Published by Te Rau Ora, 2021

Journal of
INDIGENOUS WELLBEING
Te Mauri - Pimatisiwin

Collaborative decision-making for Māori health gain: A case study in Taranaki, Aotearoa, New Zealand

Volume 6 | Issue 3

Article 5, December 2021

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Abstract

This paper tells the story of a case study of Māori Health Service Provider involvement in interpreting and utilising childhood immunisation data within the Taranaki region of *Aotearoa,* New Zealand, between 2017 and 2019. This *Kaupapa Māori* (Māori approach) qualitative research was led by a community researcher with longstanding relationships with the health organisations in this region.

Data included key informant interviews with individuals from the Taranaki District Health Board (TDHB), which funds the regional immunisation programme, and leaders from the three Māori Health Service Providers in the region. Interview data were supplemented by insightful observations of relevant meetings and a review of key documents provided.

Early in the study, there was genuine engagement between TDHB and Māori Health Service Providers with regard to reviewing and interpreting Māori childhood immunisation data. A quarterly data review cycle, which had been put in place as part of a multi-provider single alliance contract for Māori health, provided a platform for this engagement. When the alliance contract ended, so did the collaborative immunisation data and services review between TDHB and the Māori Health Service Providers.

This paper reflects on some of the general challenges for Māori Health Service Providers in working with District Health Boards. A partnership between providers and the funder requires long-term commitment, which supports wider *whānau ora* (family wellbeing) and not simply conventional outcome indicators. It requires the Crown to trust *mātauranga Māori* (Māori knowledge), structures and processes, and to provide resources over a longer timeframe if meaningful outcomes are to be achieved. This case study demonstrates the fragility of initiatives designed to improve health equity for Māori.

Keywords: Kaupapa Māori, health data, decision making, equity, collaboration, Māori health, immunisation.

He Mihi – Acknowledgements: We wish to acknowledge the support of Te Kawau Mārō Alliance Leadership Team, who partnered with Whakauae (the researchers) in the study. We note the desire of the research participants to engage in the study as a mechanism to share knowledge and contribute towards improving health outcomes for *tamariki Māori* (Māori children). We acknowledge the Health Research Council of New Zealand for funding the research and the University of Auckland Human Participants Ethics Committee in approving the study (Protocol #020 455, December 2017). We are grateful for the support of the entire research team, who provided expert advice and analysis throughout the study. We thank the journal, peer reviewers for their critique and proposed improvements, many of which have been included in this paper. *Ngā mihi ki a koutou* (Acknowledgements and greetings to all).

Introduction

Reducing health inequalities for Māori (Indigenous people of Aotearoa, New Zealand) requires health services data to inform planning and delivery of services. As Treaty partners seeking equity, Māori must be involved as active decision-makers to address inequalities from a Māori worldview (Waitangi Tribunal, 2019). Better health outcomes contribute to the overall wellbeing of Māori, thus enabling their full participation in society (Durie, 2016).

The Taranaki District Health Board (TDHB) and local Māori Health Service Providers (Māori providers) formed an Alliance Leadership Team (ALT) to review and improve Māori health services and outcomes. This paper explores key findings from a case study of the Taranaki ALT with regards to *tamariki* (children) or childhood immunisation. Taranaki, a coastal region on the west coast of the North Island, has a landscape dominated by Mount Taranaki and a population of 122,000, with 17.1 percent identifying as Māori. Eight *iwi* (tribes) maintain *ahi kā* (longstanding and continuous occupation) within this naturally rich and diverse region. The case study was one of three in a wider *Kaupapa Māori* or by Māori for Māori study exploring the use of Māori-specific health utilisation or indicators data in health services planning in three DHB regions in *Aotearoa* New Zealand. The paper highlights the determination of key players to understand immunisation data for the purpose of improving health care access for *whānau* (families) and *tamariki Māori* (Māori children) and the challenges faced in trying to achieve this goal.

Background

In 2017, Whakauae Research for Māori Health and Development (Whakauae), an iwi or tribally led research organisation, partnered with Te Kawau Mārō ALT in Taranaki on this research project. The research explored how Māori and District Health Board (DHB) leaders and decision-makers explicitly make use of routinely reported health data for health service planning aimed at improving health outcomes for Māori. It was conducted under the umbrella of a wider project entitled Data, Decision-making and Development: Using Data to Improve Health Outcomes (D3). D3 aimed to understand how Māori-specific health utilisation or indicators data was used in health services planning for Māori in three DHB regions in Aotearoa, New Zealand. With a combined track record of over 33 years between them, the two lead researchers of the D3 study used a Kaupapa Māori approach (Pihama et al., 2002; Pihama 2010; Walker et al., 2006; Mahuika, 2008) in its design which manifested in the following ways:

- a research question of importance to Māori and emerging from concerns of Māori.
- an applied research approach whereby the research addressed a 'real-world' health services issue for Māori and results were used to inform health service development.
- a Māori-led research team, drawing on the advice of an Expert Advisory Group mostly made up of Māori.
- high numbers of Māori participants and the use of participatory methods enabling participants to contribute to the design and interpretation of findings within their case study site; and
- a clear strategy within the conduct of the research for Māori health research workforce development.

This paper reports on the three research phases carried out with *one* of the D3 DHB sites. It tells the story of how the various parties responsible for the planning and implementation of health programmes and services for Māori in Taranaki have worked toward collaborative decision-making. The key stakeholder organisations in the story are the three Taranaki Māori providers (Tui Ora Limited, Ngāti Ruanui Healthcare and Ngāruahine Iwi Health Services) and the Taranaki DHB.

There are marked differences in scale among these Māori providers. Together they have been responsible for the provision of Kaupapa Māori health service delivery across the Taranaki region; services designed and delivered by Māori for Māori. The two smaller Māori providers are located in the rural region of South Taranaki. Ngāruahine Iwi Health Services, based in the small town of Manaia, work across the Southern region with a wide range of other agencies to deliver services meeting a range of whānau needs[1]. Ngāti Ruanui Health Services, based in Hāwera township, also in the South, operates primary care services and a range of associated health services. Tui Ora, a much larger organisation, is located in New Plymouth city in Northern Taranaki, where the bulk of the Taranaki population is located and offers services to whānau across the entire Taranaki region. These services are broad-ranging and include primary health, public health, health promotion and community support. Tui Ora also offers a range of health and social services for children and young people, as well as mental health and addiction services. Each of the three Māori providers has a unique culture that aligns with its scope and vision for achieving *whānau ora* (family wellbeing; Boulton, 2019), which in turn reflect the needs of their communities and the scale of their organisations.

In 2011 the Ministry of Health's 'Better, Sooner, More Convenient Health Care in the Community' policy, with its primary health care service integration focus, required DHBs to have an Alliance Agreement in place with Primary Health Organisations (PHOs; Ministry of Health, 2011). The agreement aimed to stimulate alliance contracting, in which purchasers and providers would work collaboratively to achieve desired outcomes (Tenbensel et al., 2017). In July 2013, the TDHB established an alliance contract for Māori health with an ALT made up of leaders from the three Māori providers and TDHB. Tui Ora held the overarching alliance contract on behalf of all three Māori providers, and all were responsible for delivering services under the contract.

From 2015 until December 2018, the ALT, known as Te Kawau Mārō (TKM-ALT), operated with an independent chair. A five-year, high trust, single alliance contract agreement for the planning and delivery of health services to Māori and high needs communities within the TDHB region was implemented. This new contracting environment enabled new collaborations to occur across the health and social service provider sector. Key tools were developed, including an outcome framework, performance measures, shared services, and health strategies that aligned with their Māori worldview. Decision-making for Māori health service provision occurred within the TKM-ALT forum over the five-year period 2013-2018 (see Figure 1).

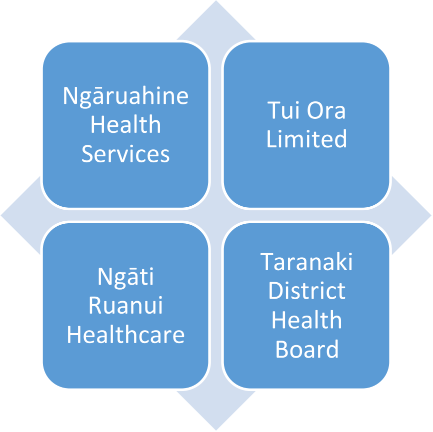

Figure 1 Te Kawau Mārō Alliance Leadership Team Composition

Whakauae (the researchers) partnered with the TKM-ALT in this research, inviting them to select a specific Māori health issue (case) for examination. Childhood immunisation rates (age

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[1] Public policy shifts since the 1980s have supported Māori providers to have greater control over health care decision-making providing opportunities for Māori providers to work creatively within their government contracts to meet the needs of their communities (Boulton et al., 2013 and Gifford et al., 2017).

0-4 years) were selected as the case. This case study explored the following:

- how childhood immunisation data was discussed within and between stakeholder groups.
- what service changes were made aimed at improving rates for tamariki Māori (Māori children); and
- what roles there were for Māori data-driven decision-making.

Contractual responsibilities for 0–6-year-old immunisation sat with the Primary Health Organisation, TDHB, Tui Ora and Ngāti Ruanui Healthcare. Ngāruahine Iwi Health Services role in immunisation was promotion and advocacy.

In 2015, TKM-ALT undertook a major review of Māori health service planning and implementation (ThinkPlace, 2016a, 2016b). A Service Level Alliance Team (SLAT) was established, bringing together a wide range of expertise, including clinicians, whānau, business managers and data analysts, to develop a new strengths-based service delivery approach that is better aligned with meeting the health needs of Māori families. The approach differed from previous service funding contracts that were mostly disease-based. It aimed to produce a positive change in Māori health service delivery and began with one particular area of focus: The broad service area *Māmā, Matua, Pēpē* and Tamariki (mothers, fathers, babies, and children; MMPT). All three Māori providers, along with TDHB clinicians and other experts, were involved in its creation. The pathway aimed to encourage increased coordination across services and reduce barriers, enabling staff to work more broadly.

The MMPT service area had evolved as an example of innovative practice driven by Māori providers through a co-design process that included Kaupapa Māori design and delivery, best practice and placing whānau or intergenerational family, at the centre of decision making. When this study began, there was a quarterly process of stakeholder review of data in place for all services relating to MMPT (see Figure 2). The quarterly review cycles aimed to assist the SLAT and the TKM-ALT to better understand data, including childhood immunisation (0-4 years) data. The goal was to encourage service providers to reflect on how and why service delivery rates may have changed over the previous quarter. This study focused specifically on understanding how the immunisation (0-4 years) data was understood and used to drive improvements in service delivery for Māori.

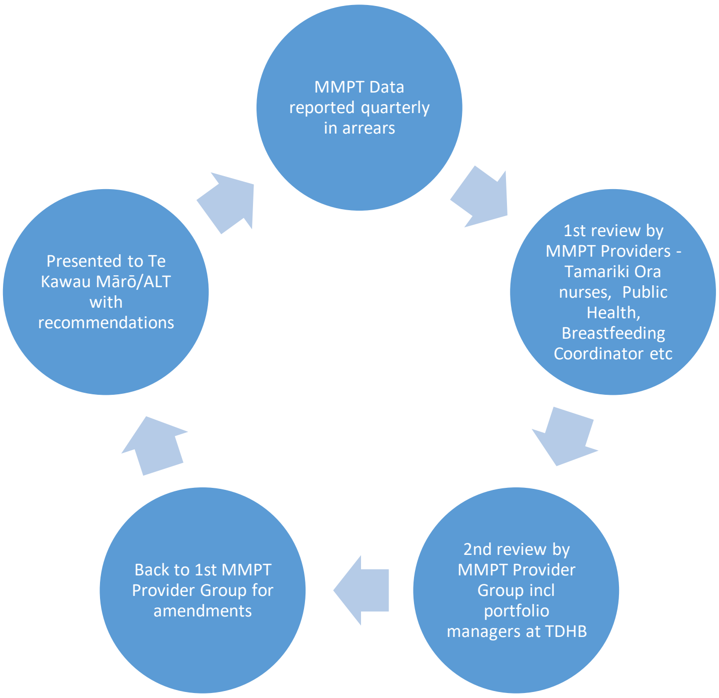

Figure 2 Quarterly Data Review Cycle for Māmā Matua Pēpē Tamariki (MMPT)

Methods

The D3 project was funded by the Health Research Council of New Zealand (17/060) and was a multi-phase research project, using qualitative Kaupapa Māori methods and a case study design, spanning three and half years (see Figure 3).

Case study data collection in Taranaki was carried out in four ways: Key informant interviews, observation of meetings, researcher field notes, and document review. Interview participants were chosen from senior positions within the funder organisation and the providers of immunisation services with the aim of examining where decision-making occurs. All participants had some involvement in the quarterly MMPT childhood immunisation data review hui (meetings).

Each of the three case study sites had a site lead researcher. The role of the D3 Taranaki site lead researcher was to plan, co-ordinate and undertake data collection for the site. As part of a wider research team, she also contributed to the data analysis and translation of data through the development of technical reports for the research team and is involved in the dissemination of findings. A total of 11 key informants were interviewed during the study, all of whom held senior management roles in their respective organisations. They came either from one of the three Māori providers noted above, from the TDHB, or from Pinnacle Midlands Health Network. Informants included four who identified as Māori and six as non-Māori. There were three participants who were interviewed at least twice during the study, at different points in time. Repeat interviews were undertaken to clarify or seek updates on data from earlier phases of the research. While the first five interviews were carried out by the lead researcher, supported by a senior member of the research team for mentoring purposes, the remaining six interviews were carried out by the lead researcher alone. Interviews were digitally audio-recorded with participant consent, transcribed in full and returned to participants for correction and validation before being used.

Along with interviews, the lead researcher also documented observations while attending six relevant meetings:

- two data review meetings with MMPT providers (16 months apart).
- two TKM-ALT meetings; and
- two quarterly TDHB Portfolio Managers meetings with immunisation and other child health professionals.

The lead researcher is a Māori community researcher with a longstanding relationship with the health organisations, and with Māori participants, in the Taranaki region. She also has *whakapapa* or family links to the region. The relationships of trust enabled access as an observer at the meetings. Observations were made on the following points of interest:

- interactions and discussions between participants;
- how data was presented, discussed, and engaged with; and
- what decisions arose as a result of engagement with the data.

Meeting participants came from each of the three Māori providers and included front line clinicians, child health managers, business analysts and two chief executives of two Māori providers. The first data review meeting (May 2018) had nine attendees – six Māori and three non-Māori. The second data review meeting (September 2019) had 13 attendees - eight Māori and five non-Māori.

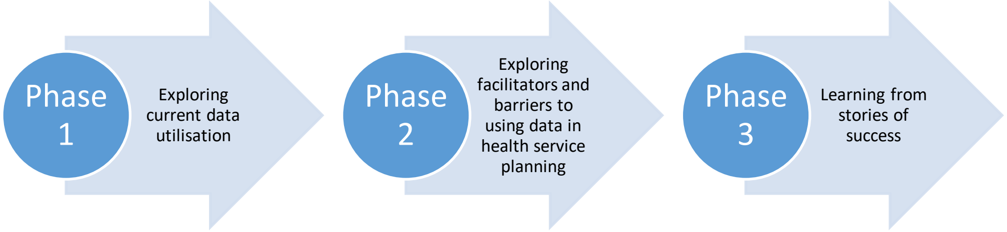

Figure 3 Phases of the D3 Research Project

To further understand the use of data and its influence on planning, the lead researcher also reviewed a broad range of documents, including:

- quarterly reports to the funder.
- meeting agendas and minutes.
- TKM-ALT strategic and work plans. the Taranaki Immunisation Advisory Group (TIAG) work plans (Taranaki Immunisation Advisory Group, 2018); and
- a HEAT[2] Equity Report on Childhood Immunisation (Taranaki Immunisation Advisory Group. 2018).).

Content analysis was initially undertaken by the lead researcher using interview transcripts and supporting data. For example, field notes were analysed with each of the transcripts and coded using the interview schedule questions. This approach allowed for comparisons of similarities and differences in data and to identify themes (Braun & Clarke, 2006). After the initial analysis of the data by the lead researcher, wider research team members further interrogated data using an abbreviated form of *mahi a roopū* (collective group work; Boulton & Kingi, 2011). Mahi a roopū is a team approach to data analysis whereby transcripts are first analysed by individual team members then collectively to compare and gain agreement on themes.

Findings

In this section, findings are presented under three key themes:

1. Moving from Competition to Trust: The Formation of TKM-ALT describes the changes in relationships and roles between TDHB as funder and the three Māori providers.
2. Observations of Collaboration between TDHB and Māori providers identifies some of the perceived merits of the ALT collaborative approach.
3. After the Alliance Contract considers the shift in relationships and trust with the change in contracting and describes how the Māori providers see their relationships with each other currently, with regard to childhood immunisation, and their views on new opportunities for using data to drive service improvement.

Moving From Competition to Trust: The Formation of TKM-ALT

During the study period, the Māori providers of TKM-ALT demonstrated respectful relationships with each other and an appreciation of the different attributes each brought to improving Māori wellbeing. Collaboration and leadership were exercised by all parties. The previous competitive environment, driven by individual contracting, had been replaced by working collaboratively to improve the lives of *Taranaki Māori* (Indigenous People of the Taranaki region), as noted by one participant:

> The partnership seems in a really solid place right now, we're strong together, we have built trust and resilience and we won't be fighting over contracts. We recognise the strengths that each organisation brings to the table. P02 Māori Provider

Another participant provided an example of the collaborative approach. He described the outcomes framework developed under the contract as being more consistent with whānau ora than during the previous Māori provider-specific outputs or disease-focused contracting:

> When Te Kawau Mārō began its outcomes framework, we decided to reposition ourselves and remodel ourselves to fit that framework and so we're very much a whānau ora type service. P01 Māori Provider

There was evidence that TDHB recognised the value of working together with Māori providers on improving Māori childhood immunisation rates, as the following excerpt illustrates:

> I think in terms of immunisation, our Māori providers are, you know, are a core function in the whole immunisation pathway, and they also have the OIS [Outreach Immunisation Service] as well as the GP services, so I think they are in a position to influence and change practice, yeah. P04 TDHB

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[2] HEAT is a planning tool intended to assist in improving the ability of mainstream health policies, programmes, and services to promote health equity (Signal et al., 2008).

Observations of Collaboration Between TDHB and Māori Providers

At the MMPT data review cycle reflective meetings, our researchers looked for the demonstration of key values in collaboration: effective leadership; clinician engagement with management and Māori providers; Māori explanations of the data; the application of an equity lens; and a whānau ora or family wellbeing perspective in decision-making.

The lead researcher's notes from one meeting (15 May 2018) included observations about the key values. Effective leadership was evident in the meeting, as the notes recorded:

> Leadership appeared to be critical for this forum as it encouraged discussion. The chair invited discussion on each of the key reporting areas. The hui [meeting] began by looking through the quarterly report topic by topic. They started with immunisation and reviewed statistics, graphs, reports and asked if there were any questions. Anomalies in the data were highlighted, and discussion took place.

The notes also highlighted that clinicians were engaged:

> Clinicians appear to have good understanding of data and are engaged. Some energetic 'on topic' discussions between members when Chair was clarifying issues with minute taker.
>
> It was notable how engaged representatives from the Māori providers were with the data. For example, when a service provider queried the accuracy of their own data at the meeting, the chair asked the relevant manager from Tui Ora to follow up and report back to the group. In another example, the representative from a Māori provider asked the following question of the group:
>
> Let's look at why the numbers in the South are declining. Is that what we expect or is there a good reason for it? Is it health promotion effort?

The chair responded by suggesting the group should take the matter to the TDHB to see what was happening in general population data from South Taranaki. Another meeting attendee suggested they also compare these numbers to the national figures.

In the discussions, an equity lens was evident. Some participants demonstrated an awareness of the power of comparing general population-level data against Māori provider data to identify inequities for Māori in both mainstream and Māori provider settings. The lead researcher noted:

> Discussions included big picture questioning and specific data-related questions and insights. At one point when looking at the immunisation statistics, a participant suggested they look at the entire population and identify how many of the tamariki that they engage with are fully immunised.
>
> At the meetings it was evident that the Māori provider partners of TKM-ALT contributed a broad understanding of hauora (Māori concepts of wellbeing) to the discussions. Māori provider informants explained that their awareness of the issues facing whānau was due to their own whānau connections and their experience in frontline service provision. A participant described the awareness that they brought to data discussion as follows:
>
> … part of my time is still on the ground, so it continues to give me good insight into what's happening on the ground …. if trends are visible, if concerns are there around, say, an outcome not being met for a certain area then, you can actively participate in the conversation to identify a new approach … learning from each other and using the collaboration to share ideas and brainstorm, always looking for positive change that is quality improvement. Really, it's just quality improvement in a non-traditional way. P01 Māori Provider

After the Alliance Contract

In mid-2018, as the existing alliance contract was coming to an end, a review of the contract was initiated by TDHB in consultation with the Māori providers. During our final data, collection phase negotiations were underway, while the contract rolled over for an extended period to allow for discussions. The outcome of the review led to a shift in the DHB-Māori providers' collaboration observed during the alliance contract. Māori providers returned to contracting directly with TDHB for their specific services. Despite the return to individual provider contracts, the relationships of trust that had been built among the Māori providers were maintained at governance and service levels. Also apparent from interviews, however, was a fragmentation of immunisation service planning and growing mistrust between the Māori providers and TDHB.

A reorganisation of TDHB's planning and funding portfolio managers responsibilities took place during 2019. The immunisation portfolio moved from the Public Health Unit, in the service delivery arm, to the Planning and Funding division. During this time, the TIAG workplan stalled. Work associated with addressing the inequities identified in the HEAT report was halted as the TIAG ceased meeting, a result of having no apparent leader to facilitate the work. The recommendations from the HEAT report included enhancing provider collaboration and developing alternative ways of operating to improve immunisation rates to address equity. There was confusion evident about the future of the collaborative effort, as highlighted by a TDHB informant:

> …we don't know where it's [collaborative immunisation effort] at because we don't have, it was usually the portfolio manager that would lead the TIAG group, so I'm waiting to see who is going to do that and, in my opinion, and in my experience, I believe it needs to be somebody at that level to be able to get everyone around the table. P41 TDHB

Fundamental differences in approach became increasingly evident; the perceived business model driven by efficiencies of the funder in comparison to the Māori providers' lens from their broader and holistic Māori worldview. By 2019 there was a shift in the discourse among TDHB informants about Māori providers. Some informants made statements that demonstrated a lack of understanding of the aspirations of the Māori provider partners in TKM-ALT, in stark contrast to the shared purpose apparent earlier in the study. One TDHB manager spoke of expectations from Māori providers*:*

> … when splitting the contract one of the things that we've been trying to achieve is, um, create greater transparency and accountability to system performance and when you're trying to do that across a collective, when you've got providers having very differing views and, you know, philosophy and a whole range of stuff there, that proved to be really difficult. P40 TDHB

When asked about TKM-ALT involvement in the Outreach Immunisation Service Review, a TDHB informant responded, *"I understand the TKM Alliance doesn't exist anymore"* (P39). The comment indicated a lack of current knowledge and wider understanding of the relationships and the history of the TKM-ALT. It appeared that, to TDHB, the relationships of trust developed in TKM-ALT were no longer important in the new contracting environment.

While TDHB staff felt that in order to achieve equity for Māori, they needed to work in partnership with Māori and value mātauranga Māori, for some TDHB portfolio managers, it appeared that the importance of the relationship with iwi and Māori health leaders was not highly regarded. In the example below, it seemed that the value of the relationship with Māori was based on the extent to which the partnership meets the needs of TDHB rather than an authentic partnership valuing the contribution of all parties. The benefit of the quarterly data review hui was questioned, with one TDHB informant asserting, *"it isn't meeting our needs."* (P40).

A lack of trust and confidence in Māori models, mātauranga Māori and Māori leadership was evident as another TDHB manager offered this critique of the TKM Alliance work, asserting that little progress had been achieved in terms of improved health outcomes for whānau in the short term. There was limited regard shown for the value of Māori provider perspectives on how to improve Māori health service design, delivery, and outcomes in the longer term:

> … we know, institutional racism is a very real factor. But the problem is if you've got a Māori health organisation saying, "give us the money cos we can improve it", well I'm not seeing any improvement…
>
> … they'll say, "well there's other determinants and factors". Well, how is that, but, you know, you want a Whānau Ora [family wellbeing] model or you want a Kaupapa Māori model and that's fine but is it actually improving rates? Or can it? P05 TDHB

The clash of worldviews and, in particular, the drivers for change had become evident. It appeared that TDHB efficiencies were now driving the agenda when previously we had observed a shared vision of whānau ora under the TDHB and TKM alliance:

> Of course, the District Health Board understand the historic kind of inequities that have led to particular Māori health challenges. Um, I believe in Planning and Funding we're very acutely aware of actually how the system needs to be more responsive. Um, I think there is a commitment to obviously reducing all disparities because when you look at this from an organisational perspective reducing disparities improves the org[anisational] efficiency because you're not needing to spend money on reactive services. P39 TDHB

After five years of working collaboratively with each other and with the TDHB under the TKM-ALT, the Māori provider partners described a significant shift occurring with the return to individual organisational contracts. They felt a higher level of scrutiny was being placed on them by TDHB, particularly with regard to achieving measurable improvements in Māori health outcomes. A TKM-ALT Māori provider participant identified the differing priorities of the TDHB, and the Māori providers involved in the ALT:

> … one of the fundamental issues is we've got different priorities, very much from a total population approach, the DHB's main concern is about being fit for purpose for an ageing population. And rightfully so. However, when we look at statistics purely for Māori, we don't have a worry about ageing population…Actually over two-thirds of our population are under the age of 30 so we've got this young people's cohort that's equally big as this non-Māori ageing cohort. P01 Māori Provider

During the final phase of data collection and interviews with research participants, it became clear that the collaborative DHB-Māori provider relationships developed during the first five years of TKM-ALT appeared to have deteriorated, with a reversion to the funder demanding evidence from the Māori providers of improved outcomes for Māori. Māori provider participants described their desire to implement solutions they knew served Māori communities well, looking to implement strengths-based models that aligned with whānau ora principles and move away from a deficit-based system that focused on disease. Māori providers wanted room to develop programmes that have flexibility for whānau. All three Māori providers have successfully incorporated the whānau ora pathway developed through the SLAT process into their delivery models, adapting their established services where necessary.

Despite the end of the shared contract for MMPT, the Māori providers demonstrated a continued commitment to working together in a collaborative way. One participant described the future role of the Māori providers of the TKM-ALT, as follows:

> Everything has been considered under the [contract] review, being the overarching mechanism, and we've had very clear conversations around the future of TKM and what that means for us individually plus collectively. And I think we all see it through a *te ao Māori* [Māori world view] lens but our DHB funder is still looking at it through a very business bureaucracy lens and struggles to separate. P01 Māori Provider

The same participant continued:

> …the DHB funder struggles to really see what the TKM space is, but I think the three provider organisations of Te Kawau Mārō are very clear… Just because the funding flows through an individually contracted mechanism doesn't alter our commitment and dedication to having a single unified strategy across Māori health for Taranaki. P01 Māori Provider

Since 2019, Māori providers in Taranaki have been actively exploring broader options beyond health funding to better meet the wellbeing and economic development needs of their people:

> … our recent conversations at the ALT level have even been about actually 'who' potentially should be at this table that's not now? … could be other sectors. But also, who are the other key players across Māori, as far as providers are concerned, around, who have a valuable contribution to Te Kawau Mārō and could enhance and support the kaupapa [principles] of Te Kawau Mārō. P01 Māori Provider

Discussion

The D3 Taranaki case study has captured some of the story of the TKM-ALT development in the TDHB region, through the MMPT work and specifically Māori childhood immunisation rates. In spite of the imposed Crown policy approach for the alliance to be formed, the establishment of a five-year single alliance contract for Māori health across the region was a significant achievement. This type of contract had been an aspiration for many Māori providers across Aotearoa, New Zealand, and Taranaki was the first region to achieve it. The TKM-ALT provided a platform for the TDHB, and Māori providers involved to establish high levels of trust across organisations.

With the alliance contract came new ways of collaborating across the health and social service provider sector to review service delivery, prompted by regular review of childhood health data. The shared data interpretation and service planning, a form of re-distribution of power, contributed to a higher trust environment for the period of the alliance. It afforded the partners the opportunity to develop key tools, including an outcome framework, performance measures, shared services, and health strategies, that aligned with the holistic world view of the Māori providers. Over the five-year period of the alliance contract, our findings suggest that there was a growing appreciation of the differences in approaches and capacity of each organisation. TKM-ALT appeared to have both the right people and effective leadership, which enabled each Māori provider to maintain its unique identity while developing stronger relationships with the others and with the TDHB.

The cohesion of the alliance and its partnerships were critical to its success. At the time of the five-year contract review, there were concurrent changes to TDHB staffing and leadership for childhood immunisation, with a shift from public health in the provider arm to the Planning and Funding arm of the TDHB. In restructuring both its personnel and contracting approach, the TDHB-led immunisation review process stalled. The strong leadership from within the public health unit that drove the initial immunisation equity review disappeared. The immunisation review process was replaced with a higher level of scrutiny of Māori providers by TDHB, focusing on contracting and compliance. The focus on evidence of outcomes and accountability over what is a very short timeframe (five years) is incompatible with the broader whānau ora approaches required to generate positive health improvement for Māori over the longer term. (Boulton, 2019; Dwyer et al., 2014).

After the TKM Alliance model changed, Māori providers looked to each other to continue the work of the TKM-ALT without TDHB at the table. While some informants at the TDHB understood the ALT no longer existed, in the minds of Māori provider study participants, TKM-ALT was alive and well by the end of Phase 3; activities and trusting collaborative relationships nurtured under the TKM-ALT continued informally. Māori providers working relationships had grown closer, despite them now contracting separately to TDHB. They were also actively seeking new funding from outside TDHB and working to establish new partnerships that aligned with their wider aspirations to empower whānau into the future. The providers had developed their own successful partnerships and remained committed to the long-term work of addressing Māori child health inequities.

Health inequities are not only avoidable but unfair and unjust. Equity recognises that people with different levels of advantage require different approaches and resources to get equitable health outcomes (Ministry of Health, 2019). If we are to address Māori health inequities using data as a lever for change then models for shared decision-making are critical to this approach. This case study demonstrates that collaborative data interpretation and service planning can occur between the Crown (through DHBs) and Māori (through Māori providers). The ALT mechanism, with its alliance contract, offered a systematic approach for developing a high degree of trust across funder and providers, at least for the length of the contract.

Partnership between providers and the funder requires long-term commitment, however, with individual and collective leadership for change. It requires the Crown to trust Māori knowledge, structures, and processes, and to provide resources over a longer timeframe, if meaningful outcomes are to be achieved. It requires the Crown to appreciate that conventional outcome indicators (such as *immunisations completed*) are too narrow a focus by which to measure the whānau ora work of Māori providers. This case demonstrates the fragility of Crown initiatives designed to improve health equity for Māori. Yet it also highlights the commitment of Māori, through Māori providers, to achieving longer-term goals, cemented through shared whakapapa and a shared vision for a better world for Māori.

Postscript

As a result of the ongoing relationships we have with each of the key parties in this Taranaki research study since developing this paper we have further evidence of positive collaboration occurring in Taranaki. Relationships between TDHB and the Māori provider network are currently robust and progressing positively. Genuine commitment is being witnessed as the parties collaborate on their annual planning processes and on contract deliverables. These important components of health service planning and delivery are now aligning with a broader national framework for whānau ora outcomes. These promising advancements indicate that despite challenges, it is possible to advance the goals of all parties if strong processes, leadership and mātauranga frameworks are in place to advance Māori health outcomes.

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