The role of the Health Funding Authority in Maori health development

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"Kahore te kumara I korero I tona reka"
The kumara does not speak of its own sweetness

Introduction

On the 30th of November 2000 the Health Funding Authority (HFA) was effectively disestablished by the Labour/Alliance Coalition Government. This action brought to a close the role of the HFA as a reasonably independent funder which had made significant contributions to an unprecedented and remarkable era in Maori health and economic development.

That era encompassed, from 1993 to 2000, the rise (and fall) of four Regional Health Authorities and the advent and demise of the Transitional Health Authority, which ushered in the HFA in 1998. These were the most profound and unsettling changes that the New Zealand publicly funded health sector had experienced in decades. Central to these changes was the introduction of the "provider-purchaser split". This led, in turn, to a restructuring of public hospital governance and administration, firstly into Crown Health Enterprises (CHE's) and later into Hospital Health Services (HHS). The changes also saw the rise of provider organisations aimed at serving the interests of "non Crown" service providers, often through organised and collective bargaining practices.

This was the age of "market principles". An age when health economic theorists and analysts sought to bring robust and rational financial prioritisation processes to bear, upon what was perceived to be, in financial terms, a "runaway" publicly funded health sector.

Sometime in the future, researchers of Maori development success stories will uncover and reveal just how, in the midst of such turbulence and upheaval, Maori health sector developments were seemingly calmly, methodically and firmly established. For now it is enough to recount what was indisputably the greatest post colonial "near decade" of unique Maori development New Zealand has ever experienced and of which the HFA was part.

Maori development

Those developments were unique in one particular way They were Maori owned and Maori operated. As such, they reflected, in a variety of ways, the WHO truism that "health is not merely the absence of disease". For these developments were "healthy" in origin, even though their proponents, proprietors and personnel were often adversely affected by the disabling effect of enduring and inter-generational Maori underdevelopment.

Despite the disabilities of having to deal with prejudice, restricted opportunities, inexperience, and technical deficiencies, Maori self belief was strong. Deeply held convictions that they could 'do better' for Maori people, drove Maori health sector and community leaders into head on confrontations with the previously 'protected industry' which had delivered health services, prior to the provider-purchase split. Unrelenting in their fervour, this new breed of Rangatira Hauora forced the 'fledgling funders' to respond. While variable both in their competence and in their comprehension of the deep seated Maori desire to be liberated from post colonial paternalism, the funders relaxed their grip on health sector finances. What followed was an outpouring of Maori enthusiasm for the changes, despite the marginal nature of funding.

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In the early days and quite understandably, this enthusiasm was not always matched with the competence or experience necessary to maintain quality in management of service delivery.

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However, our people were quick to learn and despite the rare failures and several unsuccessful attempts to discredit it, the Maori health provider sector remains robust and scandal free This, in itself, is a notable achievement when comparisons are made with other New Zealand health sector experiences.

More importantly however, is that the health of thousands of ordinary Maori people have benefited from the introduction and provision of Maori owned health services In organised cultural terms, the benefits are real and most clearly evident upon the Marae. Less than a decade ago it was acceptable for people to 'smoke' within our whare hui. Not any more. The previous 'staple fare' of the 's.o.s. (or same old stew'), and fatty brisket have been replaced by the 'new Marae staples' of lean meats, salads and fruit and vegetables galore. These are culturally revolutionary changes and clear signs of the growing influence for good, of persistent and culturally pertinent Maori health messages. Fundamental to these changes was the Maori presence. Not merely as 'bit players', but as 'lead characters'

The environment of change

None of the changes occurred within a vacuum. The prevalent factor in the general environment of change, within the health sector can be referred to as the best interpretation of 'health economics'. That interpretation held that the improvement of services was the primary goal of greater cost efficiency. In simple terms, resources should only be applied where they gained the greatest good and savings made elsewhere should be reinvested in more good services. In Maori terms however, the prevalent factor was the Maori hope for Maori owned services and health developments. This hope had been expressed mai ra ano, but had been clearly and collectively enunciated at the Hui Taumata on Maori Economic Development at Parliament buildings in 1984. The *mantra* of that hui was "Let us (Maori) control the resources". The forceful expression of these sentiments remained unabated throughout the 80's and 90's and remains so today. This Maori enthusiasm for control of development resources provided many opportunities for public sector analysts and managers to initiate programmes originating in the collective wisdom and evident approval of 'the Maori voice'.

The 'gap' in primary and pre-primary care services for Maori was identified as a chronic absence of Maori providers. Therefore the focused first step was to fill that gap.

However, and except for a few short lived attempts at the haphazard funding of 'make work' programmes, the public sector failed to effectively engage Maori in any long term and well resourced strategic development programmes.

It is a fact therefore, that prior to the health reforms of the early 90's, no significant nor durable Maori development programmes, incorporating Maori control of resources, had been initiated within the public sector This fact raises a number of questions and provides some answers which remain pertinent, not only to Maori development but to those of our Pacific cousins as well For example

Question 1: Why did the 'reformed' publicly funded health sector fund Maori owned services ?

Answer: For two reasons. *Firstly*, the pressure from Maori was unrelenting and sustained and supported by the then available evidence. *Secondly*, because the existing services were clearly inadequate in filling Maori needs, there was a genuine desire to seek alternatives.

Question 2: What enabled the funders to respond positively ?

Answer: They hired smart Maori personnel who operated in an environment largely free of political and bureaucratic control.

Question 3: Why was it so successful ?

Answer: Because it was focused The 'gap' in primary and pre-primary care services for Maori was identified as a chronic absence of Maori providers. Therefore the focused first step was to fill that gap

Question 4: How were providers selected or developed ?

Answer: By analysis of Maori health needs and consultation with Maori communities. This led to advice to funders from Maori community leaders as to 'who' could be relied upon to provide well delivered and well managed services.

Question 5: How was the funding 'risk managed' ?

Answer: Originally it was largely accidental – by over prescribed performance measures and overly close attention to due diligence standards for providers.

Question 6: What were the key strategies ?

Answer: Greater Maori participation within the health sector and Maori provider development The key was primarily to gain Maori confidence by constantly testing the Maori commitment to 'self help' and then by supporting quality funding proposals which emphasised Maori community involvement. Another key element of the strategies was to gain Maori support for a variety of Treaty based health partnerships.

Question 7: What were the key development characteristics sought from nascent Maori providers ?

Answer: Professionally qualified personnel such as registered nurses or doctors in key positions, coupled with rigour in management. These professionals were to provide 'the technical backbone' of service standards whilst simultaneously supporting non qualified Maori health promoters and voluntary health workers.

Question 8: Why the emphasis on professionals ?

Answer: For a variety of important reasons.

Firstly, the health sector operates largely according to the standards of 'rational science' and health professionals rightly guard their reputations jealously. We wanted the non Maori sector to see the Maori providers as professional colleagues and allies Initially this was very difficult and often characterised by irrational behaviours accompanied by expressions of bigotry and prejudice. Fortunately the higher principles of co-operation prevailed.

Secondly, and contrary to popular mythology, a reasonable Maori nursing resource was available, although not employed in Maori organisations. We believed that providing opportunities to work with their own, would attract Maori nurses into primary, community nursing. We also believed that by giving the kanohi Maori, or Maori human face, to the service providers, greater Maori community participation in the health gain strategies would ensue.

The chief characteristic of this policy was that it focused upon the role of the HFA in regard to Maori health gain.

Thirdly, it is a reality of all successful human development that informed and capable leadership is essential. In this regard, the health sector is unique, insofar as its practises impact directly upon individuals and their whanau in ways which are often exceptionally intrusive and reliant upon high levels of skill for safe outcomes. More than any other sector, an effective health sector requires high levels of expertise.

Question 9: Isn't this emphasis on 'professionals' a contradictory aspect of Maori community development ?

Answer: It is a happy congruence which unites Maori health developments with general Maori development. After all, a reasonable and fundamental assumption of any human development is that we enjoy sufficiently good health status to enable us to actually engage in development. Therefore, the provision of professionally competent leadership in Maori health developments is both sensible and pertinent. Focused leadership is vital to all successful developmental programmes.

Question 10: What then, of the 'non professional' or voluntary Maori health workers?

Answer: Maori development values require us to recognise every person's contribution. However, the contribution of non professional and voluntary Maori health workers is uniquely valuable. Most often it is the means by which Maori individual and community needs are originally, clearly and effectively identified and responded to. Moreover, such workers, through their acceptability to Maori, are constantly engaging in the multiple developmental processes of gaining expertise and sharing that expertise, and their considerable experience, directly with people like themselves. This is a special set of relationships, without the sharing of which, the technical expertise and contributions of professionals will never be completely effective.

The HFA and "The Treaty"

Although not definitive, the preceding questions and answers hold some of the keys to the unique experience of building a robust Maori pre-primary and primary care health sector. Behind these questions and answers stood the HFA organisation, which provided a constructive and supportive environment from which the innovation and enthusiasm of its Maori managers and analysts was unleashed.

No perspective can attempt to explain what the HFA achieved without commenting upon the features, benefits and detriments of the HFA structural and organisational design and the development of operational policies aimed at gaining Maori support. One key policy was the HFA Maori Health Policy which incorporated Treaty of Waitangi principles.

In the full knowledge that the mere mention of the Treaty of Waitangi evoked the most extravagant of reactions from the uninformed general public, some politicians and the mono culturally slanted media, The HFA needed to deliver a Treaty policy.

This needed to be done in order to clarify the HFA position on the Treaty of Waitangi and its publicly stated Maori health objectives, and to satisfy the ethics of fidelity to justifiable Maori aspirations in terms of health developments. The HFA Board endorsed the policy which emphasised the need for partnerships at every level with Maori organisations. The principal purposes of these partnerships were the betterment of Maori health.

The chief characteristic of this policy was that it focused upon the role of the HFA in regard to Maori health gain. It stated clearly what the HFA held itself responsible for. What also distinguished it, at the time, was that the policy set out a Treaty position for a major Crown agency which did not seek to speak vicariously on behalf of Maori, but which stated what it saw as its duties toward Maori health needs; imposed upon itself, the responsibilities of 'specific performance' incurred by the policy and its operational objectives

When consulting with Maori over the Treaty policy we readily acknowledged the underlying contributing factors to Maori dis-ease within New Zealand society.

However, we made it clear that while Land, Forest, Fisheries or other Claims against the Crown remained open to Iwi, the HFA was not the instrument or conduit for such actions What the policy sought (and received) was strong support for partnerships with Maori organisations which would actively help to guide, promote, support, and share in the activities related to the betterment of Maori health.

The HFA Treaty Policy and its operational implementation practices, were designed to include Maori in the benefits of New Zealand citizenship, by sharing information, resources and 'know how' between the partners. For its part the HFA accepted full financial responsibility for the provision of both Maori organisational and HFA technical and human resources for the partnerships, without which the policy would have been merely 'a bird without feathers'.

The HFA organisation

Internally the HFA was designed to maximise its impact upon the funding of services and health development of benefit to Maori. Some of the ways it set out to do that are summarised below:

The HFA Treaty Policy and its operational implementation practices, were designed to include Maori in the benefits of New Zealand citizenship ...

- Maori health needs were a publicly stated organisational priority.
- The HFA Board gave strong governance leadership in support of Maori health policies.
- The Board approved the implementation of a health based Waitangi Treaty Policy.
- The Board enjoyed the membership of a well informed and deeply experienced Maori health sector administrator and advocate.
- A Maori Health Group, with its own General Manager, was established which had oversight powers extending throughout the whole organisation.
- The CEO insisted upon performance measures in the Funding Agreement with the Minister, which required the HFA to give evidence of how it responded to Maori health needs and developments.
- All Group Managers and their staff were to have their personal performance measured against the HFA Maori policy goals and objectives.
- All HFA contracts with providers were to incorporate the HFA Maori Health and Treaty policies and expectations.
- Maori workforce development, within the HFA, was to be a human resource management priority.

Additionally, the HFA required all Group strategic and business plans to explicitly demonstrate how they would achieve Maori health gain. In terms of the HFA Maori Health Group, a deep belief in Maori development was an underlying success factor of the Group. The following strategic vision of the Group was focused on the core business of funding in order to concentrate energy upon the resourcing of Maori health developments.

The National Maori Health Operating Group's vision is that all Maori will benefit from the equitable funding of health and disability support services (DSS) and that the HFA's human, technological and financial resources, will be organised to meet Maori health need and contribute to Maori health gain.

What this vision statement did, was serve public notice on the sector that the HFA would equitably employ all of its resources (and not merely those of the Maori Health Group), for the betterment of Maori health.

Significantly, the HFA Maori Strategic Plan was the first HFA Group plan to be published and implemented. Therefore, the plan was publicly available and a constant reference point for measuring progress.

Financial accountability included undertakings to identify, in the HFA Statement of Intent, the total funding allocated for the delivery of services of benefit to Maori. In short, the HFA was an organisation designed to be responsive to Maori health needs.

The HFA was a 'human organisation' and as such its performance was variable. Nonetheless, most Group General Managers were enthusiastic supporters of the organisational commitment to Maori health and large numbers of HFA personnel actively sought 'to make a good difference'. Despite its variability in performance, the HFA went further than any other public sector organisation had previously done in regard to Maori health, both in terms of organisational design and publicly accountable performance measures. What and who enabled that to happen provides an intriguing insight into what may work again

The Maori Health Group

The principal roles of the HFA Maori Group were the development of Maori providers, contract management and ongoing resourcing of eligible Maori owned provider organisations. Simultaneously the Maori Group Team assisted other Group teams to purchase Hospital and private sector medical and other services for Maori. The Maori

Health Team was strong on analytical skills and quick to recognise both Maori provider development opportunities and contradictions between stated HFA objectives and its funding practices. The Team had an allocation of 26 full-time employees, but some positions were unfilled

The watchword of the team was 'critical analysis'. Its 'bread and butter' intellectual activities consisted largely of the collection, discernment and analysis of data from which tactical design of services and strategic funding were developed. Prior to the 1999 general election, the team had completed an arduous and lengthy analysis of nation wide Hospital services (which cost approximately 3 billion dollars), and had identified a $600 million 'gap' in Maori utilisation of services. This gap resulted from the analysis of a variety of service elements down to, and including, the duration of stay, where the equivalent of Maori 'entitlements' within funding already allocated, were not being delivered to Maori. While the amount represents significant under-utilisation, the analysis did not reveal the reasons. Those reasons require specific research, as yet to be undertaken.

However, and like most operationally driven research and analyses activities, the work of the HFA Maori Health Group was always restricted by extremely tight deadlines. While this left many questions unanswered, such as the reasons for Maori under-utilisation of Hospital services, it contributed profoundly to the Team's focus on the funding of effective services. This ***focus*** was a major enabling factor of the Team's role and effectiveness.

Equally focused was the Maori perspective of staff. This perspective was sharpened in two ways. *Firstly* by the everyday life experiences of Maori personnel through the practises of whakawhanaungatanga, where relationships with kin exposed them, in very real human terms, to Maori illness and death. *Secondly*, their daily exposure to the rationality of morbidity and mortality data heightened their sense of urgent responsibility 'to make a difference' and ***enabled*** them to take a position on Maori health issues. That position was one of resolve. Resolve to attempt to ensure that the extant data, which was more than sufficient, drove the HFA prioritisation processes.

While not always successful, they were always constant advocates, but advocates who were informed both by the real life experiences derived from whanaungatanga and the inescapable facts of Maori morbidity and mortality.

Consequently, the Group's Maori personnel grew in reputation and personal convictions. Those convictions were often forcibly expressed and 'free expression' was encouraged as a vital ingredient of the Team spirit. Inevitably, this led to dialogical exchanges both within the HFA and Ministry of Health which were often 'robust and frank'. Sharp distinctions in perceptions of Maori reality emerged as Maori funders dialogued with a variety of Ministry personnel and policy analysts. In my opinion, these distinctions were heightened by the completely different roles between the HFA and MOH. Tension was often evident, but 'hey', no guitar plays well with loose strings !

Maori management

For their part, Maori personnel within the Maori Health Group were driven by a strategic plan, managed strongly by a collective leadership. Each of the five Senior Maori Managers in the Group were treated as, and required to conduct themselves as, Rangatira in their own right. They enjoyed fully delegated financial responsibility, often for millions of dollars, and had responsibility for staff welfare and performance Collectively the Senior Managers contributed to the Rangatiratanga of the Group and their individual genius and talent is responsible for the success of the Group.

Integrating and securing the funding of Maori providers into mainstream health funding activities is the legacy they leave.

Their development as top quality managers, able to participate at all levels of HFA business, both internally and externally, is another health sector Maori development success story. Integrating and securing the funding of Maori providers into mainstream health funding activities is the legacy they leave. Their contribution to the only public sector organisation which can identify reasonably accurately, how much is expended on Personal, Hospital, Mental, Public Health and Disability Support services to Maori, is a contribution without parallel in the public sector.

The Maori Health Scholarships too, were a funder's initiative which arose inevitably from accurate Maori analytical perspective's on workforce development needs. The introduction of three Maori Co-Purchasing Organisations, through the creation of the Northern based MAPO, was a unique first in New Zealand health sector history. The Maori Development Organisations (MDO's), spread through the central and lower North Island, were another funder initiative.

All of these new developments, while acknowledging their imperfections, still hold considerable promise for ongoing Maori health developments. Significantly, it was Maori management, fully empowered and fully resourced, which brought these developments into place. This is a Maori Management success story worth repeating. Also

worthy of recording are the Maori cultural value characteristics of management which applied throughout the development period. They can be summarised as follows:

- *Whakawhanaungatanga* – the dynamics of the ongoing building of sound and supportive team relationships.
- *Manaakitanga* – the offering of unconditional care and support to each other as team members.
- *Wairuatanga* – operating within the ethos of accepting the often inexplicable influences for good, which drives personal and professional commitment and beliefs in the health kaupapa.
- *Tohungatanga* – conducting oneself with Maori professional expertise.

Conclusion

Following the introduction of the reforms the following changes that were significant to Maori occurred –

- Maori health service enterprises grew from a mere handful to over 200 at the close of the HFA
- Revenues for services grew from a few hundred thousand dollars to over $300 million over the reform era.
- Thousands of new jobs within Maori owned businesses were created
- Maori women gained satisfying and well paid employment close to home and in workplace environments which were supportive.
- Hundreds of families benefited and thousands of ordinary Maori people, often for the first time in their lives, enjoyed the unique and pleasing experience of 'choice' in the selection of a provider.
- More and more Maori entered medicine or associated health professional training.
- Many Maori nurses sought and gained specialist post graduate training in disease state management skills
- Scholarship values rose from $200 thousand to $1 million
- The Maori Provider Development Scheme delivered over $30 million for investment in Maori health enterprises

All of this was achieved through careful and rigorous planning for Maori health development. Nothing haphazard was undertaken and the vision and commitment of the Maori funding Managers and personnel were features of the success.

These were the most significant and successful Maori owned and operated, health, social and economic developments ever experienced by Maori operating within any publicly funded sector As one pioneer of Maori services described to me, "*...These developments were like the very first taste of kina. You can experience the rush of that first taste only once..* "

HE WHAKATAUAKI

He iti pounamu.

A small but wondrous thing.