

MEMORANDUM TO CABINET SOCIAL POLICY AND HEALTH COMMITTEE

SECTOR DESIGN: MÄORI ISSUES

PROPOSAL

1. In this paper, we propose options for strengthening the Crown's partnership with Mäori at the District Health Board (DHB) and other levels in the funding and provision of services. These options build on gains already made and include:
 - i. establishment of partnership arrangements with Mäori throughout the sector
 - ii. regulatory and accountability arrangements for DHBs that ensure they achieve Mäori health gain and Mäori provider development

EXECUTIVE SUMMARY

2. This paper is one of a suite of papers on policy settings for the new health sector, including the Public Health Services Bill. It provides the Government with options for effective partnership arrangements with Mäori that will contribute to Mäori health gain and improve relationships with Mäori under the Treaty of Waitangi.
3. Partnership can take many forms in the context of DHBs. The Treaty of Waitangi is the basis for partnership between Mäori and the Crown. The working group will report back to Ministers by 31 March on issues around including the Treaty in legislation.
4. Mäori capacity building and participation throughout the sector are integral to an effective partnership. Considerable gains have been made in Mäori service delivery, and there are already a range of Treaty-based partnership arrangements with Mäori operating in the sector. The paper identifies some risks that the present momentum could be lost. It recommends three mechanisms to protect the gains already made:
 - *Mäori representation*: forums for Mäori voice throughout the sector
 - *regulatory design*: DHB operating rules that ensure fair opportunities for Mäori health and disability organisations
 - *accountability mechanisms* that create incentives for DHBs to achieve Mäori health gain and effective partnerships with Mäori.
5. Options are also proposed for building forward from the current position. The starting point for an effective partnership between Mäori and the Crown would be to build on existing partnership arrangements to extend Mäori participation throughout the sector, including a national Mäori forum, Treaty relationships at DHB Board level and Mäori capacity building organisations at DHB operational level. The paper proposes further work on options for transferring some functions or responsibilities to Mäori health and disability organisations.

BACKGROUND

6. On 31 January 2000 Cabinet directed the Ministry of Health to report to the Ad Hoc Ministerial Committee by 29 February 2000 on options for appropriate partnership arrangements with Mäori at the DHB level in the funding and provision of services (CAB (00) M 2/4 (gg)(vi) refers).
7. Other reports due on the same date cover the role of DHBs and the division of functions between DHBs and the Ministry of Health, preferred options for the organisational form of DHBs and its committees, and the communication strategy.
8. These options were developed by an inter-agency working group led by Te Kete Hauora in the Ministry of Health, and including Te Puni Kōkiri, the Mäori Health Operating Group

from the Health Funding Authority, the Ministry of Justice and CCMAU (in consultation with the State Services Commission and Treasury)

9. The working group consulted on 18 February with a focus group of about 40 representatives from the Māori health and disability sector (see Health Report 845, 23 February 2000). That hui considered the Treaty of Waitangi was the starting point for partnership, and that the Treaty should be reflected in health legislation. It expressed a strong preference for Māori control over health and disability services, as part of wider whānau, hapū, iwi and Māori development.

COMMENT

The nature of partnership and its relationship to the Treaty of Waitangi

10. Partnership can take many forms in the context of DHBs. Whatever the form, partnership implies that parties have an ongoing relationship. While the status of the parties may differ, there is a common understanding that they will share decision-making in some way, and, relate to each other in good faith, with reasonable co-operation, and mutual support.
11. The outcomes of an effective partnership would include:
 - improved access and service effectiveness for Māori (both Māori-provided and mainstream)
 - corresponding reductions in avoidable illness and decreased Māori health disparities
 - reduced marginalisation of Māori and greater trust and improved relationships between Māori and Government
 - greater sector cohesiveness.
12. Any discussion of partnership between Māori and a Crown entity has to start with the Treaty of Waitangi. The Government has accepted the Treaty of Waitangi as New Zealand's founding document and as the basis of constitutional government in this country. It has also acknowledged that a special constitutional relationship is ongoing between Māori and the Crown under the Treaty of Waitangi - the relationship between Māori and the Crown will not end when health disparities between Māori and other New Zealanders are addressed. The relationship between Māori and the Crown is based on the underlying premise of the Treaty itself, that Māori could continue to live in Aotearoa as *Māori*.
13. To date, the relationship between Māori and the Crown in the health and disability sector has formed around three key strategies:
 - participation at all levels (including policy, purchasing, service delivery and workforce)
 - partnership (including explicit Treaty relationship agreements between the funders and iwi)
 - protection (including strategies for Māori health gain).
14. These strategies are interlinked. Māori health gain is critical given that Māori on average have the poorest health status of any group in New Zealand. Māori providers understand and meet the needs of Māori consumers in ways not easily achievable by non-Māori providers. They are able to provide services that are appreciated and understood by Māori and reflect Māori beliefs, values and practices. Mainstream services will continue to hold most of the more specialised medical skills and facilities required by Māori. Both need to work together if the needs of Māori consumers are to be met and health disparities reduced.
15. Work is underway in the wider public sector to clarify the contemporary application of the Treaty of Waitangi in the government sector. This work will not be completed in time to

guide decisions on new health sector legislation, however, so the advice in this paper working group is based on existing approaches to the Treaty in Health.

16. A critical issue not addressed in this paper is whether or not the Treaty of Waitangi should be included in the proposed Public Health Services Bill. While there is clear support for this option in the Ad Hoc Ministerial Committee and Māori health leaders, there are a number of issues still to be worked through (including any legal risks). It is proposed that officials report back to Ministers on this issue by 31 March 2000.

Principles for an effective partnership

17. Building on existing strategies, the main criteria for assessing options for partnership between Māori and the DHBs are the extent to which they:
 - continue to build Māori capacity for participating in the health and disability sector, and allow Māori communities to provide for their own health needs
 - encourage effective relationships between DHBs and Māori (including good information, communication in good faith and opportunities for dialogue)
 - create incentives to improve Māori health outcomes and reduce health disparities between Māori and other New Zealanders (including mainstream responsiveness to Māori and intersectoral linkages to address wider determinants of health).
18. Other principles include:
 - *Building forward* from the base already established
 - *Flexibility*: recognition of diverse Māori realities, and allowing both different organisational forms in different areas according to the wishes of local Māori and their circumstances, and change over time
 - *Integration* with social and economic services: Māori health gain requires collaboration with other sectors to address wider determinants of health; Māori consumers and whānau benefit from services provided more holistically
 - *Clear accountabilities* for achieving Māori health objectives
 - *Cost effectiveness*: options should achieve the objectives cost-effectively.

SECURING THE GAINS: MĀORI PROVISION, PURCHASING AND DEVELOPMENT

The current environment

19. Māori are playing an increasing role in the planning, purchasing and provision of services. As well as Māori participation in policy development and purchasing there are now over 200 Māori health and disability organisations delivering a growing range of services in primary care, mental health, public health and, more recently, secondary care.
20. Many Māori organisations operate across traditional health sector boundaries to co-ordinate a range of social services and economic development initiatives for their populations, which provides a base for integrated service delivery and opportunities to address some of the wider determinants of health.
21. Māori co-purchasing organisations have been working with funders to improve the delivery of services to Māori. The HFA also has a number of 'Treaty relationship' agreements with iwi organisations that are intended to inform the HFA's decision making about Māori needs and preferences, and to inform Māori communities about health and disability issues (see Annex 1).
22. A recent development has been the emergence of Māori Development Organisations, with specific responsibilities for achieving specified Māori health gain priorities, co-ordinating service delivery, and working with Māori providers to build their capacity to deliver comprehensive high quality services to Māori, and with mainstream providers to increase their responsiveness to Māori.

23. Māori Development Organisations and other Māori health organisations are beginning to identify populations. The next step is for those organisations to negotiate service agreements to take responsibility for arranging a range of services to achieve health gain for those populations.
24. Service contracts with mainstream providers now include Treaty-related clauses requiring them to plan for and meet the needs of Māori consumers, and some have established kaupapa Māori services for more effective delivery to Māori consumers.
25. This increased participation is beginning to show dividends in improving access to services for Māori and more effective service delivery, not only by Māori providers themselves but also by mainstream services. Maintaining momentum through the transitional period and in the new structures is an imperative for Māori and the Government.

Maintaining the momentum

26. An important factor allowing the rapid expansion of both Māori provider development and mainstream responsiveness has been the ability of health funders to decide on the most appropriate providers regardless of their ownership. To a lesser degree, support for fledgling Māori providers during their emergent stages (where the Māori Provider Development Scheme played a significant role), and the existence of a coherent strategy and funding pool (currently \$50 million a year for services from Māori providers, \$10 million a year for Māori provider development), have also been important, as has the move to efficient pricing.
27. Māori provider development is still, however, in its early days, and the proportion of Māori in the health professional workforce is still well below equitable levels.
28. There are a number of potential risks for ongoing Māori provider development in the DHB structure that will need to be managed. These risks include:
 - i. internal incentives for the vertically integrated DHBs to provide services through their own facilities where Māori providers would be more effective (particularly where there is overlap between DHB and Māori community based services)
 - ii. possible incentives to under-fund community based services on the assumption the community can make up the shortfall
 - iii. loss of direction for Māori provider development if a diversity of approaches develops, as well as dilution of the leverage potential of the Māori services and development funding if it is distributed amongst the 22 DHBs
 - iv. higher transaction costs for regional Māori organisations, especially those spanning more than one DHB area (for example, Ngāi Tahu spans 6 DHBs, Ngāti Kahungunu 3 DHBs)
 - v. lack of skills in DHBs to manage either an increasingly sophisticated health system or proactive and effective relationships with Māori, especially in some smaller rural boards with high Māori populations and limited budgets, (similar to the problems experienced in the Education sector in the same areas)
 - vi. the loss of key Māori people and skills from the sector due to an extended period of uncertainty.
29. Any of these risks create a downstream risk of reduced access to and effectiveness of services for Māori, and widening health disparities.
30. There are three main mechanisms available to Government to manage these potential risks to Māori provider development as well as mainstream responsiveness:
 - i. Māori representation (“voice”)
 - ii. Regulatory design (the rules under which DHBs will operate)
 - iii. Accountability (the accountability framework for DHBs, including the New Zealand Health and Disability Strategies).

31. The leadership role that the Government and Ministry of Health play in the sector can also be used to manage uncertainty and concerns, for example through:
 - clearly signalling in communications with the sector the importance of Māori service and workforce development
 - encouraging and facilitating marginal boards with insufficient capacity to manage the risks in their areas to either amalgamate or form coalitions to maximise their capacity.
32. The mechanisms are interactive - where one is weak, others need to be correspondingly stronger. The strength of the current separate purchasing function has been increased opportunities for Māori service provision. With DHBs potentially influenced by their ownership of comprehensive facilities, the Māori voice and regulatory measures become more critical. Importantly, these mechanisms are also dynamic in nature - as the DHBs evolve, the balance between them will change.
33. The following options tease out single dimensions of these measures. It is important to note, though, that the health and disability sector has long moved passed uni-dimensional measures relying on a single mechanism such as consultation with Māori and any return to such arrangements would be a backward step. Stronger forms of partnership and participation are now embedded throughout the system. These developments need to be preserved and expanded.

Options for Māori Voice

34. Māori voice options span a continuum from relatively 'soft' forms such as consultation with Māori or Māori advisory committees, through to 'stronger' forms such as participation in decision-making. This section considers consultation and advisory mechanisms, and membership on DHB boards. Additional ways of structuring the partnership between Māori and the Crown are considered in paragraphs 46-65.

Consultation with Māori

35. A given is that DHBs will consult with the Māori consumers, whānau, hapū and iwi in their areas, just as they will with other populations for whom they are responsible, but this is unlikely to achieve the desired outcomes of partnership on its own.

Māori advisory mechanisms

36. There will be occasions when the DHB will want to formally seek the advice of Māori on specific issues, and they should be able to set up ad hoc Māori advisory committees, or other means of getting Māori advice, when required.
37. Standing Māori advisory committees are not, however, recommended. Experience shows such committees can be easily sidelined and rapidly become marginalised and irrelevant. Rather, Māori (both iwi and non-iwi) should be well represented on the two major DHB committees, the Primary Care Advisory Committee and the Hospitals Committee, to ensure their advice is integral to the work of those committees.

Māori representation on DHB boards

38. The Government has agreed there should be equitable representation of Māori or tangata whenua on DHBs and their committees. [CAB (00) M2/4]. The concept of equitable representation requires a number of issues to be worked through, such as what equitable representation means, processes for selecting Māori members (election and/or appointment), the roles of any Māori members including their relationship with the local Māori community compared to the Board as a whole, their relationship with any other DHB 'Treaty partners', and their training and support needs. These issues will be included in the 31 March report to Ministers.

Regulatory Options

39. The structural design of the DHB provides a potentially powerful tool to mitigate some of the risks to Māori provider development. Provisions could include:

- i. minimising incentives for DHBs to favour their own services over Māori providers where Māori provision would be more effective; this would be assisted by:
 - putting hospital assets at arms-length within DHBs
 - ensuring internal and external providers face similar terms and conditions such as finance and monitoring regimes
 - requiring DHBs to go through certain procedures before exiting from Māori services (similar to the Change Protocols that HHSs must go through now when exiting from services)
- ii. maximising the likelihood that incumbent Māori health and disability providers will be able to continue to develop and that new providers will be able to commence providing; this would be assisted by:
 - ensuring DHBs pay sustainable prices to both mainstream and Māori providers that reflect the long term cost of providing those services (i.e. eliminating hidden subsidies for publicly owned mainstream services that would disadvantage Māori-owned providers)
 - ensuring that service agreement length is of sufficient duration for providers to make adequate arrangements for service planning and asset structure
 - ensuring that service agreements allow clinical, financial and service risks to be shared between DHBs and Māori health organisations.

Ensuring Results: Accountability Options

40. DHBs will operate within an accountability framework consisting of the primary legislation and secondary regulatory instruments, including the NZ Health and Disability strategies, and any agreements established between DHBs and the Minister's expectations with regard to funding and performance. The accountability framework can be used to mitigate some of the risks to Māori provider development and mainstream responsiveness.
41. Provisions could include strengthening incentives on DHBs to encourage Māori service development and mainstream responsiveness, where appropriate, by:
 - giving DHBs explicit objectives relating to Māori health gain, meeting Māori preferences, and Māori capacity building
 - requiring DHBs to establish relationships with local iwi and Māori
 - requiring DHBs to report on their spending on Māori health, progress towards Māori health goals and targets and other agreed performance measures (the Government has already adopted a policy of increasing accountability for Māori spending (GAP (00) M 1/1&2 REV 1)
 - maximising the transparency of DHB decisions, especially needs assessment, strategic planning, prioritisation and provider selection processes, reporting and monitoring (e.g. through public meetings, consultation requirements, annual reports, published benchmarks or scorecards)
 - using the Minister's suggested powers to reduce DHB autonomy where necessary should DHBs fail to meet their responsibilities relating to Māori health (see Roles paper).
42. Another option could be to ring-fence some aspects of Māori spending. This is a matter to be considered in the 30 June 2000 report on funding for DHBs.
43. As with mainstream services, Māori service provision could also be protected by encouraging economies of scale and lower transaction costs for Māori by allowing some Māori development functions and service provision to be funded at a regional level (e.g. the emerging Māori Development Organisations), or national level (e.g. some Māori public health services, or the Māori Provider Development Scheme). Major advantages would be more co-ordinated service delivery to Māori consumers and facilitation of integrated service planning and delivery with other sectors.

44. There may also be a need for the Ministry of Health to manage some Māori contracts until the fledgling DHBs can demonstrate they have built the capacity to effectively manage their Māori responsibilities. Such 'evolutionary devolution' is in line with the recommendations in the accompanying paper on the role of DHBs.
45. Some aspects of these recommendations would be included in the legislation, while others would belong more appropriately in the New Zealand Health Strategy or the accountability documents that give effect to both. Decisions on where to locate provisions need to be worked through in the next phase of development.

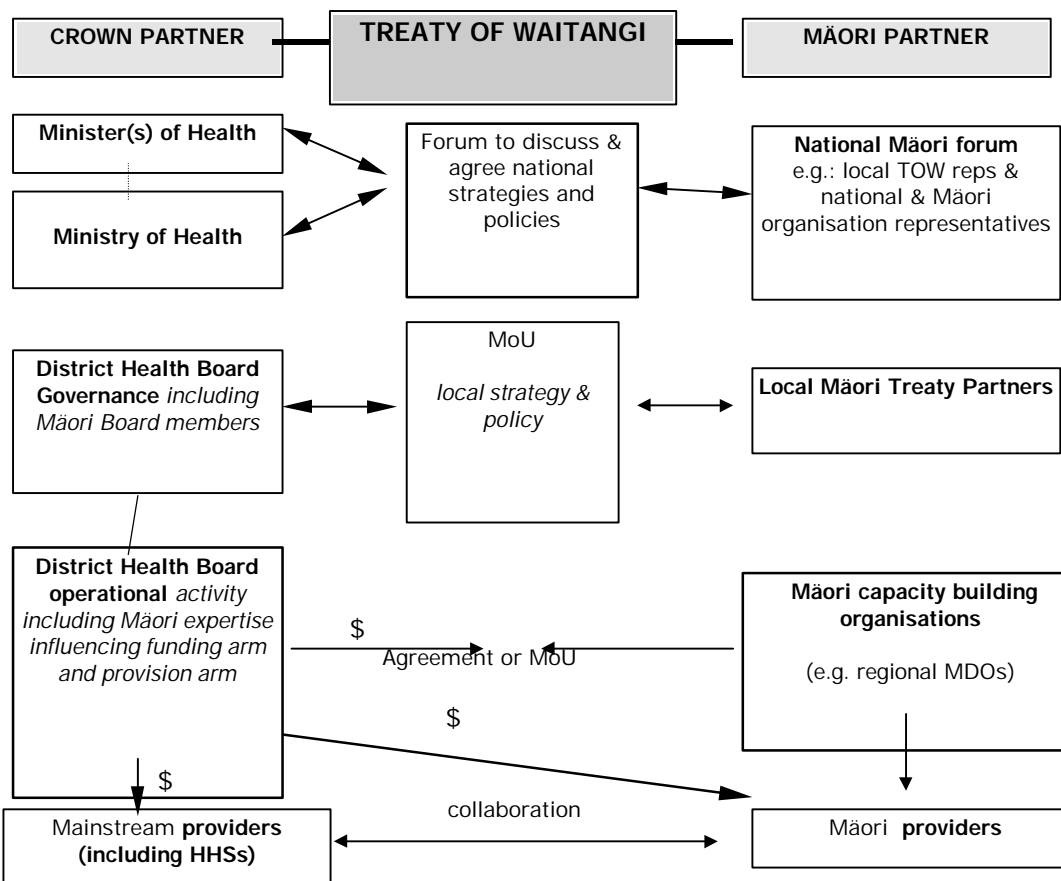
MOVING FORWARD: OPTIONS FOR EFFECTIVE PARTNERSHIP

46. Options for configuring other forms of Māori participation in decision-making over and above the Voice options in paragraphs 34-38 include:
 - (1) a sector-wide model of participation at all levels (a generic partnership model). A variation would see iwi or other appropriate Māori organisations mandated the right to be consulted on certain decisions or to nominate representatives
 - (2) a 'delegated' model, where some functions would be formally delegated to appropriate Māori organisations
 - (3) sub-purchasing models, which would allow Māori to control decisions over a narrower, specified range of services for a defined population.
47. The following sections describe each option in more detail, including assessing some of their advantages and disadvantages. None of the models are mutually exclusive (although running both the generic partnership and delegated models together could be complex and costly).

Option one: generic partnership model

48. A generic model for facilitating Māori participation at all levels of the health and disability sector is illustrated in Figure 1. Details are included in Annex 2.
49. Partnership relationships with Māori would be established at each level of the health sector from the centre to DHB operational levels. The DHB board would establish Treaty-based relationship agreements with local iwi to work together to establish strategic priorities for their Māori populations.
50. Māori capacity building organisations would work with the Boards' operational levels to arrange services to achieve the agreed strategic priorities. This would include working with Māori providers, mainstream providers, and other sectors to co-ordinate services and foster the delivery of high quality, effective services for Māori.
51. A national forum would provide opportunities for Māori to discuss issues of national strategic importance for Māori with Ministers and the Ministry of Health.
52. The arrangements would be flexible, taking different forms in different areas according to the characteristics and desires of local Māori and DHBs. They would also evolve over time, with the suggested Māori capacity building organisations perhaps taking on responsibilities for a Māori population.
53. The foundations for the arrangements are already in place, with a number of Treaty relationship agreements already operating between the HFA and iwi, and Māori Development Organisations carrying out Māori capacity building functions (see Annex 1).

Figure 1: Generic model of Māori participation at all levels of the sector



NB It is likely that one Māori partner may have relationships with several DHBs where boundaries are inconsistent

54. The advantages of this model include:

- an emphasis on partnership at all levels of the sector and strong relationships between the two partners
- flexibility and building forward - the model is equally applicable in a decentralised or centralised environment, and is easy to implement as it builds on existing structures
- a dual emphasis on both Māori capacity building and developing mainstream responsiveness
- potential to improve service integration and to develop intersectoral approaches to Māori health gain and service delivery (where Treaty partners and Māori capacity building organisations work across not only DHB boundaries but also sector boundaries)
- support from the Māori health sector.

55. Disadvantages would include:

- its very flexibility, which would require effective accountability mechanisms to ensure the sector evolved forward in a way that maximised Māori health and development objectives
- blurred accountabilities for achieving Māori health objectives
- a high requirement for skilled Māori input, which could stretch current capacity
- potentially high transaction costs
- possible difficulty in achieving consensus between different levels of Māori input.

56. A variation on option one would be to give statutory rights to local iwi or other appropriate Māori on specified matters, for example to be consulted on specific matters

such as strategic priorities, or to put up nominations for specific appointments (eg to DHB boards). Similar provisions exist in the Ngāi Tahu Claims Settlements Act 1998.

57. Mandating some functions would have symbolic value and help clarify some responsibilities. Disadvantages include potentially diluting the accountability of DHBs for Māori health outcomes and relationships. In addition, it would add little to incentives to achieve Māori health gain or build Māori capacity.

Option two: delegated model

58. This model would see some functions normally belonging to the DHBs delegated instead to regional or local Māori bodies. This delegation could either be specified in the Public Health Services Bill itself or through the accountability mechanisms. (Another possibility would be to use the Minister's proposed powers to intervene in DHB autonomy though these would normally be used only in extreme cases.) The Resource Management Act 1991 allows for powers or functions to be delegated or transferred to iwi organisations.
59. Similar provisions in Canada allow functions such as strategic planning, and workforce development to be 'transferred' in stages to First Nation and Inuit people who choose the option. The process is carefully staged over a number of years with support for capacity building. The Canadian model is a transfer only of administrative functions so it can be carried out without the need for a legislative mandate.
60. A related process operates in the United States, where Indian tribes can opt into a devolution arrangement known as "compacting", where they assume activities and responsibilities of the Indian Health Service. Compacting is carried out under the Indian Self-Determination and Self Governance Act. While the US model involves funding as well as administrative activities, which has been ruled out in the New Zealand context, there are other elements which could be effective in the New Zealand environment.
61. The advantages of a delegated model would include:
 - a strong Māori say in aspects of delivery and a strong Māori capacity building focus
 - clear accountabilities for specified functions
62. Disadvantages could include possible dilution of the DHB's overall accountability for Māori health gain.

Option three: sub-purchasing model

63. This model is not really an alternative option, since it is one that may continue to develop as more effective ways of delivering services for population health gain emerge. It is included here, however, so Ministers can see the range of ways Māori can participate in health and disability service delivery. Under this model, DHBs would give responsibility for a Māori population to a Māori organisation (eg the existing Māori Development Organisations). That organisation would either provide or arrange for a range of services for that population to improve their health status.
64. Advantages include:
 - greater Māori say over a subset of services
 - good incentives for Māori health gain at the population level
 - strong continuity with existing directions in the sector - it can happen regardless of other developments
 - clear accountabilities.
65. Disadvantages include:
 - the need for Māori to affiliate to organisations
 - financial and service risks (including risk rating)
 - higher transaction costs.

RELATIONSHIP TO PROPOSALS FOR ROLE OF DHBS

66. The accompanying paper on the *Role of DHBS and the Division of Functions between the DHBS and the Ministry* recommends a model which is compatible with an evolutionary approach to building a partnership with Māori at the DHB level. The proposal is to devolve to DHBS as much responsibility for making decisions about health and disability services as they can exercise efficiently and effectively operating within the parameters of the NZ Health strategy.
67. That paper leaves flexibility to develop the way that relationships with Māori are developed under that framework.

RELATIONSHIP TO PROPOSALS FOR GOVERNANCE

68. Aspects of governance issues have been covered in discussing partnership options, but this paper recommends a further report to Ministers on the specific issue of equitable representation on DHBS and their committees.

CONSULTATION

69. In preparing this paper the Ministry of Health consulted with Te Puni Kōkiri, the HFA, Treasury, the Ministry of Justice, the State Services Commission, CCMAU, DPMC, and a focus group of Māori health and disability sector representatives. Their views are incorporated in the paper.

FINANCIAL IMPLICATIONS

70. Full identification of the one-off costs and ongoing fiscal impacts of the proposed structural changes will be reported by 31 March 2000 (Cab 00 M2/4 refers).
71. The financial implications of the proposals in this paper have not yet been fully costed but relate to:
- the costs of expanding Māori partnership arrangements from the existing ones to include all DHB areas and a national forum under option one for generic partnership arrangements
 - the costs of delegating functions to Māori organisations under options two or three for partnership arrangements
 - any additional costs associated with electing or appointing Māori members to DHB boards or committees.

LEGISLATIVE IMPLICATIONS

72. Decisions made on the basis of this paper will contribute to a paper due on 31 March 2000 on legislative matters to be included in the Public Health Services Bill.

HUMAN RIGHTS ACT 1993

73. Initial legal review indicates the proposals are compatible with the Human Rights Act 1993, although this would need to be confirmed as options were developed.

REGULATORY IMPACT STATEMENT

74. Attached as Annex 3.

PUBLICITY

75. Communication on these matters will be included in the communication strategy on the overall sector changes.

CABINET:

TREATY OF WAITANGI ISSUES

- a noted that:
 - i at its meeting on 9 March 2000 the Ad Hoc Ministerial Committee supported inclusion of the Treaty of Waitangi in the Public Health Services Bill (which may be entitled the Public Health and Disability Services Bill);
 - ii the Health Sector Development Officials Group, in consultation with the Ministry of Justice, will provide advice to the Ad Hoc Ministerial Committee by 13 April 2000 on issues around including the Treaty of Waitangi in the Public Health Services Bill (which may be entitled the Public Health and Disability Services Bill);

ASSESSING PARTNERSHIP OPTIONS

- b agreed that partnership options be assessed against the extent to which they:
 - i continue to build Maori capacity for participating in the health and disability sector, and allow Maori communities to provide for their own health needs;
 - ii encourage effective relationships between District Health Boards (DHBs) and Maori (including good information and good communication);
 - iii create incentives to improve Maori health outcomes and reduce health disparities between Maori and other New Zealanders (including mainstream responsiveness to Maori);
 - iv build forward from the base already established;
 - v recognise diverse Maori realities, and allow both different organisational forms in different areas according to the wishes of mana whenua and their circumstances, and change over time;
 - vi encourage integration with other social and economic services. Maori health gain requires collaboration with other sectors to address wider determinants of health. Maori consumers and whanau benefit from services provided more holistically;
 - vii provide significant input and support to the ongoing development of a Maori health workforce within Maori health organisations;
 - viii establish clear accountabilities for achieving Maori health objectives;
 - ix are cost effective;

MITIGATING RISKS TO BUILDING MAORI CAPACITY

- c noted that the proposed DHB structure entails considerable possibilities for Maori capacity building, and will ensure a strong Maori voice in the health and disability sector, by the use of regulatory tools (the DHBs' operating rules and accountability framework) and the Government and Ministry of Health's leadership role in the sector;

MAORI REPRESENTATION

- d noted that DHBs will be required to consult with their Maori communities just as they will with other populations for whom they are responsible;
- e agreed that DHBs should be able to set up Maori advisory committees or similar arrangements where needed, and be monitored around the level of consultation they undertake;

- f noted that the Health Sector Development Officials Group will report to the Ad Hoc Ministerial Committee by 13 April 2000 on options for ensuring equitable representation on DHB Boards and effective representation on DHB primary care and hospital committees;

ACCOUNTABILITY REGIME

- g directed the Health Sector Development Officials Group to include in the report on the DHB accountability regime (due with the Ad Hoc Ministerial Committee by 13 April 2000) advice on how it will:
- i minimise incentives for DHBs to favour their own services over Maori providers where Maori provision would be more effective;
 - ii strengthen incentives on DHBs to encourage Maori service development where appropriate, including:
 - A giving DHBs explicit objectives relating to Maori health gain, meeting Maori preferences, and Maori capacity building;
 - B requiring DHBs to report on their spending on Maori health, progress towards Maori health goals and targets and other agreed performance measures;
 - C maximising the transparency of DHB decisions;
 - iii address risk management issues for small rural boards with high Maori populations;

FUNDING

- h directed the Health Sector Development Officials Group to advise on whether there should be a Maori health funding “ring-fence”, in its report on DHB funding that is due to the Ad Hoc Ministerial Committee by 30 June 2000;

REGIONAL / NATIONAL SERVICE MANAGEMENT

- i directed the Health Sector Development Officials Group to provide further advice to the Ad Hoc Ministerial Committee as part of its report on regional and national services, on whether some Maori health and disability services or development functions should be managed at a regional or national level, by 30 April 2000;

THE PROPOSED PARTNERSHIP MODEL

- j agreed that:
- i the starting point for an effective partnership between Maori and the Crown will be the generic partnership model described in the attached annex, which would see Maori participation throughout the sector;

- ii the Health Sector Development Officials Group undertake further work on this option and report to the Ad Hoc Ministerial Committee by 13 April 2000;
- iii the Health Sector Development Officials Group provide further advice by 13 April 2000 on the possible costs and benefits of transferring some DHB functions to Maori as proposed under the mandated or delegated options described in the paper under SPH (00) 34;

TREATY RELATIONSHIP AGREEMENTS

- k agreed that the Health Funding Authority's existing Treaty relationship agreements be continued in the new environment until replaced with more appropriate ones at the DHB level, and that where such agreements do not exist at present, DHBs develop a Treaty relationship agreement with mana whenua;

COMMUNICATIONS

- l agreed that the Government's ongoing commitment to Maori provider and workforce development is a key message to be conveyed in the communications strategy [SPH (00) M 6/6 refers].

ANNEX 1: EXISTING MĀORI RELATIONSHIPS AND HHS BOUNDARIES

TRANSITIONAL DHBS AFFECTED	EXISTING MĀORI TREATY PARTNER (to HFA governance)	EXISTING MĀORI "OPERATIONAL " ORGANISATION
1. Northland Health	Taitokerau MAPO (governance)	Taitokerau MAPO (operations)
2. Auckland Healthcare 3. Waitemata Health	Tihi Ora MAPO (governance)	Tihi Ora MAPO (operations)
4. South Auckland Health	Tainui MAPO (governance)	Tainui MAPO (operations)
5. Health Waikato	Tainui, Hauraki	Raukura Hauora and others - to be developed
6. Pacific Health 7. Lakeland Health	Te Whānau Poutirirangiora a Papa	Poutiri Trust
8. Tairāwhiti Health	Tairāwhiti iwi partnership	Ngāti Porou Hauora and Turanga Health
9. Taranaki Healthcare	Te Whare Punanga Korero	Tui Ora Ltd
10. Healthcare Hawkes Bay 11. Wairarapa Health	Ngāti Kahungunu Iwi Incorporated Rangitane	Te Roopu Huihuinga Hauora
12. Good Health Wanganui	Taumata Hauora (governance)	Taumata Hauora (operations)
13. MidCentral Health	Rangitane, Ngāti Raukawa	Bestcare Whakapai Hauora Te Runanga o Raukawa
14. Capital Coast Health 15. Hutt Valley Health	Te Punga o ngā Waka	Hauora a Iwi Trust
16. Nelson Marlborough Health	Ko te Poumanawa Oranga (governance)	Ko Te Poumanawa Oranga (operations)
17. Coast Healthcare 18. Healthlink South 19. Canterbury Health 20. Health South Canterbury 21. Healthcare Otago 22. Southern Health	Ngāi Tahu Development Corporation (governance)	Ngāi Tahu Development Corporation (operations)

ANNEX 2: GENERIC PARTICIPATION MODEL: DETAILS

National level

At the national level, there would be regular opportunities for the Ministers of Health and the Ministry to meet with national and regional Māori representatives to discuss national strategies, priorities and sector performance issues for Māori health. The Māori partners could be drawn from the regional and local Treaty partners as well as national organisations such as Te Ohu Rata (the Māori Medical Practitioners Association). It could be formalised into a forum, perhaps with the ability to report to and provide advice to Ministers or the Ministry. A formal organisation would give it status but would be expensive and run the risk of becoming irrelevant over time. The Ministry's informal Māori Provider Reference Group which meets two to three times a year on a structured but relatively informal basis for information sharing and discussion of policy issues is a current example of this type of forum.

Local governance level

Local Treaty partnerships would have the role of developing with DHBs' strategic priorities for improving Māori health in the DHB area, informing the DHB of local Māori expectations, aspirations and priorities, and other issues at the governance level. They would also have a role in disseminating information to the Māori community and monitoring DHBs on their performance on Māori health.

Local Treaty partnerships would normally be mana whenua (iwi) based (including organisations mandated by the local iwi). Partnering arrangements could be developed with significant non-iwi social service providers, but these could be most appropriately through the DHB advisory or technical committees or at the provider level. This approach may, however, be problematic and Ministers need further discussion on these issues.

A number of Māori Treaty partners would operate across DHB boundaries, so would be in a strong position to co-ordinate services across regions. Members of the Māori partner could be co-opted onto the Board's technical and advisory committees where appropriate.

The MAPO co-purchasing model currently operating in the northern region shares responsibility with the funder for strategic planning and purchasing services.

Another option is the regional model that Ngāi Tahu Development Corporation is developing, which will span its 6 DHB areas. The Corporation envisages having a pool of board members on more than one board, so sharing around expertise (some HHS boards currently have this arrangement). The Corporation is also extending its relationships to other sectors such as employment and education, so creating opportunities for an integrated approach to Māori development.

The HFA has already established Treaty relationships with around 10 iwi organisations (see Annex 1). To maintain momentum, these should be rolled over and built on in the new environment. The existing Treaty partners are eager to take on these responsibilities.

Local operational level

The DHBs would operate memoranda of understanding with Māori capacity building organisations who would work with the DHB operational arms (including its committees) to operationalise the DHBs strategies for Māori health gain and development. They would have an explicit role in fostering the development of high quality Māori providers and encouraging collaboration and co-ordination across services both within the health and disability sector, and with other sectors. This would facilitate more holistic service delivery to whānau, hapū, iwi and Māori.

As with Treaty relationships there are currently fewer Māori Development Organisations or similar with Māori capacity building functions than there will be DHBs, so it is likely many would have agreements with more than one DHB. While this will increase transaction costs for

the Māori capacity building organisations, again it would have the advantages of giving access to a range of skills that would not otherwise be available to small emerging Māori provider organisations, increasing co-ordination of Māori services across DHB boundaries and social service boundaries, creating economies of scale, and leveraging the number of skilled Māori in the sector.

At present, although some Māori Development Organisations are beginning to enrol Māori populations, they manage little service funding. Over time, the Māori capacity building organisations would be expected to assume a greater level of responsibility for a population of Māori.

ANNEX 3: REGULATORY IMPACT STATEMENT

Statement of the Public Policy Objective

1. The key policy objective of this paper is to provide options for effective partnership arrangements between Māori and the Crown in the health and disability sector (CAB (00) M 2/4 refers). Effective partnership arrangements with Māori (above and beyond partnerships with any other ethnic group in New Zealand) are inevitably grounded in the Treaty of Waitangi. They would contribute to achieving three goals:
 - Māori capacity building and participation throughout the sector
 - building forward on current gains made in Māori service delivery and policy development
 - Māori health gain and reductions in the health disparity gap between Māori and other New Zealanders.

Statement of the Problem and the Need for Action

2. The Government has signalled that key goals are to endeavour to uphold the principles of the Treaty of Waitangi and to close gaps between Māori other New Zealanders. To date there has been no clear direction from Government on the Treaty of Waitangi in relation to the health and disability sector. As a result there have been different interpretations of Treaty policies and Treaty partnerships. Despite gains made by Māori and some mainstream providers in the health and disability sector, the health disparity gap continues to widen.

Statement of Options for Achieving the Desired Objectives

Non-Regulatory Measures

3. A number of strategies are employed in the health and disability sector to achieve Māori health gain and more effective relationships with Māori, including involvement of Māori in service prioritisation and funding for Māori provider development. This paper proposes to strengthen and build on these through regulatory measures as well.

Regulatory Measures

4. Aspects of this policy will be picked up in the Public Health Services Bill, operating rules for DHBs, and accountability frameworks.

Statement of the Net Benefit of this Proposal

5. Benefits to Māori and the Government include:
 - progress towards meeting the Government's goal of upholding the principles of the Treaty of Waitangi
 - enhanced accountability to the Minister of Health on Māori health gain
 - Increased Māori participation throughout the sector at all levels of decision-making
 - further gains in Māori service delivery and policy development
 - progress towards meeting the Government's objective to support and strengthen the capacity of Māori and Pacific Island communities and better co-ordination of strategies across sectors, so that health disparities are reduced
 - reducing the health disparity gap will lead to long term social and financial benefits including lower hospital admission rates for preventable disease.

Costs

6. These include:

- compliance costs such as the establishment of partnership arrangements including election of Māori District Health Board members
- consultation is already a requirement in the sector so there will be no additional costs
- the HFA has a number of Treaty partnerships - the proposal extends these
- there will be increased transaction costs for DHBs and Māori providers through the development and implementation of strategic plans.

Consultation

7. In preparing this paper the Ministry of Health consulted with Te Puni Kōkiri, the HFA, Treasury, the Ministry of Justice, the State Services Commission, CCMAU, DPMC, and a focus group of Māori health and disability sector representatives.