# CULTURE, HEALTH, AND MĀORI DEVELOPMENT

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## INTRODUCTION

Official concerns over Māori health have been expressed for well over 170 years. In fact, and in 1837, James Busby notably described 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 unless there was some form of active intervention.[1]

These comments were a sharp contrast to earlier reports on Māori – which often described a healthy and vibrant people – though revealed the dramatic impact unmanaged colonisation was having on the native population.[2]

As a consequence, and as a direct result of these types of correspondence, a Crown plan for Māori health was suggested. And, although a number of different options were proposed, it was eventually decided to construct this around an 1840 Treaty of cessation – the Treaty of Waitangi. While of course much debate has focused on the more obvious provisions of the Treaty – the issue of sovereignty, land alienation, and translation difficulties - concerns over Māori health were not insignificant in terms of both shaping and selling the Treaty to Māori. To this end, the Treaty made specific references to Māori health and well-being, an offer of protection was also included, as was a broad desire to ensure that Māori interests were catered for. In many ways, the Treaty was New Zealand's first Māori health strategy.[3]

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

2 Bronwyn Dalley and Gavin McLean, (2006), *Frontier of Dreams: The Story of New Zealand,* Hodder Moa, Auckland.

3 Te K.R.Kingi, (2006), *The Treaty of Waitangi and Māori Health,* Te Pumanawa Hauora, School of Māori Studies, Massey University, Wellington.

However, the extent to which the Treaty facilitated Māori health gains (post 1840) is questionable to say the least. And, if population numbers are used as a crude measure, then certainly the strategy, overall, was lacking. In fact, and in the years immediately following the signing of the Treaty, the Māori population continued to fall. While it is impossible to attribute this decline to any one factor – certainly the impact of introduced diseases, warfare, land alienation, and cultural decay, were major contributors. By the turn of the century, the Māori population had declined by two thirds and it appeared that Busby's earlier prediction would in fact hold true.

The extent to which the Treaty may have prevented these problems or in fact facilitated Māori health gains is however uncertain. In that while the Māori population continued to fall (and throughout the 1800s), a failure to fully implement or recognise the Treaty (by the Crown at least), meant that its potential was never fully realised. As a broad strategy the Treaty may have assisted Māori health development, but without the drivers to implement it, these opportunities were not realised.

## POPULATION GROWTH AND DEVELOPMENT

By the turn of the 20th century many believed that the extinction of the Māori race was all but inevitable and helped reinforce the idea that a more strategic or focused approach to Māori health development was unnecessary. This may have explained the Crowns apparent apathy or ambivalence toward Māori health issues or indeed strengthened the notion that Māori health could be considered within a generic, Eurocentric framework.

Fortunately, a somewhat unlikely series of events meant that a new approach to Māori health could at least be explored. Key to this was the emergence of Māori leadership, in health and politics, which draw attention to the plight of Māori. In this regard the

efforts of Pomare, Buck, and Ngata provided a much needed catalyst for Māori health development, though did little to change the official view that the idea of "Māori health" was somewhat of a misnomer, in that the two words seemed hardly connected.[4]

Regardless of these views and a lack of political and financial support the three began to devise an approach to Māori health development. Fortunately, both Pomare and Buck were medically trained and well aware of what types of solutions were possible. Limited technology meant that basic medicines (including antibiotics) had yet to be developed and that treating many contagious diseases was merely an exercise of ensuring that the patient felt as comfortable as possible, while hoping for the best.

As a consequence, their efforts were directed at health promotion, health protection, and public health initiatives. This approach was based on the premise that most Māori had only limited access to treatment services and that once a disease had taken hold or been identified it was often too late anyway. However, it was also apparent that many Māori health concerns were linked to life-style, environmental, and behavioural factors – an approach broadly based on health promotion and public health would therefore provide the greatest opportunity for Māori health gains.[5]

Their theories on health promotion and protection would have certainly been influenced by their training and detailed understanding of how diseases were incubated and transmitted. They knew well that the cramped, damp, and cold conditions within which many Māori lived were health averse and that a lack of sanitation and ablution facilities created a fertile environment for the spread of disease. Development in these areas was therefore key and would possibly assist with the Māori recovery – however unlikely this appeared.

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

5 Ibid

Although, it was perhaps their understanding of Māori society and Māori culture which provided the critical ingredient. To this end, their plans were based on the principle that any strategy for Māori health development must align itself with Māori realities, Māori networks, and Māori ways of thinking. A failure to do would ensure (as in the past) that key health messages were lost or misinterpreted or further that any health gains were unsustainable and have limited effect.[6]

As a consequence, their approach was to actively engage the Māori community, to utilise Māori networks and to build a health workforce from within the existing tribal structures. This idea was based on two critical issues. First, a Māori health workforce did not exist and dedicated Government funding (for Māori health) was lacking. In order to create the required workforce there appeared no other alternative but to up-skill and train Māori as health workers. Second, and perhaps more critically was an understanding that a plan for Māori health development – whether based on existing theories on health promotion or public health – must fundamentally engage the Māori community in ways which made sense to them. While generic theories on health development would provide a base, cultural factors would ultimately create the pathway for this to occur.

By developing a tribally based workforce, local and customary knowledge could be used to enhance health outcomes. As the workers were drawn from the community they had a good understanding of what their particular health issues were and what approaches were most suitable. While most may have lacked the formal qualifications of other (non-Māori) health professionals, they were often leaders within their own tribes and therefore possessed skills in related areas, moreover, the authority to ensure that healthy practices were implemented and adopted. Whereas in the past the activities of health officers may have missed the mark due to a lack of

6 Ibid

cultural familiarity – Māori health workers were able to effectively engage their own communities and on appropriate terms.[7]

Measuring the success of these initiatives is difficult. However, and by again using crude measures of health (such as population) it is clear that these strategies coincided with a stabling and then increasing Māori population. A feat even more remarkable given the almost total lack of Government support. In reviewing these activities McLean[8] 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. 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.

## HEALTH GAINS AND HEALTH CHALLENGES

Pomare, Buck, and Ngata had successfully assisted with arresting the Māori population decline and were later joined by others such as Te Puea and Ratana as well as the Māori Women's Welfare and Health Leagues. And, while the population growth was slow - at first - an analysis of the 20th Century reveals a massive increase in the Māori population. A fact which is perhaps no better illustrated than by the some 604,000 New Zealanders who now claim Māori ancestry.[9]

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7 Ibid

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

9 http://www.maorilanguage.info/mao_pop_faq.html (31/05/ 06)

While the Māori race is no longer under threat, new and contemporary health issues have emerged and which will, in the coming years, similarly test Māori resilience and resolve. In meeting these challenges it is quite likely that new and innovative approaches to Māori health development will be required in order to combat a range of conditions which were more or less unknown in traditional times or even 100 years ago – mental illness, diabetes, obesity, heart disease, cancer, and motor vehicle accidents, to name but a few.[10]

As well, the contemporary environment has also changed and will likewise require innovation and originality in the design of Māori health strategies. Indeed, our lives are far more complex than they once were – we are certainly more sedentary, and have greater access to high fat and cholesterol forming foods.[11] And, although we are all likely to live longer than our parents there is no guarantee that we will necessarily be any healthier.[12] Furthermore, while access to the foreshore and seabed has apparently been improved – the majority of us still choose to live within urban areas and have limited access to the natural environment.

In many ways, and as noted, these issues call for a responsive and contemporary approach to health development – one which adequately reflects the current environment and which is cognisant of the modern challenges we now face. In constructing an overall approach to Māori health development, a focus on the future and the present is therefore imperative.

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10 School of Māori Studies, (2003), *Māori Health Foundations: Study Guide,* School of Māori Studies, Massey University, Wellington.

11 Ibid

12 Statistics New Zealand, (2004), *Life Expectancy Continues to Increase,* Media Release, Statistics New Zealand, Wellington.

However, while contemporary health strategies should align themselves with the modern environment, they should not necessarily ignore the experiences of the past and the manner in which historical gains in Māori health have been achieved. In this regard, there are two particular aspects of Māori health development that have remained constant (throughout our recent history) and which should accordingly inform our broad approach to Māori health.

The first is about leadership and the fact that Māori health gains have typically coincided with the emergence of Māori health leaders. This is clearly evidenced by the documented efforts of key individuals and organisations, and also by the work of others, though less well known, who have likewise assisted in progressing Māori health issues. Certainly, contemporary Māori health development requires broad leadership throughout the sector. Underlying this principle is the notion that Māori health is not (entirely at least) the responsibility of the government and that Māori must take an active role in the design and implementation of Māori health strategies – at a national level of course, but also more directly at iwi, hapu, and whānau levels.

The second point –the focus my presentation tonight – is that culture forms another fundamental requirement and must be considered within the design, development, and application of Māori health strategies. A failure to do so will ultimately reduce the effectiveness of any targeted approach and result in outcomes which are constrained or lack potential.

**THE CULTURAL DEBATE**

Despite the historical evidence, efforts by Māori to include culture as a consideration within the health sector have not been greeted with high enthusiasm. In fact, the idea that culture has some relationship to health seems to fly in the face of what many believe should underpin our health system. Certainly the issue of culture inevitably raises the prospect of treating people (or at least certain groups of people) differently. In the eyes of some this seems counterintuitive – and only serves to fuel the debate over ethnic privilege and by affording Māori access to additional rights, services or funding.

These types of concerns make for excellent political debate and certainly provide much in the way of fodder for our mainstream media. However, there has been less informed discussion as to why cultural perspectives in health are required – the fact that generic approaches typically lead to unbalanced outcomes (for Māori in particular) and that treating everyone the same has in fact resulted in ethnic privilege – but not for Māori.

## THE APPLICATION OF CULTURE TO HEALTH

While cultural perspectives were seen as key to reviving the fast diminishing Māori population at the turn of last century, it was not until the mid-1980s that culture was applied (in any formal way) within a clinical setting. One of the first health services to do so was Whaiora – a cultural therapy unit based within the old Tokanui mental hospital near Te Awamutu. [13] It is often said that the relationship between culture and health is no better illustrated than within the mental health sector and that thoughts, emotions, and feelings are fundamentally governed by implicit cultural values. It was little surprise therefore that the mental health sector was the first to embrace culture as a therapeutic intervention and as way of enhancing treatment outcomes for Māori.

Initial attempts at merging the cultural/clinical interface were largely aimed at assisting with more conventional therapeutic interventions - by creating a treatment environment or setting which appealed to Maori, but which was essentially based on western theories of treatment and care. Māori signage and the periodic introduction of Māori protocol were an example of this. However, and as the benefits of such activities were revealed, more sophisticated mechanisms were trialled and in order to further enhance treatment outcomes, compliance, and patient receptivity.

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13 J. F. A. Rankin, (1986), 'Whaiora: A Māori Cultural Therapy Unit', in *Community Mental Health New Zealand,* vol. 3, no. 2, pp. 38-47.

As a consequence, and by the mid-1990s, a number of frameworks had been developed and which sought to more clearly define how cultural practices or approaches could enhance clinical outcomes. Based on both evidence and experience, these frameworks usefully illustrated how and when culture could be used – but more importantly why it should.

## CULTURAL ACTIVITIES AND SERVICE PROVISION

Although the application of culture to health has tended to vary, there is at least some broad consistency within the mental health sector and in terms of what may lead to health gains. Pōwhiri, for example, has been used to good effect and as a means of enhancing the relationships between service providers and service users. Of course, and recently, the whole idea of pōwhiri within the public sector has been the subject of considerable debate. Some, particularly certain members of parliament, are concerned that these types of cultural activities have little place within the modern world – though at the same time seem happy to endorse and even protect much of the pomp and ceremony which surrounds our parliamentary process. Others, appear particularly concerned with seating arrangements and how certain gender roles are prescribed. This again however reflects a lack of insight and broader cultural understanding – an assumption that one's seating position is somehow linked to an individual's authority and status.

While this may be the case in many western institutions, anyone who has attended or actively participated in a marae based powhiri would soon realise that those speaking (or sitting in the front) are not always those that command the most influence – in fact (and in my experience) most speakers tend to receive their instructions from behind anyway - through an aunty or grandmother and often via the wharekai or kitchen.

Anyway, my point is that powhiri should not be viewed through a narrow lens and that the activities and interactions which surround it are more than just a simple process of encounter or welcome. From a health perspective, a deeper analysis reveals that this activity can also be quite settling, putting the patient and their whānau at ease, providing comfort, and creating an environment which supports recovery and rehabilitation. The formalities which guide the pōwhiri are consistent

with contemporary Māori expectations – a desire to establish a platform or springboard for ongoing care, to arrive at a common understanding, to establish parameters for engagement, and perhaps most importantly, to offer reassurance. [14]

Kaumātua or cultural advisors are now also employed within many 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 with Tangata Whaiora (particularly within the mental health sector), 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 and can likewise assist the clinical assessment process.

Te Reo Māori has also been used within Māori mental health services (for a number of years) and as means of engaging Tangata Whaiora. And, while it is accepted that most Māori are sufficiently capable of understanding and speaking Te Reo Pākehā, many are more comfortable conversing in Māori and may therefore reveal a broader and deeper range of issues. Some are in fact uncomfortable with providing detail on their personal lives and activities, and although this might be a problem regardless of language or culture, there is a tendency for Māori to describe much more within Te Reo Māori. Again, assisting with assessment and ensuring that all possible concerns are considered.

Whānau participation is likewise a characteristic of many Māori services. It is in many ways a feature of Māori culture and society and therefore appears within most Māori models of health. Whānau and the relationships that exist within them provide a base for cultural interaction and likewise a mechanism through which cultural knowledge is

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14 Te Pūmanawa Hauora, (1995), *Guidelines for Purchasing Personal Mental Health Services for Māori,* Te Pūmanawa Hauora, Department of Māori Studies, Massey University, Palmerston North.

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 therapeutic 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 Tangata Whaiora. These are often issues that clinicians are particularly interested in but are unable to completely appreciate without whānau input.[15] Although access to whānau is sometimes difficult and participation not always recommended – of significance is the potential of whānau involvement and the manner in which this is used to enhance both treatment and outcomes.

Māori leisure pursuits include painting, flax weaving, wood carving, taniko, kite making and flying, bone carving, singing and playing musical instruments have also been used to good effect. In this regard occupational therapy activities become more relevant when Māori crafts are introduced. Similarly when it is difficult to converse with words, non-verbal cultural activities may produce a greater sense of effective communication. A teenager for example may say more with a guitar than with a string of words, a reminder that programmes which depend on an exchange of words do not always appeal to Māori.

More broadly, the adaptation of Tikanga Māori (or Māori culture) within a health setting has included a variety of practices such as the manner in which visitors are received, the way meetings are conducted, group decision making processes, opportunities for consensus development, reciprocity and sharing of resources. The

15 Ibid.

underlying themes reflect group (rather than individual) bias, formality (rather than a lack of structure) and process (rather than outputs). Often Māori language is the means of communication, at least for some events, and more often than not an older person (kaumātua, whaea) lends guidance to the proceedings. While there is debate about the appropriateness of introducing tikanga into situations remote from a marae, and the risks of cultural compromise which can threaten the integrity of tikanga, in practice, Māori clients and whānau are even more uncomfortable when some aspects of tikanga are not observed.[16]

## CULTURAL APPROACHES TO PRIMARY HEALTH CARE

At a primary health care level, and within general practice, aligned mechanisms have also been developed and in order maximise opportunities for health gains. We know that Māori access primary health care in unusual ways and that these patterns have a detrimental impact on health outcomes. For example, a recent survey of GP's revealed that compliance issues appear to be a problem, as does the fact that Māori tend to access care late, have little knowledge of their medical history, and may be less forthcoming when explaining the nature of their health concern.[17] These types of issues tend to frustrate general practice physicians and obviously reduce the chances of a positive prognosis.

However, and to a large extent the underlying reasons for these problems have been linked to socio-economic or demographic characteristics and that poverty (in particular) is to blame. Of course, this may in fact be part of the issue, however, it cannot explain fully, why these problems occur - and even amongst so-called wealthy Māori.

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16 Ibid

17 http://www.nzma.org.nz/journal/115-1167/272/

In an attempt to better understand and address these various difficulties, some have actively employed culture as a routine part of service delivery. The basic approach recognises that these behaviours may in fact be influenced by cultural norms as opposed to any socio-economic variable – moreover, and by recognising these differences health outcomes can be enhanced. Again, it appears that these methods may not sit comfortably with everyone (especially clinicians) as it similarly raises the unpalatable prospect of treating people differently. Despite the fact that treating patients the same will only serve to perpetuate existing difficulties.

Nevertheless some interesting approaches have been developed and which align culture to health. Māori signage, posters, or information booklets are fairly simple ways of adding a Māori feel to any environment and which make waiting rooms (in particular) more welcoming. The employment of Māori staff is a further step which can likewise make an often difficult visit, more bearable. Although these strategies are unlikely to address the issue of late presentation (and the numerous problems associated) they will at least encourage access, ongoing care, and hopefully make some measurable contribution to improved health outcomes.

Allowing additional time during clinical examinations or consultations is often difficult but is likely to result in a better relationship with Māori patients, an improved understanding of the problem, and a greater feel for how information can be shared and what options for care should be advanced. Tipene-leach also notes that expecting Māori to engage in direct eye-to-eye contact may be detrimental to the consultation process as it could be interpreted as an invitation to demonstrate bad manners or viewed as a sign of dis-respect.[18] Similarly, medical or nursing examinations involving the head, sexual organs, hair, or nail clippings, are likely to require a measure of caution and a greater degree of circumspection.

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18 M.H.Durie, (1994), *Whaiora: Māori Health Development,* Oxford University Press, Auckland. p 67

Of course these approaches are unlikely to address completely the problems described though provide some insight into why so-called unusual Māori behaviours occur. Significantly, how simple approaches or considerations can lead to improved health outcomes.

## PUBLIC HEALTH, HEALTH PROMOTION, AND HEALTH PROTECTION

Of course, and as demonstrated by the work of Pomare and Buck, culture can also play a much broader role in the delivery and design of public health, health promotion, and health protection initiatives. As a strategy for Māori health development, these type of activities are particularly useful in that they attempt to create a structure or environment which prevent health problems from occurring and which likewise support an adoption of healthy lifestyles.

It is well considered that many of the health problems currently faced by Māori are a direct consequence of unhealthy behaviours and environments, systemic and socioeconomic factors which cumulatively create a fertile bed for the growth of disease. Fortunately, however, many of these problems (and particularly those related to lifestyle and behavioural concerns) respond well to positively targeted health promotion strategies and in fact the potential for Māori health development here is significant. If we are indeed sincere in our efforts to move the ambulance from the bottom to the top of the cliff then a more sustained and targeted approach to these types of initiatives is required.

In creating environments which support the adoption of healthy lifestyles a number of different mechanisms are required. Macro level policies have an obvious impact through the creation and distribution of wealth. Likewise, the availability of health services and access to these can similarly influence health status and health outcomes. However, in addressing behavioural and lifestyle factors more direct mechanisms are possible. Encouraging communities, groups and individuals to drink and smoke less, exercise more, eat healthier, and to take less health risks will inevitably lead to population health gains. Such initiatives will likely reduce rates of diabetes, heart disease, obesity, mental health problems, certain forms of cancer, motor vehicle

injuries and deaths. The economic, social, and health benefits of such an approach are significant.

Unlocking this potential for health gains relies on a number of factors. Funding issues (within public health and health promotion in particular) have always been an issue and indeed when vote health monies are being distributed it is far easier to justify the benefits of a hip replacement than the number of lives "potentially" saved by a "drink-safe" initiative.

Another critical issue however has to do with the manner in which key health messages are transferred and the capacity of the target audience to appropriately respond – to take a more positive approach to health and to engage in lifestyles which mitigate the risks of ill-health.

In delivering health messages it is therefore imperative that these are given in the right way, in a manner which makes sense to the target group, and which appreciates their social and cultural realities. Accordingly, a generic approach, or at least an approach which lacks cultural familiarity, may miss the point and result in outcomes which fall short of potential or which fail to fully appreciate what is possible.

Therefore, and in maximising this potential, a number of mechanism have been used to good effect. Again, and as illustrated by the developments at the turn of last century it is imperative that those delivering the health messages have some familiarity with the target group. Indeed the capacity to engage in an appropriate way is perhaps of greater significance than possessing more formal or technical skills. In a modern setting Māori health promotion and health protection workers provide the critical interface. More often than not these workers are drawn from the local community or have close ties (through whakapapa) to the area.

This approach however, is based on more than simple nepotism, and ensures that those involved in health initiatives are familiar to the local community. This familiarity means that local issues rather than national priorities can be targeted and where strategies are developed and in order to better engage the community. In doing

so the realities of local life are considered alongside opportunities for health education. This often requires visits to local marae or sports clubs, or appearances at certain hui, birthdays, tangi or other events.

Drawing health workers from the local community or iwi is also designed to enhance the effectiveness and delivery of health messages. This is in part because these people are familiar, but also because they have a long standing relationship with the people they serve. These relationships cannot be taught or manufactured yet are critical factors in the promotion of healthy behaviours. Indeed, Māori are unlikely to embrace the advice of health professionals if their ideas are foreign to them or these are presented in ways which fail to match their own realities. To this end, our communities are more likely to heed the advice of an aunty waving a stick rather than a well qualified physician waving a pamphlet.

**CONCLUSIONS**

As many of you will be aware the arrival of the constellation Matariki signals the dawn of the Māori New Year. In traditional times, Matariki arrived at the end of harvest and was therefore a time of plenty, a time for celebration, for reflection, for growth and new beginnings. The seven stars which make up this cluster are also known to other cultures, by different names of course and with different interpretations - but always as a sign of a significant event or change.

To the ancient Greeks, Matariki was known as Pleiades or the seven sisters, while in Japan the word Subaru is used. Like Māori, the ancient Inca civilisation also considered the appearance of Matariki as a time for celebration and rebirth. Similarly, African tradition links Matariki to agricultural harvest and the promise of a fruitful year to come.

While there are many cross-cultural similarities associated with this constellation – the most obvious (and perhaps most consistent) is the number seven, which is of course linked to the seven stars which make up the cluster. In recognition of this fact and in aligning this presentation with the broader Matariki lecture series, I've decided to extract seven key themes from this paper and as a summary of the major points.

The first, if not already clear, is that culture and health share a strong bond - a relationship which must be carefully nurtured and in order to further progress Māori health development.

The second is that while we all share similar anatomical and biological parallels our perspectives on health and well-being are far from uniform. To this end, culture plays a significant role in how our perceptions on health are formed – how health messages are delivered, treatment administered, and outcome identified.

The third point is linked to the previous and the fact that the health sector is not culturally neutral. In fact, and despite efforts to ensure "sameness" and "uniformity" in health service provision the constructs within which these services are delivered often reflect significant cultural bias. This of course may come as a surprise to many within mainstream society, but is perhaps a reflection of the fact that this bias typically matches their own realities and concepts of what is right and appropriate.

The fourth point therefore is that uniformity in health service provision does not equate with uniformity in health outcomes. This is perhaps our greatest folly and that while we have often tended to focus on improving access to health service we need to similarly explore the manner which these services are delivered and how outcomes (particularly for groups such as Māori) can be enhanced.

Point five is simple, and considers the need to reflect on and build upon our past. I am certainly not advocating a return to the ancient times - but that we take the opportunity to learn from our past, the mistakes made as well as the significant successes achieved.

Point six leads on from point five to identify what lesson from the past may exist. In this regard we should recognise the importance of Māori leadership to Māori health, to develop proactive solution based strategies – and despite the risks involved and challenges faced. The role of whānau to Māori health development must also be considered as should the tenacity of our people to ensure better health and well-being for the generations to come. Indeed, these issues (and in particular the efforts of our

tipuna) place expectations on the current generation and that the opportunity to enjoy good health should not be wasted or taken lightly.

My final point is that arguments for a more aligned health sector cannot rely on cultural, indigenous or even Treaty based principles. In fact the current political environment tends to regard such issues as more of a risk than opportunity. Accordingly, the justification for the inclusion of culture within health must be made in terms which make sense to the health sector. Therefore, and as shown within this presentation, my last point is that the adaptation of cultural to health actually has little to do with culture per se - and everything to do with health, well-being, equity, and the reduction of health disparities.

If we are to progress Māori health development then a number of macro and micro level strategies are required (and integrated approach) one which is based on evidence, and able to draw on a range of proven techniques. Within this, culture should be viewed as a valid option, part of a broader toolkit, and through which sustained gains in Māori health can be achieved.

Again, this is not an option but an obligation – to ourselves, our past, and future.

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