

Te Mata o te Tau
Academy for Māori Research and Scholarship

He Hokinga Mahara he Kitenga Huarahi
A Memory from the Past, a Pathway to the Future

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Introduction

2003 is significant for a number of reasons. This year we reached a population milestone passing the 4,000,000 mark. As well, issues over the foreshore and sea bed have been the focus of much media attention. To many, also, 2003 will be remembered for the Rugby world cup, the absence of certain key players, the value of hindsight and the importance of adequate planning, effective choices and strategies.

All these issues have implications for the future of New Zealand – a growing population, ethnic diversity, and changes in the dependency ratio will inevitable impact on the way in which policies are formulated, what might be expected, and what challenges will need to be faced. Treaty issues also require further and informed deliberation to elucidate what concerns exist and to reach solutions that are fair and acceptable. In terms of the world cup, the reaction is even more certain in that a new coach is likely, other administrative functions will change, with the hope that the outcome in 2007 will be much improved.

To achieve our goals or any objective, the importance of effective planning is therefore imperative. It is often said that a preferred Māori approach to planning is to look to the past for guidance – to consider where we have come from in order to predict the way forward, what opportunities exist and what potential solutions there might be. He hokinga mahara he kitenga huarahi is sometimes used to describe this concept and loosely translates to mean - a memory from the past, a pathway to the future.

In recognition of this and in reflecting on the purpose of this conference I've decided to look back in time, to unravel the past, with the aim of providing clues as to where we might head, for Māori in particular, but as a nation as a whole.

Background

It is without question that the issues we face today are somewhat different to that of our ancestors. One hundred and sixty years ago the environment we lived in was quite different and the challenges we faced equally diverse. For Māori, at the time, health was of major concern and somewhat reflected in the desire to engage with the new settlers, to enter into some kind of formal dialogue and to arrest the negative consequences of contact and rapid lifestyle change. The Treaty of Waitangi was the eventual outcome, and, while much of the discourse surrounding it has focused on issues of sovereignty, land acquisition, or textual differences – concerns over Māori health provided much of the backdrop and were not insignificant in terms of both shaping and selling the Treaty.

In the decades prior to the signing of the Treaty Māori had already undergone considerable social change. While accurate figures are not available - by 1800 it was estimated that the Māori population was around 150,000. By all accounts the people were fit, healthy, and vibrant – though not immune to disease, calamity or illness. Yet, by 1837, and when noting the need for intervention, James Busby reflected on the plight of the Māori. In his dispatch to his superiors he noted the “miserable condition” of the Māori which promised to “leave the country destitute of a single aboriginal inhabitant.”

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. The Treaty was seen, at least in part, as a way in which a more managed approach to settlement could be facilitated. However, and if these objectives were seen as a vehicle for Māori health development, the mechanism proved ineffective.

Subsequent to the signing of the Treaty, and throughout the 19th century, steady and rapid decline was the main feature of the Māori population. As noted, infectious diseases were a main cause of death, however, other factors also played a role – structural changes within the tribes were significant as was the impact of various conflicts.

In the first fifty years of the 19th century Māori society had changed to such an extent that many believed a return to traditional lifestyles and practices was impossible, Māori were now part of a global network and thus required to adapt to these changes – present were both opportunities and threats. Unfortunately, adaptation to this new global environment was difficult, planning was at best “ad-hoc” and compounded by an inability of Māori to negotiate the rate and structure of this change.

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

Apart from these physical features and mechanism, social practices had also evolved to ensure health and well-being. The concept of tapu and noa was often used to promote and protect health. Unfortunately, these practices were too frequently misinterpreted by anthropologists who often misread their fundamental purpose (in terms of health) and chose instead to focus on mystical or supernatural interpretations. Examples which illustrate the health implications of tapu and noa are not difficult to find. Immediately following birth women were considered tapu. However, the reason for this had less to do with custom and more likely a means through which lactation could be facilitated, to aid recovery, and to permit bonding between mother and child. Likewise, areas of the sea that were known to be dangerous were also tapu and further meant that accidents were avoided. Nesting birds were tapu and ensured that hunting, from year to year, would be successful. Raw meat was tapu, but after being cooked became noa or safe. Semi-completed dwellings were tapu, for a time, and until beams had been fastened and secured, at which point they too became noa.

These types of social structures and mechanism had as much to do with health as they did with tradition or custom. They had evolved over time and were an effective means of ensuring the survival of future generations. For the most part activities of the Māori were focused, fundamentally, on survival – the idea of the noble savage has not help many of these misconceptions, nor has more contemporary notions of “Once were Warriors”. As Moana Jackson put it – a more accurate description would be “Once were Farmers”

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

Wars, between tribes or over land, were also significant in terms of both morbidity and mortality. The musket was a significant technological advancement that proved an effective means of inflicting harm and on a scale that was not previously possible. At the time it truly was “a weapon of mass destruction”. From the 1840’s through to the 1870’s conflict between Māori and settler escalated. Both sides inevitably suffered as a consequence. Estimate on the number of British and Settler deaths are reasonable accurate. However, the number Māori deaths are more difficult to determine as many tribes were known to remove the dead from the battlefields.

The cumulative effects of these issues, disease, social change, and warfare, were significant, so much so that by 1896 the Māori population had reached an all-time low of just 46,000. Real concern was expressed as to whether or not the Māori would see much of the 20th century, extinction was anticipated if not inevitable. In the late 1800’s, and in reflecting on these concerns, Dr Isaac Featherston made comment and suggest that:

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

Twentieth Century Recovery

Māori entry into the 20th century was, therefore, somewhat unexpected and certainly unspectacular. Despite a relatively well-developed and well-meaning health service infrastructure, expectations for Māori health development were not high. By 1900 New Zealand had in place a fairly robust health system. For the most part this had emerged out of 18th-century England and the desire to cater more appropriately for those who, through financial incapacity, were unable to arrange their own care. Social stratification had in many ways shaped colonial attitudes to health, especially the British, but also the Scottish and Irish immigrants, many of whom had negative experiences of their homelands as a consequence of the reorganisation of rural Scotland and Ireland during the 19th century. Many colonists had a heightened sense of social and moral justice, particularly as it applied to the care of the poor or those who had traditionally (within Britain at least) suffered through the class system. Other factors further served to reinforce this notion, including the concept of ‘co-operative community’, and the idea that sickness and poverty were burdens to be shared by the community rather than the individual. Although these ideals were not universally held, or consistently applied, they reflected a collective approach to health as well as the desire to initiate a system of health care provision so that even those badly off, could receive attention.

Unfortunately, it was assumed that Māori needs could be catered for within this standard framework – this despite little signs of progress. In an attempt to arrest further population decline small but significant policy changes occurred. Before 1900, the Native Department (which was largely responsible for Māori issues) had shown all but minimal interest in Māori health and, for the most part, was preoccupied with matters of a more political nature, especially land acquisitions and those other ‘native’ situations that inevitably arose out of this process.

This guarded attitude to Māori health was somewhat surprising, as a number of individuals, including Florence Nightingale, had detailed the benefits of Māori-specific health strategies, noting in particular the value of improved nutrition,

housing, and public health measures. In 1884, the Native Minister commissioned a plan for Māori health reform that outlined health promotion and protection measures as well as community-based, early intervention initiatives. Yet despite the evidence, the Native Department often showed little interest in Māori social policy, except in education and in situations where assimilatory policies could be nurtured.

The Public Health Act of 1900 and the subsequent establishment of the Department of Public Health, however, provided direction for Māori health, in part because a means had been created for a more co-ordinated health service infrastructure, but more importantly because Māori had been included within the Department's designated responsibilities. Although the Department placed little emphasis on Māori health, and was initially more concerned with a potential outbreak of bubonic plague the process did at least ensure that public health was included within the Government's social policy agenda. Māori health problems were in many ways linked to public health concerns and this at least provided a mechanism through which issues of this nature could be afforded attention.

Other positive developments occurred when in 1901 Maui Pomare was appointed 'Health Commissioner for the Natives', and later in 1905, was joined by Te Rangihiroa (Peter Buck). Both were medical practitioners and well aware of the poor state of Māori health. Further, they identified the need to involve the Māori community in any developments, especially as no dedicated Māori health workforce existed. Adding to these problems was the issue of finance and the scant amount of funding set aside for Māori health. The Native Civil List allowance of £7,000 p.a. (from which Māori health funding was drawn) had not changed since 1852, moreover only about £3,000 was earmarked for expenditure on health.

McLean notes that Pomare had achieved some improvement in sanitation of the Māori villages, and had stimulated the Māori to look forward to the future with greater hope. In the six years, 1904 to 1909, some 1,256 unsatisfactory Māori dwellings had been demolished, and 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.

McLean states that what had been achieved was due to the personal efforts of Pomare and Buck and a small bank of inspectors.

Notwithstanding these financial and political impediments, both Pomare and Buck were instrumental in arresting what appeared to be an inevitable extinction. They actively engaged the Māori community and supported the provisions of the Māori Councils Act (1900). Under the Act, a range of public health functions was devolved into a network of regional Māori councils, and although some problems were noted, the councils appeared to function well, and were especially useful in promoting sanitary and housing regulations. Ongoing political bickering as to the council responsibilities and effectiveness, as well as cuts in funding, eventually meant they were to become nothing more than tokens. But their effectiveness had been widely recognised.

Despite political frustrations and bickering, the contribution of Pomare, Buck, and the Māori councils (as well as others) to Māori health, was significant – particularly at the turn of last century and at a time when real concerns as to survival of the population were being expressed. The introduction of Māori expertise had been accomplished and health gains were achieved as a consequence. In reviewing the contribution by Māori to Māori health development, Durie highlights the efforts of Pomare and Buck, the Māori Councils, the Division of Māori Hygiene, as well as the work of Te Puia and Ratana. Later, between 1930 and 1975, the efforts of the Women's Health League and Māori Women's Welfare league were further examined, as well as their approach that similarly built on Māori networks, traditional structures, and mechanisms based around whānau. Durie also explores the more contemporary efforts by Māori to engage the health system, the development of Māori specific health services, the thrust these services provided, and the difficulties posed through inadequate and often short-term contracting, a policy environment where the goal posts were frequently moved.

New Challenges

While the Māori population is no longer under threat of extinction new challenges are yet to be faced. If measures of health were based on life expectancy, population growth, and fertility then it is certain that Māori are now healthier than in any other time in history. However, these measures are imperfect indicators, and often fail to account for relative health status, levels of morbidity or mortality, the higher prevalence of preventable disease.

In 1903, the major health threats to Māori were typhoid, influenza, measles, scarlet fever, diphtheria, tuberculosis, pneumonia, malnutrition, and goitre. In 2003, however, the pattern has changed. The misuse of alcohol and drugs is of major concern and will further be compounded by the impending “P” epidemic. Aids, heart disease, cancer, asthma, diabetes, obesity, and motor vehicle accidents are also significant issues for Māori. Sadly, many are lifestyle related, preventable, or compounded by socio-economic circumstance.

Māori Mental Health

Another issue for Māori is mental health (or illness) which is now considered to be the number one contemporary health threat facing Māori. Historically, there was little evidence to suggest that mental health issues were of any particular concern to Māori. Many of the early investigations into Māori mental health were undertaken by anthropologists. And, there is some debate as to the accuracy of their observations and whether or not Māori behaviours could have been mis-interpreted or mis-read through western-eyes, expectations, and norms. At its most basic level, mental health problems may be defined according to a set of parameters, which govern the extent to which behaviour is accepted or otherwise classified as being abnormal. Often these parameters are founded on notions of normality that are in turn, more often than not, grounded in cultural bias. As a consequence, what is rational and clear in one system of knowledge or cultural belief, may become distorted and misread if it is analysed within the constructs of another body of knowledge. Normal and/or acceptable behaviour in one culture may be viewed as alternative, different, or even psychotic within another. Moreover, and from a Māori perspective, the apparent symptoms or characteristics of disease were not always viewed negatively, rather a gift to be nurtured or revered.

From an historical perspective such issues have a range of implications and bring into question the ability of non-Māori historians, academics or anthropologists to assess the perceived abnormal behaviours of individuals within Māori communities. Nevertheless, it appears that mental health problems were not significant and that physical health issues were, at the time, of much greater concern.

One of the first investigations into Māori mental health was conducted by Earnest Beaglehole during the 1940's. He noted that the incidence of all types of mental disorders among Māori was about a third of the general population. Psychotic disorders among Māori inmates were about half that of Pākehā, and that while 14% of returned Pakeha soldiers were diagnosed with mental health problems, the corresponding Māori rate was about 7%.

Other investigations showed similar patterns. In 1951, Blake-Palmer reported that the incidence of Māori admissions to psychiatric hospitals was less than half that of the non-Māori population. In 1960, 60 in every 100,000 Māori were admitted for the first time to a psychiatric hospital compared with a non-Māori rate of 119 per 100,000. In 1962, Foster further noted that for both males and females lower admission rates for Māori, in all age groups and for most disease categories, could be expected. Psychoneurosis, for example, accounted for only 7 percent of all Māori first admission compared with the corresponding non-Māori rate of 21 percent. In addition, the rate of psychosis related to old age was much higher for non-Māori. Alcoholism and manic-depression were also lower. Durie states:

“...during the nineteen fifties, non-Māori admission rates to psychiatric hospitals were relatively high, mental hospitals were comparatively large and general hospital psychiatric units were few and small. It was the era of institutional care; interestingly, Māori did not feature as significant consumers.”

The reasons for these lower statistics are uncertain. As much of the data was based on admissions, and given the preference by Māori for home care, it is entirely likely that some with mental health problems would not have been recorded in official statistics.

A relaxed approach to the collection of ethnicity information would have also impacted on data quality. Regardless, the rate was certainly much lower than that of the general population and lead to some interesting theories as to why.

One of the less well considered was again put forward by Beaglehole in the 1940's and was of interest due to the fact that Māori mental health problems were not significant. However, he made a somewhat prophetic comment in that he suspected that the rates would increase, over time, to more approximate the non-Māori figures, and as a consequence of cultural decay and the breakdown of traditional support structures. History, unfortunately, has confirmed this hypothesis.

Increasing Māori Admissions

By the mid-1970s, the apparent low prevalence of mental disorders among Māori was to change somewhat dramatically. In contrast to historical patterns, the past 30 years has seen a significant increase in the number of Māori accessing mental health facilities. The implications have been considerable and have led, in part, to the development of Māori-specific treatment facilities, and an increased emphasis on special mental health policies for Māori.

By the mid-1980s the rates of Māori psychiatric admissions were two, and in some categories, three times that of non-Māori. Problems related to alcohol and drug misuse were particularly evident over this period, though additional concerns were linked to the manner in which Māori were accessing psychiatric facilities. Increasingly, large numbers were being admitted under compulsion, through the justice system, rather than through conventional medical referral systems.

Between 1960 and 1990, non-Māori first-time admissions to psychiatric facilities, had only slightly increased. However, the corresponding Māori rate (over the same period) was more than 200 percent. Māori readmissions were cause for further concern. Readmission rates for Māori males increased by 65 percent between 1984 and 1994, nearly two times higher than non-Māori male rates and three times higher than corresponding Pacific Island rates. While showing an overall decrease, admissions for drug and alcohol disorders have also remained a major concern for

young people and especially Māori, both male and female. Heavy drug use amongst young Māori, particularly cannabis, has also led to a dramatic increase in drug-related disorders. Psychosis and alcohol and drug abuse account for almost a third of first admission. Māori readmission rates for affective disorders and psychotic illness, other than schizophrenia or drug or alcohol psychosis, were 36 percent for women and 75 percent for men higher than corresponding non-Māori rates. Schizophrenic psychosis is currently the second most common cause of admission for Māori males, with a rate of 2.7 per 10,000, twice the rate of non-Māori. Disproportionate numbers of Māori mental health referrals are from law enforcement or welfare services. This suggests that early access to mental health facilities is often problematic, with outcomes likely to be less favourable.

Studies have also shown that Māori are over-represented in terms of acute psychiatric admissions, accounting for 23 percent. Other investigations have also suggested that Māori spend on average 40 percent less time in hospital (due to mental health problems) compared with non-Māori, in spite of being admitted for more serious diagnoses.

Connected to mental is the issue of suicide. And, if mental health constitutes the single most significant threat to Māori health, then within this suicide must surely feature as a major contributor. As with the issues previously discussed, Māori suicide is a recent phenomena and was traditionally unknown, except by widows during bereavement. In more contemporary times however some disturbing trends have emerged. Between 1980 and 1991, suicide rates for Māori males had increased by 162 percent. And between 1984 and 1994 it was noted that the overall rates of Māori suicide had increased significantly and to such an extent that it was the second most common cause of death for young Māori behind motor vehicle crashes. In 1996 the Māori rates of youth suicide were about 38 per 100,000 with the non-Māori rate about 24. Of added concern is the fact that for every successful suicide there are about 8 or nine unsuccessful attempts.

For both Māori and non-Māori the effects of suicide are equally devastating and impact in ways that extend throughout these families and the communities within which they live. The solutions are complex and there are no easy answers. However, it is possible to provide some clues and to identify the kind of the issues that may help guide us. As I mentioned earlier, a look to the past can give direction to the future or at the very least offer hope and inspiration. There are of course many things that can be taken from this discussion, but I would like to identify a few that you may want to consider and which might inform the work that you do.

The first is that the health problems and issues we currently face are likely to change. But will only do so through co-ordinated and concerted efforts. Perhaps in 2104 a similar health conference will take place and reflect on the issues we face today, and, importantly how they were challenged and overcome. It is entirely likely that this future review will detail the problems faced, political apathy, issues of funding, or perhaps the indifference to which such problems were treated. It is also likely that the work and dedication of like-minded individuals will be profiled and how the efforts of those in 21st century eventually paid dues, to overcome adversity and work toward sustainable Solutions.

People is another related point and reflects on the value of the health workforce. Both Pomare and Buck were quick to realise this imperative and the fact that large tasks require co-ordination, collaboration, and dedication. They also showed that leadership comes in many forms and that health workers need not have formal qualifications, health training or a medical background. Rather, that complementary skills are required, an awareness of the issues, a desire to make positive change, respect within their communities, and an ability to empower others.

The third point is that health problems, including suicide, cannot be viewed in isolation or distanced from the context within which they take place. Health is not merely about service delivery or treatment, but about creating supportive environments, collective and integrated approaches. Health problems are more pronounced in situations where socio-economic disadvantage is greatest, where lifestyles are trapped, and where unemployment, violence, abuse, or deprivation is the norm. The concept of Integration is therefore important and reflects on the notion

that the promotion of good health is not merely the role of the health sector, but a responsibility of all sectors and all of us as a nation. In the first half of the 20th century gains in Māori health were achieved by integration, through the application of holistic principles - whānau development, cultural enhancement, improved housing, sanitation, and providing access to clean water. As well, increasing rates of Māori mental health have coincided with the so-called gaps that now exist and overall socio-economic disadvantage.

While the creation of good health and healthy environments is a seminal concept, dedicated interventions (derived from the health sector) are also required. Public health, health promotion, and health services (particularly in mental health sector) are required and will assist in creating an environment that is comprehensive, seamless, and integrated. As noted, the number of deaths resulting from suicide fall within the overall context of an even greater number of attempts. Well designed and well-resourced health promotion activities should complement dedicated health services and will likely have a positive impact on reducing current statistics and negative trends.

The last point is difficult to consider, but is worthy of comment. The point is however that strategies need to be designed in ways that are effective and meaningful to the target group. From a Māori perspective this implies the application of interventions that are culturally meaningful. Certainly, and as history shows, a one-size-fits-all approach may miss the mark in terms of effectiveness and especially where cultural factors are not afforded appropriate attention. For Māori youth these issues require considerable deliberation in that Māori culture may be one of many factors that shape their reality – being Māori may fit within the overall culture of being a teenager, an Aucklander, an urban youth, or a university student or scarfie. The important thing is that these types of realities are considered and that messages are delivered in the right way. As one teenager told me the messages need to be in the right **Zone**.

The framework below provides a summary of these five key points and is perhaps appropriate for a conference organised by *SPINZ*.

S olution Focused	Overcome challenges, co-ordinate efforts and work toward sustainable solutions
P eople Power	Dedication and community empowerment
I ntegration	To work within, across, and throughout other sectors
N ational Alignment	The importance of dedicated health service and health sector interventions
Z one	To present messages in ways that are meaningful and relevant