

He taonga te hauora

Lifting Māori enterprise and labour market outcomes

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Executive summary

He taonga te hauora

Health is wealth

Sector-specific insights facilitate focused policy, strategy, and programme formulation

The Māori economy has grown in significance, complexity, and depth. It has entrenched itself as a crucial component of the wider New Zealand economy. Yet its present position and growth lag well behind the remainder of the economy. A series of high-level reports have accounted for Māori economic shortfalls, largely on a national or economy-wide scale, but few have focused on economic participation in specific industries. This means variances and nuances of Māori participation in different domains of the economy are not being captured. Focused policy, strategies, and sector-specific programmes cannot be developed without these crucial industry insights.

The purpose of this report is to understand the present state of Māori participation in health sector delivery and enterprise, and subsequently develop a strategy that includes policy recommendations and direction-setting initiatives aimed at elevating Māori participation. Our mahi is guided by four key questions:

- Where are Māori employed in the health sector?
- What is the present state of Māori business ownership in the sector?
- What challenges are facing Māori employment and business ownership in health?
- How can Māori economic participation be elevated?

Given these guiding questions, our mahi is explorative in nature. It draws upon and combines quantitative data as well as qualitative insights from comprehensive stakeholder engagement.

Key findings from our mahi

Several key findings emerged from our analysis, some of which reflect broader economic issues, while others appear exclusive to Māori participation in health.

- **There are significant economic opportunities available in the health sector.** Significant budgetary expenditure coupled with health sector reformation support favourable conditions for elevating Māori economic participation in the health sector.
- **There is insufficient data concerning Māori economic participation.** Data availability, or lack thereof, prevented us from comprehensively detailing Māori participation in all domains of the health sector. More detailed data would have permitted the development of more

pointed recommendations.

- **Māori are generally underrepresented in health sector and enterprise ownership.** Broadly confirming the position of prior research, we found that Māori are underrepresented in virtually all domains of the health sector. Representation in medical specialities is especially low.
- Māori business (SMEs) owners and entrepreneurs are generally more focused on improving the health of Māori and less on commercial success. It is not clear that this mindset is understood nor recognised by Māori health service funding regimes. Māori practitioners would benefit from targeted business advice and support at the point at which they contemplate establishing a health enterprise.
- **Māori representation in tertiary health programmes is low.** Despite nominal increases in some areas, Māori representation in tertiary health programmes, as a proportion of population size, has decreased in recent years. This is broadly reflected across all health-related disciplines.
- Non-linear pathways into tertiary health education are vital to Māori representation.
- Many Māori have gained access to medical education via non-linear university access programmes, such as the Māori and Pacific Admission Scheme (MAPAS). MAPAS can be characterised as a government-funded support model to improve access to tertiary health programmes. The success of MAPAS has been attributed to its reach into secondary schools. Well-known and esteemed Māori medical professionals obtained their education through similar means.
- **Capital access issues constrain Māori enterprise formation and growth.** Māori health entrepreneurs reported difficulty accessing capital required for forming and developing their businesses. This finding is broadly reflected in the wider economy and echoes mahi conducted by Te Pūtea Matua.
- **Iwi may be missing economic opportunities in health.** Iwi do not appear to be capitalising to the fullest possible extent on the significant economic opportunities available in the health sector. A lack of iwi involvement in health is not necessarily the result of a skills or capabilities deficit, but instead reflects an opportunity cost of iwi focusing their economic activities in other sectors and industries, such as property development.
- **Iwi partnerships can create significant economic opportunities for Māori in health.** Iwi partnership models enable the provision of Māori workforces and enable investment in health enterprises. We identify them as a valuable mechanism for creating economic opportunities for Māori.
- **Enacting the Māori worldview is an expense for health enterprises.** Māori health entrepreneurs who enliven te ao Māori wear the costs of providing free, or heavily discounted,

medical treatment to their communities. The costs associated with this can prohibit Māori enterprise growth and development.

- **Māori health enterprises are often funded at lower rates to deliver similar services.** This is especially the case for those who enliven te ao Māori and 'go the extra mile' for their clients. The COVID-19 experience has highlighted the extent to which Māori deliver more for less. This can serve as a constraint to Māori health business growth and sustainability.
- **Rongoā Māori represents an avenue of economic opportunity for Māori.** Rongoā is not a new domain of the health sector, but the recent provision of ACC funding for rongoā treatments means that it represents a novel area of economic opportunity exclusively for Māori. This opportunity includes rongoā treatments and therapies, but also extends to rongoā medicinal products.

Bold action needed

The health reforms present a significant opportunity through direct commissioning through Te Aka Whai Ora, and for partnered commissioning through Te Whatu Ora. It is too early to tell how those institutional changes will play out, but a measured, objective approach, with benefits realisation and measurement of enterprise outcomes, will be a step in the right direction.

Using the findings presented in this report, there is a clear path to a strategy aimed at elevating Māori economic participation in the health sector. At a high level, our strategy focuses on the following areas:

- *Improved coordination* – as between government, iwi, health professionals, and universities. The purpose of improved coordination is to promote streamlined interactions and the identification of key synergies for mutual results.
- *Coaching* – which involves supporting the provision of mentoring and advice, including business advice, and navigating the terrain. The purpose of coaching is to shine a light on valuable pathways to ongoing prosperity and mana-enhancing growth.
- *Collection* – of information and data to accurately illustrate the landscape of participation and what changes might be required in the future. The goal of greater collection activity is to provide necessary insight and guidance for Māori (and others) to make efficient and rewarding decisions from a base of mutual understanding.
- *Culture* – which covers education and the pipeline of opportunities and resources (enterprises and individuals). The goal is to ensure that there are sufficient capability and resources available to exploit available economic prospects.

We recommend a goal-seeking approach where Te Whatu Ora and Te Aka Whai Ora look at achieving equity of participation in health enterprises and health workforces by 2035. To do this, entry into health programmes may have to change drastically, and selection of candidates for medical school might, for instance, be selected on aptitude to address equity issues rather than academic performance.

The actions needed will require strong leadership and co-ordination across the health sector and with Te Pūkenga and universities. The workforce functionality in Manatū Hauora and Te Whatu Ora will need to be much more active, and Te Aka Whai Ora and the Ministry of Health will need to hold the health sector to account for growing Māori and iwi small- and medium-sized health businesses. There is an open question as to whether the entry criteria for training for these professions is fit for purpose or whether a different approach could be taken, ensuring the most relevant students are trained and mentored into health enterprises.

Immediate actions include:

- streamlining Māori access to capital using both demand and supply side measures, including the establishment of indigenous lending institutions and the provision of financial literacy education
- rollout of apprenticeship programmes across health sector domains, including actively working with current health providers to “staircase” health skills of Māori staff
- rapid and material expansion of the MAPAS and similar programmes to increase the number of Māori studying health programmes rapidly and significantly at tertiary level
- business and financial literacy training possibly offered through an organisation focussed on improving diversity and participation in business, through a formalised contract with a provider of such services, such as Amotai
- business mentorship programmes for Māori health professionals, to deliver the business skilled required for establishing and successfully operating a health enterprise, in a way that is consistent with Māori values and aspirations
- iwi-government partnership models in developing and delivering service models, particularly in primary, community, and aged care
- authentication of rongoā Māori practice in the health sector, along the lines of ACC’s initiative
- data collection and management projects to provide accurate reporting on the dimensions of Māori participation in the health sector
- liaising with government agencies to resolve labour market issues, towards viewing Māori as the solution to labour shortages in the health sector

As a provocation, and as a way of challenging current practice, we recommend Manatū Hauora facilitate an interdepartmental/tertiary institution working group with the aim of establishing a pathway to Māori being *overrepresented* in all health professions and, also, in all health enterprise. If we aim to overshoot, then, after many years of trying but not achieving, we are more likely to attain the goal of equal representation.

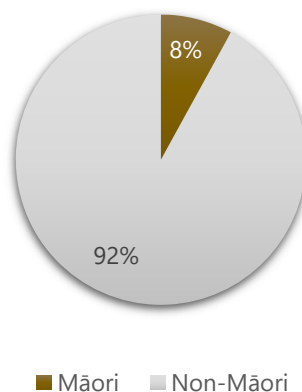
Part A: context and strategy

1. Purpose of this report

The development of a Māori health sector economic strategy follows from the innovative *Te Matapaeroa Report*, the setting of Māori Economic Development as a Te Puni Kōkiri Strategic Priority in 2021, and the Māori Economic Resilience Strategy (MERS) workstream within Te Puni Kōkiri. *Te Matapaeroa 2020* produced several pertinent Māori economy insights. Perhaps the most striking of these findings was that, proportionally, Aotearoa is approximately 20,000 Māori businesses short of equitable participation, and regrettably there has been limited growth in business ownership during the past decade.

Recent reporting (Te Puni Kōkiri, 2022) finds that approximately 8 per cent of businesses in Aotearoa are Māori-owned, significantly contrasting with the 17 per cent of Māori represented in the population at large.

Figure 1: Enterprise ownership proportions (Te Puni Kōkiri, 2022)



Nominally, to achieve population equity in enterprise ownership, roughly 23,000 new Māori enterprises would be required, assuming no growth in non-Māori business ownership. Expanding Māori enterprise in health would, therefore, help to bridge the considerable gap in business ownership between Māori and non-Māori.

Towards elevating Māori business ownership, a series of Māori industry and sector strategies are being developed. Our Māori health enterprise strategy represents an important constituent in that series for both economic and health-related outcomes.

This report aims to provide a baseline stocktake of the state of play for Māori enterprise in the health sector. Our stocktake includes:

- an examination of the financial opportunity for Māori enterprises in the health sector
- an examination of Māori employment in the health sector
- an examination of Māori enterprise ownership in the health sector
- an examination of Māori enrolment in clinical education

- the identification of key barriers and opportunities for elevating Māori economic participation in the health sector
- the identification of Māori 'best practice' and successful models and practitioners whose approach provides potential pathways for others to follow
- suggestions for moving forward.

1.1 We adopt a mixed method approach

Our mahi has two broad objectives:

- understand the landscape of Māori participation in the health sector
- understand the challenges to, and opportunities for, elevating Māori participation in the health sector.

These objectives demand different, yet complementary, approaches from qualitative and quantitative domains.

Our approach consists of quantitative analysis of Māori health sector participation data, stakeholder interviews, and a literature review. We conducted a quantitative analysis of labour market and enterprise ownership data to develop an understanding of Māori participation in the health sector landscape. This analysis permitted the identification of health sector domains where Māori are employed and own businesses. By extension, we were able to identify key areas where Māori are especially underrepresented. Additionally, we analysed tertiary education data to gain an understanding of the pipeline of Māori in clinical education. To gain insights into the challenges and opportunities facing Māori in the health sector, we conducted in-depth semi-structured interviews with a range of health sector stakeholders, including public officials and Māori health sector entrepreneurs. Our analyses were supported by a literature review that principally focused on:

- persistent inequalities in health outcomes between Māori and non-Māori
- the roles of cultural knowledge in health outcomes
- established initiatives that aim to mobilise Māori into health education
- mechanisms for supporting Māori medical students
- mechanisms for supporting Māori health workers
- challenges faced by Māori health providers
- the expression of Te Tiriti in elevating Māori participation in health.

Canvassing these areas allowed us to identify and contrast the sentiment of established literature with our quantitative data and the experiences of our stakeholders.

1.2 Our definition of a 'Māori business' is based on self-identification

For the purposes of enabling better consistency across government in the measurement and reporting of Māori business activity, Stats NZ has made considerable progress in developing a standardised definition of a 'Māori business'. Following a series of hui and Māori engagements, Stats NZ identified three primary components that can define a Māori business:

- whakapapa and self-identification
- a minimum Māori ownership level (50 per cent)
- a demonstration of Māori values and cultural connection.

Stats NZ's hui and engagements did not arrive at a consensus of what precisely constitutes a Māori business. In public sector procurement, at the time of writing, a Māori business is defined as either a Māori authority or an enterprise with at least 50 per cent Māori ownership (Te Puni Kokiri, 2022). However, for the purposes of clarity and ease of identification, we follow a self-identification methodology for sampling Māori businesses included in this report.

1.3 Human therapeutics and MedTech are excluded

There are three areas we *do not* examine for opportunity. The first area is pharmaceuticals and provision of clinical equipment, which are industries best examined through a MedTech and human therapeutics lens. The second area is that of construction of hospitals and other health service buildings. There is considerable opportunity in hospital construction, but that will be examined in a separate review of vertical construction. The third area is disability care, which is now funded by Whaikaha, the Ministry of Disabled People. Its care budgets reflect a similar opportunity to the Vote: Health's primary and community care budgets.

2. There is a compelling case for expanding Māori enterprise in the health sector

Recent reform in the health sector has significantly changed health system settings, creating new institutions and promising greater potential for the system to address health inequities for Māori. The conditions are right for change, and there is considerable opportunity for further involvement of Māori enterprise.

The health sector is a particularly important sector for the health and wellbeing of Māori, in the manner in which it serves Māori, the employment opportunities it brings in the public sector and the opportunities for Māori businesses in the private sector. In this section, we outline the recent changes to the health system and explore these interdependent but reinforcing aspects of the health sector, drawing on findings from our literature review and stakeholder interviews.

2.1 The case for change

Inequity between Māori and non-Māori is a persistent feature of the health system in Aotearoa. This is reflected both in health outcomes and access to medical services (Goodyear-Smith & Ashton, 2019). Inequitable health outcomes for Māori are indicative of limited healthcare access, but also of enduring poverty, institutional racism, and “a loss of momentum in the provision of accessible, innovative, and effective primary healthcare for high-needs groups” (Goodyear-Smith & Ashton, 2019, p. 439).

Reporting by the Ministry of Health (2013) has also indicated that Māori experience significantly greater levels of health loss when compared to non-Māori. Māori health inequities were further revealed during the COVID-19 pandemic, where Māori were 2.5 times more likely to be hospitalised by a COVID infection when compared to their non-Māori (excluding Pasifika) counterparts (Steyn et al., 2021).

2.2 The conditions are right

In 2019, the Waitangi Tribunal released a major report as part of Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575), finding that the Crown has failed to deliver equitable health outcomes for Māori in breach of Te Tiriti o Waitangi. The Tribunal argued that the primary health care framework has failed to properly provide for Māori and called for a system that genuinely empowers tino rangatiratanga for Māori. It also found that the Crown has underfunded Māori primary health organisations and providers. A separate Sapere report estimated the annual health loss in 2018 due to inadequate primary care to be \$5 billion (Love et al., 2021).

Among a number of other recommendations, the WAI 2575 report recommended the following principles for the primary health care system.

“Tino rangatiratanga: The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.

Equity: The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.

Active protection: The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

Options: The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

Partnership: The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.”¹

These principles have since been adopted by the Ministry for the wider health system. In particular, the principle of options explicitly sets out the Crown’s responsibility to fund and resource services that are culturally safe for Māori, reflecting the need and opportunity for increased Māori involvement in the system.

In July 2022, as part of wider reforms to the health and disability system and partly in response to WAI 2575, a new Māori Health Authority (Te Aka Whai Ora) was established through the Pae Ora (Healthy Futures) Act 2022. The Act has at its heart a commitment to the Treaty of Waitangi and a pro-equity view of health.

These recent changes represent a commitment to fundamentally shift the health system towards one that enables tino rangatiratanga for Māori, as well as significant opportunity for Māori-owned enterprise in the health sector.

2.3 New institutions

There has been a significant reform agenda. As briefly discussed above, the Pae Ora (Healthy Futures) Act 2022 took effect on 1 July 2022, establishing Te Whatu Ora (Health New Zealand) as the provider of hospital and specialist services and the commissioner of community and primary care services. Te Aka Whai Ora (the Māori Health Authority) was also established as an independent statutory authority to drive improvement in hauora Māori. Te Aka Whai Ora has a role in both commissioning services, particularly from Māori providers, and monitoring the performance of the health sector.

The Act also establishes Iwi-Māori Partnership Boards to represent local Māori perspectives on the needs and aspirations of Māori with respect to planning and decision-making for health services at the local level. Establishment of these boards and development of locality plans (which are intended

¹ <https://www.health.govt.nz/our-work/populations/Māori-health/te-tiriti-o-waitangi>, last accessed 6 October 2022.

to intersect health services with education, justice and social services) are in a range of stages of development but are generally just kicking off.

This reform agenda presents the sector with considerable opportunity.

The accident rehabilitation sector funded through ACC is active in providing packages of care.

With the recent health reforms providing greater focus to commissioning kaupapa Māori services and other services targeting Māori communities through the new Te Aka Whai Ora, it may be easier than before for Māori-owned enterprises to attain public funding in the health sector.

2.4 Te Tiriti

The Pae Ora Act is a legal roadmap which sets out how the Crown will meet its Te Tiriti obligations. This will have a particularly important impact on the health sector's organising institutions, from the Ministry of Health to Te Whatu Ora / Te Aka Whai Ora and meso-level network organisations such as primary health organisations (PHOs).

PHOs have previously reported working with Māori with the goal of reducing health inequities. According to PHOs, fulfilling Te Tiriti obligations is achieved through direct Māori engagement, as well as the designation of key staff in positions of responsibility, formal Māori partnerships, and providing strategic guidance. Moreover, the development of cultural competencies within PHOs is viewed as a means to live up to Te Tiriti obligations. However, more recent threads of scholarship have been critical of the health sector's ability to honour Te Tiriti (H. Came et al., 2021). Specifically, PHOs have been found to have poor to fair levels of compliance with most elements of Te Tiriti. According to Kidd et. al., (2022), for Te Tiriti to be fully realised in the health sector, PHOs need to:

- establish stronger and more robust relationships with hapū and iwi. These relationships can facilitate the understanding of Māori aspirations and, therefore, support the development of Māori health contributions.
- develop Te Tiriti responsiveness plans that are regularly reviewed and agreed upon by mana whenua. This will help ensure the PHO is maintaining its Tiriti obligations.
- develop antiracism plans to address racism, in all forms, within the organisation
- develop a health equity plan that identifies current inequities within the system. These plans should outline targets to move beyond equity and clear steps in how those targets should be achieved.
- develop a Māori health plan that is framed around the Māori worldview that includes Māori aspirations in and out of the health environment
- implement structural mechanisms that enable collaboration and co-governance
- normalise te ao Māori. This is achieved by deliberately building Māori representation and capability in the workforce, but also through encouraging cultural practice in the workplace.

2.5 Māori participation in health is important for more than economic reasons

Reflecting on the purposes of this report, we recognise the significance of mobilising more Māori into the healthcare sector for economic reasons. We acknowledge that lifting Māori representation in better paying, better qualified jobs will help lift the overall wellbeing of Māori and mitigate against job losses in lower levels during periods of economic downturn. This is especially pertinent in the health sector, where most career paths require higher levels of qualifications, and where Māori experience low levels of participation across the spectrum of roles in the sector. However, it must also be recognised that Māori participation in the healthcare sector is also important for non-economic reasons: (1) Māori health philosophies and delivery modalities require more Māori participation, and (2) underrepresentation of Māori may pose a risk to patient wellbeing.

Māori health kaupapa and delivery modalities require more Māori participation. Compared to its Western counterpart, Māori health provision takes a much broader view of health, to the point that the term *health* is often interchanged for *wellbeing*. Practically speaking, this means that Māori healthcare, or wellbeing, frequently incorporates peripheral services such as housing, social wellbeing, employment, economic support, and cultural services. A Māori provider expressed the kaupapa behind this approach:

“We take a holistic approach where we try to understand what people need to be happy, and that goes beyond health treatment. Medication is important, but it is more than that for us.”

Māori healthcare providers expressed a preference to have these wide-angled services delivered by Māori because ethnic Māori have a better comprehension of the tikanga and kaupapa behind the approach. However, their preference could not always be realised due to a general shortage of Māori clinicians, as one Māori provider articulated:

“Getting Māori into clinical roles is hugely difficult. There has not been a time when we are not recruiting. There are just not enough Māori clinicians.”

In other words, a general lack of Māori clinicians is prohibitive to the delivery of culturally sound Māori health care provision. Māori providers interviewed recognised that non-Māori clinicians can act as surrogates for Māori clinicians if they are willing to embrace tikanga and the kaupapa of Māori healthcare:

“It forces us to get non-Māori. There is nothing wrong with that if they get on board with the tikanga and kaupapa. Non-Māori will embrace it, but not necessarily understand it as we do.”

As the participant’s remarks indicate, non-Māori clinicians can stand in for Māori clinicians, but they are not considered suitable replacements as their capacity to fully comprehend tikanga and kaupapa may be limited by their lived experience as non-Māori. Perhaps more importantly, however, the lack of Māori clinicians may also have a negative impact on patient care.

Underrepresentation of Māori may pose a risk to patient wellbeing. Interview participants, both from Māori and non-Māori backgrounds, expressed concern that low numbers of Māori clinicians, but

especially GPs, posed a risk to patient wellbeing. A non-Māori GP reported that she had noticed her Māori colleagues were under significant pressure while receiving little support:

“We still only have 4 per cent Māori GPs, and I see a lot of burnt-out people that are not supported.”

Additional pressures may be faced by Māori GPs due to a “*cultural burden*” which encourages treating high numbers of patients. Pointing to a recent day at a Māori health practice, one participant advised:

“**[Health provider name]** had seen 65 clients between one doctor and one nurse. That is not sustainable in the long term, and it is dangerous.”

The participant’s example illustrates the pressures being faced by some Māori clinicians to deliver services to their communities. As the participant points out, delivering services in such high volumes, with limited resources, is unsustainable and poses a risk to patient wellbeing. Advancing Māori participation in health may, therefore, be an important lever for alleviating the pressures faced by existing Māori clinicians and minimising risks to patient wellbeing.

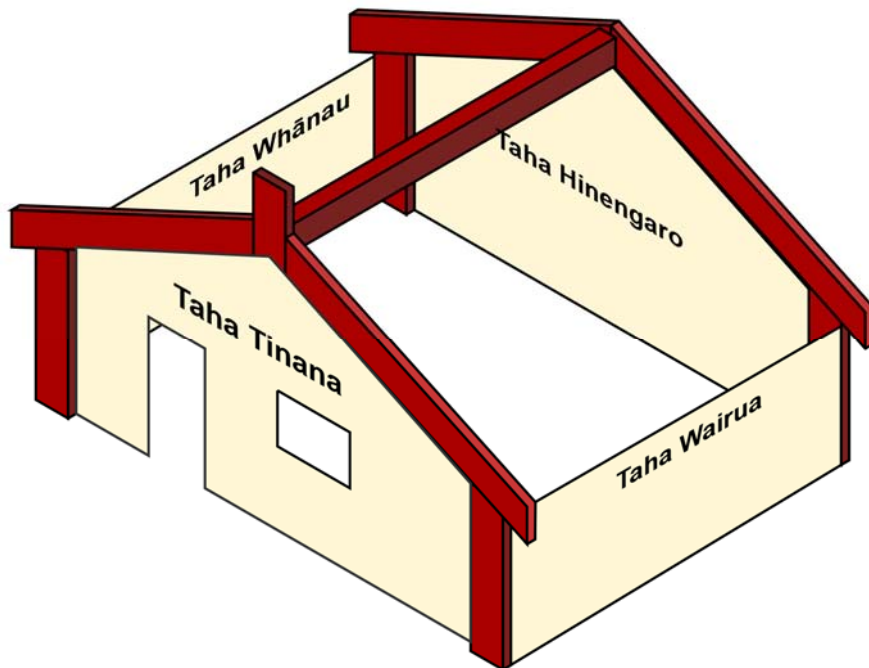
2.6 Māori enterprise can help reshape the health system

A key mechanism to minimising inequitable health outcomes is by increasing Māori representation in the health labour market and health enterprise ownership (Zambas et al., 2020). Fundamentally, this strategy focuses on elevating Māori participation in the health sector as a matter of economic outcomes. However, it is important to recognise that participation of Māori in the health sector is also relevant for Māori health outcomes. Improved economic outcomes are associated with better health outcomes (for instance, Wenzlow et al., 2004), and as such, elevating Māori health enterprise ownership and labour market participation represents an opportunity to simultaneously challenge enduring health and economic inequities.

Part of ensuring equitable health outcomes for Māori involves recognising different healthcare delivery modalities. Tā Mason Durie’s model of health, Te Whare Tapa Whā, illustrates how the Māori philosophy toward health is fundamentally holistic, in contrast to western models which have typically focussed on physical aspects of health. Te Whare Tapa Whā describes four dimensions to wellbeing:

- taha tinana (physical health)
- taha wairua (spiritual health)
- taha whānau (family health)
- taha hinengaro (mental health).

These four pillars of hauora can be illustrated by the symbol of the whareniui: four equal sides and strong foundations are needed for a whareniui – and a person’s health – to be balanced.



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An improved understanding of this holistic view of health is likely to increase the potential of the health sector to deliver culturally safe and kaupapa Māori health services, in turn helping to improve health and wellbeing outcomes for Māori. However, to be delivered effectively, practitioners are required to be knowledgeable, understanding, and confident regarding Māori culture (Kopua, 2019). As Wilson et al., (2021) suggest, there are additional dimensions to Māori healthcare delivery:

Table 1: Māori health values (Wilson et al., 2021)

Whanaungatanga (connectedness)	<i>Connectedness</i> denotes connections to the past, present, and future, as well as with whānau, mountains, rivers, and key landmarks. Remaining connected is viewed as vital for health and wellbeing.
Whakawhanaungatanga (building relationships)	Building relationships involves the mutual and reciprocal sharing of knowledge regarding who you are, where you are from, and what you do. This is conducive to cultural support and advocacy, which demonstrates manaakitanga, and is linked to Māori health and wellbeing.
Socio-political health context	The socio-political context is influential in Māori health outcomes. Effective interactions with patients require exploring issues that impact Māori health and wellbeing, such as racism, poverty, and marginalisation.

There is also reasonable evidence that race concordance between a patient and provider is associated with better patient ratings of care among adult primary care patients (Cooper and Powe, 2004). Māori are likely to be better positioned than other groups in the delivery of kaupapa services, but Māori representation in the health workforce and involvement in health enterprise needs to improve. As Curtis et al. (2012) state: "Under-representation of indigenous peoples within health professions reduces the potential of the health sector to provide a diverse, capable and culturally appropriate

workforce that meets the needs of indigenous communities.” Māori participation in the health sector is, therefore, an imperative in the push for equitable health outcomes.

2.7 More Māori culture and enterprise benefits all

In addition to health and economic outcomes, Māori participation in the health sector can lead to the expansion of Māori culture in the sector. Prevalence of culture in health has been associated with improved Māori health outcomes but also works for other priority populations.

“Cultural representation in health provision is important. Māori are more likely to engage with medical specialists who share the same cultural knowledge and background.”

Māori enterprises are guided by tikanga Māori. Māori entrepreneurs frequently utilise tikanga to navigate cultural and commercial imperatives. As Manganda et al. (2022) describe, commercial and cultural imperatives are not necessarily exclusive. Māori values can be enlivened in a commercial context. Table 2 indexes a series of Māori cultural imperatives and matches them with their non-Māori equivalents and manifestations in a commercial setting.

Table 2: Navigation of tikanga in a Māori enterprise context (Manganda et al., 2022)

Māori value	English equivalent	Manifestation in an enterprise context
Whakawhanaungatanga	Family relationships	Kinship ties are strengthened when family members are hired
Taonga tuku iho	Treasures handed down	Generational transfer of power and authority helps ensure the longevity of the firm
Mahi tahi	Working together	Collaboration between enterprises yields a collective benefit
Kotahitanga	Oneness	Providing for the tribe through employment opportunities
Whakaute	Respect	Respect for cultural values is imbued within commercial negotiations
Kaitiakitanga	Guardianship	Sustainability and resource management are highly important

The manifestation of tikanga in an enterprise setting represents a collective economic benefit for whānau, communities, and future generations. It also represents dividends in Māori culture and environmental sustainability. An uplift in Māori enterprise ownership in the health sector may, then, promote Māori economic, cultural, and environmental outcomes.

2.8 Māori business owners identified the importance of enterprise ownership

Our discussions with Māori health small and medium enterprise (SME) owners highlighted the importance of Māori business ownership for economic and non-economic reasons. Enterprise

ownership is associated with rangatiratanga and the ability to enliven Māori values in the health sector.

- **Māori health enterprise ownership is culturally and economically important:** Māori SME owners suggested that there are residual economic benefits, such as Māori employment, associated with Māori SME ownership. However, SME ownership is also important for the enacting and enlivening of Māori values in the health sector.

“I wanted to deliver pharmacy services in a way that fit with Māori values, being community facing and whānau-centric. My non-Māori colleagues never really understood that, and it could create problems.”

- **Private enterprise is required to enact the Māori worldview in health:** Working for an employer, especially in the domain of the mainstream health sector, does not provide Māori the flexibility and freedom required to deliver free or discounted medical treatment to Māori. Māori business ownership is, therefore, required in the provision of free or discounted services for Māori.

“Often dentists will have a single mother with toothache, and we’ll do it for free. I do understand that if I were in someone else’s workplace, wouldn’t have the freedom to do that and implement that culture.”

- **Māori-owned health enterprises create employment opportunities for other Māori:** Consistent with Māori values, namely whakawhanaungatanga, Māori business owners create employment opportunities for Māori. Practically, this involves offering or creating roles for Māori whānau or community members. Through this, Māori health enterprises represent an avenue for exposing Māori to health sector opportunities, which in turn may bolster the development of the Māori health workforce.

2.9 The enormous size of health spending

New Zealand’s health system is a mixed system, with services provided by public and private entities. Most of healthcare spending is funded publicly: about 81 per cent comes from public funding with the remaining portion from private insurance and out-of-pocket spending (estimated by the Health and Disability Sector Review in 2019). In this section we provide an overview of government funding for health and estimate public and private spending in different areas of the health sector. This allows insight into where it is within the health system that the key opportunities for Māori enterprise development lie.

The area of spending is 9.74 per cent of gross domestic product,² a very considerable pool of spending.

² World Bank estimate taken from https://www.theglobaleconomy.com/New-Zealand/health_spending_as_percent_of_gdp/ on 16 October 2022

2.9.1 The health budget

There are two key sources of public funding for health. The main source of public funding comes through from Vote Health, with the secondary key source being ACC – approximately 71 per cent and 19 per cent respectively (Health and Disability Sector Review, 2019). In the 2022/23 budget, Vote Health was over \$24 billion – a substantial investment in the health sector and the wellbeing of New Zealanders.

These numbers are difficult to comprehend because of the size of the spend. Even more compelling, this is what we spend year-on-year in the health sector.

The structure of the Vote has undergone major changes in the most recent budget. This reflects the structural changes in the reformed health system and the direction of broader system changes to public finance (part of the Treasury's Public Finance System Modernisation programme). Vote Health will follow a multi-year funding arrangement from Budget 2024, to align with the delivery of the first full New Zealand Health Plan.³

Prior to this year's budget, the Vote consisted of numerous appropriations (54), including one for each of the 20 District Health Boards and several appropriations for different services commissioned nationally through the Ministry of Health. These appropriations, the basis on which Parliament authorises the incurring of expenses or capital expenditure, were consolidated from Budget 2022/23, mirroring the centralisation and consolidation in the new health system operating model. Key changes to the new appropriation structure include the creation of new appropriations for:

- primary, community, population, and public health services
- hospital and specialist services
- hauora Māori services.

Budget 2022 notably provides \$168 million over four years to Te Aka Whai Ora's direct commissioning budget. This is in addition to funding that Budget 2021 provided for delivering hauora Māori services and the contracts from Māori providers which will have transferred from the Ministry to Te Aka Whai Ora.⁴

Vote 2022/23 also included:

- funding to set up the new health entities and clear the debts from the DHB system
- increased funding for community healthcare, with funding to support the new locality approach to primary and community healthcare
- the transfer of disability support services related to funding for Vote Social Development for Whaikaha, the new Ministry of Disabled People.

³ Refer Cabinet Social Wellbeing Committee minute (SWC-21-MIN-0157). Available at: <https://dpmc.govt.nz/sites/default/files/2022-08/proactive-release-htu-budget-funding-settings-aug22.pdf>. Last accessed 14 October 2022.

⁴ <https://www.health.govt.nz/about-ministry/what-we-do/budget-2022-vote-health>. Last accessed 14 October 2022.

2.9.2 Public and private spending

Here we present an approximation of public and private spending in the health sector and, thereby, identify key financial opportunities for Māori businesses.

We used four sources to estimate these figures: estimates from the Health and Disability System Review Interim Report (2019), Vote Health 2022, and the ACC 2021 Annual Report. The Interim Report estimates the amounts of public and private funding for a range of health services from 2017/18 figures. We have taken those proportions and applied them to more recent figures from Vote Health 2022 and the ACC Annual Report 2021. These provide approximate figures to understand the magnitude of spending in different health sectors, and the diverse funding sources.

While we acknowledge that COVID-19 and ongoing health reforms have altered the landscape of health sector spending, we expect proportional spending in key health sector domains to remain largely similar. Prior expenditure breakdowns, therefore, remain relevant for identifying financial opportunities for Māori businesses.

Table 3 shows our estimates of public spending across different health services.

Table 3: Public spending in the health sector for 2022

Budget breakdown (based on proportions of spend in HDSR 2019)	\$000 (Vote 2022)	\$000 (ACC 2021)
General practice and PHO services	\$1,773,838	\$982,000
Pharmaceuticals and community pharmacy	\$1,772,487	
Aged care (residential)	\$1,384,756	
Aged care (home based)	\$915,965	
Social rehabilitation	-	\$950,000
Community mental health	\$541,743	
Community referred laboratory	\$428,261	
Oral health	\$309,375	\$34,000
Maternity	\$306,673	
Ambulance and other transport	\$286,408	\$192,000
Child health	\$208,051	
Physiotherapy	-	\$193,190
Radiology	\$178,329	
Vocational rehabilitation	-	\$79,000
Māori health services	\$67,549	
Telehealth	\$36,476	
Optometry	-	

Sources: Vote Health 2022, ACC Annual Report 2021, Health and Disability System Review Interim Report (2019).

Private health sector spending estimates are shown in Table 4.

Table 4: Private health sector spending 2022

	Private funding \$m (adjusted for inflation Q2 of 2022)		
	Private insurance	Out of pocket	Sub total
General practice and PHO	\$35	\$416	\$452
Pharmaceuticals and com. pharmacy	\$9	\$883	\$892
Aged care (residential)	-	\$984	\$984
Aged care (home-based)	-	-	-
Social rehabilitation	-	-	-
Community mental health	-	\$22	\$22
Community referred lab services	-	\$3	\$3
Oral health	\$35	\$803	\$839
Maternity	\$8	-	\$8
Ambulance and other transport	-	\$9	\$9
Child health	-	-	-
Physiotherapy	-	\$86	\$86
Radiology	\$146	\$47	\$193
Vocational rehabilitation	-	-	-
Māori health services	-	-	-
Telehealth	-	-	-
Optometry	\$25	\$395	\$420
Total	\$260	\$3,648	\$3,908

Source: Based on HDSR estimates (2019) and adjusted for 2022.

2.10 Large categories of spending pose considerable opportunity

Opportunities differ across this large sector of New Zealand's economic activity. Based on interviews and our assessment, we identify three clusters of economic interest:

- Primary and community care services** – this sector, which is around \$8 billion of spending, represents high priority, high gain for growth in Māori enterprises. These services in this appropriation include a very broad range of aged care, primary and community care and allied health services. The services are generally contracted by health funders rather than being provided by health funders. They might be contracted under a notice issued under regulations (such as for midwives) or are provided by a community provider (likely a non-governmental, charitable organisation) or may be provided by a for-profit provider of general

practitioner, pharmacy, physiotherapy, or other services. Not all services are contracted and some, particularly community nursing services, may be provided by the provider arm of Te Whatu Ora. These services are exempt from government procurement rules, suggesting there could be opportunity to develop integrated workforce and commercial opportunity for Māori enterprise.

- **Hospital and specialist services** – high priority, high gain in terms of long-term specialist training, employment and then enterprise development. These hospital and specialist services are the medical and surgical services provided directly by Te Whatu Ora through its networks of regional hospitals. The occupations are regulated and provide considerable benefit both in terms of salary and, for proceduralists such as surgeons and anaesthetists, some opportunity to work both in the public sector and in private practice. There is room for a great deal of creativity in the provision of these specialist services including private hospitals, ownership and contracting of specialist equipment (e.g., magnetic resonance imaging) or outsourcing of aspects of specialists' services (e.g., contracting for provision of urology services). The workforce is complex, with a high level of involvement of international medical graduates, but this is an area for Māori enterprise to aspire to.
- **Operational support services** – medium priority, medium gain in enterprise development. Operational support services are critical to the operation of a health sector. These services include the laundry, catering, security, and maintenance contracts that support hospitals and that are generally contracted out to the private sector or to Te Whatu Ora owned joint venture companies. We speculate there is around \$70 million of spending in these services that could be well suited to joint venture with iwi and Māori SMEs, through the hospital supply chain. This category of spending is of a scale that current iwi organisations could potentially compete, from day one.

The health sector is a complex mix of contracting, provision, and substantial enabling services in facilities, information technology and workforce training. There is considerable opportunity in these areas that will be picked up in other strategies. For instance, spending on pharmaceuticals was \$1.04 billion in the year ended June 2021.⁵ However, practically all of those pharmaceuticals are imported, and likely there is opportunity, but it would be found in a science-based strategy based around human therapeutics. Likely the capital spend offers opportunity for development of a Māori workforce in vertical construction, with a health specialism, as hospital construction is complex and takes several years and a programme of hospital builds takes many years. That vertical construction opportunity is actively pursued by the health sector but needs to be seen through a construction industry lens.

⁵ Sourced from Pharmac's website <https://pharmac.govt.nz/about/what-we-do/how-pharmac-works/#:~:text=In%202020%2F21%2C%20we%20managed,in%20over%20%2C000%20different%20presentations>) on 16 October 2022.

3. A direction-setting strategy for elevating Māori economic participation

In this section we present a series of potential policy levers and direction-setting initiatives aimed at elevating Māori participation in the health sector, primarily through business ownership.

3.1 Streamlining access to capital

Some Māori business owners reported having difficulty accessing capital for business formation and for business growth. Streamlining access to capital can be viewed through the lens of both supply and demand.

- **From the demand side**, consideration could be given to the formation of indigenous lending institutions, like those operating in the Canadian context. Such a service would facilitate the provision of capital but also provide business support services and financial literacy programmes. Similarly, there is scope for replicating the Australian model of underwriting indigenous businesses that have limited access to capital.
- **From the supply side**, measures may include the provision of business and financial literacy that is consistent with obtaining lending from mainstream lending intuitions. Specifically, if loan applications from Māori health entrepreneurs are being rejected from mainstream lenders, it is important to establish why, and then seek to remedy those issues. Potentially there could be a tender for a preferred supplier of Māori banking and business mentoring services.

3.2 Rollout of apprenticeship programmes across health sector domains

Across a spectrum of health sector domains, our kōrero with key stakeholders indicated that there is considerable value in bringing Māori, especially rangatahi, into the health sector at entry level. In doing so, Māori are exposed to opportunities within the health sector and may consequently seek to upskill, or study health disciplines at university. Examples of this were evident in our analysis of our COVID-19 and Whakarongorau case studies.

The rationale for a health apprenticeship programme is informed by the view that exposure to the sector is a powerful catalyst for mobilising Māori into health sector careers. One participant made a strong case for apprenticeships in pharmacy, yet there is scope for an apprenticeship scheme to span several domains of the health sector. There are multiple options for funding an apprenticeship scheme, including following the Australian Indigenous Wage Subsidy programme, whereby the government would subsidise the wages of Māori health apprentices.

The cost of living may deter Māori involvement in an apprenticeship programme. It is, therefore, important that apprenticeships are suitably funded, and apprentices are paid a rate that is competitive in the current labour market.

3.3 Expansion of MAPAS and similar programmes to encourage Māori enrolment in health sciences

Our stakeholder kōrero indicated that the MAPAS programme has had considerable success in lifting Māori numbers in the core health science streams, including doctors, dentists, pharmacists and others. The programme has developed in strength by reaching further and deeper into secondary school learner cohorts – starting their week-long residential workshops with Year 13 students, before moving down to Years 12 and then 11.

3.4 Business and financial literacy training

Some participants suggested that a lack of business knowledge and understanding was preventing Māori health professionals from business ownership. Therefore, business and financial literacy training was identified as an important educational tool for supporting the transition from health professional to health entrepreneur.

- In addition to the core content included in mainstream business and financial training, it will be necessary to include education surrounding the health sector funding models, and the processes surrounding funding access.
- Weaving tikanga into a business and financial literacy training programme may be pertinent. Māori entrepreneurs in many parts of the economy navigate commercial and cultural imperatives. It may be valuable to demonstrate how tikanga values can be enlivened in a commercial health setting.

Our participants suggested that this training should be made available to Māori health professionals no earlier than two years post qualification. Given the proposed timeframe, there is likely an opportunity to deliver these programmes in partnership with New Zealand's health training institutions.

There is also an option to extend the *Kia ora Hauora* workforce development programme (Savage et al., 2020). Materially, the programme appears to have been successful in promoting Māori labour market outcomes. Therefore, *Kia ora Hauora* may be well-positioned to extend its reach into health enterprise ownership.

3.5 Business mentorship programmes for health professionals

As a companion to business and financial literacy training, there is scope for the implementation of a Māori business mentorship programme. Some of our participants reflected on the use of a mainstream business mentorship programme with general dissatisfaction.

- The provision of a Māori specific business mentorship programme, designed for new health entrepreneurs, may have sufficient specificity to positively influence commercial outcomes.

- A Māori-specific mentorship programme would be optimally delivered by a correspondingly Māori organisation. Te Puni Kōkiri, for example, may be well-positioned to deliver such a programme.

3.6 Iwi-government partnership models

Improved coordination and transitioning away from siloed thinking and operation is not a unique or exclusive finding of this mahi. Nevertheless, we recognise the need for streamlined interactions and the promotion of mutually beneficial opportunities and results. Simply put, capitalising on the opportunities and promoting Māori outcomes in the health sector requires a collective effort from iwi, industry, government agencies and advisors. Insights from our mahi indicate that opportunities for coordination, cooperation and collaboration are being missed – specifically, opportunities between iwi and health sector agencies that enable iwi to provide workforces and invest in health enterprises. Eventually, we would like to see such partnerships managed by Māori, but in initiating them we suggest that Te Puni Kōkiri and Manatū Hauora could play an important role in engaging iwi and presenting them with economic opportunities in health.

3.7 Authentication of rongoā Māori practice

Our report drew upon the provision of finances for the use of rongoā Māori by ACC. While the provision of a financial reservoir through ACC represents a significant opportunity for rongoā Māori enterprises, the authenticity of the service is threatened by corporations seeking to access ACC funding by identifying as rongoā. In other words, corporations may be identifying as rongoā to access funding, without delivering culturally sound rongoā services.

- Consideration should be given to a process of authenticating/legitimising rongoā Māori practitioners.
- A criterion for authenticating rongoā could be jointly developed by ACC, Te Puni Kōkiri, Te Aka Whai Ora, and rongoā practitioners.

3.8 Data collection and management projects

Both a barrier and a central finding of our mahi was the absence of data concerning Māori participation in key domains of the health sector. Insufficient data and insights constrain informed decision-making and make it exceptionally difficult to develop long-term plans for Māori participation. Therefore, we suggest the establishment of a routinely updated dataset that accounts for ethnic participation in all domains of the health sector, both in employment and business ownership. Te Puni Kōkiri has some experience in this domain with the development of *Te Matapaeroa*. We envisage that this could be undertaken as a joint effort between Te Puni Kōkiri and Manatū Hauora.

3.9 Liaising with government agencies to resolve labour market issues

Throughout our report, we identify a series of labour force issues constraining Māori participation in the health sector. Issues range from early years education to tertiary education, to workplace culture

and environments. Concurrently, however, we recognise that Māori workforce issues are longstanding in Aotearoa and are being currently managed by a collection of government agencies, not least of all Te Aka Whai Ora. Consequently, we suggest a cross-agency approach to improving Māori workforce participation across the health sector. Te Puni Kōkiri, for example, may find considerable synergies emerging from collaborations with Te Whatu Ora and Te Aka Whai Ora. Broadly, the rationale for a collaborative approach stems from a view that Māori workforce inequities cannot be resolved via siloed approach but should instead reflect a genuine partnership.

Part B: Supporting research

4. The baseline for Māori health sector enterprises

In this section, we set out what we have been able to identify about Māori enterprise involvement in the health sector.

4.1 Māori involvement

In public funding flows, general practice, community-based allied health and other community contracts represent variably the most significant financial opportunity for Māori businesses, with this overall bucket of money adding up to a very material \$8 billion per annum.

Māori enterprise ownership trails non-Māori in certain health sector domains. We examine health sector employment data to determine the proportional composition of Māori employment in the health sector. In so doing, we can identify and compare the proportions of Māori-owned business in different domains of the health sector. Regrettably, our dataset does not permit insight into all health sector domains but does allow us to examine:

- general practice
- nursing and midwifery
- dentistry
- optometry
- dieticians.

Information sourced from the Ministry of Health and Statistics New Zealand on employment status of Māori in the health sector paints a mixed picture. Although in some fields a similar proportion of Māori health professionals' own enterprises as non-Māori health professionals, Māori remain, nominally, underrepresented. Principally, this is compounded by the exceptionally low levels of Māori participation in health sector labour markets.

Digging further into these spending categories reveals some are amenable to Māori easily developing enterprises. We provide a high-level explanation of the different sectors and the relative competitiveness of Māori. We examine the structure of each of these provider markets and make comment on where there might be opportunity for Māori and for iwi.

4.1.1 General practice offers considerable opportunity for Māori social enterprise development

The general practice model has, in the past, been dominated by owner operators. Now, increasingly, practices have been sold, aggregated into larger groupings, and have been an increasingly interesting target for private equity. There has been a shortage of general practice for some years, and, with this backdrop, there are quite a few areas where practices have closed books and might be offering less responsive service. On the demand side, there is increasing need for general practice services as the population ages and patients become frailer; consultations are longer and more intense. At the same

time, practices addressing high needs have been under considerable funding pressures and some iwi have exited general practices they sought to establish.

There are some examples of Māori-owned and operated general practice, many of them supported in some way through Te Aka Whai Ora. Other models include nurse practitioner-based models, which have come about through necessity in Southland, and Māori or social enterprises that cross-subsidise high needs practices from surplus in wealthier practices.

Māori are comparatively underrepresented in general practice ownership.

Table 5: General practitioner employment outcomes

	Enterprise ownership			
	Commercial company	Self-employed - group practice	Self-employed - solo practice	Total enterprise ownership
All general practitioners	132	2680	317	3129
Māori	7	97	9	113
Māori proportion (%)	5.30%	3.62%	2.84%	3.61%

Source: Medical Council July 2022

Across the spectrum of GP business ownership types (commercial companies, group practices, and solo practices) Māori representation is significantly lower than non-Māori. When considering the Māori proportion of the population (approximately 17 per cent), it is apparent that Māori GP enterprise ownership has a considerable way to go before reaching something that can be described as 'equity' or 'parity'. Interestingly, a similar proportion of Māori GPs own a business (76.35 per cent) as non-Māori (84.70 per cent). This indicates that the most significant nominal increases in Māori GP businesses will be achieved by encouraging more Māori into tertiary health science education. However, increases would likely also be experienced by providing Māori GPs the tools, capital, and education required to establish their own practice.

Online options for primary care are coming fast and offer one level of care but are unlikely to offer the population-based, wraparound service that New Zealand's more vulnerable populations might engage with.

Entry barriers are low – iwi and Māori entrepreneurs can easily access general practice, but deep pockets are needed to develop kaimahi suited to a kaupapa model of care.

4.1.2 Maternity and midwifery

There is a strong role for Māori enterprise in this sector. Expanding the provision of Māori health services to maternity has the capacity to offset avoidable hospital admissions.

The Plunket model represents child healthcare provision in Aotearoa at present. Altering this dynamic is likely challenging given the embeddedness of the Plunket model and its political gravitas. However,

there is a gap in the market for Māori models of child healthcare that target child health issues, germane to or amplified, within the Māori community.

Being a midwife could mean being in business, but most are employed. There is good representation of Māori in this profession. There could be an opportunity to expand Māori participation in this profession, especially since, in recent times, Māori birth rates have been higher than other groups.

Table 6: Nursing employment outcomes

Group	Enterprise ownership		Employment				Total employment	Unspecified / other
	Self employed	Enterprise ownership as % of total nurses	Government	Private	Tertiary education	Iwi/Māori Trust		
All nurses and midwives	1026	1.57%	34204	24644	958	539	64393	4045
Māori nurses and midwives	81	1.69%	2405	1575	88	296	4701	337
Māori proportion (%)	7.89 %	-	7.03%	6.39%	9.19%	54.92%	7.30%	8.33%

Enterprise ownership, in the form of self-employment, is uncommon amongst nurses, both Māori and non-Māori. A similar proportion of nurses are self-employed across each demographic. However, the representation of nurses across the spectrum of employment domains and business ownership, except for iwi/Māori trusts, is significantly lower than the baseline Māori population (17 per cent). Similar to GPs, it appears that increasing representation in nurse employment and business ownership is an exercise in encouraging more Māori into health science education.

4.1.3 Mental health

Māori providers have a long history of provision of community-based mental health services often providing or working with social workers and providers of emergency housing. Secondary care facilities work hard to provide quality, up-to-date and therapeutic services. However, often patients get “stuck” in secondary care facilities while waiting for a community bed or facility or home.

Community mental health services are a domain where a broader view of health is not only desirable but essential and where a ‘by Māori, for Māori’ approach might be better for all.

Māori representation in the mental health workforce paints a mixed picture. There is considerable underrepresentation of Māori as psychologists and underrepresentation as psychotherapists, however Māori are well represented in the domain of drug and alcohol and other addiction practitioners.

Table 7: Psychology employment outcomes

Group	Enterprise ownership		Employment					Unspecified / other
	Private practice	Private practice as % of total psychologists	Government	NGO	Tertiary education	PHO	Total employment	
All psychologists	905	25.99%	1737	256	173	77	2577	334
Māori psychologists	38	25.33%	91	17	18	11	150	13
Māori proportion (%)	4.20%	-	5.24%	6.64%	10.40%	14.29%	5.82%	3.89%

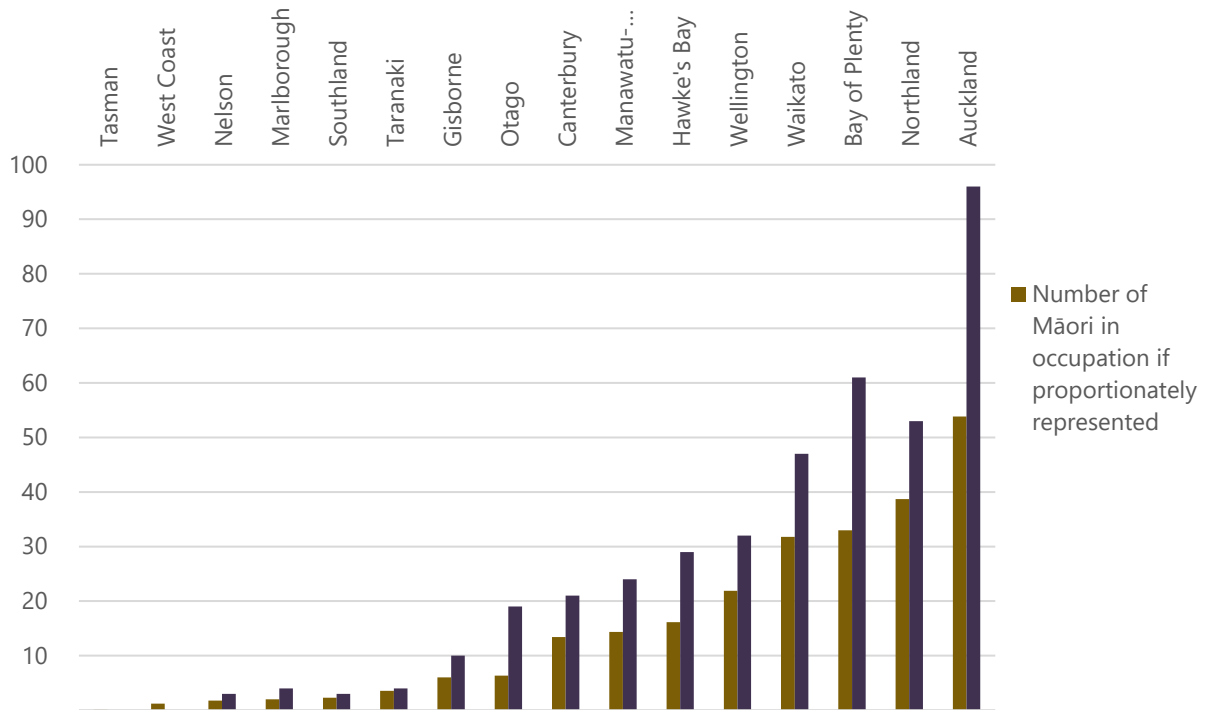
A similar proportion of Māori psychologists are involved in private practice as non-Māori. However, Māori representation across the board in psychology professions is significantly lower than non-Māori, and in all cases falls short of reflecting the Māori population at large. Again, representation in this domain appears to be, principally, an issue of enrolling Māori in relevant psychology tertiary education courses.

Table 8: Psychotherapist employment outcomes

Group	Enterprise ownership		Employment					Unspecified / other
	Private practice	Private practice as % of total psychotherapists	Government	NGO	Tertiary education	PHO	Total employment	
All psychotherapists	428	75.75%	41	51	15	5	137	25
Māori psychotherapists	13	43.33%	5	7	1	-	16	2
Māori proportion (%)	3.04%	-	12.20%	13.73%	6.67%	-	11.68%	8.00%

Private practice is clearly a big draw for psychotherapists in New Zealand. However, this appears to be the case more so for non-Māori. As with other professions mapped thus far, Māori representation is significantly lower than the general population, and a good deal lower than the Māori population at large in all areas of employment.

Figure 2: Addiction practitioner representation by regional council area



Secondary facilities are involving Māori architects as facilities are redesigned. The next brave step may be to step into co-governance of primary and secondary care activity and facilities, and actively sponsor the further development of the mental health ecosystem with Māori enterprise as one of its pillars.

- Drug and addiction services are an important corner of the mental health provider market. This encompasses a range of addiction recovery services. In 2022/23, \$20.5 million has been budgeted for gambling addiction recovery services alone. The financial opportunity this budget represents aside, Māori women are disproportionately affected by gambling addiction issues. There is, therefore, an important cultural component to capitalising on opportunities in social rehabilitation spending.

4.1.4 Residential and home-based aged care

There are a wide range of structures for residential aged care, ranging from community trusts through to privately owned care facilities in larger retirement complexes. The residential aged care sector wealth-generating enterprises are dominated by large commercial investors land-banking then building retirement homes, typically for those with higher incomes. Although these large investors provide a smaller role in residential care, there are many other trusts and other organisations running residential care facilities. In this report, we focus on the opportunities for residential support and not on the considerable opportunity for property developer premiums earned from large-scale retirement village developments.

Home-based aged care support tends to be dominated by networks of carers brought together and co-ordinated by large-scale providers, such as Enliven New Zealand, run by Presbyterian Support, or HealthCare New Zealand (with 7,500 employees). District-wide contracts are tendered from time to time. These are substantial organisations with considerable skill in the information, quality and workforce processes and technologies needed to organise thousands of patient contacts each day.⁶

Both represent a significant proportion of public health expenditure, but margins are thin and the workforce, particularly nursing in residential aged care, is fragile. Recent research found that the number of Māori entering aged care has decreased and that being cared for by family members is often seen as the first option. This is likely to reflect a lack of options for Māori to access aged care facilities that are culturally safe and offer kaupapa Māori services (Hikaka and Kerse, 2021). Moreover, Maori cultural expectations suggest that kaumātua should be cared for by whānau, which is broadly incongruent with mainstream residential care models. Entrants into this space would be welcome, but perhaps dependent on the development of kaumātua- and whānau-led care options with a sustainable aged care workforce that support tikanga and cultural expertise.

4.1.5 Dentistry and optometry

Dentistry and optometry are both experiencing corporatisation and agglomeration. Optometry is particularly affected with the entry of high-volume, low-cost providers such as Specsavers. Dentistry is particularly capital-intensive and most revenue is out of pocket spending by individuals, so it is difficult to organise social procurement.

The provision of affordable dentistry could be facilitated by Māori-owned enterprises. At present, the complexion of the oral health market is such that there are few affordable dental practices. There is an opportunity for Māori dentistry providers in this domain to establish a form of dental care that follows a low-cost model, like how some Māori general practitioners operate their services. However, the finances of these community-oriented dental care practices are tenuous. There is more wealth in being a dentist than in running a low-cost dental social enterprise.

Government employs a higher proportion of Māori dentists and dental specialists, and this is reflected in enterprise ownership.

Table 9: Dentist and dental specialist employment outcomes

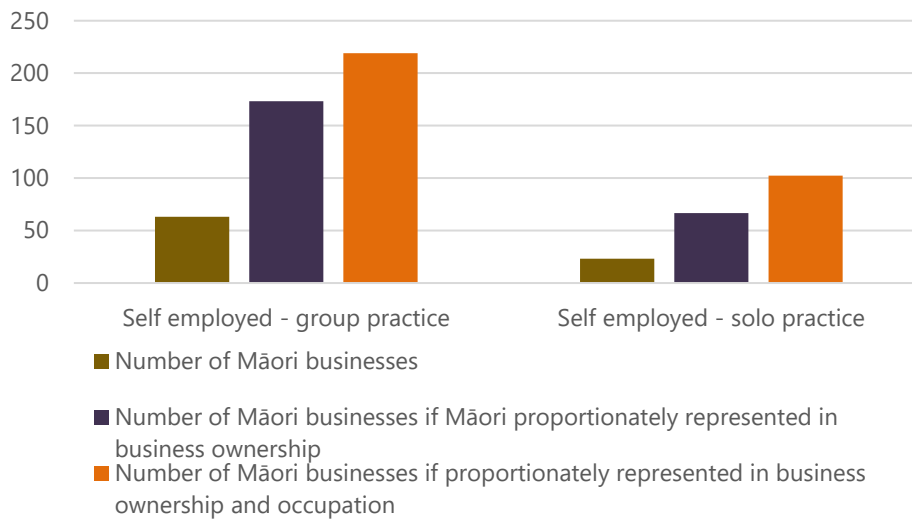
Group	Enterprise ownership				Employment				Total employment
	Commercial company	Self-employed - group practice	Self-employed - solo practice	Total enterprise ownership	Government	Private	Tertiary education	Iwi, Māori trust or charity	
All dentists	2	1460	682	2144	856	1093	127	16	1949
Māori dentists	1	63	23	87	77	47	7	6	137
Māori proportion (%)	50%	4.32%	3.37%	4.06%	9.00%	4.30%	5.51%	37.50%	7.03%

Across the population of dentists and dental specialists, there is an unsurprising tendency towards establishing enterprises in the form of solo and group practices. However, this tendency is not

⁶ <https://www.healthcarenz.co.nz/about-us/> accessed 16 October 2022.

reflected in the Māori population of Māori dental professionals who appear to tend toward employment in the public and private sector. This could be explained by the difficulties experienced by Māori in accessing capital. That said, Māori are underrepresented across the board, with the excretion of iwi/Māori trusts, across the different domains of dental employment, which points towards underrepresentation of Māori enrolments in tertiary-level dental programmes.

Figure 3: Dental science enterprise ownership outcomes



Māori are almost entirely absent from the optician profession

Table 10: Māori employment outcomes for opticians

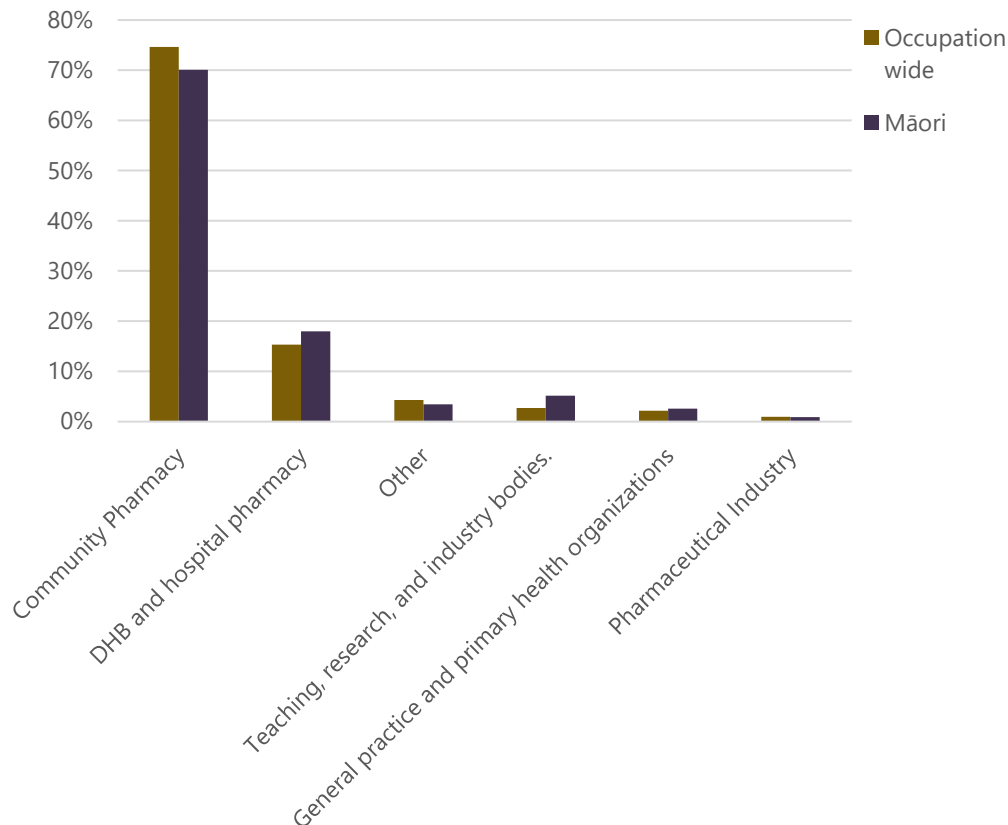
	Locum	Self-employed	Total enterprise owners	Employed
All specialists	2	36	38	144
Māori	-	-	-	3
Māori proportion (%)	-	-	-	2.08%

Firstly, we note that there may be limitations as to the accuracy of this dataset. Our interviews involved one Māori optician business owner. Nevertheless, it appears that Māori are severely underrepresented in the optician profession, accounting for around 2% of all employees in the field. Before considering the factors that support Māori enterprise development in this space, it would be prudent to first consider mechanisms for encouraging more Māori to study optical sciences.

4.1.6 Pharmacy

Pharmacy had preserved its small business structure over a long time through restrictions on ownership, although that is now changing. There are a number of trends, such as mail delivery of prescriptions, automation through robotics, and now the arrival of the Australian wholesale pharmacy chain, the Chemist Warehouse.

Figure 4: Distribution of pharmacist employment



In the pharmacy workforce, in 2022, 125 pharmacists and pharmacist prescribers identify as Māori. Proportionally, Māori represent 3 per cent of the profession. Interestingly, this proportion has barely changed during the last five years. Table 11 shows Māori representation in the pharmacy profession during the last five years.

Table 11: Representation of Māori pharmacists and pharmacist prescribers

2017	2018	2019	2020	2021	2022
2.8%	2.9%	3.0%	3.0%	3.1%	3.1%

In pharmacy enterprise ownership, there are 81 Māori pharmacists working in the domain of community pharmacy. This is the domain where enterprise ownership is most likely to occur, as it involves the purchase or establishment of a community pharmacist. According to the Māori Pharmacists Association, six of these 81 own a pharmacy, four of which are owned as joint ventures with non-Māori partners, and two are owned independently. Unfortunately, data on non-Māori

pharmacy ownership is not readily available, meaning we cannot draw a comparison across ethnic lines. Table 12 provides a breakdown of Māori participation in community pharmacy.

Table 12: Māori community pharmacy

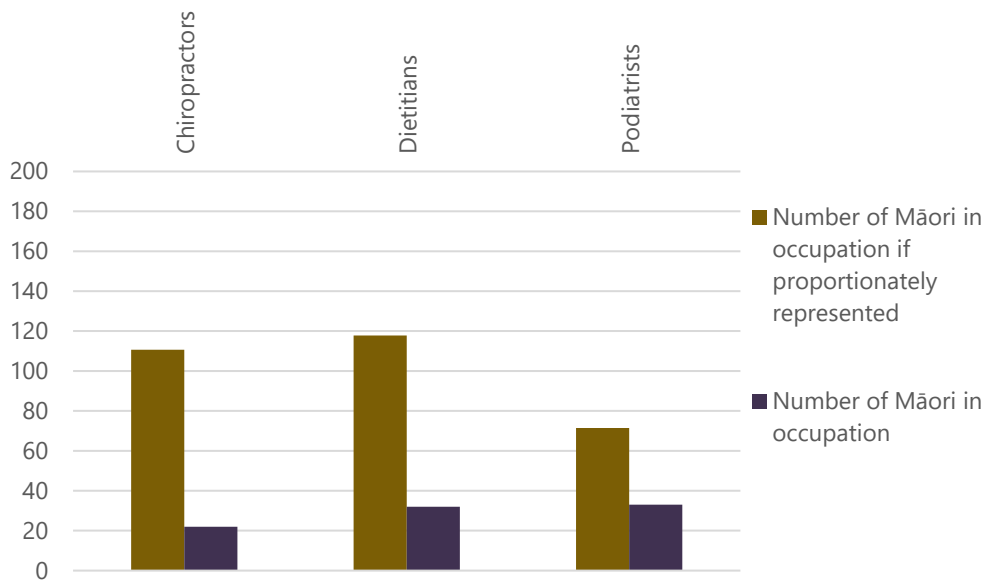
Māori community pharmacists (total)	Enterprise ownership (joint venture)	Enterprise ownership (independent ownership)	Māori community pharmacy ownership (% of total)
81	4	2	7.4%

Towards the end of this report we provide a case study which accounts for some of the challenges associated with studying, working, and operating a business in the community pharmacy domain.

4.1.7 Other allied health

There is considerable underrepresentation in other allied health professions including chiropractors, podiatrists, and dietitians.

Figure 5: Workforce representation



4.1.8 Ambulance services

A considerable sum of health money is expended on ambulances and paramedics, at around \$1.4 billion funded from the health budget and ACC, paying for personnel, equipment, and facilities. Enterprise opportunities in the domain of ambulances and transport are limited. However, there is some opportunity for workforce development in this space, particularly in rural areas where the provision of ambulance services is insufficient. A targeted workforce expansion of rural Māori paramedics may bridge expand access and provide a different model of care in some acute health situations.

4.1.9 Community labs offer much less opportunity

There are other health sector domains that may be relatively more difficult for new enterprises to enter given well-established contracts and models of care.

Over time, community and hospital laboratories have generally been integrated and operate as part of district health boards or, more usually, outsourced to a private, generally Australian provider. The laboratory provider brings capital for facilities, economies of scale leading to lower costs of reagents and information technology, allowing for storage, and a roster of pathologists (as well as a medical technician workforce and remote access of laboratory results. Exceptions to the integration rule are large-scale community laboratories in Canterbury and Auckland, the latter implementing a higher level of automation. These laboratories are technically agile and underpin continuing innovation in laboratory testing.

4.2 Māori medical specialists are slightly underrepresented in enterprise ownership

We also have data on the proportions of Māori enterprise ownership for medical specialists.

The medical specialist workforce is a complex workforce with many small specialisms. Generally, with medical specialists, there is less opportunity for enterprise development. However, for proceduralists such as surgeons and anaesthetists there are a range of opportunities for work in both the public and private sector and in their own practices.

Many specialists are trained overseas and move to New Zealand (around 40 per cent), just as many New Zealand specialists are trained and may move elsewhere, particularly to Australia, as many colleges are joint Australian and New Zealand colleges.

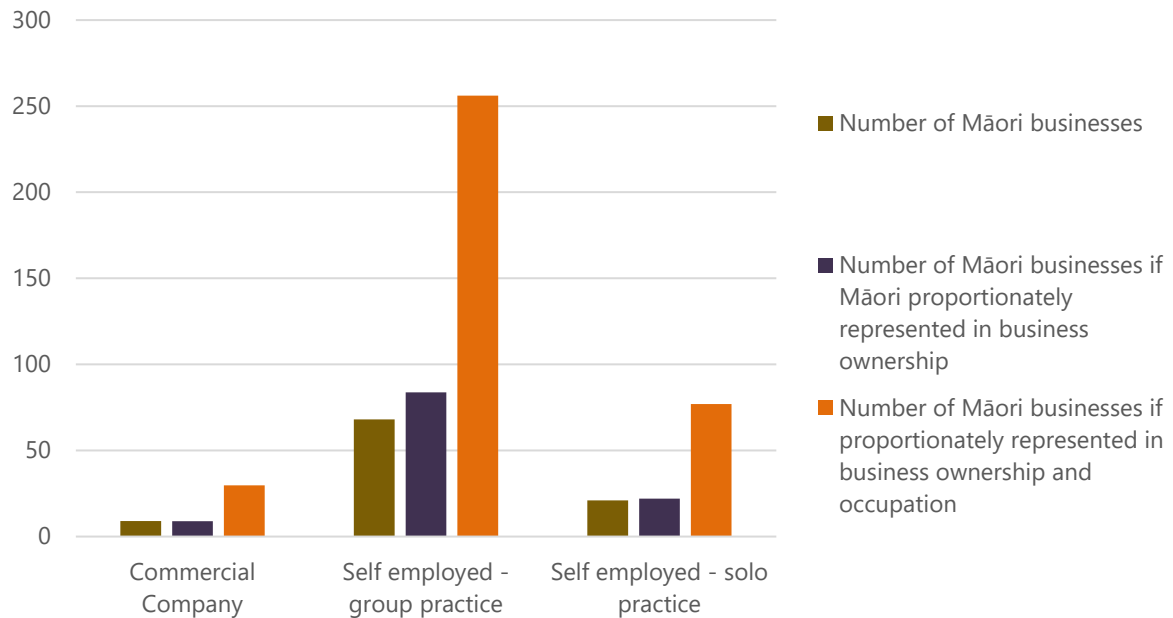
Table 13: Medical specialist employment outcomes

Group	Enterprise ownership				Employment				Unspecified / Other
	Commercial Company	Self-employed - group practice	Self-employed - solo practice	Total enterprise ownership	Government	Private	Tertiary Education	Total Employment	
All specialists	324	4338	815	5477	10895	254	296	13309	1864
Māori specialists	16	165	30	211	542	9	24	612	37
Māori proportion (%)	4.94%	3.80%	3.68%	3.85%	4.97%	3.54%	8.11%	4.60%	1.98%

Enterprise ownership for medical specialists is significantly less common when compared to general practitioners. That said, it is more common amongst the 'All specialist' population, when compared against the population of Māori medical specialists. Again, however, Māori are significantly underrepresented across all domains of employment in the medical specialities. Although access to capital and business mentoring may help transition some Māori from employment into business

ownership, the primary mechanism for increasing Māori representation would appear to be increasing the number of Māori enrolment in health science education and ensuring clear pathways to medical specialities.

Figure 6: Enterprise ownership outcomes



4.3 Supply chain participation

Te Whatu Ora is establishing a social procurement team within its supply chain and warehousing operation. There is a high consciousness of the importance of this activity and its benefits, but little in the way of data.

5. Lower Māori participation in the health labour market

The health labour market interacts with the ability to grow health enterprises, particularly when those health enterprises are led by professionals.

Consistent with contemporaneous and historical narratives, Māori participation in the health sector is lower than for non-Māori. Here, we provide a regional breakdown of Māori participation in the labour market by region and profession. Significant shifts are required if participation is to become equitable.

5.1 Regional underrepresentation

Consistent with broader narratives, Māori are proportionally underrepresented in the health sector in all regions of Aotearoa. Significant underrepresentation is experienced in regions with greater Māori populations. In this section, we present an overview of Māori representation in the following professions across Aotearoa: general practitioners and rural health specialists, medical specialists, nursing, oral health, opticians and optometrists, pharmacists, psychologists, addiction practitioners, chiropractors, podiatrists, dietitians, and psychotherapists. Examining labour market data, it is not a question of whether Māori are underrepresented in health sector roles, but instead a question of how underrepresented and where.

- Underrepresentation of Māori health specialists is intensified in regions with a high Māori population. As per Table 13, Māori medical specialists are underrepresented in all DHB regions of Aotearoa. However, underrepresentation is intensified in regions with higher Māori populations. For instance, Māori specialists are underrepresented in the Waikato (18 per cent), Bay of Plenty (19 per cent), Hawke's Bay (22 per cent), Whanganui (24 per cent), Northland (27 per cent), Lakes (28 per cent), and Tairāwhiti (47 per cent).
- In nursing, Māori are underrepresented in all DHB areas, but underrepresentation is most intense in regions with a significant Māori population.
- Reflecting medical specialists, Māori are underrepresented across Aotearoa, and underrepresentation is most intense in regions with a significant Māori population. For instance, Māori are underrepresented in the Bay of Plenty (12 per cent), Whanganui (13 per cent), Waikato (14 per cent), Hawke's Bay (15 per cent), Lakes (17 per cent), Northland (17 per cent), and Tairāwhiti (23 per cent).
- In Oral health, Māori are significantly underrepresented in areas with the most significant population. In a similar vein to other health professions, Māori are underrepresented in every region in oral health professions. Underrepresentation is most intense in regions where Māori comprise a significant proportion of the population. For example, in the Bay of Plenty (15 per cent), Whanganui (20 per cent), Lakes (22 per cent), Northland (22 per cent), Hawkes Bay (26 per cent), and Tairāwhiti (49 per cent).

- Māori optometrists are particularly underrepresented in regions with a significant Māori population. Reflecting other health sector professions, Māori are underrepresented across the board in optometry. However, underrepresentation is most intense in regions with a significant Māori population, such as the Bay of Plenty (22 per cent), Waikato (23 per cent), Hawkes Bay (26 per cent), Whanganui (27 per cent), Northland (30 per cent), Lakes (35 per cent), and Tairāwhiti (53 per cent).

5.2 Worsening representation of Māori relative to population growth

We examined Māori medical school enrolments from 2012 to 2021. We compare Māori *proportional* representation in clinical education to the Māori 18- to 25-year-old proportion of the population at large. We select this age group as the one in which most people typically attend clinical education, and higher education more broadly. Our analysis suggests proportional Māori enrolment in clinical education has been declining at all levels of education and in all disciplines since 2017. We have not seen this conclusion in the literature and this observation is preliminary, subject to further review.

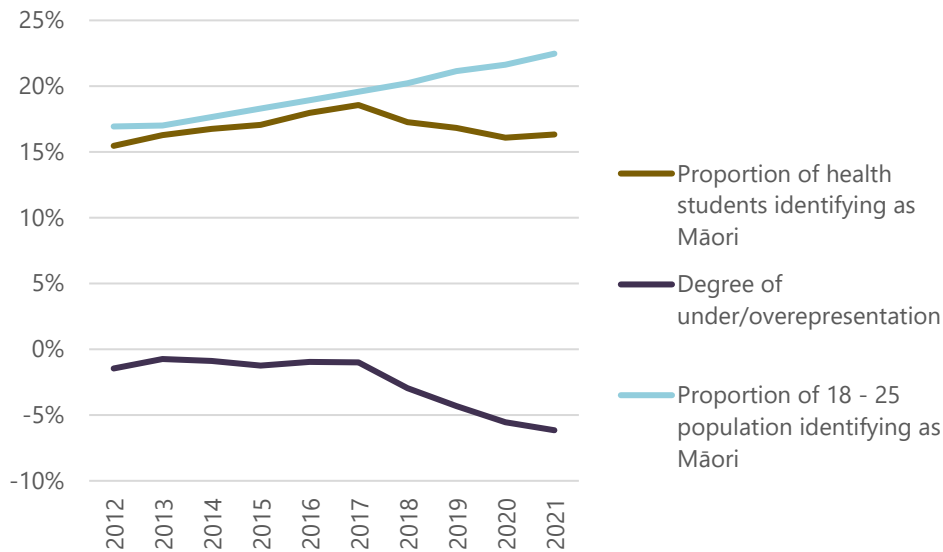
This trend down is not easily seen as the absolute numbers are constant or increasing, but that is different from relative performance.

Across all health courses and levels, proportional Māori representation has been declining. Looking at levels of tertiary study, from certificate 1-4 to postgraduate (including doctoral studies), Māori representation has experienced a downward trend from around 2017, proportionally. Here, we present these worsening trends in:

- all health courses and levels
- post-graduate qualifications
- bachelors qualifications
- certificates 1-4 qualifications.

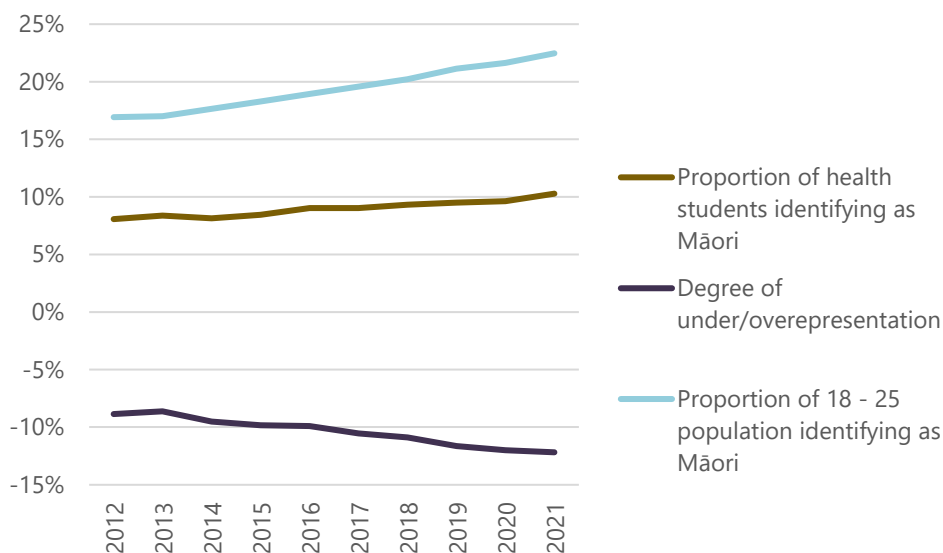
In 2017, Māori were proportionally underrepresented in all courses and levels of health study by around 1 per cent. In 2018, this figure slipped to 3 per cent, then to 4 per cent in 2019. Māori were underrepresented across the board by 6 per cent in 2020 and 2021.

Figure 7: Representation across all study areas and levels



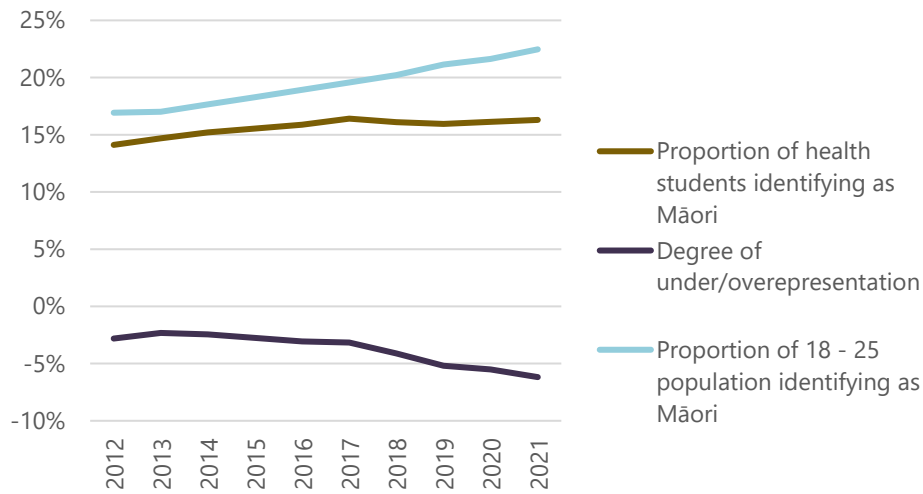
- Proportional Māori representation in post-graduate qualifications has been low for a very long time. From 2017, Māori were proportionally underrepresented in medical school post-graduate courses by approximately 11 per cent. In 2020 and 2021, underrepresentation slipped slightly to 12 per cent. 2017 does not represent a significant drop in Māori representation, which previously sat at around 10 per cent. Nevertheless, the trend regarding Māori enrolments appears to be moving further away from the goal of increased and equitable Māori participation in the health sector.

Figure 8: Representation in post-graduate study and graduate diplomas



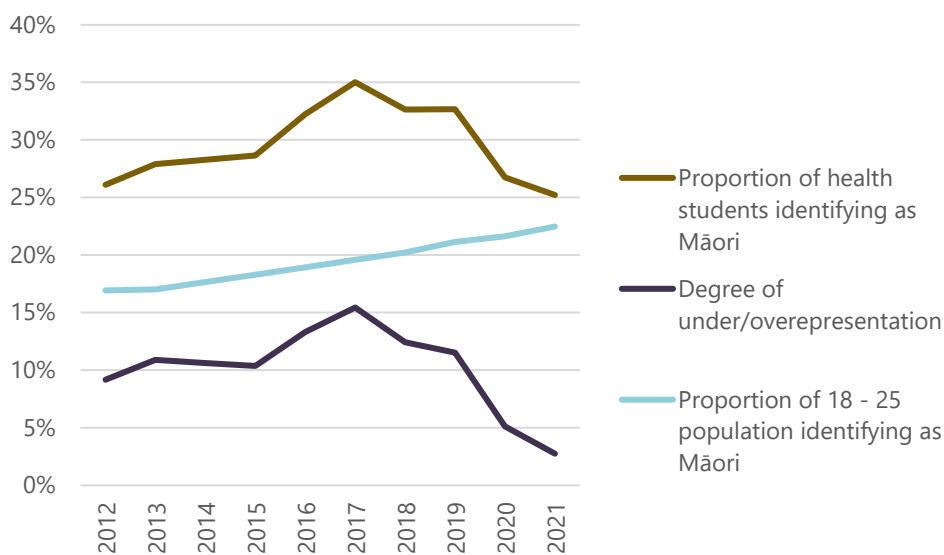
- In bachelor’s qualifications, Māori representation has been gradually declining. In 2017, Māori were underrepresented on bachelor’s courses by 3 per cent. In the intervening period, underrepresentation has doubled to 6 per cent in 2020 and 2021.

Figure 9: Representation in bachelor's degree study



- Māori remain slightly overrepresented on certificate 1-4 courses but have experienced significant declines. During the past decade, Māori have been proportionally overrepresented on certificate 1-4 courses. In 2017, Māori were overrepresented by 15 per cent. However, in the past five years proportional representation has significantly declined to 3 per cent.

Figure 10: Representation in certificates 1-4 study



5.3 Proportional representation declining across a range of health disciplines

Reflecting levels of study, Māori representation has similarly declined across a range of medical school disciplines. Here, we present the trends in:

- medical studies

- nursing
- pharmacy
- dental studies
- optical sciences
- public health
- radiography
- rehabilitation therapies
- complementary therapies, and
- other health disciplines.

We make the following summary points:

- Underrepresentation in medical studies has remained low over the past decade. Prior to 2017, Māori were underrepresented in medical studies programmes by 7 per cent. In 2021, underrepresentation shifted downwards to 8 per cent.
- Māori representation in nursing programmes has been gradually declining. In 2017, Māori were underrepresented in nursing programmes by around 4 per cent. Underrepresentation has since climbed from 4 per cent to 7 per cent in 2020 and 2021.
- Māori are significantly underrepresented in pharmacy courses. Māori representation in pharmacy courses has been declining during the past decade. In 2017, Māori were underrepresented by 11 per cent. In 2020 and 2021, underrepresentation slipped to 13 and 12 per cent respectively.
- In dental studies, Māori representation has been languishing. Reflecting other health disciplines, Māori are underrepresented in dentistry. Representation has been gradually declining since 2017. In 2017, underrepresentation was 9 per cent. In 2021, underrepresentation had slipped to 12 per cent.
- Māori representation in optical sciences is particularly low. In 2017, Māori were underrepresented on optical sciences courses by 18 per cent. By 2021, underrepresentation had shifted to 21 per cent.
- Māori representation in public health programmes has experienced significant declines since 2017. In 2017, Māori were overrepresented in public health programmes to the tune of 16 per cent. However, a dramatic decline in representation now sees Māori underrepresented on these courses by around 1 per cent.
- In radiography courses, Māori representation has been declining since 2017. In 2017, Māori were underrepresented on radiology courses by around 9 per cent. By 2021, underrepresentation further slipped towards 13 per cent.
- In rehabilitation therapies, Māori are underrepresented, but representation is not declining. From 2017, Māori have been underrepresented by around 7 per cent, and underrepresentation has hovered around this level each year since then.
- In complementary therapies, Māori representation has gradually slipped. In 2017, Māori were underrepresented in complementary therapy courses by around 5 per cent. Gradually, Māori representation in these courses has slipped, and in 2021 Māori were underrepresented by 7 per cent.

- In other health programmes, Māori representation has similarly declined. In 2017, Māori were equitably represented in other health programmes. However, by 2018, representation had declined to negative 3 per cent. By 2021, Māori were underrepresented by 4 per cent.

5.4 Understanding why Māori participation is low

Congruent with our statistical evidence, insights from our interview participants and literature review pointed towards an absence of Māori health professionals. One participant clearly articulated the issue: “We [Māori] are underrepresented in the health sector from health professional perspective, at all levels nurses’, pharmacists, etc.”

A series of reasons as to why Māori participation across a spectrum of health professions is low were identified, including (1) there are misconceptions of what healthcare roles involve, (2) early education does not focus on the subjects that are required for medical school entry, (3) Māori face significant barriers in clinical education, (4) university enrolment is not always supportive of Māori applicants, (5) medical school institutionalism focuses on grades over suitability to be a medical professional, (6) there are disconnects between clinical education and workforce planning.

- **People have misconceptions of what healthcare roles involve:** Healthcare professionals we interviewed argued that people have poorly informed views of roles in the health sector. One participant noted that people frequently have “narrow ideas of what a health career looks like”, which usually involves working as a doctor or a nurse. As an example of the perceived lack of attractiveness of being a pharmacist:

“Awareness of the profession is one of the issues, everyone wants to be a doctor/nurse etc. No one thinks about the pharmacist.”

“One of the things I’ve struggled with is when you think about pharmacy you think about the person you take the prescription to. But that’s one of the many hats that pharmacists wear. It is harder to think about yourself manufacturing drugs, designing them, quality checking, etc... even harder to think about someone as a clinical pharmacist on a ward in a hospital.”

- **Schools are providing insufficient science education.** Participants expressed a view that the importance of science in primary and high school has become less of a priority in recent years. Consequently, many school leavers do not have the requisite science education to gain entry to clinical education, as one respondent articulated the issue: “high schools aren’t preparing students enough in sciences.” A Māori health provider noted that Māori and Pasifika have historically been “streamed out” of science education, making it harder for those groups to attain the requisite qualifications for medical school.
- **Māori face significant barriers to success:** Research conducted in the recent past (Wikaire et al., 2016) identified a series of factors associated with cohorts of medical students that support an explanation of Māori medical school performance:
 - Māori students are more likely to have attended lower decile schools.
 - Māori students are more likely to have gained medical school admission through a bridging programme.

- Māori students are more likely to have achieved weaker secondary school results.
 - Māori students typically receive lower scores in the sciences.
 - Māori students are typically older than the rest of their cohort. This reflects the time spent completing a bridging programme.
 - Māori students are more likely to have relocated from their home to attend medical school.
 - Māori medical students are more likely to be first-generation tertiary education students.
- **The university environment may not always be supportive of Māori.** Participants expressed mixed perceptions of university support systems and their utility in supporting Māori students. Participants noted that some mentorship and networking does occur in the university environment, but it “tends to be individually led, rather than structurally led”, suggesting that if it were not for the efforts of a few individuals, some university support systems would not be available to Māori students. One Māori doctor advised that there has been significant progress toward establishing support structures for Māori students: “I am humbled by the hard work of Māori and Pasifika programmes within the clinical education. I have a lot of praise for that. I saw great support and a whānau approach – they were supported to come through.” However, other participants noted that more could be done in the space to ensure that Māori are fully supported while in medical school.
 - **Medical school institutionalism focuses excessively on grading rather than suitability to be a doctor.** In a scathing assessment of institutionalism in clinical education, one participant advised that clinical education can be aptly characterised by elitism and a sense of entitlement. These characteristics manifest as a system that focuses excessively on high grades:

“The sociological theory is a meritocracy, whereby the elites who stand by the rules make the rules and then claim they can’t lower standards by breaking their own rules. The desirability of the pathway is for students that go through educational pathways that allow them to get very high marks – this has no bearing on their suitability to be being a doctor.”
 - **There is a disconnect between clinical education and workforce planning.** Speaking about the role of clinical education in the health sector, some participants highlighted that tertiary education has been disconnected from workforce planning. This means the needs of the medical workforce are not reflected in the intake of students into medical school. Consequently, clinical education have historically tended towards an intake of white males:

“Health workforce planning has never properly engaged with tertiary education. Tertiary institutions have been left to be done as they pleased. With almost no policy direction, the most affirmative policy was for white males.”

5.5 Māori enterprise inhibitors

Māori health SME owners identified a series of factors that can inhibit SME formation and development. Such factors are broad ranging and include difficulties accessing capital, the costs of enacting Māori views, and experiences of racism in the wider health sector environment.

- **Māori health entrepreneurs report having difficulty accessing capital.** Establishing a health sector business requires significant capital investment. Health domains that require specialist equipment, such as dentistry, are especially prone to high capital expenditure. Māori business owners report having difficulty accessing requisite capital. Barriers to capital are, in part, explained by the ability of Māori to meet lending criteria required by banks and financial institutions, such as asset ownership and a favourable credit score. Terms and conditions of lending including high interest rates might also feature. In addition to constraining growth, high interest rates make it more difficult for Māori businesses to “give back to [their] communities”. This means the ability of Māori health enterprises to conduct pro bono work for Māori is prohibited by the conditions of commercial lending.

“It is hard for Māori to access finances – getting finances secured is tough, Māori typically have less asset ownership, financial literacy, and credit that would support access to credit.”

Māori business owners also reported that mainstream financial institutions did “not take them seriously”. This is perceived as a reflection of mainstream lenders focusing primarily on larger enterprises over smaller Māori businesses.

“Banking, corporate banking tends to focus more on the big organisations, which means we have to settle for poor financing. It also makes it harder for us to talk to people at the bank – I find it really hard to pin down my bank manager. I feel like we don’t get taken very seriously at times.”

“We have to take really high interest rates on our bank loans (roughly 9 per cent). It makes it hard for us to get the funding for the equipment that we need.”

- **Enacting the Māori worldview in a health enterprise prohibits growth and development.** Māori health owners, and practitioners more broadly, frequently deliver free or heavily discounted health services to the Māori community. The delivery of free and discounted health services is consistent with the Māori worldview, which emphasises mutual care and respect (manaakitanga) above profitability. However, this has an obvious and negative impact on the capacity of Māori health enterprises to reinvest and scale up their business operations.
-
- **Māori health enterprises experience hostility and institutionalised racism in contracting.** The contracting system, through which Māori health providers are funded, has been previously characterised as institutionally racist and hostile to Māori. In extant research (H. Came et al., 2018; Eggleton et al., 2021), two main issues with the contracting system are identified:

- The verbiage of contracts held by Māori health providers is discursive, which limits the flexibility and self-determination of health providers. Specifically, discursive verbiage seeks to redefine Māori concepts of self-determination, provide rhetoric unmatched by action, and to re-orient Māori health priorities in a way that reflects the priorities of the funder.
- Māori providers report a power imbalance between themselves and funders. Māori providers reported being 'told-off' and patronised by funders. Moreover, between 2009 and 2014, Māori health providers were audited more frequently than their non-Māori counterparts. This leads Māori health providers to perceive hostility from funders.
- **Iwi may not be capitalising on health as a business opportunity.** Māori business owners interviewed for this project broadly cited additional support from iwi as an opportunity to expand Māori participation in the health landscape. Financial investment and partnerships were identified as avenues for broadening iwi involvement in health. However, Māori business owners felt that these opportunities are not being capitalised on. A perceived lack of iwi investment in health is not necessarily a reflection of absent skills or capabilities, but of a reflection of iwi priorities, which were thought to be 'excessively focused on property development'.

5.6 An example of Māori health sector entrepreneurship

The Māori owner of a physiotherapy clinic in the Waikato discussed with us the formation and operation of his clinic. During our kōrero, the physiotherapist advised of challenges he experienced in dealing with both the mainstream health system and iwi groups.

Māori healthcare delivery can be incompatible with mainstream health sector funding. The physiotherapist advised that he had developed his practice in a way that was congruent with a Māori worldview. Specifically, this involved the building a rongoā Māori practice within the physiotherapy clinic. At first, this allowed the clinic to access ACC kaupapa funding made available for the provision of rongoā services. However, the physiotherapist advised that he later withdrew from the rongoā Māori space because of differences in how ACC interpreted it.

"Unfortunately, a year after implementing that [rongoā Māori] – we withdrew from that space. We didn't necessarily agree with the pathway for accessing rongoā Māori looks like. They are considering rongoā as a social service rather than a health service. Those practitioners are not viewed as health providers."

Put differently, mainstream interpretations of indigenous health practice may have acted as a detriment for Māori health practitioners. Moreover, the physiotherapist expressed concern that the ACC interpretation of rongoā Māori left it open to "conglomerates swallowing up rongoā Māori services". As with our rongoā Māori case example, this reflects the issue of developing a set of criteria for legitimising and authenticating indigenous health services.

A second incompatibility issue is reflected in funding limitations for allied health professionals. Our physiotherapist participant advised that his preference is to deliver whānau-centric health services on

a marae setting. Practically, this involves seeing large numbers of patients, often as a group, rather than on an individual basis.

“I might see 50 people a day currently, but that’s because we are treating whānau in a whānau-centric way.”

This modality of healthcare delivery is inconsistent with the mainstream health sector and influences how the physiotherapist is funded. Specifically, he can “only charge for 20 clients per day, as per Western parameters”. In other words, Māori modalities of healthcare delivery can result in the provision of unfunded health services.

Obtaining ‘buy-in’ from iwi has proven difficult. The physiotherapist advised that he had frequently sought to engage and partner with iwi in creating a conjoined Māori health strategy. However, each attempt at partnership had failed. Failure, according to the participant, is a consequence of a shift in iwi focus towards investing in property and maximising financial returns.

“I think the alluring dollar of property is unfortunately shifted people’s lenses. People focusing too much of property rather than health. I think the big focus is let’s put a big resource somewhere for an investment return.”

Put differently, the participant’s perception is that iwi have gravitated away from working in the health domain in favour of more lucrative financial opportunities. Providing one such example of iwi engagement, the participant stated:

“Presented to [Waikato iwi] last year – I presented a nice strategy, if they did it with us or not didn’t matter. They have the land resource and whenua – what they don’t have is experience and direction in health. We didn’t hear back from them; it has a lot to do with.... I planted some truths – I said if we address this, we need to do it properly – we need more resource, more money, otherwise we’re just chasing rabbits.”

Reflected in the participant’s account is a perception that iwi lack the requisite experience and ‘direction’ required to become actively involved in the health sector. Unfortunately, the participant does not identify the specific experience an iwi might require becoming more involved in the health sector.

Key lessons from Māori SME tensions with mainstream health and iwi

- Conflicting interpretations of rongoā Māori may cause Māori to withdraw from indigenous health services.
- Whānau-centric modalities of healthcare delivery can involve providing health services to large groups of people at once.
- Treating large numbers of patients at once is incongruent with mainstream health sector funding.
- Māori health SMEs may find iwi engagement challenging.
- Investing in the health sector may not be a priority for some iwi.
- Some iwi may lack sufficient experience to become meaningfully involved in the health sector.

- Funding models that focus on throughput are not conducive to preferred Māori health care delivery modalities.

6. Case studies

Discussions with our key stakeholders revealed three case examples that contain lessons for elevating Māori participation in the health sector. Our case examples indicate that alternate ways of thinking can mobilise Māori into the health sector. The lessons from each of our case examples can be broadly encapsulated by the term: innovative thinking. During COVID-19, unconventional approaches to workforce planning created immediate employment opportunities for Māori and subsequent upskilling opportunities. Likewise, open-mindedness towards alternative indigenous medicines have created a financial reservoir for the formation and function of Māori health enterprises. Moreover, authentic approaches to iwi engagement have facilitated non-clinical employment opportunities for Māori which, in some cases, facilitate progression into clinical domains of the health sector. Altogether, the cases examples suggest that the elevation of Māori participation in the health sector can be achieved via original thinking that challenges established systems, regulation, and widely held perceptions.

Those cases are:

- the mobilisation of the Māori workforce during COVID-19,
- the legitimisation of rongoā Māori, and
- the establishment of Whakarongorau.

6.1 COVID-19 showed what can be done

COVID-19 exemplified how informalising the workforce can elevate Māori participation. COVID-19 meant re-imagining the health workforce and expanded opportunities for Māori. COVID-19 serves as an example of where relaxed regulation and heightened workforce requirements created opportunities for Māori to enter and upskill in the health labour market.

Relaxing of regulation during COVID-19 created health sector opportunities for Māori. Heightened need during the peaks of COVID-19 led to a greater demand for health sector roles, such as vaccinators and testers. To accommodate a rapid expansion of the health workforce, regulations surrounding entry into the sector were relaxed. This created opportunities for Māori that may not have otherwise qualified for health roles:

“The other thing to do with the workforce, when COVID testing and PCR was at its peak, we said ‘train our people’, and that’s what happened, but it only happened because there was a crisis.

12 of our people became vaccinators and swabbers over the period. Something that wouldn’t happen in the normal world.”

Unconventional pathways into the health sector necessitated by the COVID-19 pandemic demonstrate that “non-traditional ways for becoming qualified” can be a powerful mechanism for elevating Māori participation. This indicates there is likely merit to normalising novel and innovative channels into the health sector, such as apprenticeships for example.

Māori exposed to health sector opportunities during COVID-19 are being upskilled. Some participants advised that many Māori, especially rangatahi, inducted into the health sector during COVID-19 were now being upskilled and staircased into other domains of the health sector. Two Māori health providers cited examples of rangatahi who are currently enrolled in nursing programmes, following their COVID-19 testing and swabbing roles:

“We have examples from the first five [swabbers], we are putting them through enrolled nursing. One was a patient, she moved into training, but others have come and applied through COVID-19.”

“One of the boys enrolled in nursing who became a tester and swabber. We would never have done that before. Sometimes you don’t need to be qualified, sometimes you need to learn then get your qualification.”

The upskilling and staircasing of Māori inducted during COVID-19 demonstrates that exposure to health sector roles is a compelling instrument for elevating levels of Māori participation in health. For this reason, many participants argued in favour of permanently relaxing regulation.

Key lessons from COVID-19:

- During times of need, non-clinical workforces can be mobilised into clinical roles.
- Relaxed regulation can create health sector roles for Māori.
- Exposure to the health sector environment encourages further learning, upskilling, and mobilisation into other health sector domains.

6.2 Rongoā Māori

Rongoā Māori has tended to operate in the background of the health sector, under the heading of alternative medicine. The Tohunga Suppression Act 1907 banned rongoā Māori. However, tohunga continued to be trained and continued to practise.

ACC has instructed a programme supporting rongoā Māori practice and has seen very strong results, ahead of what was expected. Rongoā Māori will clearly be self-regulated by Māori and clearly can be practised only by Māori. Previously, rongoā Māori would have been classified as an alternative practice. Increasingly, this practice is seen as a better opportunity for many to rebalance their lives and to view their health more deeply.

Recognition of rongoā Māori by the Crown may represent an innovative avenue for Māori in the health sector. Rongoā Māori is a form of traditional Māori healing. It encompasses Māori values, customs, and healing methods that have been embedded in Māoridom for more than a thousand years. Fundamentally, rongoā is considered a taonga and, as such, should be thought of in Te Tiriti terms. Practically, this means the Crown has a role to play in protecting rongoā in partnership with Māori.

Historically, rongoā has not been treated as a Te Tiriti taonga; its practice in Aotearoa has been largely marginalised since colonisation (Mark et al., 2019). However, recent developments, including the

provision of finances for accessing rongoā services by ACC, indicate that it may become an important avenue for mobilising Māori into the health sector.

A prominent rongoā Māori health practitioner noted that the practice has been constrained by a lack of trust:

“There has been little trust between powers that offer the work or the services to different providers. From rongoā perspective there has been distrust in our cultural ways of healing. It is deliberately made obscure.”

A lack of trust and “deliberate obscurity”, means that rangatahi do not recognise opportunities for working in rongoā Māori:

“Why would young people consider rongoā? There is no trust, no opportunities, and no money.”

Participation of Māori in this domain of the health sector has, therefore, been particularly limited.

Legitimisation of rongoā Māori by ACC creates opportunities for Māori enterprise ownership. Our rongoā Māori participant advised that there has been a recent shift towards trusting the practice and that “people are developing an interest in rongoā Māori”. In part, this shift can be attributed to the recent legitimisation of rongoā Māori by ACC:

“ACC is now legitimising rongoā Māori, which is great, now people are exposed, people who never before saw an opportunity in rongoā.”

In other words, legitimisation of rongoā Māori by ACC moves it towards the mainstream health sector, which in turn raises its profile and generates interest among potential rongoā health professionals. Moreover, legitimisation of rongoā enables the provision of funds for rongoā services, which may encourage the formation of rongoā health practices.

As rongoā moves towards the mainstream, its authenticity should be protected. While the legitimisation of rongoā by ACC is considered a positive step, it comes coupled with a risk that it could be targeted by ‘inauthentic’ rongoā practitioners, seeking to identify as rongoā for financial gain. Our rongoā Māori participant clearly articulated the issue: “We are at risk of practitioners changing their names to rongoā to access certain funding.” Without protection, therefore, the status and authenticity of rongoā Māori health delivery are at risk of being further obscured.

Delivering rongoā Māori in tandem with Western medicine could expose Māori to other health sector opportunities. Our participants did not argue in favour of rongoā Māori replacing Western medicine. Instead, it was suggested that there is an opportunity for rongoā and Westernised medicine to be delivered in tandem. Practically speaking, this would mean a patient would simultaneously consult with a practitioner of Westernised medicine and a rongoā practitioner.

“As a rongoā practitioner, I provide Māori health advice. I then pass over to a Westernised doctor and ask for their input. Then we ask the client to make a choice as to what will work for them.”

This rather collaborative approach to healthcare may expose rongoā practitioners to other domains of the health sector. Exposure may encourage and mobilise Māori into certain domains of the health sector.

Key lessons from rongoā Māori

- Recognition and provision of finances for alternative and indigenous medicines can create opportunities for new business formation.
- The status of indigenous medicine should be protected if it is to thrive as an important component of the health sector.
- Delivering indigenous medicine in tandem with mainstream medicine represents an opportunity to expose and mobilise Māori into other domains of the health sector.
- Rangatiratanga, partnership, and shared decision making surrounding rongoā resembles an arrangement close to Te Tiriti partnership. It may have broader utility in the health sector.

6.3 Whakarongorau Aotearoa is best practice in iwi engagement

Whakarongorau has been providing free public telehealth services in Aotearoa since 2015. The Whakarongorau portfolio involves services such as Healthline and Quitline. However, the service became more prominent during the COVID-19 pandemic when it began running COVID-19 Healthline, COVID Vaccination Healthline, and COVID Welfare. Whakarongorau successfully partnered with three iwi in mobilising a Māori workforce to deliver new telehealth services to Aotearoa.

A commitment to Māori employment rationalised the iwi partnership. To operate COVID-19 related telehealth services, an expanded workforce was required. Hiring an offshore workforce or contracting existing contact centres were identified as mechanisms for meeting workforce requirements. Ultimately, neither of these options were adopted. Instead, Whakarongorau enacted a “commitment to employment within Māori”. In obtaining a Māori workforce, partnerships with iwi were sought. Through these partnerships, iwi provided the workforce to operate COVID-19 telehealth services.

Time, relationship building, humbleness, and Māori outcomes are all key to effective iwi partnership. Whakarongorau credits its successful iwi partnership to matters of time, relationship building, humbleness, and Māori outcomes:

“It’s about putting in the time and effort to build relationships with iwi. Taking the time to visit for a cup of tea and build personable and social relationships. Some people struggle because they don’t necessarily have the patience for it. But also, you have got to be to go low status and ask for permission to engage. And whatever you are doing has to have equity for Māori at the centre – not at step seven, it should be at step one.”

Put differently, effective iwi partnership represents considerably more than a transactional inter-organisational relationship. If organisations are seeking to partner with iwi, consideration must be given to both the suitability of approach and the impact of organisational imperatives on Māori.

Creating a Māori workforce has generated positive economic outcomes. Through the provision of employment outcomes, economic outcomes have been elevated for Māori employed by Whakarongorau. A significant contingent of Māori employed by Whakarongorau came from economically deprived areas of Aotearoa and had previously been unemployed. Through the creation of employment opportunities, Māori reported significant improvements in their standard of living. Māori employed by Whakarongorau also reported uplifts in self-actualisation and noted that they were now setting better examples for their tamariki.

Working in a health environment can lead to better health outcomes for Māori employees. It was reported that Māori working in Whakarongorau contact centres “appeared to be taking their health more seriously”. Employees engaged group weight-loss and quit-smoking programmes organised in the workplace. Exposure to the health system and health initiatives through non-clinical health work were identified as the motivators for Māori engaging in personal health-related programmes.

Non-clinical health opportunities can lead Māori into clinical roles. Since mobilising a Māori workforce to delivery Whakarongorau telehealth services, five Māori kaimahi have undertaken studies to train as nurses. Exposure to health sector opportunities through their non-clinical roles have been credited with the interest and subsequent uptake of nursing studies. Non-clinical roles may, therefore, represent an important avenue into clinical health roles for Māori.

Māori health workforces can improve health outcomes for Māori service users. Whakarongorau reported that it was able to achieve better health outcomes through a by Māori, for Māori approach. For example, in the rollout of the COVID-19 vaccine, it was found that a Māori approach to engaging with unvaccinated Māori significantly enhanced vaccination rates:

“The first five campaigns we did, we called 53,000 Māori who were not engaging with the vaccination programme at all. They would first get a text; we changed the language to be less punitive. We achieved a 33 per cent strike rate on that. It gives Māori self-determination.”

These reflections indicate the effect a Māori-led approach can have on Māori health outcomes, and broadly support the view that equitable health outcomes require equitable participation in the health sector.

Key lessons from Whakarongorau

- Interest in improving Māori outcomes creates an opportunity for iwi partnership.
- Time, cultural understanding, and relationship building skills are essential for iwi partnership.
- Employment opportunities for Māori can support health outcomes, as well as economic outcomes.
- Exposure to the health sector via non-clinical roles can mobilise Māori into clinical health roles.
- Māori participation in the health sector can lead to better health outcomes for Māori service users.

6.4 An example of non-linear pathways to Māori community pharmacy ownership

A Māori pharmacist shared with us an interesting account of her non-linear pathway into the pharmacy profession and business ownership. Her story, while inspirational, offers several lessons and insights that can be used to inform policy and direction-setting initiatives that may mobilise more Māori into pharmacy.

6.4.1 Pathways to medical school

The pharmacist advised that during her time in secondary school, she had not considered a career in pharmacy. She explained that she did not see the potential within herself, nor did those in the school setting. However, she was incidentally exposed to the pharmaceutical profession when working in a local pharmacy as a part-time shop assistant.

The pharmacist advised that she enjoyed being exposed to the workings of the profession, but in particular, being able to identify the important role pharmacies play in supporting local communities and whānau. After leaving school, the participant had moved to Rotorua, intending to pursue a career in hairdressing. While studying towards her hairdressing qualification, the participant started working at another pharmacy.

“While I was living in Rotorua, studying my hairdressing qualification, I took on a job at another pharmacy. I was still doing the same kind of work as before, but the pharmacist, she took an interest in me. She really encouraged me to study pharmacy at university. She said that I would be great at it.”

The participant’s co-worker recognised her potential and arranged for her to study pharmacy at the University of Otago. The participant advised that she felt she was not suited to university because she had left secondary school early. Nevertheless, entrance was achieved via a special admissions

programme for people aged 20 and above. The participant advised that the pharmacist she was working for helped her navigate the entry system and helped prepare her for the entrance interviews.

"My co-worker, she was great, she knew the university system well, and knew that there were options for me as someone who left high school early and didn't have the requisite qualifications to get into pharmacy school the usual way. She helped me with the whole process and prepared me for the interviews that I needed to do to get in."

6.4.2 Experiences of the university system

While in medical school, the participant explained that she found the first year academically challenging. However, there was a solid foundation of support for her in the form of the Māori centre at Otago University. Moreover, the participant had been linked in with another pharmacist in Dunedin and was living with the parents of her Rotorua colleague. Altogether, these elements provided the participant with some support while studying far from her home.

"I found the first-year academic stuff quite hard. I suppose it was to be expected since I hadn't done academic work since leaving school. Things like statistics were difficult. But the Māori centre at Otago was really good, I got a lot of support there. And my colleague in Rotorua had linked me up with a few people down there too, I was staying with her parents for a while."

After starting a programme at Otago University, the participant transferred to Auckland University. The decision was informed by the participant falling pregnant and wanting to be closer to friends and whānau.

"I enrolled in Auckland to be a bit closer to the whānau. I was the only Māori to graduate in my year, I was called upon to deliver the oath in Te Reo, which was an honour, but maybe also reflected some 'box ticking'. I suppose I was best placed to do it."

6.4.3 Lessons in business ownership

After successfully graduating from her pharmacy degree, the participant went on to intern at a pharmacy. After accumulating a few years of experience working in and managing community pharmacies, the participant began considering options for purchasing a pharmacy.

"I had wanted to buy my own pharmacy and had looked at a few options for doing it. The first one I saw for sale and was interested in; it all fell apart at the last minute. Maybe it worked out though because I ended up buying into two pharmacies in my hometown, where I was from. It meant I could look after my own."

The participant advised that the pharmacy was purchased between herself and two non-Māori business partners. She indicated that some disagreement arose between the business partners in how the pharmacy should operate and how it should best serve the local community.

"I was in business with two non-Māori Pharmacists, that did not whakapapa to our region. They were very business orientated. I was community orientated."

Fundamentally, the participant delineates an account that reflects the friction that can arise when different business ideologies collide. Specifically, in a context where a Māori approach to health collides with conventional Western business imperatives.

After some time in operation, the third business partner elected to retire, making his share in the business available for purchase. However, due a 'loophole' in the contractual arrangement, the participant was unable to purchase the shares, and instead her business partner purchased the majority of the third partner's shares. This meant, as the minority shareholder, the participant would not have had any influence on how customer engagement, priority care with a kaupapa Māori lens or improved outcomes for her whānau could be achieved.

"There was a clause in the contract I had missed. It meant that I missed my opportunity to buy a portion of our business partner's shares. It meant the remaining partner held the majority of the shares. Because of that, I couldn't operate the business the way I felt was best for my whānau, hapū, and iwi – according to their needs, and couldn't do my community engagements. I decided that I couldn't continue to work in that environment, so decided to leave."

"For me, having a business was less about making a profit, but having the flexibility and freedom to support my local community."

Leaving the business partnership due to being unable to exercise her approach to health supports the participant's expression that for her, business ownership is "less about making a profit". Altogether, this indicates that Māori cultural imperatives are more significant than commercial ones, in a health enterprise context.

6.4.4 A way forward?

Given the participant's interesting and atypical pathway into pharmacy, we sought some insights on mechanisms that would help support other Māori students into pharmacy education and eventually the profession. The following insights were offered:

- Awareness of the sector and opportunities

"I became aware of pharmacy through my part-time job, and then because I was mentored and guided by my co-worker. If it were not for her, I wouldn't have recognised it as an opportunity. I suppose general awareness raising would be a lever here. Maybe some role modelling from people working in pharmacy."

- Student and professional mentorship

"I received a lot of support and mentoring from my co-worker and some of the people she connected me in with at university. The same support also helped in my professional career. If this

was more widespread, we might see more Māori making it through the university system and into careers.”

- **Apprenticeships in pharmacy**

“I was exposed to pharmacy through a part-time job. I was just doing shop duties, non-clinical stuff, but being in that environment was enough to encourage me into a career in pharmacy. Imagine if we could replicate that as a health apprenticeship. It would be great to get Māori exposed to the profession, get people excited for a career in pharmacy. I think that would produce some great outcomes.”

Key lessons from pharmacy

- Exposure to health sector professions through non-clinical roles can represent a first step towards a career in the sector.
- Mentoring is a valuable mechanism for securing medical school positions.
- University support systems, such as the Māori centre, can limit attrition rates and ensure the completion of qualifications.
- Māori support systems may be inconsistent across different universities.
- Māori recognise their underrepresentation in the medical school environment, and this can lead to a feeling of loneliness and isolation.
- Navigating cultural and commercial imperatives can cause friction with non-Māori business partners.
- Māori enterprise ownership in health is more concerned with supporting local communities than turning a profit.

7. Opportunities in the workforce and enterprises

We acknowledge that elevating Māori enterprise ownership in the health sector is the primary aim of this strategy. Nevertheless, a focus on labour market outcomes is required as enterprise ownership and labour market outcomes are intrinsically linked. By progressing in labour markets, employees can accumulate knowledge and experience, as well as form network connections that support business formation (Amaral & Baptista, 2007). The requirement to build a base of knowledge and experience before embarking on business ownership is pertinent in highly technical fields, such as healthcare delivery. Therefore, as part of developing a strategy to increase the number of Māori businesses in the health sector, it is important to consider Māori representation in health careers and the pipeline of potential Māori health entrepreneurs in the labour market.

Māori can be mobilised into health education via a series of initiatives and then into Māori health enterprises.

7.1 Workforce initiatives

We emphasise this report is not a workforce report but rather a report focussing on enablers of Māori enterprise. Considerable thought and effort has been put into workforce development over the years. In particular, Kia Ora Hauora, the 'Māori Health as a Career Programme', is a national Māori health workforce development programme that was established in 2009 to increase the overall number of Māori working in the health and disability sector. The evaluation of that programme is a high quality document with many similar recommendations.

Largely, our stakeholders noted that Māori participation in the health sector is achieved by ensuring a sufficient flow of Māori in clinical education. Several initiatives for mobilising Māori into health education were identified by our stakeholders and through our literature review.

- **Māori-led interventions have mobilised Māori into the health and disability workforce in the past.** Between 1992-2007, increases in Māori participation in the health and disability workforce have been credited to Māori leadership, mentoring, peer support, support within study programmes and support with the transition from secondary to tertiary education, and then to the workforce (Ratima et al., 2007). These interventions demonstrate that Māori health participation outcomes can be elevated by engaging Māori communities and providing dedicated support to Māori students.
- **Targeted bursaries have channelled Māori to certain domains of the health sector.** Recognising that greater levels of Māori representation are required to deliver mental health services for Māori, the Ministry of Health has previously issued bursaries to fund the mental health studies of 120 Māori students (Ministry of Health, 2021). This initiative was designed to ensure that Māori perspectives and experiences are built into the mental health system.
- **Early exposure to opportunities is a key part of mobilising rangatahi into health education.** Efforts to identify 'best practice' for the recruitment of indigenous secondary

school students into tertiary health education find that early exposure to health sector opportunities can encourage students to succeed in school subjects required for medical school entry (Curtis et al., 2012). Early exposure may take the form of effective career advice and tertiary exposure events, where secondary students spend time on a university campus, meet with educators, and attend specially designed classes.

- **Raising awareness of health sector roles should begin in primary schools.** Participants recognised there have been efforts to raise awareness of health careers in high schools. However, a number of stakeholders were critical of the high school approach, suggesting that it was “too late”, and raising awareness would be fruitless because there are “so few Māori at school are studying chemistry, physics, or calculus; the things you need to get in [to medical school]”. Therefore, raising awareness of health sector career opportunities “must start at primary school age”. Participants advised that there has been an acknowledgement of this, but little effort has been made to target primary schools.

- **Raising awareness of health career opportunities may encourage more participation.** Participants noted that raising awareness in the Māori community would be better served by having individual Māori speak publicly about their progression towards, and working in, the health sector. Māori health professionals are the people who advocate for careers in the health sector. This is because getting Māori interested in the sector requires advocacy from people who “walk like them and talk like them”. This kind of approach was described by one participant as “role modelling success to the Māori community”.

“People do not have to be famous, all they need to do is talk about their journey. That brings people into the workforce.”

- **Health academies support Māori in the transition from secondary school to medical school.** Two health training academies were established in South Auckland by Counties Manukau DHB and the Tindall Foundation to create a pipeline of Māori and Pasifika into the health workforce. The programmes delivered in these academies are designed to support students seeking entry into tertiary-level health sciences. Practically, this means the academies focus heavily on delivering science-based education. In 2018, it was found that students attending these academies had achieved better NCEA outcomes than their counterparts in mainstream secondary education. Collectively, the students were, therefore, better positioned when it came to medical school applications (Middleton et al., 2019). Overall, this indicates that innovative approaches are required to ensure that Māori students are equipped with the requisite qualifications for medical school entry. It also suggests that mainstream secondary schooling is underserving Māori students with medical aspirations in its present form.
- **Health sector apprenticeships may help mobilise rangatahi into health sector careers.** Participants, especially those from Māori health providers, suggested that there is an opportunity to get rangatahi involved in health via an apprenticeship scheme and on-the-job training represents an opportunity to upskill Māori in the health sector. An apprenticeship would represent a significant departure from conventional medical education and training. Yet, according to some participants, apprenticeship training is conducive to Māori learning

practices, which primarily involves learning by doing. Some providers indicated they “staircase” staff initially into the unregulated workforce, train them in different roles, including immunisation, and then encourage progression to nursing or other training. An important consideration of a health apprenticeship scheme is remuneration. Typically low apprenticeship pay may be unsustainable for Māori with cultural and whānau obligations.

“It may be we are offering workplace apprenticeships. Rangatahi are offered building courses and the likes, but there is little comparable in the health sector.”

“Lots [of Māori] didn’t go to school, but they learned by doing and watching. Start at the marae, you do dishes, clean the tables, clean the toilets. As you get older you get around to the front. Learn by doing.”

“Systemically looking at changes that allow for non-traditional ways for becoming qualified to qualify people into these roles. Enabling young people and non-health qualified people to come into the sector, and receive some on-the-job training.”

“Slide the skillsets down a wee bit to get more people on board and interested in health.”

“We were looking for opportunities for staircasing of whānau coming in at the lower end.”

“We believe in internally promoting and upskilling that way. We want to retain people and slowly work their way through the ranks. That is our responsibility.”

7.2 Māori academic success is bolstered by cultural supports

While mobilising Māori into the health training pipeline is an important lever in increasing Māori participation in the health sector, so too is supporting Māori success in medical school. Our stakeholder interviews and literature review identified a series of supports that can be used to support the success of Māori in the medical school environment.

- **Cultural knowledge and understanding are required for Māori student retention.** Tertiary education institutes represent the pipeline of Māori health professionals. Therefore, ensuring Māori student retention in tertiary education has important implications for the Māori workforce. In a study of factors influencing Māori nursing student retention (Zambas et al., 2020), it was argued that improving rates of retention was contingent upon tertiary education institutes facilitating an environment that is both welcoming and respectful of Māori values. Likewise, culturally appropriate learning environments that aim to minimise the influence of racism and unconscious bias are positively associated with student retention (Chittick et al., 2019). Supporting the pipeline of Māori health professions is thereby achieved by creating educational settings that are culturally conducive to Māori.
- **Innovative admissions programmes support Māori success in medical school.** A study that assessed the Auckland University MAPAS programme (Curtis, Wikaire, Jiang, et al., 2015), found it was strongly associated with positive academic outcomes in the first year of tertiary

education. This suggests there is considerable value in providing comprehensive and inclusive medical school admissions processes targeted at Māori, and indeed other ethnic minority groups. Moreover, the MAPAS programme demonstrates the capability of Māori cohorts to participate in tertiary medical education, and thereby indicates secondary schooling is inadequately preparing Māori students for medical school.

- **Cultural competence and inclusivity are associated with good academic outcomes.** The culturally inclusive nature of the tertiary education environment is associated with student retention, but also with student academic success. Analysis of the medical school environment (Curtis et al., 2015) finds tertiary institutions must maintain indigenous support services that include academic and pastoral support, provide 'safe spaces' for indigenous students operating in a culturally disparate environment, and foster indigenous student networking and cohesion if Māori success in clinical education is to be achieved. Moreover, the provision of a culturally sound environment in clinical education is supported by minimising contact with educators who discriminate against indigenous culture and increasing indigenous representation in medical school faculty.
- **Tikanga approaches have been shown to effectively prepare Māori for surgical selection interviews.** Using a by Māori for Māori approach, and following tikanga Māori, a course was developed to prepare Māori Non-Training Surgical Registrars for the Royal Australian College of Surgeons' Surgical Education and Training (SET) interviews. Māori who attended the course reported that it significantly improved feelings of preparedness for the interviews, and in 2020 80 per cent of course attendees were selected for SET training positions (Nicholls et al., 2021). The apparent success of this preparation course demonstrates the capacity of Māori-led education initiatives to elevate outcomes for Māori in a medical school environment.

7.3 Mentoring and awareness raising

Stakeholder interviews and our literature review indicated that Māori can be channelled into certain health sector domains via mentoring and awareness raising activities. These practices may be used to mobilise Māori into health professions where representation is especially poor.

- **Mentoring significantly influences Māori specialist pathways in medical school.** In a study of paediatricians and physicians (Lucas et al., 2014), it was found that Māori paediatricians and physicians were significantly influenced in their career trajectories by a mentor. Conversely, non-Māori paediatricians and physicians were most influenced by a personal interest in their specialisations. This suggests that mentoring can act as a powerful vehicle for mobilising Māori into domains of the health sector, especially those domains where Māori are substantially underrepresented.
- **Clarifying training pathways and awareness raising may promote Māori participation in specialist training.** Exposure to medical pathways and mentorship are likely to have a deterministic effect on the distribution of Māori health sector participation. As such, promotion of training pathways and mentorship may increase Māori participation in specialist training. For instance, the few Māori graduates who elect to pursue a career in ophthalmology

are typically highly influenced by exposure to the speciality and mentorship (Freundlich et al., 2020). Māori also report limited exposure to surgical specialities, and this may be a factor in deterring Māori participation in these domains.

7.4 Workplace environments

When in the workplace, there are conditions and initiatives that may influence the retention of Māori in the workplace. Without relevant cultural supports, there is an increased likelihood of departures of Māori from the health sector workforce.

- **Māori health professionals have experienced tension and racism when enacting tikanga at work.** Māori health professionals, but especially nurses, typically walk in two separate worlds: (1) the world of Westernised medicine, and (2) the Māori world. Seeking to bridge the gap between these two worlds, Māori health professionals have sought to enact tikanga when dealing with Māori patients. Practically, this may involve the use of cultural greetings, such as a hongi (Wilson & Baker, 2012). Enacting tikanga is essential for the preservation of Māori culture in the mainstream health environment. However, Māori health professionals report experiencing tension, resistance, and racism from colleagues and superiors when conducting cultural practices. These experiences can exacerbate Māori feelings of disconnect with the mainstream health environment, and ultimately decrease levels of Māori participation. Therefore, steps need to be taken to ensure that Māori health practitioners can weave their culture into healthcare delivery without fear of reprisal.
- **Māori-led training and development can support Māori workforce retention.** Recent research concerning the Ngā Manukura o Āpōpō national Māori nursing and midwifery clinical leadership training programmes (Pipi et al., 2021) found training focused on the development of personal, professional, and cultural identity is key for retaining and upskilling Māori nurses and midwives into leadership positions. Cultural training which focuses on bridging Māori and Westernised health paradigms was found to be especially valuable in supporting health professionals in overcoming institutionalised racism in the workplace. In other words, respect and promotion of Māori culture in the health sector are associated with improved labour market outcomes for Māori.
- **Marketing health as an opportunity to support the delivery of Māori values.** Some participants, but especially those representing Māori health providers and iwi, argued that health sector roles need to be marketed differently if they are to attract Māori applicants. This is because, on balance, Māori are not attracted to health sector roles for financial reasons, but are instead motivated by a certain passion or desire to help one's community. Based on this perceived difference in motivations, some participants suggested if Māori are to be attracted to health sector roles, they need to be marketed with Māori values in mind, especially those values pertaining to caring for other people in the community. As one iwi health provider explained:

“If you talk to a Māori clinician, they will tell you they got into health because they have it in the heart. Non-Māori might say that too. But it differentiates it away from career

prospects. You could make the sector more attractive by paying people more, but Māori aren't really driven by money."

- **Following Te Tiriti, elevate Māori participation in the health sector.** As quasi-Crown entities, health organisations have an obligation to fulfil the Crown's special relationship with Māori under Te Tiriti. Health providers should, therefore, be forming relationships with Māori health providers and local hapū or iwi (H. A. Came et al., 2017). As Minister of Health Hon Andrew Little stated in the interim Government Policy Statement for the reformed health system, a health system that honours Te Tiriti will uphold the rights of Māori and give effect to the principles contained in the new Pae Ora Act. These principles include ensuring an equitable health sector, engagement with Māori to deliver services that reflect their needs and aspirations, and providing choice of quality services to Māori through developing and maintaining a workforce that is representative of the community it serves.⁷

7.5 Māori enterprise enablers

Māori SME owners identified a series of initiatives, government and Māori initiated, that could support the formation and growth of Māori health enterprises. Such initiatives include business literacy education, Māori to Māori mentoring, cultural education, and procurement strategies.

- **Business literacy education may support Māori business formation.** Business literacy is not encompassed within medical school education. Medical school graduates are prepared for the workforce, but not necessarily prepared for enterprise ownership. The provision of business literacy education may support Māori medical graduates to establish a business in their specialist field. Business education does not need to occur in a formalised environment; it can be delivered in the form of mentorship and practical training. However, Māori business owners advised that this education should not be available to Māori health graduates with fewer than two years of work experience. This is because experience in the medical field should be obtained before enterprise ownership is considered.

"We could be doing more training for Māori in financial literacy in business skills – there's nothing like that available to Māori in university studying in different health programmes."

- **Greater support for mobilising Māori into health career pathways.** Well proven, successful programmes such as MAPAS should be expanded to support more Māori into the health qualification pipeline.
- **Māori to Māori mentoring can support new business formation.** Māori business owners we interviewed for this project received some form of mentorship from an established businessperson. Mentorship was cited as a critical success factor in the establishment and development of Māori health enterprises. An opportunity, therefore, exists to provide Māori health professionals with access to a business mentor who can support the formation, growth, and development of a Māori health enterprise.

⁷ Section 7 of the Pae Ora (Healthy Futures) Act 2022

- **Cultural education for Māori may encourage business formation.** One participant with experience working in the medical school environment suggested that cultural education should form part of medical school training for Māori. Embracing culture may lead Māori graduates to recognise that rangatiratanga, reflected in business ownership, is required to enliven Māori values in the health sector. Through cultural understanding, Māori may therefore be inclined to establish health enterprises, rather than work for an employer. However, care must be taken when determining the organisations and individuals to deliver such education. Specifically, it would be inappropriate for non-Māori organisations, such as a university, or individuals to deliver cultural education.
- **A shift in procurement towards smaller business suppliers may represent an opportunity for Māori business.** A Māori optometrist advised that public sector procurement tends to look to large corporate entities as suppliers. This is because corporations can generally leverage price more effectively than small businesses. Focusing exclusively or excessively on price procurement misses opportunities to factor in social development. Specifically, government procurement strategies could be altered for focus on smaller, Māori-owned businesses.

8. Lessons from overseas

In domestic and international contexts, especially those with significant indigenous populations, there are potential lessons to be learned for understanding the needs of, and growing, indigenous business. Here, we review environmental factors limiting Māori enterprise growth and examine approaches to indigenous business development in other settings.

8.1 Environmental changes are required to encourage Māori business growth

In developing Māori enterprise, four alterations to the business environment have been identified to support formation of Māori businesses, as shown in Table 14. The environmental conditions for developing Māori enterprise identified include establishing a pipeline of Māori business and human capital, enhancing Māori managerial capability, leveraging Māori-Crown relationships, and establishing Māori entrepreneurial ecosystems.

Table 14: Māori business growth imperatives (Vunibola et al., 2021)

Establishing a pipeline of Māori business and human capital	<p>The talent pool of Māori with the skills and experience required to establish and run Māori firms is small. Moreover, demands on this small talent pool are increasing due to competing interests from non-Māori firms seeking Māori business skills. There is a need to build Māori skills and capability in this domain both through education and mentorship from established Māori entrepreneurs.</p>
Enhancing managerial capability	<p>The pool of existing Māori managerial talent is small. Growing this pool of talent is essential for Māori enterprise growth. Māori business management programmes have been developed by tertiary education institutes, but Māori business education should be integrated with mainstream management programmes, to prepare Māori managers to be able to walk in the Māori and non-Māori business worlds.</p>
Leveraging Māori-Crown relationships	<p>Conventional government procurement processes need to be 'de-cluttered' to make room for authentic Māori-Crown partnerships. This means government should minimise red tape associated with procurement to allow Māori businesses greater engagement with the process. As tangata whenua, Māori are frequently well-positioned as procurement partners. Moreover, social procurement strategies that target Māori enterprise involvement are an opportunity for the Crown to facilitate Māori enterprise development.</p>
Establishing Māori entrepreneurial ecosystems	<p>Enterprise assistance is generally accepted as a worthwhile use of public funds. However, there is little understanding in New Zealand of the specific needs of Māori businesses and how to respond to those needs. The establishment of an enterprise ecosystem has been identified as a mechanism for fostering Māori business formation. Such an ecosystem should reflect the following: (1) Māori-owned entity, (2) partial government funding, (3) delivery by Māori with NGOs and private providers, (4) diversified assistance (financial, non-financial, local, international, specialised), (5) cultural authenticity, flexibility, and responsiveness, (6) long-term relationships with Māori businesses, (7) varied assistance over time that changes per the needs of the business.</p>

8.2 Approaches to indigenous business development overseas

There are strong examples of enterprise development in Canada and some much weaker examples in Australia.

8.2.1 Canada

In the Canadian indigenous enterprise context, formation and development of aboriginal businesses has been influenced by factors of connectivity, education, access to capital, and procurement.

The Canadian Aboriginal Entrepreneurship Programme (AEP) has been instrumental to indigenous business success. The AEP seeks to increase the number of viable businesses in Canada owned and controlled by indigenous people. The programme is delivered by 53 Aboriginal Financial Institutions (AFIs). These are autonomous, indigenous-controlled and delivered, community-based organisations.

AFIs support indigenous entrepreneurs by:

- providing non-repayable contributions i.e., grants
- providing developmental capital/business loans
- providing unlimited capacity building and mentoring support
- financial services and management consultant services
- business start-up and aftercare services
- facilitating an indigenous business network
- providing regional and industry strategic leadership.

The AEP has an established pathway for growing indigenous business in Canada.

Table 15: AEP business formation and growth pathway

Concept phase	An applicant will approach AFI with a business concept and request for a financial support.
Business support	If the applicant has a business plan, the AIF will assess its suitability. If the business plan is satisfactory it proceeds to the next stage. If not, AFI will support the applicant in bringing the business plan up to standard. If the applicant does not have a business plan, AFI will support the applicant in the development of one that can support a lending application.
Equity/financing	A needs assessment is made concerning how much support can be offered under the Aboriginal Business Financing Program.
Loan approval	Lending is approved by an AFI. Rates vary but are typically higher than mainstream lending institutions. Higher interest rates reflect the higher risk nature of lending. Loans are typically drawn on a five-year term.
Post-lending services	The AFI will support the applicant in (1) developing further business plans, (2) raising equity for expansion, (3) accessing account and human resource training, (4) restructuring lending, (5) filing income tax.

Through the provision of lending and business support services, the AEP circumnavigates two of the most significant barriers to indigenous enterprise: lack of capital access and poor business literacy.

Figures suggest the AEP has fostered the development of indigenous Canadian business. In the three decades of its operation the AEP has been integral to the establishment and growth of over 45,000 new indigenous businesses – while issuing over 46,000 loans to indigenous entrepreneurs. The value of these loans in the same period is approximately CAD\$2.75 billion. Moreover, 95 per cent of all loans have been repaid. In recent years (2018-2020), CAD\$125 million has been issued to 1,200 businesses per annum.

8.2.2 Australia

There are four main avenues of indigenous business support found in the Australian context. Support levers include underwriting indigenous business, wage subsidy programmes, mentoring and financial literacy training, and business skills training.

Table 16: Australian indigenous business support mechanisms (Hunter, 2013)

Underwriting indigenous businesses with limited access to capital	Australian government agencies, such as Indigenous Business Australia (IBA), can support indigenous enterprises by underwriting businesses with limited access to capital.
The government creates opportunity by subsidising indigenous wages	The Indigenous Wage Subsidy is designed to support indigenous entrepreneurs who employ other indigenous peoples.
Government-backed mentoring and financial literacy training supports would-be entrepreneurs	The Indigenous Small Business Fund and Indigenous Capital Assistance Scheme both offer access to commercial finance and professional mentoring support services.
Business skills training and development are made available to indigenous entrepreneurs	The Indigenous Employment Programme can support people with financial literacy training, conducting feasibility studies, and develop and implement business plans and risk management plans.

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