

Hauora Taranaki PHO

Māori Health and Cultural Responsiveness

**Te Kani Kingi
Te Pūmanawa Hauora
School of Māori Studies
Massey University
WELLINGTON**

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INTRODUCTION

Firstly, I would like to thank you all for the opportunity to speak today and to discuss some of my thoughts on Māori health. I've have often thought however, that the expression "Māori health" was somewhat of a misnomer in that the two words almost never sit that well together, at least when health statistics are reviewed, and certainly when disparity issues are discussed. Periodically, and about once every four years, there tends to be an increased emphasis on the nature, extent, and reasons for these disparities, and in particular what strategies are in place to address them. As a consequence, plans aimed at reducing disparities often form much of the political debate – though unfortunately is often ill-informed and frequently (yet surprisingly) designed to somehow highlight Māori and race-based privilege. As a result the more pragmatic or meaningful issues are lost and have accordingly led to some confusion as to how Māori health issues can best be addressed.

In considering the content of my presentation, I was very much aware of the fact that others (far more experienced than myself) had developed plans for Māori health and likewise explored what solutions were possible. As a result, and with these issues in mind, I've decided to take a slightly different approach to this discussion and to explore Māori health from both an historical and contemporary perspective, to consider the macro and micro issues, the conceptual and more pragmatic solutions, and to hopefully do so within the space of 40minutes.

THE HISTORY OF MĀORI HEALTH

As an introduction and in light of the promise to provide an historical overview I've decided to firstly examine past trends in Māori health, and from about 1800 onwards. At this time, information on Māori health was not extensive, though not entirely absent. We know for example (and based on the log books of various sea captains) that pre-colonial Māori were relatively fit, healthy, and vibrant – though certainly not immune to disease, calamity or illness.¹ Average life expectancy was somewhere around 35 years, and while concerning from a contemporary perspective this figure was in fact consistent with other parts of Europe and better than in most parts of Asia.² We know also, that many systems and procedure were in place to either promote or protect health and which served to guide everyday activities.

Belief systems such as Tapu and Noa were often incorrectly interpreted, particularly by anthropologist, and as religious or supernatural curiosities. However, and as a consequence, their true application (in terms of health) was often lost. At a high level Māori society was governed by a series of sanctions and prohibitions and concepts like tapu and noa were used to provide practical guidance on what was safe and that which required a degree of caution. Whereas in modern times reliance is placed on regulations and laws (“No Smoking” – “Danger Keep Out” – “No Children Allowed”) traditionally concepts like tapu and noa were equality effective in terms of guiding healthy behaviors.

We know for example that un-cooked food was tapu and because in it's raw state it could lead to infection or gastro-enteritis. Sources of dwindling food supplies were made tapu and to protect the resource and conserve it for later harvest – and so to avoid starvation. A breast-feeding mother was tapu – so that suckling her child would not be disturbed and further pregnancy avoided, at least until the child was older.³

In contrast, anything that had been declared noa did not pose a risk to health. Once a building had been completed, the state of tapu was removed and it became noa. This

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

2 World Resources Institute (1998)

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

meant that it was now safe to enter and the risks of injury from loose rafters of flimsily constructed walls were reduced.⁴

Other practices and cultural activities were likewise governed by more pragmatic concerns over health. From the construction of hilltop PA in sunny, warm, and dry areas, to traditions for welcoming visitors and in order to determine their intent. Romantic descriptions of Māori as a race of warriors, has done much to conceal the more mundane and usual activities of everyday life and the fact that for the most part life was focused on the more basic need to survive.

However, and as early as 1837, real concerns were being expressed as to the state of Māori health, and in particular the apparent population decline. In a dispatch to his superiors in London, James Busby (the then New Zealand Resident) noted the “miserable condition” of the Māori and which promised to “leave the country destitute of a single aboriginal inhabitant.” Keen to avoid the disastrous mistakes made in other parts of the world, and aware of the fact that indigenous populations had typically suffered as a consequence of unmanaged colonization, the Colonial Office recommended some form in active British intervention. While a number of initial plans were put forward, the Treaty of Waitangi was the eventual outcome. And, although much has been made of the more covert aspects of the Treaty – the issue of Māori health was not insignificant in shaping the Treaty’s overall design and structure.⁵

Insofar as the prescribed intent of the Treaty matched the eventual outcomes then the Treaty was far from successful. In fact if there were a single word to describe Māori during the 18th Century then depopulation would certainly seem appropriate. While accurate statistics are not available we know that the Māori population in 1800 was about 150,000. Yet, and in the space of two generations, the population had fallen to all time low of just 42,000 in 1896.

4 Ibid

5 School of Māori Studies, (2005), *The Treaty of Waitangi in New Zealand Society: Study Guide*, Massey University, Palmerston Nth.

The reasons for this decline are complex and certainly no single issue is to blame. We know however, that introduced diseases in particular had a dramatic effect on Māori. 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.

In addition and 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. Traditional mechanisms for the promotion and protection of health – such as Tapu and Noa were soon abandoned. And, while in the past these mechanisms would have guided individual and community behaviors, their absence ultimately led to a loss of structure and parameters for positive health development.

Likewise, the traditional PA (which had served Māori well for many hundreds of years) were left vacant. Either by choice (or more often force) Māori moved to areas that were more health averse – further contributing to the population decline. Wars – particular over land, made a dual contribution to Māori depopulation. And quite apart from the devastating affect the musket had on Māori; many have also noted the obvious correlation between decreasing levels of Māori land ownership and the declining Māori population. In the end, however, there is no single or simply answer to the question of Māori depopulation during the 1800s.

A MĀORI RESPONSE TO MĀORI HEALTH PROBLEMS

Toward the end of the 18th Century specific plans for Māori health were not well advanced – to say the least. Due to the fact that the population had dropped by so much, many were of the opinion that the Māori people, as a race, were all but extinct and would only exist as historical curiosities and within anthropological text. In what was to become a rather famous quote Dr Isaac Featherstone summed up the prevailing attitude and noted that;

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

Māori entry into the 20th Century was therefore both unexpected and unspectacular. Further population decline was anticipated as being more or less inevitable. However, and as history has shown, the Māori did survive and in fact has shown considerable growth since 1900. In attempting to explain this turnaround, Mason Durie describes three periods of Māori health development during the 20th Century. The first is characterized by the work of two Māori physicians – Maui Pomare and Peter Buck, who, coincidentally, were also both from the Taranaki region.

Pomare of course was the first Māori doctor although Buck was actually the first to graduate from a New Zealand University. Both had distinguished careers in health and politics and Buck was to further developed his interest in anthropology. In 1900 however, their prime focus was on arresting the seemingly inevitable population decline and in developing sustainable and robust strategies for Māori health. Lacking financial support as well as a dedicated health workforce the options available to them were not extensive. As well, and adding to these problems, was the notion that whole idea of a dedicated Māori health strategy was in fact a pointless exercise – as noted, the race was considered all but extinct.

However, and in an inspired move, they decided to focus their energies on public health initiatives and to utilise Māori community leaders as a public health workforce. They understood also that Māori health problems were in many ways linked to lifestyle and

public health issues. Health promotion initiatives could therefore assist with changing negative behaviors to those that were more consistent with health gains, further, that providing access to clean water, shelter, and ablution facilities could likewise lead to positive developments.

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. McLean⁶ states that all this had been done at the cost of the Māori themselves without a penny of Government assistance or compensation – sounds familiar. What had been achieved was due to the personal efforts of Pomare and Buck and a small bank of inspectors.

As a consequence the population (slowly at first) began to increase. Later, others were to make similar contributions to Māori health development and likewise built on the idea that a Māori initiated and designed approach was best. In this regard the Māori Womens Welfare and Health Leagues responded well to the new challenges posed during the 1930s and onwards. In the 1970s and 80s the approach was taken further and through the development of Māori specific health services.

While it is not possible, at least within this presentation, to consider the extent Māori initiatives contributed to Māori health gains – certainly the work of Pomare and Buck, the Māori Woman's Welfare and Health Leagues, as well as Māori dedicated health services have done much to shape our approach to Māori health and Māori health development. It is also encouraging to note that from a low of just 42,000 in 1896, and in just over 100 years, the population now stands at an incredible 604,110.7 Māori are now more populous and living longer than at any other time in our history.

⁶ MacLean, F.S, (1964), Challenge for Health: A History of Public Health in New Zealand, Government Printer, Wellington.

⁷ http://www.maorilanguage.info/mao_pop_faq.html (2 Feb 2005)

A NEW CENTURY AND NEW CHALLENGES

While it is important to at least recognise the developments which have occurred over the past 100 years it is well known that significant problems in Māori health remain. At the turn of last century the main threats to Māori health were typhoid, influenza, measles, scarlet fever, diphtheria, tuberculosis, pneumonia, malnutrition, and goitre. Today, different types of problems exist and include heart disease, obesity, diabetes, mental illness, cancer, asthma, and motor vehicle accidents – the list in fact is almost endless.⁸

A characteristic of these modern problems however is that for the most part (though not always) they are lifestyle or environmentally related and do not reflect a biological or genetic predisposition – that is, we are not ill by the mere fact that we are Māori. Often, the problems are referred to as the diseases of affluence though likewise exist in populations where poverty is high. Of greater interest however is that they are by and large preventable and respond positively to well targeted health promotion and public health initiatives.

The fact that Māori often suffer disproportionate rates of both morbidity and mortality is therefore of some concern. The reasons for this are complex and not easily described or quantified. There is some evidence that Māori tend to respond less positively to generic health promotion messages and that in fact the rights messages are getting to the wrong people, in the wrong way, or at the wrong time. As well, the socio-economic position of Māori tends to reduce the extent to which healthy choices can be made.

Some have further argued that the process of colonization and discriminatory attitudes have created a socio-political environment which has ill-positioned Māori to take full advantage of the health system. Behavioral factors linked to excessive smoking, drinking, and sedentary lifestyles have likewise made Māori prone to a range of related health problems. In the end however, it is not possible to identify any single issue which explains the relative poor health position of Māori – though certainly these disparities are a result of a complex interaction between a range of associated and dynamic variables.

⁸ School of Māori Studies, (2003), *Māori Health Foundations: Study Guide*, School of Māori Studies, Massey University, Wellington.

A PRIMARY HEALTH CARE APPROACH

At this stage of the presentation, and while accepting the fact that considerable problems in Māori health exist I would like to narrow the focus somewhat and to explore what opportunities for development might be possible - and within primary health. There are three reasons for this. First, and while an examination of deficits is useful in terms of making comparisons or establishing baselines, I always find it more helpful to examine what possible solutions might exist. Second, the focus on primary health allows some of the more pragmatic issues to be considered. And third, it is always useful to take away some practical examples of how both responsiveness and outcomes for Māori can be improved - rather than to exclusively focus on epidemiological patterns, rates, or other high level concerns.

To begin with, and in order to provide a framework for this, I would like to reflect on some research which appeared in the NZMJ in 2002⁹ and which explored non-Māori GP's perspectives of their Māori patients. The research is perhaps of less interest due to the fact that the sample was gathered from Auckland and with only 25 physicians. However, it did raise some interesting and perhaps common views on the health of Māori and what responses there might be.

For example, the study revealed that by and large, most respondents agreed that there was a particular problem with Māori health (nationally) and that based on their experiences and interactions with Māori, these problems tended to be more complex and serious. However, and when questioned about the potential reasons for this, most cited socio-economic factors and generally did not regard historical, political, or even cultural factors as being relevant. This finding was of interest due to the fact that these perspectives were somewhat inconsistent with the academic and research discourse. And, that while issues of poverty, income, and unemployment, are catalysts for poor health, a number of studies have consistently shown that when these issues are controlled for - the disparities remain. The implication are that Māori health problems cannot be explained by socio-economic factors alone and that any solutions must accordingly consider a range of associated variables – such as culture and access to health services.

⁹ <http://www.nzma.org.nz/journal/115-1167/272/>

This is not to say that the issue of poverty (for example) are not important, what it does suggest however is that other factors will also need to be considered.

Insofar as the study collected views on Māori health status, and the reasons for the current disparities, it further explored some of the more common issues GP's had faced when engaging Māori patients. For example, many noted that due to intermarriage, mixed ancestry and issues of cultural diversity it was not always possible to identify which patients were Māori and accordingly what approaches to interaction or dialogue were appropriate. Compliance issues were also raised and it was noted that;

Key issues were non-compliance. Maori do not do the right things in relation to their health. In terms of a standard medical definition of compliance, they do not take their medication, do not follow prescribed regimes of treatment, do not arrange for repeat courses of medication, do not attend to follow up.

It was also noted that;

Maori present late, and do not attend regularly or sufficiently frequently. They have diffuse lines of personal responsibility, which means for example that you cannot be sure who is a child's caregiver, or that whanau members may present instead of the actual patient. They do not know their personal medical history, they do not know what medications they have taken or what the medications they take are for. They have different attitudes and expectations about health, based in a present-focussed, laissez faire world-view. They do not embrace preventive medicine and they expect a quick-fix solution in a crisis. Maori men almost never come to the doctor.

While some noted that they would take a non-discriminatory approach to dealing with Māori and non-Māori patients – more commonly, it was stated that different methods would be used. In particular, it was said that more time was required to engage Māori patients – to build a rapport and to explore their medical history. Information needed to be presented as simply and clearly as possible – and sometimes through the use pictures. It was also frequently noted that different lines of communication existed and that group consultations were sometimes required and in order to obtain and provide relevant and comprehensive information. In general, it was thought that more time and effort was needed and in order to deal with Māori patients – especially during follow-up and

preventative medicine. A more flexible approach to punctuality and payment was further recommended. In terms of particular cultural practices or approaches, it was described that;

Some participants with knowledge of Maori culture spoke of protocols for touching or examining patients, and of appropriate ways of asking permission, explaining treatments or conditions. The call was for greater cultural sensitivity on issues specific to Maori, with appropriate use of reo, kaumatua, ritual and protocol.

INTERACTING WITH MĀORI PATIENTS

These types of studies usefully illustrate some of the more pragmatic issues faced by primary health care providers – and in particular their interactions with Māori. The strategies described are simple examples of how relationships and responsiveness can be improved and which are ultimately designed to improved health outcomes. Māori health services providers are in many ways designed to respond to these types of cultural needs and by delivering health services in a manner which best reflects the expectations of their clients. Again, and in this regard, the fundamental purpose is to improve health outcomes through cultural responsiveness.

In considering the broad issue of how to better engage and respond to Māori patients, Mason Durie has also shed some light on what approaches are useful and beneficial. For example, he has for a number of years considered the issue of Māori cultural diversity and the fact that ethnic or racial indicators now serve as imperfect proxies for cultural identification. That is, an individual's level of Māori ancestry, complexion, appearance, or facial characteristics, cannot be used with any precision and in order to determine their level of cultural affinity. He notes that;

Far from being homogenous Māori individuals have a variety of cultural characteristics and live in a number of cultural and socio-economic realities. The relevance of so-called traditional values is not the same for all Māori, nor can it be assumed that all Māori will wish to define their ethnic identity according to classical constructs. They may or may not enjoy active links with hapū or iwi, yet will still describe themselves as Māori and even if they do not enjoy close links

with conventional Māori institutions, they will reject any notion that they are “less Māori” than their peers.¹⁰

The implications for health service providers (or at least those that engage Māori patients) is that certain assumptions may need to be dispensed with and that a more active approach to the identification of Māori will be required. There are two important implications in this regard. The first refers to the identification of Māori patients and the fact that appearance or last name is an imprecise “rule-of-thumb” to follow. The second is that even if ethnicity is determined, there is no generic or uniform cultural reality and therefore the cultural expectations of patients will almost certainly vary.

Understandably, there is some reluctance (albeit uneasiness) associated with asking ethnicity questions and both experiences and strategies for dealing with this can be quite different. Some prefer to gather this type of information in a “matter-of-fact” way and as part of routine information collection. While others are less direct, cautious, and prefer to develop a more covert approach, perhaps exploring associated issues first and before asking an ethnicity question. In the end however, there are no hard and fast rules, although it is often possible to get a feel for this, based on initial discussions, and to decide what approach is best. Of course this becomes less of an issue and where a detailed history (which includes ethnicity) is available. Otherwise, an approach to ethnic identification will need to be developed – this should necessarily be guided by the perceived preference of the patient, though likewise influenced by what the practitioner feels comfortable with.

Of course having Māori ancestry or associating with this particular ethnic group does not address the issue of cultural diversity and what level of cultural adherence is appropriate in every situation. There have been issues in the recent past and where the level of cultural interaction has not matched the expectations of the patient. This can occur in two ways; either when too much culture is included or not enough. More usually (and within the research and academic discourse) there has been a focus on cultural absence and when not enough is done to engage Māori patients in the correct way.

10 M.H Durie (1995), *Ngā Matatini Māori : Diverse Māori Realities*, Paper prepared for the Ministry of Health

However, and while the negative implications of this can be significant, the risks of presenting too much culture is equally as problematic. In this regard a service may develop protocols for care which utilise Māori processes and which are designed to enhance Māori responsiveness. However, and if these are applied too enthusiastically they may in fact have a negative impact on care. Greeting Māori patients in Māori or using Māori phrases or expressions can build a sense of trust and familiarity, it may likewise present staff with the opportunity to test and utilise these skills. However, and if the patient has limited understanding of Māori then the whole process may seem rather contrived (at best) – unsettling, uncomfortable, and un-therapeutic at worst. As a general rule, therefore, the overall level of cultural input should be guided by the expectations of the patient and not the preferences of the service.

There are of course many other examples of how culture can be introduced within a health service and in order to create a more therapeutic and engaging environment. 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. And, while most patients are unlikely to be fluent (or even competent) speakers of Māori – information presented in Te Reo can be of greater interest and likewise show a desire to at least reflect Māori interests. The employment of Māori staff is a further step which can likewise make an often difficult visit, more bearable. Regardless of ethnicity, going to the doctor can be unpleasant, though is even more difficult when all the staff are unfamiliar – at least in appearance.

A simple “kia ora” at the reception area or on the phone is another low-cost method of introducing an appropriate feel to a service. In the past there have been some negative responses (by non-Māori) to this simple greeting which surprisingly means – “good health to you”. However, and at the risk of potentially offending a few, it seems appropriate for health services in particular to greet their clients in this way. Although these strategies are unlikely to address the issue of late presentation (and the numerous problems which are associated with this) they will at least encourage early access, ongoing care, and hopefully make some measurable contribution to improved health outcomes.

While these examples are simple illustrations of how culture can be introduced into a health service, there is a risk however that they may appear superficial or contrived and unless supported by additional mechanisms. Often, these can be introduced within the doctor's surgery and during consultations. Again, and when bearing in mind that the cultural understanding and requirements of patients are likely to vary, there are certain approaches a doctor may apply and in order to improve responsiveness, understanding, compliance, and ultimately health outcomes. Importantly, these require little training, cost nothing, and are unlikely to encounter the problem of cultural diversity.

For example, it is well considered that Māori patients may require more time and in order to reveal the precise nature of their health problem. This may manifest in a way which means other, associated issues, are discussed first and before the more relevant concern is considered. In some cases it may also result in several consultations taking place - until an appropriate repore is developed - and at which time the patient feel comfortable in discussing the actual issue. In considering these types of issues Tipene-Leach describes a number of sensitivities and behaviors relevant to communication during clinical examinations. For example, immediately asking a patient to reveal their names, without any preliminary remarks, could make some Māori feel apprehensive, and even before the examination takes place. As well, expecting Māori to engage in direct eye-to-eye contact may be unlikely as it could be interpreted as an invitation to demonstrate bad manners as looking at an older person in the eye could be viewed as a sign of dis-respect.¹¹

He also noted that certain parts of the body tended to have special significance, though not always at a conscious level. Medical or nursing examinations involving the head, sexual organs, hair, or nail clippings, required a measure of caution and a greater degree of circumspection than was customary in busy hospital wards. A broad understanding of these types of behaviors has obvious implications for the way in which consultations or examinations take place and how a more open and meaningful discussion can take place. However, it also reveals how contemporary practice and cultural expectations may not always match – and especially where time is concerned.

11 Whaiora page 67

There is some evidence, also, to suggest that Māori patients may require alternative approaches to information sharing and certainly the issue of non-compliance is an indicator of this. Research, conducted within a range of sectors, highlights the fact that Māori are sometimes more likely to indicate they understand something, when in fact more information is required. Furthermore, that they are less likely to ask questions or engage in more open or frank dialogue with a doctor. This has obvious implications for the self-management of certain health problems and how treatment plans are developed. It suggests, again, that more time may be required to consult with Māori patients, that alternative approaches to information sharing are required, and that nodding one's head is an imperfect measure of understanding. For Māori elderly (in particular) it may mean that other whānau members are engaged, to explain certain issues, or to assist with management. I remember one example of an individual who upon being told they had diabetes immediately cut their consumption of sugar – though made no effort to reduce their daily fat intake.

CONCLUSIONS

The current problems in Māori health are not easily quantified and reflect a complex interaction between a range of social, cultural, political, historical and economic determinants. This presentation has touched on few of these problems though in main has focused on the issue of culture and how this relates to the delivery of health services. It is clear that Māori tend to have a rather unusual relationship with health services – we often access services late, and as a consequence have more complex needs. Research reveals that we are less likely to heed critical advice, ask the right questions, or understand the nature and extent of our health problems. The result being that we tend to have poorer health outcomes when compared to the general population.

As noted, there are of course other factors involved and which contribute to these disparities. However, the interface which exists at a primary level provides an opportunity to develop some pragmatic strategies in order to at least improve this interaction – how services are accessed, how assessments take place, and how critical information is presented. Through an awareness of cultural needs or expectations it becomes possible to understand why certain issues or behaviors take place and to develop strategies so that these needs are met. In meeting these needs there is an

opportunity improve interactions with Māori patients and to likewise improve health outcomes. These strategies are not the panacea to the issue of Māori health, but nor are they designed to be – more correctly they reflect an opportunity to improve health outcomes which is I guess is an opportunity that should not be missed.