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Indigenous participation in the 'new' New Zealand health structure

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Objectives: This paper presents preliminary evaluative findings from research on key areas of concern to Māori and forms part of a wider project on the 2001 health system reforms in New Zealand. The paper reports on the development and implementation of the Māori Health Strategy, representation in decision making at governance level in District Health Boards, the inclusion of the Treaty of Waitangi in legislation and workforce issues.

Methods: Key informant interviews with 35 Māori and non-Māori respondents, in addition to data from five case study districts, were thematically analysed to gain an understanding of views on the health system reforms to date.

Results: The development of a Māori Health Strategy and the mandatory inclusion of Māori in governance and consultation processes have had a positive effect on Māori participation in the public health sector. Whereas previously Māori participation was concentrated in health service provision, the inclusion of specific provisions in the New Zealand Public Health and Disability Act 2000 has resulted in greater Māori inclusion in governance, planning and decision-making roles. However, there are concerns over strategy implementation, sustainability and workforce development.

Conclusions: Overall, the findings at this stage indicate that there is support for the post-2000 model. Māori and non-Māori alike have identified positive features of the model that could go some way towards contributing to improved Māori health. However challenges still remain.

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Introduction

The New Zealand health care sector is dominated by government provision. Over the past two decades the sector has shifted from a centrally run state bureaucracy to a series of devolved health authorities: initially 14 Area Health Boards (AHBs), then four Regional Health Authorities (RHAs), followed by a national Health Funding Authority (HFA) and currently 21 District Health Boards. In late 1999 a change of government in New Zealand saw a Labour-led coalition come to power which promised significant changes to the organisation of health care purchasing and provision: the fourth major restructuring of the health sector in New Zealand in 15 years. The resulting changes in the form of the New Zealand Public Health and Disability Act 2000 (NZPHD Act), were implemented from January 2001.

This paper presents some of the interim findings from the Health Reforms 2001 Research Project; a study that both monitors the progress of, and evaluates the impact of, the health reforms enacted by the NZPHD Act, as they were implemented. The material presented in this paper is based upon interim findings from the Treaty of Waitangi and Māori Health themes of the Health Reforms 2001 Research Project.

Background

The Treaty of Waitangi and Māori Health

Māori are the indigenous people of New Zealand. In 1840 Māori and the Crown signed the Treaty of Waitangi, acknowledged as the founding document of New Zealand. Differences in the Māori and the English versions of the text have resulted in discrepancies between Māori and non-Māori interpretations of the intent of the document to this day. According to the English version, Māori exchanged the right to govern themselves for Crown protection,¹ whereas tribal chiefs of the day may have understood that they were being offered an 'arrangement akin to a protectorate'² or administrative authority. In spite of these differing interpretations, both Māori and non-Māori generally accept the three principles of the Treaty: partnership;

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participation; and protection.³ These principles have guided much of the Crown's public policy in relation to Māori and underpin the most recent Māori health policy.

Māori, along with many indigenous peoples around the world, have experienced unacceptably large differences in health compared with the non-indigenous populations in developed nations.⁴ Māori experience higher death rates and lower life expectancy than any other ethnic group, including Pacific Islanders, in New Zealand.^{5,6} Ajwani et al note that in the last two decades there has been little (if any) decline in Māori and Pacific mortality rates, in spite of a steady decline in mortality rates among non-Māori and non-Pacific peoples.⁷

Māori have consistently recognised the need for health services delivered by 'Māori, for Māori'. However, it has only been in the last decade that the New Zealand government has acknowledged that for some types of health care, Māori themselves are best able to deliver health services that are accessible, integrated with Māori culture, values and aspirations, and, therefore, more likely to be used by Māori.³ As a result, in the period leading up to the latest health care reforms, there had been an increase in the number of Māori providers of health and disability support services, from around 20 in 1993, to 233 in 2003 (unpublished data).

Increasing the number of Māori providers is not a guarantee of improved health outcomes for Māori. Māori are grossly under-represented across the range of health professions, with only 1.6% of doctors and fewer than 4% of registered nurses in New Zealand being Māori.⁸ Having too few Māori in the health workforce may exacerbate differences in health status, if mainstream services are perceived as unable to meet Māori needs. The more a clinician is able to appreciate the cultural perceptions of the client, including spiritual and religious beliefs, the greater the opportunity for effective care.⁸ Māori and government agree that gains in the numbers of providers must be accompanied by gains in quality of service provision and in the numbers of skilled Māori health professionals.

Health care reforms, 2001

The health reforms implemented in 2001 have a number of distinct characteristics differentiating them from earlier models of health planning, purchasing and provision. There are three main elements: a new set of organisational arrangements with 21 majority-elected District Health Boards (DHBs); a number of high-profile sector-wide strategies driven from central government; and a 'health funding package' where the size of the health budget is signalled clearly three years at a time.

In the new model, 21 DHBs act as local agencies responsible for organising health care in their districts. DHB governing boards comprise up to 11 members, the majority of whom are elected. Central government can appoint up to four members. In making appointments

to the board, the Minister of Health must endeavour to ensure that Māori membership in the board is proportional to the number of Māori in the DHB's resident population. In any event, there must be at least two Māori board members.⁹

DHBs undertake planning of services for their districts, provide services through their 'provider arms' (hospitals) and purchase services delivered by non-DHB providers. The model emphasises local, cooperative and collaborative arrangements; however there is upwards accountability from the Board directly to the Minister of Health, through her agent, the Ministry of Health.¹⁰

A range of strategies has been designed to set national health priorities¹⁰ including: the New Zealand Health Strategy; the New Zealand Disability Strategy; the Primary Health Care Strategy; and He Korowai Oranga – the Māori Health Strategy.⁵ While strategic plans are not new to Māori health, in the past they have tended to concentrate on specific areas of health care such as public health or mental health.

He Korowai Oranga is the first strategic document that attempts to cover all aspects of Māori health. The government's stated purpose with He Korowai Oranga is twofold: to affirm Māori approaches to health and disability; and to improve Māori health outcomes.⁵ The overall aim of He Korowai Oranga is 'whānau ora', defined in the strategy as, 'Māori families supported to achieve their maximum health and wellbeing'.⁵

The NZPHD Act is significant for at least three reasons. Firstly the legislation represents the first time the Treaty of Waitangi had been incorporated into social policy legislation. The Act provides for mechanisms to enable Māori to contribute to both decision-making and delivery of health and disability services, with a view to improving health outcomes for Māori.⁹ While there are numerous Acts of Parliament that contain a reference to the principles of the Treaty of Waitangi, these have tended to deal mainly with the use of physical resources and/or the resolution of Treaty grievances.³

Secondly, the legislation is aimed at increasing participation by Māori in the health sector particularly in service delivery, policy development and in prioritising the allocation of resources to Māori health services.

Finally, the Act compels DHBs to take responsibility for improving Māori health. One of the objectives of DHBs is to 'reduce health disparities by improving the health outcomes of Māori and other population groups'.⁹ To achieve this objective, DHBs must establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement, foster the development of Māori capacity and provide relevant information to Māori.⁹

Health care reforms 2001 research project

This is a three-year formative evaluation running in parallel to the reforms as they are implemented from 2001 to 2004.¹⁰ This is the first time that a nationwide

health care reform process has been charted as it occurs. The research identifies features of the NZPHDA model and government goals for the sector; identifies stakeholder goals, concerns and issues; documents the activities of the Ministry of Health and DHBs as they implement the model; identifies innovation; and draws conclusions about the strengths and weaknesses of the model.¹⁰

The project comprises four concurrent streams of work covering 11 themes. Stream one investigates the overall expectations and experiences of the new system; stream two examines five DHBs in greater depth; stream three documents the policy context in which the reforms are embedded; and stream four compares this model with the previous AHB, RHA and HFA models.

Methods

The project uses a variety of quantitative and qualitative methods of data collection. The various methods of data collection, and the timing of each are: a public telephone survey (mid-2001); document analysis (ongoing); key informant interviews (two rounds, 2002 and 2004); postal questionnaires to DHB board members (two rounds, 2002 and 2004); quantitative analysis of administrative data on expenditure levels and allocations, financial performance, outputs, and intermediate health outcomes (ongoing); in-depth interviews with DHB chairs and chief executive officers (one per year, 2002–2004); separate in-depth interviews with planning and funding managers (2002); and case study research in five districts (ongoing).

The case study research involves document analysis, key informant interviews and observation of board meetings,¹⁰ and has been designed to allow a closer examination of DHB decision-making, governance and accountability. Five Boards were chosen to be representative of DHBs with different characteristics. They serve small, medium and large populations, communities with different age and ethnic mixes, and cover urban, rural and provincial communities. The financial situation of these case study Boards also differs.¹⁰

Eleven themes have been identified as central to the 2001 health reforms including: governance; strategic decision-making, implementation of key strategies; funding; purchasing and contracting; Treaty of Waitangi and Māori health; Pacific peoples and Pacific health; devolution; capacity and capability; adaptation of the Ministry of Health to its new role; and analysis of the performance of the NZPHDA model. This paper presents preliminary findings from the Treaty of Waitangi and Māori health theme.

The data reported come from two main sources: key informant interviews; and interviews in each of the five case-study sites. Key informant interviews were undertaken with sixteen Māori and two non-Māori regarding the development of He Korowai Oranga (the Māori Health Strategy), developments in primary health care, the Treaty of Waitangi, and the perceived strengths and weaknesses of the reforms for Māori and Māori health. A

further 17 non-Māori were interviewed regarding the Treaty of Waitangi and the drafting of the NZPHD Act. Interviews were carried out in the first year of the reforms (2001–2002).

Key informants comprised a mix of Members of Parliament, government officials and health professionals. Some were chosen on the basis of their involvement and contribution to the inclusion of the Treaty of Waitangi clause in legislation, and others for their knowledge of the development of He Korowai Oranga. The questions used were derived from the objectives of the evaluation project. Case study data include interviews with DHB board members, senior DHB staff and community providers in the five case-study sites.

Interviews were taped, with permission, and then later transcribed. Transcriptions were cleaned, checked by the interviewees and then entered into an NVivo database. Transcripts were analysed thematically. Themes were developed a priori from the research objectives, literature, the NZPHD Act and sector knowledge. Transcripts were coded by theme and sub-theme. All themes and sub-themes were then compared across interviews by one member of the research team.¹⁰

Results

Māori Health Strategy

A key feature of the NZPHD model has been the development of over-arching health strategies to set national priorities. The key strategy document for Māori health is He Korowai Oranga, the Māori Health Strategy.

He Korowai Oranga has been described as a 'break-through' in that Māori health workers, in partnership with officials, developed an agreed approach to improving indigenous health.¹¹ According to the Associate Minister of Health responsible for Māori health (a key Minister in the drafting of the NZPHD Act) the whānau or extended family is the 'foundation of indigenous social, cultural and political organisation. It is the source of identity, security, support and strength. The strategy requires health workers to consider individual patients as part of a whānau and to take a multidisciplinary approach'.¹¹

However, while 'whānau ora' is expressed as the overall aim of He Korowai Oranga, there is no operational definition of the term in the document and respondents felt this was problematic. Respondents questioned how DHBs would know if they were implementing whānau ora initiatives that were in accordance with the Act's intentions when no definition of whānau ora had been provided.

We've still got the draft Māori Health Strategy here and to be honest with you, I'm not too sure that we have actually formally defined that [whānau ora] (case study participant).

The lack of definition was also perceived as problematic from a monitoring point of view. Respondents were looking forward to seeing what monitoring processes

the Ministry of Health would put in place to ensure DHBs were implementing the strategy. Several Māori respondents felt that while they had a personal sense of the philosophy of *whānau ora*, the concept was not well understood by non-Māori or the system more widely.

I think there are some people on the Board that understand the *whānau* concept but we haven't really... seen it I guess being implemented or anything yet... but I think non-Māori are a lot more informed about Māori than they were say five or ten years ago (case study participant).

Concerns were expressed over the implementation of the strategy. In conjunction with the release of the strategic plan, the Government also released a related implementation document, *Whakatātaka* – the Māori Health Action Plan. It was noted in interviews that some *iwi*/tribes, *hapū*/sub-tribes, *whānau*/extended families and communities would need more help than others to achieve the commitment required by the Strategy. Many of those interviewed were critical about the lack of funding devoted to implementing the strategy, an unease heightened by the fact that the Strategy was being released into an environment in which many DHBs were managing an operating deficit.

Some of them [DHBs] welcome it [the Strategy] and are already moving to implement it. Probably the vast majority are just paying lip service to it so far because they are just so pre-occupied with just getting up and running and a minority are complaining that they are not going to be able to do anything unless we give them the extra funding to implement (key informant).

The research also found some positive reaction to the development and promulgation of the Māori Health Strategy. Participants noted that the Strategy not only built on past gains but was also designed to improve Māori health. It was regarded as a health strategy for Māori with clear directions and pathways for the future.

He *Korowai Oranga* was based on all the previous health gains and other strategies that had been produced firstly by the Ministry of Health and then the former HFA. So the whole basis from my understanding is that we would build on the gains that we had . . . and looking at the greater Māori participation . . . so it was really based on the work that has been done before (key informant).

Participants also noted that the Strategy would be a useful tool through which DHBs could reach the communities with poor access to health care.

Some respondents noted that the Strategy indicated a shift away from a 'deficit model' (i.e. closing the gaps between Māori and non-Māori health status) towards positively building the conditions for good health, well being and relationships within the community. Others identified the Strategy as an opportunity to change the direction of Māori health and encourage positive participation by *whānau*/extended families, *hapū*/sub-tribes, *iwi*/tribes and Māori communities.

A number of participants noted that ultimately the success of this Strategy would depend upon the

capability and capacity of DHBs themselves to make the Strategy 'their core business' and a real priority.

Governance and representation in decision-making

Key informants reported Māori participation as an apparent strength of the reforms and indicated that this participation included involvement in service delivery, policy development and in the prioritisation process for the allocation of resources to Māori health. A number of participants commented that the legislative requirement for two Māori board members and the commitment by the Minister of Health and Associate Minister Health (Māori) to improving Māori health were clear signals to DHBs to improve their services to Māori.

. . . most District Health Boards are developing partnerships, that is they're concerned with policy and priorities and the strategic direction and they've been able to get Māori involved in that in two ways. First of all by forming partnerships with groups, sometimes with *iwi* groups, sometimes with Māori communities generally and also by ensuring that there are Māori members on each District Health Board (key informant).

When asked specifically about the relationships between Māori and their DHBs, there were mixed comments. In some boards, the environment was receptive to Māori influence with Māori governance group arrangements established to provide advice on strategic policy and direction.

. . . I think we have a very good approach with Māori, we certainly support the principles of the Treaty of Waitangi . . . the key word that we use is relationship, though probably we understand the other principles. We've done that primarily through *Manawhenua Hauora*. We worked really hard to get our Memorandum of Understanding between all *iwi* . . . we are pretty proud of that relationship, it works quite well actually (case study participant).

However, governance arrangements and relationships with Māori took on many forms and differed from area to area. For example, in one district, the Māori governance group had a partnership arrangement directly with the DHB board, in another district the Māori governance group was outside the DHB. Overall, there was evidence of DHBs developing protocols for communication and collaboration with Māori, and developing relationships. However, while governance arrangements with Māori were being established, it was agreed that Māori governance groups were not well resourced.

Inclusion of the Treaty of Waitangi in legislation

The inclusion of a Treaty of Waitangi clause in the Act was seen as a significant step in compelling boards and the Ministry to incorporate the Treaty in their business. Key informants perceived the Treaty statement in the Act (s.4) to be a less effective, 'diluted' statement compared with the original statement in the Bill, which had applied to all the agents and organisations referred

to in the Bill, including DHBs, Pharmac (the Pharmaceutical Management Agency) and the National Health Committee (a committee providing advice to the Minister of Health on the kinds and relative priorities of public health services, personal health services and disability services that it believes should be publicly funded). The Act, when it was passed, confined the Treaty clause solely to DHBs.

Key informants were asked to define the Ministry's and DHBs' Treaty obligations. There were diverse views. Some felt that by shifting the Treaty relationship from the Minister/Ministry to a Crown agency, the DHB, there was an abdication of *kawanatanga* (governance) responsibilities which was not consistent with the intent of the Treaty. Other informants thought that the Treaty clause in the NZPHD Act operationalised the Treaty as it required the Crown to address Māori health issues in the present, rather than the Crown's traditional role of dealing with historic Treaty grievances. This was seen as a positive step, giving the Treaty a 'modern, legal presence' in the health system. Furthermore, there was a perception that by honouring Treaty commitments in this way, the health system would have to take the involvement of Māori more seriously.

...so I think that's probably a strength of the current model, that you've got a legislative requirement to recognise the Treaty by forming relationships in the way DHBs go about their business (key informant).

Informants also thought the purpose of the Treaty clause was to provide DHBs with a platform upon which to build relationships with Māori. Informants hoped it would shift the focus from increasing the number of Māori health providers to improving health outcomes for Māori. One informant said that although 'nothing in the law makes things change, it helps to focus attention on Māori health'.¹⁰

Case study informants, in particular, noted that with the inclusion of the Treaty in legislation, the expectation was that Māori and non-Māori health status should be brought up to the same level, that resource allocation should be fair and that Māori should have the right to determine their own system of health care delivery.

It's about involving Māori communities from the grass-roots right through to ensure that they do have the representation at operational and governance levels. It's about the DHB understanding how Māori think and how Māori health providers think and supporting them and nurturing them and developing true active Treaty partnerships with them and at the end of the day it's about recognising the path that Māori want to take to improve their health (case study participant).

However, a number of respondents identified obstacles associated with implementing Treaty of Waitangi relationships. The logistics of establishing 21 separate Treaty relationships with all 21 DHBs was considered problematic. For example, some DHBs cross iwi or tribal boundaries, meaning that some DHBs would need to establish governance arrangements with more than one iwi/tribe. A further concern voiced by participants was

that in some districts there might be difficulty in finding Māori and non-Māori with the right skills to develop Treaty of Waitangi relationships. These skills might include an understanding of local *whānau*/extended family, *hapū*/sub-tribe, *iwi*/tribe and Māori community issues; financial expertise; governance expertise and experience; and relationship management. These skills would be necessary for both parties in the relationship.

Workforce

District Health Boards, like others in the sector, were aware of the need to plan for Māori workforce development. Some DHBs considered that they had lacked vision and planning ability in the past. The number of Māori staff in DHBs is still quite small and they are highly sought after, which is not satisfactory given the high health need of Māori.

The development of policies for recruitment and retention of a Māori workforce was seen as a key action and indicator to assess the effectiveness of the reforms for Māori health development.

I think... if a Board is recognising its Treaty obligation, not only will it keep an eye on its patients, but it would recognise the importance of Māori workforce development and you would expect to see some targets being set. So that it says... in 10 years time 5% of our doctors should be Māori, 20% of our nurses should be Māori and so on (key informant).

Respondents noted that Māori providers find it difficult to retain qualified staff, as competition is high. While a Māori provider development fund exists some participants thought the scope of this scheme should be extended.

The fragility of the workforce is heightened by the greater burden of ill-health among Māori patients, therefore putting staff under pressure. One participant commented that to increase the numbers of Māori entering the health workforce, children at school should be targeted before they had decided on a career. Measuring Māori workforce development and funding allocations were mentioned as areas that could be measured to assess whether DHBs were making gains in Māori health.

Views on the NZPHD model from a Māori perspective

Comments on the model overall were mixed. Key informants noted that the model reflected a more holistic approach to health, more in line with the Māori world-view, and that Māori participation was a real strength of the reforms.

...well I mean the current reforms are pretty much in line with what Māori have been saying for a long time, we want to actively participate in health, don't want to be just consumers, we want to be delivering services, want to be helping with policies, want to be in the prioritisation process (key informant).

The explicit goals for Māori health separate from other population groups, through the New Zealand Health Strategy and Māori Health Strategy, were identified as positive developments. The ability to benchmark DHB future performance through monitoring spending on Māori health services was also seen as positive. However, participants noted that this benchmarking was dependent on the accurate collection of ethnicity data.

However, a number of weaknesses in the model were also identified. Some informants expressed cynicism over the capability of the system to deliver health improvements to Māori, given a long history of inadequate health care delivered by mainstream providers, and the health inequalities experienced by Māori. One informant noted that it was difficult to say whether participation at governance level alone would translate into health gains, given that some of the variables that influence health lie outside the health sector (e.g. poor housing, education, unemployment).

...We're never going to achieve health gain for Māori without the other education, employment, housing, all those other social determinants of health. You know for improved health gain ... we need to have that other part as well (key informant).

Not all Māori health care providers agreed that the reformed model was an improvement nor did they agree that there was a real commitment to improving Māori health on the part of DHBs. One senior DHB manager commented that change for Māori would require a different approach – a larger financial investment, more skills, a project management approach, plus real commitment by the system.

Providers also commented that the funding level in contracts had remained static even though demand had grown; that DHB contracts were too detailed and prescriptive; that 'by Māori, for Māori' providers faced barriers obtaining necessary information; and that DHB processes were too cumbersome.

Conclusion

The research thus far indicates there is support for the new model from a Māori perspective. A number of positive features of the model were identified by a range of people working in the sector that could go some way towards contributing to better Māori health. However, the research raises issues that require further investigation such as the implementation of the Māori Health Strategy in practice, the impact of Māori participation in governance of health services on health for Māori, and the development of an adequate Māori workforce.

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