

*Te Matarau: Provider Innovation Conference 2005*

**Māori Innovation, Māori Development, and Māori  
Models of Health**

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## **Introduction**

First of all I would like to extend my thanks to the organisers, and for the invitation to speak today. It is not often that I'm given the opportunity to present to such a diverse group of people and it is even less often that I am able to visit this part of the country – in fact this is my first visit to Taranaki and to the west coast of the Island.

In considering the content of my paper today I thought it somewhat strange that I had travelled and spoken in a few countries but had yet to fully traverse my own and to appreciate what we have here to offer. This even more surprising given the fact that local developments (particularly with regards to indigenous issues in health) often lead the world and provide templates that others from abroad are keen to emulate. This is not to say that we do not experience our own issues, far from it, but it illustrates our desire to confront difficult issues and to develop robust and sustainable solutions. While problems are often the focus of Māori activity there is sometimes a need to reflect on what has been achieved and how this may inspire future development.

In keeping with the theme of this conference and the desire to reflect on Māori innovation, development and progress, I've decided to explore the contributions Māori have made to Māori health development, and further what contributions to international health perspectives are also possible. Both historical and contemporary examples are used to illustrate this, as is an examination of Māori models of health. In such a way a diverse, though not comprehensive, coverage of issues is possible and will perhaps make for a more interesting and informative presentation.

## **An Historical Backdrop**

To begin with, I would like to look back in time, and in order to provide an appropriate foundation for this presentation. Indeed it is often said that a preferred Māori approach to development is to look toward the past, as much as the future, for guidance, and so as to learn from the experiences gained and the wisdom of our ancestors.

Prior to colonisation and the advent of European settlement we know that Māori lived a somewhat subsistence lifestyle. A large part of daily activity was dedicated to the cultivation of crops, hunting and fishing, and in the preparation of shelters. By modern standards the difficulties of life were immense and meant that life expectancy was somewhere around 35 years. Though difficult to appreciate in an age where life expectancy has now increased to around 80 years,<sup>1</sup> this mid-30s figure was in fact consistent with other parts of the world and again reflected the types of difficulties people faced. An examination of following framework reveals that in fact Māori life expectancy during the 1800s was about the same as that in France and the United Kingdom.

### **Years of Life Expectancy at Birth**

Place	Middle Ages	Select Years	1950-55	1975-80	2000
Sources: Lee and Feng (1999); Peterson (1995); Wrigley and Schofield (1981, 529); World Resources Institute (1998); UNDP (2000).					
France		~30 (1800)	66	74	78
United Kingdom	20-30	36 (1799-1803)	69	73	77
India		25 (1901-11)	39	53	63
China		25-35 (1929-31)	41	65	70
Africa			38	48	54
World	20-30		46	60	67

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<sup>1</sup> Statistics New Zealand, (2004), *Life Expectancy Continues to Increase*, Media Release, Statistics New Zealand, Wellington.

Despite the low, though consistent life expectancy figures, historical accounts and descriptions of Maori were generally positive, often referring to a handsome, tall, and athletic people, healthy and vibrant - though not immune to disease, calamity or illness. And, while I am not suggesting an idyllic island lifestyle, these initial descriptions are in stark contrast to what was to later define the Māori population.

While we have some indication of life-expectancy, pre-colonial or pre-contact population figures for Maori are more difficult to estimate. Figures vary greatly and without the benefit of a census, various guesstimates have been put forward. And, have also led to some interesting methods of calculating the Māori population - such as apply a mathematical formula based on the number of fighting men within each village.

Although estimates vary considerably (from 100,000 to 500,000), a probably figure of 150,000 is likely at around 1800 and is a number that appears to have the most sustained support.<sup>2</sup> By 1896 however, and when an actual “head-count” was conducted a number of just 42,000 was presented and revealed a significant population decline. That is, and in under a century, more than 2/3rds of the Māori population were gone.

### **Population Decline**

The reasons for this decline are varied and complex and it is important to appreciate that no single factor or issue can be attributed. One of the more major explanations however is linked to the impact of introduced diseases and the fact that Māori had little biological protection from many of the new viruses and infections brought from overseas. Isolation from other parts of the world, allowed a unique culture to develop and flourish, but it also made Māori susceptible to many of the diseases which had

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<sup>2</sup> M.H.Durie, (1994), *Whaiora: Māori Health Development*, Oxford University Press, Auckland.p29

ravaged other parts of the world. The population was unprepared, biologically and socially, the effects therefore were often quite devastating.<sup>3</sup>

Cultural decay and social dislocation had a similar, though less obvious affect on Māori health, and especially as old lifestyles and practices were abandoned and replaced by western beliefs and expectations. In the first fifty years of the 19<sup>th</sup> century Māori society had changed to such an extent that many believed a return to traditional lifestyles and practices was impossible, Māori were now part of a global network and thus required to adapt to these changes – present were both opportunities and threats.<sup>4</sup> Unfortunately, adaptation to this new global environment was difficult, planning was at best “ad-hoc” and compounded by an inability of Māori to negotiate the rate and structure of this change.<sup>5</sup>

The traditional PA had historically served Māori well but were ill-designed to meet the opportunities of the modern world - commercial activity, trade and industry - so were quickly abandoned. Their hill-top locations had proved effective in terms of public health and health promotion. These sites were deliberately selected and designed to ensure warmth and avoid dampness and the cold. Access to clean water was also a priority – PA were typically located near fresh water springs and structured so that water would not pool, become stagnant, and serve as an incubator for disease. To further avoid the potential spread of disease areas were set aside for the disposal of effluent. As well, storage facilities would ensure that food was available throughout the year and especially in the winter months.<sup>6</sup>

It is of interest to note that these mechanisms revealed an advanced understanding of public health, how diseases were transmitted, the importance of clean water, and the requirement to safely dispose of effluent. At the time these so-called primitive PA

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<sup>3</sup> Ibid

<sup>4</sup> School of Māori Studies, (2004), *Treaty of Waitangi in New Zealand Society: Study Guide*, School of Māori Studies, Massey University, Wellington.

<sup>5</sup> M.H.Durie, (1998), *Te Mana Te Kawanatanga: The Politics of Māori Self-determination*, Oxford University Press, Auckland.

<sup>6</sup> School of Māori Studies, (2003), *Māori Health Foundations: Study Guide*, School of Māori Studies, Massey University, Wellington.

were flourishing, many of the major cities throughout Europe had yet to appreciate their significance in terms of health and in particular the need for an effective system of sewage disposal. Chamber pots were the norm in most city dwellings (especially in London) and since no plumbing was present these were typically emptied out windows and onto the street below.<sup>7</sup> To warn unsuspecting passers-by people would often use the French phrase *gardez l'eau* loosely translated as “watch out for the water!”. Overtime the phrase became anglosised and shortened to “loo” – to this day toilets are often referred to as “loo’s”.<sup>8</sup> In 1830 and when describing the steets on Leeds in England R.H Mottram, stated in a public report that: "568 streets were taken in for examination...Whole streets were flooded with sewage..."<sup>9</sup>

Apart from these physical features and mechanism, traditional Māori social practices had also evolved to ensure health and well-being. The concept of tapu and noa was often used to promote and protect health. Unfortunately, these practices were too frequently misinterpreted by anthropologists who often misread their fundamental purpose (in terms of health) and chose instead to focus on mystical or supernatural interpretations.<sup>10</sup> Examples which illustrate the health implications of tapu and noa are not difficult to find. Immediately following birth, women were deemed as being tapu. However, the reason for this had less to do with custom and more likely a means through which lactation could be facilitated, to aid recovery, and to permit bonding between mother and child. All these now considered as critical to a child’s development.

Likewise, areas of the sea that were known to be dangerous were also tapu and further meant that accidents were avoided. Nesting birds were tapu and ensured that hunting, from year to year, would be successful. Raw meat was tapu, but after being cooked

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<sup>7</sup> R.H Mottram, in 1830, stated in a public report regarding the streets of Leeds, England: "568 streets were taken in for examination...Whole streets were flooded with sewage..."

<sup>8</sup> Maureen Francis talks about the Development of the Toilet  
[http://www.masterplumbers.com/plumbviews/1999/toilet\\_tribute.asp](http://www.masterplumbers.com/plumbviews/1999/toilet_tribute.asp) (2 Feb 2005)

<sup>9</sup> Ibid

<sup>10</sup> <http://teiho.org/Print.aspx?instanceId=1986> (2 Feb 2005)

became noa or safe. Semi-completed dwellings were tapu, for a time, and until beams had been fastened and secured, at which point they too became noa.<sup>11</sup>

These types of social structures and mechanism had as much to do with health as they did with tradition or custom. They had evolved over time and were an effective means of ensuring the survival of future generations. For the most part activities of the Māori were focused, fundamentally, on survival and health.

Unfortunately, these illustrations are also good examples of the concepts that were dismantled as social change took effect. Either by choice or force the hill-top PA were abandoned. Māori were quick to see the opportunities presented by trade and often relocated to areas where harvesting of natural resources could better be facilitated. In the North this economy was frequently linked to gum-digging – this, a fairly sustainable form of economy, but which typically meant living in damp, cold, and poorly ventilated domiciles, ill-suited to health. Others were forced to leave and similarly required to relocate to areas that were health-averse. However, and regardless of reason, the outcomes in terms of health, were the same. Cultural decay had a similar effect as parameters for living (such as tapu and noa) were displaced, but not replaced.

Wars, between tribes or over land, were also significant in terms of both morbidity and mortality. When introduced, the musket was a significant technological advancement that proved an effective means of inflicting harm and on a scale that was not previously possible. At the time it truly was “a weapon of mass destruction”. From the 1840’s through to the 1870’s conflict between Māori and settler escalated and further served to assist Māori population decline.<sup>12</sup>

The cumulative effects of these issues - disease, social change, and warfare, were significant and it is not surprising therefore that the population fell by so much during the 1800s. These problems however were not entirely unexpected. The colonial

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<sup>11</sup> School of Māori Studies, (2003), *Māori Health Foundations: Study Guide*, School of Māori Studies, Massey University, Wellington.

<sup>12</sup> Belich, J, (1988), *The New Zealand Wars and the Victorian Interpretation of Racial Conflict*. Penguin, Auckland, N.Z.

experience from other parts of the world revealed the extent to which indigenous populations had suffered, and, in an attempt to somehow avoid their ill consequences a unique proposal was put forward as early as 1840 - which of course, was the Treaty of Waitangi.

### **The Treaty and Health**

While much of the discourse surrounding it has focused on issues of sovereignty, land acquisition, or textual differences – concerns over Māori health provided much of the backdrop and were not insignificant in terms of both shaping and selling the Treaty. By 1837, and when noting the need for intervention (and perhaps a Treaty), James Busby (the then New Zealand Resident) reflected on the plight of the Māori. In his dispatch to his superiors in England he noted the “miserable condition” of the Māori which promised to “leave the country destitute of a single aboriginal inhabitant”. Contained, therefore, within the Treaty is an explicit desire by Her Majesty “to avert the evil consequences that must result from the absence of necessary laws and institutions”. References to “Royal Protection” are also contained within the Treaty and likewise suggest that health problems were anticipated. Moreover, that this notion of protection would assist in selling the Treaty to Māori.<sup>13</sup>

The potential of the Treaty as a mechanism for Māori health development was certainly evident, though a reluctance to fully implement it restricted its overall effectiveness. By the close of the 19<sup>th</sup> century, and when reflecting on the population decline the situation for Māori seemed hopeless prompting many to believe extinction was inevitable. In a notable quote Dr Isaac Featherston summed up what was at the time the prevailing attitude and noted that:

“all we can do, is to smooth pillow of the dying Māori race”

Others were more circumspect, suggesting that the population decline was a consequence of *natural selection* though similarly espousing views that the process was albeit inevitable. Buller suggesting in 1884 that:

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<sup>13</sup> Orange, C, *The Treaty of Waitangi*, Port Nicholson Press, Wellington, NZ.

“Just as the Norwegian rat has displaced the Māori rat, as introduced plants have replaced native plants, so the white man will replace the Māori”

Māori entry into the 20<sup>th</sup> century was, therefore, somewhat unexpected and certainly unspectacular. Far from being a healthy, vibrant, and handsome people, the situation was now much more precarious. Something had to be done – and soon. Unfortunately, and if Māori health problems were afforded any special attention, it was assumed that these could be addressed through conventional means and through the European based hospital system.<sup>14</sup>

The approach, however, was flawed in several respects. First of all, medical technology had not yet progressed to a stage where many lethal conditions could in fact be cured. Antibiotics were still some years off and other interventions were primitive by modern standards.<sup>15</sup> Second, there remained a suspicion by many Māori of westerns treatment and care facilities, this led to an overall reluctance by Māori to utilise these facilities.<sup>16</sup> Third, Māori health concerns were often connected to public health issues – hospitals (a focus on illness and treatment of disease) would have limited affect here. By the time Māori made it to hospital (if at all) the problem had often progressed to a stage where little could be done.

### **A Glimmer of Hope**

It would be inaccurate to suggest that by 1900 the Government was dismissive of Māori health issues, although certainly a more proactive, informed, and less generic approach could have led to more positive health gains for Māori. In 1901 however a significant event took place when Maui Pomare was appointed ‘Health Commissioner for the Natives’, and later in 1905, was joined by Te Rangihiroa (Peter Buck). Both were medical practitioners and well aware of the poor state of Māori health.

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<sup>14</sup> Dow, D.A, (1999), *Māori Health and Government Policy, 1840–1940*, Victoria University Press, Wellington

<sup>15</sup> Alexander Fleming first discovered the healing properties of antibiotics in 1928. However, it was not until WWII that its true potential was realised.

<sup>16</sup> MacLean, F.S, (1964), *Challenge for Health: A History of Public Health in New Zealand*, Government Printer, Wellington.

Together they embarked on a programme designed to arrest what at the time must have been a mammoth task. The fate of the Māori race was at stake and required urgent action. Unfortunately, the funding available for Māori health was limited, moreover, a dedicated health workforce was also lacking.

In an inspired move their approach was to develop a Māori health workforce from within - and to utilise so-called non-health professions as health workers. They understood that Māori health problems were in many ways linked to lifestyle and public health issues. Health promotion initiatives could therefore assist with changing negative behaviours to those that were more consistent with health gains, further, that providing access to clean water, shelter, and ablution facilities could likewise lead to positive developments. Almost a reapplication of traditional concepts.

They understood also that Māori people were in fact best positioned to deliver these health messages and to initiate change.<sup>17</sup> While those with formal training and qualifications may possess one type of knowledge they often lacked the experience and respect through which the Māori tribes could be engaged. Unlike western communities it was not always clear who the leaders were or who those with influence might be. The same can be said even today as many of us are more likely to heed the warnings of an Auntie waving a stick than a well qualified physician waving a pamphlet. In any event both Buck and Pomare understood the fundamental principle that a by Māori for Māori approach to health promotion and education was best.

In the six years between 1904 and 1909 they saw to it that some 1,256 unsatisfactory Māori dwellings had been demolished. Further, that 2,103 new houses and over 1,000 privies built. A number of villages had also been moved to higher ground. McLean<sup>18</sup> states that all this had been done at the cost of the Māori themselves without a penny of Government assistance or compensation – sounds familiar. What had been

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<sup>17</sup> M.H.Durie, (1994), *Whaiora: Māori Health Development*, Oxford University Press, Auckland

<sup>18</sup> MacLean, F.S, (1964), *Challenge for Health: A History of Public Health in New Zealand*, Government Printer, Wellington.

achieved was due to the personal efforts of Pomare and Buck and a small bank of inspectors.

It is without question that these factors, coupled with some political nous, allowed Pomare and Buck to make the changes required and to turn the tide of despair. Later, others were to make similar contributions and likewise built on the idea that a Māori initiated and designed approach was best. In this regard the Māori Womens Welfare and Health Leagues responded well to the new challenges posed during the 1930s and onwards. The individual contributions of Te Puia and Ratana should also be recognised.<sup>19</sup>

It is perhaps at this point to note that the collective efforts of many Māori led to what must be considered as one of the greatest comebacks in human history. From a low of just 42,000 in 1896, and in just over 100 years, the population now stands at an incredible 604,110.<sup>20</sup> We are now more populous and living longer than at any other time in our history. While numerous, albeit significant, problems remain, it is at least of comfort to know that the expected extinction did not eventuate and that the efforts of so many before us were in fact successful.

### **New Challenges and Māori Perspectives of Health**

In order to meet the challenges of a new Century new and innovative approaches to health will be required. One hundred years ago the main threats to Māori health were typhoid, influenza, measles, scarlet fever, diphtheria, tuberculosis, pneumonia, malnutrition, and goitre. Today, different types of problems exist and include heart disease, obesity, diabetes, mental illness, cancer, asthma, and motor vehicle accidents – the list in fact is almost endless.<sup>21</sup> A characteristic of these modern problems however is that for the most part they are lifestyle related and do not reflect a biological predisposition – that is, we are not susceptible to these problems by the mere fact that we are Māori. Often, these are referred to as the diseases of affluence.

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<sup>19</sup> M.H.Durie, (1994), *Whaiora: Māori Health Development*, Oxford University Press, Auckland

<sup>20</sup> [http://www.maorilanguage.info/mao\\_pop\\_faq.html](http://www.maorilanguage.info/mao_pop_faq.html) (2 Feb 2005)

<sup>21</sup> School of Māori Studies, (2003), *Māori Health Foundations: Study Guide*, School of Māori Studies, Massey University, Wellington.

Of greater interest however is that they are largely preventable and respond positively to well targeted health promotion and public health initiatives.

Another characteristic of contemporary Māori health problems is that they call for a multi-sectoral, integrated, and holistic approach. The issues are often complex and not easily resolved through short-term, narrowly targeted, or isolated programmes. If we have learnt anything from the past it is that simplistic solutions are unlikely to lead to sustained gains.

In the mid-1980s, and in an attempt to better articulate Māori perspectives on health, Mason Durie described a model called Te Whare Tapa Whā. Made up of four key components the model described the importance of viewing health from a more holistic perspective and that the absence of physical illness did not necessarily equate with health – at least from a Māori perspective. Contrary to what many believe, Te Whare Tapa Whā is not a traditional model of health, rather, a contemporary model through which traditional concepts can be articulated.

Other models have also been developed and likewise reflect the same fundamental notions of holism, integration, culture, and the desire to consider more than just the physical aspects of health and well-being.<sup>22</sup>

When introduced, these Māori models were somewhat of a departure from what had previously been developed though were at least consistent with the World Health Definition of health.<sup>23</sup> During the earlier stages of the 20<sup>th</sup> Century for example the medical model of health was promoted and with it the idea that health was the business of so-called health professionals. The approach was illness and treatment orientated and allowed for little consumer involvement and input. Health was a biomedical construct, therefore it was believed that health gains would result from technological advancements. Certainly, the discovery of antibiotics and the promise of further miracle drugs added weight to this assumption, though ultimately this

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<sup>22</sup> For example: Te Wheke and Nga Pou Mana

<sup>23</sup> Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

approach is viewed by most as being too narrow and out of sync with the broader needs of patients.

Institutionalisation was another model of health and emphasised the idea that health treatment, care and delivery, was the function of large purpose built institutions and that this specialist environment was required in order to best meet the needs of patients. Again however, the approach was inconsistent with Māori views and perspectives on health. Institutionalisation often meant isolation and alienation – from whānau and friends, support networks, marae, hapu and iwi.<sup>24</sup>

The mental health sector was particularly keen on this institutionalised model of treatment and as a consequence built enormous treatment facilities or campuses – for the most part these were self-sufficient and self-supporting, complete with laundries and farms and even shops. Many were situated in rural or isolated communities, and, while this environment was deemed more therapeutic for patients it also served to placate public fears of the mentally ill and to reduce the risk of potential contamination.<sup>25</sup>

When in full operation, the facility at Porirua Hospital was amongst the largest in the southern hemisphere, and there are stories of some patients spending years (if not decades) without setting foot outside of the complex. Those of you who enjoy skiing may also be interested to know that there is a quite famous hotel within the Tongariro National Park that was also at one stage, briefly used as a psychiatric hospital.

Professionalism is another model of health and as the name implies, it suggests that health professionals (or at least those with formal training) are best able to deliver health care, health messages, and advice. This a logical assumption and has some merit, though a rigid interpretation of this model runs the risk of alienating those with

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<sup>24</sup> Baker, R, (1988), 'Kia Koutou', in C. Walsh and S. Johnson (eds.), *Psych Nurses*, 88, Wellington, p. 40.

<sup>25</sup> Mason, K., (1988), *Psychiatric Report: Report of the Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients*, Department of Health, Wellington

associated skills, who are perhaps not formally or medically trained, but likewise have much to offer and contribute.

Socialisation is the final model I would like to look at. Within it is suggested the notion that health is primarily a product of social factors. This concept has been around for some time and appreciates the various influences (such as income or employment for example) that impact on health status. However, and again, a rigid interpretation of this is unwise. In a recent address to the Social Policy, Research & Evaluation Conference, Mason Durie notes that:

Maori who live in the most affluent areas...have health outcomes that are similar to non-Maori living in the most deprived areas.<sup>26</sup>

He notes further, that:

Despite having similar levels of deprivation, Maori consumers were more likely than other groups to have higher levels of severity and lower levels of functioning. Further, in contrast to the general population, Maori who were living in areas of least relative deprivation were more likely to have higher levels of severity and lower levels of functioning than those living in areas of greater deprivation.<sup>27</sup>

In essence, and while social factors play a large role in determining health outcomes and health expectations, ethnic factors are also determinants that should be considered. Indeed we also know that affluent Māori are more likely to die sooner than non-Māori of similar socio-economic status.<sup>28</sup>

It would appear therefore, that overly descriptive or narrow models of health are inconsistent with contemporary expectations – further that these new and holistic Māori models offer a way forward. However, and despite this growing enthusiasm for a more balanced approach, it is important to remember that these Māori models are often based on quite old concepts that have guided Māori views on health for centuries. And, that while many models come and go - for the most part Māori

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<sup>26</sup> Durie, M. (2004, November). *Race and Ethnicity in Public Policy: Does it work?* Paper presented at the Social Policy, Research & Evaluation Conference 2004, Wellington, NZ.p 8.

<sup>27</sup> Ibid.

<sup>28</sup> <http://www.kiwinews.co.nz/cgi-bin/editor/print.pl?article=3866> (2 Feb 2005)

perspectives on health have remained consistent. It is only now that many have come to appreciate the value contained within them.

### **The Application of Māori Models of Health**

While there exists a need to consider health from a variety of perspectives, and as described within Māori models, the prospect of applying these can be difficult. From a consumer perspective, expectations are that a Māori service will promote and strive for outcomes in a number of different domains – perhaps addressing the physical health problem, but also examining and possibly treating wairua, hinengaro, and whānau domains. However, service descriptions, contractual arrangements, and a silo type mentality may not always permit this. Often, services are funded to deliver one type of intervention and may not permit/allow/ or finance other domains. On the other hand it can be quite difficult to find individuals with sufficient skill to administer a comprehensive range of interventions.

This can lead to some frustration in that while holistic approaches to health are gaining more prominence, applying these at a service level, can be difficult. And, while some services are able to do so (and quite effectively) others are perhaps less fortunate.

Although there are many factors that prevent the application of holistic methods, part of the problem relates to the measurement of such approaches and the perceived benefits that result. This may seem somewhat surprising given the acceptance of holistic models. However, funders are often more concerned with determining the extent to which what they fund is linked to measurable health outcomes. In this regard conventional modes of delivery, tried and tested, often take precedence. Moreover, clinical decisions often require that some forms of treatment are afforded greater priority than others.<sup>29</sup>

I do not wish to delve too much into these issues, suffice to say that they are very complex. Moreover, further discussion may detract from my prime point of interest

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<sup>29</sup> Te K.R.Kingi, (2002), *Hua Oranga: Best Health Outcomes for Māori*, Unpublished Ph.D. Thesis, School of Māori Studies, Massey University, Wellington.

and to show the value of Māori models and concepts. Highlighting this value may likewise lead to a greater willingness to fund and promote holistic service provision.

In this respect there is often confusion as to the purpose of adopting Māori approach to service delivery or when applying Māori models of health. To some, Māori centred approaches are linked to Treaty of Waitangi obligations, ideas of partnership and protection, or even a means through which notions of Tino Rangatiratanga can be expressed.

These are of course all important concepts, however, and within this debate, the clinical and health related objectives are often lost. In this regard it is important to appreciate that the reason for including culture within any health setting has less to do with culture itself and everything to do with health. To this end, culture has little place within a health setting unless it contribute to health gains.

Fortunately, there is a significant and growing pool of evidence which highlights this. In this regard, and while clinical interventions may be the focus of care it is often cultural factors that provide the context and background. A Māori health promotion officer, for example, is likely to have more success within Māori communities and in modifying unhealthy behaviours. However, and while formals skills will assist this, it is their ability to effectively engage the Māori community which provides the vehicle and thrust – their innate ability to recognise opportunities, to utilise marae activities, to interact with those most at risk, to appreciate local realities, and to foster a relationship of trust and respect. These are all critical to achieving positive health outcomes, they are often culturally bound, and are fundamental skills that many Māori health promotion officers possess.

Within the mental health sector other examples of cultural interventions or activities are also evident. Within many service, and before receiving care, patients are often greeted with a pōwhiri or mihi whakatau. While this can be a significant cultural experience, from a clinical perspective the process can also be quite settling, putting the patients at ease, providing reassurance, and creating an environment which supports recovery and rehabilitation. Cultural assessments are also used to complement the more usual clinical assessments. In this way a more comprehensive

assessment of the problem is possible and the relationship between cultural and health better understood. As a consequence broader options for treatment and care can be explored.<sup>30</sup>

Kaumātua are now employed within many mental health services and provide valuable support on issues of tikanga and protocol. However, and more than this, kaumātua are a vital link to the local community and can often identify solutions where previously none existed. In some instances they are also better able to engage the patient, to create dialogue that is more open and which allows for a better understanding of the problem. In the assessment of issues such as mate Māori their advice is also critical.

Te Reo Māori has also been used within mental health services and as means of treating Māori patients. And, while it is accepted that most Māori are sufficiently capable of understanding Te Reo Pākehā, many are more comfortable conversing in Māori and may reveal a broader and deeper range of issues. Again, assisting with assessment and ensuring that all possible concerns are considered.

Whānau participation is likewise a characteristic of many Māori health services. It is in many ways a feature of Māori culture and society and therefore appears within Māori health models. Whānau and the relationships that exist within them provide a base for cultural interaction and likewise a mechanism through which cultural knowledge is transferred from one generation to the next. Within a health service however, whānau participation has a range of additional benefits. Māori are likely to appreciate the advice and support of whānau members, and whānau will often expect to contribute to the treatment and healing process by actively participating in treatment activities. Whānau participation can be particularly useful within mental health services and at the assessment phase. Here they are able to distinguishing between cultural norms and mental disorder and in furnishing a more accurate picture of the stresses and strains that impact on a patient. These are often issues that

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<sup>30</sup> Te Pumanawa Hauora, (1995), *Guidelines for Purchasing Personal Mental Health Services for Māori*, Department of Māori Studies, Massey University, Palmerston Nth.

psychiatrists are particularly interested in but are unable to completely appreciate without whānau input.<sup>31</sup>

Insofar as rationalising a holistic approach to service delivery – an approach consistent with Māori models of health – some interesting developments have also occurred. Putting aside funding and resource issues, and again taking a health outcomes based approach, there is sufficient evidence to suggest that consumer outcomes are best served by approaches that include and consider a broad range of health domains.

An instrument for measuring Māori mental health outcomes is currently being developed by researchers at Massey University. The tool is based on Te Whare Tapa Whā and stresses the need to promote outcomes that move beyond the more usual objectives of psychiatric care which has typically focused on symptom ablation, cognition and behaviour. For mental health patients these are all important issues, however, it is asserted through the tool that for Māori patients a broader range of outcomes will need to be considered.<sup>32</sup>

When initially devised, some within the mental health profession were less than enthusiastic about the tools application – noting that mental health care and training was fundamentally focused on one dimension of care – as perhaps it should. However, there is now a considerable pool of evidence which highlights the relationship between physical health and mental well-being,<sup>33</sup> likewise the role of whānau and the wider community in promoting positive mental health outcomes.<sup>34 35</sup>

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<sup>31</sup> Ibid.

<sup>32</sup> M.H.Durie and T.R.Kingi, (1998), *A Framework for Measuring Māori Mental Health Outcomes*, School of Māori Studies, Massey University, Palmerston Nth.

<sup>33</sup> See G. Arling, (1987), 'Depression Among Elderly Residents of Local Authority Residential Homes: Its Nature and Efficacy of Intervention', in *British Journal of Psychiatry*, vol. 156, pp. 667-675. See also J. Sadavoy, I. Smith, D. K. Conn, *et al.* (1990), 'Depression in Geriatric Patients with Chronic Mental Illness', in *International Journal of Geriatric Psychiatry*, vol. 5, pp. 187-192.

<sup>34</sup> Vera Keefe-Ormsby, Naina Watene-Hayden, Winston Maniapoto, Gloria Taumata-Bishara, and Helen Potaka, (1993), *Tino Rangatiratanga and Māori Mental Health*, Department of Health, Wellington, p. 242.

<sup>36</sup> The World Health Organisation has also acknowledge the place of spirituality in the assessment of health outcomes.<sup>37 38</sup>

## Conclusions

As noted within the introduction to this paper a range of issues, both historical and contemporary, would be discussed. In tying together the various strands of this paper seven key themes have emerged and are used to illustrate Māori development and innovation – over time, at present, and perhaps in the future.

The first theme in fact, has to do with *Māori development* and the notion that health gains for Māori must take place from within a broad framework. Unemployment, poverty, educational underachievement, and trapped lifestyles, are inconsistent with positive health gains though are often quoted characteristics of contemporary Māori society. As in the past, Māori health development and Māori development are pre-requisites for each other.

The second theme has to do with *Advancements in knowledge* and the role Māori have played within the broad field of health. In this regard, Māori have contributed to the development of holistic modes of care – long before they were popular. Innovations in treatment and service delivery have also been achieved, along with advancements

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<sup>35</sup> School of Māori Studies, (1999), *Proceedings of Te Hua o te Whānau Conference*, School of Māori Studies, Massey University, Palmerston North.

<sup>36</sup> Mental Health Section, (1995), 'Guidelines for Cultural Assessment', in *Mental Health Services, He Purongo e pa ana, Te Whakahiātanga o Ngā Arotakenga Tika kei roto I Te Ratonga o Te Oranga Hinengaro*, Ministry of Health, Wellington.

<sup>37</sup> Spirituality was considered as part of the WHOQOL-100 Measure.

<sup>38</sup> See also J. Turbott, (1996), 'Religion, Spirituality, and Psychiatry: Conceptual, Cultural, and Personal Challenges' in *Australian and New Zealand Journal of Psychiatry*, vol. 30, pp. 721-730. Mental Health Foundation, (1986), *The Future of Mental Health Services in New Zealand*, Mental Health Foundation, Wellington; M. H. Durie, (1996), 'A Framework for Purchasing Traditional Health Services', a report prepared for the Ministry of Health, Department of Māori Studies, Massey University, Palmerston North; D. Chaplow, (1993), 'Addressing Cultural Differences in Institutions: Changing Health Practices in New Zealand', in *Criminal Behaviour and Mental Health*, vol. 3, pp. 307-321; K. Hawten, (1987), 'Assessment of Suicide Risk', in *British Journal of Psychiatry*, vol. 150, pp. 145-153.

in the field of health promotion, health education, and health protection. While these developments are nationally significant, they have also influenced international trends, approaches, and academic discourse.

The third theme is *Tikanaga* and highlights the fact that traditional Māori practices, protocols, and culture, provide frameworks for health development. And, while I am not advocating a return to the past – I certainly am suggesting that culture and health are intimately related and should be considered as part of any modern health strategy.

Theme four is *Active Leadership* and reflects on how Māori leaders have often emerged to guide Māori health development. As in the past, this idea also states that leadership may come in many forms and is not the reserve of any one group or individual, profession or qualification. In fact, Māori health leaders have typically appeared from a range of different backgrounds but have been duly armed with the skills to effectively engage Māori.

Theme five is *Rangatiratanga* and is in reference to the fact that Māori health gains have often occurred at the initiation and often insistence of Māori. In this regard themes four and five are connected. However, *Rangatiratanga* (in this sense at least) is broader in scope and is based on the principle that Māori are perhaps best positioned to undertake activities in Māori health development - to provides health services, to identify health priorities, to identify appropriate outcomes and perhaps even to provide health funding.

Theme six is *Application* and considers the fact that Māori models of health should be applied and in order to deliver the best possible outcomes to Māori. The evidence in this regard is clear and that in order to effectively meet the needs of patients, Māori models of health can provide essential and fundamental guidance.

The last theme is entitled *Unity* and is really a call for a collective approach to Māori health development. *Unity* requires collaboration, within, throughout, and across sectors. It implies that individuals takes a multi-disciplinary approach to health service delivery and that Māori and western ways of thinking are merged and in order to achieve positive health gains. Most of all it states that Māori health is the

responsibility of all of us and that collaborative efforts are required for positive and sustainable health outcomes.

The framework below is a summary of these seven themes – Māori Development, Advancements in Knowledge, Tikanga Māori, Active Leadership, Rangatiratanga, Application, and Unity. It is not intended to be anything other than a basic summary of issues – however, and if it serves to initiate debate and dialogue, then perhaps it may make a broader contribution to this conference.

### **The M.A.T.A.R.A.U Framework**

Māori Development	Māori health gains must be seen within the overall context of Māori development
Advancements in Knowledge	Māori have contribute to innovations in health – nationally and internationally
Tikanga Māori	Māori custom and protocol can be used as base for positive health gains
Active Leadership	Māori leaders in health are required and may emerge from a variety of settings
Rangatiratanga	Māori autonomy in health offers much potential
Application	Māori models of health contribute to positive health gains
Unity	Māori unity and a collective approach to health development will lead to sustained health gains

As a final point, I would like to wish you all the best for the remainder of your conference and hope that your efforts, ideas, work, and enthusiasm contribute to a long traditional of Māori development and innovation. Kia Ora.

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