
- Kawharu, I H. 1989. *Waitangi: Māori & Pākehā Perspectives of the Treaty of Waitangi*. Auckland. Oxford University Press.
- Kingdon, J 2003, *Agendas, Alternatives, and Public Policies*. 2nd edn., New York, Longman.
- Kiro, C. (2001). *Kimihia Hauora Māori : Māori Health Policy and Practice*. Auckland, Massey University. Unpublished PhD Thesis.
- Marsden, Rev. Māori. 1987 'Part One of a submission to the Royal Commission on Social Policy' In 2003. *The Woven Universe. Selected Writings of Rev. Māori Marsden*, ed. Royal, Te Ahukaramu. The Estate of Rev. Māori Marsden
- Mintrom, M. & S. Vergari. 'Advocacy coalitions, policy entrepreneurs, and policy change' *Policy Studies Journal*, 24:420-435
- Ministry of Health. 2002. *He Korowai Oranga: Māori Health Strategy*
- Reid, P. 1999. 'Nga mahi whakahaehae a te tangata tiriti'. In *Health and Society in Aotearoa New Zealand*. eds. P. Davis, K. Dew. Auckland, Oxford University Press.
- Royal, Te Ahukaramu (editor), 2003. *The Woven Universe. Selected Writings of Rev. Māori Marsden*. The Estate of Rev. Māori Marsden
- Sabatier, P & Jenkins-Smith, H (1999) '*The Advocacy Coalition Framework: An Assessment*'. In Sabatier, P (ed) *Theories of the Policy Process*, USA, Swestview Press.

Walker, Ranginui. 1990. *Ka Whawhai Tonu Matou – Struggle Without End*. Auckland. Penguin.

Walker, Ratana. 1995. *Maori in the North Health Region: An analysis of health information*. Northern Regional Health Authority, Auckland