THE TREATY OF WAITAINGI; A FRAMEWORK FOR MAORI HEALTH DEVELOPMENT

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INTRODUCTION

I would like to firstly extend my thanks to the organisers of this conference and for the opportunity to speak to you this morning. It is always an extreme privilege to receive these types of invitations and to play some small role in ensuring that the broad objectives of the conference are met. One of the challenges, when presenting at any type of forum, is to provide something which is both interesting and entertaining but which also offers more pragmatic insight and which contributes to the practice and activities of the participants - the everyday work they do.

In developing this morning's paper, these issues were very much at the forefront, and indeed I was asked to specifically consider Māori health issues and how therapists could better engage Māori clients and the Māori community. In considering how best to do this and to effectively reconcile and consider the multiple objectives of this presentation, I've decided to frame all these issues within the broader context of the Treaty of Waitangi. And, to ideally construct a presentation which is informative, interesting, entertaining, and accurate - but perhaps most importantly pragmatic and useful.

BACKGROUND

Using the Treaty as a framework for any type of discussion or dialogue presents many challenges and indeed opinions and ideas on the Treaty are often formed even before discussions take place. Within New Zealand, you are unlikely to find anyone who doesn't have an opinion on the Treaty or who are not prepared to espouse their views on the place of the Treaty within contemporary society. The unfortunate reality, however, is that our views on the Treaty are often informed by the media or even worse through political debate. And, as a consequence, our broad understanding of the Treaty and Treaty related issues are not always derived from an informed base.

However, and regardless of these concerns, there is some general agreement that the Treaty holds some special significance - as the founding document of our country and as an agreement which formalised the initial relationship between Māori and the Crown. Signed on the 6th of February 1840 the Treaty was made up of five parts – a pre-amble, three articles, and a post-script (all translated from English into Māori).

The Treaty of Waitangi was essentially a treaty of cessation and as such resulted in a transfer of sovereignty (or absolute control) from Māori to the British Crown.[1] While the Māori version of the Treaty placed some restrictions on this notion of sovereignty, the Treaty nevertheless facilitated British rule, colonisation, and the establishment of British systems of governance, land tenure, law, and social development. In effect, it legitimised Crown intervention and therefore permitted the creation of many of the Western institutions and structures we now take for granted.

Insofar as the Treaty facilitated Crown intervention, it was also, and perhaps more fundamentally, an exchange - and indeed these transfers of authority were not unconditional in that the expectations of Māori at the time were quite considerable. There is of course some debate as to whether or not Māori actually understood the Treaty and what was being negotiated. The Treaty itself was poorly translated and even less well explained. In the Māori version of the Treaty the idea of sovereignty (for example) was interpreted as governorship and meant that those that signed it anticipated crown management but also some form of Māori control. As well, there was a broader expectation, and that in exchange for Māori signatures, the interest of Māori would also be protected and in order to make good the agreement.[2]

The extent to which these Treaty based exchanges have been met has been the subject of some considerable debate and from the outset. The obligations agreed to by Māori (and more) have largely been met, however, there is less agreement on the extent to which the Crown has matched these – whether or not mechanisms for Māori self-governance have been made and the level to which Māori interests have been protected.

However, and putting aside the multiple interpretations of the Treaty, the position advanced within this presentation is that a fundamental intent of the Treaty was centred around a desire to promote and protect Māori health. Of course this is not typically the way in which the Treaty is described and indeed my views are not

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1 C.Orange, (1987), *The Treaty of Waitangi,* Port Nicholson Press, Wellington.

2 M.H.Durie, (1998), *Te Mana te Kawanatanga: The Politics of Māori Self-Determination,* OUP, Melbourne, Australia.

always consistent with other interpretations. However, the purpose of this presentation, is to unravel and explore the Treaty of Waitangi, it's background and history, the principles and text, its interpretation and application and how this is all connected to Māori health. In this regard the broader objective is to create an understanding of the relationship between the Treaty of Waitangi and Māori health and to likewise establish a platform through which interactions with Māori, at a personal, organisational, or community level, may be improved.

A TREATY IS PLANNED

To begin with, and despite my own views this subject, there is no single opinion on what was the original intent of the Treaty of Waitangi. However, an analysis of its wording reveals that there were at least three broad objectives – first, (and already mentioned) the cession of sovereignty, second, absolute control (by the Crown) of land matters, and lastly, law and order equally for Māori and settlers. William Hobson was responsible for drafting the Treaty, however, he was guided by a set of instructions from Lord Normanby, who in turn was influenced by various other reports on the New Zealand situation.

These reports were based on what was observed here during the early 1800s and in particular the impact unmanaged colonisation was having on the indigenous Māori population. In an 1832 report to his superiors in England, James Busby (the official New Zealand Resident) made light of the "miserable condition of the natives" and which "promised to leave the country destitute of a single aboriginal inhabitant." Even then, the population was in sharp decline and expectations were that this would continue and unless there was some form of active intervention.[3]

The type of intervention initially recommended by Busby was a "protectorate" and where the Crown would administer the affairs of the country and in the interest of all inhabitants – Māori and European.[4] William Hobson, New Zealand's first Governor,

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3 School of Māori Studies, (2005), *Treaty of Waitangi in Contemporary Society: 150:202 Study Guide,* Massey University, Palmerston Nth.

4 http://www.dnzb.govt.nz/dnzb/default.asp?Find_Quick.asp?PersonEssay=1B54 (07/11/05)

promoted an alternative "factory" plan. This would have led to the establishment of European type settlements within certain geographical locations and within which British laws would be put in place. Māori settlements would similarly be established and likewise see the application of Māori laws and custom within these boundaries.

Despite this, the Colonial Office in England determined that the only way to protect Māori interests (including health) was to annex the country – transferring sovereignty (absolute control) from Māori to the Crown. For this to occur, a Treaty of cessation (the Treaty of Waitangi) was required. In this regard, my main point is that while the Treaty is at times difficult to interpret there is certainly little doubt that the issue of Māori health or welfare formed much of the background to the Treaty and was significant in terms of both shaping and selling the Treaty to Māori. Indeed, and when we look at the English version of the Treaty it makes specific reference to the idea of "Royal Protection" as well desire the "to avert the evil consequences that must result from the absence of necessary laws and institutions".[5]

A PEOPLE IN DECLINE

While the objectives of the Treaty were in part designed as a platform for Māori health development, based on the continued population decline, it proved to be less than successful. In fact, the 1800s was a century characterised by significant and sustained Māori de-population. Although accurate population figures were not available it was estimated that Māori numbered about 150,000 in 1800. Yet, and when an actual census was conducted in 1896, the figure was just 42,000.

The reasons for this decline and change in health profile are complex, though are not difficult to identify. The land and tribal wars during the 1800s had a particular and negative impact on the Māori population. Estimates on the number of Māori lost during tribal conflicts vary considerably – however, the most recent lowest

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5 State Services Commission, (2005), *The Treaty of Waitangi Information Programme,* State Services Commission, Wellington.

"guestimate" is about 20,000.[6] Putting this figure in perspective, it exceeds the total number of New Zealand casualties in either of the two World Wars. Certainly the introduction of the musket was a critical tool in this process and resulted in a level of devastation hitherto impossible.

The Land Wars (between Māori and Pākehā) had a similar effect as did of course the introduction of diseases that Māori had little biological protection from. 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 ravaged other parts of the world. The population was unprepared, biologically and socially, the effects therefore were often quite devastating.[7]

Cultural decay had a comparable, though perhaps less obvious impact. As colonization took effect, cultural decay resulted in the abandonment of many of the social structures and practices which for hundreds of years had been used to promote and protect Māori health.[8] The traditional PA for example had evolved into a complex series of physical and social structures. Deliberate mechanisms were put in place and in order to ensure that fresh food and clean water was available, people were protected from the elements, waste was disposed of and in order to prevent contamination and a range of other health based practices were also adopted. However, these mechanism were in many ways inconsistent with how the new colony was developing and in the end were abandoned as other opportunities and lifestyles were explored.

While certainly traditional ways of living would have eventually been lost, the rate at which this occurred was the real issue and especially as Māori moved directly from traditional systems to western based environments. This cultural transfer often resulted in traditional mechanism and safeguards being abandoned. It the end it

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6 B.Dalley, and G.McLean, (2005), *Frontier of Dreams: The Story of New Zealand,* Hodder Moa, Auckland.p 78.

7 M.H.Durie, (1994), *Whaiora: Māori Health Development,* Oxford University Press, Auckland.p29

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

wasn't that western systems were bad for Māori, but, that appropriate mechanisms for health and safety were displaced and not replaced.

While it is difficult to say with any certainty how each issue directly impacted on Māori health, the cumulative effect of these changes was a dramatic decline in the Māori population and with it a corresponding loss of Māori land, Māori control, and Māori culture.

By the end of the 1800s, and even well before, it was clear that Māori expectations of the Treaty were unlikely to be met. Insofar as providing a framework for Māori health development the offerings of the 1840 agreement had failed to materialise. Though this is perhaps not a fault of the Treaty itself, but more a reluctance by the Crown to fully implement its many provisions – including those directly connected to Māori health.

Even though, and by the beginning of the1900s, there seemed little reason to develop any plans for Māori health – Treaty based or otherwise – when in fact many believed that the population was doomed to extinction. The only plan required was that which would manage the demise of this once noble race.

In what was to become a somewhat famous quote, Dr Isaac Featherstone summed up what was perhaps the prevailing attitude of the day;

> "The Māoris are dying out, and nothing can save them. Our plain duty, as good compassionate colonists, is to smooth down their dying pillow. Then history will have nothing to reproach us with."[9]

Others held similar views and went further to suggest that the population decline was an inevitable process – consistent with Darwinian theories of natural selection and in particular the survival of the fittest.

> "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"[10]

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9 http://www.teara.govt.nz/1966/F/FeatherstonDrIsaacEarl/FeatherstonDrIsaacEarl/en (07/11/05)

RECOVERY

Of course, the population did recover, and in dramatic fashion. And while the 1800s were characterised by depopulation, despondency, and despair, the 1900s illustrated Māori resilience and resolve, a determination which was to eventually result in one of the greatest and perhaps most un-expected recoveries in human history. Again however, the Treaty and the Crown played only a minimal role in this and in fact it was largely due to the determination of Māori and a desire to address their own health problems that a platform for Māori health development was established.

The efforts of Pomare, Buck, Ngata, Te Puia, Ratana, and organisations such as the Māori Woman's Health and Welfare leagues require particular mention in this regard.[11] Indeed their role in responding to the health needs of Māori at a time of absolute crisis deserves more popular recognition. Of added interest is the fact that these health gains were often achieved in spite of limited government assistance and in the face of what must have seemed to be insurmountable odds. For example and when describing the work of Pomare and Buck, McLean notes that:

> 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. He notes that all this had been done at the cost of the Māori themselves without a penny of Government assistance or compensation. What had been achieved was due to the personal efforts of Pomare and Buck and a small bank of inspectors.[12]

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10 http://culturalsafety.massey.ac.nz/ChapterFive.htm (07/11/05)

11 Durie, M. H., (1994), *Whaiora: Māori Health Development,* Oxford University Press, Auckland.

12 MacLean, F.S, (1964), *Challenge for Health: A History of Public Health in New Zealand*, Government Printer, Wellington.

THE ROLE OF THE TREATY

While I have argued that the Treaty was initially (in part at least) designed as a platform for Māori health development, concerns over land confiscations and other acquisitions saw to it that the Treaty soon became an outlet for Māori frustrations. In fact, and for much of the 19th, and 20th Century the Treaty had evolved into a document which served only to highlight a series of broken promises, particularly with respect to land, but also unmet expectations for Māori control and governance.

These concerns were complicated further by a general reluctance by the Crown to recognise the Treaty as anything other than an historical curiosity. Indeed, and in less than 40years after it's signing, Judge Prendergast notably described the Treaty as a "simple nullity" – and since "Treaties entered into with primitive barbarians lacked legal validity". This served as the prevailing legal position on the Treaty for nearly 100 years. It also reinforced the position of successive governments, and judges alike, and that the Treaty of Waitangi was of little importance and certainly irrelevant to legal issues.[13]

THE WAITANGI TRIBUNAL

Over the years the legal position of the Treaty has changed, and as a result of various court cases. These decisions have often resulted in legal comment on the constitutional position of the Treaty, how each version (Māori or English) should be treated, and its relationship to legislation. These cases did much to reinforce the idea that the Treaty was primarily a tool to consider and potentially resolve historical conflicts or grievances – though were less useful in determining how the Treaty could inform contemporary and future development. For Māori also, the courts had often proved to be a fruitless and expensive exercise as debates were often limited to the English version of the Treaty and to the few instances where it actually appeared within legislation.

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13 M.H.Durie, (1998), *Te Mana te Kawanatanga: The Politics of Māori Self-Determination,* OUP, Melbourne, Australia.

A significant change occurred, however, and with the establishment of the Waitangi Tribunal in 1975. Initially criticised due to the fact that it could only make non-binding recommendations, the Tribunal did at least provide a forum through which Treaty related concerns could be raised – outside of the courts and in a way that provided greater flexibility in terms of how the Treaty could be interpreted. To this end the Waitangi Tribunal is not a court, but a commission of inquiry. While its hearings are based on a format which mirrors courtroom procedure and process (complete with judges and lawyers), unlike a court, the rulings are not binding on the crown – they may in fact choose not to accept the tribunals findings or only partly implement what recommendations are made.

Other interesting features of the Tribunal are that only Māori can bring a claim to it, but these must be against the crown and not individuals or third parties. Despite a drive to windup the Tribunal and in order to settle historical treaty claims it is also important to note that most claims of this type are not actually settled through the tribunal process. In addition – settlement negotiations are not typically delayed by a reluctance by Māori to settle – but by the rigid settlement framework imposed by the Crown.

When further examining the Act under which the Tribunal was established it states that both versions of the Treaty should be regarded equally and when considering claims brought to it. Additionally, the Tribunal focuses on the "principles" or "spirit" of the Treaty as opposed to the actual text.[14]

The use of "principles" was designed to avoid the obvious problem of having two different versions of the Treaty, but also provided a more flexible framework for the interpretation of Treaty related concerns and obligations. Whereas in the past the Treaty (particularly within the courts) had been applied to physical resources, such as land, forest, and fisheries, the principles were broader and therefore not as restrictive. Adding to this was the opportunity to consider specific words such as Taonga and

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14 http://www.waitangi-tribunal.govt.nz (24/02/06)

Tino Rangatiratanga as contained within the Māori version of the Treaty. It seemed, therefore, only a matter of time before the link between Māori health and the Treaty would be established or at least re-established.

THE TREATY TEXT AND MAORI HEALTH

In considering how the Treaty may be applied to health there are (therefore) at least two broad approaches – one which is founded on the text or wording of the Treaty, and the other which is based on broader and more interpretive principles – such as those mentioned within the Treaty of Waitangi/Waitangi Tribunal Act.

By first examining the Treaty text it is clear that both versions (Māori and English) make particular references to health and which are again consistent with the various concerns that originally informed the Treaty in 1840. In the English version of the Treaty, Article 2 emphasises property rights and Article 3 stresses individual rights. There is a guarantee of "royal protection" and that Māori will be afforded the same "Rights and Privileges of British Subjects". As well, the pre-amble to the Treaty further sets out the desire to "protect" Māori rights and "to secure the enjoyment of peace and good order". The pre-amble also highlights the need for intervention and the fact that un-managed colonisation is unlikely to result in a positive outcome – for Māori at least.

The Māori version of the Treaty has similar objectives, although, and due to translation differences, Article 2 places added emphasis on Māori control over "things Māori" and further uses the words "taonga katoa" implying a connection between the Treaty and Māori social and economic development.

As noted, these statements reflected the contemporary concerns of 1840 and would have done much to encourage Māori agreement and by offering protection, certain rights, and an expectation that the outcomes for Māori would be at least as good as that of non-Māori. However, and as shown, Māori outcomes have seldom (if ever) matched those of non-Māori – especially in health, but within a full range of socio-economic indices.

It is little wonder, therefore, that Māori have come to view the Treaty as an ideal framework for Māori health development. While some have interpreted the Treaty as affording Māori additional rights or privileges it is clear that above all else it is concerned with equity and the promise that Māori can enjoy – at the very least – the same health and well-being as non-Māori – this is clear from an examination of both the Māori and English text of the Treaty.

Confusion arises however, and when attempts are made to ensure that existing inequalities are eliminated. Some are uncomfortable with considering the Treaty in a contemporary setting even though it was never designed to sit within an 1840 vacuum. Others fail to see how it could relate to health, despite the fact that Māori health and well-being was crucial to the Treaty's design and promotion.

Official plans for Māori health have not always embraced the Treaty as an appropriate start-point or as a suitable framework from which to begin. Nevertheless, this has not prevented Māori from aligning these policies or plans with Treaty related obligations. Indeed, and regardless of whether or not targeted plans are based on need, equity, or disparities, it is clear that these are consistent with the Treaty. On the other hand, specific Treaty related plans are often framed within the notion of Māori privilege, when essentially they are about equality and balance.

In any event, my main point is that the Treaty text (both Māori and English) make clear references to Māori health and place obligations on the crown to ensure that Māori health interest are actively protected. Further, and that while the Crown has not always employed the Treaty as an appropriate framework for health policy, this has not prevented Māori from aligning targeted approaches (in whatever context) with Treaty related obligations.

THE PRINCIPLES OF THE TREATY AND MĀORI HEALTH

Despite textual references to health, debate as to the actual wording of the Treaty, and it's meaning, has not always resulted in a consistent view (even amongst Māori). Some, for example, feel that the idea of Tino Rangatiratanga (as defined in the Māori version of the Treaty) is adequately met through the development of Māori specific

health services and that this provides a reasonable degree of self-determination. Others are less convinced and feel that until Māori have full control of health funding and service delivery (outside of the present framework) then true Tino Rangatiratanga remains an unrealised dream.

These types of debates again highlight the variety of ways in which the Treaty may be interpreted - the meaning of certain words – in Māori and English, their historical intent and contemporary application. As noted, the Treaty of Waitangi principles were introduced in part and in order to somehow mitigate these difficulties – to arrive at a common understanding based on both versions of the Treaty and to allow it to be considered in a variety of settings.

The difficulty however, is that these principles, while frequently referred to, are mentioned nowhere within the Treaty (Māori or English) and therefore it has been difficult to say with any degree of certainty what these principles are - other than to state that they originate or are derived from the two Treaty text. Even the legislation which led to formation of the Waitangi Tribunal is unclear about this issue and that while the Act clearly refers to the principles of the Treaty, it is silent on what these actually are.

So as to better elucidate what these principles were The Waitangi Tribunal, The New Zealand Government, the Court of Appeal, and The New Zealand Māori Council, have all developed their own set of principles and usually as a result of claims to the Waitangi Tribunal.[15] These principles were broadly consistent with each other and the Treaty, though were considered within the context of a particular tribunal claim. In 1988 however, the relationship between the Treaty and health was clarified and through a set of principles identified by the Royal Commission on Social Policy. And, although in 1975 the Tribunal had made way for the broader interpretation of the

15 School of Māori Studies, (2005), *Treaty of Waitangi in Contemporary Society: 150:202 Study Guide,* Massey University, Palmerston Nth.

Treaty, it wasn't until 1988 that a set of principles, directly applicable to health and social policy, were developed.[16]

Like other Treaty principles, the Commission's principles of Partnership, Protection, and Participation are drawn from both versions of the Treaty and are used to better understand how the Treaty may be applied.

The principle of Partnership is derived from the original Treaty Partnership and from a health perspective places an obligation on the Crown to include Māori in the design of health legislation, policies, and strategies. It draws on the idea that Māori should play an active role in whatever plans for Māori health are devised. Further, that these relationships extend beyond central government, to local government, and how interactions with local iwi can be improved.

This principle is in part designed to address concerns that health strategies are out of sync with contemporary Māori realities and that any targeted approach should be informed by the target group. This is true for Māori health strategies, but in any situation where disadvantage exists and where development is required. In the past Māori health issues were addressed through generic frameworks and an approach derived from the notion that cultural factors played only a minor role in the delivery of health services.

As a consequence Māori health gains were limited and it was only until cultural factors were introduced (and as part of the strategies developed by Pomare and Buck) that significant health gains were achieved. Certainly currently Māori health disparities will benefit from targeted approaches – but as discussed, these must necessarily be informed by Māori and Māori realities and consistent with the principle of Partnership.

The principle of Protection is in direct reference to the Preamble, Article 2 and 3 of the Treaty. It reflects on the Crown's duty to actively protect Māori interests and to

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16 Royal Commission on Social Policy, (1988), *The April Report,* Royal Commission on Social Policy, Wellington.

ensure that Māori are able to enjoy (at the very least) the same level of well-being as non-Māori. As noted, this principle is not designed to promote Māori privilege or to create an inequitable environment. In fact, the more fundamental objective of this principle is to eliminate inequities at all levels and to ensure that health outcomes for Māori and non-Māori are the same. In doing so two possible approaches exist. The first is to somehow slow or regress non-Māori health gains. The second, and more reasonable approach, is to lift the health status of Māori, through a range of mechanisms, and in a manner consistent with the notion of active protection.

Targeting Māori health, and in a way which leads to a reduction in disparities is another issues which has resulted in much debate about the best approach for this. Again, strategies which focus on a particular ethnic group appear to be falling out favour and are reflected in approaches which focus primarily on socio-economic factors or contributors. These ideas are based on good science and research and are consistent with what we know about the precipitators or poor health. However, a focus on socio-economic factors alone may fail to appreciate the role of culture as a determinant of health. The fact that strategies for health promotion, public health, health protection, and even primary health care can all be enhanced through cultural means. Moreover, and while socio-economic and demographic factors are major determinants of health – they do not explain fully, why disparities exist across different ethics groups.

The principle of Participation is linked to the principle of Partnership and Protection, but also the idea of Tino Rangatiratanga and the obligation to ensure that Māori are able to participate in the delivery of health services. For much of the last century, Māori participation within the health sector was largely confined to the role of consumer and even then access was not always guaranteed. Viewed from a health perspective, the principle of Participation is designed to encourage Māori involvement in the delivery of health services, but also in the planning and design of these and associated policies.[17] At present access difficulties play a significant role in the perpetuation of Māori health disparities. Addressing these require a range of strategies including the development of Māori health services and giving effect to the

17 Ibid

principle of participation. In addition – it places an associated emphasis on mainstream providers and in order to ensure that at risk populations (such as Māori) have the opportunity to access the type of care they need. The fact remains that the majority Māori access the health system through conventional mainstream health service. Despite efforts to improve access (particularly by PHOs) research suggests that care pathways are uneven and that in many cases Māori do not receive the type of care they require.

As seen, these principles are not discrete or mutually exclusive and in fact none of the principles can be applied in isolation and without considering how one affects the other. To this end the principles of Partnership, Protection, and Participation, while derived from the Treaty have a more fundamental objective and to promote and sustain positive Māori development. Indeed, and when plans for Māori health are developed, they must consider the broader issues of Māori employment, education, social and cultural well-being.

APPLICATION OF THE TREATY TO HEALTH

The extent to which these principles have been applied has varied and has largely depended on the willingness of successive governments to utilise the Treaty (principles or text) within the planning process. Needless to say, a consistent approach has yet to emerge. A major development occurred however, and with the introduction of the Public Health and Disability Act 2000. The Act was responsible for ushering in the current set of health reforms, however, and for Māori, the Act represented the first piece of social policy legislation to include references to the Treaty principles. In fact, and in so far as the Treaty is described within legislation, it is the principles, as opposed to the Treaty itself, which are used.

The inclusion of Treaty principles had a predictably negative impact on the legislation's passage through parliament and even now there is a move to have all references to Treaty principles removed from legislation. At the time the bill was being debated in parliament some were critical in that it would somehow afford Māori special privileges, though at the same time little had been made of the obvious disparities which led to its introduction in the first place. In this regard the Act (and in

particular the Treaty principles) has been caught up in the unfortunate debate over political correctness and ethnic privilege, when it's more fundamental purpose (to improve Māori health outcomes and reduce disparities) seems to have been lost.

Nevertheless the Act was eventually passed, though in a somewhat watered-down version. As well, and in order to establish clear parameters for the interpretation of these principles the Act is fairly prescriptive in terms of how these principles should be interpreted. This was in part to allay the fears of some and that the Treaty would not over-ride any other sections of the legislation but also to ensure that these principles did in fact facilitate a quantifiable outcome. For example (and with respect to the principles) the Act requires a minimum Māori membership on DHB boards, and the provision for Māori membership on DHB committees. As well, it requires that board members are familiar with the Treaty of Waitangi and Māori health issues.[18]

Nearly six years on, and despite the initial fears of some, the principles within the Act did not push Māori to the head of the cue nor did they miraculously transform our poor health statistics. What the Act proved however, was that the Treaty did have legislative relevance to social policy and health, and that despite conflicting views on how the Treaty should be interpreted and applied it was nevertheless possible to use the Treaty and without too much conflict or compromise. In hindsight, the Act also proved that applying the Treaty did not necessarily mean that the rights of others had to be compromised or eroded.

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18 T. Bennion, (2001), *Māori Law Review: A Monthly Review of Law Affecting Māori*, September Issue, Tom Bennion, Wellington.

CONCLUSIONS

This presentation has given a brief and albeit simplistic perspective on the connections between the Treaty of Waitangi and Māori health. Of course there are other issues which potentially could inform this discussion, however, added detail does not always bring with it added enlightenment. And certainly, an overly prescriptive and detailed discussion often results in the main issues or singular point being lost.

With this in mind, and if it is not already clear from the presentation, there are at least seven points which have hopefully been made and which may potentially improve your interactions with Māori.

The first is that the Treaty of 1840 was a contemporary response to the issues of the day and was a necessary mechanism in the face of significant and inevitable change.

The second is that Māori would not have signed the Treaty and unless they could see some benefit from it. In 1840, New Zealand was in fact made up of numerous and independent states, geographically defined by tribal boundaries, and well accustomed to negotiations, trade and debate. Māori were politically astute, a fact not missed by the Crown, and which would have influenced the overall design of the Treaty. To this end, signatures would not have been given lightly and without an expectation of something in return.

The third point is that while the Treaty was signed in 1840 it was always designed as a platform for future development. This is clear, not only from the language which was used, but also from the way in which Māori have always viewed it, and as a mechanism for contemporary development. Certainly, a number of issues have shifted it focus from the future to the past and as a consequence of numerous breaches and broken promises. Nevertheless, the opportunities presented by the Treaty still remain and may yet form a platform for mutual development and advancement.

The fourth point is that despite difficulties over the interpretation and meaning of the Treaty it has a clear and explicit relationship to heath. Whether examining the Māori or English text, the provisions or principles, the outcomes and conclusion are the

same. Over time, and largely as a result of broken promises, this connection has been lost and against the backdrop of land confiscations, indigenous rights and desires for self-determination. I am certainly not suggesting that these issues are not important or that Māori well-being was the only feature of the Treaty. However, and when the multiple applications of the Treaty are explored, then the issue of Māori health must, at the very least, be considered.

The fifth point is that the Crowns approach to the Treaty (and with respect to health) is neither clear nor consistent. The health reforms of 2000 did however illustrate a willingness to at least explore, within legislation, how the Treaty could influence the shape and design of the New Zealand health infrastructure. Some, especially Māori, were initially of the opinion that it would amount to little. However, and if there is one thing that will prevent the Treaty from being included within future plans or legislation it is the idea that it will somehow negatively impact on non-Māori, create division and Māori privilege. However, and while this Act could have made a more forceful Treaty statement, the fact that the predicted social fallout did not eventuate provides clear evidence that the seamless integration of the Treaty (within legislation) is quite possible If anything, the Act strengthens the argument for greater use of the Treaty throughout all legislation.

The sixth point, is that the Treaty may be applied in a variety of ways, at different levels, and in multiple settings. As described, the Treaty has been used to guide both health policy and health legislation. At another level it can also be used to assist health service delivery and more focused interactions between health professionals and clients. Despite confusion as to how the Treaty may be applied (especially to health) it is clear that once all perspectives are considered it is essentially about promoting or providing the best possible outcomes. In fact, this singular objective is perhaps the easiest way to understand the Treaty, and which reflects its fundamental intent.

Of course promoting the best outcomes at an individual level is the ultimate challenge, and there is no simple way of doing so. Some useful, pragmatic, and cost effective mechanisms have however been developed and which may usefully guide clinical interactions with Māori and assist with promoting health gains. Māori

signage, posters, or information booklets are fairly simple ways of adding a Māori feel to any environment and which make health services (in particular) more welcoming. And, while most patients are unlikely to be fluent (or even competent) speakers of Māori – information presented in Te Reo is likely to be of greater interest and likewise reveals a desire to at least consider Māori perspectives.

It is well considered that Māori may require more time and in order to reveal the precise nature of their health problem or in fact what their specific needs are. This may manifest in a way that means other, associated issues, are discussed first and before the more relevant concern is considered. In some cases it may also result in several consultations taking place - until an appropriate relationship is developed - and at which time the individual feels comfortable in discussing the actual issue.

Other sensitivities and behaviours may also be required. For example, immediately asking a client to reveal their name, without any preliminary remarks, could make some Māori feel apprehensive. As well, expecting Māori to engage in direct eye-to-eye contact could be interpreted as an invitation to demonstrate bad manners as looking at an older person in the eye could be viewed as a sign of dis-respect. Alternatives to the way in which health information is provided can also be explored. And, there is some evidence to suggest that non-compliance issues are directly linked to what and how information is presented.[19] Again, these are but some examples of simple approaches, but which may lead to measurable improvements in assessment, planning, compliance, recovery, and health outcomes.

The fundamental task of health professionals is to promote and protect health and well-being, to assist and aid recovery and to ensure that the best possible health outcomes are achieved. This is a constant and indiscriminate objective – one which is blind to ethnicity or nationality, culture or identity, socio-economic or demographic profiles. The mistake however is when these generic objectives for health and well-being are translated into generic approaches for health service delivery, treatment, and care. Aligned with this is the flawed assumption that treating people the same will somehow translate into similar health outcomes.

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The reality however, is that treating people the same is unlikely to result in similar outcomes and that ignoring cultural or ethic factors will only serve to widen existing disparities. This is sometimes difficult to fully appreciate and indeed seems counterintuitive to the ideals of a country which has often taken pride in its non-discriminatory approach to welfare and social service deliver. However, it is perhaps time that we re-focus our lens and place greater emphasis on achieving equity from the outcomes of care as opposed to neutrality in the delivery of health services.

The seventh, and final point, is that the Treaty is not about Māori privilege or a desire to erode non-Māori rights. What it is however, is about equality and balance - an expectation by Māori of equal access to health services, appropriate outcomes, and in the design and delivery of health policies and services. These issues are of course also based on need - Māori health inequalities, and any number of well-considered disparities. However, a needs based analysis is but one framework through which Māori health concerns can be addressed and in reality differs little from an approach derived from the Treaty. The only difference however, is that a Treaty based approach is likely to have broader Māori appeal – in part because it avoids a deficit based model, but fundamentally because it is aligned with Māori development, Māori advancement and a desire to focus on solutions rather than negative statistics. In this regard the Treaty may be considered as an appropriate framework for Māori health development.

Kia ora koutou.

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