Perspectives on Quality

New Zealand Māori quality improvement in health care: lessons from an ideal type

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Abstract

There is no single best approach to quality improvement. Quality improvement has been adapted from its predominantly Japanese origins to form distinct, hybrid systems embedded in national cultures. These systems have seldom been studied despite their potential internationally to inform the local management of health care organizations. This article suggests six lessons from an ‘ideal type’ of one such system, New Zealand Māori quality improvement in health care. Mapped against ‘mainstream’ concepts of quality improvement, the lessons are to: emulate the character of leaders in health care; encourage ‘cultural governance’; operate the health care organization as a ‘family’; move forward with eyes on the past; foster spiritual health; and respect everything for itself. These lessons support a global struggle by indigenous peoples to have their national cultures reflected in programmes to improve their health care, and have potential relevance to mainstream services. By increasing cultural competence, responsiveness to indigenous health needs, and awareness of insights from another culture, the lessons reveal opportunities to improve quality by incorporating aspects of a Māori ideal type.

Keywords: ideal type, lessons, Māori, national culture, quality improvement

Is there ‘one best way’ to achieve quality improvement? It is easy to believe so. The ‘quality gurus’ each state what quality is and how to achieve it. For example, Crosby defined ‘five absolutes of quality management’ [1]. Deming identified ‘seven deadly sins’ that managers must eliminate and a seven-point action plan describing what must be done to implement his 14 principles for transformation [2]. Little has changed with contemporary thinking. There is still a tendency to frame quality improvement as a single, pre-packaged approach to organizational effectiveness. Quality improvement is typically represented as an integrated, holistic philosophy or culture by which organizations can empower workers to continually improve the process of their service delivery and respond to customer needs and expectations [3]. However, this universalistic representation ignores developments in management thinking. One of these, ‘critical systems thinking’, rejects any single best approach to quality improvement in health care [4]. Instead, each approach is considered potentially useful in organizational contexts that can accommodate its assumptions.

The meaning of quality improvement can vary, therefore, with particular ‘organizational cultures’. These describe patterns of practices (including openness, collaboration, and teamwork), norms and values, and basic assumptions [5–7], which support the goals of individual organizations. However, the patterns are themselves embedded in the national cultures of different health systems [8–10]. The presumption that a common set of values and assumptions underpins one practical, normative approach to quality improvement obscures the distinctiveness of multicultural social environments, and so quality improvement has been adapted from its predominantly Japanese origins to form distinct, hybrid systems. Whereas Ishikawa [11] referred to the ‘Japanese Way’ of ‘total quality control’, fusions of cultures have produced, for example, an American style of quality improvement and a Chinese style [8–10]. The different systems have developed to help quality improvement succeed in particular national cultures. Commonalities may exist across the different styles and frameworks, but an unmet need remains to recognize the role of national cultures in shaping distinctive approaches to quality improvement in multicultural, pluralistic settings.

This article draws on one national culture, the indigenous Māori population of New Zealand, in seeking to delineate and discuss six lessons from an ‘ideal type’ (defined below) of Māori quality improvement in health care. The lessons are described and shown to resemble or contrast with ‘mainstream’ concepts of quality improvement. Three sets of factors define the rationale for the article. They clarify an appropriate role for a Māori ideal type, while guiding a response from readers in different settings.

Firstly, the article moves beyond the organizational cultures needed for quality improvement. Its juxtaposition of a Māori ideal type and notions of mainstream quality improvement may inform an ideal type of quality improvement for all health

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systems, and benefit mainstream services in and beyond
New Zealand. Seminal literature on how national cultures can
influence organizational cultures has identified dimensions on
which national cultures tend to differ [5,6,12], but national
culture-specific quality improvement has been studied in a
limited range of health care contexts [8–10].

Secondly, a Māori ideal type may contribute an indigenous
perspective that transcends multiculturalism, emphasizes the
seamless unification of people with nature, and resonates with
the world views of other indigenous populations. In common
with Māori, these populations struggle to have their cultures
reflected in mainstream health care. Māori insights may sup-
port the development of indigenous health programmes, most
clearly in New Zealand, and reduce health inequalities between
indigenous and non-indigenous peoples through indigenous
health gains. Thirdly, this article may have heuristic value, rais-
ing awareness of a Māori perspective on quality improvement
in health care.

Māori quality improvement: lessons
from an ideal type

The six lessons from an ideal Māori type of quality improve-
ment were identified from two sources. The first source was
personal experience. Questioning whether non-Māori can
ever comprehend the Māori world or are entitled to try, some
commentators [13] state that Māori research should only be
undertaken by or with Māori. I have chosen nevertheless to
write this article alone as a non-Māori because: (i) my Jewish
background in New Zealand has given me an empathetic and
sympathetic connectedness to Māori; (ii) I have previously
conducted research with and about Māori [14] and have con-
sulted Māori on this article; (iii) Māori believe it is not for
Māori to praise Māori: ‘The kumara (a sweet potato) does not
say how sweet it is’; and (iv) my ethnicity aids a comparison of
mainstream concepts of quality improvement with those of a
Māori ideal type. The second source of lessons from this ideal
type was published literature and grey literature in English on
Māori philosophy, governance, and health, including Māori
providers that have reaffirmed and resurrected core Māori
values and beliefs. This literature was located from a non-
 systematic review of my personal files, electronic databases,
the Internet, and reference lists of retrieved works.

Max Weber (1864–1920) [15] defined the unified, analytical
construct of the ideal type. The lessons suggested by this art-
icle apply the same sociological framework to Māori quality
improvement. A Māori ideal type does not necessarily describe
how services approach quality improvement in reality or how
they ought to (an ideal model). Instead, rooted in cultural and
historical particularities, it logically accentuates and synthe-
sizes Māori values, philosophies, beliefs, and conduct where
these correspond with New Zealand’s founding document, the
1840 Treaty of Waitangi, and contemporary thinking. It tran-
scends differences among Māori tribes (iwi), although what is
‘customary’ (tīkanga) may vary from tribe to tribe and there is no
universal Māori reality. An ideal type does not obscure tribal
differences because, in common with other, generic Māori
models [16], it can be implemented using local protocols and
customs. It also offers a benchmark that health workers can
use to compare mainstream notions of quality improvement
with how their own organizations function. The following
discussion suggests lessons for quality improvement by health
care organizations in all health systems. Table 1 summarizes
these lessons.

<table>
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<th>Table 1 Lessons for quality improvement in health care</th>
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Emulate the character of health care leaders

Mainstream quality improvement in health care is based on a
set of principles or rules of conduct in which moral values are
embedded. In contrast, the ethics foundation of Māori quality
improvement is an ethics of being, rather than of doing.

Although the agent-centred focus of this Māori ‘virtue eth-
ics’ resembles the traditional mainstream notion of quality as an
attribute of health professionals, mainstream quality improve-
ment now tends ‘to define quality in terms of the attributes and
results of care provided by practitioners and received by patients’ ([17], p. 892). A Māori ideal type renews a focus on
what health workers, including professionals, ought to be, rather
than what actions they ought to take.

Therefore, despite also recognizing group needs and organi-
zational systems, this ideal type emphasizes the attributes of
individual health workers. In common with two dimensions on
which national cultures can differ—long-term versus short-
term orientation [12] and ‘achievement ascription’ (status
conferred according to performance versus what people ‘are’
and how others relate to them) [7]—it gives insights into
character traits that enable these workers and hence organiza-
tions to excel. It suggests that to discover and acquire these
traits, such as honesty, integrity, fairness, and responsibility,
health workers should seek to emulate the character of chiefs (rangatira) or leaders in health care; [18] this elaborates on the importance that mainstream quality improvement assigns to leadership activity. For Māori, the virtues or qualities of the rangatira are passed on through the bloodline and cannot be learnt, but in practice the term ‘rangatira’ is sometimes applied to any adult, with some persons embodying the rangatira ideal more completely than others [18].

Consequently, all health workers can and should aspire to follow this ideal, cultivating virtues from custom and the common practice of leaders. In becoming intrinsic to the human nature of workers, these virtues can constantly animate their quality improvement behaviour and expand the ethical parameters of this behaviour beyond prescribed rules and duties. Resembling Macintyre’s [19] location of virtue in social roles and traditions, this provides an ontological foundation for professional ethics in quality improvement. It reminds us that, in emphasizing systems and the use of ‘fact based management and scientific methodology’ [3], quality improvement tends to neglect what it means to ‘be’ a health worker in terms of the qualities expected of that individual. Virtue defines a foundation on which health workers can actualize their human capacities through the direction afforded by leaders within their organization and discipline. Thus, health care organizations should offer all health workers the opportunity to learn from, and demonstrate, the qualities of virtuous leaders.

**Encourage cultural governance**

Clinical governance, with its integration of clinical and financial accountability, is a mainstream, organizational arrangement to which quality management increasingly refers. However, clinical governance implicitly accommodates, rather than constructively engages, cultural differences, and fails to respond to the transformative politics of indigeneity. Therefore, a lesson from Māori philosophy and experience in New Zealand, reinforced by indigenous struggles elsewhere, is a need for health care quality improvement through organizational self-determination by indigenous peoples.

Indeed, Māori claim their entitlement, under the Treaty of Waitangi, to relatively autonomous control over their ‘treasures’, such as their health resources. Partly in response to this claim, organizational structures have been established in New Zealand that enable patients to choose to use mainstream health services or health services controlled by Māori, in accord with national health objectives [16] and within the coordinated, systems-based framework of clinical governance. Hence, Māori services have developed despite, rather than because of, clinical governance. They signify nonetheless a model of ‘cultural governance’ that elaborates clinical governance through structural adjustment and power-sharing. In New Zealand, cultural governance has strengthened collective Māori agency, preservation of Māori distinctiveness and identity, and Māori advancement ‘within a framework of Māori self-sufficiency and control’. However, this example has implications beyond New Zealand.

In creating self-governing structures that share in the sovereignty of mainstream society, cultural governance establishes an organizational foundation for cultural equality on which to improve indigenous health care. Despite operating independently of need, cultural governance can help to liberate indigenous peoples from the historical experience of political oppression that consistently underpins unacceptably large differences between their health and the health of non-indigenous peoples. Trust is promoted by restoring to the indigenous group the power and freedom to control resources and decisions, and implement culturally appropriate quality improvement.

Non-indigenous minorities may also exercise cultural governance, although not from statutory right. Hence, I have referred to ‘cultural governance’ rather than ‘indigenous governance’. Governance of public health care organizations by cultural minorities should be considered when these groups request relative autonomy within a systems-based framework for quality improvement, and have special expertise to meet cultural and other needs of patients and health workers.

**Manage the organization as a ‘family’**

In emphasizing organizational goals, mainstream quality improvement in health care highlights effective teamwork and participative problem-solving by all workers through a radical change in the power structure and systems of health care organizations. However, managing the ‘organization as a family’ has never been widely articulated in mainstream quality improvement, despite the metaphor being common for example in Asia, where many organizations are managed along family lines. It resonates with the authority structure of some organizations and the support that a family ethos in the workplace, and ‘family-friendly’ work arrangements, can occasion.

I accept that mainstream thought now defines a schism between the family, as a private social institution, and organizations in the public sphere. With respect to some characteristics, health care organizations are ‘unfamily-like’. For example, joining them is no longer a life-time commitment; they can no longer deliver life-long employment, and quality assurance has made organizational structures unforgiving. Taken to the extreme, the organization as a family can breed paternalism, cronyism, and insularity.

Yet, a Māori ideal type emphasizes the organization as a family (whānau) to help define shared interests, a common sense of purpose (kaupapa), and unity. A focus on organizational goals ahead of individual goals resembles mainstream quality improvement [2]. However, a Māori ideal type goes further by committing to family values for organizational character and development. These values include aroha, a feeling of empathy that promotes social interaction and positive reciprocity: ‘people and family come first... [ahead] of process and policy procedure’ ([20], p. 67).

By engendering loyalty and support, the organization as a family helps to maintain and harmonize work relationships. So too does a flat management structure, and ‘dislike of compartmentalization and over-strict differentiation of roles’ ([21], p.72). This resembles concepts of mainstream quality improvement. However, a Māori ideal type differs in a key respect: collective responsibility for unsafe practice operates within a culture of shame (whakamā), although not blame.
This requires the cohesive community of a ‘family’ whose members acknowledge judgements as a moral sanction [18]. Collective responsibility and whakama also require proactively appraising the motives and character of workers whose actions may affect the mana (spiritual power and authority) of the health care organization. This implies a need to test, rather than necessarily trust in [22], workers’ ongoing commitment to improve quality.

For Māori, the relationship of the health care organization to other health providers can also resemble a family, and the organization will respond to the needs of families and the community besides its own needs and those of individual workers. In turn, community inputs are valued directly. This defines a model of corporate social responsibility, not merely for minimum legal compliance or enlightened self-interest, but rather to improve society independently of any direct benefit to the organization itself.

In summary, in all health systems, the health care organization operating as a family can: cooperatively and demonstrably care for its staff, clientele, and the larger community; guard and share organizational, including cultural, resources; promote ongoing relationships; be collectively accountable, yet more willing than mainstream quality improvement to question the necessary location of unsafe practices in systems problems; and be empowering, for example in fostering cultural identity. The health care organization, its workers, and their clients can be helped therefore to obtain a clear sense of who they are, where they belong, and what this means for them.

**Move forward with eyes on the past**

Mainstream quality improvement depends on the ability of organizations to learn from experience, in the context of advocacy for using history to influence practical decision-making and management [23]. However, a Māori ideal type of quality improvement is distinctive in suggesting that the future can only be meaningfully accessed through past events. Specifically, Māori locate the past in front and the future behind, where it cannot be seen. This conceptualizes the past as lying between us and the future. We must look through the lens of the past to see and create a significant future that lies behind (or beyond) this past. The future cannot lie behind as because to move toward it, with our eyes on the past in front, would require walking backwards.

The mainstream perspective that the past lies behind us, with the future in front, implies that we may (rather than must) review and use history by making the effort to ‘turn around’. By comparison, an ideal Māori type implies that the past is less easily avoided. This perspective maximizes use of the past as a living source of identity, understanding, and guidance, and can unify time by moving ‘back to the future’; that is in returning to the possibilities of being and excellence defined by leaders. In practice, this requires organizations to be aware of, and learn from the past by ‘encoding inferences from history into routines that guide behaviour’ (24), p. 319). These routines may be transmitted through education, professionalization, emulation, and socialization [24].

**Foster spiritual health**

The World Health Organization (WHO) Constitution defines health as ‘a state of complete physical, mental and social well-being’. This definition by the WHO, as a mainstream health agency, can be imputed to mainstream quality improvement in health care. The 1999 meeting of the World Health Assembly debated a proposal to add spiritual well-being to the definition, but decided not to consider further amendment of the Constitution. Although the Director General was requested to keep the matter under review [25], the WHO has implicitly repudiated a holistic recognition of spiritual well-being as a distinct, yet interrelated, dimension of health. In contrast, the Geneva Declaration on the Health and Survival of Indigenous Peoples defines health as comprising four dimensions: spiritual, intellectual, physical, and emotional [26].

A Māori ideal type exemplifies and reinforces this indigenous peoples’ perspective. The best known Māori model compares health to a ‘four-sided house’, comprising the interconnecting ‘rooms’ of spiritual, mental, physical, and family health [16]. Other Māori models, such as ‘the octopus’, also recognize spirituality as a dimension of health. Moreover, a Māori ideal type emphasizes spiritual health in a state of balance. It recognizes that disruption to any one part of this system can interfere with the harmonious whole, with the need for effectiveness, and with health.

An acknowledgement and fostering of spiritual health would strengthen mainstream understanding of linkages between health and the environment, and of health systems, while broadening the scope for quality improvement in all populations. It would also reinforce the need for a taxonomy of spirituality in health care [27], and help workers to respond to their own, and others’ ‘search for meaning’. In protecting the spirit or life force (maurit) of these workers and their health care organizations, this could help to create unity from diversity.

The feasibility of incorporating spirituality into quality improvement programmes has been increased by a measure of mental health outcomes incorporating four dimensions of Māori spirituality: dignity and respect; cultural identity; personal contentment; and spirituality in terms of non-physical existence [28]. Scores on these dimensions can be used to assess, monitor, and improve spiritual health.

**Respect everything for itself**

Elements of mainstream quality improvement—including heavy investment in worker education and training; modern supervision methods, devolution of problem-solving and decision-making to teams supported from the top; and conservation and efficient use of resources—imply respect by organizations for what they perceive to help fulfill organizational goals and to have value. Set against this utilitarian perspective is the perspective of a Māori ideal type that everything is sacred for itself. All things are considered to have an intrinsic life force and demand respect because of their worthiness, which derives from their ‘being’ and having tapu (‘being with potentiality for power’). Hence, workers and their materials are each worthy of their function, although they may need to
have their value enhanced to acquire an intrinsic vitality or quality of excellence. This perspective responds to an otherwise missed opportunity to: lay bare the inner nature of all things; fully value their revealed, innate qualities, including their history, which may facilitate recognition of their potential to be good (including useful) and bad; and use this awareness to improve behaviour toward these things through a sense of guardianship. Respect for everything for itself can be regarded as a precondition for maximizing the total interacting performance of the health care organization, and achieving quality as an emergent property of the system.

Respect for everything also mollifies an ‘obsession with measurement’ in ‘an ambience where numbers take precedence over people’ ([29], p. 666). As a concept unifying cultural groups, it recognizes that quality in health care cannot be exclusively defined from the ‘truths’ of Western science. Any scientific theory approximates an unobtainable truth, and this helps to explain why a Māori ideal type concerns itself with virtue rather than truth, and emphasizes respect as a core value.

When ‘bad things’ disturb the state of balance, respect for everything necessitates restoring the balance. This requires organizations to demonstrate technical or clinical competence, everything necessitates restoring the balance. This requires organizations to demonstrate technical or clinical competence, including an ideal type. This article has considered how six lessons revealed may be expected to increase awareness of differences in philosophy and approach that define local opportunities for quality improvement, for example by incorporating aspects of a Māori ideal type. Such comparisons may be expected to increase awareness of differences in philosophy and approach that define local opportunities for quality improvement, for example by incorporating aspects of a Māori ideal type. This article has considered how six lessons revealed by this type differ in substance or emphasis from mainstream concepts, and complement, rather than replace, existing organizational approaches to quality improvement in health care.

The way forward

There is no single best approach to quality improvement in health care. Distinct, hybrid systems of quality improvement have developed in pluralistic national cultures. Although these systems are partial and have their own ‘limitations and legitimacies’, a Māori ideal type of quality improvement has lessons for organizations everywhere. In New Zealand, it can enhance both mainstream and Māori quality improvement programmes. It also locates Māori into a global struggle by indigenous populations to have their national cultures reflected in programmes to improve indigenous health care. Moreover, it describes how all health systems benefit from comparing their own national cultures and conduct of quality improvement with other types of quality improvement, including an ideal Māori type. Such comparisons may be expected to increase awareness of differences in philosophy and approach that define local opportunities for quality improvement, for example by incorporating aspects of a Māori ideal type. This article has considered how six lessons revealed by this type differ in substance or emphasis from mainstream concepts, and complement, rather than replace, existing organizational approaches to quality improvement in health care.

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