Whole population services: evaluating their impact on Māori

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Abstract

Since the 1990s, in New Zealand, the number of Māori providers in the social service sectors has risen exponentially in response to Māori communities' desire for by-Māori-for-Māori services. This is supported through legislation: for example, the New Zealand Public Health and Disability Act 2000 requires recognition and respect of the principles of the Treaty of Waitangi, the protection and strengthening of Māori provider and workforce development, improving whole population service responsiveness to Māori, and reductions in Māori health inequalities.

Nevertheless, despite the rise in Māori service provision and other measures, the reality is that the majority of Māori access social services through whole population services. Consequently, whole population services have an obligation to provide services that benefit Māori, and are required to undertake evaluation and monitoring to determine if this is occurring.

This paper is based on the experiences of The Quit Group, a national whole population smoking cessation provider. The Quit Group has an average of 21% Māori clients and its organisational objectives requires that it meets specific Māori needs.

The paper explores the practicalities of undertaking whole population evaluation and research that seeks to measure both Māori and whole population outcomes. This will include:

- considering the problem of success – challenges for a whole population service that is effective for Māori in an environment of a by-Māori-for-Māori preference;
- understanding Māori research paradigms and the impact of these on whole population evaluation and research; and
- establishing a relevant evaluation and research process for Māori.

Introduction

Māori is the general name for the tāngata whenua (indigenous people) of Aotearoa New Zealand. In 1840 the Treaty of Waitangi was agreed between tāngata whenua and the British Crown (Orange 1987). Previous and subsequent British colonisation, in disregard for that Treaty, enforced cultural hegemony[1] through congruent policies of assimilation and integration (Kawharu 1995).

Tāngata whenua loss of economic, social, personal, and spiritual autonomy has had effects that mirror the experiences of colonised peoples internationally. Today, Māori are disadvantaged in every social and economic indicator in Aotearoa New Zealand (TPK 2000). In spite of this, tāngata whenua continue to work to reclaim tino rangatiratanga (sovereignty) over all aspects of their lives.

Particularly since the increased social action by tāngata whenua to highlight colonisation's impact and the Crown's Treaty of Waitangi breaches in the 1970s, government policies have increasingly articulated bicultural goals and direct references to the Treaty of Waitangi.

The Aotearoa New Zealand health and disability sector

During the health reforms of the early 1990s the 1993 Health and Disability Services Act (superceded by the 2000 New Zealand Public Health and Disability Act) opened the health sector to, among other things, a competitive contracting environment, and a commitment to increased responsiveness to the health and well-being of Māori, both of which opened the doors to Māori health providers (Gauld 2001).

As a direct result of those reforms, Māori health providers are now widely available throughout New Zealand. There are currently 240 Māori health providers contracted to 21 District Health Boards throughout Aotearoa New Zealand. Their service is distinguishable by use of Māori kaupapa and delivery frameworks (MOH 2002b).

However, "the majority of Māori continue to receive most of their health care from [whole population][2] services" (MOH 2002a) by necessity (for example, radiology services) or by choice. The Ministry of Health seeks to address this reality in *He Korowai Oranga* (MOH 2002a) and *Whakatātaka* (MOH 2002c) through four inter-related strategies: development of whānau, hapū, iwi and Māori communities; Māori participation in the health and disability sector; effective health and disability services; and working across sectors.

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[1] Marxist theorist Antonio Gramsci used the term hegemony to denote the predominance of one social class over others. This represents not only political and economic control, but also the ability of the dominant class to project its own way of seeing the world so that those who are subordinated by it accept it as 'common sense' and 'natural'.

[2] "Whole population services" are also known as mainstream services. However, 'mainstream' is a pejorative term that enforces minority world hegemony. 'Whole population' will be used throughout this paper.

By Māori for Māori

Tāngata whenua have consistently suffered under the hegemony of a minority world[3] health and disability sector. To illustrate, in 1907 the Tohunga Suppression Act imposed penalties on tohunga (experts in Māori medicine and Māori spirituality) for practising. This bill was sponsored by Sir Maui Pomare, the first Māori Doctor of Medicine and a Minister of the Crown at the turn of the century. He reflected the complicated mixture of positive intent, colonisation of the mind and oppressive hegemony that sum up the history of Māori and the health and disability sector:

> It was with a heart full of fear and trembling that my mission was undertaken. Fear and trembling did I say? Yes, for the deeply rooted superstition of ages - the strongholds of tohungaism, the binding law of tapu, the habits and practices of centuries, the mistrust of the Pākehā - these were the Goliaths in the way of sanitary progress among the Māori (Pomare cited in Winder 2003).

The result of this and other legislation and health initiatives is illustrated in measures of health outcomes. Tāngata whenua are over-represented in every negative health indicator, and this is reflected in the broad scope of the Ministry of Health's Māori health priorities: immunisation; injury prevention; hearing; asthma; smoking; diabetes; mental health; oral health; disability support services; rangatahi health; sexual and reproductive health; and alcohol and drug use (MOH 2002a; 2002b).

The key response to these negative health realities has been the development of by-Māori-for-Māori service provision:

> Improved responsiveness requires health services to recognise the significance of culture to health and to adopt methods that actively engage patients – through appropriate language, respect for custom, the use of culturally validated assessment protocols and outcome measures, and the employment of indigenous health workers (Durie 2003b).

The philosophical positions of academics Professor Mason Durie, Dr Paparangi Reid and Dr Irihapeti Ramsden and the relatively successful outcomes for Māori accessing Māori health services underpin strategic documents such as *He Korowai Oranga*. It is worth noting that Durie and others are activists as well as advocates for Māori health services, and tend to focus on by-Māori-for-Māori, in the process not giving a full picture of how Māori health is to be improved.

A fuller picture is explained in the Ministry of Health's response to Māori service provision and whole population service provision in the health and disability sector, which has the dual strategies of increasing Māori service provision and improving the responsiveness of whole population service provision to Māori, as "it is likely that each is required if high quality services are to be provided across the country" (McPherson et al 2003).

Yet, while academic research and government reporting support the dual strategy, the strategic overview is not readily communicated in popular reporting and convention in

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[3] "Minority world" is a more literal description of the West or the First World which comprise the minority of the world's population. Both of the latter terms are hegemonic, as they put the minority world in the position of power, and hence have not been used in this paper.

Aotearoa New Zealand. The focus is on the necessity to increase Māori service provision, under the presumption that these services *alone* will benefit tāngata whenua, as illustrated below:

> …equitable health access was a fiction…. The health sector had not connected in a meaningful way with Maori (Ross 2003).
>
> …the key was to get into people's homes to address their total wellbeing, in the "kaupapa Maori way." "That's where mainstream providers are falling down" (Ngata cited in Ross 2003).

Again, the presumption is made that whole population services do not and will not work for tāngata whenua. Therefore, when whole population services *do* succeed, surprise and offence is the common reaction of popular reporting and convention. The findings are treated as a one-off, or as likely wrong, or even as a deliberate attack on Māori service provision.

Such views are understandable in a health and disability sector with a competitive contracting environment, uncertainty of short-term contracts and a funding environment in which "some of [the] increased funding… [for] Māori services from mainstream… budgets has elements of a pea-and-thimble trick, as it was offset by major reductions in dedicated funding" (Nowland-Foreman 1998). This environment creates instability for health and disability providers, consequently it is unsurprising that anything, at least at face-value, that justifies the status quo in these areas is treated with caution and criticism.

However, it is important to face some home truths. There is no denying the historical damage caused by whole population services and health legislation to tāngata whenua health. In response to its wrongs, the government has sought to increase Māori service provision and improve whole population services' responsiveness. The consequences of that strategy are that some whole population services are now appropriate for tāngata whenua and, indeed, improve Māori health.

Case Study: The Quit Group

The Quit Group provides two services: the Quitline; and Quit Cards. The Quitline is a free quit smoking telephone helpline with subsidised Nicotine Replacement Therapy (NRT). Quit Cards enables health providers to distribute exchange cards for subsidised NRT to people wanting to quit smoking.

These services are supported by advertising and public relations activities, in particular three media campaigns: *Every cigarette is doing you damage*; *It's about whānau*[4]; and a *Second-hand smoke campaign* (TQG 2004c).

In the 12 months from July 2002 to June 2003, the Quitline received a total of 99,969 calls to its free-phone number. Of these, 9,253 relapsed clients registered and 33,520 new callers wanting to quit smoking registered. So, in total during this period 42,773 callers registered with the Quitline. This averaged out to around 3,564 callers each month (TQG 2004b).

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[4] Family.

An average of 21 percent of callers ringing and registering on the Quitline identified themselves as Māori. This was a total of 7,103 Māori callers in that year (TQG 2004b). Since the national Quitline service began in 1999, 24.1 percent (32,716) of 135,465 Māori smokers nationally have called and registered to quit (Statistics NZ 1997).

Sixty-one percent of Māori callers in the 2002-03 year were female, and 39 percent male. The majority of calls were from the 20-39 year age group, in keeping with the target audience (25 to 44 years) of Quit media campaigns (TQG 2004b).

In February 2002, a telephone survey of 400 first time callers to the Quitline service was conducted by BRC Marketing & Social Research. This survey is one part of the overall evaluation of the Quitline Subsidised NRT Programme. Overall the Quitline was rated highly by respondents, with most agreeing or strongly agreeing with positive statements about the service. Māori and non-Māori respondents rated the Quitline highly. Māori strongly agreed or agreed that the service was convenient (91 percent), that they would recommend it to friends and whānau (96 percent) and that the information given was relevant (96 percent). Māori (32 percent) were more likely than non-Māori (20 percent) to strongly agree that the advice and support from the Quit Advisors, in particular, would help them stop smoking completely (TQG 2004a).

A cohort study of 2,000 callers (including 1,000 Māori) to the Quitline in 2002/03 was conducted by BRC Marketing & Social Research. This cohort study also formed part of the wider evaluation of the Quitline Subsidised NRT Programme (TQG 2004b).

The cohort study provided point prevalence quit rates for Māori callers to the Quitline. At six months, 27 percent of those Māori callers that received a full intervention[5] were quit.[6] At twelve months, 16 percent of those Māori callers that received a full intervention were quit. There were no significant differences in point prevalence quit rates (at both six and 12 months) between Māori and non-Māori who received a full intervention. Callers that used a total of eight weeks of NRT (a subset of those who received a full intervention) were more likely to be quit at 12 months (an overall quit rate of 25 percent) (TQG 2004b).

Furthermore, additional benefits of the Quitline for both those who quit or failed to quit were identified from the evaluation. Twenty-eight percent of people introduced smokefree environments in the home. Those who did not quit on average cut their number of cigarettes per day from 15 to 10, and fewer smoked a packet a day, from 29 percent to seven percent (BRC 2004).

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[5] A "full intervention" was defined as callers who had redeemed at least one Exchange Card for NRT (four weeks of product), had spoken to a Quit Advisor at least twice and had read some of the Quitline quitting resources.

[6] "Quit" is defined as "not smoked for two days with no occasional puffs." People lost to follow-up were assumed to be still smoking.

In summary, The Quit Group services are having a relatively positive impact on a Māori population that has a high smoking rate[7]. To be able to show that there are no significant differences between outcomes for Māori and non-Māori in a successful service is encouraging. Further to this, The Quit Group's aspiration is to attract a greater level of Māori callers so moving beyond proportionality to achieving a greater impact on Māori smoking rates. This has lead to a service change to ensure more callers receive a full intervention.

This whole population service is demonstrably successful for tāngata whenua. It forms, therefore, one valid part of the smoking cessation services available[8] to tāngata whenua. The key to communicating the whole population service's validity and legitimacy to tāngata whenua is providing relevant information.

Research with a Māori focus

In partnership with improving the responsiveness of whole population services came an attempt to improve the appropriateness of research methodologies. The primary response of whole population services and policy and funding agencies has been to undertake Māori-focused research. The Quit Group has an in-house research function that has been a part of Māori-focused research process development, and the organisation has undertaken activities to realise bicultural and Māori-specific concerns and goals identified in its strategic planning.

At all stages of the research process, consideration is given to issues for tāngata whenua. In the initial sampling and terms of reference development, oversampling and specific Māori research objectives are developed. For example, the aforementioned BRC Marketing & Social Research cohort study of 2,000 Quitline callers included 1,000 Māori callers, providing a large sample to ensure reliable results. The Quit Group employs a Māori senior researcher (in a research unit of four) who works on both Māori-specific issues and whole population issues. Both that researcher and other employees of The Quit Group are able to converse at varying levels in Māori language, and this has allowed the development of Māori language resources for use with Māori clients. Analysis of evidence collected in data collection is undertaken using Māori analytical frameworks, Te Wheke (Pere 1997), Te Whare Tapa Whā (Durie 1998) and Te Pae Māhutonga (Durie 1999).

Finally, and most importantly, research that particularly relates to Māori often involves, is considered by and subject to comment from Te Roopū Māori, a Māori oversight group that includes all staff who are tāngata whenua in The Quit Group. This group are not 'experts' in research as understood within minority world paradigms. The group operates within a Māori context by including the expertise of kaumātua (elders) and work on a consensus model that provides a useful internal check to research processes. It is the author's experience that research processes have been subject to change as a result of the involvement of Te Roopū Māori.

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[7] Māori comprise 15 percent of the total New Zealand population, and the Māori smoking rate is 22 percent of the total population and 41 percent of the total Māori population (Stats NZ 1997; 2002).

[8] There are three national smoking cessation services: the Quitline; Quit Cards; and Aukati Kai Paipa (a by Māori for Māori face-to-face service).

It is in the nature of undertaking the above processes, in seeking in effect to provide a voice for Māori within a whole population service, that some significant challenges for the future of whole population services' research arise. Firstly, all the research currently undertaken is instigated by The Quit Group. Whatever the intentions, this disempowers Māori, as research is done *to* tāngata whenua rather than *for* tāngata whenua. Furthermore, while community involvement has begun, particularly by the involvement of Te Roopū Māori and through regular community consultation, The Quit Group has no awareness of what use there is for its research in the community, and subsequently does not adjust to better suit communities.

In summary, The Quit Group research continues to be driven out of minority world paradigms. The Quit Group needs to consider making changes that are relevant for all research undertaken by whole population services. Research that will benefit tāngata whenua needs to undertaken through a Māori lens, that is, within Māori research paradigms. In effect, this would require whole population services undertaking Kaupapa Māori research.

Kaupapa Māori research

A Kaupapa Māori research paradigm has three essential themes: the validity and legitimacy of Māori are taken for granted; the survival and revival of Māori language and culture are imperative; and the struggle for autonomy over cultural well-being and lives is vital to the wider Māori sovereignty struggle (Smith 1997).

"Kaupapa Maori research is collectivistic and is oriented toward benefiting all the research participants" (Bishop 1998). It works from a presumption that when Māori language and culture "are viewed as valid and legitimate, then Maori are no longer positioned as the Other, but rather hold a position of being the norm in our own constructions" (Pihama et al. 2002).

Whereas minority world research ensures the researcher is the initiator, Kaupapa Māori research "is Maori initiated, defined and controlled," (Pihama et al. 2002) ensuring full community involvement and ownership. In this way it "challenges the political context of unequal power relations and associated structural impediments" (Pihama et al. 2002).

While minority world research aims to objectify the Other, Kaupapa Māori research seeks to identify with the Other. This is an implicit criticism of objective empiricism, "the belief that one can actually distance oneself, and then regulate that distance in order to come to know… [as that] has… left us alienated from each other, from nature and from ourselves" (Heshusius 1994). The converse is that "the concerns, interests, and agendas of the researcher become the concerns, interests, and agendas of the researched and vice versa" (Bishop 1998).

Kaupapa Māori research in action

Undertaking Kaupapa Māori research has four features. Firstly, it is undertaken in the Māori language. "Te Reo Maori is the only language that can access, conceptualize, and internalize in spiritual terms this body of knowledge" (Pihama et al. 2002). Whole population providers, unsurprisingly, undertake the majority of their activities in the English language, which firmly places their activities within a minority world lens. Language is the delivery system of any world view, therefore a change in language is foremost in a change in world view.

Secondly, the researcher must become powerless. S/he must accept the role of manuhiri (guest). In essence, the researcher is legitimising the sovereignty of the tāngata whenua. This is essential to a colonised people, as "the hosts can refuse what guests want. On their land, in their ancestor, with their people, they can insist on their sovereign rights. This much is to be expected of those who have been willing to abide by the protocols that got them to this time and space" (Harvey 2003).

As a consequence of being involved as manuhiri, the entire research process – terms of reference, design, data collection, data analysis, findings, recommendations – must be offered as a koha (offering of acknowledgement), which can be rejected or accepted by the tāngata whenua.

Thirdly, if the researcher is accepted by the tāngata whenua, if their research koha is accepted, then they have the role and obligations as a member of the whānau of the tāngata whenua. Those obligations "can be summed up in the words *aroha* (love in the broadest sense i.e., mutuality), *awhi* (helpfulness), *manaaki* (hospitality), *tiaki* (guidance)" (Bishop 1998). The researcher will need to identify with, not objectify, the tāngata whenua.

Fourthly, Kaupapa Māori research changes the actual process of research. In particular, the process must be consensual, whereby "The discourse spirals, in that the flow of talk may seem circuitous, opinions may vary and waver, but the seeking of a collaboratively constructed story is central" (Bishop 1998). The process becomes one that seeks consensus rather than the researcher's opinion and findings. This repositioning of the process repositions knowledge, such that it becomes matauranga Māori (Māori knowledge) – it is useful specifically to Māori in their context, and does not necessarily bear a relation to minority world knowledge.

Conclusion

> a [Kaupapa Maori] position is constantly under attack within Aotearoa/New Zealand from a wide front; neo-conservative voices who deny Maori culture any legitimacy and liberal notions of integrating what is the best of both worlds in order to create a rosy future for all New Zealanders to radical/emancipatory voices who claim that they have the formula for emancipation of Maori as oppressed and marginalized people (Bishop 1998).

Whole population services have traditionally been part of a destructive minority world hegemony in Aotearoa New Zealand in both research and practice. In acknowledgement of past wrongs, the Crown and its funded providers have sought to establish a growing commitment to partnership as agreed under the Treaty of Waitangi.

This has taken the form of two particular policies: increasing Māori service provision; and improved responsiveness of whole population services to Māori. The second strategy to improve responsiveness to Māori has met with resistance as a result of the competitive contracting environment and limited funding pool.

Nevertheless, there have been improvements in whole population service delivery to tāngata whenua. For example, The Quit Group provides a service that is as effective for Māori as it is for others. To communicate this success, the organisation undertakes research with a Māori focus, as part of efforts to validate its service to Māori. This progressive attempt has increased Māori involvement and ownership, but has also led to recognising the need to further validate tāngata whenua by moving beyond these research paradigms to Kaupapa Māori research.

Kaupapa Māori research has four features: it is undertaken in Māori language; the researcher must accept the role of manuhiri; the researcher has the role and obligations as a member of the whānau of the tāngata whenua; and the actual process of research will be changed to seek consensus. The intent is to empower Māori, and consequently ensure best practice from whole population services for tāngata whenua.

The key question for whole population services that are seeking to address the needs of disadvantaged populations is "who has the authority and legitimacy to engage in constructions and definitions of what is "normal" and what is "reality"" (Bishop 1998)? If there is a sincere desire to change marginalisation, it seems clear that there must be a sincere desire to devolve power to marginalised communities.

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