

WHĀNAU-CENTRED HEALTH AND SOCIAL SERVICE DELIVERY IN NEW ZEALAND

The challenges to, and opportunities for, innovation

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Abstract

In New Zealand, Māori are entitled to the same level of well-being experienced by non-Māori citizens. However, disparities between the two populations are evident. In 2010, a new public policy approach to health and social service delivery was announced: one underpinned by Māori values, and which ostensibly provided the Crown with another mechanism to reduce health and social well-being disparities. The whānau (family) centred approach seeks to achieve the goal of “whānau-ora” (well-being of the extended family) and requires health services to work across traditional sector boundaries to improve client health.

This paper traces the emergence of Māori health service provision and the whānau ora philosophy that became the cornerstone of Māori health policy in the early 2000s. It discusses the implications for Māori health and social service providers of the latest iteration of the whānau ora approach to social service delivery, as outlined in the *Whānau Ora Taskforce Report of 2010*. By synthesising public management literature, examples from a local “whānau ora” model of service delivery, and findings from previous research conducted in the area of Māori health

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service provision, a number of observations as to the significance of this new policy approach are offered.

Keywords

Māori, whānau ora, health services, health policy, health reform

Introduction

New Zealand's health sector has undergone four major reforms since the 1980s which completely remodelled and restructured the way health services are delivered in this country. The most recent of these, in 2000, arguably led to some of the most significant changes to the provision of health services to Māori, the indigenous peoples of New Zealand. Not only did these reforms greatly increase the requirement to include Māori views in health care decisions affecting them as a population group, the reforms also introduced a new concept into the lexicon of health policy: the concept of whānau ora. Introduced as the primary goal of the government's "Māori Health Strategy He Korowai Oranga", whānau ora in this sense was defined as "Māori families supported to achieve their maximum health and well-being" (Ministry of Health, 2002a). The concept of whānau ora has, since its introduction as a goal for Māori health, evolved and recently become even further entrenched in our health and social service delivery sector, through the introduction in 2010 of the "Whānau Ora Approach to Social Service Delivery" (Taskforce on Whānau Centred Initiatives, 2010). Whānau ora is an inclusive and culturally anchored approach based on a Māori worldview of health which assumes that changes in the well-being of an individual can be brought about by focusing on the family collective (or whānau) and vice versa (Families Commission, 2009). With the introduction of the "Whānau Ora Approach to Social Service Delivery", and a dedicated budget to support this policy announcement, service

providers from the health and social service sectors have, in effect, received a formal mandate to work across traditional sector boundaries in a cooperative and collaborative manner and place whānau and whānau needs at the centre of any and all care plans.

This paper discusses the key features of the new Whānau Ora approach to social service provision, as outlined by the Taskforce on Whānau Centred Initiatives (2010). We examine the opportunities this novel approach offers to Māori health and social service practitioners who, out of necessity, and in order to remain true to their cultural values (Boulton, 2007; Brannelly, Boulton, & Te Hiini, in press), work across boundaries to provide the best health and well-being services for their clients: Māori whānau. The paper begins by outlining the unique position Māori health and social service provision occupies within the wider health and social sector in New Zealand; a position fought for by Māori in an effort to reverse the growing inequalities between Māori and non-Māori health status. The paper then briefly discusses the current health sector context into which the Whānau Ora approach has been introduced, before presenting the key features of the approach. By synthesising public management literature, examples from a local case study (Te Oranganui Iwi Health Authority Primary Healthcare Organisation, based in Whanganui), and the findings of earlier research conducted in the area of Māori health service provision, the paper then examines a number of opportunities and challenges that the approach presents Māori health providers as they work across traditional sector boundaries to provide

the best health and well-being services for their clients. The paper concludes by offering a series of observations as to the significance of this new policy approach, both for Māori providers working in this unique space and for the public sector more widely.

Māori: Constitutional partners

Māori are the indigenous people of New Zealand. The term indigenous has many definitions and many usages (Cunningham & Stanley, 2003); however, key features which unite indigenous peoples include an ancient relationship with a defined territory, ethnic distinctiveness (Durie, 2003), and a shared worldview that places significance upon the idea that humans are intrinsically linked to the natural world (Royal, 2003). Indigenous peoples also share the common bond of experiencing “unacceptably large” differences between their health status and that of the non-indigenous populations in developed nations (Ring & Brown, 2003, p. 404).

Māori use the term *tangata whenua* or “people of the land”, to distinguish themselves from the English, French and other nationalities who began colonising the country from the late 1700s. Colonisation, once begun, swiftly changed the physical and social landscape of New Zealand. The British, who claimed an interest in the country, were concerned that some form of legal document be drawn up with Māori to confirm their sovereignty over the land. Both Māori and Pākehā (non-Māori) were interested in identifying the other’s interests, intents and future plans for their respective peoples (Orange, 1987).

In 1840 Māori and the British Crown signed the Treaty of Waitangi, recognised as New Zealand’s founding document (Te Puni Kōkiri, 2001). In the years since its signing, the Treaty has become an integral part of the New Zealand constitutional framework, with attempts by recent governments to implement so-called

“Treaty principles” in order to redress past breaches of the Treaty (Te Puni Kōkiri, 2001). The three principles—partnership, participation and protection—have been established by New Zealand Courts, by the Waitangi Tribunal (Te Puni Kōkiri, 2001) and by the Royal Commission on Social Policy (1988). These principles have guided much of the Crown’s public policy in relation to Māori, and indeed underpin the most recent Māori health policy documents (Boulton, Simonsen, Walker, Cunningham, & Cumming, 2004). Enactment of the Treaty of Waitangi principles is now regarded as crucial for redressing health inequalities and improving Māori health outcomes (Durie, 1994; Howden-Chapman & Tobias, 2000; Robson & Harris, 2007).

Whereas at the time of the Treaty’s signing Māori were predominantly a tribal people living on their ancestral lands and with strong spiritual ties to their wider environment, 21st century Māori are as diverse a population as any other. Contemporary Māori live a host of different lifestyles, from those who remain on their ancestral lands and practise a more traditional lifestyle, to those who are completely urbanised and Westernised with very little knowledge of their heritage, ancestry or culture. Durie (1995) has coined the term “diverse Māori realities” as a means of illustrating that Māori are no longer a homogenous people, but rather, are as diverse and complex as any other population group in New Zealand.

Contemporary New Zealand has a unique health sector, one that combines aspects of Western and Māori health service provision to best meet the needs of its diverse indigenous population. The environment of health service provision to Māori has evolved from one where Māori were merely the passive recipients of clinical and health services, to the contemporary context, where Māori have a greater role in all aspects of health care delivery and management—from leading service provision, through to providing advice and comment into funding and planning decision-making and in

the development of strategic health policy.

Efforts to include Māori perspectives in health policy, health care funding decision-making and service delivery were, in part, a consequence of the broader public policy changes which occurred in the late 1980s and demands, on the part of Māori themselves, for more autonomy in health care decisions affecting them. To understand the government's most recent model for improving Māori health, *whānau ora* or family-centred service provision, it is first necessary to understand the broader public policy changes which set the scene for the emergence of Māori health service provision and which provide the context in which this latest model has been introduced.

The emergence of Māori health service provision

From about the mid-1980s onwards New Zealand embarked on a process of significant societal change (Durie, 1998). In the state sector, an extensive series of government-led reforms re-shaped and re-ordered the structures, institutions and processes of the public service. These reforms, as in other Western democratic nations, resulted from the unique convergence of economic pressures and political opportunities and were influenced by rising public indebtedness, a preference for a smaller and more efficient public sector and a political and ideological swing towards "the right", with its concomitant market mechanisms of contracting-out, commercialisation and privatisation (Boston, Martin, Pallot, & Walsh, 1996). Their overall purpose was to improve the performance of the State sector, firstly by removing the functions that were no longer considered to be the business of the State, and secondly, by ensuring the agencies that were responsible for the remaining functions were structured in such a way that they were able to deliver services in the most efficient and effective means possible (State Services Commission, 1996).

Several policy instruments were employed to make requisite changes to the sector including the devolution of management responsibilities, a shift in focus from inputs to output and outcome measures, tighter performance specifications and contracting-out of services (Boston et al., 1996). Together, these instruments came to be known as the New Zealand model of public management (Boston et al., 1996).

The health sector was not unaffected by desires for greater accountability, greater efficiency and evidence that funding was making a difference to outcomes. A series of wide-ranging reforms and restructures, beginning with the Area Health Boards Act in 1983 and continuing through to the New Zealand Public Health and Disability Act 2000 (NZPHDA), completely altered the New Zealand health sector landscape. The idea that the two functions of health service provision and health service purchasing (or funding) should be separate was introduced; lines of accountability were clarified and strengthened; and a range of contracting mechanisms and new providers of health services emerged, as contracting became a central part of the management of the health system. Contracts for service became the mechanisms by which the Crown ensured the effective and safe delivery of health services (Ashton, Cumming, McLean, Mckinlay, & Fae, 2004) and remain an important feature of health service provision today; a point to which we will return.

At the same time as these changes were occurring, consideration was also being given to the effectiveness of a mono-cultural health system for Māori. At a governmental level philosophical debates were occurring about whether a policy of universality for all New Zealanders should be pursued, or whether some form of positive discrimination for Māori needed to be introduced. The political philosophy of biculturalism, whereby institutions, government departments and community organisations were required to consider how they might give effect to the principles of the Treaty of Waitangi

in their operations (Durie, 2001), was being widely promoted. Furthermore, questions were being asked as to whether the government's preferred policy of "mainstreaming" health service delivery, whereby "mainstream" government organisations and agencies deal with Māori as merely part of the larger population of New Zealand, was effective for Māori. Kiro notes that at a philosophical level, "mainstreaming" up until the early 1990s was underpinned by the view that Māori interests are best served by organisations that are responsible for Māori as citizens of New Zealand, rather than as a distinct ethnic group with a different worldview (Kiro, 2001). Mainstream services were expected to be "responsive to" Māori and reflect Māori perspectives both in their policy and in their practice (Cunningham & Durie, 1999). The way in which "responsiveness to Māori" became manifest in health and social service delivery produced token changes only, such as the introduction of cultural awareness programmes for health service staff and clinicians, the appointment of Māori to health boards and an expectation that non-Māori would become more "culturally aware" (Cunningham & Durie, 1999, p. 240).

The philosophies of biculturalism and mainstreaming service provision began to be challenged by the growing demands from within, and outside, Māori society, that Māori themselves should manage and deliver their own programmes and care for their own people (Royal Commission on Social Policy, 1988). Calls for greater autonomy by Māori in health care decision-making that affected them as a people came from many quarters, but particularly from mental health service providers throughout the 1990s. During this time mental health practitioners began to acknowledge the role culture had to play in the recovery of Māori mental health consumers. The empowerment of service users and their families was regarded as critical to the successful governance and delivery of mental health services and systems. Arguably, mainstreaming as a

practice, whereby the bulk of funding goes to mainstream providers who also have responsibilities for delivery to Māori, continues to this day. However, the philosophical premise that mainstream or "Western" systems of health care can best serve Māori interests and health needs is continually challenged by researchers, academics and policy-makers alike.

The recognition of greater control by Māori in the health services that were delivering care to them, in combination with a purchasing and funding framework that supported the development of contracted third-sector health service provision, led to the emergence of kaupapa Māori services. By the late 1990s purchasing decisions were made using an explicit set of funding principles: effectiveness, cost, equity, Māori health and acceptability. Whilst the equity principle focused on reducing the disparities in Māori and non-Māori health status, the Māori health funding principle ensured funding decisions would acknowledge the Treaty of Waitangi and encourage Māori participation in the provision and use of health services (Health Funding Authority, 1999a, 1999b).

So called "kaupapa Māori services", those which provide a treatment environment based on Māori cultural values, processes and beliefs, began to emerge in the mental health, primary health care, health promotion and education, and public health sectors. Kaupapa Māori services accommodate views and philosophies of holistic health and well-being that are not necessarily predicated on Western concepts of health, disease or illness (Durie & Allan, 1995). Kaupapa Māori health services, whether incorporated into public hospitals, or delivered in the community by non-governmental organisation (NGO) providers, are centred on Māori cultural practices and are usually delivered by Māori staff (Durie, 2001). Such services typically include some or all of the following characteristics:

- management by Māori staff, for the benefit of the Māori population, often

referred to as “by Māori, for Māori” service provision;

- the incorporation of tikanga Māori (Māori values);
- the involvement of whānau (family), hapū (sub-tribe) and iwi (tribe) in all aspects of the service, including treatment;
- the use of traditional Māori healing practices;
- the provision for cultural assessment cultural practices; and
- whakawhanaungatanga (connectedness between people, often based on genealogical connections). (Durie, 2001)

Since the early 1990s the number of kaupapa Māori health service providers, or “by Maori, for Māori” service providers has burgeoned from around 20, in 1993, to somewhere in the order of 250–300, today. However, the relatively recent development of kaupapa Māori services has not lessened the need for mainstream services, as some Māori feel more comfortable receiving treatment in a mainstream environment. The diverse nature of the contemporary Māori population similarly requires a diversity of service provision options, from rongoā, or traditional medicines and practices, through to mainstream or Western treatment options. Accordingly, today we recognise that mainstream services must not only understand the needs of their Māori service users, but they must also offer culturally appropriate and effective treatment environments. Often, this results in service users drawing from both kaupapa Māori and Western systems; for example, opting to take Western-developed and produced medications, but receiving their treatment through a kaupapa Māori service.

Whānau Ora as a health goal

Today, kaupapa Māori service provision, while a unique feature of New Zealand’s health and

social service landscape, is now regarded as commonplace. The practice of delivering services according to a Māori worldview and in accordance with Māori principles and values was occurring throughout the country by the late 1990s. However, it was not until a further series of health reforms was introduced, with the passing of the NZPHDA, that the overarching policy environment to support Māori health service provision was created, and the Māori concept of whānau ora was introduced into the lexicon of the health sector.

The NZPHDA signalled a number of important changes to the funding and provision of health services and a return to greater public participation in identifying, and making decisions about, the health needs of local communities (Goodhead et al., 2007; Pere, Boulton, Smiler, Walker, & Kingi, 2007). Key features of importance to Māori health service provision include the establishment of 21, subsequently now 20, majority-elected district health boards (DHBs), a requirement to ensure Māori are involved in decision-making on issues that affect them, and the use of high-profile, sector-wide strategies to communicate central government priorities (Boulton et al., 2004).

In the NZPHDA model, funding for health services is devolved to DHBs, which are responsible for the purchasing and provision of hospital care and funding community providers. DHBs are governed by boards, the members of which comprise a mix of locally elected representatives and ministerial appointments. In making appointments to a DHB, a Minister must endeavour to ensure that Māori membership of the board is proportional to the number of Māori in the DHB’s resident population, with a minimum of two Māori board members. The inclusion of a reference to the Treaty of Waitangi in the legislation, and the explicit requirements that Māori be represented on health boards and that DHBs were to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement,

have resulted in greater involvement by Māori in decision-making processes. It has also led to the establishment of a range of manawhenua groups: governance boards comprising representatives from the tribes within a DHB area who provide strategic advice to the DHB on issues relating to Māori health.

The NZPHDA model introduced the use of overarching strategies to establish national priorities and provide overall guidance for the health sector. Three strategies in particular set the scene for Māori health service funding, purchasing and provision: The New Zealand Health Strategy, The New Zealand Disability Strategy, and The Māori Health Strategy He Korowai Oranga. The Māori Health Strategy He Korowai Oranga instituted a new direction in Māori health policy, with a focus on “whānau ora”. From a health policy perspective, whānau ora has a very definite meaning; namely, “families supported to achieve their maximum health and well-being” (Ministry of Health, 2002a). The promulgation of the concept through the Māori Health Strategy He Korowai Oranga represents a shift from an individualistic approach to health and well-being to one which is more inclusive of a Māori worldview. As Chant has recently noted (2011), the creation of whānau ora as the overall goal for Māori health occurred in such a way that Māori health providers did not have to change their own unique models of service delivery, as it was sufficiently grounded within a Māori worldview to encompass a range of models for hauora or health.

Over the course of the last three decades then, in addition to promoting greater involvement by Māori in service delivery, a range of public policy mechanisms have been employed to encourage a focus on Māori health and improve whānau ora: at the policy level, through the provision of strategic leadership; at the governance level, by increasing the requirement for Māori to be involved in health care decision-making opportunities; through the development of specific funding streams and the provision of

additional funding for Māori through funding formulae to DHBs and to Primary Health Organisations (PHOs) (Ministry of Health, 2002b, 2003); and by including requirements to promote Māori health in accountability arrangements between the Crown and DHBs, and between DHBs and PHOs (Ministry of Health, 2007, n.d.).

These efforts all aim to raise the health status of Māori to, at the very least, a similar level as that experienced by non-Māori. However, at best, success in achieving this goal has been variable. For example, the age-sex-standardised all-cause mortality rate for Māori is twice that of non-Māori (434 per 100,000 and 213 per 100,000 respectively) (Robson & Purdie, 2007), and in terms of specific causes of mortality, Māori are over six times more likely to die from rheumatic heart disease, and two-and-a-half times more likely to die from cardiovascular disease, than non-Māori (Ministry of Health, 2010). Despite a narrowing of the life expectancy gap between Māori and non-Māori (Blakely et al., 2010), Māori life expectancy remains approximately 8 years shorter overall compared with non-Māori (Alcorn, 2011).

The most recent policy mechanism which has been introduced to improve health and social outcomes for Māori is the Whānau Ora Approach to Social Service Provision, introduced in 2010 (Taskforce on Whānau Centred Initiatives, 2010) and it is to this that we now turn.

The Whānau Ora model 2010: An intersectoral approach

The Whānau Ora approach to social service provision seeks to build on the gains made in the health sector and consolidate the Whānau Ora approach as an integrated model of health and social service delivery, across the range of human services. With the introduction of this approach, the use of the term whānau ora has evolved. Whereas once the term simply referred

to a long-term health goal, it now also refers to a philosophy (which focuses on the health of the whole whānau, not just the health of the individual), a distinct model of practice (embracing the health and social service sectors), and an outcome (Taskforce on Whānau Centred Initiatives, 2010).

At the heart of the Whānau Ora approach is a framework comprising seven principles that support the achievement of whānau ora in philosophical terms, and therefore underpin and drive whānau-centred service delivery. The principles are derived from both Māori cultural beliefs and values, and from public policy best practice. They include ngā kaupapa tuku iho (the presence of Māori values, beliefs, obligations and responsibilities, to guide whānau in their day-to-day lives); whānau opportunity (the chances in life that enable whānau to engage with their communities and foster whanaungatanga or connectedness); best whānau outcomes (increases in whānau capacities to undertake those functions that are necessary for healthy living and the well-being of whānau members); coherent service delivery (the unification of interventions so distinctions between service sectors do not overshadow whānau needs); whānau integrity (the acknowledgement of whānau accountability, innovation and dignity); effective resourcing (that resourcing should be adequate to the size of the task and tied to results); and competent and innovative provision (recognising the need for skilled practitioners able to contribute to whānau empowerment and positive outcomes) (Taskforce on Whānau Centred Initiatives, 2010). Notably, the principles recognise and acknowledge that both Māori and the Crown are responsible for the achievement of whānau ora, and that each has its own area of influence and accountability.

The overall philosophy and approach to service delivery, as outlined in the Taskforce document, is not new. As stated by the Taskforce, and evident from empirical research undertaken with Māori community-based services (Crengle,

1997; Boulton, 2005), Māori community-based service agencies have been aware of the collective needs of whānau for many years, but have been constrained in their ability to work with whānau as a whole, due to narrowly defined sectoral boundaries (Taskforce on Whānau Centred Initiatives, 2010).

Nevertheless, the complexity inherent in the Whānau Ora framework (that is, being at once a philosophy, a model of practice and an outcome) is expected to result in an equally complex set of whānau ora arrangements across New Zealand, as health and social service providers re-shuffle and re-structure their practice, processes and systems to better respond to, and meet, the aims of the framework, and in particular, the requirement to demonstrate the achievement of whānau ora outcomes. The expectation of outcome reporting represents a significant shift in the performance monitoring, reporting and accountability mindset; one made even more challenging by the recognition that whānau ora outcomes may be iwi (tribe) and hapū (sub-tribe) specific. The example provided by one case study illustrates the complexity, and possibilities for innovation, the new framework presents.

Implementing the Whānau Ora model in Whanganui

Te Oranganui Iwi Health Authority (TOIHA) is a Māori-governed and Māori-led PHO operating in the Whanganui DHB region of New Zealand. The Whanganui DHB serves a population of approximately 62,000 who reside either in the city of Whanganui (population of 39,990) or in the remaining rural hinterland. The city of Whanganui is characterised by a large percentage of Māori compared with the New Zealand average (23% compared with 14%), and has a mix of very highly deprived and more affluent areas. TOIHA has an enrolled population of some 7,400 clients, making it one of the largest Māori PHOs in the country. Established in 1993, as Māori health service provision in New Zealand was emerging, TOIHA now provides a

range of programmes reflecting a broad determinants approach to increasing Māori health and well-being; for example, home ownership services, employment brokerage for people with disabilities, family support, mental health and rongoā services, injury prevention programmes and primary health care, and community development programmes (Te Oranganui Iwi Health Authority, 2007).

As with many other Māori health and social service providers who provide services in accordance with cultural values and imperatives (Crengle, 1997; Boulton, 1999; Gifford, 1999; Chant, 2011; Kara et al., 2011), TOIHA's practice in the past has been to combine a number of different and separate contracts from funders such as DHBs and the Ministries of Health, Social Development, Justice and Housing to resource the work the organisation carries out with whānau. Because whānau and whānau well-being are the prime reason for the organisation's existence, resources are mobilised around the whānau. This often requires staff to work inter-sectorally and innovatively; however, working in this manner is not recognised by traditional contracts or traditional outputs-based reporting systems. Research with Māori mental health providers has demonstrated that services may interpret contracts in an innovative manner, and staff may undertake work that is additional to their contractual obligations, in order to deliver a culturally appropriate service (Boulton, 2005, 2007).

The need to work outside the scope of narrowly defined contracts is expected to lessen with the introduction of the Whānau Ora approach. To facilitate the new approach, TOIHA has recently reviewed its service delivery model and is in the process of re-configuring its many different service contracts into one integrated contract, which delivers whānau ora outcomes. As a consequence of the service review, which critically examined the practices of the organisation, a number of innovations have occurred. For example, a year-long process of developing relevant, meaningful, appropriate

and measurable whānau ora outcomes has been completed and a Whānau Ora Assessment Tool, for use by clinicians and Whānau Ora practitioners, has also been developed, piloted and trialled. The purpose of the Whānau Ora Assessment Tool is to measure or assess whānau well-being when the client enters the service; assist clinicians and Whānau Ora practitioners to set achievable well-being goals for the individual to attain; assist clinicians and Whānau Ora practitioners to develop appropriate care and management plans; and measure changes in health and well-being over time.

The newly created position of Whānau Ora practitioner is a further innovation for the organisation. The role of the Whānau Ora practitioner is to work alongside a clinician to individually assess individuals and whānau and ensure specific care plans are developed. Whānau Ora practitioners are assigned a small caseload of whānau who they will work with intensively to progress the care plan. Care plans include at least one visit every 3 weeks by the Whānau Ora practitioner and 6-weekly visits by a clinician (although visits may be increased if necessary). The main benefit of the introduction of the Whānau Ora practitioner position is that whānau have a direct contact within the organisation and Whānau Ora practitioners act as the lead carer and advocate for the individual or whānau. Whānau Ora practitioners ensure the service user has access to the relevant TOIHA resources and convene multi-disciplinary teams, where support from external agencies is required. The following diagram illustrates the role of the Whānau Ora practitioners in managing whānau need.

Finally, due to the challenges associated with recruiting and retaining culturally competent para-professional staff such as Community Health Workers (Boulton, Gifford, & Potaka Osborne, 2009) to ensure the organisation has sufficient Whānau Ora practitioners to meet demand, TOIHA have developed their own indigenous, iwi (tribally) validated training programme for Whānau Ora practitioners. Upon

completion of the training, graduates exit with the equivalent of an undergraduate diploma qualification, and are able to begin work using the Whānau Ora Assessment tool, with community members and whānau.

Opportunities and challenges

The introduction of the Whānau Ora approach has, in many ways, simply formalised the manner in which many Māori health providers, such as TOIHA, have been operating since their inception in the early 1990s. Earlier research (Boulton, 1999, 2005, 2007; Crengle, 1997) has noted that working across the somewhat artificial boundaries that construct and define “social”, “health”, “education” and other

human services has been a commonplace feature of Māori service provision. The requirement to work across these boundaries is regarded as a necessity for services which have emerged from a cultural understanding of the well-being of the whole whānau (family) and which are driven by a philosophy that seeks to work with the individual and their family in the attainment and maintenance of their full health and well-being potential.

Formal recognition of the practice of working across sector boundaries has resulted in a number of important innovations for TOIHA: organisational restructuring to better facilitate the use of multi-disciplinary teams and the introduction of the concept of single point of entry to clinicians and other para-professional staff; the development of a whānau ora assessment

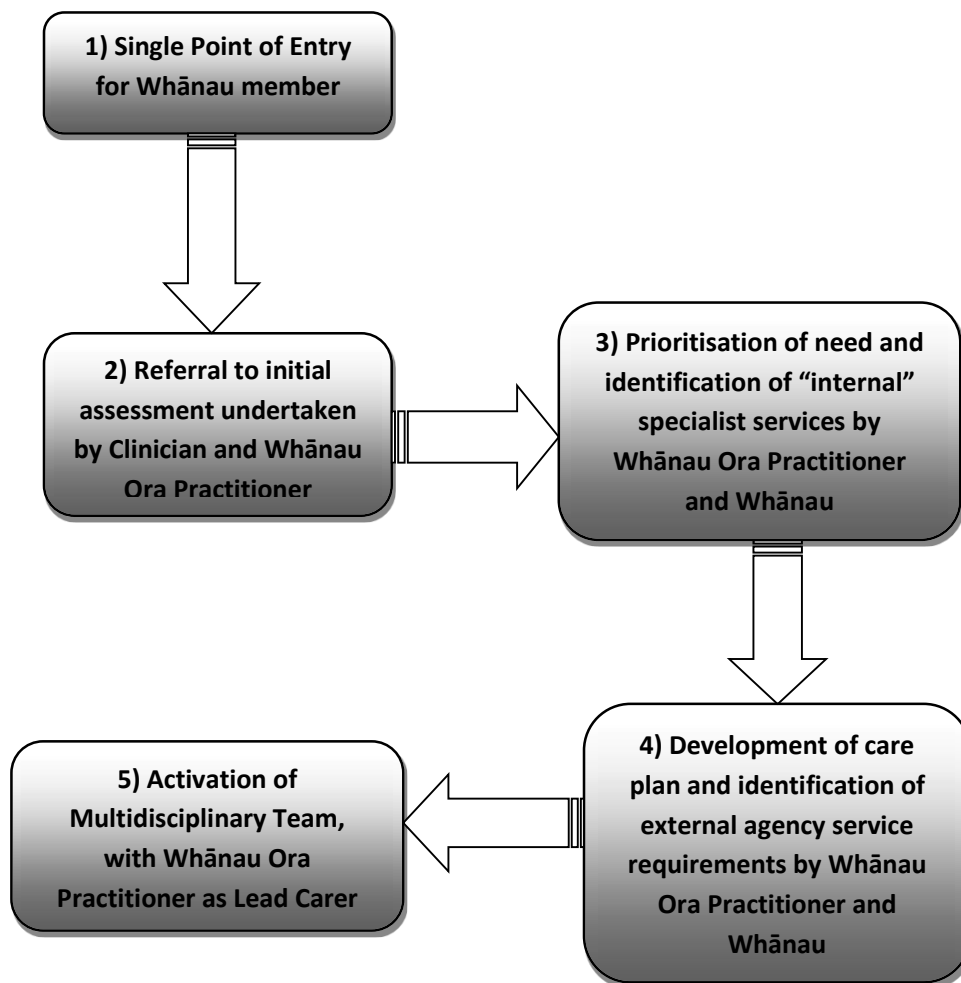


FIGURE 1 Te Oranganui Iwi Health Authority (TOIHA) Whānau Ora assessment and treatment pathway.

framework, a tool which practitioners can use to both assess an individual's whānau ora at the point of entry and monitor improvements over the course of time; a training and development programme for staff of the organisation in the use of the framework; and the development of whānau ora outcome measures.

These opportunities also present a series of challenges for the Māori health and social service sector. One of the most pressing challenges from a public policy, and indeed contracting and accountability, perspective, is the extent to which concepts of whānau ora may differ across organisations, across regions, between funders and providers, and even between providers and the whānau themselves. A particular challenge is the need for flexibility in the design, operation, contracting and evaluating of the services which, as required by the policy itself, are necessarily locality specific. Furthermore, it has been argued that Whānau Ora will really only be successful if local communities are engaged with the overall approach, develop and drive solutions, and determine their own outcome measures (Alcorn, 2011).

The importance of local community and Māori buy-in to the success of the approach cannot be ignored. Whānau ora as a concept may have as many different interpretations as there are Māori tribes and sub-tribes. At a central government policy level a generic definition of whānau ora may be sufficient to guide policy direction and funding accordingly; however, the monitoring of achievement of whānau ora outcomes requires a detailed examination by the funder and the provider alike of the elements that comprise whānau ora in that particular setting or context. In other words, the achievement of whānau ora for the tribes who govern TOIHA may be completely different for the tribes associated with an urban provider in a large metropolitan city. The alignment of expectations of whānau ora outcomes not only requires significant time commitment on the part of both the funder and the provider (as demonstrated in the case of TOIHA) but also

a performance monitoring and accountability system that is flexible, responsive and able to adapt to local variation.

Identifying the most appropriate contractual arrangements and performance measures at the outset is imperative to the success of an integrated contract, the achievement of meaningful outcomes and the ongoing viability of the provider. Earlier research with Māori health providers indicates that local or regional difference is rarely reflected in contracts, and that in circumstances where it is, these differences are not translated into performance measures that are meaningful to either the provider or the community they service (Boulton, 2005). Regionally defined performance measures that address local priorities and are dynamic and updated regularly (Epstein, 1995) are more useful to a provider than those which are established at the outset of a contract and never reviewed. The challenge is that both parties to the contract need to make the time to regularly review performance measures and the performance measurement framework must be sensitive enough to cope with the demands of ongoing review and change. The measurement of the impacts and activities would benefit from a reduction in a managerialist approach to one that is localised and more fine-tuned to community and whānau development. Such an approach represents a significant change to the measures, tools and frameworks that have been used to assess the performance of health and social services up until now. Yet it would appear that the optimal contractual environment for the achievement of whānau ora outcomes is one which ensures that flexibility and responsiveness to local needs are protected (Lavoie, Boulton, & Dwyer, 2010).

From a health funding perspective, responsibility of understanding the local context in which a health provider works lies with the Funding and Planning units within DHBs and by extension the DHB itself (Boulton, 2005). The NZPHDA outlines the relationship DHBs are to have with central government and with

the community, placing considerable emphasis on local input into decisions about health care, health needs and health services. DHBs have obligations to improve the health of people and communities, particularly Māori, while having regard to, and by taking cognisance of, the interests of the local people (NZPHDA, 2000). It is well within the spirit of the Act for DHBs to use contracts with providers to pick up on local variation, include more meaningful measures and reflect back to Māori an understanding of the context in which they work. To do so in a formal document, through an additional schedule to which both parties agree, would acknowledge the unique aspects of Māori service delivery which differentiate it from mainstream services, as well as the unique aspects of service delivery particular to that service, and which differentiate it from other Māori health providers in the community (Boulton, 2005).

Conclusion

The introduction of the whānau ora approach to social service delivery has the potential to radically transform the way health and social services are delivered to some of the most vulnerable whānau in New Zealand. However, to fully implement the approach in all communities is not without its challenges. In rising to the challenge, Māori providers are uniquely placed to take advantage of the opportunities afforded by changes stemming from the public management reforms of the late 1990s, the consolidation of these changes in the last decade, and more recently, the growing awareness of and respect for Māori worldviews and the contribution these make to health and social service provision (Brannelly et. al., in press). The changes we allude to include:

- recognition and acknowledgement in the public services of the need for greater coordination and collaboration, of joint

working across both organisational and sector boundaries; that is, intersectorally (Ryan, 2011). Collaboratively, providers can effect change for Māori whānau through partnership links that encourage and support efficient and effective referral systems and seamless and integrated patient care. Greater collaboration may be internal (for example, in TOIHA's case this might occur between teams within a service, or through referrals to other service arms), or intersectoral, as in the instances that TOIHA links in with other iwi and social service providers (for example, budgeting, housing and employment services);

- acknowledgement that Māori providers take a holistic view of health and well-being insofar as they gain understanding by appreciating the whole, as opposed to component parts (Durie, 2001). They recognise that health and well-being are as much affected by the collective as by the individual and that to work most effectively with people, the social context must be taken into account (Kara et. al., 2011). For TOIHA, and indeed for many other Māori health and social service providers, the Whānau Ora approach formalises this holistic view of health and social service delivery, removing the artificial demarcations between a health service, an education service and a social service, and instead redirecting the focus of effort to the well-being of the whole; that is, what is required to ensure the whānau is well; and
- greater acceptability of the view that providing health and social services in a culturally meaningful manner, one which acknowledges mātauranga Māori, tikanga Māori and Māori ways of being and doing, can lead to improvements in the health and well-being of Māori families.

In implementing the new Whānau Ora approach to social service delivery, as outlined in the Whānau Ora Taskforce Report of 2010, Māori health and social service providers will be subject to a critical and unrelenting gaze from a number of stakeholders: officials eager to see a return on the budgetary “investment”; policymakers impatient for improvements in “whānau ora outcomes”; and whānau and community who ultimately seek a better life for themselves and their children. The attainment of an overall improvement in health and well-being standards for whānau, evidenced by the measurement and portrayal of whānau ora outcomes that are meaningful at both the community level and at a central government level, will prove a major challenge for this unique and innovative policy. Arguably, it is beholden upon those same stakeholders who are disposed towards the success of this policy to help ensure that the investment that has been made in the future of whānau is maximised.

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