TE TOI HAUORA-NUI

Achieving excellence through innovative Māori health service delivery

A report prepared for the Ministry of Health

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MAURIORA KI TE AO

LIVING UNIVERSE LIMITED

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Te Toi Hauora-Nui

When preparing our original proposal, MKTA carefully considered an overall title for the project. In particularly, we looked at mātauranga Māori inspired concepts for insight.

The title of this project captures ideas of excellence (Toi) and the fullness of health and wellbeing (Hauora-Nui). Therefore the title reflects the traditional idea that health and wellbeing is grounded upon the presence of mana in the experience of the individual and his/her people. It expresses a mana derived approach to health and wellbeing.

Throughout this exercise, we have attempted to provide an avenue for mātauranga Māori derived approaches to health and service delivery to be acknowledged and recognised.

SUMMARY

Key Messages

- There is much to do and on a number of fronts to directly address the health inequalities experienced by Māori. The challenge is considerable and must be an ongoing priority for the health and disability sector.

- A notable development over the past two decades has been the critical role Māori health providers have played towards whānau ora – supporting Māori families to achieve their maximum health and wellbeing.

- Chronic conditions contribute the major share of the disparity in life expectancy between Māori and non-Māori. There are significant disparities between Māori and non-Māori in disease rates and outcomes for CVD and Type 2 diabetes.

- Māori health providers offer a range of services in response to the growing chronic disease burden. Primary care GP services aimed at empowerng patients and their whānau to take greater control of their health and wellbeing feature prominently.

- Māori health providers are distinctive because they are -

    - kaupapa Māori inspired and Māori led
    - culturally authentic and responsive
    - dedicated to achieving whānau ora - supporting Māori families to achieve their maximum health and wellbeing
    - committed to fostering, building and maintaining trusting relationships with patients and their whānau, and with other interests and organisations
    - holistic in approach to the assessment, monitoring and treatment of patients and their whānau
    - utilising multidisciplinary teams with a mix of clinical, non clinical and community workers
    - preferential employers (where possible) committed to increasing the Māori health workforce
    - investing in professional development opportunities for all staff including non-Māori staff to understand and practice Māori cultural values, and
    - committed to community buy in and involvement in the design, development and implementation of their services.

- Māori health providers also rely on strong leadership both at a governance and management level, dedicated and skilled staff and voluntary assistance to deliver its services.

- A concern from this study is the lack of available supporting clinical data and evidence to assess the effectiveness of interventions for improving cardiovascular and diabetes amongst Māori. This area requires immediate attention.

- On the whole, the Māori health provider sector continues to evolve moving from a period of establishment to a phase of consolidation and maintenance. There are areas including governance, management, accountability and reporting systems, IT systems, financial systems and processes, and workforce capability that require ongoing investment and support.

- Because of their networks and their track record of working with whānau, Māori health providers have the potential to be influential organisations in the future. This is particularly so as more iwi settle Treaty claims and look at delivery models and organisations that will assist their beneficiaries on a number of fronts.

- The Ministry of Health and District Health Boards have an ongoing responsibility to support Māori health providers to achieve whānau ora.

CHAPTER ONE: INTRODUCTION

This chapter describes the research project including its objectives and the methodology undertaken.

Background to Research

Mauriora-ki-te-Ao/Living Universe Ltd (MKTA)[1] was engaged by the Ministry of Health (Ministry) to examine the service structures and approaches that Māori health providers use to manage chronic conditions and to identify processes leading to successful results.

This project, Te Toi-Hauora-Nui, highlights examples of innovative service approaches to improving Māori health, and those critical success factors in service delivery that contribute to whānau ora. This study has a specific focus on primary health care services aimed at managing cardiovascular disease and diabetes.

Research Objectives

The specific objectives of the project are:

- Producing a **literature review** that provides an overview of what is happening in the area of innovative service approaches for indigenous populations. In particular, the literature review will look at services/programmes delivered in the primary care setting that are involved in the management of chronic conditions, such as cardiovascular disease and diabetes.

- Carrying out a **study** that looks at models of practice used by Māori health providers to improve Māori health outcomes and attain whānau ora. The study will focus on service approaches in the primary care setting where programmes to address cardiovascular disease and diabetes exist.

- Based on the literature review and information gathered in the study, provide a **report on innovative service approaches** to improving Māori health. The report will document critical factors that lead to successful results. The report will inform policy and service development planning and will assist the health sector in their advice, monitoring frameworks, contracting and decision making processes, particularly relating to Māori health providers.

Research Methodology

This project required that models of provider practice especially those which are being used to improve Māori health outcomes and attain whānau ora be documented. It is particularly focused on service delivery practices, systems and approaches and cultural aspects employed by Māori health providers to address chronic care management. Of major interest are the distinctive approaches that are being used

[1] See Appendix A for project team.

which present a "point of difference" between Māori health providers and other providers.

The approach taken by MKTA included:

- a review of relevant literature
- engagement of a group of Māori health providers to participate in this study
- case studies of Māori health provider practice
- analysis of material gathered through the case studies and other documented sources
- assessment of patient related feedback, and the
- preparation of a final report.

Throughout this study, MKTA has drawn on the advice of a Reference Group comprising representatives from the Ministry of Health and the Counties Manukau District Health Board.

Māori Health Providers

Nine Māori health providers have participated in this study. The process of identifying the providers occurred in consultation with the Ministry of Health.

An initial list of potential Māori health providers was identified and provided to MKTA from the Ministry. The initial list included providers recognised for their participation and delivery of programmes relevant to the area of investigation. In addition, a particular emphasis by the Ministry was placed on identifying 'successful providers' that displayed one or more of the following characteristics:

- is recognised and nominated by others
- is known to have delivered services with positive outcomes, and
- has credibility across the sector because of the services delivered.

The MKTA project team also considered the composition of the initial list and recommended other providers to ensure an urban, rural and geographical spread.

Following consideration, a list of nine providers[2] was finalised following consultation, recommendations of others, in-depth knowledge of the field which they work in, and the range of their community experiences.

The participating providers are:

- Maraeroa Marae Health Clinic, Waitangirua
- Te Kohao Health Ltd, Kirikiriroa
- Whakawhiti Ora Pai, Pukenui
- Te Rūnanga o Ngā Maata Waka, Otautahi/Christchurch
- Te Korowai Hauora o Hauraki, Thames
- Ngā Kakano Foundation Ltd, Te Puke

[2] See Appendix B for table listing the characteristics of each of the providers.

- Whakatu Marae, Nelson
- Ngāti Porou Hauora, Te Puia
- Te Hauora o Te Hiku o Te Ika, Kaitaia

These providers were contacted directly about the research and background material on the project was provided.

Interviews

A written questionnaire[3] was developed by MKTA following consultation and input from the Ministry and the Te Toi Hauora-Nui Reference Group. The questionnaire was specifically designed to capture information about:

- the establishment and structure of the organisation
- distinctive features that shape the delivery of services
- models used to influence service delivery
- monitoring and review approaches of operational activities
- funding sources
- how services will be developed over the short, medium and long term
- general approach to chronic conditions
- specific approaches to diabetes and cardiovascular disease, and
- patient base and workforce status.

All interviews occurred at the place of work of the provider and during work time. The MKTA Team leader with other members of the project team conducted the interviews. In all instances the MKTA project team met with either the CEO or Manager or Senior Team Leader or a combination of these. Each provider was given an information sheet, a consent form, contact list and the written questionnaire about the project prior to the interview. The consent forms were signed by the provider at the time of the interview.

All visits culminated with the MKTA project team being given a tour of the provider's operations.

The interview followed the format of the written questionnaire. Follow-up questions were asked when necessary during the course of the interview. In two cases, providers had already completed the questionnaire prior to the interview and the arrival of the team.

The interviews lasted from 60 to 120 minutes. Discussion notes were also made during the interview. The discussion notes and written and oral responses to the questionnaire have formed the database for this project.

In every case key informants were open, sincere, and passionate about their organisation's kaupapa. Following the interview the providers were given a koha to thank them for their contribution toward the research.

[3] See Appendix C for interview questionnaire.

Supporting Documentation

Key informants were asked to supply any documentation they had available about their service. This information supplemented both our understanding of the services being provided and added to the literature database.

The MKTA project team also reviewed other relevant documents and used information on websites drawn from the Ministry, District Health Boards of New Zealand and those from the participating providers.

Research Ethics

Two of the nine providers interviewed were sceptical about the research. They expressed concern and doubts about the effectiveness of the research and whether or not there would be a positive end result for Māori health providers and their patients. They sought assurances from the MKTA Team Leader that their information would be safeguarded and not used for any other purposes. In one situation the interview did not proceed until the objectives of the research and the process to be used was fully explained. This took about thirty minutes. Overall, however, the response from the participating providers has been positive with considerable support for the study.

Transcripts of interviews were returned to all informants. They were asked if they wished to add to, amend or delete any of the information. Consent forms were signed by five of the providers. Four informants elected not to take up this option and were comfortable with proceeding as required, without formal sign off.

Wānanga

On Thursday 12 February 2009, a wānanga with participating providers was held in Auckland. The goal of the wānanga was to consider further the distinctive service delivery features and practices that give Māori health providers a point of difference to their mainstream counterparts. The project team also took the opportunity to share some of the key themes from the visits so far. An independent facilitator was engaged to assist with the discussion. The key themes from the wānanga are incorporated in Chapter Four and included as Appendix D.

Client Feedback

To complement the information gathered, some patient feedback was also obtained through a series of interviews. In one case a facilitated discussion was held with an exercise group of women. Commentary from patients have been considered, and where appropriate woven throughout this report.

CHAPTER TWO: CONTEXT

In this chapter, we provide background information about He Korowai Oranga: Māori Health Strategy, whānau ora, and the primary health care sector. A description of chronic conditions and Māori health disparities sets the scene for the following sections of this report.

He Korowai Oranga, Māori Health Strategy

Launched in 2002, He Korowai Oranga: Māori Health Strategy sets the direction for Māori health development in the health and disability sector[4]. The strategy provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of whānau.

He Korowai Oranga recognises that health and wellbeing is influenced and affected by the 'collective' as well as the individual, and the need to work with people within their own contexts, not just with their physical symptoms.

He Korowai Oranga has two purposes –

- **Affirming Māori approaches.** The Strategy strongly supports Māori holistic models and wellness approaches to health and disability. He Korowai Oranga seeks to support Māori-led initiatives to improve the health of whānau, hapū and iwi. The strategy recognises the desire by Māori to have control of their future direction and is therefore a strong motivation for Māori to seek their own solutions and to manage their own services.

- **Improving Māori outcomes.** Achieving this will mean a gradual reorientation of the way that Māori health and disability services are planned, funded and delivered. Government, District Health Boards and the health and disability sector will continue to have a responsibility to deliver improved health services for Māori and improve Māori outcomes.

He Korowai Oranga provides a framework for the public sector to take responsibility for its role in supporting the health status of whānau. This includes public policies that actively promote:

- whānau wellbeing
- high-quality education
- employment opportunities
- suitable housing
- safe working conditions
- improvements in income and wealth, and
- address system barriers, including institutional racism.

[4] See Minister of Health (2002).

Whānau Ora

The overall aim of He Korowai Oranga is whānau ora - Māori families supported to achieve their maximum health and wellbeing. As a principal source of strength, support, security and identity, whānau play a central role in the wellbeing of Māori individually and collectively.

The outcomes sought are that whānau members:

- experience physical, spiritual, mental and emotional health
- have control over their own destinies
- live longer and enjoy a better quality of life, and
- participate fully in Te Ao Māori and New Zealand society generally.

These outcomes are more likely when whānau:

- are cohesive, nurturing and safe
- are able to give and receive support
- have a secure identify, high self esteem, confidence and pride
- have the necessary physical, social and economic means to participate fully and provide for their own needs, and
- live, work and play in safe environments.

Whānau ora is an empowering concept both in principle and practice. It has become the key driver for many Māori health and social service delivery organisations. It places whānau health and wellbeing as a matter for everyones concern, where no one should be sick on their own and where wellness is a collective aspiration.

Whānau ora also involves facilitating positive and adaptive relationships with whānau and recognising the interconnectedness of health, education, housing, justice, welfare and employment and lifestyle as elements of whānau wellbeing.[5] Achieving whānau ora requires a multiple pronged approach that focuses on:

- whānau, hapu, and community development
- Māori participation including supporting effective Māori health providers and a highly skilled Māori health workforce
- effective service delivery, and
- working across a range of social sectors such as social development, education and housing to effect change.

NZ Primary Health Care Setting

Primary health care covers a broad range of out-of-hospital services such as:

- GP and mobile nursing services
- pharmacy and laboratory services

[5] Ministry of Health (2009) *Statement of Intent 2009-12.*

- community health services such as maternity, family planning and sexual health services, dentistry, and mental health services, and
- physiotherapy, chiropractic, and osteopathy services.

Launched in February 2001, the New Zealand Primary Health Care Strategy sets out a vision for primary health care services. The vision statement includes six inherent goals:

- People will be part of local primary health care services that
  - improve their health
  - keep them well
  - are easy to get to and
  - co-ordinate their ongoing care.

- People will be part of local primary health care services that focus on better health for a population, and actively work to reduce health inequalities between different groups.

The Strategy is the Government's response to four main concerns :

- differences in the health across different population groups
- high levels of preventable illness
- high levels of preventable hospital admissions, and
- barriers to getting primary health care services.

Figure 1 sets out the Six Key Directions and Five Priorities for Early Action listed in the Strategy and that it would "evolve over the next few years and may not be fully realised for five to ten years".[6]

Figure 1: The Strategy's Six Key Directions and Five Priorities for Early Action

The Six Key Directions are:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain, and restore people's health
- co-ordinate care across service areas
- develop the primary health care workforce, and
- continuously improve quality, using good information.

The Strategy's Five Priorities for Early Action are:

- reducing the barriers, particularly financial barriers, for the groups with the greatest health need, both in terms of additional services to improve health and to improve access to first-contact services
- supporting the development of PHOs that work with the people enrolled with them

[6] See Minister of Health (2001).

- encouraging developments that emphasise multi-disciplinary approaches to services and decision-making
- supporting the development of services by Māori and Pacific providers, and
- facilitating a smooth transition to widespread enrolment with PHOs through a public information and education campaign to explain enrolment and promote its benefits for communities.

New entities, called PHOs, were created as the core means for improving primary health care services, although any organisation or health care worker with a primary health care role could contribute to the Strategy's goals. PHOs were to be funded differently from the existing methods, and primary health care funding was to be increased.

The principles for "ensuring a stable and constructive transition" are:

- to protect the gains already made and build on successful initiatives
- involve, discuss and collaborate with the primary health care sector, providers and communities in the implementation of the Strategy
- focus on stepwise, evolutionary, change.

The Primary Health Care Strategy Implementation Work Programme 2006 - 2010 focuses on reducing inequalities, engaging communities, and the management of chronic conditions.

Central to the Primary Health Care Strategy is addressing the health inequalities that exist between Māori and non-Māori.

Chronic Conditions

Chronic conditions or long-term conditions are those that can only be controlled but not, at present, cured. Some common long-term conditions are:

- alcohol and other addictions
- alzheimer and other dementias
- asthma
- arthritis
- cancer
- cardiovascular disease
- chronic obstructive pulmonary disease (COPD)
- chronic pain
- congestive heart failure
- depression and anxiety disorders
- diabetes
- stroke.

There are many other long-term conditions, including rare conditions with a genetic origin and oral health conditions. Unlike acute illness, most long-term conditions develop over longer periods of time, sometimes having their origins antenatally. They do not always have a clear point of onset, and may have multiple causes, including genetic inheritance that can be modified through early life experience. Accidents and

injuries can also result in long-term conditions requiring ongoing health care and support and management, such as chronic pain, depression and the effects of head injury.

Often people have more than one long-term condition (referred to as co-morbidities or multiple morbidities). Some long-term conditions cause other long-term conditions, while others can be the result of acute illnesses. Long-term conditions that arise in childhood and adolescence may be more advanced or severe in adulthood, unless they are well managed in the early stages.[7]

The WHO has described managing chronic conditions as the healthcare challenge of this century.[8] It estimates that the global disease burden from chronic illnesses will increase to 60% by 2020. That would make chronic conditions the leading cause of disability and, if not successfully managed, the most expensive problem for healthcare systems worldwide.

In New Zealand:

- An estimated 70% of health care funds are spent on chronic conditions.
- 80% of all deaths in NZ result from chronic conditions.
- Chronic conditions contribute the major share of the disparity in life expectancy between Māori and non-Māori.

Chronic conditions place new demands on health systems and require a different approach to the organisation of care across medical, social, and community factors. This includes proactively stratifying patients by risk, encouraging self-management, and actively supporting and monitoring the patient's health condition over time.

Where New Zealand specific research is available, most cost of illness studies on long-term conditions report annual societal costs greater than $100 million. In New Zealand intangible costs tend to be estimated in the billions, for example, intangible costs were estimated at over $2.5 billion for arthritis in 2005 and over $9 billion for dementia in 2008. Where they exist, cost of risk factor studies, including for tobacco use, physical inactivity and obesity, report annual societal costs of over $800 million.[9] There are no studies on the overall economic cost of all long-term conditions in New Zealand. Although the costs of these conditions and risk factors can not be entirely eliminated, they do, however, highlight the vast investment in the management of long-term conditions. Understanding these costs can help to inform how best to invest resources.

Currently, there are significant disparities between Māori and non-Māori in disease rates and outcomes for CVD and Type 2 diabetes. Addressing these is a key priority

[7] Ministry of Health (2009) *Long-Term Conditions Direction for Action.*
[8] World Health Organisation (2002) *Innovative Care for Chronic Conditions: Building Blocks for Action.* Geneva, WHO.
[9] Ministry of Health, (2009)

of the Diabetes and Cardiovascular Disease Quality Improvement Plan[10], which includes:

- specific actions to reduce inequalities in risk, incidence and outcomes of CVD and diabetes
- analyses of access and quality issues in service delivery
- collaboration on strategies to improve current services and/or develop innovative models with Māori, and
- monitoring the effectiveness of care and outcomes by ethnicity.

Cardiovascular Disease

Cardiovascular disease (CVD) is the leading cause of death in New Zealand, accounting for 40 percent of all deaths in 2001 and encompasses all diseases of the heart and circulation, including stroke. Of these deaths, 22 percent were due to coronary heart disease, 10 percent to stroke and 8 percent to other vascular causes. Many of these deaths are premature and preventable.[11]

CVD was the most common cause of death for Māori accounting for a third of all Māori deaths. Cardiovascular disease death rates were 2.3 times higher for Māori than for non-Māori during 2000-2004.[12]

Ischemic heart disease accounted for 18% of all Māori deaths and 23% of all non-Māori deaths. Among Māori 45% of deaths occurred in people aged under 65 years compared to 11% among non-Māori. The higher proportion of young deaths in Māori is partly due to the higher risk for Māori in younger ages and because of the younger age structure of the Māori population compared to the non-Māori population.

Large inequalities in risk, outcomes and access to care exist for CVD. These inequalities reflect a complex mix of socioeconomic, ethnic and access-related factors.

The Māori Cardiovascular Action Plan[13] was developed to improve the responsiveness of the health sector to Māori, improve Māori cardiovascular health and remove inequalities in CVD outcomes between Māori and non-Māori. The plan is organised around six categories:

1. Policy development – the need to prioritise Māori health gain in all health policy directives, in explicit recognition of the Treaty Waitangi.

2. Information systems – the need for complete and consistent collection of ethnicity data in order to monitor CVD inequalities.

[10] Ministry of Health (2008) *Diabetes and Cardiovascular Disease: Quality Improvement Plan.*
[11] Ibid, 2008.
[12] Robson B, Harris R. (eds) (2007). *Hauora: Maori Standards of Health IV. A study of the years 2000-2005.* Wellington: Te Ropu Rangahau Hauora of Eru Pomare.
[13] Bramley et al (2004).

3. Needs assessment – cardiovascular health needs assessments for Māori communities are required to identify the level of met and unmet need.

4. Quality standards – Māori specific and equity based performance indicators are applied across the heart healthcare continuum.

5. Workforce development – there is a critical shortage of Māori cardiovascular health workers. Priority areas for Māori recruitment, training, and retention include cardiovascular doctors, nurses, health researchers, and public health workers.

6. Research – both quantitative and qualitative research pertaining to access and equity of health care for Māori with CVD is needed.

Diabetes

Diabetes is a common condition that potentially affects all New Zealanders. Addressing diabetes is a well-established health priority for New Zealand for four major reasons:[14]

- the prevalence of diabetes is increasing at an accelerated rate
- diabetes is the major preventable cause of renal failure and dialysis, lower-limb amputation and avoidable blindness (in working adults)
- diabetes is a major risk factor for cardiovascular disease, and
- diabetes is a major contribution to inequalities in life expectancy, cardiovascular outcomes and diabetes-specific health outcomes for Māori and Pacific peoples.

The major reason for the increasing prevalence is the increasing number of Type 2 diabetes. According to the latest Ministry of Health estimates, 125,000 people in New Zealand had diagnosed Type 2 diabetes in 2001, and this number is predicted to increase by at least 45 percent to 180,000 by 2011.

Diabetes is almost three times more common in Māori than non-Māori. In addition, for Māori aged 45-64 years death rates due to diabetes are nine times higher than for non-Māori New Zealanders of the same age. Māori are diagnosed younger and are more likely to develop diabetic complications such as eye disease, kidney failure, strokes and heart disease.

Incidence and mortality rates for Type 2 diabetes are expected to significantly increase over the next 20 years with the biggest impact being on Māori and Pacific peoples.

Ethnic disparities for diabetic complications are disproportionately higher than for prevalence. This suggests that Māori are much more likely to suffer complications such as renal failure, lower limb amputation, eye problems and heart disease, from diabetes than non-Māori.[15]

[14] Ministry of Health (2008).
[15] Te Ropu Rangāhau Hauora a Eru Pomare (2007).

CHAPTER THREE: INNOVATIVE SERVICE APPROACHES

This chapter identifies features of community based approaches and details the role Māori health providers play in the delivery of services. It is followed by accounts profiling nine Māori health providers.

Community-based approaches to service delivery

Community development, community based or inspired approaches are a key feature of primary health care delivery in Aotearoa-New Zealand. Broadly speaking, the key aspects of community development are:

- believing that the social, cultural and economic lives of people can be improved
- working alongside community groups to achieve wellbeing and sustainable communities
- enabling and empowering people to identify their own resources and strengths and to support them to meet their own needs in a constructive manner
- encouraging people to work collectively to secure resources and skills. This includes the sharing of knowledge and disrupting the notion of the "expert"
- building on existing community networks to develop better support and community control of services, and
- identifying long term strategies for development.

For a community based health or social service provider, typically there are a number of steps that are taken to support a community and enable community action. These include:

- identifying community priorities
- supporting local initiatives that make community residents more able to control and improve their situation
- finding out what people know and what they think is important
- sharing information
- assisting with skills development
- assisting with research and information collection
- helping to plan community action, and
- providing or helping to locate resources if needed.

There are number of iwi/Māori community based organisations delivering a range of health and social services. The majority are Māori-led and owned, tend to be closely integrated to their communities, and have a better understanding of the needs of their communities than other groups of providers. Many exhibit the characteristics identified above.

Māori Health Providers

The health and disability sector is large, multi-dimensional and has evolved[16] in recent years, to the current model focused on decentralised decision-making, community-oriented services and improving population health outcomes.

Māori health providers are a key feature of this sector. Growing from a figure of 20 providers in the early 1990s, there are now approximately 250 providers located throughout the country.[17] Māori health providers are typically small, relatively new organisations with a strong not-for-profit philosophy.

What differentiate Māori health providers from other mainstream providers are the underlying cultural values and principles, or kaupapa, guiding their operation and development. Many see their work as an extension of their community with personnel directly drawn from within the community they serve. Many are also linked with providing a broader range of non-health services like family violence initiatives, alternative education programmes, budgetary advice, youth related initiatives and so on. Other features of this sector include:

- services delivered away from formal medical settings
- a limited range of public health services on offer, and
- a reliance on voluntary labour.

While many of these providers hold small specific contracts, others are much larger and offer a wide range of services, including medical, nursing, allied health professional services and community care.

The commonality, irrespective of size, is the "ownership" of the provider by a tribal or community-based group, the lack of medical dominance in governance and the use of tikanga Māori or Māori-defined frameworks for understanding health and delivering health care. Also, Māori providers have generally focused on providing easier access to services for their patients and have been driven by the evident disparities in health between the Māori and non-Māori communities. Whānau ora is also a desired outcome and driver for Māori health providers.

In terms of the Primary Health Care Strategy, the policy and structural changes closely resemble those that these providers have adhered or aspired to since their establishment. Many cannot become a primary health organisation in their own right as do they not provide a range of first contact primary health care services. However, they can become part of a PHO along with other specialised service providers. A

[16] The evolution has included the introduction of the 'provider-funder' split; to an integration of these arrangements to what currently exists with District Health Boards making decisions for their respective health populations at the local level and the Ministry of Health tasked with providing policy advice, monitoring performance, funder of DHBs and national services such as national screening services, and a provider of regulatory and other functions.

[17] Refer Appendix one of Cabinet Paper: Review of Targeted Policies and Programmes: Ministry of Health Reviews of the Māori Provider Development Scheme and Pacific Provider Development Scheme (2004).

small number of Māori health providers have evolved into large-scale diversified providers delivering a range of primary health care services. In general, this is not representative of the whole sector. The sector continues to evolve and grow.

The following case studies provide a descriptive account of nine Māori health providers.

Case Study: Maraeroa Marae Health Clinic

Background

Located in Waitangirua-Porirua, the Maraeroa Marae Health Clinic (the Clinic) was established in June 1995 to provide primary health services for Māori and other groups in the area.[18]

The Clinic is based next to Maraeroa Marae in Waitangirua with a service coverage area from Porirua East to Plimmerton. Because of the clinic's location, the immediate target area is Cannons Creek, Waitangirua and Ascot Park – areas with a deprivation index of Deciles 9 and 10.

Structure

The Maraeroa Marae Health Clinic is governed by the constitution of the Maraeroa Marae Association Incorporated. An executive body provides overarching governance support and guidance to the Clinic. The governing body works to facilitate the following:

Moemoea, Kaupapa

- Strategic direction
- Stewardship

Kawa and Tikanga

- Policy management
- Risk management and controls
- Legislative compliance
- Contractual performance
- Financial performance
- Monitoring performance

Crucial to the overall functioning of the organisation is the active role of kaumātua. This group provide guidance, wisdom and experience to all involved in the work at Maraeroa Marae including the Clinic. A Business Manager leads the operational arm of the organisation.

Purpose

The core purposes of the Maraeroa Marae Health Clinic are:

- To establish a community centre type urban marae complex in Porirua East.

[18] Refer Maraeroa Marae Health Clinci *Strategic Plan, 2007-2012,* p5.

- To provide an organisation which will enable its members to play an effective role in the social, educational, economic, spiritual and cultural development of the community and in particular to:
    - encourage the active participation of rangatahi in marae and other local activities;
    - revive, maintain and preserve the teaching of Māori arts and crafts, the Māori language, Māori cultural practices and traditions;
    - provide and encourage fellowship and understanding between all races and to cooperate with other organisations, departments of state and local bodies.

- To cater for the particular needs of Māori and Island communities in Porirua.

Funding

The Clinic receives funding from Capital and Coast District Health Board, Regional Public Health, the Haoura-a-Iwi Trust, Mana Wahine Inc. and the Ministry of Health.

Service Provision

The Maraeroa Marae Health Clinic offers a range of services, including health promotion and education, support and advice, as well as services for asthma, cervical and breast screening, well child care and whānau health. Services include:

- Whānau ora
- Tamariki ora
- Ante Natal support
- Hauora-a-Iwi
- Injury Prevention, Tamariki car seat scheme
- Outreach Immunisation service
- Asthma Education service
- Improving Access service
- Cervical/breast education services
- Doctors clinic
- Support groups
- Exercise programmes

With the exception of the Tamariki Car Seat Scheme, the Clinic's services are provided free of charge. The services are mobile with a base facility for staff, the doctor's clinic, administration and consultation/outpatient clinics when the need arises. Mobile services enable the Clinic to visit patients in their home if this is more convenient as well as deliver services directly at community localities e.g. outreach immunization service or Tamariki Ora/Well Child programme. Whānau and individuals are able to access asthma and diabetes management through the clinical and community teams in their own homes. The Clinic also provides transport services to assist patients to access appropriate services external to the health clinic and to attend programmes at the Marae.

The Clinic promotes its services though a range of avenues – attendance at hui, participation in community events and by networking with other agencies. The Clinic also provides a range of pamphlets on the services its offer, and other material aimed at providing information specific to different health needs e.g. asthma management, breastfeeding, and food nutrition.

The Clinic actively collaborates with other providers in the community to meet the needs of high risk/high needs patients that require integrated care, support and advocacy. Contact with other local community providers is maintained on a regular basis.

The Clinic deploys a team approach involving both clinical and non-clinical staff. Knowing and proactively working alongside their local community is critical. Many staff at Maraeroa are active members of their community involved in local schools, sports clubs and church groups. This is considered important by Maraeroa and provides the basis for strong community connections.

Chronic Care Management

The key focus is on health promotion and education. With its local PHO, the Clinic supported the launch in February 2009 of a cardiovascular health promotion initiative and with the Capital and Coast DHB, the marae hosted a pulmonary rehabilitation programme for 6 weeks.

The Clinic also runs a number of programmes aimed at changing lifestyle factors. An example of this is Kool Kats – an exercise group for Māori and Pacific Island women over the age of 50years. While the group meets on a regular basis to increase their mobility levels, more importantly it provides an avenue (led by staff) to discuss other related health issues in a supportive environment.

The Clinic will do anything that fits or promotes activities to reduce the incidence of diabetes and CVD.

Monitoring and Quality Assurance

Monitoring operational activities including the delivery of services is undertaken on a regular basis. While this is largely in response to contractual requirements, the Clinic is also committed to continuous improvement and therefore considers monitoring performance as essential. The Clinic received Te Wana[19] Accreditation in 2008.

The Clinic is committed to engaging directly with its community. It seeks feedback from its patients on a regular basis. Its 2007 Annual Patient Survey received both

[19] Te Wana provides a combination of standards and indicators for clinical practice and organisational functions, and is based on an Australasian primary care accreditation programme. Te Tiriti o Waitangi and community relationships are a prominent feature of the programme. Te Wana goes beyond clinical practice to include systems for effective governance, consumer input, community engagement and health promotion. Organisations must be able to show they are responsible to the priorities and needs of both individuals and their wider communities fostering a holistic, population view of health and healthcare.The programme is recognised in the Primary Health Care Strategy.

positive feedback and comments on areas for improvement. Some of the feedback included:

- nursing care provided was excellent
- community health worker advocacy and support was excellent
- information provided was helpful and easy to understand
- assistance provided was appropriate to the needs of 99.5% of all patients accessing health clinic services
- requests for more regular consultations
- continue transport service
- no room for private consultation, and
- not enough experienced nurses on hand.

Workforce

In November 2008, the Clinic employed 2.2 FTE clinical staff, 2 administrators and 3 volunteers. There are 3 managers. Most staff are Māori and many come from the community itself – either residing in or having grown up in the area. Wherever possible the Clinic endeavours to engage people from within their community or alternatively personnel who can engage with communities especially the 'hard to reach'. All staff are subject to annual performance appraisals.

The Clinic's community health worker team is responsible for leading its health promotion initiatives. Their roles are varied and involve transporting patients to doctor and hospital appointments, supporting patients at appointments in the community with other agencies e.g. Work and Income. Community health workers also plan and implement health promotions i.e Auahi Kore, breast screening, immunization, nutrition, exercise, etc on a regular basis. Community health workers also participate in local community events such as Creekfest in Porirua.

Workforce development and investing in professional development is a priority for the Clinic. Clinical and community team members increase their knowledge about major health issues such as cardiovascular disease through a range of avenues e.g. attendance at seminars, specific courses, etc. Over the years, the Clinic has supported a number of staff obtain necessary qualifications.

Like many other providers throughout the country, the Clinic finds it difficult to attract and recruit clinical professionals. This remains an ongoing priority. However the Clinic has a positive working relationship with the Whitireia Community Polytechnic's School of Nursing and Health with many of its students undertaking placements on a regular basis. The arrangement is of mutual benefit to both organisations.

Distinctive Organisational Characteristics

Being marae based is central to the Clinic and the delivery of its services. The Clinic pays particular heed to the values and tikanga of Maraeroa. A key value is manaakitanga – that of supporting others. This value is embedded in how the Clinic operates, how it engages with others, and how it works to treat individual patients and their whānau.

The Clinic's guiding principles are based on the Māori concepts of:

- Pono: mana motuhake, tikanga, te reo
- Aroha: aroha, manaaki, whānaungātanga, kotahitanga, and
- Tika: empathetic, proactive, relevant, quality service.

Māori cultural practices (hui, karakia, pōwhiri and so on) feature promintently in the day-to-day operations of the Clinic.

The Clinic's services are influenced by, and draw upon the Te Whare Tapa Whā model. Developed by Professor Mason Durie, this model brings together the physical, mental, social and spiritual dimensions of health and healing and takes an integrated approach to healthcare.

The Clinic is acutely aware that the health status of its patients and whānau are influenced by multiple environmental factors such as standards of housing, employment, improved income, education and the like. Because of this, the Clinic has built up and maintains strong relationships with other local health and social service providers, government and non-governmental agencies and institutions such as Whitireia Community Polytechnic so that an integrated and solutions based approach is taken.

Looking Forward – Opportunities and Challenges

In the short to medium term, the Clinic's focus will be to stabilise and consolidate its operations without compromising its community focus. It will continue to strengthen its relationships with others especially working in partnership with its local PHO.

Like many other providers, increasing its workforce especially clinical staff is an important goal. The Clinic is working towards securing the services of a full time GP. Dental services have been identified as a significant need. The Clinic has often provided its base for other providers to utilise and plans to continue to do this.

Case Study: Te Kohao Health Ltd

Background

Established in 1984, Te Kohao Health Ltd is based at Kirikiriroa Marae in Hamilton. Kirikiriroa Marae was opened in 1984 and over time has established a number of core services including –

- Rongoātea – residential drug and alcohol rehabilitation centre
- Te Rāranga – traditional Māori carving school
- To Kohanga o te Ngira Kohanga Reo
- Ngā Mara Atea – day programme for adults with an intellectual disability
- Alternative high school for students stood down, and
- Three kaumātua flats.

Te Kohao Health is the only marae based health and social service facility in Hamilton.

Structure

Te Kohao Health is a charitable company, registered under the Companies Act 1993. The company has five directors and collectively they provide governance oversight for Te Kohao Health. The Managing Director of Te Kohao is also a member of the Board.

Purpose

The Te Ara Kitenga or vision of Te Kohao is "living our rangatiratanga through strong, healthy, vibrant and prosperous whānau". Its mission is –

- To provide a high quality standard of holistic service to whānau
- To support whānau to take control of their own health and wellbeing
- To realise Te Tiriti o Waitangi for everyone
- To be a leading provider in Aotearoa
- Active observance of tikanga Māori

The guiding principles for Te Kohao are as follows –

Kotahi ano te kohao o te ngira, e kuhuna ai te miro ma, te miro pango, te miro whero. I muri i ahau, kia mau ki te aroha, ki te ture me te whakapono (Potatau Te Wherowhero, 1858)

There is but eye of the needle through which the white, black and red threads must pass. After I am gone, hold fast to love, to that which is just and to the faith.

Whāia tau e hiahia ai, kia eke ki te taumata.

Follow your desires and you will reach the summit.

These guiding principles are constantly drawn upon to motivate and inspire the way in which the organisation collaborates with, and delivers to its community.

Funding

Te Kohao is primarily funded through contract for services with the Waikato District Health Board, the Ministry of Health, ACC, Toiora PHO Coalition and the Ministry of Social Development. Te Kohao also fundraises and actively seeks out sponsorship and grants to support its strategic and operational goals.

Service Provision

Te Kohao provides over 20 different health and social service contracts servicing approximately 4,000 patients from all ethnicities – most categorised at being high deprivation and low decile. Of this population, 84% are Māori, 3% are Pacific, 2% are Asian, 9% are NZ European and 2% are various other ethnicities. The health related services include:

Clinical Services

- Disease State Management
- Tamariki Ora
- Immunisation Outreach
- Cardiovascular Rehabilition Programme
- Health promotion and education

Iwi Health Services

- Auahi Kore – education, promotion, one-on-one support on how to quit smoking
- Smoking Cessation – quit smoking through the use of nicotine replacement therapy
- Nutrition, hearing, injury prevent, immunisation
- Kaumātua and kuia programme
- Project Energize – improving physical activity and nutrition in tamariki
- Mirimiri/massage services

Disability and ACC Services

- Home based rehabilitation
- Medical care
- Assessments of those who require home help, personal care and so on

Te Kohao delivers these services through its marae based clinic and mobile/outreach services.

Chronic Care Management

As highlighted, Te Kohao offers a number of services aimed at reducing the incidence of CVD and diabetes. Specifically, Te Kohao has:

- GP health clinics that undertake regular diabetes and retinal screening
- a Māori cardiovascular rehabilitation service aimed at reducing the number of hospital admissions to secondary care through holistic health and social services, and
- nurse-led disease state management services that include home visits to whānau for diabetes, heart and lung disease.

Health promotion, educational initiatives and annual check-ups are also important services offered to patients. Whānau and individual patients are regularly monitored by clinical staff and by the network of Te Kohao whānau ora community workers.

Monitoring Operational Activities

Monitoring the operational activities of Te Kohao is done on a regular basis. Patient satisfaction surveys are conducted on an annual basis and these have proven valuable. As a consequence of feedback received, Te Kohao has implemented changes.

In 2006, Te Kohao achieved Cornerstone accreditation, under the New Zealand Royal College of General Practitioners. They also achieved accreditation for the whole organization, under Quality Health New Zealand, who has since amalgamated with Telarc SAI Ltd.

Collaborative Relationships

Te Kohao works collaboratively with a number of other community organisations throughout the region including with Raukura Social Services, Waikato Social Services, Raukura Hauora, Ngā Miro Health, Taumarunui Kokiri Trust, Te Rohe Potae in Te Kuiti, Te Hotu Manawa Māori, Sport Waikato, Anglican Action, Catholic Social Services, Te Ahurei, Ngāti Haua Hauora and Social Services, Rauawaawa o Frankton, Maeroa Lodge Hospital and Plunket. These relationships are also indicative of Te Kohao's integrated and holistic approach to whānau ora.

Workforce

Te Kohao employs approximately 95 staff, of which 42 are based at the marae while the rest are home-based support service staff, all of whom work in the homes of their patients.

Te Kohao is committed to supporting its staff to develop their skills, experience and expertise. All staff are encouraged to undertake cultural and clinical training. In recent years, Te Kohao staff have participated in training programmes facilitated by Mauri Ora Associates Ltd. On the whole, the workforce is enthusiastic and committed to the kaupapa of Te Kohao.

Te Kohao also works closely with its local tertiary education institutions notably the Waikato Institute of Technology and Te Wānanga o Aotearoa by providing the opportunity for students to gain practical experience.

Distinctive Organisational Characteristics

Kirikiriroa Marae is central to Te Kohao Health. Over the years many Māori, through urbanisation, have drifted from their own connections to their whānau, hapū and iwi. Kirikiriroa Marae was established to meet this need in an urban setting as a turangawaewae, or place to stand regardless of place of origin, ethnicity, gender, religious or spiritual belief. Since its establishment, the Marae has supported a number of initiatives for the benefit of children, youth, elderly and whānau/families. The Marae provides the foundation upon which Te Kohao operates and, along with the guiding principles identified earlier, is a distinctive characteristic.

Te Kohao Health is a Māori-led and Māori centred organisation. It is governed by a Board of Directors who all identify as Māori. Māori cultural values and practices provide the impetus for the strategic direction of the organisation and are embedded in its day to day operations. While Te Kohao services all ethnic groups, its patientele base is predominantly Māori.

Te Kohao Health delivers services from a Māori world view based on the model - Te Pae Mahutonga (The Southern Cross). Te Pae Mahutonga takes a holistic approach to enhancing community leadership and autonomy. The model focuses on four components – Mauriora (access to Te Ao Māori); Waiora (Environmental Protection); Toiora (Healthy Lifestyles) and Te Oranga (Participation in Society). Te Kohao Health proactively works to incorporate all these elements in their business.

The priority for Te Kohao Health is aptly described in its vision – 'living our tino rangatiratanga through strong, healthy, vibrant whānau'. This vision drives the organisation's desire to deliver quality services and empower individual patients and whānau to achieve their own rangatiratanga.

Another distinguishing feature is the time their staff (clinical and non clinical) spend getting to know their patients. On average their GP consultations take 27 minutes. Repeat visits by patients are common. While Te Kohao indicated it had been criticised for lower volumes when compared with other providers, the 'whakawhānaungatanga' aspect (or getting to know their patient and whānau) is important to the organisation and valued by their patients.

Looking Forward – Opportunities and Challenges

Te Kohao Health's future focus is to continue to grow. Considerable effort has been made to extend its premises especially the completion of its new premises in 2009. The building will house a larger GP clinic, a pharmacy, a gym, a café, rongoā services, a room for kaumātua and other services. Te Kohao also plan to establish a working garden to produce kai to meet the needs of the marae, the proposed cafe, the needs of their patients and enough left over to sell commercially to supplement its income. In short, Te Kohao aspires to deliver a range of integrated services, progammes and initiatives to whānau.

In the medium to long term Te Kohao aspires to provide dental services and to have a Māori-led hospital and hospice. Beyond health and social services, there is potential for the Kirikiriroa Marae complex to expand into other ventures like tourism.

For Te Kohao, realising their future aspirations is dependent upon a number of capacity related issues including securing ongoing funding support and other essential resources.

Te Kohao has been frustrated by the 'red tape' and increasing reporting demands placed on it.

Within the community it services, Te Kohao Health notes that ongoing poverty and stress for whānau remains a major challenge.

Case Study: Whakawhiti Ora Pai

Background

Originally a resource centre, Whakawhiti Ora Pai ("Bridge to Good Health") was established as a Māori health provider in 1996. Whakawhiti Ora Pai delivers fully integrated health services to the Far North – Motutangi in the south to Te Rerengā Wairua/Cape Reingā in the north. The population ranges in the area from a low of 2,500 to 8,000 during the Christmas peak season.

Structure

Whakawhiti Ora Pai was formally registered as an Incorporated Society in 1996. A board or management committee drawn from representatives of the communities that it services provides governance oversight and direction. A General Manager is responsible for the overall management of the organisation.

Purpose

The core purpose of Whakawhiti Ora Pai is to deliver fully integrated health services that are affordable, accessible and appropriate to meet the needs of their community.

Funding

Whakawhiti Ora Pai receives funding from the Northland District Health Board, the Ministry of Health, grants, fundraising and sponsorship.

Service Provision

Whakawhiti Ora Pai provides community health and nursing care that is fully integrated with other health services. Specific services delivered include –

- Health Promotion
- Health Education
- Public, Community and District Nursing
- Kaupapa Māori Advanced Chronic Care Nursing Service
- Kaupapa Māori Advanced Nursing Practitioner Service
- General Practitioner Services
- Injury Prevention Programmes
- Mobile Nursing Services

All services are provided at low cost or no cost and while services are primarily for Māori, they are accessible to all ethnic groups within the community. Whakawhiti Ora Pai has three outreach clinics (where both a nurse and GP clinics to take patients at dedicated weekly times) at Te Hapūa, Te Kao and Pukenui. It also has a mobile district nurse service.

Chronic Care Management

Whakawhiti Ora Pai's general approach is to implement programmes that focus on awareness raising, prevention and better management of chronic conditions.

In 2003-2004, Whakawhiti Ora Pai joined forces with Te Hauora o Te Hiku o Te Ika allowing them to deploy full time primary health care services to the region.

In 2006, the organisation was awarded 'Runners Up' (small providers section) at the Ministry of Health Whānau Ora Awards for their 'Hei Oranga te Iwi o Whakawhiti Ora Pai' community health and nutrition programme. This programme was developed in consultation with its communities and resulted in the provision of a nutrition programme. Launched in Te Kao, the programme has been delivered into other communities via schools and marae. Stronger community relationships, shared knowledge and a greater appreciation of resources and resourcefulness are the key outcomes to have emerged.

Whakawhiti Ora Pai draws upon locally led initiatives and experiences to increase awareness. In 2006, it held a Men's Health Day. To encourage participation, the organisation offered a prize – an entry ticket to major fishing contest. At the event, Whakawhiti Ora Pai ran a quiz, put up information boards about prostate cancer, skin cancer, sexual health, nutrition and exercise. It drew upon the support of local Māori male leaders to be mentors and work with groups of men on the day. Buck Shelford was also engaged to work with the mentors and deliver key messages. A further event was held in 2007. The initiative has since been delivered in other communities throughout Te Taitokerau.

Knowing their community, engaging and working closely with them is critical for this rural based health provider. Whakawhiti Ora Pai prides itself on providing patient focused and innovative health care services.

Monitoring

Monitoring the performance of its operational activities is conducted on a regular basis, and in response to contractual requirements. It also relies on feedback received from its patients and whānau and from time to time, undertakes external evaluations. The organisation is accredited with Quality Health New Zealand.[20]

Workforce

Whakawhiti Ora Pai has 6 clinical staff, 3 managers and 2.5 administrators. The organisation relies on many volunteers. Whakawhiti Ora Pai supports the professional development of its staff through attendance at seminars, conferences and workshops. Cultural development is important and for this, Whakawhiti Ora Pai utilises kaumātua to mentor and assist its staff. Like other rural providers, attracting and retaining staff is challenging.

[20] A division of Telarc SAI Ltd

Distinctive Organisational Characteristics

Whakawhiti Ora Pai is a Māori-led organisation. Its population base is predominantly Māori. It utilises Māori cultural values and practices in its day to day operations. It networks extensively throughout its community and draws upon kaumātua expertise as and when necessary.

Looking Forward – Opportunities and Challenges

In the health promotion area, Whakawhiti Ora Pai is committed to providing up to date information to its communities in ways that connect and are 'real' for them. The organisation has developed a health promotion strategic plan which is currently being implemented. The plan encompasses a range of activities including cooking classes, mahi-a-Rehia, rongoa Māori as well as exercise and nutrition initiatives. The focus on health promotion and education working involving the community will continue to be a priority for Whakawhiti Ora Pai.

As a rural based provider, Whakawhiti Ora Pai faces a number of challenges including servicing isolated areas and workforce issues.

Case Study: Te Rūnanga o Ngā Maata Waka

Background

Resulting from social and political change in the 1970s, tribal groups from the North Island resident in the Te Waipounamu district established an urban Māori authority. A group of kaumātua, including the late Hohua Tutengāehe, identified the need for an organisation that would cater to the social, health and educational needs of iwi from outside the rohe of Ngāi Tahu. From the outset, Māori youth were identified as the target group for the organisation, and specific educational programmes were set up for them.

Structure

Te Rūnanga o Ngā Maata Waka was registered as an Incorporated Society in 1989 and is currently led by a Chief Executive. At the time of its incorporation, 'Te Rūnanga o Ngā Maata Waka' is defined as the 'Confederation of all Tribes, all Nations, all People, exclusive of none'. This philosophy is represented in the Ngā Maata Waka logo and represents the four winds on a sail, the unification of all people from everywhere[21]. The organisation places a strong emphasis on non-exclusivity and is committed to advocating and supporting everyone particularly those who are socially and economically disadvantaged.

As demand for its health services grew, in 2000 Te Rūnanga o Ngā Maata Waka formed a charitable company whose work and efforts culminated in the opening of a medical centre that provides low cost care. Over time, the medical centre developed and expanded its services including the creation of its own diabetes centre.

Purpose

Te Rūnanga o Ngā Maata Waka is people driven and delivers health, education and social services to its community. Its mission is –

- To take mainstream values and integrate them into Māori values.
- To encourage and inspire.
- To focus on helping those who are socially and/or economically disadvantaged.
- To dignify our tupuna and take control of our own waka.
- To unify our nation (people) and strive for excellence in all that we choose to participate in.
- To contribute to the intellectual, cultural and spiritual richness of our nation.
- To improve access for Māori to the resources that surround them.
- To be vigilant and to behave with respect and integrity to all people.

The organisation's vision includes –

[21] http://christchurchcitylibraries.com/TiKouka Whenua/Maata Waka/

- To assist Māori to fulfil their dreams and aspirations and strive towards independence (tino rangatiratanga) with integrity.
- To take responsibility for our actions and to acknowledge that they too have consequences.
- To demonstrate that the Treaty of Waitangi is this nation's most powerful and unifying document.
- To be a preferred provider in the domain of education, health, recreation, employment, housing, culture and tourism, justice, road safety, research, entertainment, community development, economic development and social services.

A key objective is to ensure that a positive relationship is maintained with the Crown, its entities and Te Rūnanga o Ngāi Tahu. As already noted, one of the prime objectives is to provide a range of services that are accessible and affordable for all people.

Funding

Te Rūnanga o Ngā Maata Waka is contracted and funded to deliver services in the fields of health, education and social services.

Service Provision

Te Rūnanga o Ngā Maata Waka has adopted a collaborative approach in the delivery of low cost, high quality medical services that includes a diabetes centre.

Chronic Care Management

The organisation estimates it services approximately 190 people with diabetes each year. Its primary focus around the management of chronic conditions is:

- early intervention;
- prevention;
- health promotion and,
- education.

The approach is two-fold. The first is to clinically monitor patients and their whānau and secondly to provide them with the necessary knowledge specific to their condition. Critical to this approach is the empowerment of individuals and their whānau so that they can take control of, and manage, their own wellbeing.

Te Rūnanga o Ngā Maata Waka delivers an outreach initiative aimed at life style change. The focus is on physical activity and nutrition that has seen the establishment of gardens at Tuahiwi, a small rural settlement approximately 6kms north of Kaiapoi. Produce from these gardens are made available to locals, community groups, kaumātua and any one in need. Administratively, at least once a month, the group meets to discuss progress, debate future projects and seek support as appropriate.

The diabetes centre maintains close relationships with dieticians, podiatrists and diabetes specialists which is particularly important for the provision of integrated care and support.

Other activities undertaken by Te Rūnanga o Ngā Maata Waka, include transporting patients and whānau to health and other appointments.

The organisation uses Māori models of wellbeing like Te Whāre Tapa Whā to guide its level of intervention and engagement with its patient base. Māori cultural values are paramount and are practiced throughout the organisation.

Monitoring of Operational Activities

Regular monitoring of the organisation's services is undertaken at various intervals during the year with contractual requirements to report against milestones being adhered to. Using verbal or written surveys, Te Rūnanga o Ngā Maata Waka seeks feedback on its services from its staff and users. In particular, patient satisfaction surveys are conducted on a six-monthly basis.

Collaborative Relationships

Te Rūnanga o Maata Waka works collaboratively with a number of organisations including government agencies, other providers, private sector entities and other Māori groups including Te Rūnanga o Ngāi Tahu.

Workforce

The organisation has a workforce of 26 and an extensive network of volunteers including kaumātua who have supported the Rūnanga since its inception. The majority of the staff at Te Rūnanga o Ngā Maata Waka came into the organisation as unemployed or had very low qualifications and education[22].

Distinctive Organisational Characteristics

In their own words, Te Rūnanga o Ngā Maata Waka is a kaupapa based Māori service provider. It exists to serve the needs and interests of its community. The Ngā Hau e Whā National Marae is central to the organisation's development and it is here that the head office of Te Rūnanga o Ngā Maata Waka is located. Management of the marae passed to Te Rūnanga o Ngā Maata Waka in 2005 and the activities of the two operations are closely aligned and mutually compatible.

Looking Forward – Opportunities and Challenges

Apart from health services, Te Rūnanga o Ngā Maata Waka delivers a range of services including education, counselling, driver education, advocacy, early childhood education, recreation, sport, justice, courts, legal support and employment related initiatives. It has a community garden at Tuahiwi (see earlier comments under 'Service Provision') and is looking to form an independent research group. Te

[22] ibid

Rūnanga o Ngā Maata Waka is an integrated provider of services. It aspires to continue to grow this capacity in all areas of its business. While Te Rūnanga o Ngā Maata Waka is cognisant of government policy settings, a more important factor is the needs of the community. It is this component which will continue to drive the organisation's direction and growth.

Case Study: Te Korowai Hauora O Hauraki

Background

With the help of the Hauraki Māori Trust Board, Te Korowai Hauora o Hauraki ("The Cloak of Wellness for Hauraki") was established in 1994 to work towards achieving wellness for Hauraki whānui.

Structure

Te Korowai Hauora o Hauraki is a tribally based, not-for-profit Incorporated Society. Operating from seven sites[23] throughout the rohe of Hauraki, its main office is located in Thames.

Te Korowai Hauora o Hauraki began its journey in the 1980s when Manaia whānau identified gaps in mental health and a wider aspiration to achieve wellness for Hauraki whānau. In 1994 that aspiration became a reality with the establishment of Te Korowai Hauora o Hauraki. Other important developments include –

- 2001: ISO 9002 accreditation received
- 2002: Thames Whare opened
- 2004: Hauraki PHO established with Te Korowai as lead manager

Te Korowai Hauora o Hauraki is governed by a Board who provide strategic direction and guidance to the organisation. Two positions on the Board are appointed by the Hauraki Māori Trust Board. A Chief Executive is responsible for the overall management of Te Korowai.

Purpose

Te Korowai Hauora o Hauraki serves all people within its rohe. A kaupapa Māori philosophy underpins the way in which it operates and delivers its services. The organisation's mission statement is:

- To continually strive for excellence in the way we provide our services to our people

The organisation's vision is "Hauraki as a healthy nation" and its core principles are to be -

- Accessible
- Cost Effective
- Comfortable
- Efficient
- Culturally & Clinically Safe
- Sustainable

[23] Coromandel, Paeroa, Thames, Te Aroha, Waihi, Whitiangā and Whangamata.

Te Korowai Hauora o Hauraki services a population base of:

- 46,000 people living in Hauraki
- 8,500 are Māori
- 6,500 registered with Te Korowai (for all services)
- 4,000[24] registered for GP services (3,314 funded under Hauraki PHO)

Funding

Te Korowai Hauora o Hauraki receives funding from the Waikato District Health Board, Ministry of Health, ACC and the Ministry of Social Development. It also seeks out grants from other funding avenue sources.

Service Provision

Te Korowai Hauora o Hauraki offers a large variety of services from home based support, rangatahi and general counselling, dental care, mirimiri, tattoo removal services, podiatry plunket services and GP visits under a Primary Health Organisation (PHO). Specific services include:

Nursing Services

- Liaison with GP services
- Well Child Checks
- Tamariki Ora
- Immunisation
- Chronic Disease Management – diabetes, heart care, asthma
- Hearing/Sight Tests
- Cervical Screening
- Sexual Health

Kaiāwhina Counselling Services

- Maternal mental health
- Mental health counselling, support and advocacy
- Residential and day programmes
- Anger management support
- Alcohol and drug counselling/support
- Gambling prevention
- Violence prevention
- Sexual abuse support and prevention
- Home based support

Rangatahi Services

- Counselling
- Mentoring

[24] 2401 (59%) are Māori.

Kaiāwhina Services

- Kaiāwhina Plunket
- Advocacy Support
- Whānau support with other health services, WINZ, Housing NZ, CYFS and government departments
- Coordination with community agencies, schools and iwi organisations
- Transport information and support

Kuia/Koroua Support

- Home care services
- Advocacy and whānau support
- Liaison with Disability Support Link and Hospital Services

Iwi Health Services

- Injury prevention
- Violence prevention
- Wellness/healthy living
- Nutrition and physical activity
- Smoking cessation
- Sexual health

These services are offered free or at low cost and are available by mobile service and through its clinics.

Chronic Care Management

The general focus of Te Korowai is on early intervention and whānau focused wellness support services. Approximately 450 of Te Korowai's enrolled population have diabetes. Specific programmes to respond to their needs range from –

- Healthy Eating, Healthy Action initiatives
- Get Checked Aotearoa
- Home Based Support particularly for Care Plus patients.

These programmes complement regular screening checks and active monitoring by the provider's GPs, nurses and community health workers.

Te Korowai estimates that 5% of its enrolled population have cardiovascular disease. Other interventions include nutrition and exercise programmes, utilising the Predict screening tool and Care Plus.

Collaborative Relationships

The organisation works collaboratively with other providers and agencies in its rohe through the sharing of information and resources where it can. It does this because it recognises that many factors contribute to the wellness of its patients and their whānau. Ultimately, Te Korowai Hauora o Hauraki is committed to empowering its communities.

Monitoring Operational Activities

Operational activities are monitored regularly. A financial audit is conducted annually while internal and external audits are conducted on a six monthly basis. All aspects (financial, service delivery, processes and systems) are reviewed. Patient satisfaction surveys are undertaken annually and feedback is taken into account and responded to. Extending Te Korowai Hauora o Hauraki's GP services and the start up of the Kaiwhākaora service were as a result of patient feedback.

Te Korowai employs a Quality Manager whose role is primarily around writing and auditing policy and procedures and ensuring that quality standards are maintained to a high standard for all areas of service delivery.

Workforce

Te Korowai Hauora o Hauraki has a workforce comprising 5 managers, 12 clinical/health professionals, 14 mental health and disability workers, 6 administrators, 52 home based support workers and 6 volunteers. The organisation recognises the importance of professional development and invests in upskilling and training its staff. Staff turnover has been low and Te Korowai believes this is because of its investment in staff.

Distinctive Organisational Characteristics

As a kaupapa Māori service provider, Te Korowai Hauora o Hauraki integrates Māori cultural values and principles alongside clinical practice. Karakia, pōwhiri, wānanga and the like are integral to the way in which the organisation operates on a daily basis. Te Korowai also draws upon the model Te Whāre Tapa Whā - taking a holistic approach to the treatment and the delivery of its services.

Being an iwi inspired organisation is also a distinguishing feature. The Hauraki Māori Trust Board and Hauraki whānui have been influential stakeholders since the establishment of Te Korowai Hauora o Hauraki. While their services are available and accessible to all, improving the wellbeing of Hauraki iwi is the main priority now and into the future.

Looking Forward – Opportunities and Challenges

Te Korowai Hauora o Hauraki recognises that services continually change and develop over time. Its patientele base has recently increased due to the closure of a local medical centre. Practically this has meant, for some people, a wait of up to three days for a GP appointment.

In the medium to long term, the organisation will continue to develop and strengthen its services including expansion of its GP services into other communities like Whitianga. Home based support services are growing and with an ageing population will continue to feature prominently in the future. Beyond health related services, the organisation sees the potential to broaden delivery into other social service areas.

To achieve these aspirations requires a well trained and professional workforce. Attracting and retaining staff is challenging especially for rural providers like Te Korowai Hauora o Hauraki. Sustainable funding to support the organisation's growth is a challenge especially in the current economic climate while changing the hearts, minds and attitudes of whānau remains an ongoing quest.

Case Study: Ngā Kakano Foundation Ltd

Background

Based in Te Puke, Ngā Kakano Foundation Ltd was established in 1986 by tangata whenua to provide health and social services to whānau living in its district. As a tangata whenua based organisation, it operates services within the Tauranga, Te Puke, Opotiki and Murupara districts.

In 2002 the Ngā Kakano Foundation Ltd purchased the Waitangi Family Practice to complement its existing health and social services.

Structure

Ngā Kakano Foundation Ltd was formally incorporated as a charitable trust in 1987 and is governed by a Board of Directors. The Board provides strategic direction and oversight of the organisation.

Purpose

The core purpose of Ngā Kakano is to provide services to improve the health and social wellbeing of its community. 'Hei awhi mo te tangata' - caring for the people – is central to the organisation's existence.

Funding

Ngā Kakano receives health related funding from the Bay of Plenty District Health Board and the Ministry of Health.

Service Provision

Ngā Kakano delivers services within the Te Puke area which include mental health, whānau ora, koroua and kuia, diabetes management and Auahi Kore. Ngā Kakano also has a GP medical service in Te Puke.

The services delivered are kaupapa driven - developed through a shared vision and a commitment to achieving it. The key driver for Ngā Kakano is a commitment to address the poor health status of its patients and a determination to succeed. Strong leadership within the organisation, amongst the community and within the sector have assisted Ngā Kakano to respond to these drivers.

While no single model has informed its service delivery approach, some fundamental principles like being whānau oriented, fostering strategic relationships, promoting integration and a passion for innovation have catalysed action.

Chronic Care Management

The general approach to chronic care is early intervention, prevention and health promotion. For diabetes, the focus is on prevention through one-on-one monitoring,

fortnightly nutrition and exercise classes and regular medical checks. In terms of cardiovascular disease, targeted programmes aimed at men and screenings are in place.

Monitoring Operational Activities

Monitoring of operational activities is undertaken on a regular basis and as part of contract performance management. All aspects – financial, quality, staff performance and management systems - are monitored. A patient satisfaction survey is done on an annual basis and has led to improvements in patient waiting times for appointments and moving to a more culturally affirming environment.

Workforce

Ngā Kakano is committed to building the capacity and capability of its staff. Currently, their workforce consists of a management team of four, 3.5FTE in the clinical area, 24 community workers and three administration personnel. This team operates from two sites in Te Puke – an administrative base and their Waitangi family practice clinic. From these locations they provide services within the Tauranga, Te Puke, Opotiki and Murupara districts.

Measuring management and staff development outcomes is a priority over the coming year.

Distinctive Organisational Characteristics

Ngā Kakano's patient base is 75% Māori and this drives its delivery approach – one that is whānau based and kaupapa driven. Māori cultural values and principles are practiced in the organisation's day to day operations. Cultural assessment tools based on Te Whāre Tapa Whā have been developed and implemented.

Looking Forward – Opportunities and Challenges

In the immediate future, Ngā Kakano remains focused on consolidating its services. At a governance level, it plans to implement a succession planning strategy. From an administrative perspective it will continue its tertiary level sponsorship of whānau at medical school and will continue to sponsor education initiatives for Tapuika rangatahi. Ngā Kakano is looking beyond its immediate rohe and to developing a presence in Australia in recognition of the increasing Māori population base there and as an extension of the guiding principle of whakawhanaungatanga.

In the medium to long term, the organisation's goals are the establishment of a larger complex, further diversification of its core business, measurable returns and improved outcomes on its community investment and a workforce that is predominantly Māori and Tapuika. In addition, service delivery in Australia will be in place and gaining momentum. To achieve these aspirations, Ngā Kakano recognises that good planning, commitment and the implementation of its strategic goals are essential.

Some of the challenges facing these developments include the political will to support Ngā Kakano's strategic directions, changing priorities, conflict between a medical

model and addressing the needs of the community and increasing compliance. To combat some of these relies on a well established operation, experienced staff, on-going professional development, strong systems that are accredited and innovative systems to increase capacity.

Case Study: Whakatu Marae

Background

Whakatu Marae is community based health and social service provider located in Nelson. Established in 1993, Whakatu Marae delivers a range of services to whānau from the Nelson-Marlborough district.

Structure

Whakatu Marae was formally registered as an Incorporated Society in December 1997 and is governed by a committee of nine from the main iwi of the Nelson-Marlborough district, a Maata Waka representative and a community representative.

Purpose

Whakatu Marae aims to address, restore and enhance the mana and tapu of the whānau in Whakatu. Whakatu marae works to achieve this by empowering whānau to attain their full potential as valued members of their iwi and the marae.

Whakatu Marae is committed to ensuring that the welfare and safety of tamariki/ mokopuna is at all times paramount. Its vision is –

- To provide a turangawaewae for tino rangatiratanga to flourish for whānau, hapū and iwi.

The organisation's core values are based on –

- Ngā mea Tikanga, ngā mea Pono me te Aroha
- Integrity
- Whanaungatanga
- Tino Rangatiratanga
- Manaakitanga
- Te Reo me ona Tikanga: whakapapa, mana, tapu, mauri, wairua
- Communication
- Accountability
- Responsibility
- Sustainability

Funding

Whakatu Marae receives funding from the Nelson-Marlborough District Health Board, the Ministry of Health, CYFS, Ministry of Social Development, its local authority and through donations.

Service Provision

Whakatu Marae provides home visits and free services to all whānau. Services provided include:

- Whānau ora health promotion and prevention
- Social Services and programmes for rangatahi, wahine, tane and whānau.
- Palliative care
- Diabetes awareness, education and advocacy for all whānau and all age groups
- Nutrition/health life styles
- Asthma
- Heart plan
- Glue ear/hearing loss
- Immunisation
- Aukati Kaipaipa
- Full counselling services
- Kaumātua services
- Sexual health
- Maternity support
- Cervical and breast screening
- Whānau specific plans
- Advocacy
- Whānau violence and intervention programmes

From time to time Whakatu Marae adds or removes services to suit the needs, economic situation and social demands of its whānau. These services are delivered through the one site located at Whakatu Marae.

Chronic Care Management

The primary focus is on early intervention, prevention, health promotion and care and support. On the health promotion front, Whakatu runs events to promote key messages to its community in a supportive and fun way. Part of that strategy is attracting whānau to the marae including to specific hui and then introducing simple health and wellbeing messages. Information brochures and other material are located prominently around the marae complex including the whārekai, kitchen, administrative offices and the gym. Recently, Whakatu marae removed a vending machine and replaced it with water coolers located around the marae complex. The marae has also taken steps to change how it prepares its kai through reducing the use of fat when cooking, composting food scraps, and having nutrition plans in place.

Clinical practice is focused on screening and monitoring the health status of those most affected.

Other support provided by Whakatu include transport services to GP or specialist appointments, being an advocate, facilitating contact and liaison with other services and agencies, and participating in events alongside whānau e.g. walks, waka ama, gym and other sporting activities.

Overall, Whakatu marae health and social services seek to address a person's whole wellbeing not just the specific ailment.

Monitoring Operational Activities

Because of funding requirements and a desire by Whakatu marae to improve the quality of its services, regular monitoring is undertaken. Services are monitored on a quarterly, six monthly and annual basis. All contracts with government agencies contain specific milestones which Whakatu is required to report against. In addition, Whakatu marae also produces an annual report to iwi. A patient survey is also implemented on an annual basis. Feedback from patients is considered and responded to. The establishment of the gym is in direct response to feedback received from whānau.

Workforce

Whakatu marae has a workforce comprising social workers, counsellors, a registered nurse, quit smoking coach, violence programme facilitators and health promoters. There are two managers, up to five clinical staff and an administrator. Over the years, it has utilised the services of many volunteers. This remains the case today.

Whakatu staff are supported to increase their knowledge and skills by attending training courses, seminars and conferences.

Distinctive Organisational Characteristics

Being a marae based organisation provides a distinctive point of difference for Whakatu marae. Māori cultural values and practices are central to the health and social services delivered.

Contact with patients is approached in a holistic way with the individual considered part of a whānau and wider community. Manaakitanga and whakawhanaugatanga are recognised core values of Whakatu marae.

Looking Forward – Opportunities and Challenges

Aligned with its goal of continuous improvement, Whakatu marae will continue to evaluate and monitor its services over the next 12 months. Building and maintaining collaborative relationships with other marae and Māori organisations in the region remains a priority. It has plans to further develop its gardens, open an orchard and introduce carving and weaving programmes.

In the medium to long term, Whakatu would like to:

- develop a palliative care suite
- further expand its buildings
- upgrade its IT systems and other capital items
- continue to expand its hauora centre on the marae,
- be a sustainable organisation that provides real employment opportunities for its community, and

- move towards greater self sufficiency.

Achieving these aspirations relies on funding, a passionate and committed workforce, ongoing relationships with key organisations and influential people, teamwork and most importantly, the ongoing support of whānau, hapū and iwi. Barriers include not being able to secure the necessary consents to expand, lack of funding and workforce recruitment challenges.

Case Study: Ngāti Porou Hauora

Background

Ngāti Porou Hauora Incorporated (NPH) was established as a not-for-profit charitable organisation in 1995 after considerable consultation with local communities.

Purpose

Its aim is to ensure the ongoing provision of sustainable, appropriate, high-quality, integrated health services to all people (approximately 13,000 enrolled population) within the Ngāti Porou rohe, covering some 200km of the East Coast of the North Island from Potikirua near Hicks Bay in the north to Te Toka-a-Taiau, Gisborne, in the south. Although it is owned and governed by Ngāti Porou, the organisation offers services to all within the Tairawhiti region, as a "by Māori, for all" service.

The organisation's values of Ngāti Poroutanga, Tikanga, Tiriti o Waitangi, Rangatiratanga, and Whakapakari are reflected in everything it does. The principles of equity and equality; efficiency and effectiveness; participation and information; and access and affordability guide the way services are delivered.

Structure

Since its establishment, Ngāti Porou Hauora has been owned and managed by a Board of elected community members representing the various local communities of the East Coast.

The first health service contract, obtained in 1995, was for residential mental health. NPH went on to integrate the general practice clinics on the East Coast and obtained increasing numbers of other service contracts.

By 1997 it had twenty service contracts and signed a Heads of Agreement with Tairawhiti Healthcare Ltd. In 1998 the first CEO was appointed and a formal management structure was put in place. The following year NPH signed a direct contract with the Health Funding Authority for the majority of East Coast health services and later that year health facilities and assets, including Te Puia Springs Hospital, were transferred to NPH ownership under a Community Trusts Assistance Scheme. Some major health education and health promotion contracts, including Māori Mobile Nursing, Regional Asthma & Diabetes and Smoking Cessation contracts, followed.

In September 2000, the organisation expanded into urban Gisborne with the establishment of a primary health service in Kaiti. This health clinic, Puhi Kaiti Hauora, offers full GP services and led to a further increase in NPH's registered population. The purchase of another urban clinic in 2002 further added to the population base.

Funding

Ngāti Porou Hauora receives funding from the Tairawhiti District Health Board, the Ministry of Health, Te Puni Kōkiri, Ministry of Social Development, grants and sponsorship.

Service Provision

Ngāti Porou Hauora provides a range of personal health, public health, disability support and mental health services to an enrolled population of just under 13,000 patients, 5,500 of whom reside in the rural coastal regions and the remainder of whom reside in Gisborne and surrounds. These services are provided at low or no cost to its registered patients.

Service contracts include Well Child, Whānau Ora, Community Support Services, Palliative Care, Disease State Management, Aukati KaiPaipa (smoking cessation) and the Ngāti & Healthy Programme[25]. NPH takes a holistic approach to health and has ventured into health research and health environment projects such as alternative power research, and water and sewerage reticulation.

The significant majority of enrolled patients are Māori, most of whom are Ngāti Porou. Non-Māori patients are mostly Pākehā, although many of Gisborne's small Pacific community are also enrolled patients.

Ngāti Porou Hauora offers a holistic health service to all its enrolled patients, with a stated emphasis on improving whānau and hapū health and preventing disease. The core focus is on providing integrated and comprehensive primary health services, backed up on the East Coast by the small GP-run hospital at Te Whare Hauora o Ngāti Porou in Te Puia Springs.

Chronic Care Management

Primary health services are offered by multidisciplinary primary health care teams that are based in eight community clinics, six of which are spread throughout the East Coast communities and two located in the Ngāti Porou rohe of (northern) urban Gisborne.

In 2004-2006, the Ngāti & Healthy programme was initiated as a collaborative venture between Ngāti Porou Hauora and Otago University. The project was designed to reduce the risk of Type 2 diabetes and now also aims to reduce other chronic conditions such as cardiovascular disease through a population health focused intervention of health promotion, community education and initiatives to increase the availability and adoption of healthier options and community ownership.

The health promotion and community activities components includes:

- radio messages

[25] This programme was the recipient of the Ministry of Health's Te Tohu Kahukura (Overall Winner), Whānau Ora Award in 2006.

- poster campaigns
- community gardening
- access to gym and pool facilities
- men's health initiatives such as māhinga kai activities and kai & kōrero evenings,
- whenua rediscovery, and
- traditional Māori sports and elite sports initiatives.

The education component includes physical activity groups, food and cooking demonstrations and the follow-up of high-risk individuals.

Gaining tribal buy in to ownership of the healthy lifestyles strategy and a change in practices around nutrition at schools, workplaces and on the marae is also an important component.

Impact of Ngāti & Healthy programme

The results from the second (2006/07) diabetes prevalence survey suggested that 'overall, IR (insulin resistance) prevalence decreased markedly from 35.5% to 25.4%. Most changes were observed amongst 25-49 year old women for whom there was a significant change in prevalence of IR and glucose metabolism disorders, largely due to reduced IR prevalence (38.2% to 25.6%).

In 2006, 60.3% achieved minimum recommended exercise levels and 65.4% ate wholegrain bread compared with 45.1% and 42.2% respectively, in 2003. Participation in a community diabetes prevention intervention appeared to reduce IR prevalence after 2 years in those with the highest level of participation and most marked lifestyle changes[26].

One of the intended longer-term outcomes of Ngāti & Healthy is to improve patient, iwi and community self-management of their health by empowering them and their whānau.

Monitoring Operational Activities

Monitoring of NPH's services occur on a regular basis as part of business planning and contractual milestones. A coordinator with responsibility for monitoring the quality of service provision has recently been appointed.

In addition, service users and whānau can contribute to service planning and delivery by attending Board meetings, which are open to the public and rotate geographically. A kaumātua network is in place and regular consultation hui are held.

[26] Coppell,K., Tipene-Leach D.C., Pahau H, Williams, S., Abel, S., Iles M., Harré Hindmarsh, J., Mann, J. (June 2009) *Two-year results from a community-wide diabetes prevention intervention in a high risk indigenous community: the Ngāti and Healthy project*
http://www.diabetesresearchclinicalpractice.com/inpress

Collaborative Relationships

The organisation has Memoranda of Understanding with a wide range of organisations, including Te Rūnanga o Ngāti Porou, the Turanganui Primary Health Organisation, Work and Income, the Housing New Zealand Corporation, the New Zealand Police, the University of Otago, Roche Diagnostics New Zealand, Flinders University, and Industrial Research Ltd.

It is also an active member of Health Care Aotearoa - a national organisation of third sector health care providers, Te Matarau - a national organisation of Māori Development Organisations, the Diabetes Society, and more recently the Māori PHO Coalition.

Workforce

The organisation employs over 170 people, comprising 135 full-time equivalent staff. Many have strong whānau links to the communities they serve. The multidisciplinary teams comprise kaiāwhina (community health workers), practice nurses, general practitioners and receptionists. On the East Coast, the teams also include rural health nurses, a physiotherapist, counsellors, community support service workers and dental health workers.

The organisation provides employment to a significant number of Ngāti Porou on the East Coast. There is a policy to train and move workers into more skilled positions within the organisation, for example, from kaiāwhina to information technology, and from administration to management. In addition, the organisation provides a range of health professional training scholarships to encourage Ngāti Porou people to undertake medical, dental, nursing or physiotherapy training, and to bring this expertise back to the region.

Mainstream forms of workforce development are also evident in the sponsorship of many of its general practitioners through the General Practice Primex training and its nurses through postgraduate courses. In the area of diabetes, nursing staff are expected to attend the 5-day diabetes course at Waikato Hospital. The course is intensive and provides the opportunity for staff to experience first-hand what their patients go through.

The organisation also offers placement opportunities for local nursing students, medical students and postgraduate medical trainees from overseas and New Zealand. Ngāti Porou Hauora's MOU with the University of Otago has resulted in sixth year medical students working on the coast. This relationship has proven mutually beneficial for both parties.

Distinctive Organisational Characteristics

There are a number of distinctive features about Ngāti Porou Hauora. It is an organisation that is governed by elected members from within the Ngāti Porou rohe. Eligible members must be resident on the East Coast and be registered with Ngāti

Porou Hauora. As highlighted, the organisation proactively engages and employs Ngāti Porou or Māori from within the communities its services.

As far as possible the organisation has drawn upon and uses Te Pae Mahutonga as the framework for its health promotion and public health work because of its holistic approach to wellbeing. The organisation's health promotion plan comprises a matrix based on these objectives and capacities with tino rangatiratanga (self-determination) as a guiding principle for the practical applications in each component. Ngāti and Healthy reflects this model. It uses a population based approach to reduce the prevalence of diabetes risk in East Coast communities identified to be at high levels in a pre-intervention prevalence survey (2003/04), as well as the risk of other chronic conditions. A multidisciplinary team has been applied, with kaiāwhina taking a lead role within their communities and the inclusion of other local organisations and businesses. It takes a broad Māori perspective on factors affecting health behaviours and has strong community support.

The clinical teams, particularly the kaiāwhina and rural health nurses, use their relationships and intimate knowledge of the community to work with the whole whānau. Where appropriate, Ngāti Porou Hauora has also utilised and drawn upon the expertise of others.[27]

As noted, Ngāti Porou Hauora has been involved in a range of research and evaluation initiatives that contribute to improving health outcomes for their people and develops their workforce. Current projects include research into gout within Ngāti Porou and clinical trials of combination pills for those at high risk of cardiovascular disease while previous research projects have included Whakatau Mai Ra: The impacts of gambling for Māori communities, whānau, hapū, iwi and Coding for Ethnicity: Sub-project for the inequalities in Use of Prescribed Medicines Project.[28]

Research projects must be of specific benefit to Ngāti Porou and meet the NPH Board's other policy criteria, including that the research project:

- is relevant to health improvement and service development priorities (see NPH Strategic Plan)
- strengthens our strategic partnerships and resources
- involves and/or develops Ngāti Porou researchers
- involves whānau and hapū in project design and management where appropriate, and
- improves NPH's health database.[29]

Looking Forward – Opportunities and Challenges

Ngāti Porou Hauora is committed to consolidating its existing services and programmes. As a remote rural provider, Ngāti Porou Hauora has a number of challenges especially in the area of workforce planning and development. It has had to be innovative in the delivery of services and in addressing workforce issues. Working

[27] Dr Pat Sneddon and Dr Peter Glensor were identified as two individuals who had been influential in the past.
[28] www.nph.org.nz – Ngāti Porou Hauora Research
[29] ibid

collaboratively with others to ensure that services are effective and are responsive to the needs of patients and whānau will remain an ongoing priority.

Case Study: Te Hauora O Te Hiku O Te Ika

Background

Based in Kaitaia, Te Hauora o Te Hiku of Te Ika (the Trust) was established as a charitable trust in 1997. It is mandated by, and has representation on the Board of Trustees from the five iwi of Ngāti Kuri, Te Aupouri, Ngāitakoto, Te Rarawa and Ngāti Kahu along with community representatives. The Trust's services cover the north of the Hokianga Harbour in the west and Whangaroa Harbour in the east and north to the tip of the Far North Peninsula, Spirits Bay and Cape Reinga.

Purpose

The Trust is one of a number of Māori health provider organizations set up in the 1990s to try and 'narrow the gaps' in health status of Māori by offering effective and accessible primary health care to the Far North community. The Trust's objectives include promoting, supporting, preserving and enhancing the health status of Māori and others in need.

Service Provision

Originally established as a nurse-led provider, the Trust has adopted a multi-disciplinary approach to health care incorporating: health promotion; home support; mobile nursing services; advanced chronic care nurses; diabetes and cardiac specialist nurses, mental health and respiratory nurses; dental health education; breast-screening; smoking cessation; midwives; maternity and breastfeeding support; a community health worker; practice nurses and GPs, as part of its move towards a one-stop-shop for health care. The Trust operates full time GP services from two locations - Kaitaia and Coopers Beach - with weekly GP clinics in Te Kao and fortnightly ones in Te Hāpua. A mobile clinic is also available and is run by a nurse practitioner service.

As well as providing primary health care, Te Hiku is also heavily involved in health promotion and awareness, utilising community workers and enrolled nurses. The Trust developed a midwifery service in 2005.

Chronic Care Management

A major focus of the Trust's work is on chronic care. The 'One Heart Many Lives'[30] (OHML) programme is an initiative that the Trust has implemented with a measure of success.

With Pharmac and the Northland District Health Board, the programme is a cardiovascular disease primary prevention programme, which targets Māori and

[30] The outcomes of the programme include - increase the use of statins among those people with high risk of heart disease, particularly Māori and Pacific Island men; keep awareness high in the community about the need to get your heart checked and increase the uptake of Green Prescriptions and other lifestyle changing practices.

Pacific Island men aged 35+. It aims to raise both awareness of heart disease and what causes it and decrease the level of cardiovascular risk. Before Pharmac and DHB involvement, Te Hiku had done preliminary work on cardiovascular disease and so was well placed to implement the OHML initiative.

An important component is the communication of simple messages. Bro' files motivate men to get their hearts checked and to do something about it if the results are not good. TXT messaging, messages via TV into GP practices, local community activities, specific pharmacy and point of sale activity, advertising and media have helped to keep awareness high.

The Trust's inclusive approach resulted in Te Hiku receiving considerable buy-in from local men. The mobile approach meant the programme was taken into workplaces, recreational and sporting clubs, homes and on to marae. Te Hiku have been asked by many other providers to share their success story with other regions. They have also been invited to present their experience at an international conference.

As well as the One Heart Many Lives[31] campaign, Te Hiku carries out regular patient monitoring and screening, develops and implements individual and community health plans, provides support at and transport to appointments, delivers exercise and nutritional classes and home based support. Patients with chronic care conditions are also involved in Get Checked Aotearoa and Care Plus. A key goal of Te Hiku is to support the independence of their patients.

The Trust also has delivers a 12 week Māori cardiac rehabilitation programme aimed at improving the health and wellbeing of Māori with coronary disease. The programme works to address:

- Modifiable and non-modifiable risk factors
- Nutrition
- Physical activity
- Stress management
- Psychological aspects
- Whānau support
- Return to work
- Medication
- Coronary heart disease management

Funding

The Trust receives funding from the Northland District Health Board, the Ministry of Health and Pharmac.

Workforce

The Trust has a primary health care team of 18 registered nurses and 3 full time doctors, as well as a number of health promotion staff, community workers and

[31] Te Hauora o Te Hiku o Te Ika won the Ministry of Health's Whānau Ora award, Whānau Whanui, in 2008.

enrolled nurses. A mobile clinic is run by a nurse practitioner services. A part of its commitment to quality, the Trust employs highly qualified staff and strongly supports training at all levels of the organisation. Staff maintain their knowledge base by attending seminars and workshops, through information and resources received, working alongside nurses/specialists and other health professionals, reviewing and or participating in medical research and through their various community networks.

Te Hiku works as a team to provide a total health care package. They recognise that each individual staff member has their own skill set and they look to utilise and combine those individual strengths in all that they do while also recognising any weaknesses.

Distinctive Organisational Characteristics

While the Trust delivers services to all within its regions, the majority of its patient base is Māori. It is a proactive organisation and spends whatever amount of time is needed getting to know and understand their patients' conditions and needs. It takes a holistic approach where the focus is not just on the prevailing health condition but also addressing other environmental factors. The Trust is a whānau and community-oriented organisation.

Māori cultural values and practices are an integral part of the Trust's operations. Providing an environment that patients and whānau are comfortable with is also important.

As reflected in the OHML initiative, the Trust keeps its messages simple and easy to understand.

As a rural organisation servicing a high needs Māori population located in some remote areas, engaging with and involving their communities is critical. Te Hiku views itself as a facilitator that works alongside communities to meet their needs.

Looking Forward – Opportunities and Challenges

In the future, the Trust is committed to consolidating its services leveraging off the successful OHML initiative An immediate aspiration is to see the OHML programme delivered throughout all of Te Taitokerau. However this aspiration has encountered some problems including the lack of support from the District Health Board. Whilst the OHML programme has been hugely successful raising awareness throughout the community, a lack of funding and resources has meant that Te Hiku is unable to maintain a focus on the programme.

A significant amount of data has been accumulated but to date the Trust have been unable to find the necessary time to collate all this information and produce reports containing detailed analysis and outcomes. Similarly, their ability to undertake follow-up work i.e. management of cases has been compromised on account of capacity and capability issues. These remain a priority for Te Hiku as they seek solutions to enable them to dedicate resources to these tasks.

CHAPTER FOUR: EXAMINING THE EVIDENCE

In this chapter, we provide an assessment of the case studies highlighting, in particular, key distinctive features and offer some observations about critical factors for successful results.

Overview

The providers in this study vary in size, came from a variety of locations across Aotearoa-New Zealand, and were distributed across Iwi, community and pan-Māori organisations. The length of time the providers have been operational ranged from nine to twenty three years. All the providers receive government funding with some also reliant on grants, sponsorship and local authority support.

Through this study, a number of defining characteristics or a distinctive way of working in the delivery of services was evident. These are detailed below.

A significant gap is the lack of clinical data and information about cardiovascular disease and diabetes. Two organisations presented figures around patient numbers with CVD, while four were able to do so for diabetes. Apart from Ngāti Porou Hauora, we were unable to obtain statistical and medical information about the effectiveness of some of the interventions used by the providers. Where data existed, there are limited personnel with the expertise within these organisations to collate and provide meaningful analysis. For one particular provider, they relied on a nurse to help with this but not surprisingly it did not work given the demands of her position and lack of time available to commit to 'extra-curricular' activities. More support is certainly required in this area.

Distinctive Features

Kaupapa Inspired, Tikanga Based and Māori Led

Kaupapa Māori inspired and based approaches feature strongly as a point of difference identified by all the providers surveyed. All of the providers in this study are led, governed or owned by iwi/Māori organisations and groups. They are all committed to, and dedicated to supporting their patients and whānau to improve their health and wellbeing.

Māori cultural values, beliefs and practices are central to the operational activities of all the providers. Tikanga Māori and Māori models of wellbeing have been a source of inspiration, and therefore applied in the development and delivery of services. When asked the question what makes your organisation distinctive, all of the providers without a second thought responded 'kaupapa Māori principles and practices'.

Why this is the case is simple. The majority of patients that come to Māori health providers are predominantly Māori who are disadvantaged economically with high health needs. The service paradigm reflects a desire by these providers that their

working environment and engagement approach towards patients and their whānau, is inviting, culturally appropriate and comfortable.

Whānau Ora – Supporting Māori families to achieve their maximum health and wellbeing

The providers in this study are bound together by their strong desire to achieve whānau ora. In their own particular ways, each exhibited a determination to empower their patients and whānau to take greater control of their health and wellbeing. An example of getting beyond the client was illustrated by one provider referring to the whānau 'swoops' they carry out. Often they go into a home to see a patient and while there, take the opportunity to carry out medical checks of all other members within the household.

Currently, health providers are bound together by a range of factors e.g. shared ethos or history, financial incentives, etc. Whānau ora is the 'glue' that binds many Māori providers together.

Whakawhanaungatanga – Building Trusting Relationships

Developing relationships and effective communication is a central feature for the Māori health providers in this study. All the providers emphasised the importance of building trusting relationships with patients and their whānau. Spending time to get to know their patients is common practice and reflected in GP consultations, repeat visits, attendance at specific programmes such as exercise and healthy eating initiatives, and the frequency of patients just 'dropping' in to pay their particular provider a visit.

We were told on a number of occasions that building trusting relationships is key to effective care. A number of the providers took pride in being an understanding organisation with strong connections to their communities. This is important and for most of the providers has a positive impact on patient understanding, patient satisfaction and adherence to treatment.

Holistic Approach

All the providers are acutely aware of, and conscious that a number of factors contribute to improving the health and wellbeing of their communities. They recognise they are not just dealing with the health status of their patients but also responding to other environmental factors (housing, income, employment situation, etc) that impact on them.

In most cases, there was a readiness on the part of the providers to spend whatever time necessary to ensure that patient's needs be they – medical, social, spiritual and so on - are addressed fully. Māori health providers treat the whole person, which can also include the wider whānau and their issues, and do not look at their patients purely as a number or statistic or a particular medical condition.

Multidisciplinary Teams

Many of the providers were committed to, and have experienced the value of multidisciplinary teams especially in the treatment of chronic illnesses. A multidisciplinary team approach that utilises clinical and community staff is prevalent amongst a number of the providers. For these providers, the team approach especially to meet the complex needs of chronically ill Māori patients and their whānau is important. The approach reduced the risk of duplication or gaps in care, improved coordination and fostered greater team work and collaboration.

Collaborative Relationships

Collaborative relationships occurr where two or more people or organisations work together to achieve common goals and sharing knowledge and learnings, especially where resources are limited or finite.

Some of the providers have established strong alliances with other health and social service providers in their areas especially when they are unable to offer specialist services. These relationships tended to evolve around a commitment to ensuring patient and whānau needs are being met. Where these relationships existed, there was considerable reciprocity between organisations.

Working collaboratively with others is essential especially where resources and capacity are limited.

Community Oriented Services

A strong community based focus with local needs driving and/or influencing the services is evident across all the Māori health providers in this project. All worked with their respective communities to ascertain specific needs and to seek their assistance in the design and delivery of initiatives.

The method of service delivery ranges from on-site to a wide variety of community locations, and mobile and suitcase services. Those providers based on a marae were very much involved in marae life and activities. Marae facilities were used to host health related events and staff were active participants and supporters of all hui held on the marae.

Affordable, accessible and acceptable services are essential features for all the providers.

Support Services

A wide range of social services via the health service such as transportation, referral to other services, advice on income and support, ACC entitlements, etc are delivered by the Māori health providers in this study.

Non Health Related Services

Many of the Māori health providers fulfil and take on responsibilities that are not just health specific. A number in this study talked about the advocacy role they played and the increasing demand this was placing on them. Advocacy ranged from ensuring patients were receiving the necessary information and care from secondary or tertiary providers through to political advocacy.[32] Some of the providers are assuming this added responsibility as a positive and a step towards integrated models of care.

A number of the providers aspired to provide 'seamless' care (including preventative care, social care, and care and support in the home) to their patients especially those with acute and chronic health problems at any point in the health care system. This approach presumes that chronic care management can be most effective when established within a wider system of integrated care. Many of the providers support this view and want to make it a reality and quickly.

Workforce Issues and Workforce Development

Many of the providers are committed to increasing their Māori health and community workforce. All of them made no secret about employing Māori with tribal connections to the areas they service. Others (in urban settings) preferred to employ those who either lived or had worked amongst the communities they service. If this was not possible, they looked to engage people who had proven they could also 'connect' with their clientele base. A common challenge for all the providers is the recruitment and retention of clinical staff.

All the providers invested in upskilling and providing professional development opportunities to their staff. While this is not a unique characteristic to Māori health providers, all the providers supported non Māori staff to understand Māori culture in order to be able to communicate effectively with their patients and respond to cultural cues.

Accountability

Community accountability is important and reflected in the governance arrangements for the providers. Meetings, sponsored events, community reporting and patient satisfaction surveys all contribute to increasing transparency and accountability. The Māori health providers in this study were committed to doing this as well as viewing feedback as a necessary prerequisite to improving the delivery of their services generally.

Leadership

Strong leadership at a governance and management level is evident amongst the providers in this study. There are some passionate and inspiring leaders working in this area. They drive and inspire others within their organisation to bring to reality

[32] Through this project, we were aware of a number of individuals who met regularly with policy makers, politicians, community and sector leaders seeking greater support and resources for addressing Māori health inequalities. The health sector is reknown for political advocacy therefore Iwi/Māori are no different to other stakeholder groups seeking to advance their particular interests.

their particular kaupapa, vision or mission. Such energy and passion is to be applauded given the reality of the challenges that Māori health providers face on a daily basis.

Nurse-Led

The significance of Māori nurses in the leadership, development and maintenance of Māori health providers cannot be underestimated. Māori nurses are at the forefront of primary health care – screening patients for blood pressure, weight, promoting healthy lifestyles, providing support and so on. Their services complement GP intervention. Through this study we met a number of Māori nurses working at the coalface – inspiring, being persistent and empowering others to make life style changes.

Proactive monitoring and follow up, and support of the patient was often the primary responsibility of these nurses. A number in this study, however, indicated that they worked closely with and/or provided complementary services to their GPs. For some of the rural providers, nurses were often the first (and possibly the only) point of contact for many patients.

Improving Quality of Care

Continually improving the quality of services is an important goal for all the providers in this study. Performance monitoring and gaining patient feedback is undertaken on a regular basis. All the providers were able to provide an example where patient feedback had led to some changes – both small and significant - in their operations.

Health Promotion and Prevention

Proactive health promotion and prevention campaigns such as diabetes clinics, exercise and nutrition classes, health related quiz evenings, etc were evident across all the Māori health providers. All acknowledged that increasing patient (and their carers and whānau) knowledge, skills and confidence in managing their own condition(s) and achieving their health and lifestyle goals is essential. Self-management was the utltimate goal. As one interviewee expressed it - ‘tino rangatiratanga starts with yourself and your whānau’.

Voluntary Contribution

Many of the providers in this study relied on voluntary assistance and have been over the years. This ranged from kaumātua support, mentors for specific health promotion initiatives, helping at particular events and hui, tikanga Māori advice and support, transport, pastoral care and so on.

Critical Factors For Successful Results: Observations

The previous discussion highlights a number of characteristics that Māori health provider’s exhibit. Some are not necessarily unique to these providers but services delivered through a Māori cultural paradigm, with an overall kaupapa of whānau ora, does distinguish these providers from others.

Does being a kaupapa Māori-based service deliver superior health benefits? It is not possible to say this with confidence without further research being carried out. The perception amongst the providers is that the more distinctively Māori they are then the more superior the benefits. Evidence suggests Māori benefit from all types of approaches – the key being that they are done well. Certainly some beneficial effects exist from the presence of Māori health providers.

What this study has identified is that there are factors which can contribute to, and do have the potential to lead to improved outcomes. The following offers insights about some of these factors.

Leaders and Leadership

There is considerable leadership capability within the Māori health provider sector and amongst those communities they service. Leaders are the people or groups that 'show the way' - aligning people and action with the organisation's purpose and direction. Quality leadership is critical for ensuring the high performance of an institution. It is a key enabler of all the other dimensions of capability, from setting the strategic direction of an organisation and developing engaged staff, through to choosing what interventions to implement to achieve outcomes.

Furthermore, leaders send powerful messages to staff by role modelling the patient/whānau-focused, collaborative and ethical behaviours required in response to an organisation's kaupapa, vision and goals. Ideas about leadership have moved from a focus on managers to recognition that every employee plays a leadership role in their own sphere. This is important in providers and community based organisations.

For the participating Māori health providers, this is evident in the multidisciplinary team approach taken by the likes of Ngati Porou Hauora (Ngāti and Healthy) and Te Hauora o Te Hiku o Te Ika (One Hearts Many Lives). It was also demonstrated by the initiative and empowering presence of some of the Māori nurses we met. Other evidence included the powerful driving force and presence of the leaders – usually the Chief Executive - within some of the providers.

Although beyond the scope of this study, succession planning in leadership is important. We were unable to determine the extent to which the Māori health providers in this study are investing in this. Anecdotal evidence suggests that this is an area for attention. We are aware that it took some time for one of the providers in this study to recruit for a Chief Executive and in the end a Board member was appointed into the position.

He Tangata, He Tangata, He Tangata – People Oriented

An organisation's most valuable asset is its human capital – the accumulated skills, knowledge, networks, and expertise of its workers. Attracting, engaging and developing staff well is crucial. Planning for, and analysing what an organisation has, and what workforce it needs to deliver its strategy in the future is essential. Finally, rewarding and providing incentives for quality performance is also important.

Māori health providers depend on their workforce to deliver quality services, build trusting relationships and showcase or promote what they offer. Many of the staff we met during this study are committed to whānau ora and to empowering their patients and whānau. Succession and workforce planning was evident for some of the providers in this study. For those who had done some planning they were very clear about their particular workforce needs – be it clinical, community or administrative.

A measure of success or not for a Māori health provider is the extent to which they can attract, recruit, develop and retain (where possible) their staff. All of the providers are committed to professional development opportunities by -

- upskilling their staff, and
- maintaining professional workforce standards at all times and across a range of operational areas.

All of the providers indicated they conduct regular performance reviews of their staff.

Clinical Best Practice

Ensuring clinical care is safe, effective and efficient, as well as appropriate to the needs of a particular service user is critical. The challenge for health professionals is not just to identify inadequate care, but to make changes that improve clinical practice and health care service delivery. Meeting this challenge is primarily a health service responsibility involving a range of health professionals represented in the team who contribute to patient outcomes. There is also an individual professional responsibility to ensure ongoing competence within an identified scope of practice.

Improving clinical care is not new. It requires providers developing service quality plans to document what they do and identify areas for development. Evidence based practice (qualitative and quantitative) and service users' views should be drawn upon to ensure services are effective. Within the health sector there are a range of clinical practice guidelines that promote interventions with proven benefit to reduce morbidity and mortality and improve quality of life for some conditions, thereby increasing the cost-effectiveness of care provided.

The providers in this study were unequivocal that clinical services delivered by them must be timely, safe, effective and responsive to meeting the needs of their patients. They were all committed to continous improvement by:

- being people-centred
- involving Māori consumers/patients/whānau in the planning, delivery and assessment of services
- having in place processes to gather information on patient/whānau satisfaction levels
- ensuring Māori aspirations and priorities are taken into account when planning and delivering services, and
- being accredited service providers.

Holistic Care

The key to whānau ora lies in a holistic approach. One that must look at hinengaro (mental health), tinana (physical health), wairua (spiritual health) and whānau (family) and provide interventions that seek to address, where required, these. Holistic care also means addressing the range of socio-economic determinants that contribute to poor health outcomes.

Action to reduce health inequalities requires a combined health sector, social support sector, intersectoral and community and voluntary sector response. Success in reducing inequalities in long-term health conditions brings positive results for the individual, their family and whānau, the economy and society.

Cultural Integrity and Responsiveness

The way things are done is important. It is the product of organisational beliefs, values, behaviours and assumptions. Culture is created by people, learnt over time, shared by a group and constantly tested and reinforced. An organisation's culture is an important capability aspect because it guides the way employees behave without them having to think through actions each time a situation is encountered - for example, how a meeting is run, who speaks when and so on.

As described in this report, Māori cultural values, principles and practices are fundamental to Māori health providers and guide, lead and inform the delivery of services. Many of the providers worked at ensuring their cultural values and practices are iwi/Māori derived, grounded firmly in mātauranga Māori or inspired by Māori frameworks and supported by kaumātua and pākeke. Cultural integrity especially consistency in the way things are done, the values and principles that underpin action, and the outcome sought are paramount.

Cultural practices and values do make a difference for communicating effectively and building trusting relationships with patients. Māori health providers in this study demonstrated this aspect.

Relationships Matter

Relationships are the web of interactions and connections between an organisation and other institutions and stakeholders. Relationships must be a purposeful means to help achieve positive results for all. An organisation that is clear about its purpose and who it needs to engage with to achieve its goals is much more likely to succeed and perform at an optimal level. Relationships do not happen in a vacuum but evolve over time and with support.

Māori health providers have extensive networks and relationships. In particular, they invest considerably in building and maintaining effective relationships with their communities of interest. They will continue to do so now and into the future. Throughout this study it is apparent that Māori health providers cannot be effective if they do not have community buy-in and participation or support from other organisations to achieve whānau ora.

Compelling Aspiration

Defining a compelling aspiration for the future and remaining focused on it is important. All of the Māori health providers are driven by a broader kaupapa. While expressed in various ways, underpinning this drive is an overwhelming dedication to improving the health and wellbeing of their patients and their whānau i.e. to achieve whānau ora. More indepth research and examination of whānau ora practice amongst Māori health providers would be useful.

Empowering Others

Increasing patient (and their carers and whānau) knowledge, skills and confidence in managing their own condition(s) and achieving their health and lifestyle goals is essential. Changing lifestyle-compromising behaviour (smoking, eating, lack of exercise) requires a change in mindsets and attitudes. Māori health providers are proactive health promoters and educators. They provide information that is simple, easy to understand and targeted to most in need. They work hard to empower others.

CHAPTER FIVE: CONCLUSIONS

There is much to do and on a number of fronts to directly address the health disparities experienced by Māori. A notable development over the past two decades has been the critical role Māori health providers have played towards whānau ora – supporting Māori families to achieve their maximum health and wellbeing.

Role of Maori Health Providers

Māori health providers have achieved a great deal in a short amount of time delivering a range of public, primary health care and mental health services to patients and their whānau. They have had to grapple with complex and changing policy environments, and clinical services. Despite this, Māori health providers have managed to establish credible services that offer Māori and others genuine alternatives not available a few years ago. A small number are now significant organisations with aspirations to further expand their services.

Māori health providers also offer a range of primary health care services in response to the growing chronic disease burden. Cardiovascular disease is the most common cause of death among Māori accounting for a third of all Māori deaths. Likewise diabetes is almost three times more common in Māori than non- Māori. Urgent action on multiple levels is required to address this burden. Māori health providers are doing their part by working through a Māori cultural paradigm with whānau to make a difference.

Distinctive Features

This study has examined the service structures and approaches that Māori health providers have used for responding to cardiovascular disease and diabetes. Of particular interest are the distinctive characteristics that set Māori health providers apart from other providers.

This exercise has found that the unique features displayed by Māori health providers in the delivery of services include:

- being kaupapa Māori inspired and Māori-led
- being culturally authentic and responsive
- an unswerving dedication to achieving whānau ora - supporting Māori families to achieve their maximum health and wellbeing
- a commitment to fostering, building and maintaining trusting relationships with patients and their whānau and other interests and organisations
- taking a holistic approach to the assessment, monitoring and treatment of patients and their whānau
- deploying multidisciplinary teams with a mix of clinical, non clinical and community workers
- preferential employment (where possible) of Māori staff or for urban based providers, the engagement of staff resident within their service area

- investing in professional development opportunities for all staff including non-Māori staff to understand and practice Māori cultural values, and
- community buy in and involvement in the design, development and implementation of primary health care services.

Gaps

A concern from this study is the lack of available supporting clinical data and evidence to assess the effectiveness of interventions for improving cardiovascular and diabetes amongst Māori. This requires attention.

CHAPTER SIX: CHALLENGES FOR ATTENTION

In this chapter, we highlight some key issues for ongoing attention now and into the future. It is not an exhaustive list but highlights matters that were either identified during this study, are known across the sector as challenges or in our view are worth considering.

Recent and Future Issues for Māori Health Providers

Sustainable Funding

- Providers expressed concern about ongoing funding to support their aspirations to grow and expand in the future. This was a particular concern given the current economic climate and the reality that there would be constraints in government funding across all portfolios not just in the health and disability sectors.

- Many providers in this study consider they are already 'lean, mean' organisations operating efficiently and effectively to support those most economically disadvantaged with the highest health needs.

Measuring Success

- An issue that has arisen concerns the appropriate key performance indicators (KPIs) for evidencing health gains for Māori. While there are some established ones, the overall view is the need to keep quantitative and qualitative measures simple, meaningful and relevant for Māori. For example, key performance indicators could include:

    - clients and their whānau accessing Māori health providers
    - clients and their whānau registering with a Māori health provider
    - keeping patients out of hospital
    - % that experience weight loss
    - % changing nutrition patterns, and
    - 80% of provider clients visiting a GP for their annual checks i.e retinal screening and so on.

Integrated Services and Integrated Contracts

- Many providers aspire to delivering a seamless model providing health and other social services. As highlighted, an integrated service delivery reduces duplication and gaps and provides a coordinated approach to address the multiple needs of patients.

- Integrated contracts are crucial and have been rolled out, in recent years, as part of the Funding for Outcomes[33] work. This approach must continue. Evaluation of integrated contracts found that[34] -

    - services delivered under an integrated outcomes-focused contract are more proactive and strategic than under traditional contracts
    - providers have more time to spend on service improvements
    - providers have an increased capacity to provide quality holistic services, meet client needs and operate more effectively and efficiently
    - reports produced under the integrated contracts are more relevant and useful
    - providers feel they are on a more equal footing with funders through their involvement in contract development
    - providers have an opportunity to contribute their experience to discussion on service development, and
    - outcomes-focussed contracts give providers the opportunity to be creative and to deliver the service which best meets their clients' needs.

Workforce Development and Planning

- Workforce development and planning is a significant priority for Māori health providers and addressing it requires action on a number of levels and by a number of stakeholders. Planning for, and analysing what an organisation has, and what workforce it needs to deliver its strategy in the future is essential.

- While succession and workforce planning was evident for some of the providers in this study it is not happening across the entire sector. For those who had done some planning they were very clear about their particular workforce needs – be it clinical, community or administrative. For those who did not, they require assistance and support including access to quality Māori health and workforce information. Significant resources are also required to accelerate Māori health workforce development.

- A comprehensive approach focused on recruitment, retention, proactive leadership between health sector stakeholders and the development of partnerships between sectors (especially health, education and labour) is necessary.

Sharing of information and best practice approaches

- Lessons, especially knowledge about what works and is effective must be shared and made available to Māori health providers and across the health sector generally.

[33] Led by the Ministry of Social Development, Funding For Outcomes introduced and implemented a number of integrated contracts across the health and social services sector.
[34] Refer www.familyservices.govt.nz/documents/our-work/funding-outcomes/funding-for-outcomes

- Where 'pockets of success' exist and have been evaluated for effectiveness, these should be rolled out (tailored as appropriate) to other communities.

- Best practice and striving for excellence should be encouraged and expected by all in the health sector especially when addressing Māori health inequalities.

Reducing Compliance Costs

- Providers expressed concern at the compliance and reporting requirements placed on them. This was particularly problematic for small providers with limited capcity and resources to comply with reporting standards.

Being an Influential Player in the Future

- The Māori health provider sector has been in existence for over 20 years now. A small number are substantial organisations with well developed systems and processes, are recognised as proven deliverers of quality services, have a range of contracts and extensive networks.

- Because of these characteristics and their track record of working with whānau, Māori health providers have the potential to be influential organisations in the future. This is particularly so as more iwi settle Treaty claims and look at delivery models and organisations that will assist their beneficiaries.

Ongoing Capacity Building

- The Māori health provider sector can be generally characterised as having moved from a period of establishment to the consolidation and maintenance of its services. While Māori health providers are 'fit for purpose', there are still areas including governance, management, accountability and reporting systems, IT systems, financial systems and processes, and workforce capability that require investment. These are not insurmountable but require continuing support from the Ministry of Health, District Health Boards and other government agencies.

Policy and Service Development Issues for the Health Sector

Workforce Development and Planning

- New Zealand faces critical workforce shortages. The Ministry of Health and District Health Boards have a significant role to play to support health workforce development and planning. Indeed, all stakeholders across the sector have a responsibility to work collaboratively to target resources and effort to support Māori health workforce development. Unless, this is done in a comprehensive and sustainable way, then the under-representation of Māori in the health and disability will continue to persist.

Māori Participation in Service Design and Development

- Māori health inequalities require urgent action and attention. The health system has not worked as well for Māori as it could have.[35] Solutions and interventions to support whānau ora demands Māori input in the design and development of policy and operational drivers. A one size fits all approach will not work and therefore taking into account the views and perspectives of Māori working at the service delivery end with tangible actions that are properly resourced is required.

- Again, the Ministry and District Health Boards have an obligation and a responsibility to ensure Māori input and engagement occurs in a well planned and systematic way and beyond discrete projects.

Patient Centred and Whānau Ora Approaches

- Supporting, developing and delivering services tailored towards patients/whānau must be a priority for the Ministry, District Health Board and other key stakeholders across the sector. Applying a patient or whānau-centred approach means tailoring health care and support to the needs, aspirations and goals of the person, their whānau, and other carers. It involves taking the diversity of mental, emotional, cultural, social, economic and spiritual needs into account alongside physical health needs. It also means listening to and acknowledging people's own expertise in managing their long-term conditions, so that they become a partner in health care. It is also about health professionals coming to a shared understanding about a person's condition. Health sector interventions should be adaptable to people's changing circumstances and support people to increase their control over their own lives. This means the development and implementation of models of care that are seamless and provide continuity across services for patients.

- A person-centred health information environment is also important. A health system organised around the needs of each person and whānau needs to ensure that the health information follows the person so that the right care can be provided by the right health provider at the right place and time. This requires more connected IT systems so that information is shared.

Performance Evaluation and Quality Improvement

- The Ministry of Health and District Health Boards must work with providers to evaluate existing initiatives for removing barriers to accessing diabetes and CVD care, and ensure that there is a mechanism in place to disseminate successful initiatives throughout district health boards, Māori health providers and PHOs

[35] Refer Ministry of Health *Statement of Intent 2009-12*

APPENDICES

Appendix A: Mauriora-ki-te-Ao/Living Universe Project Team

Led by Parekāwhia McLean, the Te Toi Hauora-Nui project team included a mix of clinical, health management, governance, policy and research (health and mātauranga Māori) experience and comprised -

- Dr Matire Harwood, GP from Tamaki Healthcare PHO and Māori Health Researcher
- Wayne McLean, Chief Executive, Raukura Hauora o Tainui
- Dina Hippolite, Nurse,[36] Raukura Hauora O Tainui
- Dr Charles Royal, Company Director of MKTA, Researcher in Mātauranga Māori
- Dene Ainsworth, Business Manager at MKTA, Project Administrator and Research Assistant

[36] Dina is now the Leader of Tamariki Ora Services at Raukura Hauora-o-Tainui but at the time of engagement for this project was a Disease State Management Nurse.

Appendix B: Table of Māori Health Providers

The following is a list of Māori Health Providers that participated in the Toi Haurora-Nui project. The providers were selected for their participation and delivery of key programmes relevant to the area of study.

Provider	DHB	Māori-led PHO Mainstream PHO	Urban /Rural	GP services	CVD prog (clinical/ non-clinical)	Diabetes prog (clinical/ non-clinical)	Careplus	Whānau Ora Award	Integration of services
Te Kohao Health Ltd (Hamilton)	WDHB	ML	U	X	X	X	X		X
Ngāti Porou Hauora (Te Tairawhiti)	TDHB	ML	R	X	X	X	X	Whānau Kaupapa /Te Tohu Kahukura	X
Ngā Kakano Foundation Ltd (Te Puke)	BOPDHB	ML	R	Nurse Led	X	X			
Te Korowai Hauora o Hauraki (Thames)	WDHB	MS	R/U	X	X	X	X		X
Te Hauora o Te Hiku o te Ika (Te Tai Tokerau PHO)	NDHB	ML	R/U	X	X		X	Whānau Whānui	X
Whakatu Marae Health Services (Nelson)	NMDHB	ML	U	Nurse Led	X	X			X
Whakawhiti Ora Pai (Te Tai Tokerau PHO) (Kaitaia)	NDHB	ML	R	Nurse Led	X	X		Whānau Whāiti	
Maraeroa Marae Health Centre (Porirua)	CCDHB	ML	U	Nurse Led					
Te Rūnanga o Ngā Maata Waka (Christchurch)	CDHB	ML	U	X	X	X			X

Appendix C: Māori Health Provider Questionnaire

General

1. Your organisation/operation has been identified as a provider of quality health services to Māori. When did you start your operation/s?

2. What are the features of your work which you believe are distinctive and successful in the delivery of these services?

3. How were these features developed?

4. In developing your services and practices, were there other models and experiences that you drew upon? What were these?

5. Do you undertake any kind of business monitoring of your operational activities? If yes:

   How often?
   Internal or external reviewers?
   What areas are reviewed?
   Why those areas?
   Do you ever undertake a patient satisfaction survey? If yes,
   How often?

   Have you ever implemented changes as a result of the comments from a patient survey? Please provide an example/s.

6. How are you funded? Please tick all areas that apply

DHB	[ ]
MOH	[ ]
Other govt agencies	[ ]
Local Authority	[ ]
Grants	[ ]
Donations	[ ]
Sponsorship	[ ]
Iwi/Hapū	[ ]
Māori Organisations	[ ]
Other	[ ]

7. How do you see your services developing over:

   [a] The next 12 months?
   [b] The next 5 years?

[c] Beyond the next 5 years?

8. What things do you think will help you achieve these aims?

9. What factors have you identified that may hinder the developments listed in your response to question 8?

10. What strategies do you have to overcome those factors that you have listed in response to question 9?

11. Do you monitor the health of your patient base at a population level? If yes, how?

12. What are the areas/conditions with the highest prevalence?

13. Based on your findings with regards to question 12, how have you responded i.e. what measures have you introduced, or what have you changed, operationally andor clinically?

14. What is your general approach to chronic conditions?

15. Do you have any kind of outreach initiatives? If yes, please provide details?

16. What aspects of traditional Māori elements/protocols such as tikanga, kawa, manaakitangā, etc are contained or woven into your operation and/or activities? Please provide examples.

<u>Diabetes.</u>

17. Is diabetes prevalent among your patient base? If yes, please provide an indication of numbers.

18. Do you have specific programmes addressing diabetes? If yes, are these [please provide details]

Educational?
Clinical?
Care and Support?

19. How do you maintain your knowledge base concerning issues, initiatives, developments of relevance to diabetes?

20. Do you believe that your approach to the treatment and care of patients with diabetes has unique points of difference that other health providers may benefit from incorporating into their practice? Please provide examples and why/what you think makes them unique.

Cardiovascular Disease.

21. Is cardiovascular disease prevalent among your patient base? If yes, please provide an indication as to numbers.

22. Do you have specific programmes addressing cardiovascular disease? If yes, are these [please provide details]

Educational?
Clinical?
Care and Support?

23. How do you maintain your knowledge base concerning issues, initiatives, developments of relevance to cardiovascular disease?

24. Do you believe that your approach to the treatment and care of patients with cardiovascular disease has unique points of difference that other health providers may benefit from incorporating into their practice? Please provide examples and why/what you think makes them unique.

Statistical Information.

25. How many staff do you have: To be provided

Management - FTEs?
Clinical/Medical - FTEs?
Administration - FTEs?
Volunteers?

26. How many sites do you operate from? Where?

27. Please complete the following table as regards your patient base numbers:

	0 – 15 yrs		15-2yrs		25 – 40yrs		41 – 60yrs		60+yrs	
	Māori	**Other**	**Māori**	**Other**	**Māori**	**Other**	**Māori**	**Other**	**Māori**	**Other**
Male										
Female										
Total										

Appendix D: Te Toi Hauora-Nui Wānanga

Te Toi Hauora-nui Project
Achieving excellence through innovative Māori health service delivery

Māori Health Provider Wānanga
Jet Park Airport Inn
Mangere, Auckland.

10th February 2009

Participants:

Māori Health Providers

Maraeroa Marae Health Centre	Missy McLean, Business Manager
Te Kohao Health Ltd	Tureiti Moxon, Managing, Director
Whakatu Marae Health & Social Services	Carol Hippolite, Kaimahi Hauora
Whakawhiti Ora Pai	Errol Murray, General Manager

Te Toi Hauora-nui Project

Parekāwhia McLean	Project Leader
Dene Ainsworth	
Dina Hippolite	

Independent

Rawiri Faulkner	Facilitator

Wānanga commenced at 10-30a.m with karakia – Errol

Rawiri welcomed everyone and briefly introduced himself and the day's proceedings (see attached agenda). Mihimihi then followed.

Session 1. Setting the Scene

Rawiri provided an overview of the day's agenda and how he would like the day to progress. He covered goals and objectives for the day and how he saw his role as facilitator. Rawiri explained that there would be occasions when he would take on the role as 'Devil's Advocate' to challenge comments made and to ensure clarity for all.

Session 2. Update on Progress

Parekāwhia gave a presentation that detailed the background to:

Project Origins

- a desire by the Ministry to document the delivery of services by Māori health providers (MHPs) with a focus on addressing cardio-vascular disease and diabetes

Progres Update

- draft literature report completed. Review has highlighted the paucity of information available about the delivery of services by MHPs in response to cardiovascular disease and diabetes
- through a written questionnaire, MHPs have been surveyed
- MHP site visits
- MHP site visit notes completed and sent to participants for checking of detail
- Collection of some MHP patient stories although this was proving to be more difficult than envisaged

What next

- notes from this wānanga to be prepared and sent to participants for comment
- meeting with project reference group later in February
- period of analysis and drafting of report.

A copy of the presentation was distributed to participants.

Session3. What makes Māori Health Providers Unique?

An overwhelming response to this question has been the response that 'we are a kaupapa Māori based operation' so it is timely to ask what is actually meant by that response?

Kaupapa Māori means different things to different people i.e.
Individual level
Organisational level
Governance level
Bottom line is that these are our core values

Kaupapa Māori is based on the values and principles that are ensconced in tikanga Māori and the Māori world view. It is then reflected in the behaviours, processes and practices of an organisation.

The approach to Māori mental health is an example of where the approach used is not kaupapa based i.e. it is purely mainstream. However, MHPs are all about people at all levels – kaumātua, pākēkē, rangātahi, tamariki.

Need to recognise also that it is governed by the kawa of the tāngāta whenua so varies from rohe to rohe.

It's all about relationships, about taking time to establish and build relationships. For MHPs it's about ascertaining what the patients want/need and then going about

meeting those wants/needs by doing whatever was necessary. If that meant getting resources then we found ways to do that.

Question from Rawiri - can we take these various factors that you have identified and transport/transplant into a mainstream or pākehā organisation?

No! It's innate; it's part of being Māori, what makes us Māori.

No, they are too structured and focussed on number crunching. They are not interested in relationships or holistic issues.

Agree, they don't look at the bigger, wider picture.

Kaupapa Māori is not limited to health i.e. also present in other disciplines such as social services. So there must be common threads or key ingredients that come into play. It is the nature of our [Māori] delivery that makes us unique.

It is the cultural paradigm – how we see the world and not how others see it. In our world we are mainstream so everyone else is non-Māori or pākehā. To be in this cultural paradigm we must have:

Te Reo - we must learn/know our own language to enable us to know aour world
Principles – we must know our guiding principles [whakapapa, wairuatanga, manaakitanga, ūkaipotanga etc] – we must not just know them but use them, apply them in our work, in our operations, in our lives i.e. in everything we do. To be a true kaupapa Māori organisation we need to know and practice our principles and values.

Comes back to relationships e.g. marae, Iwi, Hapū, Whānau. Being able to engage, at whatever level that it needed to be at, irrespective of age.

You need to be Māori to be able to connect i.e. no hea koe? It's whakapapa. A pākehā can learn to kōrero Māori and be fluent but that doesn't make them Māori or understand what it is to be and identify as Māori.

We need to recognise the need to differentiate between organisational principles and service deliveries.

There is a need to recognise that pākehā systems revolve around power and control. MHPs need to reverse the roles where we tell them what we are going to do, when we are going to do it and how we are going to do it

<u>*Summary of key points from Session 3*</u>

Care based on:

Core values
Kawa me ona tikanga
Trust and relationships
Empowering our people to make good well being decisions
A holistic approach [considering education, health and the environment]

Session 4 Measuring Success

How do we know or measure that we are providing excellent service?

No one should consider that they are excellent as that suggests that we are at the top of our game and there is no need for improvement. So what makes us successful – the results of our interventions.

So is it all about measuring tangibles?

Well people – that's our No. 1 measurement of success. Tikanga Maori - knowing it throughout the organisation and practicing that 24/7.

Knowing/understanding our Māori knowledge and using technology to add value.

It's about the population – getting people accessing a MHP, having them enrolled asap, increasing the patient base, database etc, changing the statistics.

What is wellness?

Being healthy, individually and as a whānau. Being educated. Participating in society, the community and contributing. Knowing our culture, language, tikanga.

Breaking down institutional racism, institutional barriers. Reduction in violence, reduction in crime, reduction in disparities. MHPs work with the whole i.e. we work well outside our contracted obligations.

MHPs success is not their success but is the patient's success i.e. MHPs make a contribution and provide facilitation that leads to the patient getting well.

Two measurements:

Quantitative data
Qualitative research such as narrative stories and anecdotal evidence

Tools are out there to measure, what needs to change is the focus of what we are measuring.

So what/where are the gaps?

Pākehā dominate funding allocations, too many inequalities.

Pharmaceutical costs.

Capability issues.

Accessing health care – medical/dental/mental – need to reduce/eliminatecosts.

Overstructured – too many layers and too many hoops to jump through.

Different expectations – funders v MHPs v patients. Patient's expectations are greater. They know that you have funds, don't care what you have to do to satisfy funders just want to know what you are going to do for them.

Knowledge transfers – comes down to relationships where sharing of knowledge is encouraged and/or available. Important factor here is to ensure that there are sufficient resources, capable resources to collect the right information to provide meaningful measurements.

Prime measurement tool is patient satisfaction survey. We survey on annual basis and also have a facility to enable the lodging of complaints. Patients with complaints are actively encouraged to lodge those complaints.

If there was no requirement to report to funders, would we still measure and if so would we do it differently?

Yes, it would change from being a number to being whānau. We would look at whānau being well and not just the individual.

Pākehā measurement is time i.e. allocate a set number of minutes per consultation so look to treat a specific minimum number of patients each day. MHPs allocate whatever amount of time is necessary so number seen each day varies, sometimes significantly. Would also look at intangibles within the organisation; use/application of values e.g. pōwhiri, poroporoaki, koha, wānanga, tangihana leave and attendance at tangi.

Why don't we just change the measurement tool? Why not design a kaupapa Māori measuring tool when assessing MHPS success?

Need to reposition MHPs to reflect advocacy roles undertaken by MHPs across the board. MHPs fulfil a number of roles not just health specific – provide other services as well Being clear of what the MHPs needs and keeping that as the main focus in determining the level of funding needed. Believe that the current situation is overregulated particularly from a compliance perspective. Many examples of MHPs being audited numerous times each year; guarantee that pākehā providers don't face the same amount of scrutiny.

Have people in power who understand the environment that MHP operate in and they [people] are in a position to support what MHPs need to provide their services.

Summary of key points from Session 4

Excellence can be measured in many ways. These include:

- Being at significant events and functions that matter to our people
- Displaying manaakitanga
- Having time to spend with our people [not just a number]
- Measuring progress when intervention is sought
- Having a healthy, educated, connected society

All of these things contribute to excellence in well being.

Gaps identified included:

- Funding and compliance restraints
- Lack of capability
- Some services not being accessible to our people
- No developed power or control

Session 5 Feedback on Today

All participants acknowledged the benefit of getting together in a forum such as today's and appreciated the opportunity to share knowledge, information and experiences.

It is good to know that the problems that we face are not ours alone. All MHPs have the same barriers to overcome and it is clear that this is something that needs to be addressed at a higher level.

I've recognised that a number of the things that we do are second nature, we just don't think about why we are doing it, we just do it. Sometimes we get caught up with what funders need and forget the good things that we are doing.

Set high expectations; don't settle for anything less. We are an extremely innovative people and we must believe in ourselves.

It's all about Māori well-being.

Appendix E: Collation of Responses to Provider Questionnaire

Q1. When did you start your operation/s?

On average the providers have been operating for 12 years with the 'oldest' staring up in 1986 and the 'youngest' commencing in 2007.

Q2. What are the features of your work which you believe are distinctive and successful in the delivery of these services?

There were numerous responses to this question with over 20 different aspects being recorded. The following are the most common responses and these are listed according to the number of times they occur starting from most frequent:

- Kaupapa Māori principles and practices[37]
- Marae based operations
- It's all about whānau, understanding whānau
- Workforce development/professional development
- Good communicators and equally good listeners
- Multi-skilled, enthusiastic, committed staff
- Always looking for new services to offer/deliver innovatively
- Strategic relationships
- Work to engage/empower communities

Q3. How were these features developed?

Again a number of responses here however the most common among the participants were:

- Recognizing the needs of whānau and community
- Kaupapa Māori

Q4. .....were there other models and experiences that you drew upon? What were these?

- Māori concepts and models e.g. Te Whāre Tapa Whā
- Just listening to the needs of the whānau/Māori/community
- Strategic planning, setting goals and objectives
- Discussions with, and listening to, kaumātua
- Incorporating Tikanga, kawa and te reo
- Review of past performances and experiences

[37] Tikanga, kawa, values e.g. manaakitanga, whanaungatanga, whakapapa, wairuatanga etc.

Q5 [a] Do you undertake any kind of business monitoring of your operational activities?

All participants undertook business monitoring.

[b] How often?

Most of the participants [60%] monitor on a quarterly basis with the remainder six-monthly or yearly.

[c] Internal or external reviewers?

All participants – both.

[d] What areas are reviewed?

A wide range of areas were noted with the most common being:

- All contracts and regulatory/legislative areas
- Operations, services and delivery of services
- Systems
- Financial

[e] Why those areas?

- Regulations/legislation
- Desire to improve services
- Funding/funder's requirements

[f] Do you ever undertake a patient satisfaction survey? If so, how often?

All participants carried out patient surveys at least once a year.

[g] Have you ever implemented changes as a result of the comments from a patient survey?

Most participants had implemented some level of change in their operation as a result of feedback from their patient survey/s. Some of the changes were relatively minor and designed to ease/enable access to services while others were significant such as the establishment and equipping of a gymnasium.

Q6 How are you funded?

The primary source of funding is from District Health Boards with the Ministry of Health also featuring as a significant funder. Other funding avenues noted were:

- Grants
- Government agencies e.g. MSD, ACC
- Local Authorities
- Sponsorship
- Fundraising

Q7 How do you see your services developing over:
[a] the next 12 months?

Again there was a wide range of activities listed in response to this question. The most common answer revolved around the on-going review and evaluation of existing services with the view to add new services/programmes as circumstances dictated and, similarly, removing services/programmes no longer relevant and/or considered necessary. Other common answers included:

- Working collaboratively with other medical/social/service providers
- Establishing gardens/orchards
- New educational programmes

[b] the next 5 years?

As for 7[a] above with a similarly wide ranging number of developments offered in response to this question. These ranged from the construction of new/additional buildings to looking to expansion both nationally and internationally. Common answers amongst participants were:

- Provision of increased employment
- Extension/enhancement of existing services
- Enhanced infrastructure
- Establishment of gardens/orchards to sustain entire community
- Provision of affordable dental services
- Fill the gaps in broader social services

[c] beyond 5 years?

- As for 7[b], and
- Extension of community services while avoiding duplication
- Māori led hospital and hospice
- Self sufficiency
- Knowledge transfer

Q8 What things do you think will help you achieve these aims?

Responses here were wide and varied however the key areas identified were:

- Team work with a strong, focussed staff
- Establishing key relationships and working collaboratively
- Continued passion and desire
- The ability to dream and have a vision
- Continued funding being available

Q9. What factors have you identified that may hinder the developments that you have listed?

As with the previous question, a wide range of responses with the following recurring areas identified:

- Decreased/diminishing workforce i.e. limited or reduced/reducing resources
- Regulatory restraints e.g. Resource Management Act, 'red tape' resulting in staff/management being tied up with administrative functions instead of providing services
- No or heavily reduced levels of funding
- Conflict:
  - Medical model v actual needs
  - Health promotion approach v individual/disease based approach

Q10. What strategies do you have to overcome the factors that you have identified in the previous question?

Over twenty strategies were provided in response to this question and, surprisingly, only one of these was mentioned more than once namely staff stability. Other strategies promoted included:

- Strong management
- Strong relationships
- Empowering others
- Evaluating/implementing change
- Induction to cultural development
- Self-directed communities
- Ability to work in cycles recognising change
- Strong, innovative systems in place

Q11. Do you monitor the health of your patient base at a population basis? How?

All participants responded in the affirmative here. The most quoted 'method' here related to the role of the staff whereby they play an active part in monitoring their patient base. They are active in the community and by maintaining a strong presence and listening/knowing what is happening in the community and who is doing what, experiencing what. The other 'method' mentioned was the sharing of information and working collaboratively with other health providers/professionals.

Q12. What are the areas/conditions with the highest prevalence?

Responses to this question are as follows with the most prevalent listed first.

- Diabetes
- Asthma
- Cardio-vascular
- Chronic diseases
- Cancers
- Obesity
- Suicide
- Cellulitis
- Mental Health especially around drug and alcohol
- Dental

Q13. Based on your response to the previous question, how have you responded i.e. what measures have you introduced or what have you changed operationally and/or clinically?

The main response here has been to address the patient's whole wellbeing to reduce/stop the symptoms' progress. In this context whole wellbeing refers to the integration of physical/medical/mental/spiritual/social services i.e. the providers endeavour to be a one stop shop that looks at the bigger picture and not just the symptom or illness that has presented. A second major response has been to increase the number of health awareness and promotion programmes. Other responses included:

- Monitor/profile
- Rehabilitation programmes
- Working with community to design/develop programmes that reflect community needs

Q14. What is your general approach to chronic conditions?

- Education of staff via research and attendance at courses, seminars etc. from which they then design programmes to promote and raise awareness of the particular health issue
- Establish/maintain/build relationships with health specialists/professionals/providers and affected patients
- Treatment/clinical activities
- Active monitoring

Q15. Do you have any kind of outreach initiatives? What are they?

- Provision of regular doctor clinics throughout the provider's rohe
- Provision of home visit services
- Implementation of immunisation programmes
- Screening programmes [breast/cervical] via mobile services

Q17. What aspects of traditional Māori elements/protocols are contained or woven into your organisation and/or activities?

Tikanga Māori was the most common response to this question and encompassed all elements that are associated with that term e.g. manaakitanga, wairuatanga, whānaungātanga, whakapapa. Other aspects that featured prominently included:

- Whākatauki
- Kaumātua teaching and/or guidance
- Karakia
- Pōwhiri

Also mentioned were:

- Iwi specific artwork
- Marae teachings
- Whānau
- Respect of rohe - tāngāta whenua delivery of services
- Wānanga
- Kaiwhākaora
- Mirimiri

DIABETES.

Q17. Is diabetes prevalent among your patient base? Please provide an indication of numbers.

Not surprisingly, all participants indicated that diabetes figured prominently among their patient base. Not all participants were able to provide numbers [refer OAG effectiveness review around Get Checked Aotearoa] only four able to do so and these were as follows:

26 150 190 450 Total: 816

Q18. Do you have specific programmes addressing/preventing diabetes? Please provide details of:
[a] Educational

- Whānua Ora
- HEHA/Kaumātua hui
- Quarterly promotional events
- 1 on 1 kōrero at home or clinic

[b] Clinical

- Nurse 1 on 1
- Annual screening
- Get Checked Aotearoa
- Individual/Community Health Plan

[c] Care and Support

- Support at and transport to appointments
- Health plans and working collaboratively with other providers
- Regular monitoring
- Exercise/nutritional classes and advice
- Home based support
- Care Plus

Q19. How do you maintain your knowledge base concerning issues, initiatives, developments of relevance to diabetes?

- Seminars/conferences/workshops
- Information/resources received
- Joint ventures [Otago University]
- Student doctor exchange visits
- Working with nurses/specialists/dieticians etc
- Training and upskilling
- Medical research
- Community links
- Medtech 32 systems

Q20. Do you believe that your approach to the treatment and care of patients with diabetes has unique points of difference that other health providers may benefit from incorporating into their practices?

- Spending whatever amount of time is needed with patients, especially in the home, and getting to know and understand them
- Ensuring that you provide an environment that the patients are comfortable with particularly the observance of Tikanga where you clearly demonstrate that you understand and are aware of Tikanga Māori practices
- Focus is on the whole well being and that focus is Māori
- Walking the talk – pōwhiri, karakia, tangi, whanaungatanga, whakakpapa, community involvement
- Keeping everything simple and easy to understand
- Assisting and supporting as and how required

Challenges

- Workforce
- Information – data collection
- Gauging effectiveness of interventions for Māori – what performance indicators/measures do you use? Māori providers – whānau and spiritual wellebing, culturally appropriate service delivery and a prioritised commitment to Māori workforce development. There is a need to frame indicators around Māori perspectives of health (Durie, 2003).

Cardiovascular Disease

Q21. Is cardiovascular disease prevalent among your patient base? Please provide an indication of numbers.

Once again all providers indicated that cardiovascular disease was also prevalent among their patient base. Only two participants were able to provide an indication as to numbers viz.:

50 116 Total: 166

Q22. Do you have specific programmes addressing/preventing cardiovascular disease? Please provide details of:
[a] Educational

- Information via notices, flyers, brochures
- Prevention programmes
- Kai Oranga
- HEHA/Kaumātua hui
- Promotional events

[b] Clinical

- Screening
- Specific programmes [exercise/nutrition]
- Collaborative work with PHOs, GPs

[c] Care and Support

- Mail out campaigns [not that successful]
- Whānau activities
- Care Plus
- Walking the talk

Q23. How do you maintain your knowledge base concerning issues, initiatives, developments of relevance to diabetes?

- Attending courses
- On the job training
- Working collaboratively
- Medtech 32 system
- Information, resources received

Statistics

Staff:

Mgmnt	Clin/Med	Admin	Volunteers	Other
2	4	2		5
5	26	6	6	52
3	2	2	3	
22	2	3		
2	5	1		
34	39	14	9	57

Patient Base:

	0 - 5		6 - 20		21 - 45		46 - 60		60+	
	Māori	Other	Māori	Other	Māori	Other	Māori	Other	Māori	Other
Male	600	1103	1239	2269	1040	1795	649	1791	182	1014
Female	647	1032	1241	2298	1314	2000	726	1913	287	1095
Total	1247	2135	2480	4567	2354	3795	1375	3704	469	2109
	3382		**7047**		**6149**		**5079**		**2578**	

Patient Base Analysis:

Total No. of Patients:	**24235**	
Total No. of Māori:	**7925**	**32.7%**
Total No. of Other:	**16310**	**67.3%**
Total No. of Males:	**11682**	**48.2%**
Total No. of Māori Males:	**3710**	**31.8%**
Total No. of Other Males:	**7972**	**68.2%**
Total No. of Females:	**12553**	**51.8%**
Total No. of Māori Females:	**4215**	**33.6%**
Total No. of Other Females:	**8338**	**66.4%**

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