

**Unleashing Innovation in Health Care  
Alberta's Symposium on Health**

**INDIGENOUS HEALTH REFORMS:  
BEST HEALTH OUTCOMES FOR  
MĀORI IN NEW ZEALAND**

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## **Indigenous Health Reforms: Best Health Outcomes For Māori In New Zealand**

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### **Introduction**

Alberta's Symposium on Health provides an opportunity for communities around the globe to share ideas and to learn from each other so that high standards of health might be achieved. It is an important event that brings together views from several nations, many peoples, and diverse cultures in order that the many guises within which health care takes shape, can be unravelled. However, while observations from the several perspectives may highlight differences in health care, it is also important to remember that the foundations of quality health care are firmly built on the human condition and on hopes that transcend nationhood and diversity. There is, so to speak, a common platform made up of universal human values.

Good health depends on many factors, most of which are well outside the health sector – quality housing, a decent education, meaningful employment, access to goods and services, opportunities for sport and recreation. But even if it is not the most influential factor, health care is also a crucial determinant of good health, the more so where other factors create health risks and predispose to ill health.

Alberta's Symposium on Health takes place in an era when technological advances are transforming the health sector. From an essentially caring activity it is being enriched by innovations in diagnostics, treatment, analysis, and management. At the same time, technology by itself is unlikely to lead to uniformly high standards of health or necessarily the best quality of care. There is a human factor that cannot be simply reduced to technological opportunities or the mass application of scientific breakthroughs. While technology and science have a critical place in modern health care and offer fresh hope for the future, human feelings and beliefs are equally important to the healing process and need to be factored into the health care equation.

In that respect, indigenous health care is largely about the balance between scientific advancement and human spirituality.

## **Indigenous Peoples**

An important milestone for indigenous peoples was the establishment of the Permanent Forum on Indigenous Issues at the United Nations in 2002. The Forum represents a significant advance in the struggle of indigenous peoples for recognition within their own lands and territories and has brought global attention to the impacts of colonisation, discrimination, ethnocide, and sometimes frank genocide.

While there are significant differences in the circumstances of indigenous peoples in various parts of the world, there are also commonalities in experiences and world-views. Colonisation for example was a common experience, associated with epidemics of infectious diseases, depopulation and disempowerment at local, tribal and national levels. And it was followed by a common pattern of alienation: loss of culture, loss of land, loss of voice, loss of dignity, loss of health and loss of intellectual traditions.

In modern times the common threads that bind indigenous communities are linked to their similar socio-economic positions, their rejection of assimilation, their comparable aspirations for greater autonomy, and their similar experience of patterns of disease. However, the defining element of indigeneity is not colonisation, socio-economic disadvantage or political ambitions. Instead, most indigenous peoples believe that the primary starting point is a strong sense of unity with the environment – and a healthy environment.<sup>1</sup> This appears to be the most significant characteristic of indigeneity at least according to indigenous writers.<sup>2, 3</sup> ‘People are the land and the land is the people.’ ‘We are the river, the river is us.’<sup>4</sup>

Loss of that environment and changing lifestyles were associated with new patterns of disease. However, the infectious diseases that underlay much of the population decline in the nineteenth century was soon to give way to the twentieth century diseases associated with new social environments, the so-called life-style diseases of diabetes, motor vehicle accidents, alcohol and drug misuse, cancers, heart disease, depression and suicide.

The ecological approach underlies much of the indigenous approaches to health. In 1999 at Geneva, the World Health Organisation arranged an International

Consultation on the Health of Indigenous Peoples. Arising from the Consultation a *Declaration on the Health and Survival of Indigenous Peoples* was subsequently presented to the U. N. Permanent Forum on Indigenous Issues in 2002.<sup>5</sup> The Declaration affirms the links between culture, the wider natural environment, human rights, and health proposes a definition of health.

‘Indigenous Peoples’ concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously.’

As part of a movement to reclaim culture and identity, indigenous peoples have fought to reshape health care and health services so that they align more sensibly with indigenous world views and modern indigenous realities. They have urged for the adoption of cultural protocols into health care, and are keen that greater recognition be given to socio-economic disadvantage as significant barriers to effective care. In some communities traditional healing has also been given new emphasis though more often the call has been for the development of an indigenous health workforce that draws on indigenous values as well as the modern health sciences.

### **The Māori Experience**

Māori experience has not been substantially different from other indigenous peoples except in three important respects. First Māori demographic patterns are distinctive; second the 1840 Treaty of Waitangi has created a special relationship between Māori and the Crown with implications for health policy; and third there has been effective Māori leadership in health for more than a century.

### ***Leadership***

In 1905 the first two Māori doctors, Maui Pomare and Peter Buck (Te Rangi Hiroa) were entrusted with improving the health status of Māori people at a time when mortality rates were appallingly high and life expectancy was around 32 years. The strategy adopted by the two young doctors was to appoint a team of sanitary

inspectors - leaders among their own people – who although having no previous training in health were effective community and tribal leaders. Together they faced the daunting task of turning around a rapidly declining Māori population that had become victim to endemic tuberculosis, malnutrition, pneumonia, goitre, excessively high child mortality rates and a host of infectious diseases.

Other community leaders also emerged in that era including the much revered spiritual healer, Tahupotiki Wiremu Ratana and Te Puea Herangi, a tribal leader who, after the 1918 influenza epidemic fought to establish a hospital where Māori values and customs could enrich conventional medical practices. She was unsuccessful but 64 years later in 1984, her tribe was among the first to pioneer a health centre that integrated Māori perspectives into practice in a modern primary care clinic. In the 1930s and again in the 1950s two influential womens organisations, the Womens Health League and the Māori Womens Welfare League provided leadership, largely on a voluntary basis. Both groups continue to make substantial contributions to Māori health advancement and have been staunch advocates for improved Māori access to health care.

### ***Demographic Change***

In 1905, the Māori population was estimated at 45,000 and close to extinction. But not only did it survive, within a century it had become more numerous than at any other time in history. Even though changes to statistical definitions of Māori make it difficult to draw comparisons, there is strong evidence of a substantial and sustained increase in the Māori population. In the 2001 census 526,281 New Zealanders identified as Māori; 85% were classed as urban dwellers.<sup>6</sup>

Although accounting for some fourteen percent of the total New Zealand population in 2001, by 2051 the Māori ethnic population will almost double in size to close to a million, or twenty-two percent of the total New Zealand population. Even more dramatic, by 2051 thirty-three percent of all children in the country will be Māori.<sup>7</sup>

### ***The Treaty of Waitangi***

The Treaty of Waitangi is the third unique aspect of Māori health development. After nearly one hundred years of legal and political dismissal the Treaty is now

acknowledged as a source of constitutional rights for Māori. Signed in 1840 between Britain and most tribes, the Treaty provided for British governance, certain guarantees to the tribes relating to property rights and (at least in the Māori text of the Treaty) to continuing tribal authority, and the conferment of citizenship rights on individual Māori people. In the immediate years after being signed the Treaty and its lofty goals were taken seriously by the Crown but in 1877 the Treaty, was declared by a court of law as ‘a simple nullity’ and more or less abandoned as a serious Crown obligation.<sup>8</sup>

Although the application of the Treaty to land and the physical environment was eventually re-established and even confirmed in legislation, it was not until the mid-1980s that there was also recognition of relevance to social and economic domains.<sup>9</sup>

A commitment to the Treaty by the fourth Labour Government in 1984 gave it greatly increased prominence across the range of government activities and ushered in what amounted to a Māori constitutional revolution.<sup>10</sup> Three years later the Department of Health formally recognised the Treaty as important to health services and instigated initiatives aimed at giving Māori greater say in health policy and the delivery of health programmes. By 2000 there was sufficient support to include a reference to the Treaty in the New Zealand Public Health and Disability Act 2000.

### ***Patterns of Disease and Disparities***

Over the past century Māori health has improved in a highly significant manner. Māori infant death rates for example, as high as 94 per 1000 live births in 1929, had reduced to 54 per 1000 by 1959 and to 18 by 1991. Similarly Māori life expectancy increased from 33 (for males) and 30 (for females) in 1903, to 66 (for males) and 71 (for females) in 1996, and to 69 (males) and 73.2 (females) by 2002. As already discussed, these gains have been associated with rapid population growth, from 45,000 a hundred years ago to 526,000 in 2001.

The diseases that ravaged Māori communities in the late nineteenth and early twentieth centuries have largely disappeared, at least as major causes of death and disability. Early Māori had to contend with constant shortages of food, cold and damp conditions, pneumonia, gastro-enteritis, infant deaths due to infection, and accidents. By 1901 the main health risks were still largely related to malnutrition and

infectious diseases but had come to include tuberculosis, typhoid, and diphtheria. The fact that those diseases are now largely consigned to history is cause for celebration.

But the reality is that the old threats to health have been replaced by modern health problems, less lethal perhaps but contributing to the disproportionately high rates of disease and disability for Māori people. Whereas tuberculosis, diphtheria and malnutrition were major causes of ill health a century ago, the contemporary health problems for Māori now include rheumatic fever, sudden infant death syndrome, injury, diabetes, cancer, heart disease, depression and youth suicide. They comprise the most common causes of death and greatly inflate the burden of disease carried by New Zealand.

While Māori health status measured over time has improved, disparities in standards of health between Māori and non-Māori remain. Recent evidence suggests that over the past two decades the disparities are even growing. In the twenty years between 1980 and 1999 mortality rates for Māori men increased from 1.48 times higher than the non-Māori rate to 1.74 times higher, while for Māori women the disparity rose from 1.96 to 2.20. Similar trends can be observed for Pacific peoples living in New Zealand.

Ethnic disparities in life expectancy have also increased. While Māori male life expectancy increased from 64.6 years to 65.8 years in the twenty years between 1980 and 1999, non-Māori male life expectancy increased from 70.9 years to 75.7 years, a gain of 4.8 years compared to the Māori gain of only 1.2 years.<sup>11</sup> By 2000-2002, however, Māori life expectancy had increased even further to 69 years for males and 73.2 years for females and there were signs that the gap (vis a vis non-Māori) was decreasing, from 9.1% (in 1995/97) to 8.5% (by 2002).<sup>12</sup>

### ***Māori Health Development***

In that context contemporary Māori health policies evolved built around a series of principles, goals, and platforms. Although a number of principles have been identified, three stand out as especially important for health outcomes: indigeneity, clinical and cultural competence, and human dignity.

### *Principles*

The principle of indigeneity takes into account the determination of indigenous peoples to retain their own distinctive cultural identity, avoid assimilation and exercise a degree of autonomy. This principle goes beyond cultural recognition to claim a special place for indigenous peoples in the life of the nation. The principle of indigeneity does not mean other cultures should not also be duly recognised in health care, but it does acknowledge a unique position for indigenous peoples.

Clinical and cultural competence is the second principle. Māori as much as other New Zealanders expect the best possible treatment using tried and true methods. They also hope they will not be subjected to unnecessary interventions and will have access to new technologies and developments benchmarked against the best in the world. There are also expectations that health care workers will be competent at the interface between their own culture and the culture of others. Language barriers, differing codes for social interaction, variable community expectations and a willingness to involve friends or families in assessment, treatment and rehabilitation make important differences to the way care is experienced.

A third principle, human dignity, is concerned with the process of care. Health interventions that do not afford due respect for human values, cultural world views and differing health perspectives, will undermine dignity and diminish self respect. Technology and cost containment do not replace human values as the driver of quality and in an outcome-driven environment, health care must also be concerned with processes, the ways in which technology is applied.

### *Goals*

As contributors to the overall aim of improved health outcomes, four major goals can be identified: the promotion of healthy lifestyles, equitable health outcomes, reduced socio-economic disparities between Māori and non-Māori and self determination and self management.

The first goal, the promotion of healthy lifestyles, recognises the importance of families as vehicles for healthy lifestyles and the significance of a strong cultural identity for health. Indigenous writers have emphasised the link between cultural

certainty and good health and many indigenous health programmes have been developed around strong cultural practices. Community leadership coupled with expert advice regarding sensible nutrition, sport and exercise and the avoidance of known health risks such as tobacco, alcohol and drugs, have also been influential in effecting changes, even in communities where unhealthy lifestyles were endemic. Although much remains to be done, there are encouraging signs that major modifications to day to day life-styles and health-related practices are attainable by individuals as well as families and communities. Smoking uptake rates for Māori men for example have decreased and an increase in physical activity has occurred, especially for older Māori.

The goal of achieving equitable health outcomes recognises the disparities between Māori and non-Māori in respect of most disease categories and in levels of disability. Co-morbidities occur with higher frequency in the Māori population and can diminish the prospect of equal outcomes because of a cumulative effect. Exclusion criteria can also count against Māori in so far as eligibility for selected interventions such as coronary bypass operations can eliminate a disproportionate number of potential candidates either because they are smokers or are obese. Equitable outcomes for health also require equitable access to services and funding arrangements which are based around results rather than processes, volumes or staff establishments. However, outcome measurements are relatively unsophisticated, especially as they apply to indigenous peoples. While some outcome measures are universal, and can be applied to all populations, measures of outcomes for Māori, especially in areas such as mental health, need to include Māori perspectives, world views and values.

A third goal is to reduce inequalities between Māori and other New Zealanders. Sub-standard housing, poor educational attainment, low incomes, unemployment, and reduced access to key societal institutions, all contribute to poor health. There is now considerable evidence that while access to health services is one important determinant of health status, structural causes account for much of the increasing disparities.<sup>13</sup> In 1984 New Zealand's major social and economic reforms impacted adversely on Māori and Pacific peoples with widening gaps in employment status, housing, education and income. Widening health inequalities were predictable outcomes.

Self determination and self management represent a fourth goal. But Māori communities also recognise that self management requires access to information and technology, a level of expertise, and rather than absolute independence, opportunities to establish collaborative relationships with other Māori and with other health providers. The goal of self determination is viewed cautiously by some states which fear that cession will be an ultimate outcome. In that respect there is a constitutional dimension to the goal. Māori generally do not aspire to form a ‘state within a state’ but do want to be able to manage their own affairs and to provide for their own people. And they are inclined to the view that a level of autonomy is guaranteed in the Treaty of Waitangi.

### *Platforms*

Six platforms have provided springboards for action to achieve Māori health goals. First Māori cultural paradigms have provided a philosophical basis; second health policies have increasingly identified gains in Māori health as a priority area; third Māori leadership and Māori services have been important elements to achieving good outcomes; fourth health services that are responsive to Māori; fifth integrated development with inter-sectoral collaboration; and sixth a parallel Māori health research stream has emerged.

### Māori Health Paradigms

The promotion of Māori concepts of health was evident in the early 1980s. When the Māori Womens Welfare League was embarking on a survey of the health of Māori women for example, a model of health known as Te Whare Tapa Wha anchored their study.<sup>14</sup> The models’ appeal was based on its holistic approach to health and the recognition of spirituality as a significant contributor to good health. Until then discussions about Māori health had dwelt on the rates and consequences of disease, creating a sense of disempowerment and passivity. But by reconfiguring health in terms that made sense to Māori, it was possible for Māori communities to experience a sense of ownership and to balance medical and professional dominance with community involvement and local leadership. Te Whare Tapa Wha was presented as a four-sided house, each wall representing one aspect of health – spirituality (taha

wairua), the mind (taha hinengaro), physical health (taha tinana) and family and social relationships (taha whānau).

Taha wairua remains important to Māori since it captures the notion of a special relationship with the environment, as well as a Māori cultural identity. Taha hinengaro concerns the way people think, feel and behave and recognises that Māori patterns of thought value metaphor and allusion. Taha Tinana is not only about physical illness but also fitness, mobility and freedom from pain while taha whānau focuses on the nature of interpersonal relationships, within the family but also beyond into wider society. Increasingly the model is being used as a framework for the development of models of assessment, treatment, care, the measurement of outcomes and the formulation of health policies.

### Health Policies

When the New Zealand Board of Health promoted the Treaty of Waitangi in 1987 as a document that had relevance to health<sup>15</sup>, and then endorsed tribal authorities as agents for health<sup>16</sup>, a new era of health policy was launched. It recognised two approaches to Māori health: Māori delivery systems and state responsiveness to Māori based on the principles of the Treaty of Waitangi.

Since then successive waves of health reforms have recognised the significance of the Treaty and have recommended specific strategies for Māori health.

Current health legislation, the New Zealand Public Health and Disability Act 2000, recognises the Treaty of Waitangi, the first piece of social policy legislation to do so. But when the legislation was first proposed, there was some concern about risks to the Crown and the litigation that might follow if Māori were to claim that the health sector had not delivered the best outcomes. By having a Treaty provision within legislation, it was also argued that Māori might be able to make a demand on health services for preferential treatment.

Although it was unlikely that a Treaty clause could have over-ridden other aspects of the Act or even overturned clinical common sense, the perceived clash between the principle of universality and the principle indigeneity was sufficient to lead to a redraft. In the event, the statute now makes it clear that district health boards must

address Māori health and must recognise the Treaty of Waitangi in decision-making and priority setting. To emphasise the point, the Minister of Health has appointed two Māori members to each of the twenty-one district health boards. The Act also requires that health disparities be decreased by ‘improving the health outcomes of Māori and other population groups.’

While there has not been full agreement with policies that identify Māori health as a focus, distinct from the health of other New Zealanders there has been acceptance that quality health care for Māori requires a range of factors to be taken into account, including cultural competence and Māori health views.

Currently health system objectives for Māori are not only contained in legislation but appear in the New Zealand National Health Strategy, the Primary Health Care Strategy and the Māori Health Strategy. For the most part, national policies for Māori health have obligatory consequences for district health boards which are required to report against progress made towards improved health outcomes for Māori and to indicate how their funding allocations have addressed Māori health issues. To a greater nor lesser extent, district health boards have responded positively though have not always found it possible to provide the levels of resource sought by Māori nor to reconfigure health service compliance requirements so that they align with Māori health perspectives.

### Māori Health Leadership

Māori leadership in the health sector owes much to Drs Pomare and Buck (Te Rangi Hiroa). However, Māori community leadership in health had been replaced by professional leadership - nurses and medical officers of health – by 1920. Although there was a steady stream of health professionals who were Māori, professional and institutional domination did little to encourage leadership within Māori communities or to link health gains with wider aspirations fro Māori advancement.

It was not until the mid 1980s that active Māori leadership re-emerged. It did so in the form of a series of Māori health initiatives. At first the initiatives revolved around community liaison and health promotion and arose largely because of perceived gaps in arrangements for formal health care. Māori dissatisfaction often stemmed from

concerns about cultural inappropriateness in health interventions as well as barriers to access. In contrast to the prevailing health services, Māori initiatives revolved around community workers who were well versed in Māori values, familiar with local Māori networks and sufficiently aware of health systems to advocate on behalf of consumers.

The 1993 health reforms with emphases on deregulation, devolution and contestability, provided a further opportunity for Māori health groups to tender for the delivery of services, mostly in primary health care, disability support and mental health. Quite quickly provider organisations multiplied from as few as five or six programmes in 1984 to some hundreds of registered Māori provider organisations, tribal and community, by 2004. Their approach was typically based on Māori perspectives but also came to employ conventional methods and professional staff. In fact a criticism emerging by the late 1990s was that some Māori health services had become indistinguishable from conventional services. To some extent that criticism arose out of a contracting regime that required all providers to meet similar objectives, in effect squeezing Māori providers to trade cultural innovation for compliance with measures standardised against a wider ‘norm.’ The engagement of traditional healers in primary health contracts for example was hindered because some healers regarded the suggested performance measures as too intrusive.

But by 2002, when primary health care organisations (PHOs) were first established, the rapid growth of Māori health care providers meant there was a vigorous Māori health care infrastructure able to bring a dimension to health care that was not available in earlier conservative practices. In many ways, however, workforce capacity still lagged behind Māori initiative for more provider services.

Workforce development is another common theme in indigenous health development. Māori make up around fourteen percent of the total population but only five percent of the national health workforce.<sup>17</sup> Two broad strategies have been used to address that situation. First, efforts to recruit more Māori into the health professions have included affirmative action programmes. Initiated at the University of Otago in 1900 when two positions were created for Māori students at Medical School, the policy has since been extended to the Auckland Medical School and other tertiary educational

institutions. There are now over 200 Māori medical practitioners across range of specialties. In addition scholarships have been offered as incentives to encourage enrolment in other disciplines such as nursing, social work, clinical psychology and pharmacy.

The second workforce strategy has been to engage cultural workers or Māori community health workers to work alongside health professionals, bringing first-hand knowledge of community and a capacity to engage diffident patients. Often the combination has been highly effective though there has also been concern that the two streams of workers – cultural and clinical – have simply created potential for professional and cultural interventions to diverge. An integration of cultural and clinical dimensions is one of the more pressing challenges facing Māori health care.

#### Health Service Responsiveness

Although the rise in Māori health care organisations was rapid, most Māori people were and still are, reliant on conventional primary and secondary care services. The Māori health message, however, had penetrated the prevailing health system and by 1995 most North Island hospitals had introduced a range of cultural initiatives to ensure that their processes, if not outcomes, were more able to address Māori concerns. Sometimes it was by using Māori words on public signage; sometimes by employing Māori staff; sometimes by requiring staff to attend cultural safety courses. In addition, the practice of cultural safety, introduced by the late Dr Irihapeti Ramsden, was being taken seriously by nurses and led to increased awareness of cultural difference as a factor in health care.

At a corporate level, the requirement to comply with Treaty of Waitangi obligations resulted into greater Māori representation on boards and committees, and formal links with tribal groups and Māori community organisations. Attitudes to care were also changed by the involvement of whānau (family) who pushed for more flexible visiting arrangements in hospitals and improved facilities to accommodate relatives who wished to stay close to their sick family member. But the impact of responsiveness on actual health outcomes has yet to be measured. Partly this is because it is not clear what ought to be measured. Suggestions that effectiveness could be gauged by reduced hospital admission rates did not fully recognise the level of undiagnosed

pathology existing in Māori communities so that increased admissions might actually reflect better utilisation of health facilities.

### Integrated Development

Economic restructuring in 1984 was accompanied by new approaches to Māori policy. Positive Māori development, as the policy was known, prescribed a shift away from state dependency and a welfare mentality to a greater emphasis on self-determination, economic self-sufficiency, social equity, and cultural reaffirmation. The move was in part a response to free market policies, but also consistent with world-wide indigenous rejection of assimilation and submission. For Māori it was to lead to a revitalisation of Māori language, greater confidence in tribal systems of governance and management, increasing entry in the commercial world, and the establishment of distinctive Māori provider organisations for the delivery of education, social services, housing, legal services and health care. Importantly, health initiatives were seen as integral to broader social goals as well as tribal economic development. In other words, an inter-sectoral approach was favoured by tribes. The state sectoral system, however, had difficulty accommodating that approach even though it was known that the determinants of health were multiple and linked to a range of social and economic conditions.

### Māori Health Research

Efforts to recognise Māori world views in research were greatly boosted in 1993 when the Health Research Council of New Zealand funded two Māori health research units and established a Māori Health Committee to support Māori led research projects. In addition a series of scholarships and training fellowships have enabled more than twenty Māori researchers to seek advanced research qualifications. Māori health research objectives are two-fold: to increase the Māori research capacity and to encourage the development of methodologies that reflect Māori world views and intellectual traditions.

Useful clinical applications have resulted. Te Taura Tieke, for example, is a three-part framework for describing health service effectiveness. It encompasses technical and clinical competence, structural and systemic responsiveness and consumer satisfaction.<sup>18</sup> Hua Oranga is a measure of outcome designed for users of mental

health services. Based on a Māori health perspective, it assesses outcome from a holistic viewpoint and includes ratings from clinician, client and a family member.<sup>19</sup>

### ***Results***

Whether the new approaches to health care for Māori can be translated into health gains is a question of considerable importance. Media reports have often claimed that, given continuing disparities in the health standards of Māori and non-Māori, the current approaches have been unsuccessful. It is a shallow analysis that fails to take account of the wider socio-economic context within which Māori live and it implicitly places an unfair burden on the health sector as a panacea for the ills generated within wider society.

Anecdotal evidence suggests that there have been demonstrable gains in some areas such as immunisation, smoking cessation, improved Māori self management of diabetes, asthma and hypertension. Of equal importance, however, is the degree to which Māori health awareness has been raised. Active participation within the health sector by providers, consumers or advisors has been accompanied by a level of enthusiasm that augers well for positive change. Nonetheless the full impacts of the new approaches to Māori health care need to be formally assessed.

There are of course many other issues that need further discussion and investigation. Importantly the relationship between cultural interventions and clinical interventions is often ill defined and two parallel streams can easily be formed without adequate linkages or synergies. Contracts for health services may exacerbate that particular problem by separating cultural and clinical components, especially in disability support services. In some areas Māori providers are encouraged to take up cultural support contracts quite independently of associated clinical contracts.

### **A Framework for Considering Quality Health Care for Māori**

The principles, goals and platforms that have evolved over the past two decades constitute the elements of a framework for considering how to achieve best health outcomes for Māori. The framework can be represented as a matrix, the horizontal axis containing the four goals and the vertical axis containing three principles and six platforms.

This framework, the Indigenous Health Outcomes Framework, (Table 1) has been constructed on the basis of Māori experience over the past two decades. It needs to be seen alongside the other models and frameworks presented at the Alberta Symposium on Health so that a comprehensive and clear picture of quality health care can emerge. Meanwhile, in New Zealand the several elements in the framework have positioned Māori to move forward with greater confidence and a clearer sense of direction than was evident in 1984 when the first Māori health conference was held (the Hui Whakaoranga). The framework has also allowed Māori aspirations for improved health outcomes to be addressed within the context of national health policies and strategies, policies for Māori development, and district health board priorities.

Table 1 Indigenous Health Outcomes Framework

<b>Goals</b> →	<b>Healthy lifestyles</b>	<b>Equitable health outcomes</b>	<b>Reduced socio-economic disparities</b>	<b>Self determination and self management</b>
<b>Principles</b> <ul style="list-style-type: none"> <li>• Indigeneity</li> <li>• Clinical &amp; cultural competence</li> <li>• Human dignity</li> </ul>				
<b>Platforms</b> <ul style="list-style-type: none"> <li>• Māori paradigms</li> <li>• Health policies</li> <li>• Māori leadership</li> <li>• Responsive health services</li> <li>• Integrated development</li> <li>• Research</li> </ul>				

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