WHĀNAU ORA:

WHERE DID IT COME FROM?

WHERE WILL IT LEAD?

Independent Research Study

HLTH 405

by Helen Catherine Mataiti

Health Sciences Centre

University of Canterbury

2011

Acknowledgements

This study was carried out in most extraordinary circumstances, across the time of the September 4 2010 and February 22 2011 Christchurch earthquakes. I would like to acknowledge a number of people for helping ensure this project reached an end.

First and foremost, I would like to thank my supervisor, Associate Professor Pauline Barnett, for her guidance, academic support, and ongoing patience. Her background knowledge of the New Zealand Health and Disability system and expertise in health policy has added tremendously to my learning.

To my children, for giving me added reason to write about such an important topic.

Finally, to my extended family and friends, for the emotional and moral support from near and far, through difficult times. Thank you for teaching me the meaning of connection, caring and security.

Contents

Abstract

In March 2010, the New Zealand Government launched the *Whānau Ora* policy initiative. *Whānau Ora* is a cross sector policy that seeks to improve whānau experiences of social, cultural economic wellbeing, through empowerment and self-determination. It is thought the policy will have a positive impact on the health of New Zealanders, and address ongoing issues of inequity. This is strongly supported by health determinants research. This independent study describes the development and early implementation of *Whānau Ora*, utilising a theoretical policy-making framework (Buse, Mays, & Walt, 2005). In order to answer a number of research questions, it examines contexts, processes and actors that contributed to policy making (Walt & Gillson, 1994). A qualitative documentary analysis method was used. Findings are presented in four areas, corresponding to the four identified stages of the policy cycle framework: problem identification and issue recognition, policy formulation, policy implementation, and policy evaluation (Buse et al, 2005). Findings are summarised and recommendations are made based on identified areas of concern to date. To close, limitations of the research study are identified, and future research directions outlined.

Introduction

Background

In early 2010, the New Zealand Government (NZ Govt) launched *Whānau Ora*, a collaborative policy initiative between Te Puni Kōkiri (TPK), the Ministry of Social Development (MoSD), and the Ministry of Health (MoH) (NZ Govt, 2010 a, b; TPK, 2010a). It is thought *Whānau Ora* will have a positive impact on the health of New Zealanders. This is strongly supported by evidence that shows relationships between economic, social and cultural circumstances and individual and collective health and wellbeing (Durie, 2001; National Health Committee (NHC), 1998; Wilkinson & Marmot, 2003). Generally, research suggests health and wellbeing is likely to be achieved when individuals are supported "to play a full and useful role in the social, economic and cultural life of their society" (Wilkinson & Marmot, 2003, p 11). In particular, a number of social determinants of health have been identified. These include stress, early life experiences, work, unemployment, social exclusion, social support, transport, food, and addictions (Howden-Chapman & Tobias, 2000; Wilkinson & Marmot, 2003). Individual determinants such as genetics, health behaviour, and psychological coherence (especially in relation to cultural identity) have also been found to affect health (Dew & Davis, 2005; Durie, 1999, 2001, 2003a; MoH, 2002). *Whānau Ora* combines much that is known about determining health, and offers a way for Māori and non-Māori to enhance family functioning and improve everyday experiences of health and wellbeing.

What is Health?

The concept of health was defined by the WHO in 1946 as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946), however, indigenous peoples have developed health knowledge over thousands of years. Indigenous peoples view health as a dynamic system that is dependent on balance and harmony in relationships between individuals, communities and the environment (WHO, 2007a). For example, Maher (1999) found groups of Aboriginal peoples viewed ill-health as physiological, social or spiritual dysfunction, often relating to one's inability to meet obligations to family, society, or sacred resources (such as land). These views are congruent with those of Māori, indigenous peoples of Aotearoa New Zealand (NZ). Although understandings of health may differ across geographic areas and tribe (iwi), Māori share the belief they are 'bound to the physical environment through whakapapa' (Shaw & Deed, 2010, p 96). Durie (2001, 2003b) suggests health may be affected when this bond is interrupted (eg through physical resource alienation).

Māori understandings of health have been represented in a number of health models - Te Whare Tapa Whā (Durie, 1984, 2001), Te Pae Mahutonga (Durie, 1999), Te Wheke (Pere, 1984), Nga Pou Mana (Henare, 1988), and the Meihana model (Pitama, Robertson, Cram, et al, 2007). Te Whare Tapa Whā (Durie, 1984,) is probably the most commonly known model. It consists of four domains: taha Tinana (the body), taha Wairua (spirituality), taha Hinengaro (thoughts and feelings) and taha Whānau (family and relational ties). All models mentioned are holistic in outlook, and are made up of a number of different domains or dimensions, which are seen to interact to influence health and

wellbeing. No domain exists on its own and wellness is present when all domains are respected and in balance.

Health systems

A well functioning health system aims to "promote, restore, maintain health" (WHO, 2007b, p 2) for all individuals, families and communities, while protecting against the cost of ill health, and allowing active participation of individuals (WHO, 2010). Health-care systems are made up of smaller subsystems and include actors at national, regional and local levels. These smaller systems include governmental management (economic, financial, health ministry), the primary health care system, the secondary healthcare system (specialist hospital services), and the public health system (Last, 2007). In some cases, self-care and informal care by family members and friends is viewed as part of the primary health care system (Last, 2007). This is of significance to the *Whānau Ora* approach, as individuals within whānau are seen to play an active role in improving and maintaining their own and whānau health and wellbeing.

Whānau and Whānau Ora

Whānau is the family system one is connected to through whakapapa (kinship) or kaupapa (shared practices or purpose) (Durie, 2001; Metge, 1995), but is not necessarily comparable to the non-Māori conception of family (Families Commission (FC), 2010a). Whānau is also an important subsystem of wider social systems. The importance of whānau for health and wellbeing of Maori is clearly stated in Te Korowai Oranga, Maori Health Strategy (MoH, 2002):

> "Whānau (kuia, koroua, pakeke, rangatahi and tamariki) is recognised as the foundation of Māori society. As a principal source of strength, support, security and identity, whānau plays a central role in the wellbeing of Māori individually and collectively"
>
> (MoH, 2002, p 1).

Health lies in part in the hands of the individual, but it also lies in part to others close to us. The whānau system provides social connectedness and involves relationships that hold meaning. Whānau offers a place for one to be well. Some within whānau are fully or partially dependent (children, persons that are disabled, or the elderly infirmed). At times life may be difficult and stressful, but collective responsibility, care, and actions of whānau members mean the impact is evenly distributed, and steps can be taken to restore wellness. Within whānau, adults may share principles for living, and ways of coping with life's demands, with younger generations. It is the performance of whānau-related activities that gives one a sense of purpose (Office for the Community and Voluntary Sector (OCVS), 2007). It is within whānau that one belongs and contributes.

.

Health and wellbeing of the whānau system is represented as different things to different people (FC, 2010a). However, Durie (2009) suggests that whānau ora exists when there is "balance between physical, psychological, emotional, spiritual, familial and environmental domains" in the whānau system. Government agencies have independently worked toward a vision of whānau ora for all New Zealanders for quite some time (see "Ngā kaupapa o moemoeā - a dream for families" as an example (Family Services National Advisory Council, 2004)). The policy *Whānau Ora* offers a vehicle for this to be more than simply a dream. *Whānau Ora* appears to be more than a further attempt at a government policy to address disparity. However, this is difficult to determine without thorough

investigation. Therefore, this study aims to examine the development of the policy from a theoretical perspective. In order to analyse the policy in more detail, it is useful to set a background framework to do so.

Policy-making framework

Various theoretical stages frameworks have been developed to describe the process of policy-making across time (Davis & Ashton, 2001, see pages 18 & 145; Sabitier & Jenkins-Smith, 1993). Different models contain anywhere between four and nine stages. Buse, Mays, & Walt (2005, p. 13-14) identify four key stages that apply across most models. These four stages are:

1) problem identification and issue recognition,

2) policy formulation,

3) policy implementation, and

4) policy evaluation

Stages models have some limitations. Researchers agree that in real-life the policy-making process is neither linear nor broken into distinct phases (Buse et al, 2005), and is both complex and messy (Davis & Ashton, 2001; Dew & Davis, 2005). Taking these limitations into consideration, it is probably helpful to think of the four stages as elements, each part of a continuous cycle. This study aims to understand *Whānau Ora* from a theoretical perspective of policy development. The four elements of the policy-making cycle framework offer a structure to examine the content of *Whānau Ora,* the context in which it developed, and actors and processes involved in the making of the policy (Walt & Gillson, 1994).

This independent study describes the development and early implementation of *Whānau Ora*, utilising a theoretical policy-making framework. Research aims and method are presented in the following section. A qualitative documentary analysis method was used. Findings are presented in four areas, corresponding to the four identified stages of the policy cycle framework: problem identification and issue recognition, policy formulation, policy implementation, and policy evaluation (Buse et al, 2005). Findings are summarised and recommendations are made, based on identified strengths and weaknesses of the policy. To close, limitations of the research study are identified, and future research directions outlined.

Research Aims and Questions

The overall aim of this study was to examine the making of *Whānau Ora* policy, utilising four elements of the policy cycle as a theoretical framework (Buse et al, 2005). Key research questions were developed in relation to the four elements of the policy cycle framework. These research questions (RQ) follow:

1) Problem identification and issue recognition

RQ 1: What are the "issues" in the NZ Health System?

RQ 2: In what context/s did the "issues" develop?

RQ 3: Which processes and key events helped reveal these "issues"?

2) Policy Formulation

RQ 4: Which individual and collective actors were involved in the formulation of *Whānau Ora* as policy?

3) Policy Implementation

RQ 5: What are the characteristics and structure of *Whānau Ora*?

RQ 6: What key events have occurred in the implementation process to date?

RQ 7: How will *Whānau Ora* change current practice?

RQ 8: Who will benefit from the *Whānau Ora* approach?

4) Policy Evaluation

RQ 9: How will *Whānau Ora* be evaluated?

The first cycle element is *problem identification and issue recognition*. The corresponding first section aims to identify the issues within the NZ health system that indicated a need for policy change (RQ1), and describe the historical, socio-cultural, and political context/s in which these issues arose (RQ2). An additional aim was to identify the

processes that helped reveal the issues in order for them to be placed on the political agenda (RQ3). The second element is *policy formulation.* This section identified all key governmental and non-governmental actors, and the roles they had in formulating *Whānau Ora* (RQ4). In particular, the critical role played by the Taskforce on Māori-Centred Initiatives (TMCI) in moving the policy from formulation to implementation will be outlined. The third element in the policy framework is *policy implementation.* This section aims to establish the characteristics and structure of *Whānau Ora* policy (RQ 5), and all key events that have occurred in the implementation process thus far (RQ 6). In addition, it seeks to determine how the policy might bring about changes in practice (RQ7), and identifies who might benefit from the policy (RQ8). Predicted success of the policy based on implementation data will be discussed in comparison to research in successful policy implementation. The final element in the policy cycle framework for this study is *policy evaluation*. Evaluation is ongoing and continuously feeds back into the policy cycle, therefore this element cannot be considered an end point. This fourth section aims to describe how *Whānau Ora* will be evaluated, and the proposed research plan for the policy (RQ9).

Method

The study was carried out using a documentary analysis research approach (Bowling, 2009). Data was gathered from both general and specific written document sources. General source documents included relevant books, government and crown entity publications, and academic research. Specific source documents used for Section 2, 3 and 4 were NZ Govt media releases, public speeches by Ministers of Parliament, and questions, speeches, and debate from daily Parliamentary Hansards. All documents were accessed online via public search domains. Documents were identified via the search terms "Whanau Ora", and "Whānau Ora. Speeches and releases were also found using a secondary search term, 'Tariana Turia' (Minister in charge of *Whānau Ora* initiative). With the exception of a television interview script (Espiner, 2010), and the press release, Morgan (2010), NZ media items on *Whānau Ora* have been avoided. As media reports are available from a multiple range of sources and are potentially selective in their reporting (for example bias, incompetence, institutional racism, ignorance....etc) (Bowling, 2009), their inclusion would have required methods and level of critical analysis beyond the scope of the current project.

Data was analysed in four ways. Firstly, data was analysed to identify the contexts in *Whānau Ora* developed. Secondly, actors and relationships between actors were identified. Thirdly, analysis was carried out in order to establish a chronology of events, and to identify processes that contributed to the development of the policy. Finally, data was analysed to determine policy characteristics and content, and any key qualitative themes running throughout documents were identified.

Findings

1. Problem Identification and Issue recognition

Health is of high public interest and regularly finds a place on the political agenda (Buse et al, 2005). Generally speaking, a policy is more likely to gain a place on the political agenda if there is public affiliation with the identified issues. However, if it is in the political interests of a party, or of economic interest to the country, party leaders help issues to the agenda and on to formulation stage more quickly (Davis & Ashton, 2001). Government and philosophy changes, campaign promises, key personalities, and chance events also play a part (Davis & Ashton, 2001; Rissmiller, 2000).

1.1 The 'issues'

Health inequality issues within the NZ health care system have been apparent for quite some time. Many different primary and public health care schemes have been implemented across the last twenty years to reduce health inequities. In some cases programmes have been successful, however, they have failed to reach all New Zealanders (King & Turia, 2010). Clearly, the NZ health system does not work effectively for some populations (Public Health Advisory Committee (PHAC), 2010; NHC, 2010a, 2010b). In particular, Māori, lower socio-economic groups, rural and incarcerated populations continue to experience inequitable health outcomes. Furthermore, Māori are strongly represented in prison populations, and in rural and lower socio-economic areas (NHC, 2010a, 2010b), therefore it is important that possible solutions are Māori focused. Overall patterns of

inequity are comparable to experiences of colonised indigenous cultures worldwide (Durie, 2003b; Robinson & Harris, 2007).

Data collected across the last twenty years has shown differences in health outcomes for Māori and non-Māori across high-level indicators such as life expectancy, infant mortality, and disability (Robinson & Harris, 2007). Specifically, Māori are inequitably represented in the following health areas: infant health, infectious diseases, mental health, suicide and intentional self- harm, oral health, diabetes, cardiovascular and respiratory diseases, cancers, addiction, unintentional injury and interpersonal violence (Durie, 2001, 2003; Robinson & Harris, 2007; MoH, 2009). Note that many diseases mentioned are preventable. Recent data indicates some improvement in the health of New Zealanders (MoH, 2008). However, although some gains have been made, it is unlikely such deep-seated inequities can right themselves without intervention. The imbalance in health of Māori and non-Māori came about within a set of historical, cultural, political, and social contexts (Shaw & Deed, 2010). It is possible these contexts have helped define a pathway to address the issues.

1.2 Contexts

1.2.1 Historical Context

Māori are tangata whenua of Aotearoa NZ. Non-māori (pākehā) arrived to the country first as visitors, then as missionaries, traders, and settlers (Consedine & Consedine, 2005). In 1835, fifty-two chiefs signed the Declaration of Independence of NZ (He Wakaputanga o te Rangatiratanga o Nu Tirene) stating their independence and right to self govern (States Services Commission, 2005). This move was organized by James Busby, but

not supported by the British Crown. In 1840, representatives of the British Crown and Māori entered into a partnership by signing the Treaty of Waitangi (Te Tiriti o Waitangi) (Consedine & Consedine, 2005; Durie, 2001; State Services Commission, 2005). Māori understood the treaty to mean they would continue to self-govern, with the protection the Crown. However, over the following 150 years the Crown failed to live up to these expectations. A succession of unjust events occurred, threatening the survival of Māori as indigenous peoples. These events included the loss of land, loss of right to land, inequitable provision and division of state resources, exposure to previously unheard of diseases such as influenza, and the creation of a crown-dependent relationship (Consedine & Consedine, 2005; Durie, 2001). Undoubtedly, this had a significant effect on the way Māori were able to live (Durie, 2001).

The hardship experienced by Māori from prevailing colonial attitudes has been difficult to repair. However the Treaty of Waitangi Act (1975), and the establishment of the Waitangi Tribunal (which soon followed) provided a forum for Māori to present grievances, and the Crown to acknowledge their failure to uphold Treaty promises (Waitangi Tribunal, 2011). Under National governments of 1990 - 93 and 1993 – 96 grievances were also addressed financially through the Treaty settlement process (State Services Commission, 2005). Over time, a shared understanding of Māori and English versions of the Treaty has developed and a number of common principles have been agreed upon (State Services Commission, 2005), These include the principles of protection, participation and partnership, which are currently used to support policy-making (Kingi, 2007).

1.2.2 Socio - Cultural Context

From a socio-cultural perspective, global and national events such as the World Wars, the Depression, periods of unemployment, and globalisation helped determine the way New Zealanders live (Durie, 2001, 2003a). There were also changes in family structure and function due to shifts in attitude toward gender roles, work practices, family formation, dissolution and reformation, home ownership and living situations (Jacobsen, Fursman, Bryant, et al, 2004). For Māori, acculturation, urbanisation, racism, and paternalism, also had significant effects (Consedine & Consedine 2004; Durie, 2001; Robinson & Harris, 2007). Together, these processes contributed to a collective loss of cultural identity, which in turn impacted on Māori health and wellbeing.

Acculturation (Born, 1970) occurred as Māori and non- Māori interacted in society. As the Māori population quickly became outnumbered, an unequal power dynamic developed. Non-Māori practices and ideals dominated, diminishing connection to *Te Ao Māori* (Durie, 2001). For example, fewer and fewer people spoke Te Reo Māori. The loss of language, a significant part of any cultural identity, was concerning and resulted in the establishment of the Te Kōhanga Reo movement in the 1980s (Te Kōhanga Reo National Trust, 2010). Over time government policy and economic necessity resulted in the movement of Māori away from their land, to towns and cities. Separating from land, whānau, hapu, and iwi, in some ways created a physical, relational and spiritual void for Māori. Many worked hard to re-establish and maintain traditional practices (Durie, 2001). However, ongoing institutional and interpersonal racism had an extreme effect on self-perception and behaviour (Robinson & Harris, 2007). Māori continued to experience poor quality and access to health services (Robinson & Harris, 2007), with this issue affecting Māori living in rural settings most often (NHC, 2010a).

The socio-cultural context has influenced both Māori health and health service delivery. In 1994, this was demonstrated by the Te Whānau O Waipareira Trust claim, to the Waitangi Tribunal (Waitangi Tribunal, 1998). The case reminded those in power that urban Māori were geographically distanced from their people (*iwi*) and land (*whenua*), which directly affected health and wellbeing. An indirect impact on health was also pointed out. Constraints in governmental directives in relation to providing services were also affecting the growing urban Māori population. Te Whānau o Waipareira Trust formally sought the right to self determine its services. This event was a significant turning point in the empowerment and self-determination of Māori service organizations. To this day Te Whānau o Waipareira Trust continues to be viewed as a successful whānau ora model (New Zealand Taskforce on Whānau Centred Initiatives (NZTWCI), 2010).

1.2.3. Political Context

The Labour or National parties held political power through to 1995 when the mixed member proportional (MMP) system was supported by referendum and enacted by Parliament (Elections NZ, 2010a). The new system allowed coalition government structures, and began to be address issues of ethnic and gender diversity. Although four Māori electorates had been part of the NZ political system since 1868, and Māori representatives had been part of the main parties for many years, representation in parliament had still appeared disproportionate. As part of the new system, an additional Māori electorate was created based on the growing Māori electoral roll (Elections NZ, 2010b). While National and Labour governments were in power across the 1990s, they carried out wide-scale health care reforms and four health systems were developed in relatively quick succession (Gauld, 2003). It has been suggested there was a failure to consult with stakeholders adequately, as

the reforms occurred so quickly (Davis & Ashton, 2001). There is of course a chance that the lack of consultation simply reflected the residual paternalistic attitudes of government at that time. Outside formal government structures, Māori political movements grew in strength, asserting the rights of Maori and gaining recognition for the issues they faced (Consedine & Consedine, 2005). In doing so Māori became increasingly self-determined in their cause to move forward from political oppression (Durie, 1998, 2003b).

1.3 Processes contributing to policy change

Health inequities in NZ had been recognised as an ongoing issue. However, for an issue to find a place on the policy agenda, a possible solution also needed to be presented (Kingdon, 1995). Kingdon (1995) discusses three streams or processes that work in parallel, to create a readiness for policy change. These are the issue, political and policy processes (Kingdon, 1995). The 'issues' process for *Whānau Ora* was mobilised years earlier with the appearance of international health documents such as the Alma Ata Declaration (WHO, 1976), and the Ottawa Charter (WHO, 1986). The issues were uncovered further in epidemiological research surround health determinants and indicators across the 1990s. In essence, the issues relevant to *Whānau Ora* were the same as those made public by the Labour party when they introduced the 'Closing the Gaps' policy in 1999 (Dew & Davis, 2005).

The "policy" process involves decision-making, strategic planning, distribution of resources, actions, and evaluation (Kingdon, 1995). Development of Māori health policy from the 1980s through to the early 2000s has been outlined in detail in other sources (Davis & Ashton, 2001; Dew and Davis, 2005; Durie, 1999). Frenk (2010) suggests that there is a

great deal of evidence available to show policymakers "what works and what does not work" in national health systems (p 1). Analysis of earlier comparable policies such as 'Closing the Gaps" provided direction for the *Whānau Ora* initiative. 'Closing the Gaps' used a deficit-based model and relied on heavy programming of services (TPK, 2008). Evaluation measures focused on service outputs and compliance. Accusations of the policy being race-based meant it ended up being used in a reduced form (TPK, 2008). Although ineffective in decreasing disparities, 'Closing the Gaps' helped focus policy on equal outcomes (TPK, 2008). It also helped show the importance of communities, the capability of indigenous organisations, and the need for planning and governance structures (TPK, 2008). Most importantly, it identified that Māori needed to succeed as Māori. This was something Māori academics and political leaders had been suggesting for some time.

The need for involvement of whānau and families in Māori health was mentioned in He Matariki (Public Health Commission, 1995) and further detailed in Whaia te whānaungatanga: Oranga whānau (MoH, 1998). Strategic health documents such as the NZ Health Strategy (MoH, 2000) and the NZ Disability Strategy (MoH, 2001) also acknowledged the role of whānau in health and wellbeing. The goal of whānau ora was more formally stated in the Maori health strategy, He Korowai Oranga (MoH, 2002). From this point, whānau wellbeing remained a focus for the MoSD, MoH, and OCVS (MoSD, 2004; Minister of Health and Associate MoH, 2006; Ihimaera, 2007; MoH, 2007; & OCVS, 2007). To add to the growing body of local policy knowledge, strong recommendations were made in the annual World Health Report on primary health care systems in 2008 (WHO, 2008). They urged governments to adopt cross sector approaches to address primary health-care needs.

The political process involves changes in government, parties, political philosophies, and leadership (or voting systems) (Kingdon, 1995). NZ's political context has already been described. However, in 2004, a number of events significant to the development of *Whānau Ora* occurred. Firstly, in protest over Labour's position on foreshore and seabed issues Tariana Turia MP left the Labour party, and re-won her Te Tai Hauauru seat in a by-election (Māori Party, 2010a). Then, the Māori party was formed with Dr Pita Sharples and Tariana Turia as co-leaders (Māori Party, 2010b). In the 2005 election, the party won 4 out of 7 Maori electorate seats, which entitled them to three list seats. Whilst other countries were still utilising a model in which indigenous peoples were consulted as interested stakeholder groups at different stages of the policy making process (Matthews, Jackson Pulver & Ring, 2008), Aotearoa NZ had advanced to a unique political position. Indigenous peoples had attained a strong political presence in the form of a mainstream Māori party. Interestingly, the National Party indicated a willingness to cooperate with the party. In itself, this relationship indicated a readiness for policy change.

1.4 Opportunity for change

A turning point for policymakers occurred at the time of the 2008 election. Although relevant 'issues' and a possible solution were on the political agenda, it required the presence of the Māori party in government, for *Whānau Ora* to proceed to the next phase. Kingdon (1995) suggests windows of opportunity, or policy windows are predictable at the time of elections and changing governments. Policy windows are present for just a short space in time, creating an opportunity for an issue on the political agenda to move forward on to formulation stage. Evidence supporting policy change may be gathered across decades, however, while the window is open, makers need to act quickly. In the case of *Whānau Ora*,

a "policy window" was opened under the terms of National – Māori Party coalition confidence and supply agreement. The agreement (Māori Party, 2010c) made a commitment for party co-leaders Dr Pita Sharples and Hon Tariana Turia be appointed to ministerial positions outside Cabinet. These positions were to be in areas in which significant outcomes were sought:

> "The Māori Party seeks significant outcomes in whānau ora, through eliminating poverty, advocating for social justice, and advancing Māori social, cultural, economic and community development in the best interests of the nation"
>
> (Māori Party, 2010c)

Undoubtedly, the presence of a mainstream Māori party in government (representing key stakeholders) helped provide *Whānau Ora* with the momentum it needed, and increased the likelihood the policy would be carried through to implementation.

2. Policy Formulation

Policy formulation involves knowledge building, public debate, development of guiding principles, and decision-making (Buse et al, 2005). *Whānau Ora* needed to 1) successfully address the ongoing issue of inequitable health and wellbeing statistics, 2) be determined by those it affected the most, 3) be acceptable to all stakeholders, 4) be strongly based on the principles of the Treaty of Waitangi, and 5) be financially and economically viable for the country. Both governmental and non-governmental actors have been identified in the formulation of *Whānau Ora.* All actors listed below played a part in policy

formulation. However, other actors who may have been involved 'behind the scenes' within government and non-governmental bodies, have failed to be identified due to the scope of this study.

2.1 Non-governmental actors

For the most part, non-governmental actors were in the field of research. Research from wide-ranging fields (life course development, psychology, health, education, counselling, sociology, geography etc) had broadened understandings of whānau, and individual and collective wellbeing across two decades. However, for *Whānau Ora* more specific research was needed. Collective and individual actors outlined below contributed to the development of a newly focused body of knowledge.

Families Commission

Although formed in a different political era, for a different purpose, this existing organization was enlisted to produce a number of key reports, reviews and studies prior to and during the formulation process (FC, 2005; FC, 2009; FC, 2010b, c). During formulation of *Whānau Ora,* the FC published a review in April 2010 ("Definitions of Whānau", FC, 2010a) in order to inform their own Whānau Strategic Framework 2009-2012 (FC, 2010d; Turia, 2010, 22 April). The study helped redefine the role of the FC and refocus it's efforts in "advocacy, engagement, social policy and research" in line with new governmental directions (FC, 2010d, p 7). In doing so, the published document interlinked with work carried out by the TWCI. More recently, the FC has published documents on the role of workplaces and schools in supporting family relationships (FC, 2010e), and prevention of child neglect (FC, 2010f) as supporting evidence for the policy.

The National Health (and Disability) Committee (NHC)

As a statutory body providing independent research advice to the Minister of Health, the NHC produced a number of reports that provided background evidence about ways *Whānau Ora* might best implemented with specific populations or in certain geographies. Published reports in 2010 focused on health in justice, rural health and caring for carers (NHC, 2010 a, b, c). Similarly, the PHAC, a subcommittee of the NHC, published "The best start in life - achieving effective action on child health and wellbeing" (PHAC, 2010) to help ascertain how the NZ health system fails many children. It recommended integrative approaches such as *Whānau Ora* as a way to improve the situation.

Family and Whānau Wellbeing project

The Auckland University-based Family and Whānau Wellbeing project (also known as Pathways to Positive Outcomes for Family and Whānau) utilised Statistics New Zealand data, to develop methods of measuring "social and economic determinants of family and whānau wellbeing"(1981-2006) (Milligan, Fabian, Coupe, et al, 2006; University of Auckland, 2010). In addition, they looked at impacts of policy on these determinants across time. The same dataset was utilised in Kiro, von Randow, Sporle (2010) to investigate trends in wellbeing for Māori households between 1981-2006.

Health Research Council (HRC)

The HRC's role was to guide and fund quality health research in NZ. This crown agency is overseen by the Minister of Health and funded through the ministry of Research, Science and Technology (HRC, 2010). Most recently, the HRC funded a project that

investigated research methods relevant to the evaluation of *Whānau Ora* (Cram & Kennedy, 2010).

Professor Mason Durie

Although many actors played a part in *Whānau Ora*, probably the most influential individual actor has been Mason Durie, Maori academic and leader (Turia, 2010, 8 November). His body of research dating back two decades helped shaped the policy, and he played an instrumental role in the TWCI (discussed below). Durie is also a member of the *Whānau Ora* governance group (TPK, 2010c).

2.2 Governmental actors

Governmental actors included government departments, ministers, political parties and leaders. Although ministers of "Health, Education, Social Development and Employment, Housing, Finance, Police, Corrections, Maori Affairs, Community and Voluntary Sector and Disability" were all involved in discussions about *Whānau Ora* (Turia, 2010, 11 February), it became the work of just three government agencies to collaboratively formulate and implement the policy. As each of these actors had held whānau ora as an outcome focus for some time, their ongoing commitment to the policy was unsurprising.

National – Māori Party Coalition.

As previously discussed, the Māori party led by Pita Sharples and Tariana Turia, and the National Party led by John Key, entered into a confidence and supply agreement in order to form a coalition government in 2008 (Māori Party, 2010c). Through the strength and determination of the Māori Party *Whānau Ora* remained an important focus in the political arena.

The Hon. Tariana Turia

Under the terms of the National-Māori Party coalition confidence and supply agreement, Tariana Turia held roles as Minister for the OCVS; and Disability Issues; and as Associate Minister for Health, and Social Development and Employment (Māori Party, 2010a). She was made Minister responsible for *Whānau Ora* in April 2010 (NZ Govt, 2010c). As the front-person for the policy, the Hon. Tariana Turia worked to spread the *Whānau Ora* message, through a series of public speeches (eg Turia, 2010, 6 May, 28 May, 21 June, 27 August, 31 August, 1 November, & 4 November). Carefully chosen audiences were spoken to using persuasive methods. Speeches involved praise for current work of organizations, explanation about how current endeavours were applicable to the concept of whānau ora and identification and selling of *Whānau Ora* as the way forward. Although Turia's admiration for organisation's work to date appeared honest, and her desire to ensure the wider community understood *Whānau Ora* was obvious, there was no doubt the speeches were attempting to enlist support for the policy.

Office for Community and Voluntary Sector

As mentioned, under the terms of the coalition agreement, Tariana Turia became Minister for the government agency OCVS. It was in this position that she commissioned the TWCI. This government agency also contributes historical strategic reports and documents relevant to *Whānau Ora* (eg OVCS, 2007)

Ministry of Social Development

Pre-formulation phase, the Family and Community Services arm of the MoSD had been independently developing a whānau ora type model in an attempt to address family violence issues (E Tu Whānau-ora: programme of action for addressing family violence

2008 -2013 (Māori Reference Group, 2009)). During formulation, the MoSD appears to have been both a contributor to the developing policy in terms of aspirations, and a motivated supporter of the initiative. The ministry also acted as a distributor of information through the formulation phase.

Ministry of Health

The MoH played a significant role in revealing issues of health inequities, helping issues reach the political agenda, and developing solutions, through research evidence. More recently, as part of the formulation process, an examination of Whānau Ora Integrated Service Delivery was undertaken on behalf of the MOH (Mauri Ora Kite Ao (MKTA), 2010). The study looked at "examples and models of practice" (p 10), across six Māori health providers. Findings showed an overall commitment by health agencies to *Whānau Ora*, however, a number of potential issues with implementation were foreseen. These issues related to integration of contracts and services, catalysation of attitudinal shifts, communication and relationship building, and the need for capacity and capability support. In particular, the need for balancing clinical and cultural competence was noted (NZ Govt, 2010d)

Te Puni Kōkiri (TPK)

TPK had previously worked in a co-ordination and advisory role, and governed and distributed funding (eg Te Whanau Social Assistance Programmes - Maara Kai, Kaitoko Whānau and Oranga Whānau (Cram & Paipa, 2010). The role of Ministry in *Whānau Ora* became clearer to the public, following the release of the Taskforce report, when implementation was imminent. It was decided TPK would act as lead governmental agency for the collaborative policy. Although their "capability and capacity" to do so was

questioned, supporting ministers dispelled these concerns (King & Sharples, 2010, p 9614). TPK was to go on and oversee a number of activities critical to the implementation of the policy.

2.3 The Taskforce on Whānau-centred Initiatives (TWCI*)*

The TWCI was significant actor and played an important role in moving the policy from formulation to implementation stage. The Hon. Tariana Turia, Minister for the OCVS commissioned the TWCI in June 2009 (MoSD, 2010a). The Taskforce was made up of six members: Mason Durie (chair), Rob Cooper, Suzanne Snively, Di Grennel, Nancy Tuaine, and Linda Grenell (MoSD, 2010a). The Taskforce was required to integrate available information to produce a workable document in a short space of time. Their brief was to construct an evidence-based framework for the development of an integrative policy that focused on whānau wellbeing and strengthening whānau capabilities (MSD, 2010b). Bi-monthly reports to the Minister for the Community and Voluntary Sector were required. The Taskforce report was based on relevant research knowledge, as well as:

> "experiences of health and social service agencies, an analysis of oral submissions received at 22 hui throughout the country, and over 100 written submissions from individuals and organizations"
>
> (NZTWCI, 2010).

The Taskforce report was handed over to the Minister on 11 February 2010, and released to Government on 8 April (Mahuta & Turia, 2010; NZ Govt, 2010e; Turia, 2010, 11 February; & 8 April.)

The Taskforce developed a whānau-centred framework based on five domains regarding aspirational aims, underlying principles, outcome goals, whānau-centred services, and a Whānau Ora Trust**.** The framework provided a structure for service integration across sectors (NZTWCI, 2010). The document also demonstrated how *Whānau Ora* was a multiple layered concept, simultaneously acting as a philosophy, model of practice, outcome goal, mechanism for funding providers, and a foundation for future generations (NZTWCI, 2010). The Taskforce report recommended that: *Whānau Ora* be based on kaupapa Māori values, be determined by Māori, decision-making occur at local level, and governmental red tape be kept to a minimum (NZTWCI, 2010). It also recommended the policy beappropriately resourced and sustainable, and that it have a strong research and evaluation focus. Finally, it stated clearly that integration of Māori-Centred initiatives would require high quality trust based relationships between whānau, providers and iwi.

2.4 Symbolic transformation and healing

The making of *Whānau Ora* has been significant in terms of healing and transformation of Māori as indigenous peoples in a bi-cultural nation. Morgan (2010) writes that *Whānau Ora* is a "historical milestone in modern Māori social and economic transformation" and suggests that it shows a "new level of maturity in the partnership between Maori and the Crown" (p A11). Not only was the work of the Taskforce a critical step in moving from formulation to implementation of *Whānau Ora,* it was significant as part of a symbolic transformation and healing process (Kirmayer, 2004). Kirmayer (2004) explains that healing includes both physiological and symbolic processes. Although initially managed by the OCVS and the Ministry of Social Development, Te Puni Kōkiri was placed in a lead role in readiness for implementation phase (King & Sharples, 2010). Such an act,

confirmed the government's commitment to improve Māori health and wellbeing by empowering Māori, offering a freedom to self-determine. However, it could also be viewed as a symbolic and transformative act. Similarly, the uttering of the *te reo* term '*Whānau Ora'* in a wide range of circles could also be viewed as transformative. Kirmayer (2004) suggests symbolic transformation has physiological, psychological and social effects. *Whānau Ora* has potential to improve physical health outcomes for those most vulnerable, by way of improved family function, economic capabilities, and care. More importantly, Māori empowerment and self-determination can be seen as large-scale transformative acts that could lead to symbolic healing effects. They are also likely to impact on health and wellbeing across physical, psychological, and social domains.

3. Policy Implementation

3.1 Policy structure and key implementation events

Whānau Ora implementation began in April 2010 with the TWCI report being welcomed by the government and the announcement of Hon. Tariana Turia as policy Minister (NZ Govt, 2010c, e; Turia, 2010, 8 April). In order to support the implementation process, a governance group was formed to advise the minister, government agencies and stakeholders (TPK, 2010c). The governance group was to be led by Rob Cooper, (also a member of the TMCI). In May 2010, twelve regional hui were held around NZ, for Turia and TPK, MoH and MoSD officials to discuss the policy at a local level. In the May budget, it was announced that $134 million was being allocated to the initiative over the following 4 years (English, 2010). The funding was aimed at establishing "capacity and capability" for

the first wave of providers, including changes in provider business models, improvement of IT systems, and training (NZ Govt, 2010a). Twenty million of the funding was tagged for the *Whānau Ora* research, evaluation, and monitoring programme (NZ Govt, 2010a). Further funding for the initiative was to be obtained through redistribution of existent funds. For example, Social Development Minister Paula Bennett announced that $120 million previously allocated to the Pathway to Partnership fund would be redistributed to *Whānau Ora* (NZ Govt, 2010b).

In June, Regional Leadership Group (RLG) nominations and the provider Expression of Interest (EoI) process were opened via the TPK website (MoSD, 2010c, TPK, d). RLGs were established in ten TPK geographic areas, and made up of local representatives from MoSD, TPK, district health boards (DHB's), non-governmental organisations (NGO's) and the wider community (NZ Govt, 2010f). Their main role was to evaluate EoI's according to set criteria in order to choose 20 providers nationwide (Huria, 2010; TPK, 2010e). A second call for proposals was made on 9 July (TPK, 2010f). One hundred and thirty EoI proposals from 347 providers were received from across the country (TPK, 2010g; NZ Govt, 2010g). It was always intended locally based services would join as collectives to win provider contracts, helping to address the issue of service double ups in some regions. Twenty-five integrated provider contracts were announced in October 2010 (MoH, 2010a; MoSD, 2010d; NZ Govt, 2010h). In most cases providers were an integrated collective of previously independent Māori health and social service trusts or agencies.

Two other important events occurred in October 2010. Firstly, the Whānau Engagement Innovation and Integration (WEEI) fund was announced (NZ Govt, 2010h). The $6.6 million dollar fund was established to support providers, NGOs, iwi, hapu, and

whanau trusts, and marae committees, by providing extra financial backing to run programmes and services and distribute information and resources to improve social, cultural, and economic outcomes for whānau (NZ Govt, 2010h). The fund would be managed and distributed by TPK, with proposals considered locally by already established RLGs. Secondly, a further expression of interest process was initiated to choose research groups for carrying out *Whānau Ora* research. This will be discussed further in the section four.

3.2 Policy Characteristics and Practice Changes

Whānau Ora helps existent service providers, to refocus their aims toward whanau wellbeing (Katene & Turia, 2010; TPK, 2010h). The policy attempts to address residual paternalistic attitudes of service agencies and re-develop practice to ensure whānau experience a sense of control in their futures. Thus, it is expected whānau will determine and act toward goals independently, or choose to enlist the support of *Whānau Ora* providers or other agencies (TPK, 2010a). The policy is restorative in nature as it aims to work with whānau, rather than "to" or "for" those in need (Espiner, 2010; Katene & Turia, 2010). Specified goal areas include healthy lifestyles, "participation in society", and economic security (TPK, 2010a; Māori Party, 2010c).

It has been openly acknowledged that the policy is strengths-based and outcomes focused (Espiner, 2010) (compare with solutions focused counselling). In considering *Whānau Ora*, the individual envisages a best-case scenario of whānau health and wellbeing, thus recording a vision toward which efforts can be directed. A characteristic of *Whānau Ora* policy is the use of positive language. One can assume all language-use is intentional.

Macdonald and Davis, in Dew and Davis (2005) suggest language is "embedded in social, historical, and political settings and is used both purposely and strategically, to communicate and to achieve certain ends" (p 90). Documents and presentations used in the implementation of the initiative are positively phrased, creating the impression of a positive and forward moving policy. Examples of these words include 'aspiration', 'determination', 'innovation', 'inspiration', and 'transformation' (Turia, 2010, 21 June; NZTWCI, 2010; TPK, 2010h, i).

Whānau Ora is likely to change current practice in a number of ways. In the first instance, the policy establishes a whānau-centred environment. Rather than government bureaucracy or service practitioners dictating what needs to occur, the whānau leads its own process (Katene & Turia, 2010). Examples of self-management at an individual level have recently been seen in the disability sector. Former 'clients' have rid themselves of case-managers and independently negotiate contracts for required services (MoH, 2010b). Although not a new concept in health and human services field, the starting point for all interactions between governmental agencies and providers, and providers and whānau, will be positive and respectful relationships based on integrity, trust, and inter-dependence.

Further practice changes are likely to result from focusing on whānau as a whole. This will prevent situations in which whānau have multiple service agencies with numbers of personnel, working with individual whānau members in a fragmented fashion within the same household (Turia, 2010, 7 May). An over-riding aim is for whānau to have a single whānau worker, who empowers them to determine their own direction and goals. Further service support can be requested as required. In difficult cases, where care and protection of

children or vulnerable adults is queried, one would assume that mandatory reporting and involvement of associated professionals would still go ahead.

Developing the "capability of the providers - the training for the navigators" has been identified as an area of need for *Whānau Ora* (Katene & Turia, p 10817). It appears that "some providers had begun to provide training to their staff…. from their own budgets and in their own time" (King & Turia, 2010, p 10452). This suggests there is a great deal of support for the new approach. However, thus far, *Whānau Ora* documentation has not fully explained how transformation will occur at the whānau level, nor the role provider practitioners will play in catalysing that change. Given that the policy openly states an outcomes or solutions focused model, involving goal setting, it is possible that specific techniques such as solutions focused counselling or motivational interviewing may be used. However, these techniques are fairly specialised and would require intensive training. It is likely some practitioners will also require help to find ways to shift attitudes and behaviour that promote dependency of whānau (for example maintainance of boundaries).

3.3 Who will benefit?

Early in 2010, there was a great deal of political debate about who might benefit from *Whānau Ora* policy. The main questions were ethnicity foccused. Confusion within government was evident when King quoted two differing prime ministerial statements regarding who stood to benefit form the policy (King & Sharples, 2010). The statements suggested *Whānau Ora* would benefit either all New Zealanders and be based on need, or Māori, as it was based on Māori values and practices (King & Sharples, 2010). The Hon. Dr Pita Sharples explained that the policy was built on cultural principles, and based on need, and as Māori principles are inclusive, the policy would also benefit non-Māori New

Zealanders (King & Sharples, 2010). The debate was all but laid to rest by the results from a Families Commission study carried out on behalf of the MoSD (FC, 2010c; NZ Govt, 2010i). The study looked at the use of an integrated Māori service in Masterton. It appeared one third of the Māori service users were non-Māori, a figure similar to those of the Te Whānau o Waipareira Trust (King & Sharples, 2010). Based on evidence it appears those in need are likely to use inclusive integrated Māori services.

Whānau Ora is likely to benefit whānau in need, by helping empower them to determine and achieve their own outcomes, gain a sense of control in their world, and experience physical and social health and wellbeing. Achievement of self-determined goals is likely to result in feelings of self-efficacy and satisfaction. Two other groups also stand to benefit from the policy change. These are the providers, and the government. The new approach is likely to benefit providers in a number of different ways. A single integrated contract means fewer administrative restrictions. And, as the contract period has been set at 3 years, there is less "pressure to achieve quick, highly visible results in short funding cycles" (Buse et al, 2005, p 122). Furthermore, in the case of smaller providers who have amalgamated into a larger collective, extra support may be offered at both administrative and practitioner level. Providers are also likely to receive additional training, and develop new skills to support whānau in an efficient and effective manner. In turn this may result in more rewarding work experiences.

The government is the third main stakeholder. Their benefit lies in the establishment of integrated contracts. Overall, this type of contract will require less monitoring and reduce financial wastage from overlapping support services. Flavell (2010) goes so far as to suggest it will improve government business practice. In some ways this may explain the

National Party's support for the policy. Furthermore, three involved government ministries have chosen to pool and integrate resources in support of the policy therefore outside of the $134 million startup costs, the policy does not require huge amount of new funding. The government's use of existent infrastructure and capabilities appears to demonstrate that *Whānau Ora* is not so much about money, but about a way of thinking and working.

3.4 Predicted success of implementation

There has been some discussion about whether *Whānau Ora* will meet its intended outcomes (NZ Parliament, 2010, 9 February). Theoretical models of policy implementation provide hints about the predicted success of a policy. Based on evidence from a top-down theoretical approach (Sabatier & Mazmanian, 1979) it seems a number of conditions need to be present for implementation to occur successfully. These conditions are 1) adequate causal theory, 2) clear and logically consistent objectives, 3) low likelihood of conflict with other policies, 3) committed and competent leadership within implementing agencies, 4) a policy change structure designed to gain "buy-in" from implementers, 5) supporting legislature, and 6) a policy that is resistant to social, and economic change. *Whānau Ora* is strongly evidence based. Its underlying framework is clear and concise and reflective of the cultural values of New Zealand society. Leadership in the form of government ministers, governance groups and RLGs are visible and committed to implementation. The policy has a firm base in the principles of the Treaty of Waitangi, and is supported by existent legislation such as Children, Young Persons and their Families Act (2009), and the Families Commission Act (2003), and Health, Māori Health, and Disability Strategies (MoH, 2000, 2001, 2002). *Whānau Ora* requires an attitudinal shift on the part of practitioners and government agencies, and empowerment of families to be self determining, healthy and

economically self-sufficient, therefore, one could predict it is resistant to economic change. It is possible that *Whānau Ora* itself is a representation of social change.

It was not within the scope of this study to determine stakeholder perspectives on their support for *Whānau Ora*. However, available data suggests it is supported politically, as demonstrated by the follow-through on a commitment by National and the Māori party; and by government, across three ministries. Note that it cannot be predicted what might occur should the government and coalition partners change. Support from providers has also been shown (Morgan, 2010; MKTA, 2010). Whānau support at local levels is more difficult to determine. It is likely that most NZ whānau would support a policy that is beneficial to those in need. However, many families receiving ongoing support services may be unaccustomed to determining their own futures, and could experience some distress, when known methods of support are withdrawn or changed. It should be noted that with adequate training, practitioners would be able judge if distress might be detrimental to the overall process, or indicative of positive change within the whānau.

4. Evaluation

Policy analysis and evaluation plays an important part in the policy-making cycle (James and Jorgensen, 2009). Policy knowledge feeds back into all stages of the cycle, informing policymakers about policy effectiveness and possible directions for change. It also serves to evaluate if intentions have been met through implementation. The Whānau Ora Taskforce report (NZTWCI, 2010) called for measurement of outcomes using quantitative and qualitative data, collected in a continuous and timely manner. Whānau,

provider, and population outcomes would be measured (p 23-25). Overall, the proposed evaluation plan was developed in line with the *Whānau Ora* outcomes framework (NZTWCI, 2010). In Espiner (2010), Hon. Tariana Turia stated *Whānau Ora* outcomes would "speak for themselves". She explained that while previous schemes utilised formative methods of evaluation (measuring work output of social service and health organizations); *Whānau Ora* would focus on measuring whānau outcomes through summative methods, by whānau and providers themselves. The report recommended both. This suggested evaluation was viewed as an integral part of provider practice and governmental policy implementation.

The Taskforce report acknowledges that evidence of health and wellbeing outcomes at population level may take years, and also that other influences may contribute to any gains found (NZTMCI, 2010). In October 2010, a call for Expression of Interests for *Whānau Ora* research was made via the TPK website. (TPK, 2010j). An information document accompanying the call for interest, indicated action research was the preferred qualitative method when working with whānau and providers (TPK, 2010j).

There are a number of reasons why the action research approach may have been chosen. Firstly, the approach allows for flexibility, a critical feature when self-determined whānau goals will differ, and the type and amount of support offered could be variable. Secondly, it addresses an issue raised in Māori Reference Group (2009) regarding research in family violence. They suggested evaluation by external researchers was unsatisfactory. By establishing an environment in which provider organisations have the potential to carry out, or lead their own research with the support of established research groups, suggestions from a grass-roots level appeared to be acknowledged. Thirdly, action research utilises

cycles of critical reflection, pursuing change and understanding (Action Research Resources, 2010). The method is likely to enhance provider practice by encouraging them to plan, act, and critically reflect in their work with whānau, likewise whānau with providers. Finally, there are obvious links between action research approaches, and kaupapa Māori research methods (Hudson, Milne, Reynolds, et al, 2010). For example both approaches allow active participation and are based on sound relationship building and communication.

In support of the research and evaluation programme, Cram and Kennedy (2010) investigated methods of research in the Whānau Collectives' Project. The project group aimed to identify and pre-test appropriate research methods for research with whānau collectives, and evaluate the compatibility of various qualitative methods with Kaupapa Māori research. TPK (2010j) suggested the *Whānau Ora* research programme would be carried out in two phases, focusing firstly on early implementation of policy from the perspective of providers and practitioners. In Phase two, experiences of whānau will be considered. The action research directive cannot be interpreted to mean the government is no longer interested in formative data. Rather, there has been a call for research method that benefits both providers and whānau as much as government agencies, and helps identify methods of best practice when working toward outcomes.

Summary and Recommendations

This study aimed to investigate the context, processes and actors contributing to the making of *Whānau Ora.* The policy was introduced to address inequities in physical and social wellbeing in New Zealand. In order to examine aspects of policy-making a four-stage framework was used (Buse, et al, 2005). Findings suggested policymakers utilised research and policy knowledge to create a transformational policy. Whānau Ora is kaupapa Māori based and focused to work for Māori. However, it will also help other New Zealanders in need. The policy was designed to integrate existent Māori health and social service agencies into larger collectives working under a single provider contract. Providers from each of TPKs geographic regions have been chosen. Contract funding has been created through the re-distribution of TPK, MoH, and MoSD funding. In addition, 134 million dollars announced in the 2010 budget will be spent on provider development and research to support the policy change. *Whānau Ora* has a single focus. It aims for all NZ whānau to be healthy and economically secure.

Study findings suggest *Whānau Ora* is the result of the cumulative effort of numerous actors, across the last twenty years. There is no doubt the policy is strongly research based. The National and Māori party coalition government formulated and followed through with implementation in a short space in time, showing a commitment to the policy and a belief in it. The policy is also supported by governmental and provider stakeholders. *Whānau Ora* is likely to benefit all stakeholders by developing future aspirations of whānau, guiding appropriate provider practice and providing simple, yet powerful strategic focus for governmental bodies. Evidence suggests the policy has the elements required to meet intended implementation outcomes. It is possible that the NZ

government has developed a cross-sector policy that leads the way in solving issues of health and social wellbeing in a bi-cultural nation. However, to ensure *Whānau Ora* achieves these intended outcomes, some aspects of the policy should be considered.

Some areas of *Whānau Ora* may benefit from further attention. Most importantly, *Whānau Ora* would benefit from involvement of other government sectors relevant to health and social wellbeing, including police, justice, and education. It appears these agencies were involved in early discussions about the policy but are not considered part of current implementation. In addition, there has been general discussion about training needs by the minister in charge of *Whānau Ora*, however, overall, there appears to be a lack of information about the "specialised" training that is required. It is recommended that types of specialised training are soon made public; in order to ensure appropriate training has been chosen, and training programmes can begin to be implemented. Furthermore, whānau ora is a holistic concept, therefore it may cover dimensions that are not easily tangible eg spirituality. Although highly relevant to overall wellbeing, it should be considered that some goals (or pathways to goals) might contain variables that are difficult to measure. However, it is possible that qualitative measures may cover this concern. Moreover, it is uncertain if the NZ media and general public understand the relevance and significance of *Whānau Ora* and its potential for symbolic transformation and healing for Māori. Questions regarding the involvement and influence of the media in the policy's potential success should be investigated. It may be possible for implementers of the policy to utilise the media, to improve whānau outcomes. For example, in a nationwide education campaign similar to those used in tobacco control, such as "It's about whānau" (Price & Allen, 2003).

Finally, given that *Whānau Ora* has the potential to improve outcomes for many New Zealand families, it is important to acknowledge that governmental changes may influence the policy's success. The Māori party had a significant role in reintroducing issues of health and social inequalities to the political agenda, and in making *Whānau Ora* policy. Although the success of the policy is not necessarily dependent on the presence of the Māori party in government, it could be suggested main support for the policy lies within the party. However, there is a possibility the 2011 general election could result in a changed coalition makeup, and policy change is more likely during the associated windows of opportunity. Therefore, through this stage *Whānau Ora* policy remains vulnerable. Steps should be taken to ensure decisions to change policy are based on evidence rather than on political whim. To this point, an appropriate amount of time should be allowed to pass in order for policy outcomes to be accurately measured. Should the policy prove successful, there is potential for it to be continued across successive governments as a universal policy of health and wellbeing.

Research Limitations and Future Research directions

This study provides an overview of the making of *Whānau Ora* policy, and adds to existing research in health and Māori policy development in NZ. There are a number of limitations to the study, mostly related to scope and size, and choice of research method. Firstly, the majority of data collected was obtained from governmental organisations. Future research could involve data collection from a wider range of sources including providers and whānau, to gain a more balanced perspective of the policy-making process. Secondly, as documents were the chosen data type, "behind the scenes" work that occurs in policy making was not able to be determined. Clearly, governmental records tell one side of the "story" only. Future research might utilise research methods that document actors and processes hidden from the public eye, to more accurately represent policy-making. Such methods might include key informants interviews and focus group discussions. Thirdly, although this study avoided media sources, there is a likelihood media influences policy making (Buse et al, 2005). Future studies could include media records to analyse the role of media in the implementation of *Whānau Ora*. Whānau and provider perceptions of the policy based on interaction with media might be of particular interest. Finally, this study was carried out while *Whānau Ora* was in its early stages of implementation. For an accurate picture of the success of the policy, research should be continued over an extended period of time, including data on additional provider contracts, funding, and research and training initiatives.

References

Bowling, A. (2009). *Research methods in health: investigating health and health services*. Maidenhead, United Kingdom: Open University Press.

Born, D. O. (1970). Psychological adaptation and development under acculturative stress. *Social Science and Medicine, 3*, 529 – 547.

Buse, K., Mays, N., & Walt, G. (2005). *Making health policy*. Maidenhead, United Kingdom: Open University Press.

Consedine, R., & Consedine, J. (2005). *Healing our history: the challenge of the Treaty of Waitangi*. Northshore, NZ: Penguin Books.

Cram, F & Kennedy, V. (2010) Researching with Whānau collectives*, MAI Review, 3 (1).*

Cram, F. & Paipa, K. (2010). *Whānau social assistance programme. Evaluation framework – Maara Kai, Kaitoko Whānau, Oranga Whānau. Part 3. Programme description & expanded intervention logics*. Report prepared for Te Puni Kōkiri. NZ: Katoa Ltd.

Davis, P., & Ashton, T. (2001). *Health and public policy in New Zealand*. Auckland, New Zealand: Oxford University Press.

Dew, K. & Davis, P. (Eds). (2005). *Health and society in Aotearoa New Zealand* (2nd edition). Melbourne, Australia: Oxford University Press.

Durie, M. H. (1998). *Te mana, te kāwanatanga – The politics of Māori self-determination*. Auckland, New Zealand: Oxford University Press.

Durie, M. (1999). *Whaiora: Māori health development* (2nd edition). Melbourne, Australia. Oxford University Press.

Durie, M. (2001). *Mauri Ora: The dynamics of Māori health*. Melbourne, Australia: Oxford University Press.

Durie, M. H. (2003a). The health of indigenous peoples: depends on genetics, politics, and socioeconomic factors. (Editorial). *British Medical Journal,* 326 (7388), 510-512.

Durie, M. H. (2003b). *Ngā kahui pou – launching Māori futures*. Wellington, New Zealand: Huia Publishers.

Durie, M. H. (2009). *Pae ora. Ma□ori health horizons.* Te Mata o Te Tau Lecture Series, Massey University. Palmerston North.

Elections New Zealand. (2010). *From FFP to MMP*. Voting, MMP how it works. http://www.elections.org.nz/voting/mmp/history-mmp.html

Elections New Zealand. (2010). Māori and the vote. http://www.elections.org.nz/maori/ntkm-democracy/maori-vote.html

English, B (2010). Budget statement. *Parliamentary Hansard,* 20 May 2010, 11045.

Espiner, G. (2010). Interview with Tariana Turia and Mason Durie. http://tvnz.co.nz/q-and-a-news/interview-tariana-turia-and-mason-durie-3446834

Families Commission – Kōmihana ā Whānau. (2005). *Focus on families. Reinforcing the importance of family*. Wellington, New Zealand: Families Commission http://www.nzfamilies.org.nz/sites/default/files/downloads/focus-on-families.pdf

Families Commission – Kōmihana ā Whānau. (2009). *Family centred communities. The planning process*. A report for the Families Commission, Research Report No 1/09. http://www.nzfamilies.org.nz/sites/default/files/downloads/Family-Centred-Communities.pdf

Families Commission – Kōmihana ā Whānau. (2010a). *Definitions of Whānau. A review of selected literature*. Wellington, New Zealand: Families Commission.

Families Commission – Kōmihana ā Whānau. (2010b). *Whānau taketake Māori – recessions and Māori Resilience. A report for the Families Commission.* Wellington, New Zealand: Families Commission.

Families Commission – Kōmihana ā Whānau. (2010c). *Social Services in Masterton: the views of families and whānau*

Families Commission – Kōmihana ā Whānau. (2010d) *Whānau strategic framework 2009 – 2012*. Wellington, New Zealand: Families Commission.

Families Commission – Kōmihana ā Whānau. (2010e). *Connections: supporting family relationships through schools and workplaces*. Wellington, New Zealand: Families Commission.

Families Commission – Kōmihana ā Whānau. (2010f). *Preventing child neglect in New Zealand*. Wellington, New Zealand: Families Commission,

Family Services National Advisory Council (2004). *Ngā kaupapa o moemoeā – the dream for families*. http://www.familyservices.govt.nz/working-with-us/about-us/moemoea/index.html

Flavell, T. (2010). Debate on budget policy. *Parliamentary Hansard,* 17 March 2010, 9557-9558.

Frenk, J. (2010). The global health system: strengthening national health systems as the next step for global progress. PLoS Medicine 7(1) .

Gauld, R (2003). One country, four systems: comparing changing health policies in New Zealand. *International Political Science Review, 24* (2), 199-218.

Health Research Council (2010). *About the Health Research Council of New Zealand.* http://www.hrc.govt.nz/root/About%20the%20HRC/About_the_HRC.html

Henare, M. (1988). Ngā tikanga me ngā ritenga o te ao Māori: Standards and foundations of Maori society. In *The April Report of the Royal Commission on Social Policy*, *3 (1),* 3-41. Wellington, New Zealand: Royal Commission on Social Policy.

Howden-Chapman, P., & Tobias, M. (eds). (2000). *Social inequalities in health: New Zealand 1999.* Wellington: Ministry of Health and Wellington School of Medicine.

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara tika. Guidelines for Ma□ori research ethics: A framework for researchers and ethics committee members.* Auckland: New Zealand: Health Research Council of New Zealand.

Huria, G. (2010). *Whanau Ora*. Presentation to PUBH 709 Hauora - Māori health issues class, at St Elmo's Courts, Otago Department of Public Medicine, Christchurch, New Zealand. 6 August 2010.

Ihimaera, L. V. (2007). *Whakarato whanau ora –Whanau wellbeing is central to Maori wellbeing*. Companion paper to Te Raukura: Mental health and alcohol and other drugs: improving outcomes for children and youth, Ministry of Health, (2007). Palmerston North, New Zealand: Te Rau Matatini.

Jacobsen, V., Fursman, L., Bryant, J., Claridge, & Jensen, B. (2004). *Theories of the family and policy. New Zealand Treasury working paper 04/02*. Wellington, New Zealand: The Treasury.

Katene, R., & Turia, T (2010). Questions for oral answer: Whānau Ora – significance. *Parliamentary Hansard,* 6 May 2010, 10816-10817.

King, A, & Sharples, P. (2010). Questions for oral Answer: Te Puni Kōkiri - role in policy development. *Parliamentary Hansard,* 18 March 2010, 9613-9614.

King, A, & Turia, T. (2010). Questions for oral answer: Whānau Ora establishment of contracts. *Parliamentary Hansard,* 21 April 2010, 10317.

King, A., & Turia, T. (2010, 27 April). Questions for oral answer: Whānau Ora, Minister – statements. *Parliamentary Hansard,* 27 April 2010, 10451-10452.

Kingdon, J. W. (1995). *Agendas, alternatives, and public policies* (2nd edition). New York, USA: Harper Collins College Publishers.

Kingi, T. R. (2007). The Treaty of Waitangi: A framework for Māori health development. New Zealand Journal of Occupational Therapy, 54(1), 4-10.

Kiro, C., von Randow, M., & Sporle, A. (2010). *Trends in wellbeing for Māori households and families*. Wellington: Family Whānau and Wellbeing Project, Massey University and University of Auckland.

Kirmayer, L.J. (2004). The cultural diversity of healing: meaning, metaphor and mechanism. *British Medical Bulletin, 69*, 33–48.

Last, J. M. (Ed.) (2007). *A Dictionary of Public Health*. Oxford Reference Online. Oxford University Press. Canterbury University. <http://www.oxfordreference.com/views/ENTRY.html?subview=Main&entry=t235.e1953>

Maher, P. (1999). A review of 'traditional' Aboriginal health beliefs. *Australian Journal of Rural Health, 7*, 229-236.

Mahuta, N. & Turia, T. (2010). Questions for oral answer: Whānau ora taskforce – recommendations. *Parliamentary Hansard*, 16 February 2010, 8876-8877.

Māori Party (2010a). *Hon Tariana Turia.* http://www.maoriparty.org/index.php?pag=cms&id=144&p=tariana-turia.html

Māori Party (2010b). *Our achievements, your achievements - November 2008 to June 2010.* http://www.maoriparty.org/file_uploads/maoriparty.pdf

Māori Party (2010c). *Confidence and supply agreement between us and the National party*. http://www.maoriparty.org/index.php?pag=cms&id=153&p=national-party-and-the-ma□ori-party-agreement.html.

Māori Reference Group (2009). *E Tu Whanau-ora: programme of action for addressing family violence 2008 -2013*. Wellington New Zealand: Ministry of Social Development.

Matthews, A., Jackson Pulver, L. R., & Ring, I. T. (2008). Strengthening the link between policy formulation and implementation of indigenous health policy directions. *Australian Health review, 32* (4), 613 - 625.

Mauriora Ki Te Ao - Living Universe Limited. (2010). *Whānau Ora integrated services delivery. A report prepared for the Ministry of Health.* Wellington, New Zealand: Ministry of Health.

Metge, J. (1995). *New growth from old: the wha□nau in the modern world.* Victoria University Press, Wellington.

Milligan, S., Fabian, A., Coupe, P., Errington, C. (2006). *Family wellbeing indicators from the 1981–2001 New Zealand Censuses*. New Zealand: Statistics New Zealand.

Ministry of Health. (1998). *Whaia te whanaungatanga: Oranga whanau – The wellbeing of whanau. The Public health issues.* Wellington, New Zealand: Ministry of Health.

Ministry of Health. (2000). *The New Zealand health strategy*. Wellington, NZ: Ministry of Health.

Ministry of Health. (2001). *The New Zealand disability strategy*. Wellington, NZ: Ministry of Health.

Ministry of Health. (2002). *He Korowai Oranga – Māori Health Strategy*. Wellington, New Zealand: Ministry of Health.

Ministry of Health. (2007). *Te Raukura Mental health and alcohol and other drugs: Improving outcomes for children and youth.* Wellington: Ministry of Health.

Ministry of Health. (2008). *A portrait of health: key results of the 2006/07 New Zealand health survey.* Wellington: Ministry of Health.

Ministry of Health. (2009). *A focus on the health of Māori and Pacific Children: key findings of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.

Ministry of Health (2010a). *Ministry of Health commends providers selected for Whanau ora collectives*. (Media Release, 29 October 2010). http://www.moh.govt.nz/moh.nsf/indexmh/whanau-ora-providers-selected?Open

Ministry of Health. (2010b). *Disability in New Zealand. Individalised Funding project*. http://www.moh.govt.nz/moh.nsf/indexmh/disability-keyprojects-ifp

Minister of Health and Associate Minister of Health. (2006). *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011.* Wellington: Ministry of Health.

Ministry of Social Development (2004). *Families Outcomes Hierarchy. Family Services National Advisory Council*. Family and Community Services. Ratonga ā-whānau, ā-hapori.

Ministry of Social Development (2010a). *About us and our work: Work programmes - Initiatives: Whānau Ora: Taskforce on Whānau-centred Initiatives.* http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/whanau-ora/index.html

Ministry of Social Development. (2010b). *About us and our work: Work programmes - Initiatives: Taskforce on Whānau-centred initiatives terms of reference* http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/whanau-ora/terms-of-reference.html

Ministry of Social Development (2010c). *Whānau Ora Implementation Gets Underway*. (Media Release). http://www.msd.govt.nz/about-msd-and-our-work/newsroom/media-releases/2010/whanau-ora.html

Ministry of Social Development (2010d). *Whānau Ora providers show widening enthusiasm for whānau-centred services*. (Media Release). http://www.msd.govt.nz/about-msd-and-our-work/newsroom/media-releases/2010/whanau-ora-providers.html

Milligan, S., Fabian, A., Coope, P., & Errington, C. (2006). *Family wellbeing indicators from the 1981–2001 New Zealand Censuses.* Wellington, New Zealand: Statistics New Zealand.

Morgan, T. (2010, November 5). Iwi find own solution to history of state neglect, NZ Herald, p A11.

National Health Committee (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health*. Wellington. New Zealand: National Advisory Committee on Health and Disability.

National Health Committee. (2010a). *Rural health: Challenges of distance, opportunities for innovation*. Wellington. National Health Committee.

National Health Committee. (2010b). *Health in justice: kia piki te ora, kia tika! – Improving the health of prisoners and their families and whānau: He whakapiki i te ora o ngā mauhere me ō rātou whānau*. Wellington: Ministry of Health.

National Health Committee. (2010c). *How should we care for the carers, now and into the future?* Wellington: Ministry of Health.

New Zealand Government - Kāwanatanga o Aotearoa. (2010a). *Whanau Ora an investment in families*. (Media Release, 6 May).http://beehive.govt.nz/release/whanau-ora-investment-families

New Zealand Government - Kāwanatanga o Aotearoa. (2010b). *Whanau Ora a bold move from innovative government*. Paula Bennett. (Media Release, 6 May). http://beehive.govt.nz/release/whanau-ora-bold-move-innovative-govt

New Zealand Government - Kāwanatanga o Aotearoa. (2010c). *PM appoints Whanau Ora minister*. (Media Release, 8 April). http://www.beehive.govt.nz/release/pm-appoints-whanau-ora-minister

New Zealand Government - Kāwanatanga o Aotearoa. (2010d). *Seamless delivery of services a goal for Maori providers*. Tariana Turia (Media release, 24 November).

New Zealand Government - Kāwanatanga o Aotearoa. (2010e). *Government welcome Whanau Ora report*. Bill English, Tariana Turia. (Media Release, 8 April). http://beehive.govt.nz/release/government-welcomes-whanau-ora-report

New Zealand Government - Kāwanatanga o Aotearoa. (2010f). *Regional Leadership groups announced*. (Media Release, 18 July). http://beehive.govt.nz/release/regional-leadership-groups-announced

New Zealand Government - Kāwanatanga o Aotearoa. (2010g). *Whanau ora announcement this Friday*. http://beehive.govt.nz/release/whanau-ora-announcement-friday

New Zealand Government - Kāwanatanga o Aotearoa. (2010h). *Whanau fund launched*. (Media Release, 29 October). http://beehive.govt.nz/release/whanau-fund-launched

New Zealand Government - Kāwanatanga o Aotearoa. (2010i). *Turia welcomes Social Services Report*. (Media Release, 2 September). http://beehive.govt.nz/release/turia-welcomes-social-services-report

New Zealand Taskforce on Whānau Centred Initiatives (2010). *Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives*. Wellington, New Zealand: Office for the Community and Voluntary Sector.

NZ Legislation (1975). Treaty of Waitangi Act 1975 No 114 (as at 16 December 2010), Public Act. http://www.legislation.govt.nz/act/public/1975/0114/latest/DLM435368.html

NZ Legislation (1989). *Children, Young Persons, and Their Families Act 1989*, No 24 (as at 29 November 2010), Public Act. http://www.legislation.govt.nz/act/public/1989/0024/latest/DLM147088.html

NZ Legislation (2003). *Families Commission Act 2003*, No 128 (as at 26 April 2005), Public Act. http://www.legislation.govt.nz/act/public/2003/0128/latest/DLM236104.html

Office for the Community and Voluntary Sector. (2007). *Mahi ora: Maori perspectives on volunteering and cultural obligations*. Wellington, New Zealand: Office for the Community and Voluntary Sector.

Pitama, S., Robertson, P., Cram, F., Gillies, G., Huria, T., & Dallas-Katoa, W., (2007). Meihana model: a clinical assessment framework. *New Zealand Journal of Psychology, 36* (3), 118 – 125

Price, L., & Allen, M. (2003). *Effective access to tobacco dependence treatment, New Zealand*. Geneva, World Health Organization, (WHO/NMH/TFI/FTC/03.8).

Public Health Commission. (1995). *He Matariki. A strategic plan for Maori public health - he kaupapa whainga roa mo te hauora tumatanui Maori: the Public Health Commission's advice to the Minister of Health, 1994-1995*. New Zealand: Public Health Commission.

Public Health Advisory Committee. (2010). *The best start in life: achieving effective action on child health and wellbeing*. Wellington: Ministry of Health.

Rissmiller, K. (2000). *Approaching a model of policy change: a challenge to political science.* Proceedings for the Eighteenth International Conference of the System Dynamics Society August 6 – 10, 2000. Bergen, Norway.

Robinson, B., & Harris, R. (Eds.) (2007) *Hauora Ma□ori Standards of Health IV. A Study of the Years 2000–2005*. Wellington: Te Rōpu Rangahau Hauora a Eru Pōmare.

Rossi, P. H., Lipsey, M. W., Freeman, H. E. (2004). *Evaluation: a systematic approach* (7th edition). California, USA: Sage Publications, Inc.

Sabatier, P. A., & Jenkins-Smith, H. C. (Eds.) (1993). *Policy Change and Learning: An Advocacy Coalition Approach*. Boulder, CO: Westview Press.

Sabitier, P., & Mazmanian, D. (1979). The conditions of effective implementation: a guide to accomplishing policy objectives. *Policy Analysis, 5* (4), 481 – 504.

Shaw, S., & Deed, B. (Eds). (2010). *Health & Environment in Aotearoa New Zealand.* Melbourne, Australia: Oxford University Press.

State Services Commission. (2005). *The Treaty of Waitangi information programme*, *booklets 1 – 5*. Wellington, New Zealand: States Services Commission.

Te Kōhanga Reo National Trust. (2010). *Te Kōhanga Reo national trust*, homepage. http://www.kohanga.ac.nz/

Te Puni Kōkiri (2010a). *Whanau Ora launches with $134.3m*. (Media Release, 6 May)

http://www.tpk.govt.nz/en/newsevents/news/archive/2010/5/6/whanau-ora-launches-with-134.3m--/

Te Puni Kōkiri (2010b). *Whānau Ora: Regional Hui*. (Media Release, 6 May) http://www.tpk.govt.nz/en/newsevents/news/archive/2010/5/6/whanau-ora-regional-hui/

Te Puni Kōkiri. (2010c). Whanau Ora. The governnance group. http://www.tpk.govt.nz/en/in-focus/whanau-ora/governance/

Te Puni Kōkiri (2010d). *Whānau Ora implementation gets underway expression of interest process & regional leadership group nominations open*. (Media Release, 9 June). http://www.tpk.govt.nz/en/newsevents/news/archive/2010/6/9/whanauora-eoi-rlg/

Te Puni Kōkiri (2010e). *Whānau Ora expressions of interest*. (Media Release, 5 August). http://www.tpk.govt.nz/en/newsevents/news/archive/2010/8/5/whanau-ora-expressions-of-interest/

Te Puni Kōkiri (2010f). *Second wave of Whānau Ora EOI proposals still open*. (Media Release, 9 July). http://www.tpk.govt.nz/en/newsevents/news/archive/2010/7/9/second-wave-of-whanau-ora-eoi-proposals-still-open/

Te Puni Kōkiri (2010g). The latest from Whānau Ora. Kōkiri, 20. http://www.tpk.govt.nz/en/in-print/kokiri/kokiri-20-2010/the-latest-from-whanau-ora/

Te Puni Kōkiri (2010h). Programme of Action Presentation. Whanau Ora: Aspiration, Inspiration, Determination. http://www.tpk.govt.nz/_documents/tpk-leithpresentprogramaction-2010-en.pdf

Te Puni Kōkiri (2010i). Whānau Ora providers presentation. http://www.tpk.govt.nz/_documents/tpk-whanau%20ora%20providers_rob%20cooper-2010-en.pdf

Te Puni Kōkiri (2010j). *Expressions of interest for Whānau Ora action research*. (Media Release). http://www.tpk.govt.nz/en/newsevents/news/archive/2010/10/20/expressions-of-interest--for-whanau-ora-action-research/

Te Puni Kōkiri. (2008). *Closing the Gaps - Lessons from New Zealand*. Leith Comer Chief Executive, Ministry of Maori development, To Ministerial Council for Aboriginal & Torres Strait Islander Affairs.

The Treaty of Waitangi Act. (1975). *No 114 (as at 16 December 2010), Public Act*. http://www.legislation.govt.nz/act/public/1975/0114/latest/DLM435368.html

Turia, T. (2010, 11 February). Handover of Report from the Taskforce on Whanau Centred Initiatives. (Speech). http://www.beehive.govt.nz/speech/handover-report-taskforce-whanau-centred-initiatives

Turia, T. (2010, 8 April). *Report of the Ttaskforce on Whanau centred initiatives*. (Speech). http://beehive.govt.nz/speech/report-taskforce-whanau-centred-initiatives

Turia, T. (2010, 22 April). *Speech made at launch of the Families Commission's Whanau Strategy*. http://beehive.govt.nz/speech/launch-families-commission%E2%80%99s-whanau-strategy

Turia, T. (2010, 6 May). *Whanau Ora: Budget 2010*. (Speech). http://beehive.govt.nz/speech/speech-whanau-ora-budget-2010

Turia, T. (2010, 7 May). *Aroha Mamaku Whero Piwakawaka hui. Huihuinga 2010*. (Speech)

Turia, T. (2010, 28 May). *Speech made at Pasifika Youth Event*. http://beehive.govt.nz/speech/pasifika-youth-event

Turia, T. (2010, 21 June). *Whanau Ora: Transformation.* (Speech). http://beehive.govt.nz/speech/whanau-ora-transformation

Turia, T. (2010, 27 August). *Whakatipuranga Rima Rau towards 500*. (Speech). http://beehive.govt.nz/speech/whakatipuranga-rima-rau-towards-500

Turia, T. (2010, 31 August). *Tu Kaha 2010: Looking ahead - Te Karu Rarapa o te Ika: Our People, our Strengths; our Way.* (Speech). http://beehive.govt.nz/speech/tu-kaha-2010-looking-ahead-te-karu-rarapa-o-te-ika-our-people-our-strengths-our-way

Turia, T (2010, 1 November). *Speech made at the'Taking Back Control' - Co-existing Disorders Symposium*. http://beehive.govt.nz/speech/quottaking-back-control039-co-existing-disorders-symposium

Turia, T (2010, 4 November). *Speech made at the National Collective of Independent Women's Refuges Inc Conference 2010*. http://beehive.govt.nz/speech/national-collective-independent-women039s-refuges-inc-conference-2010

Turia, T. (2010, 8 November). *Speech made at Maori academic achievement dinner acknowledging significant contribution to Maori academic achievement.* http://beehive.govt.nz/speech/maori-academic-achievement-dinner-acknowledging-significant-contribution-maori-academic-achie

University of Auckland. (2010). *Faculty of Arts - Centre of Methods and Policy Application in the Social Sciences. Family Whanau and Wellbeing Project (FWWP).* http://www.arts.auckland.ac.nz/uoa/family-whanau-and-wellbeing-project-fwwp

Waitangi Tribunal. (1998). *Te Whanau o Waipareira Report. Wai 414.* Wellington, New Zealand: GP Publications. http://www.waitangi-tribunal.govt.nz/scripts/reports/reports/414/C4DFA609-93A5-4619-8FBE-F8C0D6EC68D8.pdf

Waitangi Tribunal. (2011). Waitangi Tribunal. Te roopu whakamana o te tiriti Waitangi. http://www.legislation.govt.nz/act/public/1975/0114/latest/DLM435368.html

Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning, 9* (4), 353-370.

Wilkinson, R,. & Marmot, M. (Eds.). (2003). *Social determinants of health: The solid facts (2nd ed.*). Denmark: World Health Organization.

World Health Organization. (1946). Preamble to the constitution of the World Health Organization as adopted by the International Health Conference, 19-22 June 1946. New York, USA.

World Health Organisation. (1978). *Declaration of Alma-Ata*. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. Available at http://www.who.int/hpr/archive/ docs/almaata.html

World Health Organization. (1986). *Ottawa Charter for Health Promotion*. WHO/HPR/HEP/95.1. Geneva: World Health Organization.

World Health Organization. (2007a). *Media Centre. Health of indigenous peoples*. Fact sheet Number 326. http://www.who.int/mediacentre/factsheets/fs326/en/index.html#

World Health Organization. (2007b). *Everybody's business: strengthening health systems*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2008) The world health report. Primary health care: Now more than ever. Geneva: World Health Organization.

World Health Organization. (2010). The components of a well functioning health system. http://www.who.int/healthsystems/EN_HSSkeycomponents.pdf