

Evaluation of the Māori Oral Health Providers Project

A project to enhance the capacity and capability of Māori oral health providers to deliver oral health services in their communities

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Abbreviations

AUT	Auckland University of Technology
DCNZ	Dental Council of New Zealand
DHB	District Health Board
DHBNZ	District Health Boards of New Zealand
DTTAG	Dental Therapy Technical Advisory Group
HPCA Act 2003	Health Practitioners Competency Assurance Act 2003
HWAC	Health Workforce Advisory Committee (disestablished September 2006)
MoH	Ministry of Health
MDU	Mobile Dental Unit
NHC	National Health Committee
NZDTA	New Zealand Dental Therapists Association
NCEA	National Certificate of Educational Achievement
Otago	University of Otago
PHAC	Public Health Advisory Committee
PHO	Primary Health Organisation
SDS	School Dental Service
TEC	Tertiary Education Commission
WHO	World Health Organization

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Executive Summary

Introduction

1. The 2003 report of the National Health Committee identified significant disparities in oral health outcomes between population groups. In particular, Māori and Pacific children and adolescents from low income families having poorer oral health outcomes than other children. The school dental services review (DHBNZ, 2004) and the Māori child oral health services review (Mauri Ora Associates, 2004) also noted that the current school dental service model no longer met the needs of children from Māori, Pacific and low income families.

The Māori oral health project

2. In light of these findings, the Māori Health Directorate of the Ministry of Health (the Ministry) implemented the Māori Oral Health Project (the Project). The Ministry identified five Māori oral health providers (the Providers) through a business case process undertaken in early 2005, with significant potential to contribute to the overall vision for oral health
3. The specific aim of the Project was to enhance the position of these Providers to deliver oral health services in their communities consistent with the strategic vision for oral health (MoH, 2006a). It also aimed to strengthen Provider and DHB relationships and to raise the profile of Māori oral health providers as key contributors to the oral health needs of Māori and their communities.
4. The key Project processes were: an expression of interest and business case development and assessment process (December 2004 to August 2005); separate but interdependent contracting processes involving Ministry and Provider contract negotiations for the purchase of capital equipment and, DHB and Provider negotiations for the funding of oral health services (August 2005 to February 2007); and implementation of Project related oral health services by Providers (July 2007 to March 2008).
5. In 2007, five Providers received one off Ministry funding totalling \$1,208,378.00 (exclusive of GST) and completed procurement processes to purchase their capital requirements to deliver oral health services. From June 2006 to February 2007 Providers signed contracts with DHBs totalling \$607,000¹ for the support and delivery of new oral health services and/or to expand or maintain existing services.

¹ This figure excludes payments based on fees for services claims such as those claimed under the oral health services for adolescents contracts and school dental specials. See Table 6, pages 25-27 for a breakdown of Ministry and DHB funding by provider.

6. The Project spanned a period of some 52 months from the date of the expression of interest being issued (December 2004) to the service launch date (March 2008) of the fifth and final Provider. During this same period DHBs were focused on the development of strategic asset management plans and subsequent DHB business cases for their child and adolescent oral health service delivery. These later business cases had a requirement that Māori oral health providers be consulted with and be included in the delivery.

The evaluation

7. The aims of the evaluation were to assess the extent that:
 - the Project was aligned to capacity and capability development literature and 'good' practice
 - the provision of one-off funding impacted on the capacity and capability of the Providers to develop and/or establish appropriate oral health services
 - the relationships between the Ministry, Project Providers and their respective DHBs improved as a result of the Project
 - there is sufficient evidence that overall, this kind of initiative should be repeated.

Methodology

8. The evaluation employed a mixed method approach to address the evaluation aims and objectives. The methods employed in this evaluation were: a literature review, development of intervention (project) logic, document review, two phases of key informant interviews, a relationships survey and a one day workshop involving all five providers, the evaluation team and Ministry representatives. The literature review and intervention logic informed the development of a capacity and capability framework, adapting work of Baser and Morgan (2008).
9. Five core capabilities are identified by Baser and Morgan (2008) as essential to capacity development; the capability to: (1) commit and engage (2) carry out technical, service delivery and logistical tasks; (3) relate and attract; (4) balance diversity and coherence; and (5) adapt and self renew. This framework was used to assess the Project relative to the evaluation aims.

To what extent was the Project aligned to capacity and capability development literature and 'good' practice

10. Overall, the Project had a *good*² degree of alignment to the capacity and capability development literature and 'good' practice.
11. The Project addressed all five core capabilities in the Baser and Morgan model. The Project had a primary focus on two capability elements and contributed to the other three capability elements indirectly through the process and the flow-on effects of the Project. While the Māori Oral Health Project investment was

² On the three point scale of limited degree, moderate degree and high degree the Project clearly exceeds moderate degree but does not quite meet a high degree. The term 'good' is used here to convey this position.

relatively small, the process aimed to develop capacity and capability through a 'seeding' approach.

To what extent did the provision of one-off funding impact on the capacity and capability of the Providers to develop and/or establish appropriate oral health services

12. The provision of one-off funding has positively impacted on the capacity and capability of all five Providers to develop and/or establish appropriate oral health services. Specifically, Ministry funding has resulted in all five Providers having increased capital equipment and physical assets to deliver oral health services.
13. Support and funding of Providers varied considerably between DHBs and this diminished the ability of some providers to develop and/or establish oral health services in their communities. For example:
 - Te Manu Toroa and Ngāti Hine Hauora Trust were funded to deliver new oral health services and to expand their existing oral health services.
 - Ora Toa is delivering a new adolescent oral health service. They did not seek a DHB contract for services funding as they deliver oral health services on a claims for services basis. However, the DHB was supportive of the development of this oral health service.
 - Te Taiwhenua o Heretaunga enhanced their service delivery capability, through the use of a purpose built Mobile Dental Unit (MDU). The previous oral health service delivery contracts were maintained/rolled over, but no new/additional funding for services was provided by the DHB.
 - Tipu Ora received funding for depreciation of the MDU and their previous oral health service delivery contract was maintained/rolled over. No new/additional funding for services was provided by the DHB. From time-to-time the MDU is utilised by the DHB because there is no funding for it to be utilised fulltime by the provider.
14. Overall, the provision of one-off funding had a *moderate degree* of impact on Providers' ability to develop or establish appropriate oral health services, when assessed against the capability to commit and engage and the capability to carry out technical, service delivery and logistical tasks.

~ The capability to commit and engage

15. Providers demonstrated a *high degree* of capability to commit and engage with the Project as the following table shows. (The shading shows the extent to which the capability was evident in the intervention logic and the '◆' shows the extent to which it was evident in the Project.)

Table 1: Capability to commit and engage

Evaluative criteria	Dimensions of merit	Extent evident in Project		
		Limited degree	Moderate degree	High degree
Capability to commit and engage	<p>Overall capability to commit and engage depends on a series of skills or abilities, including:</p> <ul style="list-style-type: none"> • the ability to encourage mindfulness • the ability and willingness to persevere • the ability to aspire • the ability to embed conviction • the ability to take ownership and • the ability to be determined 			<p>◆</p> <p>◆</p> <p>◆</p> <p>◆</p> <p>◆</p> <p>◆</p>

Source: Adapted from Baser and Morgan (2008, p. 26–33.)

16. The Ministry resourcing of the business case process ensured that selected Providers had the opportunity to participate. However ‘ownership’ of the decision to participate rested with the Providers. The Ministry judged (correctly) that Providers would be prepared to participate in the Project, despite possible resistance from some DHBs, because Māori providers had a high level of commitment to their communities.
17. At the outset of the Project, the Ministry did not prescribe the scope of business cases developed by Providers, except that they were required to align with the new direction for oral health services. The business cases therefore reflected Provider assessment of the assets and oral health needs evident in their communities and how they could best meet those needs. Further, it meant that Providers’ were not constrained (e.g. by DHB priorities) in setting the agenda for oral health services provision for Māori in their communities.
18. While taking a broad approach at the outset did create tensions later in contracting process between Providers and DHBs, it encouraged Providers to look at the bigger picture, and put forward a bigger strategic vision for their region—a valuable aspect of capacity building.
19. It is possible that a more narrowly specified brief may have resulted in Provider business cases being more closely aligned to DHB objectives and priorities and may have reduced some of the later tension that emerged between Providers and DHBs. On the other hand it may have simply served to prematurely limit the service delivery options for Providers by defining their service aspirations within the expectations and priorities of DHBs. The approach taken within the Project therefore resulted in Providers ‘casting dreams’ and then required Providers, DHBs and the Ministry to work back to an agreed position.

~ *The capability to carry out technical, service delivery and logistical tasks*

20. Overall, providers demonstrated a *moderate degree* of capability to carry out technical, service delivery and logistical tasks with the Project, as the following table shows:

Table 2: Capability to carry out technical, service delivery and logistical tasks

Evaluative criteria	Dimensions of merit	Extent evident in Project		
		Limited degree	Moderate degree	High degree
Capability to carry out technical, service delivery and logistical tasks	Overall capability to carry out technical, service delivery and logistical tasks includes the following capabilities: <ul style="list-style-type: none"> • to deliver services • for strategic planning and management • for financial management 		◆	
	The capability to carry out technical and logistical tasks needs to be supplemented and combined with the four other capabilities to enable sustainable capacity to emerge.		◆	

Source: Adapted from Baser and Morgan (2008, p. 26–33.)

21. The Ministry provided funding of \$10,000 to each Provider to support the development of business cases. This funding allowed Providers to obtain advice or resources to support the development of the business case. Later in the process Providers were required to tender for equipment, and this required expert knowledge that Providers did not have in-house. Thus in addition to funding, Providers would have benefited from access to suitably qualified or experienced (oral health) personnel to assist in some of these technical decisions. While it should be noted that staff from within the Ministry gave considerable support and responded to questions from providers, and assessed tenders, it may have been more effective to have had a more collaborative process at this stage with the Providers working together. Resources such as templates for developing the business case, and tools for the tendering process for equipment, would also be beneficial to providers.
22. There was no opportunity for collective purchasing, and Providers felt it would have been useful to have some form of co-ordinated advice for the development of tender specifications (especially around future planning and cost efficiency). The Ministry knowingly did not use a collective purchasing process on this occasion, as in their view to align with DHB processes would have delayed the procurement processes for a further two years, which they considered unacceptable. At the time they considered it was more important to maintain the Project momentum and to get the services up and running as quickly as possible, rather than to wait for all Providers to be in a position to tender together, or tender as part of the DHB tendering process. In future it would be good to consider a more co-ordinated tendering and purchase process.

23. The evaluation found securing a workforce was at times problematic at a regional level for Providers. This appears in line with the wider national shortage of dental therapists and oral health care clinicians identified in Workforce Development (Cram, Oakden & Wehipeihana, 2009). The evaluation further identified that there was a somewhat uneven playing field in terms of recruitment of oral health staff, with DHBs typically being in the position to pay more than it was possible for most Providers to pay their staff. In addition, Māori oral health providers required staff to be comfortable in Māori and community settings and when engaging with Māori. This indicated a greater need for Providers to build relationships with Otago and AUT and negotiate opportunities for students to work in Māori contexts to improve their cultural competence as well as to ensure their own training and workplace environment supported the culturally competent practice of all staff.
24. More recently,³ there was also a reported productivity issue in relation to oral health care delivered by Providers, who were seen to have lower productivity levels than non-Māori providers. However, Providers would argue this assessment didn't take account of the high level of oral health care need that many Māori patients presented with. It was not possible to explore this issue within the scope and time frame of the evaluation and further research is suggested to look more closely at productivity and the extent to which Māori are presenting with high levels of oral health needs and the impact on service quality, delivery and costs.

To what extent did relationships between the Ministry, Project Providers and their respective DHBs improve as a result of the Project

25. The evaluation explored five different aspects of relationships: Whakawhanaungantanga – engaging relationships; Whakawhiti korero – exchanging views, being understood; Te niko o te kaupapa – developing an understanding of the issues; Te mohiotanga – envisioning solutions; and Mahi tahi – making commitments.
26. The findings from the relationship survey indicate that despite the protracted Project timeframe and communication challenges that emerged throughout the Project and up to the present day, Provider and DHB relationships have improved, and continue to improve. When compared to the start of the project, both DHBs and Providers reported an improved ability to: engage with each other; express views and be heard on Māori oral health issues; develop understanding on Māori oral health issues; be realistic when setting objectives for Māori oral health; work collaboratively to find realistic solutions; and to make joint commitments to reduce Māori oral health disparities.
27. Overall, the provision of one-off funding had a *moderate degree* of impact on relationships between the Ministry, Project Providers and their respective DHBs improve as a result of the Project, when assessed against the capabilities to: relate and attract, balance diversity and coherence and to adapt and self renew.

³ Raised at the March 2009 workshop involving all five Providers, the evaluation team and Ministry representatives.

~ *Capability to relate and attract*

28. Overall, Providers demonstrated a *moderate degree* of capability to relate and attract during the project, as the following table shows:

Table 3: Capability to relate and attract

Evaluative criteria	Dimensions of merit	Extent evident in Project		
		Limited degree	Moderate degree	High degree
Capability to relate and attract	Overall capability to relate and attract <i>includes the following capabilities:</i>		◆	
	• to earn credibility and legitimacy		◆	
	• to buffer the organisation or system from intrusions			◆
	• to earn the trust of others, such as donors and clients and		◆	
	• to combine political neutrality and assertive advocacy		◆	

Source: Adapted from Baser and Morgan (2008, p. 26–33.)

29. The Ministry provided an environment where providers could pursue some of their key goals to negotiate with DHBs to provide oral health services to Māori children. By securing capital expenditure grants, providers were afforded 'legitimacy',⁴ with Ministry support, to operate in a way that might not otherwise have been available to them. Providers had control, by virtue of the tender process to choose the direction in which they built their capacity. Further, the process afforded flexibility to providers to choose different paths.
30. The Ministry also set up a process where the DHBs had to underwrite the maintenance and depreciation of the capital equipment and fund the staff to operate that equipment for a three to five year time frame to provide ongoing resources for the initiatives. In this way the Ministry endeavoured to establish a medium-term partnership between DHBs and Providers. In some instances DHBs and Providers already had existing relationships, whereas in others these contracts forced more regular contact working together.
31. One of the key hopes of the Ministry was that the contractual process would assist in the forming of deeper relationships, using the Project as an informal structure to bring DHBs and Providers 'to the table', where this had not already occurred. All of the Providers already had existing relationships with DHBs either delivering oral health services and or oral health promotion. There is evidence in the literature (Baser & Morgan, 2008) that it is better to develop these relationships through informal means (as in the case of Ora Toa) than to use formal structures, as there is a risk of organisations forced into formal structures becoming protective of their own vested interests. There was evidence this protectionism occurred in the case of some of the DHBs, especially where Providers talked of 'taking over' and wanting to significantly increase the delivery of oral health service provision in a region.

⁴ Legitimacy relates to "the capability to manage symbolic appearances, to communicate effectively, to enter productive partnerships and alliances, to manage political conflict and, in general to secure the organisation's operating space ... (Baser and Morgan 2008, p.31).

~ *Capability to balance diversity and coherence*

32. Overall, providers demonstrated a *moderate degree* of capability to balance diversity during the project over a number of dimensions of merit, as the following table shows:

Table 4: Capability to balance diversity and coherence

Evaluative criteria	Dimensions of merit	Extent evident in Project		
		Limited degree	Moderate degree	High degree
Capability to balance diversity and coherence	Overall capability to balance diversity and coherence <i>includes the following capabilities:</i>		◆	
	• to communicate		◆	
	• to build connections		◆	
	• to manage diversity and		◆	
	• to manage paradox and tension		◆	

Source: Adapted from Baser and Morgan (2008, p. 26–33.)

33. The Ministry was clearly committed to building diversity of service provision to meet the needs of Māori. There is a potential paradox and tension for the DHBs between providing services for ‘all’ and allowing their delivery mechanisms to become fragmented. However, given the pressing need for service provision for Māori, fragmentation would seem of secondary concern.
34. At the start of the Project, the Providers and Ministry were in communication, but only minimal communication with DHBs was evident. It is now clear that there was no role for the DHBs in the business case/provider selection process. Despite DHB (and to a lesser extent Provider) calls for more inclusion of DHBs at the outset of the project, there is greater evidence that the resistance evident among many of the DHBs would have slowed the overall project momentum. This evaluation suggests that it was the culmination of Providers having well developed oral health business cases, Ministry support, funding and leverage that provided the mechanism, where necessary, to engender DHB support of Providers and their plans for oral health care services in their communities.
35. This evaluation found evidence that direct engagement between the Ministry and Providers had the effect of ‘kick starting’ the engagement of DHBs to prioritise the provision of services to Māori. It should be noted that some DHBs were already in discussion with Māori service providers, but this was not the case in all instances.
36. It is important to note that some DHBs are becoming responsive to Māori oral health providers, but DHBs in different regions do not respond consistently or equitably to Māori oral health needs. It was evident that the Ministry cannot rely solely on the goodwill of DHBs to increase their focus or priorities on Māori oral health. The Ministry consistently held their ground and brought a weight to bear on the DHBs who had a range of perceptions of Māori provider oral health service capabilities, which tended to improve over the project.

~ *Capability to adapt and self renew*

37. Overall, providers demonstrated a *moderate degree* of capability to adapt and self renew during the project over a number of dimensions of merit, as the following table shows:

Table 5: Capability to adapt and self renew

Evaluative criteria	Dimensions of merit	Extent evident in Project		
		Limited degree	Moderate degree	High degree
Capability to adapt and self renew	Overall capabilities associated with adaptation and change include the following capabilities:		◆	
	• to improve individual and organisational learning		◆	
	• to foster internal dialogue	◆		
	• to reposition and reconfigure the organisation		◆	
	• to incorporate new ideas		◆	
	• to map out a growth path		◆	

Source: Adapted from Baser and Morgan (2008, p. 26–33.)

38. It was serendipitous, but also a complicating factor, that the project took place concurrent with the call from the Ministry for DHBs to provide a strategic assessment management plan and business cases for the reorganisation of oral health services in DHB regions. The strategic assessment management plans were a lever by which the Ministry could exert some influence over DHBs to seriously consider and make provision for Māori oral health providers in the delivery of services to Māori.
39. The Ministry in setting up processes where the DHBs and Providers had to work together over the strategic plans ensured individual learning (and to a lesser extent organisational learning) occurred. The hope was that the Māori oral health providers would learn more of the DHB processes and strategies while the DHB learned more about the benefits Māori oral health providers could deliver to the community.
40. It was clear that at different times throughout the Project, particularly around the contracting phases, relationships between Providers and DHBs were tense. Despite being brought/forced together by the Project processes, and the long drawn out nature of the contract negotiations, there was evidence of new learning on both sides, indicating a level of reciprocity of learning that might not have been expected from such a fraught process.
41. There is still some way to go before all DHBs elicit and value the contribution of Māori oral health providers to the planning and delivery of oral health care and services. The evaluation found lots of evidence that the provision of one-off funding to purchase capital equipment did increase the capacity and capability of Providers to deliver oral health services to their communities and strengthened the relationships between Māori oral health providers and DHBs.
42. However, some of the relationships appear to be built on goodwill between individuals, particularly from the DHB side, and so the challenge now is to

consolidate those relationship gains evident at an individual and personal level to an institutional level.

To what extent is there sufficient evidence that overall, this kind of initiative should be repeated.

43. The Oral Health Project was an opportunistic and innovative process, using surplus funding, to build the capacity of five selected Māori oral health providers. In addition there were a number of other levers, present at the time, which were brought to bear on DHBs to comply with Ministry requests.
44. The Project took a long time to implement, and the Ministry carefully and systematically worked through a wide range of issues to ensure it was possible to support Providers to deliver on Project requirements.
45. It is evident that many unexpected issues were identified during the project, some of a quite difficult and technical legal nature, (such as the asset registration being assigned to DHBs). However, most of the issues have now been identified, ways to manage these have been found, so future contracting timeframes are likely to be reduced (and less protracted).
46. Despite these issues, the evaluation found that the Project enhanced the position of these Providers to deliver oral health services in their communities, facilitated a greater awareness of Māori provider oral health service capability with some DHBs and contributed to a strengthening of relationships between Māori oral health providers and DHBs
47. Based on the Project outcomes achieved, we believe that it would be worthwhile for the Ministry to implement this Project again in the future. This suggestion is endorsed by Providers, who comment that despite the challenges of this Project, they would recommend to other Māori oral health providers to participate in a similar project.

Conclusions

48. The specific aim of the Project was to enhance the position of these Providers to deliver oral health services in their communities consistent with the strategic vision for oral health (MoH, 2006a). It also aimed to strengthen Provider and DHB relationships and to raise the profile of Māori oral health providers as key contributors to the oral health needs of Māori and their communities.
49. In summary, as a result of the Project:
 - All Providers have increased their capacity and capability to deliver oral health services in their communities.
 - Relationships between Providers and DHBs have variously been strengthened
 - Some Providers are accepted and valued for their contribution to oral health planning and service delivery in their community.
 - There is greater awareness of Māori provider oral health service capability within some DHBs.

Areas of attention

50. There is a need to further investigate claims that Māori presenting with high levels of oral health needs, impact on service quality, delivery and costs.
51. Despite the challenges of this Project, Providers would recommend to other Māori oral health providers to participate in a similar project
52. This report identified possible efficiency gains which could be made in the future around Project implementation, bringing Providers and possibly DHBs together at critical stages of the project.
53. However, the evaluation concluded that continued Ministry involvement is required to ensure an increased focus by DHBs on Māori oral health and to achieve greater presence of Māori oral health provider service delivery.

Detailed Summary of Findings

1 Fund Establishment and Distribution

Overview

54. This section discusses the Ministry and DHB funding and contracting processes in relation to the Māori Oral Health Project (the Project). It firstly examines the Ministry business case/provider selection process and the Ministry contracting process for the purchase of capital equipment. It then goes on to discuss the DHB contracting process for Project related service delivery funding. An assessment of the appropriateness of the funding process both internally and externally follows and the critical factors that led to the successful contracting of services are identified.

Business case and provider selection process

Background

55. The National Health Committee 2003 report *'Improving Child Oral Health and Reducing Child Oral Health Inequalities'* identified significant disparities in oral health outcomes between population groups. In particular, Māori and Pacific children and adolescents from low income families having poorer oral health outcomes than other children. The school dental services review (DHBNZ, 2004) and the Māori child oral health services review (Mauri Ora Associates, 2004) also noted that the current school dental service model no longer met the needs of children from Māori, Pacific and low income families.
56. In light of these findings, the recommendations of the National Health Committee, and the Ministry's strategic vision for oral health (Ministry of Health, 2006a) the Ministry signalled a major shift in focus of oral health services for children and adolescents to:
- community based oral health services, including Māori oral health services, with strong links to schools and primary care
 - a seamless 0–18 year old structure, which has the flexibility to extend to all whānau
 - delivery through a mix of fixed and mobile facilities that were suitable for modern dentistry
 - a focus on prevention and very early intervention
 - an appropriate and skilled workforce
 - nationally consistent dental data collection system.
57. Prior to the review, one-off funding came available, and the Ministry decided to implement the Māori Oral Health Project (the Project) to assist Māori health providers to become a core part of the oral health system and not an adjunct or after thought to the main service delivery. The Project was also aligned to *He*

Korowai Oranga, Reducing Inequalities in Health and the principles of the Primary Care Strategy.

58. Specific aims of the Project therefore were to enhance the position of these Māori health providers to deliver a model of care that was responsive to the oral health needs of Māori, consistent with the future direction of community based oral health services, as articulated in the strategic vision for oral health.

Overview of the business case development process

59. The school dental services and Māori child oral health services reviews identified 16 Māori health providers as delivering some kind of oral health service. In December 2004 these Providers were invited to register their interest in submitting business cases for existing or new oral health services. By the end of January 2005, 12⁵ Providers had responded to the registration of interest and the Ministry negotiated service agreements with these providers to submit business cases. Business cases were originally due on 7 March 2005 (later extended to 14 March 2005) and funding was provided to support Provider development of business cases.
60. The majority of Providers invited to develop a business case were involved in the Māori oral health review, and delivered oral health services either through clinical practice and/or oral health education and promotion. These Providers had experience working with Māori in the health and social service sector, knowledge of the wider systemic issues within the oral health care sector as well as knowledge of the regional needs of their Māori communities.
61. During this stage the Ministry informed relevant DHBs that a Māori health provider/s in their region had registered interest in developing an oral health business case. In this initial letter the Ministry indicated that they would value the input of the DHB in the development of the proposed business cases and in ongoing discussion about how the oral health needs of children and Māori could be met collaboratively.

Development of business cases by providers

62. Following the registration of interest the Ministry developed service agreements with interested Providers and a letter was sent to Providers briefly outlining the business case framework and Ministry expectations. In developing their business case Providers were asked to include:
 - an executive summary
 - a strategic analysis and background
 - service analysis and requirements
 - financial analysis and requirements
 - timeframes for implementation.
63. The business cases also needed to refer to the Ministry's strategic vision for oral health (Ministry of Health, 2006a); *Improving Child Oral Health and Reducing Child Oral Health Inequalities* (May, 2003); He Korowai Oranga;

⁵ Two providers combined to submit one business case, so there were a total of 11 business cases.

Primary Health Care Strategy, Reducing Inequalities in Health document and the Review of Maori Child Oral Health Services report (November 2004).

64. Providers reported they relied heavily on the information in that letter, and the adequacy of this information mechanism is discussed later in the report. The Ministry also provided funding of ten thousand dollars to support Providers to write their business case.

Provider reaction

65. Providers were highly motivated to develop business cases to address the oral health needs of Māori, particularly tamariki and rangatahi, in their communities. Across DHBs data indicated that Māori children had (on average) a four times greater chance of dental caries.
66. Providers saw a need to improve access and availability to appropriate oral health services for Māori and believed they were well placed to access tamariki and whānau through their: existing health services; understanding of the needs of whānau; and knowledge and relationships with kohanga, kura kaupapa and whānau generally. Providers further recognised the need to grow their own capacity and capability to deliver oral health services.
67. Providers consulted with a number of services including iwi social services, community organisations, community dentists, private practitioners and dental equipment suppliers to gain a complete understanding of their communities needs and to devise the most appropriate responses to deal with the issues.⁶
68. Providers also sourced key information from recent reviews undertaken by the Ministry, *Improving child oral health and reducing child oral health inequalities* report, and advice from dental practitioners.
69. Some Providers used the funding provided by the Ministry to contract a consultant/project manager to assist with the development of the business case. Consultants generally provided added value and expertise in areas where the person responsible for writing the business case was less knowledgeable. For example, support was obtained from a business accountancy perspective as well as detailed knowledge of delivery of oral health services.

Review of the business case process

70. The Ministry saw the business case process as a chance for Māori oral health providers to think of the 'big picture' – not just prevention work, but also

⁶ Some key community issues identified by Providers included:

- Anecdotal reports that many dentists preferred not to carry out dental benefit work as it was considered uneconomical for the amount of costs, time and effort associated with the service.
- Many adolescents (majority Māori) appeared to be missing out on treatment because they (a) were unaware of what they were entitled to and (b) private practice dentists were unwilling to treat them because the level of the government subsidy was insufficient to cover costs.
- The current level of funding provided for each child to receive oral health care did not cover the costs to effectively treat Māori. For example a non-Māori child may only need a clean and one filling whereas a Māori child generally required more work (e.g. more than one filling).

treatment options and workforce development. Some of the unsuccessful providers' business cases did not have this breadth of focus.

71. The Provider business cases appeared to be, in most instances, developed independently of the DHBs. The Ministry felt that DHBs could have been more helpful in working through the issues with the Providers. However, the Ministry also accepts that the lack of consultation at the outset between Providers and the DHB was not solely due to the DHBs. In some cases the language in Provider business cases – of 'taking over' oral health service delivery in the region did not help foster collaboration.
72. Providers identified four areas that, ideally, would have further assisted their development of business cases (and would also be beneficial if a similar process was utilised by the Ministry in the future): (1) a detailed business case template; (2) clear specification of the 'scope' of business cases (3) full knowledge of the business case assessment criteria; and (4) longer lead times and increased level of resourcing and support for the development of business cases. Each of these areas is now discussed in turn.

A detailed business case template

73. The Ministry communications (registration of interest letter and service agreement letter) provided some overall guidance about the expected business case content (e.g. outline aspects of any current oral health delivery, history of relevant contacts and the overall vision providers had for their oral health services etc). Providers suggested a more detailed template, something akin to a detailed table of contents, would have assisted the development of their business cases. Such a template would help Providers identify the specific information sought under each of the suggested content areas, and the template would facilitate the completion and improve the quality of business cases developed. However, it was also noted that four of the five selected business cases used the standard business case template.

The scope of business cases is clearly specified

74. The Ministry communications did not place any limitations on the nature of oral health services (what could be delivered) or the scope of oral health services (the range, volume, range and extent of services) that providers could develop or expand on, except in terms of alignment to key policy drivers.
75. Based on their understanding of Ministry expectations and requirements, Providers typically developed their business cases within an overall vision of Māori oral health services in their community, and used the business case process to 'cast dreams' with a big picture focus on building capacity and service delivery.⁷
76. Eleven business cases were completed in March and presented to the Ministry. Based on the viability assessment rating system (see below) five providers were selected. These providers achieved the highest scores across the

⁷ However, this caused problems later in the contract negotiating process when the Ministry and DHBs were presented with the business cases that were outside of the level of funding available, some significantly so, and Providers had to rewrite or scale-back their plans.

business cases and received notification in August 2005 that their business cases had been accepted.

Viability assessment rating system of business cases

77. The Ministry developed a set of assessment criteria to rate the 11 business cases. According to the assessment documentation, the assessment areas included the:
- level of DHB support
 - existing relationship with school dental service
 - consideration of school dental service and Māori oral health review in planning
 - seamless nature of the proposed service
 - focus on prevention, promotion and education
 - focus on inequalities
 - history of oral health experience
 - workforce strategy to recruit for the proposed service.
78. Providers were unaware of the assessment criteria and assumed that provider selection was based on the five points in the letter of agreement for business case development. Providers perceived that a large part of being selected was dependent on 'clinical' oral health delivery experience.
79. Although the Providers interviewed were 'successful' in terms of being selected as one of the Project providers, having the business case assessment criteria would have usefully informed the development and quality of their business cases.

Longer lead times and additional support to develop business cases

80. Providers' core business is about delivering services to their community and there is never an ideal time to add significant tasks, such as the development of a business case to what is typically an overfull workload. The service agreement funding did provide the means to contract additional support to assist with the development of the business case. Nonetheless the process required Providers to invest significant time in the business case process and to find this time within an already resource and time-poor context.⁸
81. The registration of interest letter was sent out late December 2004, and the service agreement notification in late January 2005. The timing of these communications over the Christmas, New Year period was less than ideal; neither was the timeframe of six to eight weeks for completion of the business case (originally due 7 March, later extended to 14 March).
82. Longer lead times and additional support and resources to assist Providers develop their business cases were suggested.

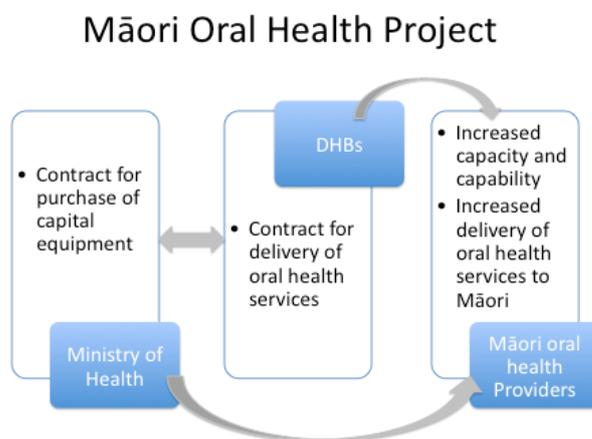
⁸ Concurrent with business case development a number of providers were also going through organisational change with infrastructure restructuring, employment of new management staff and/or accreditation processes.

Ministry and DHB contracting processes

Overview

83. Following the selection of the five business cases/providers, two separate but interdependent contracting processes commenced; Ministry and Provider negotiations around contract development for purchase of capital equipment; and DHB and Provider negotiations for funding of oral health services. During this time there were ongoing communications between the Ministry and DHBs about this project as well as the substantive and significantly larger oral health strategic asset management plans being developed by DHBs.
84. The strategic asset management plan was required to provide an initial indication to government of how much it was going to cost to set up a new child school dental service. Later DHBs were asked to submit business cases for their child and adolescent oral health service delivery. These later business cases had a requirement that Māori oral health providers be consulted with and be considered as a potential deliverer of oral health care, particularly in relation to Māori. Ministry personnel maintain that they had to push DHBs hard to be more open to considering Māori oral health providers as part of the mainstream plan. Indeed, Ministry personnel believed that there was considerable growth required by DHBs to become more open to thinking of other ways of delivering to Māori.

Figure 1: Overview of Project relationships



85. The successful completion of the contracting processes by both the Ministry and DHBs was essential to the achievement of the overall Project goals. This was because the capital equipment funding from the Ministry was conditional on DHBs providing operational funding in relation to the new capital equipment. In practice the dual contracting processes were not linear as this order might suggest, rather the two contracting processes were sequentially interdependent. Further, timeframes and sequencing of Ministry discussions and negotiations varied significantly from provider to provider and from DHB to DHB. This section:
- outlines the Ministry capital equipment contracting processes and reviews those processes
 - describes the DHB contracting processes and reviews those processes

- concludes with an overall assessment of the Project implementation and key Project 'learnings'.

The Ministry capital equipment contracting process

86. Following Ministry selection of five providers/business cases, DHBs were advised that a Māori provider in their region had been selected and were asked to accept the following conditions from the Ministry:
- to enter into a service arrangement with providers for a minimum period of five years
 - to ensure that the service agreements covered the costs to providers of delivering the oral health care service as well as an amount to cover capital depreciation, maintenance and administrative overheads
 - to take ownership of the assets purchased under the Ministry contract if the contractor (the provider) was unable to provide services under the service agreement or where the contractor commits a breach of the service agreement which results in termination of the service agreement.
87. This letter highlighted to Providers and DHBs the conditional co-funding arrangement envisaged by the Ministry. DHBs were required to agree to Ministry conditions to fund the service delivery component of the Project before the capital equipment contract between the Ministry and Providers could proceed. Negotiations between the Ministry, DHBs and Providers took place over a 15-month period, between August 2005 and November 2006.
88. During this time the Ministry variously received confirmation from DHBs that they would support Providers through either service agreements and/or funds for depreciation. As DHB support was gained the Ministry began to sign capital equipment contracts with Providers and these were finalised over a nine month period, from June 2006 to February 2007.
89. Once the capital equipment contracts between the Ministry and Providers had been signed, Providers had to move quickly to develop request for tender (RFT) documentation for the building of mobile dental units (MDU). This ensured that contracts were tendered and Ministry funding was expended in the 2006/07 financial year.
90. Four Providers decided to build MDUs and one Provider chose to develop a two-chair static clinic facility as part of their business case. Providers completed their RFT documents between December 2006 and January 2007. MDUs were built between February and June 2007, and Providers launched their services between July 2007 and March 2008.
91. The contracting process spanned a period of some 30 months from the date of the Ministry confirmation of business case/provider selection (August 2005) to the service launch date (March 2008) of the fifth and final Provider as outlined in the table below.

Process description	Timeframe
Ministry 'expression of interest' invited Māori oral health providers to register their interest in submitting a Project (oral health) business case	December 2004
Business case submission date	14 March 2005
Business case / Provider confirmation	August 2005
DHBs confirm 'commitment' to support	August 2005 to November 2006
DHBs negotiations with Providers	August 2005 to November 2006
Capital equipment contracts between the Ministry and Providers signed	June 2006 to February 2007
Request for tender documentation completed by Providers	December 2006 to January 2007
Providers let tenders for MDUs and facilities build and equipment purchased	February to June 2007
Operational funding contracts between DHBs and Providers signed	June 2006 to February 2007
Providers launch services	July 2007 to March 2008

92. The protracted contracting process delayed the signing of contracts by Providers for MDUs and equipment. In acknowledgement of these delays and the subsequent price increases since the original business cases were selected, the Ministry provided additional funding to Providers to help cover price increases in facilities and equipment.

Review of the Ministry contracting processes

93. From the Ministry perspective, as the Project was opportunistic, the process evolved as the project proceeded. It was therefore important to document learnings from the project for future reference.
94. Providers felt that the Ministry contracting process to secure the capital equipment funding was complex and protracted. Providers commented on four areas in particular the:
- co-funding / dual contracting with the Ministry and DHBs
 - lack of a co-ordinated and supported approach to the tendering and purchase of facilities and equipment
 - contract payment process
 - protracted contracting process.
95. The Ministry concedes that it may have been beneficial to bring the DHBs and providers together after the successful business cases were awarded to set expectations of Ministry requirements and to communicate more effectively with all parties at once. However, at the time, the Ministry didn't realise the level of complexity that was to evolve. Further there was a tension as some of the DHBs really were somewhat resistant to being part of the Project and there was a concern that bringing the DHBs together might have further exacerbated the issues to be resolved.

96. As the project became more complex than was initially expected, (especially in relation to the securities of interest) in hindsight it was apparent that the team assembled within the Māori Health Directorate was perhaps insufficient to deal with the issues in a timely manner. On the other hand, by having a small team, the Ministry did work systematically and fairly with all Providers and DHBs.
97. The Ministry held the view that the project was potentially perceived as an inconvenience to DHBs, in the midst of other more pressing demands. Provision of Māori oral health services was not, for most DHBs, a priority and this may have contributed to the protracted negotiations. Indeed there was little progress with some DHBs until they realised that:
- the Ministry required them to find funding from within their own budgets rather than provide DHBs with additional funding
 - the Ministry was directing them to resolve the issues in a certain manner that was not negotiable.
98. The Project was a catalyst for the 'community' focus not previously required of the School Dental Service (SDS). One of the roles of the Māori Health Directorate therefore was to ensure that DHBs were aware of the contribution of the Project (and more broadly Māori health providers) to the Ministry's strategic vision for oral health.

The co-funding / dual contracting with the Ministry and DHBs

99. In August 2005 the Ministry advised DHBs that a Māori provider in their region had been selected as part of the Project. The Ministry sought DHB commitment to funding of services (related to the capital equipment) for a period of five years. Funding was to cover capital depreciation, maintenance and administrative overheads. In addition, the DHBs were required to take ownership of the assets purchased under the Ministry contract, if the Provider was unable to provide services under the service agreement or if the service agreement was terminated.
100. This letter highlighted to Providers the conditional co-funding arrangement envisaged by the Ministry, and some Providers reported being 'surprised' by this arrangement and expressed disappointment that the Ministry had not fully explained the critical role of DHBs (in the Project) to realise their oral health / business case plans.
101. Some Providers were under the mistaken impression that the Ministry could, and would, instruct DHBs to fund their business cases and some Providers thought that the Ministry would provide all of the business case funding.

Lack of a co-ordinated and supported approach to the tendering and purchase of facilities and equipment.

102. As already noted, the Ministry concedes that the co-ordination and tender process was not optimal timing wise. At all stages of the process, the Māori Health Directorate and the Project were ahead of the broader oral health activities of the Ministry, at the time by a year to 18 months.

103. Timeframes for developing the tender document for building the MDUs and selecting the companies to build the units were extremely tight and occurred over the Christmas and New Year period.
104. As stated previously, Providers felt they lacked the necessary technical and oral health expertise for the development of the request for tender documents. Whilst dental therapists contributed to the process, it was not necessarily their area of expertise and had to be done on top of their clinical work. However, some Providers came together and collaborated with other Providers who were more experienced with RFT development, and purchasing oral health equipment.
105. Whilst Providers felt they did the 'best job possible' given the time and knowledge constraints, they suggest future projects would benefit from a more co-ordinated approach on the part of the Ministry, for the RFT process. They also suggested that it would be optimal if there was a project manager, contracted by the Ministry, to work with all providers to facilitate the design, tendering and purchasing of MDU and equipment. A co-ordinated approach would also have allowed for a joint procurement process and the possible realisation of cost savings, volume discounts and some value add incentives such as improved or new products and models (at no additional cost).
106. The lost opportunity for a joint procurement was galling for Providers given that not long after the Project RFT process was completed, a centralised process was utilised for the design, commission and purchase of MDUs and oral health equipment for DHBs.
107. The Ministry rationale for proceeding and not waiting was that they knew the oral health service provision was in a process of change from a school based system, to a more community based oral health delivery system and they wanted DHBs to start seeing Māori providers as part of the system, not as an adjunct to the system. In addition the processes with DHBs took nearly three years to complete and just involved purchasing units. For these reasons, the Māori Health Directorate did not want to delay the progression and implementation of the Project.
108. Further, in a tandem process, DHBs were required to include provision for service delivery by Māori providers in their strategic asset plans. The Ministry perceived DHBs either did not know how to include Māori oral health providers' initiatives in their strategic asset plans, or were reluctant to do so. The Ministry had to escalate the issue to CEO level in their respective DHBs to achieve this. The Ministry perceives that in some instances the DHBs made a good job *thinking* about how to include Māori oral health providers, but they had not *actioned* including Māori oral health providers in their plans.
109. Providers would have liked more support to access technical advice for the RFT as well as for the accounting and legal issues that arose as part of the Project/contracting processes. An example is the complex legal issue of security of interest of the MDUs. The Ministry appreciated that on the surface the contracts looked straight-forward, but the detail was complex.

The contract payment process

110. A number of providers also found the contract payment method less than ideal. Providers were expected to pay suppliers directly and to claim this amount back by invoicing the Ministry. Thus providers needed sufficient cashflow or financial reserves to meet these costs. This impacted on Provider cashflow and created delays for payment to suppliers who deemed the Māori providers as the client. However, Providers also reported that the Ministry were very prompt once they received invoices.
111. On the other hand, this type of payment process, is a typical business process. In addition, the Ministry note that project funding was not grant funding and as such the contract required confirmation/proof of purchase of services or outputs before payment could be made.

Protracted contracting process

112. The process spanned a 30-month timeframe from the date of the Ministry confirmation of business case/provider selection (August 2005) to the service launch date (March 2008) of the fifth and final Provider.
113. In addition, Providers needed to access legal advice in relation to the Ministry and DHB contracts. This impacted on the contracting timeframes and was an added expense that Providers had not anticipated.
114. Although the business case RFP had a closing date, there was no indication of timeframe post the initial selection period. The need to secure DHB commitment to funding of services meant there was a 12- to 18-month lapse between the submission of the business cases and contract negotiation with the Ministry; and this was followed by DHB and Provider contract negotiations which took a further nine months.
115. The overall duration of the contracting processes took much longer than either Providers or the Ministry expected, and a large part of the time delay was due to the Ministry and DHB negotiations around operational funding and DHB registration of security of interest over the assets and equipment.

The DHB operational funding contracting process

116. This next section of the report reviews the DHB operational funding contract process between DHBs and Providers. To recap, the process was as follows:
 - January 2005 the Māori Health Directorate sent letters to 11 DHBs informing them about the Project and that a Māori provider in their region was developing a business case.
 - August 2005, the Māori Health Directorate contacted five DHBs advising them that a Māori provider in their region had been selected as part of the Project. DHBs were required to confirm their agreement to support Providers (as part of the Project) either through service agreements and/or funds for depreciation.
 - August 2005 to November 2006 all five DHBs confirmed their agreement to the Ministry to provide support/funding for Providers as part of the Project – and thus the Ministry could finalise capital equipment contracts with providers.

- August 2005 to November 2006 DHBs variously negotiated service agreements with Providers.
 - June 2006 to February 2007 DHBs signed operational funding contracts with Providers.
 - Services were launched from July 2007 to March 2008.
117. Throughout the process the Māori Health Directorate and the Chief Advisor Oral Health of the Ministry kept DHBs informed through letters, emails and verbal communications.
118. Concurrent to this process, it is important to note that in March 2005, DHBs were advised by the Ministry of the need to develop oral health strategic asset management plans. There was a requirement that the development of the plans include consultation with Māori oral health providers, outline the role of Māori oral health providers within the overall DHB provision of oral health services and the DHBs purchasing intentions.

Review of the DHB contracting processes

119. The DHB contracting was complex. It involved:
- Ministry and DHB negotiations – in relation to service agreements and depreciation funding of Providers/business cases and registration of security of interest over the capital equipment funded by the Ministry. It was also linked to the development of oral health strategic asset management plans by DHBs.
 - DHB and Providers negotiations – in relation to the Project, business as usual requirements and the development of oral health strategic asset management plans (and Provider involvement in these).
120. Further, Providers and DHBs had existing relationships prior to the project and variously had a range of contracts with DHBs for services such as tamariki ora as well as contracts for oral health services and or oral health promotion. Providers were also dealing with different groups and their respective personnel within DHBs.
121. In addition, each DHB was negotiating with a single Provider and with the Māori Health Directorate in relation to the Project and the Oral Health group in relation to the development of the oral health strategic asset management plans.
122. The Māori Health Directorate however was negotiating and liaising with 10 organisations; five DHBs and five Providers, as well as internally.

DHB perceptions

123. DHB and Ministry Project documentation and communications and the evaluation data, provide some insight into DHB perceptions and concerns about the Project, the Ministry implementation of the Project and the role of DHBs in the Project. DHB concerns related mainly to Ministry processes including:
- a perceived lack of consultation by the Ministry with DHBs prior to the Project development
 - a perceived lack of DHB involvement in the business case selection process

- lack of Ministry guidelines around the scope and parameters of business cases.
124. The 15-month duration to secure the commitment of all five DHBs to operational funding, was in part DHBs seeking greater clarity about the Project and their role within the Project, as well as DHBs ‘pushing-back’ against what was seen as the Ministry ‘directing’ DHB expenditure.

Lack of consultation and involvement of DHBs in Project scoping

125. There is evidence of a range of communications between the Māori Health Directorate, the Chief Advisor Oral Health about the Project with DHBs (see paragraph 117).
126. The issue therefore appears to be not so much a lack of consultation but from a DHB perspective, the adequacy of the consultation process and, meaningful involvement in the Project.
127. Despite the Ministry’s repeated attempts to communicate the purpose of the Project with the DHBs, the evaluators found there was a lack of understanding by some DHB staff of the Project and its origins. Some DHB staff thought that the Ministry initiative was at the behest of the Providers and that those Providers had approached the Ministry for support in accessing funds from the DHB. This lack of clarity of the origin of the project may have made negotiations between the Providers and the DHB more difficult than if DHBs had known the true origin of the Project.
128. The Ministry acknowledges they did not consult with DHBs prior to inviting Providers to submit business cases, mostly due to pragmatic factors such as time and personnel resource issues. Firstly, the timing of sending out the requests for the expressions of interest in late December did not allow for prior consultation with DHBs. Secondly, at the same time Ministry staff were preparing documentation to support the approval of the new strategic direction for oral health. Thirdly, it is questionable about the worth of engaging with all 21 DHBs when it was unlikely that the Project would operate in all DHB regions.

Lack of DHB involvement in the business case/Provider selection process

129. Some DHBs felt they would have added value to the business case process if they had been more actively involved. Their view was that for some business cases the Ministry did not have all the relevant information to inform selection including; a clear understanding of the Māori provider and DHB relationship, the past history of Māori providers to deliver, the funding capacity of the DHB, and DHB priorities.
130. DHBs observed that the Project gave greater priority to Māori service provision than was otherwise planned and had an increased focus on Māori child oral health service provision. For example, one DHB had decided to make a number of changes to how they would deliver and fund oral health services but the Provider’s business case sought funding to deliver services in an area the DHB had planned to discontinue services.
131. Within DHBs a number of portfolio managers or Māori planning and funding staff supported the Providers and acted as advocates for the development of

their oral health services. The process for Providers within the DHB systems was testing. Some Providers had to rewrite business cases in order for the DHB planning and funding committees to consider funding. However, a number of DHB personnel provided good advice and provided resources such as regional DHB statistics so proposed services were aligned with DHB planning. Indeed, within the DHB the onus was on Māori providers to prove the oral health service and expansion they were proposing was essential.

132. Some DHB staff also believed that the Project would have worked better if a partnership approach was used between the Ministry and DHBs. Given the necessity for DHB funding as a key Project input most DHBs felt they were not adequately consulted by the Ministry; either prior to the Project development, during the business case selection process or during the overall implementation of the project. Because of this perceived lack of consultation and minimal involvement in the selection of business cases some DHBs feel they were pressured or 'coerced' into the Project co-funding arrangement, and indeed from a Ministry perspective, this was the case.
133. From a Ministry perspective, one of the reasons for this initiative was that a number of barriers to Māori oral health providers entering and continuing in the market as an oral health provider had been identified in the Māori child oral health review. The DHBs did not have a track record of addressing Māori child oral health issues and this was an opportunity for an acknowledged catch up. Given the unusual nature of the project, it was not surprising DHBs were perplexed, but the lack of priority the initiative received from some DHBs until considerable Ministry pressure at a senior level was applied, substantiated the need for the approach.

Lack of Ministry guidelines around the scope and parameters of business cases

134. The business case specification did not prescribe or limit the oral health services that Providers could develop except in terms of alignment to key policy drivers. Internal DHB communications (and evaluation findings) indicated DHB disappointment in the Ministry's management of Provider expectations, which was largely attributed to a lack of guidelines around the scope and parameters of business cases. As a consequence Providers presented DHBs with substantial plans which DHBs felt in no position to support and DHBs required initiatives to be scaled back. This caused some tension between Providers and DHBs, as Providers tended to see this as DHBs being resistant and non-supportive of their kaupapa and their aspirations for oral health services for Māori.

Registration of security of interest

135. DHBs were slow in registering the security of interest. There was considerable communication required between lawyers, DHB, the Ministry and Providers to achieve registration of the security of interest. The main difficulties from the DHBs perspective were that the registration requirement was a completely new process and was viewed as a rather unusual request – not something that DHBs usually did. It took the DHB legal teams some time to work through what was required. Once the security of interest was ready to sign it appeared that it was not a priority of DHBs and hence there were more delays in finalising.

Overall assessment of the fund distribution process

136. There were three main and interrelated components to the fund distribution process: the business case process, the Ministry capital equipment contracting process and the DHB operational funding contract process. This section makes an assessment of those processes.

Assessment of the business case process

137. Overall the business case process – the development of business cases by Providers and assessment by the Ministry – was a relatively smooth process. Providers reported that a significant investment of time in the business case application, a commitment to better meeting the oral health needs of their Māori communities and funding provided by the Ministry and DHBs were critical to the successful completion of this component of the project.

Key learnings from the business case process

Improved communication processes

138. The evaluation identified that both Providers and DHBs did not have a detailed understanding of the Project purposes and/or Project processes.
139. Whilst Providers suggested a more collaborative process from the outset involving DHBs, the Ministry and Providers this would have been difficult for the Ministry to sustain across all DHBs and all invited Māori Oral Health providers – given the personnel resources of the Māori Health Directorate. Further given the level of pressure required to get some DHBs to participate, there is no clear evidence to suggest that DHBs would have participated in genuine, constructive collaboration. On the other hand, some DHBs felt that increased involvement would have better positioned them to work with successful Providers.
140. The challenge therefore was one of both improved communications and improved communications processes, whilst balancing the level of involvement of all parties to achieve the optimum level of engagement necessary to have fully informed stakeholders.

Improved business case guidelines and project parameters.

141. Both DHBs and Providers felt that the business case and contracting processes would have been aided by greater specification of the scope and parameters of the business case. Providers also suggested that a detailed business case template and full knowledge of the business case assessment criteria would have supported the development of high quality business case proposals. In addition, longer lead times and increased level of resourcing and support were also suggested.

The Ministry and DHB contracting process

142. Following the selection of business cases/Providers by the Ministry and notification to Providers and DHBs the process became more complex. It variously involved the Ministry, DHBs and Providers as well as different groups within the Ministry such as the Māori Health Directorate, Oral Health team and Ministry legal services and two main groups within DHBs, such as Funding and Planning and School Dental Services.
143. The co-funding and dual contracting arrangement, coupled with Ministry and DHB contracting processes to give effect to this arrangement, was complex and resulted in a protracted contracting process. As noted previously, the complexity of the inter-relationships variously between the Ministry, DHBs and Providers further added to the time required to work through the contracting processes. Further, Ministry negotiations were typically undertaken with individual DHBs, who were often at different stages in their decision making process. Thus the project supervision requirements for the Ministry grew rapidly and exponentially.
144. At the same time, a number of parallel processes occurred between Providers and DHBs including negotiations around operational funding for the new proposed oral health services, existing contracts new oral health contracts unrelated to the Ministry capital funding and the development of the strategic asset management plans. In addition, Providers had relationships with different groups within the DHBs, planning and funding and School Dental Services, and at times tensions surfaced within DHBs because of the perceived conflict of interest between School Dental Services and services Providers wanted to deliver.
145. The Ministry capital equipment contract took considerable time to finalise due to the delays in gaining commitment from the DHBs to fund operations and to work through the legal process to arrive at the registration of security of interest over the MDUs, which was a new approach to 'risk management' for all parties.
146. The unique approach taken by the Ministry to make a difference and have an impact on Māori oral health meant that processes and structures were developed as the Ministry implemented the Project with providers and DHBs. As with all pilot projects this meant there was an element of trial and error and the Ministry worked to, essentially, an action-research model where solutions were developed to deal with and manage issues as they arose.

2 Project Implementation

147. The Project has supported Māori oral health providers to establish new services and/or expand existing oral health services. This section of the report discusses Provider implementation of services with a focus on the first year of service delivery and issues in relation to the establishment of services. It then concludes with an assessment of implementation issues of how funding has supported the development of Māori provider oral health capacity and capability and participation in the oral health sector.

New or expanded oral health services delivered

148. As a result of the Project, Providers have been able to establish new or expanded oral health services, renegotiate existing oral health promotion and service contracts and to increase their knowledge and understanding of DHBs systems and processes.

Challenges in the first year of operations

149. The first year of operations resulted in a number of challenges for Providers to deliver either new or expanded services including marketing and promotion, staff recruitment and retention, implementation and refinement of monitoring and reporting. Providers were also challenged by the high level of oral health needs patients presented with and the subsequent impact on service delivery.

Marketing and promotion

150. As well as setting up new services, some Providers had to market and promote these new services to their respective communities, kura/schools and kohanga reo. There were different tensions evident depending on the community and oral health service environment in which Providers operated. Where new services were introduced it was relatively simple to market them. For example, Providers visited kohanga reo and kura or promoted the service to the existing client base.
151. In other situations where Providers replaced the School Dental Service relationships needed to be managed with schools/communities and with the School Dental Service/ DHB.

There was a sense that the SDS had a loss of control of a service they had delivered for the last 85 years. They felt like they were losing part of themselves. (Provider Manager)

SDS dental therapists spread messages to schools like 'we won't be coming here' and played on the fear of a new provider and a Māori provider. (DHB Manager)

152. The Providers were also very aware that widespread marketing of the new service could add considerable pressure on the oral health clinicians, especially if large numbers of whānau became aware of the service and sought treatment simultaneously. Providers mitigated the potential for being swamped by over-demand by gradually rolling out their promotional activity, firstly promoting the new service within the existing Māori provider services and/or targeting whānau who had been clients when their children were younger to let them know about new adolescent services, prior to undertaking wider promotional activities.

Recruitment of staff

153. Staff recruitment was a priority for all Providers in the first year of operation. From the outset, Providers realised that securing the right staff was critical to implementing and delivering their oral health services. Providers were also aware that there was a national shortage of oral health clinicians generally – particularly Māori, as well as regional variations in the availability of oral health clinicians.
154. As a result Providers undertook a range of recruitment activities to secure staff. Providers:
- developed relationships with AUT and Otago University to receive information about students looking for placements or about to graduate
 - sent staff to Otago dental school to recruit students
 - advertised in the New Zealand Dental Association magazine, online and the New Zealand Herald
 - shoulder-tapped clinicians and offered accommodation incentives and relocation costs.
 - attempted to grow their own oral health staff by training and/or upskilling current or new staff, supporting interested staff members into dental assistant or dental therapy training by paying fees for courses and providing hands-on training.
155. Despite these initiatives, Providers all experienced recruitment difficulties and Providers have variously used temporary or contract staff to cover staffing shortfalls. Whilst some Providers offered above market rates of pay other Providers did not favour such a strategy; believing that it fuels regional rates (and national rates) overall, sets up a competitive local context and is not sustainable in the long term.
156. Another approach to manage workforce recruitment and retention was via the DHB, where the DHB funded the dental therapist position and the Provider contracted to the DHB for staff. Thus the DHB assumed the risk in terms of staffing (although it did not build Provider capacity in the longer term). One Provider put this approach in place prior to the Project to address workforce recruitment issues. In addition, some Providers liaised with DHBs to contract DHB staff willing to work in the school holidays for Providers.
157. In recognition of long term workforce needs some Providers offered secondary school students work experience.

Staff retention

158. Providers recognised that retention of staff is key to ongoing service delivery, quality of services and future opportunities for expansion. Providers ensured that staff attrition stayed as low as possible and ensured that oral health staff felt supported and acknowledged in their work. Staff were encouraged to attend Te Ao Marama (the New Zealand Māori Dental Association) forums and in many of the provider organisations, the costs of staff attendance at conferences was fully or partially subsidised. Opportunities to attend oral health forums/conferences were seen as valuable for networking with other dental therapists and dentists and for ongoing professional development.

It's a place for comradeship. A staff member went to the last one and came back rejuvenated. She said it was fruitful and interesting listening to discussions like about fluoridation.

159. To support Māori and non-Māori staff to engage with Māori clients, a range of cultural programmes were offered to staff and support from support from kaumatua (elders) was also made available to staff. Examples cited included:
- advice and support for staff provided by a pou tikanga kaumatua (senior cultural advisor)
 - daily karakia (prayer) and waiata (singing)
 - te reo Māori classes
 - annual noho marae (marae based seminar).

High level of oral health care need of presenting patients

160. Providers reported that children, adolescents and adults presented with a high level of oral health care need.

We see these beautiful, beautiful teenagers from here coming in [to the clinic] and then they open their mouths and are so ashamed. Some of them haven't been seen since primary, if at all. (Dentist).

"For the teenagers (12 and over) if there is a little bit that needs to be done like tartar, then normally under the standard package it will take 5 minutes, but if it takes 15 minutes, there are costs. So we have to spend time taking x-rays, doing prior approval forms, writing an [explanation] to do the extra work and then if we have spent three to five attempts to get this teenager to the chair, then this 15 minutes of extra work required – although it sounds trivial, can be the difference between getting it clean. Then we have the risk of losing them and having our Admin go through the process of trying to recontact the patient. Sometimes it could take another six weeks to just make contact with them and then trying to get them to keep the appointment again. The other thing is we are booked up almost six weeks in advance! It's frustrating for us! (Dentist).

161. This high level of oral health care need impacted on Providers in a number of ways:
- The contract funding was based on 'typical' oral health needs and Providers reported that a significant proportion of their targeted clients had not had any form of dental care or treatment for very long periods. Thus the time taken for treatment (and the associated costs) was longer than envisaged and allowed

for in the contracts. For example, where funding is allocated for 1.5 fillings per client, some clients are presenting needing 6–8 fillings.

- Most Providers reported that a considerable number of patients were presenting with oral health care needs which could not be solely met by the dental therapist. This required a greater level of treatment from dentists than envisaged e.g. for treatment or prescription of antibiotics. Whilst some Providers had a dentist on staff or on contract, the available dentist time, appeared insufficient to fully meet the oral health needs of some Māori patients.
- Many Providers found the treatment of adolescents challenging. In general they attended the first appointment and then a considerable subgroup did not continue with further treatments even when they were needed. This impacted on the administration (setting and following up appointments) and loss of clinical time when patients missed their appointments. Some Providers tried to encourage adolescent re-visits by texting reminders to patients.

Reporting and information management systems

162. Providers typically had well developed organisation infrastructure and systems in place prior to the Project as they had been delivering health and social services contracts for a number of years. Provider systems variously included:

- intelligent tracking and reporting tools
- a safe and secure network server which provides centralised and universal organisational access to information with password protection
- a consistent approach to file management in accordance with an organisational file management system and associated policies
- automated off-site file backup and uninterrupted power supply
- continually updated anti-virus and firewall protection.

163. Additional developments amongst Providers included:

- a revised service management model
- hiring additional clinical staff
- training in new equipment, and mobile systems
- practice management software
- installing power sockets at schools and laying concrete pads for safe access of MDUs.

164. Most Providers variously purchased new software to align with DHB reporting and patient management systems such as Excellence patient management, Titanium and Exact software.

165. One software product which had the ability to text message patients to remind people of appointments looked promising. It had the facility to manage appointments systems, provide templates for reporting and provide historical data and stock take reports. Patient details were entered by the receptionist and the dentist retrieved that data when the patient arrived. When patient information was accurately entered into the system, the dental therapist/dentist was able to accurately determine the amount of treatment required for the patient and the number of appointments needed to complete the treatment.

166. Whilst the cost of purchase and training was not inconsiderable, Providers commented that appropriate software streamlined clinical and administrative processes. For example, one Provider did not currently have an electronic system for making claims for payment to the DHB—a time consuming administrative task when completed manually

Monitoring and reporting more generally

167. Providers undertook a number of monitoring and reporting activities for the purposes of audit and quality assurance including:
- monthly meetings of all operational units including divisions and units
 - monthly reporting by oral health managers to either the General Manager or CEO of the provider organisation
 - General Manager/CEOs report to the provider Trust boards of performance against contract targets and budgets
 - development of Corrective Action Plans (CAPs) where contract or budget variance or deficiencies were detected.
 - monthly reports were accumulated and summarised in quarterly reports for both internal purposes and contract reporting to funding agencies. Reporting requirements were then managed in accordance with contractual compliance. For example one DHB required School Dental Service contract reporting on a quarterly basis to the provider arm, while the Rangatahi contract required six monthly reporting to the DHB funder arm.

Assessment of the first year of implementation

168. Employment, retention and professional development of oral health workers is the key challenge variously evident across all providers. In addition, support to cope with high demand and complex cases is also of concern.

Oral health workforce

169. All Providers were acutely aware of the current workforce context; that dental therapists are an aging population and there are a limited number of graduates from AUT and Otago each year, with many of the graduates choosing to go into private practice. To counter this workforce capacity issue, along with traditional recruitment methods, Providers choose to both develop and train existing staff and identify and support local candidates who wished to train in dental therapy and who were likely to return to work in the local community.
170. Providers variously used a range of different recruitment strategies but were aware of the need to closely monitor their own internal and regional context. They were also highly aware of the need to develop and maintain networks with AUT and Otago and with the professional oral health associations to stay abreast of workforce trends in dental therapy and the wider oral health sector.

171. Providers acknowledged the need to create supportive working environments for their staff and, ideally, for remuneration packages to be on a par with those offered by DHBs and the private sector. A large part of the ability to competitively remunerate depended on the level of contract funding, particularly the staffing component of contracts.

High demand and complex cases

172. Providers recognised that the environmental and treatment context for staff was demanding. Patients often presented with high oral health care needs and the work was often harder and more challenging due to the amount and nature of treatment needed by each patient. Further, community based dental therapists were often 'isolated' in terms of clinical support and needed to be independent thinkers, disciplined and able to lead themselves.
173. Providers continually grappled to address professional isolation in day-to-day practice and to provide ongoing professional development. Some Providers suggested that two chair clinics or MDUs potentially created a more supportive clinical work environment for staff.
174. How much credence should we give to reports that clients were presenting with high levels of oral health care need? It was evident that Providers made highly credible claims and this was backed by the literature. It is clear that an oral health disparity that exists between Māori and European (non-Pacific) children as Ministry of Health (2007:11) reported that 'regardless of fluoridation status, Māori children at school Year 8 had the fewest caries-free teeth and the most decayed, missing or filled teeth, followed by Pacific children'.
175. Further "dental therapists only see children once every 12 months and it is anticipated that the Māori need for oral health services is greater because of the state of their oral health, and also due to the need to change behaviour and encourage preventative behaviours (e.g. fluoride applications)" (Cram, Oakden and Wehipeihana, 2009).
176. However, the extent to which this high level of disparity is taken into account as part of the funding formulas and overall service contract amounts is unclear, and requires further investigation.

3 Project Outcomes and Relationships

177. The primary objective of the Project was to increase the capacity and capability of Māori oral health providers to deliver oral health services to their communities. A secondary objective was to facilitate a strengthening of relationships between DHBs and Māori oral health providers.
178. This section briefly summarises the capacity and capability gains of Providers as a result of the Project. It then describes the DHB Provider relationship over the duration of the Project and the nature of any changes that have occurred and concludes with an assessment of the extent to which the Project has achieved its primary and secondary objectives.

Provider capacity and capability outcomes

179. The following table provides a summary of the Ministry and DHB funding and briefly describes the oral health services Providers delivered before the Project and oral health services delivered as a result of Project funding.

Table 6: Project funding and services

Providers	Oral health services delivered prior to the Project	New services delivered as a result of the Project
<p>Te Manu Toroa</p> <ul style="list-style-type: none"> Ministry funding \$204,873 DHB funding \$307,070* Total funds \$511,943 <p><i>* per annum for new rangatahi contract linked to the MDU</i></p> <p>Resulting in the purchase of:</p> <p>1 x self drive dental unit plus equipment</p>	<p>Since 1998 delivery of Kaupapa Māori Oral Health Services to mainly Māori children, 0–5 years of age delivered from static clinics based at Te Akau Hauora (Papamoa), Waitaha Hauoranga (Te Puke), Pirirakau Hauora (Te Puna) and Te Runanga o Ngaitamawhariua.</p> <p>In 2000 the service expanded to Merivale Primary School (due to its mainly Māori population and decile rating) working in partnerships with School Dental Services.</p> <p>Services further expanded to include schools with high Māori rolls – Maketu Primary School (0–Y6); Matipihi and Matakana Primary Schools (0–12 years) and Te Kura Kaupapa Māori o Otepou – full immersion school (0–12 years) and Te Kura Nga Papaka o Rangataua (5–13 years).</p>	<p>New and expanded services</p> <p>The new services were launched in December 2007. TMT are now providing oral health services to:</p> <ul style="list-style-type: none"> all 21 kohanga reo in Western Bay of Plenty rangatahi from years 9 to 13 in rural communities employ a dentist for one day per week to carry out the adolescent referral contract for work that is outside of the dental therapist scope of practice.

Providers	Oral health services delivered prior to the Project	New services delivered as a result of the Project
<p>Ngāti Hine Hauora Trust</p> <ul style="list-style-type: none"> Ministry funding \$375,300 DHB funding \$150,000* plus claims for services Total funds \$525,300 <p>One off funding of \$180,000 allocated over five projects: (1) \$30,000 workforce development – funding one position at AUT over three years; (2) \$65,000 for contracting of a dentist for one year; (3) purchase additional equipment; (4) \$35,000 for one year services co-ordination and SDS service implementation; (5) \$10,000 over two years for dental therapist placement programme with Otago Dental School</p> <p>Results in the purchase of:</p> <ul style="list-style-type: none"> 1x self-drive mobile dental unit 1x caravan dental unit Dental equipment 	<p>Since 1996 delivery of adolescent oral health services originally to three high schools and expanded scope to deliver to all schools in 1999.</p> <p>Two Oral health promotion and education contracts: one with MoH, one with DHB which was targeted to school brush-ins and screening of young mothers and babies.</p> <p>Specialist dental services where need is deemed outside the scope of practice of a dental therapist and when a dentist was available (special dental benefit).</p>	<p>New and expanded services</p> <p>The new/expanded services were launched in August 2007 and are providing:</p> <p>Treatment services extended to children attending 14 low decile primary schools (and the pre-schoolers which fed in those schools). This equates to more than 20 pre-schools.</p> <p>Responsible for annual examination of approximately 1400 primary students and an estimated 800 pre-schoolers which was previously carried out by SDS/DHB.</p>
<p>Ora Toa</p> <ul style="list-style-type: none"> Ministry funding \$185,505 DHB funding \$0* plus claims for services Total funds \$185,505 <p>* No funding, two contracts were given by the DHB which are claim based and run as a fee paying service.</p> <p>Resulting in the purchase of:</p> <p>1x fit-out of static two-chair dental unit including equipment</p>	<p>Not delivering oral health services before the Project.</p> <p>Prior to the start of the Project (the expression of interest) Ora Toa had submitted with their previous PHO partner a proposal to C&CDHB, to consider funding the establishment of a dental service.</p> <p>Ora Toa were then approached by the DHB to further develop their original proposal to provide oral health services for adolescents.</p> <p>It subsequently formed the basis of the Ora Toa Project expression of interest and business case.</p>	<p>New services launched June 2008</p> <p>Two contracts: one is for oral health services for adolescents (OHSA); the second is for school dental specials. This is work carried out by a dentist that is outside the scope of dental therapists.</p> <p>Payments for both contracts are based on claims for the services.</p>
<p>Te Taiwhenua o Heretaunga (TTOH)</p> <ul style="list-style-type: none"> Ministry funding \$270,222 DHB funding 91,000* Total funds \$361,222 <p>* \$11,000 given to cover depreciation. In addition the HDHB had given \$80,000 to TTOH in 2005. This was linked to the Ministry as the new investment funds.</p> <p>Resulting in the purchase of:</p> <p>1x double unit dental caravan unit equipment.</p>	<p>Contracted to deliver treatment services to adolescents.</p> <p>TTOH used transportable equipment which was conveyed and set up at each school. This was time consuming to set up and because schools did not have appropriate treatment rooms, clinical treatment was often from make shift classrooms, which made treatment clinically unsafe in terms of cross infection control.</p>	<p>Continuation of existing service and expanded service capability</p> <p>Deliver adolescent treatment services via a MDU adolescents. Continuation of previous contract now a dentist can work alongside a dental therapist when necessary.</p>

Providers	Oral health services delivered prior to the Project	New services delivered as a result of the Project
<p>Tipu Ora</p> <ul style="list-style-type: none"> Ministry funding \$183,102 DHB funding \$59,000* <p>\$36,000 to cover depreciation of MDU and the normal 2.9% inflation increase on existing contract a total of \$101,057 per annum, \$20,000 for additional MDU equipment and \$3000 to cover Project related legal expenses.</p> <ul style="list-style-type: none"> Total funds \$284,159 <p>Resulting in the purchase of:</p> <p>1x double unit dental caravan plus equipment</p>	<p>Delivered a pre-school dental clinic for one day per week in partnership with Lakes DHB. The service was based at their dental clinic at Ohinemutu.</p> <p>Provides free dental checks for local Māori and practical experience for dental students in partnership with Otago Dental School.</p>	<p>Continuation of existing service</p> <p>No new services are being delivered as a result of the Ministry. It was the intention of the Lakes DHB to fund an additional dental therapist position to ensure that the MDU would be fully utilised; however this did not eventuate.</p> <p>Instead the existing contract for pre-school and primary treatment has had an amount added for depreciation.</p>

180. Ministry funding to purchase capital equipment resulted in all Providers having increased capital equipment and physical assets to deliver services. However, support and funding of the Project/Providers varied considerably between DHBs. As Table 4 highlights:

- two providers, Te Manu Toroa and Ngāti Hine Hauora Trust received DHB funding to deliver new oral health services and to expand their existing oral health services
- one provider, Ora Toa, delivered a new adolescent oral health service. They did not seek a DHB contract for services funding as they delivered oral health services on a claims for services basis, however the DHB was supportive of the development of this oral health service
- one provider, Te Taiwhenua o Heretaunga enhanced their service delivery capability, through the use of a purpose built MDU. The previous oral health service delivery contracts were maintained/rolled over but no new/additional funding was provided by the DHB
- Tipu Ora received funding for depreciation of the MDU and their previous oral health service delivery contract was maintained/rolled over.

181. To further explore the extent to which the Project increased the capacity and capability of Providers to deliver oral health services to their communities the following criteria⁹ derived from the literature was used to develop the evaluation capacity framework. The elements of the framework included the:

- capability to commit and engage
- capability to carry out technical, service delivery and logistical tasks
- capability to relate and attract
- capability to balance diversity and coherence
- capability to adapt and self renew.

⁹ Adapted from Baser and Morgan (2008, p. 26–33.)

182. The shading in the table shows the extent to which these criteria of capacity building were present in the programme logic, and the diamonds (◆) shows the extent to which there was evidence of Providers (and at times the Ministry and DHBs) achieving improvements in these areas.

Table 7: Capacity framework for the evaluation

Evaluative criteria	Dimensions of merit	Extent present in Project ¹⁰		
		Limited degree	Moderate degree	High degree
Capability (a) to commit and engage	Overall capability to commit and engage <i>depends on a series of skills or abilities, including:</i> <ul style="list-style-type: none"> the ability to encourage mindfulness the ability and willingness to persevere the ability to aspire the ability to embed conviction the ability to take ownership and the ability to be determined 			◆ ◆ ◆ ◆ ◆ ◆
Capability (b) to carry out technical, service delivery and logistical tasks	Overall capability to carry out technical, service delivery and logistical tasks <i>includes the following capabilities:</i> <ul style="list-style-type: none"> to deliver services for strategic planning and management for financial management 		◆ ◆ ◆	
	The capability to carry out technical and logistical tasks needs to be supplemented and combined with the four other capabilities to enable sustainable capacity to emerge.		◆	
Capability (c) to relate and attract	Overall capability to relate and attract <i>includes the following capabilities:</i> <ul style="list-style-type: none"> to earn credibility and legitimacy to buffer the organisation or system from intrusions to earn the trust of others, such as donors and clients and to combine political neutrality and assertive advocacy 		◆ ◆ ◆ ◆	◆
Capability (d) to balance diversity and coherence	Overall capability to balance diversity and coherence <i>includes the following capabilities:</i> <ul style="list-style-type: none"> to communicate to build connections to manage diversity and to manage paradox and tension 		◆ ◆ ◆ ◆	
			◆	
			◆	
			◆	
Capability (e) to adapt and self renew	Overall capabilities associated with adaptation and change <i>include the following capabilities:</i> <ul style="list-style-type: none"> to improve individual and organisational learning to foster internal dialogue to reposition and reconfigure the organisation to incorporate new ideas to map out a growth path 		◆ ◆	
		◆		
			◆	
			◆	
			◆	

¹⁰ The shading shows the extent evident in the programme logic, and the x marks show the extent evident in the programme itself.

183. In summary, there is evidence *to a high degree* that Providers increased their capability to commit and engage; and there is evidence *to a moderate degree* that Providers increased their capability to: carry out technical, service delivery and logistical tasks; relate and attract; balance diversity and coherence and to adapt and self renew.

Provider and DHB relationships

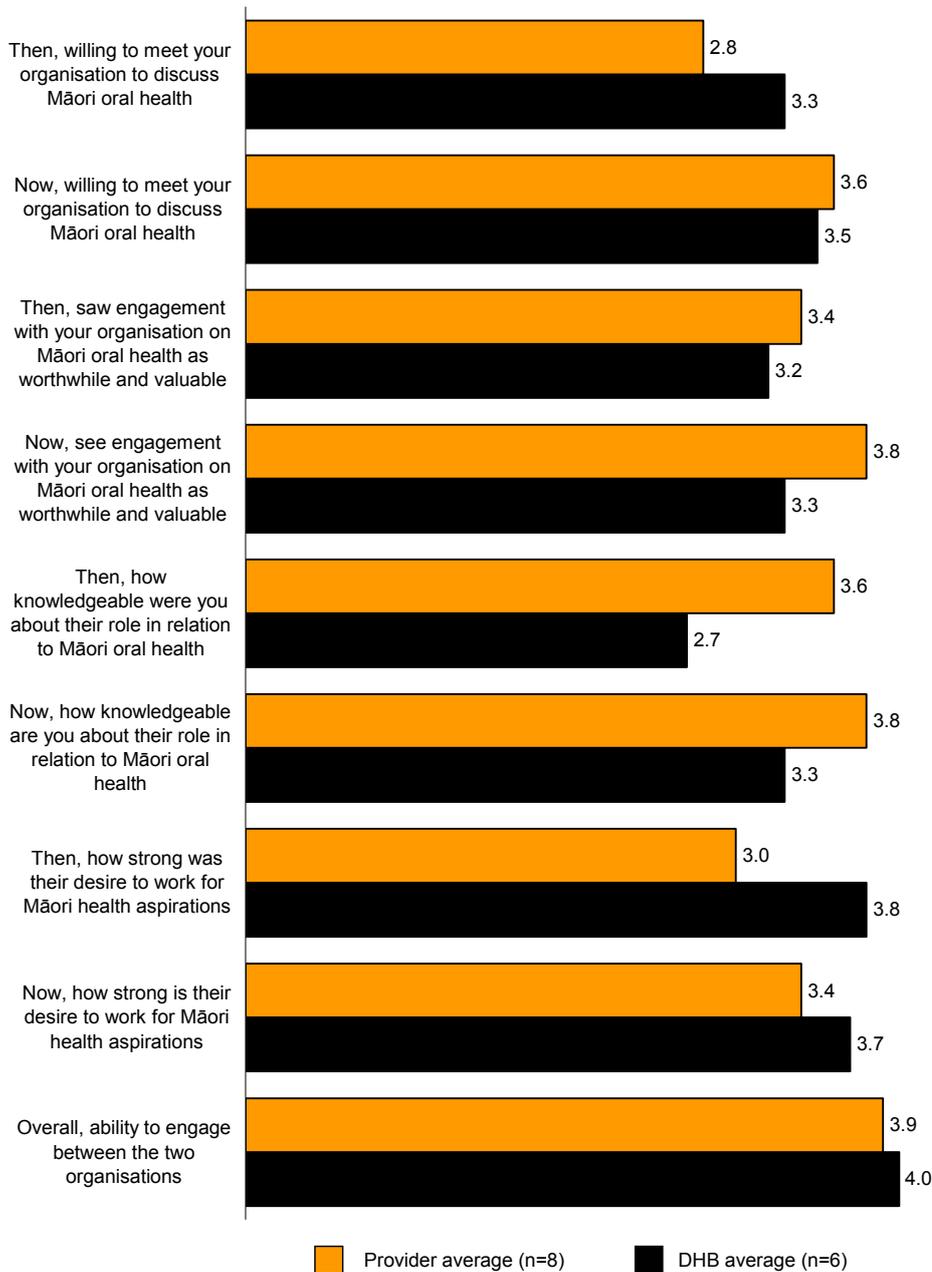
184. An important backdrop to the Project and to project implementation and oral health service delivery are the relationships between Providers and DHBs. One of the key project objectives underpinning the Project logic was the desire to improve relationships between Providers and DHBs. Specific outcomes included:
- relationships between Māori oral health providers and DHBs are strengthened
 - Māori oral health providers are accepted and valued for their contribution to oral health planning and service delivery in their community
 - Māori oral health providers are seen as an integral part of the oral health system.
 - Māori oral health providers and DHBs work effectively together to achieve Māori oral health objectives
 - Māori providers have (increased) capacity and capability to deliver effective oral health services for Māori and the wider community.
185. The evaluation examined five different aspects of relationships:
- Whakawhanaungantanga – Engaging relationships
 - Whakawhiti korero – Exchanging views, being understood
 - Te niko o te kaupapa – Developing an understanding of the issues
 - Te mohiotanga – Envisioning solutions
 - Mahi tahi – Making commitments
186. A relationship self-completion questionnaire was developed and completed by Providers and DHB personnel in February March 2009. Providers and DHBs were asked to rate themselves, on a scale of one to five, in each of the relationships areas and attributes at two points in time; at the start of the Project and in February March 2009.

Whakawhanaungantanga – Engaging relationships

187. Overall, both DHBs and Providers reported an improved ability to engage with each other since the start of the Project.
188. Providers perceived that DHBs were more willing to meet and discuss Māori oral health with them than at the start of the project. Both parties saw engagement on Māori oral health as worthwhile and valuable, but there was little change over the course of the project.
189. DHBs were slightly more likely to feel they were now more knowledgeable of Māori oral health providers in relation to Māori oral health, but were clear from

the outset that Māori oral health providers had a strong desire to work for Māori oral health aspirations.

Whakawhanaungatanga – engaging relationships



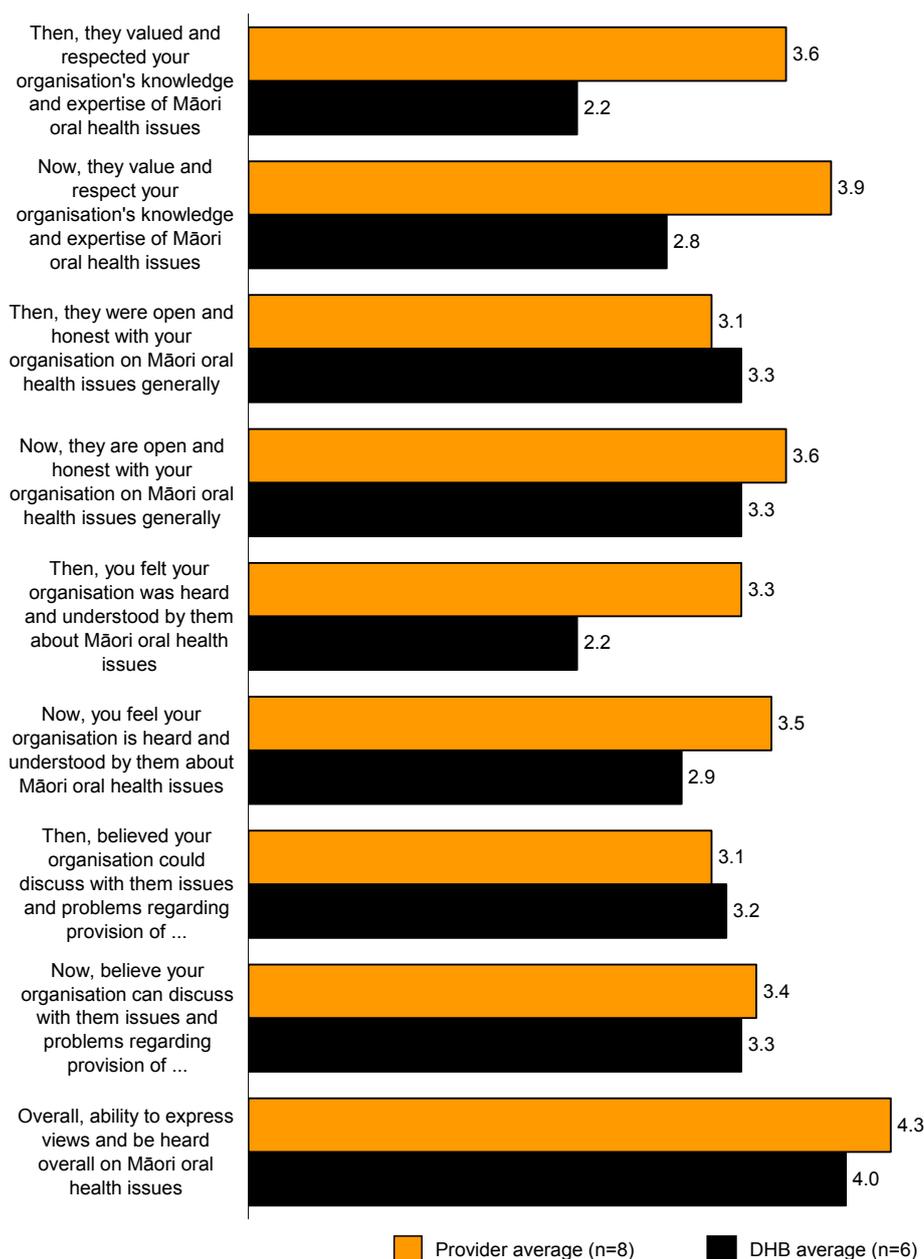
Whakawhiti korero – Exchanging views, being understood

190. Overall both DHBs and Providers felt their ability to express and exchange views and be heard on Māori oral health issues had improved between the organisations since the start of the Project. While Providers felt DHBs valued and respected their knowledge, DHBs were less likely to feel Providers valued the DHBs knowledge and expertise in Māori oral health, although DHBs felt this improved over the course of the project. There was general agreement by both parties that they could be open and honest with the other regarding Māori oral

health issues generally, with some slight improvement in agreement amongst Māori oral health providers.

191. DHBs were more likely to maintain that they felt their organisation was now better heard and understood by Providers about Māori oral health issues as a result of the project, where results showed little change for Providers. There were similar levels of agreement that DHBs and Providers could discuss issues and problems regarding the provision of oral health with each other.

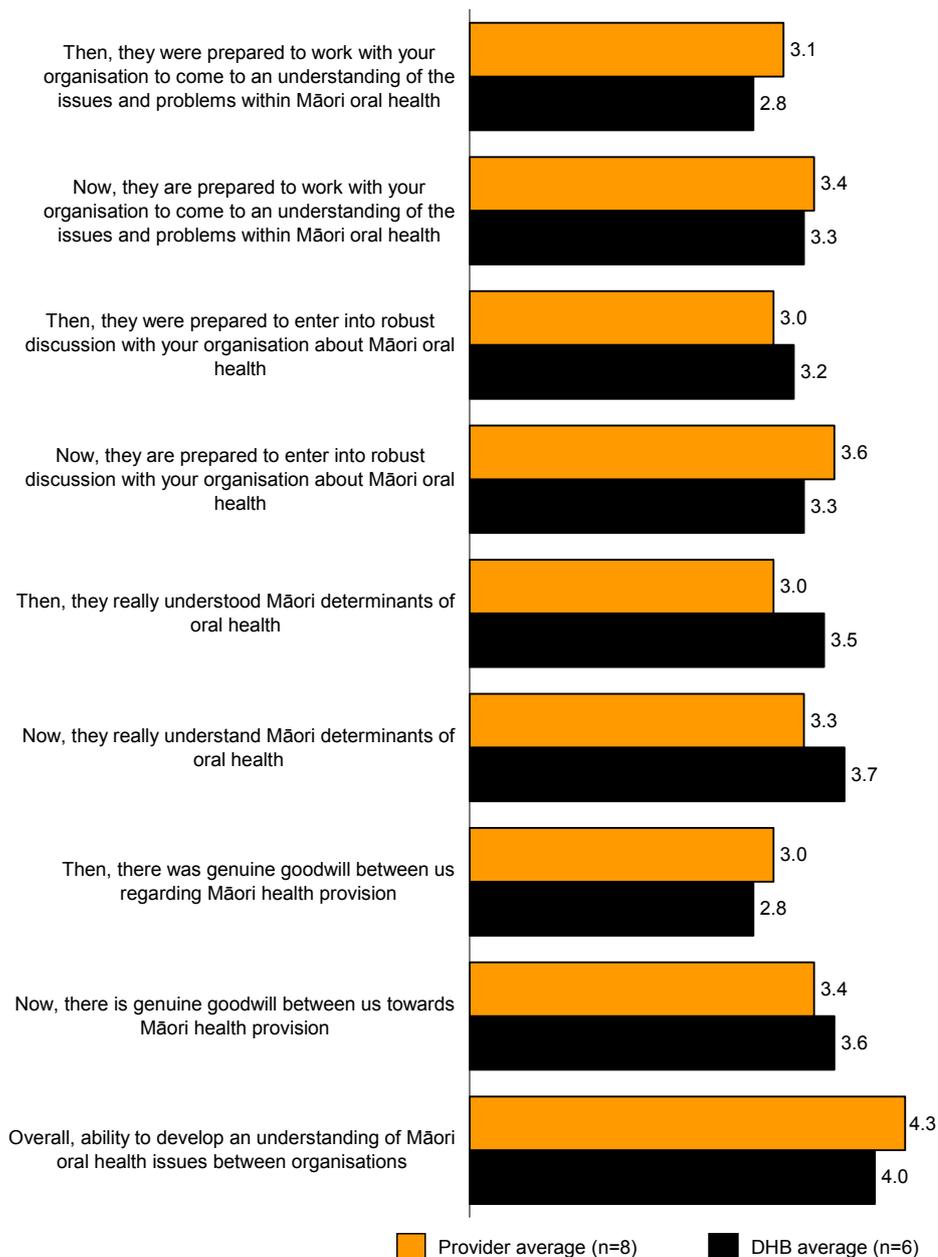
Whakawhiti korero – expressing views, being understood



Te niko o te kaupapa – Developing an understanding of the issues

192. Overall both DHBs and Providers maintained that the ability to develop an understanding on Māori oral health issues had improved between organisations since the start of the Project. Providers observed that DHBs were prepared to enter into robust discussion with them about Māori oral health, and DHBs also felt there was improved genuine goodwill between the two organisations regarding Māori health determinants. To a lesser extent, DHBs felt Providers were more prepared to work with them to come to an understanding of the issues in relation to Māori oral health, than had been the case in the past. Both parties thought there had been a slight improvement to understanding the determinants of oral health since the start of the Project.

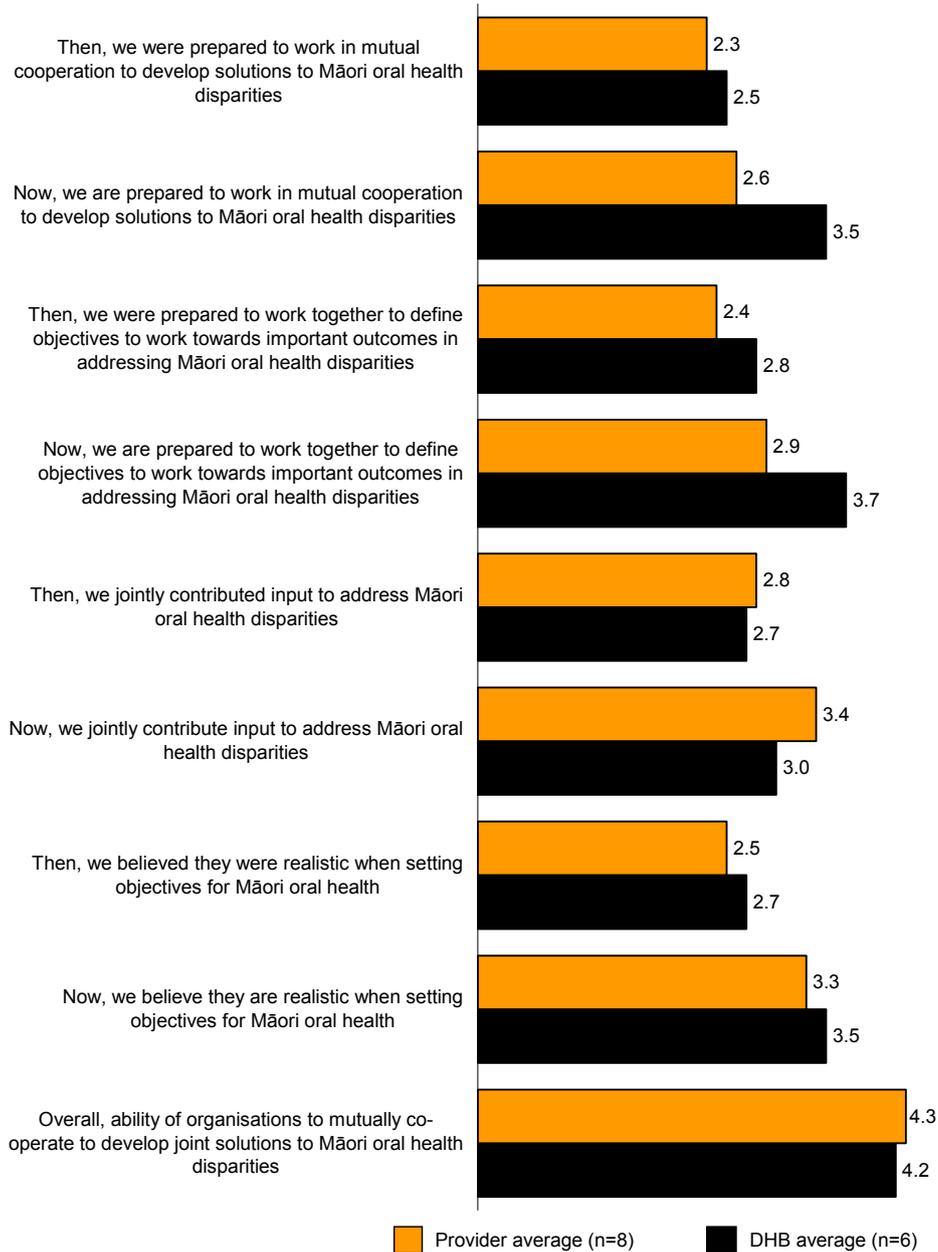
Te niko o te kaupapa – developing an understanding of the issues



Te Mohiotanga – Envisioning solutions

193. Overall, both Providers and DHBs maintained that there was an improved ability to be realistic when setting objectives for Māori oral health.

Te mohiotanga – envisioning solutions

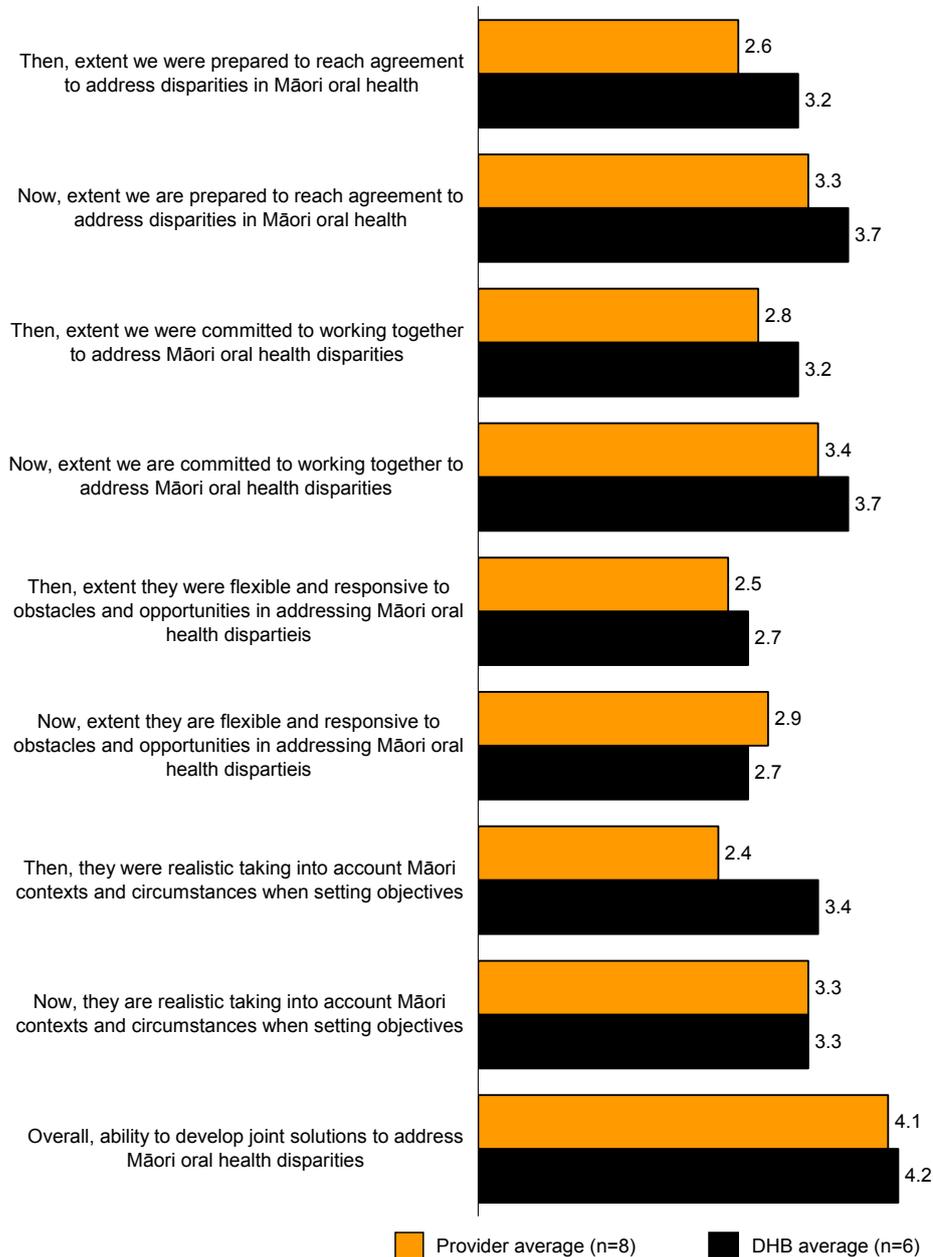


194. DHBs were noticeably more likely to claim that they were prepared to work in mutual co-operation to develop solutions and Providers were more likely to claim that there was now joint contribution to input/address Māori oral health disparities.

Mahi tahi – Making commitments

195. Overall both Providers and DHBs maintained that there was an improved ability to develop joint solutions to address Māori oral health disparities since the start of the Project.

Mahi tahi – making commitments



196. Providers were more likely as a result of the Project to believe DHBs were realistic in taking into account Māori contexts and circumstances when setting objectives. There were no changes in DHBs perspectives of Māori oral health providers.

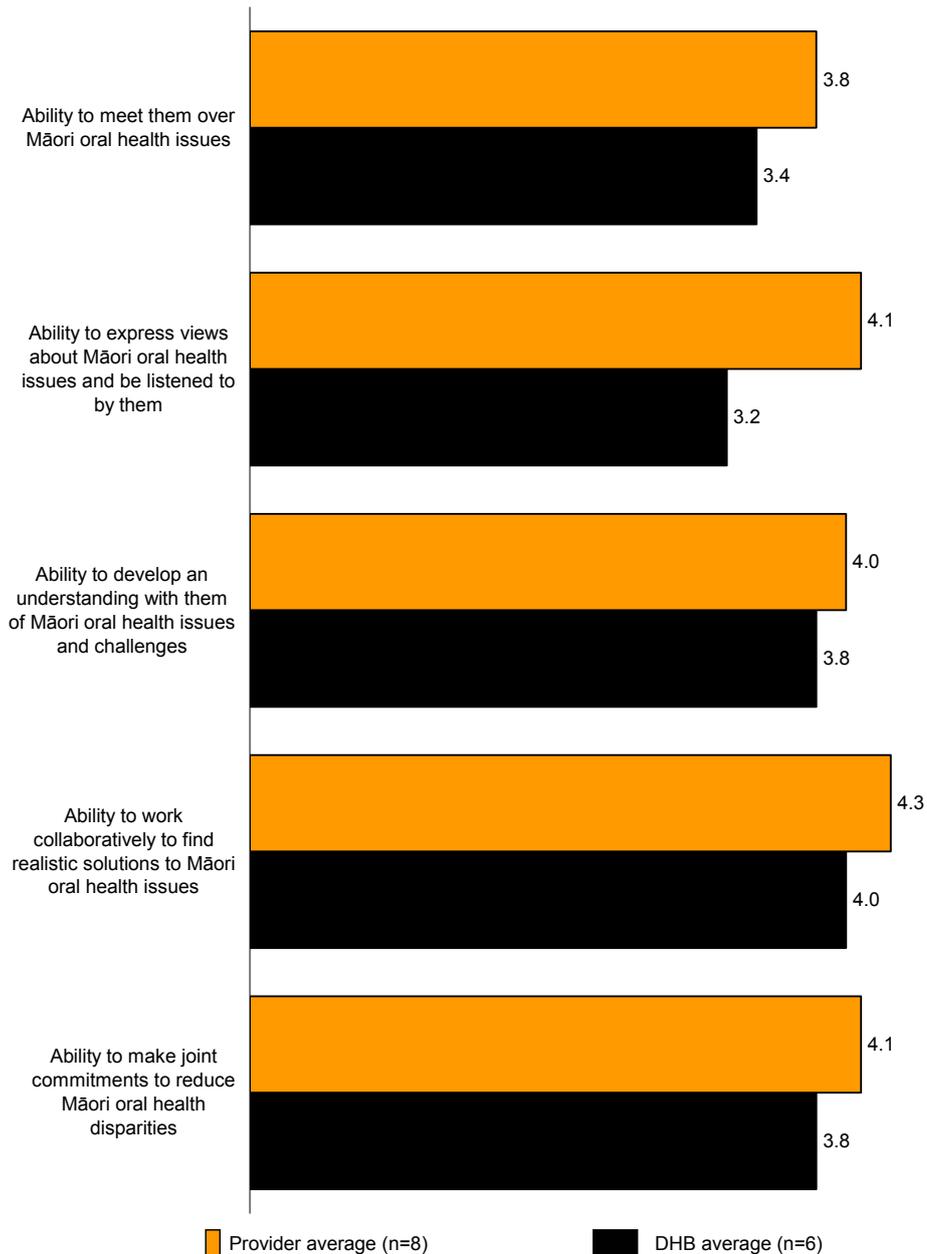
197. Both Providers and DHBs believed there had been improvement in the extent to which each was prepared to reach agreements with the other to address disparities in Māori oral health.

Providers felt DHBs had improved somewhat in their flexibility and responsiveness to obstacles and opportunities in addressing Māori oral health disparities, while there was no change in DHBs perceptions.

Extent to which the Māori Oral Health project improved or hindered relationships

198. Overall the Project was judged a success by Providers and DHBs in terms of improving relationships between the organisations.

Extent the MoH Project improved or hindered relationships



199. Both DHBs and Providers agreed that the project had improved their ability to work collaboratively to find realistic solutions for Māori, and to make joint commitments to reduce Māori oral health disparities.

200. DHBs were less likely than Providers to feel that they had an improved ability to express their views about Māori oral health issues and be listened to by Providers.

Assessment of the Projects' contribution to Provider and DHB relationships

201. It is clear that at different times throughout the Project, particularly around the contracting phases, relationships between Providers and DHBs were tense.
202. When first interviewed, three DHBs reported feeling forced to work with Providers and to fund services in relation to the Project; whereas two DHBs were already working with Providers jointly planning oral health services for Māori and the Providers' contribution to that service. This same perception of relationships with DHBs at the outset of the project is mirrored by Providers.
203. Despite being brought/forced together by the Project processes, and the long drawn out nature of the contract negotiations, there appeared to be improved relationships between Providers and DHBs. There is evidence of new learning on both sides, indicating a level of reciprocity of learning that might not have been expected from such a fraught process.
204. Generally once the contract processes between the Ministry, Providers and DHBs were finalised more of a partnership type relationship developed between Providers and DHBs. For one Provider perceptions of a strong Provider and DHB partnership have been borne out in terms of significant support and finding of services in relation to the Project and wider oral health services for Māori. On the other hand, in the case of another Provider it is also evident that, despite believing they had a strong relationship with their DHB, when compared to the support and resourcing other DHBs gave to the Project Providers, their 'positive' relationship had not resulted in similar service gains.
205. Whilst 'good' relationships per se provided a platform for engagement, they did not necessarily result in improved support, resourcing and funding. This was a function of a range of factors including DHB views of Māori oral health need, the role of Māori oral health providers in addressing need and perceptions of provider capacity and capability to meet that need.
206. For another Provider for whom relationships at the outset of the Project, and today, continue to involve robust challenges between the Provider and DHB, Project and other oral health related support and funding has been forthcoming.
207. This similarly points to the varied attributes of relationships and the need for Providers to continue to engage despite that at times tense and heated environment (*the capability to balance diversity and coherence*).
208. The ability to secure resources and funding can be seen as another aspect of a good relationship (*the capability to relate and attract*).
209. Over the course of the Project DHBs have developed more confidence in the Provider to deliver services (*the capability to carry out technical service delivery and logistical tasks*) where this was an issue.

210. Where it was not an issue then Providers and DHBs have gone on to develop improved working relationships with each other based on mutual respect and trust (*the capability to relate and attract*).
211. For two Providers in particular there was evidence that through the Project, and the opportunity facilitated by the Project, they have been able to map out a plan for oral health in their community, and to 'reposition' their organisation to deliver the related oral health care and services to the community (*the capability to adapt and self renew*). This despite the ongoing and robust challenge that the relationship continues to surface.
212. There is evidence of a willingness from some DHBs to work in partnership with Providers and to support Providers to develop and deliver oral health services based on Providers' knowledge and understanding of their communities.
213. To varying degrees all DHBs included Providers in the strategic asset management planning and the more recent DHB oral health business case development. Some Project Providers have had significant input into the development of DHB business cases and as a result of this involvement have been able to influence and secure resources for a number of key developments such as the funding: of new community based oral health services and clinics in Māori communities, for additional dental therapists and to change part time clinical and health promotion positions to full time positions.
214. Within DHBs commitment to the Project and the role of Māori oral health providers in meeting the oral health needs of Māori varies. On the one hand some personnel within DHBs have been strongly supportive of Providers and advocated for them internally as well as supported the provision of additional resources. Māori staff within DHBs have been particularly supportive of Project Providers. On the other hand, some service delivery arms of DHBs have found it difficult to relinquish or to hand over the SDS contract to Providers. These tensions vary within and across DHBs.
215. There are also examples of Providers actively supporting DHB services. For example in one DHB they had been advertising for a community dentist for 18 months to service a largely Māori population. The Provider utilised their networks to identify a community dentist and within a two week period they were contracted by the DHB.

Summary

216. The relationship survey suggests that despite the protracted Project timeframe and the communication challenges and tension that emerged throughout the project up to the current context, Provider and DHB relationships have improved and continue to improve.
217. There is evidence that relationships between Providers and DHBs have variously been strengthened for most Providers.
218. To a lesser degree there is evidence that some Providers are accepted and valued for their contribution to oral health planning and service delivery in their community; and some Providers are seen as an integral part of the oral health system.

219. There is good evidence that as a result of the Project providers have increased capacity and capability to deliver effective oral health services for Māori and the wider community.
220. There is evidence that some providers and DHBs are working effectively together to achieve Māori oral health objectives.
221. There is still some way to go before all DHBs elicit and value the contribution of Māori oral health providers to the planning and delivery of oral health care and services. The provision of one-off funding to purchase capital equipment on the part of the Māori Health Directorate of the Ministry has increased the capacity and capability of Providers to deliver oral health services to their communities and strengthened the relationships between Māori oral health providers and DHBs.

Appendices

Appendix A: Background, Evaluation Aims and Methods

Background

222. The 2003 report¹¹ of the NHC highlighted the inequalities that existed in the oral health of New Zealand children, especially among Māori and Pacific children and those families with low socioeconomic status and provided advice to the Minister of Health on how to improve child oral health and reduce inequalities in child oral health in New Zealand. The report identified seven action areas including: “influencing socioeconomic determinants; improving Māori oral health; encouraging fluoridation; reorienting oral health services; a responsive and skilled workforce; better information about child oral health and inequalities and using child oral health as an indicator of health inequalities” (NHC, 2003, p. 2.)
223. The report was also instrumental in shaping the school dental services review to include dental services for children and adolescents and the inclusion of Māori oral health providers because of the oral health disparities particularly for Māori and Pacific children.
224. Two reviews were undertaken in 2004 of school dental services and Māori child oral health services (the Reviews). The Reviews identified that the current school dental model for young people was no longer meeting the needs of communities and that there were significant disparities in oral health outcomes between population groups.
225. In August 2006, the Ministry of Health (the Ministry) released a Strategic Vision for oral health. The Strategic Vision set the direction for improving oral health and reducing oral health inequalities. In addition to the Strategic Vision, ‘improving oral health’ is one of thirteen population health objectives identified in the New Zealand Health Strategy.
226. In light of the recommendations from the NHC and the Reviews, the Māori Health Directorate of the Ministry identified five Māori health providers (the Providers), through a business case process, with significant potential to contribute to the overall vision for oral health and the delivery of child and adolescent oral health service in their communities. In 2005, the Ministry undertook a project to provide oral health capacity and capability support for these Providers – the Māori Oral Health Project (the Project).
227. The overall aim of the Project was to enhance the position of Māori oral health providers to deliver a model of care that was consistent with the future direction of community based oral health services as articulated in the strategic vision for oral health. It also aimed to enhance Provider relationships with DHBs and to

¹¹ National Health Committee (2003). Improving Child Oral Health and Reducing Child Oral Health Inequalities: Report to the Minister of Health from the Public Health Advisory Committee. Wellington, Ministry of Health.

position Providers as key contributors to improving the oral health of Māori children and adolescents in their communities.

228. The specific aims of the Project were to:
- increase the capacity and capability of Māori oral health providers to deliver oral health services in their communities
 - position Māori oral health providers as critical to the delivery of oral health services to Māori
 - strengthen the relationships between Māori oral health providers and DHBs .
229. Further, the Māori Health Directorate believed it was critical that Māori health providers were integral to any roll out of 're-oriented' child and adolescent oral health service in their DHBs. In 2005, the Ministry undertook a project to provide oral health capacity and capability support for these Providers (the Project).
230. In 2007, five Providers received the one off Ministry funding totalling \$1,208,378.00 (exclusive of GST) and completed procurement processes to purchase their capital requirements to deliver oral health services.

Evaluation aims

231. The overarching aims of the evaluation were to assess the extent that:
- the Project aligned to capacity and capability development literature and good practice
 - the provision of one-off funding impacted on the capacity and capability of the Providers to develop and/or establish appropriate oral health services
 - the relationships between the Ministry, Project Providers and their respective DHBs improved as a result of the Project
 - there is sufficient evidence that overall, this kind of initiative should be repeated.
232. An additional evaluation objective, added midway through the evaluation was to determine whether there was sufficient evidence that overall, this kind of initiative should be repeated.

Evaluation objectives

233. The objectives the evaluation were to:
1. describe and critique the intervention logic that underpins the Project
 2. assess the process of distributing the funding to the Providers
 3. examine the first year of operation and how funding supported Māori provider participation in the oral health sector.

Evaluation approach and methodology

234. The methods employed in this evaluation were: a literature review, development of programme (project) logic, document review, key informant interviews, a relationships survey and a one day workshop involving all five providers, the evaluation team and Ministry representatives.
235. The evaluation commenced with a review of the literature about indigenous health provider development, including provider capacity and capability building. This was followed by the development of a retrospective programme logic based on key informant interviews with key Ministry personnel involved in the project and a review of Ministry documentation. The literature review and the programme logic informed the data collection tools developed for each series of visits with providers and DHBs.
236. A series of three visits to providers and DHBs was conducted over an 18-month period.
- The first visits, conducted in November to December 2007, had a focus on relationships building, outlining the purpose of the evaluation, obtaining key project documentation and setting up the timeframe and processes for subsequent visits with providers and DHBs.
 - The purpose of the second visit, conducted in March to April 2008 was to: profile the organisation and to describe the oral health service and where it fits in relation to the other services/activities of the organisation; and to document the business case application process.¹²
 - The purpose of the third site visit, conducted in February to March 2009 was to collect data about Providers' current services and the implementation of the Ministry/DHB contracts, including a more in-depth look at monitoring outcomes for providers. Information about the quality of relationships between Providers and DHBs was also collected that this stage through a relationship survey.
237. A team analysis hui was held at the end of each of the data collection rounds (visits). Each member of the team summarised their notes into the data collection template, circulated to providers and DHBs for review and 'finalised' once feedback had been received from Providers. The findings from each of the analysis hui informed the focus for the next visit and the development of interview guides and survey instruments.
238. A workshop involving Providers, the evaluation team and Ministry representatives was held immediately prior to the third (final) team analysis hui. The purpose of the workshop was for Providers to provide collective input into the evaluation through a process of facilitated reflection on their participation in Project and the delivery of oral health services to Māori more generally. A further objective was for Providers to share best practice and key 'learnings' from the Project with other Māori oral health providers, and with the Ministry.

¹² During this visit we also interviewed provider oral health workers, e.g. dentists, dental therapists, chair side and infectious control nurses to inform the Māori Dental Therapist Workforce research also being carried out by this research team.

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