

**THE TREATY OF WAITAINGI AND MĀORI HEALTH**

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## INTRODUCTION

The Treaty of Waitangi is often described as the founding document of our country and by formalising the initial relationship between Māori and the Crown. Signed on the 6<sup>th</sup> of February 1840 it was essentially a treaty of cessation and as such resulted in a transfer of sovereignty (or absolute control) from Māori to the British Crown.<sup>1</sup> 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 an exchange, and indeed these transfers of authority were not unconditional - and in fact the expectations of Māori at the time were considerable. There is 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 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.<sup>2</sup>

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. The purpose of this presentation, therefore, is to unravel and explore the Treaty of Waitangi, the implications of this exchange, and with a particular focus on

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

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

Māori health. While much of this discussion is focused on contemporary issues, a range of historical and background concerns are also considered and in order to provide an appropriate foundation and context.

## **A TREATY IS PLANNED**

There is no single view 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 - the cession of sovereignty, absolute control (by the Crown) of land matters, and 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 the impact unmanaged colonisation was having on the indigenous population. In an 1832 report to his superiors in England, James Busby (the official New Zealand Resident) noted 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.<sup>3</sup>

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.<sup>4</sup> William Hobson, New Zealand’s first Governor, 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.

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

<sup>4</sup> [http://www.dnzb.govt.nz/dnzb/default.asp?Find\\_Quick.asp?PersonEssay=1B54](http://www.dnzb.govt.nz/dnzb/default.asp?Find_Quick.asp?PersonEssay=1B54) (07/11/05)

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) to the Crown. For this to occur, a Treaty of cessation (the Treaty of Waitangi) was required. To this end, and while there were a number of reasons for the Treaty, certainly the issue of Māori health or welfare was not insignificant in terms of both shaping and selling the Treaty to Māori. Indeed, the English version of the Treaty makes specific reference to the idea of “Royal Protection” as well desire “to avert the evil consequences that must result from the absence of necessary laws and institutions”.<sup>5</sup>

### **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 “guestimate” is about 20,000.<sup>6</sup> 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

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

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

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.<sup>7</sup>

Cultural decay had a similar, 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.<sup>8</sup> The cumulative effect of these changes was a dramatic decline in the Māori population and with it a 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 the 1900s, 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.

## **RECOVERY**

Of course, the population did recover, and in a somewhat 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

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<sup>7</sup> M.H.Durie, (1994), *Whaiora: Māori Health Development*, Oxford University Press, Auckland. p 29

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

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.<sup>9</sup>

### **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 19<sup>th</sup>, and 20<sup>th</sup> 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 40 years after its signing, Judge Predergast 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.<sup>10</sup>

### **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

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<sup>9</sup> Durie, M. H., (1994), *Whaiora: Māori Health Development*, Oxford University Press, Auckland.

<sup>10</sup> M.H.Durie, (1998), *Te Mana te Kawanatanga: The Politics of Māori Self-Determination*, OUP, Melbourne, Australia.

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.

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. The Act under which the Tribunal was formed 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.<sup>11</sup>

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 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 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.

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<sup>11</sup> <http://www.waitangi-tribunal.govt.nz> (24/02/06)

## **THE TREATY TEXT AND MĀORI 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.

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 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.

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 in 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 an 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 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, had all developed their own set of principles and usually as a result of claims to the Waitangi Tribunal.<sup>12</sup> These principles were broadly consistent with each other and the Treaty, though were often situation specific and only applicable to a narrow range of issues. In 1988 however, the relationship between the Treaty, and social policy in particular, 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 Treaty, it wasn't until 1988 that a set of principles, directly applicable to health, were developed.<sup>13</sup>

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

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<sup>12</sup> School of Māori Studies, (2005), *Treaty of Waitangi in Contemporary Society: 150:202 Study Guide*, Massey University, Palmerston Nth.

<sup>13</sup> Royal Commission on Social Policy, (1988), *The April Report*, Royal Commission on Social Policy, Wellington.

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.

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 ensure that Māori are able to enjoy (at the very least) the same level of well-being as non-Māori.

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.<sup>14</sup>

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 it affects the others. 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.

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

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<sup>14</sup> Ibid

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 always used.

The inclusion of Treaty principles had a predictably negative impact on the legislation's passage through 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.

The Act is of additional interest because of the way in which the Treaty principles are described. As noted, not only have Treaty principles been difficult to identify, but they have also posed challenges in terms of their interpretation (particularly within legislation) and in order to ensure some kind of pragmatic outcome is achieved. However, 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.<sup>15</sup>

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 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 it 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, moreover, that non-Māori had nothing to fear from the exchange of 1840.

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<sup>15</sup> 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 six points which have hopefully been made.

The first is that the Treaty of 1840 was a response to the contemporary 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 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. Beside this, treaties with indigenous peoples are almost never locked into a particular point in time and even despite efforts to brush over their significance and as nothing more than an historical curiosity.

The fourth point is that despite difficulties over the interpretation and meaning of the Treaty it has a clear and unequivocal relationship to health. 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 Crown's 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, and final point, is linked to the previous and 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 is not a deficit based model, but fundamentally because it is aligned with Māori development or advancement and a desire to focus on solutions rather than negative statistics. Kia ora koutou.

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