Health challenges for Aotearoa – Māori Health

Ma te ara mai, ka kite te ara atu.

(*The path here reveals the path ahead.*)

At the time of first contact, early explorers like Captain Cook and James Busby noted the robust health of Māori as being superior to that of the average European, noting that those he had shot recovered remarkably quickly.[1]

For most of the history of our nation, Māori have suffered a greater burden of disease and premature death than non-Māori. The state of Māori health speaks to the journey of development as a culture from Polynesian roots to the devastating impact of exposure to infectious diseases caused by colonisation by the British Empire, and to recovery and growth throughout the 20th century.

Disparities have continued, however. For example, WAI 2575, the Waitangi Tribunal's Kaupapa inquiry into health, found the Crown has breached te Tiriti o Waitangi by failing to design and administer the current Primary Health Care system to actively address persistent Māori health inequities and by failing to give effect to the Treaty's guarantee of tino rangatiratanga (autonomy, self-determination, sovereignty, self-government).

To consider these disparities further, this paper takes an historical lens to describe colonisation and then introduces theories of health on social capital and the impact of social hierarchy. The paper then describes current health disparities between Māori and non-Māori.

Section 1: Historical and contextual analysis

Te Tiriti o Waitangi

Aotearoa New Zealand was established as a nation in 1840 by the signing of te Tiriti o Waitangi between the British Crown and Māori iwi and hapū, the tangata whenua. It was through te Tiriti that the British Crown gained authority in New Zealand and the clauses of te Tiriti set the terms and responsibilities of that authority. The clauses have become accepted as:

- Kawanatanga: the Crown holds the responsibility to govern and protect the wellbeing of the nation
- Tino rangatiratanga: iwi and hapū have the right to shape their own destiny
- Ōritenga: the Crown treats Māori as equal to British citizens.

It is a matter of record that te Tiriti has been imperfectly implemented[2] and the Crown's failure to honour te Tiriti o Waitangi has been the principal driver of disparities in health and other social inequities. The Crown failed to protect the rights and aspirations of iwi Māori, the principal task of **kawanatanga** set out in Article 1.

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[1] Crosby, A. 1986. *Ecological Imperialism. The Biological Expansion of Europe, 900-1900*. Cambridge University Press. Cambridge.

[2] Queen Elizabeth. *New Zealand Herald*, 7 January 1990, p. 2.

It has also: deprived Māori of the resources and rights needed to enable them to exercise **tino rangatiratanga**; left Māori vulnerable to economic forces beyond their borders and their control; and as a result deprived them of the capacity to shape their own destiny.

The impact of these failures alongside targeted racist policies, such as banning te reo from schools, has been disparities in all social outcomes. These constitute breaches of the Crown's obligation of **ōritenga**, that is, to treat Māori as having the same rights non-Māori.

The breaches have compounded more than 180 years of settler state misrule and put Māori far from the aspirations of our tīpuna who thought by agreeing to te Tiriti o Waitangi they were securing the future of te iwi Māori.

Land alienation

Māori did not choose to lose their lands but the settler state from 1853 was determined to remove them. Māori were separated from their principal asset, their lands, by outright war, legislation, duress and 'unconscionable fraud.'

The result was Māori went from owning around 30 million hectares of land in 1840 to a low point of 1.2 million hectares by 1986. For much of this time, even the land Māori did own was managed by land trusts, over which the owners had very little control. Much of trust lands were leased out at very low cost to non-Māori, leaving whānau with land they were unable to use or even earn an income from.[3]

A long history of deliberate alienation of land from Māori by the Crown is clearly laid out in reports by the Waitangi Tribunal. Its reports on district inquiries outline the determination of the Crown to strip Māori of their land. In 1885, MP Robert Bruce declared that:

> *we could not devise a more ingenious method of destroying the whole of the Māori race than by these land courts. The natives come from the villages in the interior, and have to hang about for months in our centres of population... They are brought into contact with the lowest classes of society, and are exposed to temptation, the result is that a great number contract our diseases and die.*[4]

Suppression of culture

While Māori were being squeezed off their land, the use of Reo Māori was banned in schools and laws such as the Tohunga Suppression Act 1907 were used to suppress traditions – and those leaders who sought to exercise rangatiratanga for their hapū, such as Rua Kenana.

Landless Māori became a rural workforce forced to work their lost lands to survive. In the period after the Second World War, agricultural industrialisation forced Māori into towns and cities to find work. This great diaspora across urban centres undermined hapū and whānau structures that had maintained traditions and cultural norms. Tikanga and matauranga Māori were demeaned and both formal and informal pressures were used to break up Māori whānau. The intention was for Māori to lose their identity and to become integrated or absorbed into the Pakeha population, albeit at the bottom.

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[3] Durie M. (1998). *Te Mana, Te Kawanatanga.* Oxford University Press.

[4] New Zealand Parliamentary Debates, 1885, vol. 52, p. 515.

Urbanisation

Urbanisation led to larger numbers of Māori living in cities in low skilled, low paid jobs. However, many were unionised and this saw some Māori begin to establish significant improvements in income and wellbeing. Unionisation reflected an alliance forged between the Labour Party and the Ratana Church, whose followers, known as te morehu (survivors), became the dominant force in Māori politics.

There were some who did not fare well from urbanisation. The response of the Crown was to separate families which led to the creation of stolen generations who were taken from their families and placed in the 'care' of state institutions.

The horrific impact of these institutions on Māori has been exposed by the work of the Royal Commission of Inquiry into Abuse in Care. Although far from completing their work, they have already identified the Crown's actions as a significant contributor to many Māori social problems such as gangs, drug addiction, and mass incarceration where Māori now represent more than 50 percent of the prison muster, despite being 17 percent of the population.

Neoliberal reforms

In difficult times the Crown has adopted policies to punish the poor, seeking to blame them for the failings of an economy they have no influence over, and Māori have become the shock absorbers of the economy.

Even those who made gains in the 1950s and 60s found themselves going backwards after the neo-liberal reforms of the 1980s. The Crown abandoning its social obligations led to the deconstruction of many urban economies and the destruction of workers' rights. Māori unemployment was four to five times that of non-Māori and this led to an increase in Māori mortality.

The neoliberal reforms also deconstructed provincial infrastructure and collapsed rural towns. Rural neglect has left areas with high Māori populations such as Tai Tokerau, Bay of Plenty, and Tai Rawhiti with intrenched intergenerational unemployment.

This period of economic policy drove cycles of disadvantage that deprived whole communities of economic opportunity and created a welfare dependency that was unheard of during the time of the welfare state (1935-75). Notably, the only period of decline in Māori life expectancy was during the neo-liberal policies that defined the last 15 years of the 20th century.[5]

Economic policies that increased inequalities, such as the neo-liberal reforms of 1984-1999, leave poorer people vulnerable to poorer health outcomes.

Neo-liberal reform and meningococcal disease

An example of the cost of the neo-liberal experiment was the unique strain (B;4:PI.7b,4) of meningococcal disease that became an epidemic in New Zealand in the 1990s. Its increase can be linked to social policies adopted over that period that led to an increase in crowded accommodation for people living in poverty.

The impact was significantly greater for Māori (three times the infection rate than that of European) and Pacific peoples (six times that of European) and concentrated in young people living in urban areas, particularly in South Auckland.

[5] Pomare, E., Keefe-Ormsby, V., Ormsby, C., Pierce, N., Reid, P., Robson, B., & Watene-Haydon, N. (1995). *Hauora: Māori standards of health*. GP Print, New Zealand.

The first meningococcal spike occurred in 1991 almost directly after the “Mother of All Budgets” introduced by Finance Minister Ruth Richardson. Significantly reduced benefits paid to sole parents led to greater shared accommodation by beneficiaries and created an ideal environment for the new strain of meningococcal disease to thrive.

The epidemic was further exacerbated by a second spike in 1994-5, following the adoption of a set of radical market driven housing reforms that profoundly transformed the role of the state in the housing system and forced the poor into increasingly crowded houses.

The meningococcal epidemic had a major impact on Māori and Pacific peoples who carried the bulk of the burden of the epidemic which infected 6128 people with a mortality rate of 4.1 percent (or 251 deaths) by the year 2007.[6]

While the 21st century governments have not pursued the extreme neo-liberal policies of the 1990s they have not reversed them and inequality has continued to be a dominant fact in our nation, despite many stated Crown aspirations.

Social capital

To understand the full impact of colonisation it is useful to consider the role of social hierarchy in health. Studies have consistently shown that the higher someone is in any social hierarchy the better their chances of a longer life. These studies came from diverse populations – from English public servants to rhesus macaque monkeys – that have shown that place in a social hierarchy is a better predictor of mortality than any known health risk, such as obesity, smoking or lack of exercise.[7]

Further, access to social support networks or social capital have been shown to reduce health risks, particularly if those networks access support from within power elites.[8] [9] Inclusion within power elites comes from common ethnicity, class and gender; a lack of commonality can easily become exclusion.

Stress

Studies of the impact of hierarchy impacts on health show that stress is a key factor in increasing health risk. The adrenal response is a normal part of the body’s response to any perceived threat. Stress is well described in medical literature and commonly known as the ‘flight or fight’ response.

In essence the adrenal response shifts the body from balancing short- and long-term needs, to focusing on a short-term response to a perceived threat. However, if stress is a constant then people begin to suffer from chronic stress.

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[6] Kieft C, Baker M. Martin D. (2001). *The epidemiology of meningococcal disease in New Zealand in 2000.* Report prepared for the Ministry of Health by the Institute of Environmental Science and Research Limited (ESR).

Wong, S., and Reid, S. (2019). Group B meningococcal disease in New Zealand: Epidemiology and Prevention. *Research Review New Zealand.*

[7] Marmot, M. (2015). The health Gap: the challenge of an unequal world. *Lancet, 386,* 2442–4.

Marmot, M. (2015). *The status syndrome: how social standing affects our health and longevity.* Bloomsbury.

Marmot, M., & Wilkinson, R. G. (2006) [1999]. *Social determinants of health (2nd ed.).* Oxford University Press.

Sapolsky, R. (1997). *The trouble with testosterone: and other essays on the biology of the human predicament.*

Shively, C. A. & Willard S. L. (2012). Behavioral and neurobiological characteristics of social stress versus depression in nonhuman primates. *Experimental Neurology*, 233, 87–94.

[8] Bizzi, L. (2015). The concept of social capital. *International Encyclopedia of the Social and Behavioral Sciences* (Second Edition).

[9] Patulny, R.V., Lind, G., Svendsen, H. (2007). Exploring the social capital grid: bonding, bridging, qualitative, quantitative. *International Journal of Sociology and Social Policy, 27* (1/2), 32-51.

Chronic stress is associated with heart disease, Type 2 diabetes, and cancers, which are the principal causes of illness and premature death for Māori. This process of wearing down the body has been described as premature ageing.[10]

Stress becomes chronic when there is not the means to respond to these challenges, or where people lack agency over managing risks or the resources to respond to them. The higher up someone is in social hierarchies means they have greater control over those threats, resources to respond, access to support, and therefore a reduced health impact of stress.

If people are excluded from accessing state institutions, as Māori have been during much of our colonisation, then the health costs of stress increase. If the social support structures are dismantled, as have been Māori structures of iwi and hapū, then protective aspects of social cohesion are lost. Even close whānau lose their strength when iwi and hapū are not given autonomy to act and have no connection to power elites.

Racism

In settler-colonial states like New Zealand, a key border of inclusion/exclusion is usually ethnicity, as the institutions of the settler state are designed to maintain the settler influence and control over the resources of the state. To maintain settler control, the settler culture must be given hegemony over the indigenous population it has supplanted.[11]

In Aotearoa New Zealand racism has been a consistent feature of our history and is reflected in the institutions that shape our lives, including the health and education systems.[12] [13] The impact of racism on our health has been studied and is significant.[14]

Racism takes several forms[15] and institutional racism reflects the purpose of the settler state. There is also personal racism and what has often been called unconscious bias (although it is seldom perpetrated by someone who is asleep).

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[10] Jones, C.P. (1994). *Methods for comparing distributions: development and application exploring "race" – associated differences in systolic blood pressure.* Dissertation. Johns Hopkins School of Hygiene and Public Health, Baltimore, MD.

Jones, C.P. (1999). *Māori-Pākehā health disparities: can treaty settlements reverse the impact of racism?* Ian Axford Fellowships Office, New Zealand.

Jones, C.P. (2000). Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health, 90* (8), 1212–1215.

[11] Durie, M. (1998). *Te Mana, Te Kawanatanga.* Oxford University Press.

[12] Simon, J, (2001) (ed). *A civilising mission? Perceptions and representations of the New Zealand native schools system.* Auckland University Press

[13] Came, H. (2012). *Institutional racism and the dynamics of privilege in public health*. Doctoral thesis. University of Waikato.

[14] Harris, R., Cormack, D., Tobias, M., Yeh, L-C, Talamaivao, N., Minster, J., & Timutimu, R. (2012). Self-reported experience of racial discrimination and health care use in New Zealand: Results from the 2006/07 New Zealand health survey. *American Journal of Public Health, 102*, 1012-1019.

[15] Jones, C.P. (2000). Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health, 90* (8), 1212–1215.

Section 2: Current state

The impact of colonisation can be clearly seen in the disparities that occur across all measurable social indicators. This section gives clarity to the impact by detailing examples of these disparities in health.

Life expectancy

The current gap between Māori and non-Māori life expectancy at birth was 7.5 years for males and 7.3 years for females in 2017–2019. This is down from 8.6 years for males and 7.9 years for females in 2005–2007, and from 8.8 and 9.3 years respectively in 1995–1997.

Life expectancy at birth was 73.4 years for Māori males in 2017–2019 (up 3.1 years from 2005–2007), and 77.1 years for Māori females (up 2.0 years from 2005–2007). In comparison, non-Māori males are expected to live to 80.9 years, while non-Māori females are expected to live to 84.4 years. The gap has grown slightly from 2012–2014.

Cancer

A closer examination of the above data tells us more clearly that drivers of disparities are both wider socioeconomic differences and access to timely health care.

An example is cancer, where disparities in outcomes show poorer outcomes in cancers, even when the prevalence of some cancers is lower.[16] Māori continue to have poorer survival rates than non-Māori for 23 of the 24 most common causes of Māori cancer deaths, with the extent of this disparity ranging from 12 percent to 156 percent. The magnitude of these disparities varies according to deprivation, comorbidity, and stage.[17] The overall mortality rate for Māori for cancer is 215.6 per 100,000 compared to 120.3 for non-Māori.[18] There is strong evidence that access to diagnosis and early treatment improves cancer survival.[19]

Heart disease

Similar patterns occur in all the major causes of morbidity and mortality for Māori. For example, Pomare and others identified that, while Māori are more likely to die or be hospitalised for heart failure,[20] they are less likely to be admitted to hospital for heart interventions. This was confirmed by Westbrooke and Baxter's study that considered hospital admissions for heart failure and heart interventions.[21]

It should also be noted that causes of significant heart morbidity or premature mortality are similar for all, but for Māori the health burden arrives earlier and more severely.

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[16] Robson, B., Cormack, D., & Purdie, G. (2010). *Unequal impact II: Māori and non-Māori cancer statistics by deprivation and rural–urban status, 2002–2006*. Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago.

[17] Gurney, J., Stanley, J., McLeod, M., Koea, J., Jackson, C., & Sarfati, D. (2000). Disparities in cancer-specific survival between Māori and non-Māori New Zealanders, 2007-2016. *JCO Global Oncology,* 6, 766-774

[18] https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics

[19] Rubin, G., Vedsted, P., & Emery, J. (2011). Improving cancer outcomes: better access to diagnostics in primary care could be critical. British Journal of General Practice. May;61(586), 317-8.

[20] Pōmare, E. W., & de Boer, G. M. (1988). *Hauora: Māori standards of health. A study of the years 1970-1984*.

New Zealand Department of Health.

Pōmare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B., & Watene-Hayden, N. (1995). *Hauora III: Māori standards of health*. Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago.

[21] Westbrooke, I., Baxter, J., Hohan, J. & (2001). Are Māori under-served for cardiac interventions? *New Zealand Medical Journal,* 114(1143), 484–487.

Mental health

Information about mental health outcomes is much harder to obtain. Mental health data has yet to emerge from the total collapse of national data in the early 1990s, when diagnoses of psychiatric illness was expanded to Primary Health Care doctors as part of the de-institutionalisation of the mental health system.

Access to mental health services is harder for Māori and, additionally, there is a high rate of Māori entry into the mental health system through the compulsory route through the justice system. This strongly suggests that Māori do not have good access and support in the early stages of mental distress.[22]

A comprehensive review of the mental health and addictions sector, He Ara Oranga, examined quantitative evidence as well as interviews of those with lived experience of the system. It is well worth quoting from the report's conclusion:

> *Many Māori pointed out that current mental health services, strategies and policies do not reflect a genuine partnership between the Crown and Māori. They argued that the way our health system approaches mental distress and illness reflects a colonising world view largely hostile to Māori understandings of wellbeing. They spoke of compulsory treatment as a threat to mana and to their ability to live as Māori.*
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> *We heard that recognition of the importance and significance of ties to whānau, hapū, iwi and family group, including the contribution those ties make to wellbeing, and proper respect for cultural and ethnic identity and language, rarely form part of psychiatric assessments. They are routinely not addressed by courts, tribunals or others when making decisions about compulsory assessment and treatment. We also heard that patients are denied their entitlement to be dealt with in a manner that accords with the spirit of proper respect for cultural identity.*
>
> *Māori explained that their mental health has suffered as a direct result of a long-standing alienation from their land and the impact of colonisation and generational deprivation. They said that reclaiming mental wellbeing requires reconnection to land, culture, whakapapa and history, but many mental health and addiction services barely acknowledge the importance of this connection and thus reinforce trauma.*[23]

Infectious diseases

Disparities in infectious diseases illustrate the lack of equitable care for Māori, as well as the deep historical roots of disparities. Māori were particularly vulnerable to infectious disease on early contact with European explorers. Māori were bacteriologically 'naive' having lived in small, isolated populations as they traversed the Pacific, while early European arrivals were bacteriologically 'fecund'. This resulted in devastation to Māori as it did across the Pacific and the Americas.[24] [25]

In the period after the Land Wars, when Māori had most of their resources taken from them by deliberate Crown policy, Māori were driven into poverty and became prone to severe epidemics. The most severe of these was the 1918-19 influenza pandemic. Around eight thousand New Zealanders died and while exact numbers were not recorded it has been

[22] He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction www.mental health.inquiry.govt.nz/inquiry report/

[23] Ibid

[24] Moorhead A. (1966). *The fatal impact*. Hamish Hamilton.

[25] Crosby A. (1986). *Ecological imperialism: the biological expansion of Europe, 900-1900*. Cambridge University Press.

estimated 2000-2500 of these were Māori. More than 25 percent of the deaths were Māori who were around 5 percent of the population.

A review of the Government's response by Royal Commission in 1919 did not have any Māori witnesses and Māori were only described as a source of infection for others.[26] [27] A discussion on rheumatic fever in the heart disease section is of particular concern:

> For the first two decades of the 21st century, 93 percent of initial rheumatic fever cases have been in Māori and Pacific people under 30, with the majority of those cases affecting children between the ages of 5 and 14 years. A table of rheumatic fever rates by DHB region for 2020-21 tells the story. Northland with 6.7 cases per 100,000 people has the highest incidence. In Auckland, Counties Manukau DHB recorded three times the rate of Auckland and Waitematā DHBs, in the Auckland region. Institute of Environmental Science and Research (ESR) data estimates 159 premature deaths a year due to rheumatic fever: young people whose parents and families have had to farewell before their time.[28]

Infectious diseases continue to present higher risks for Māori including the current COVID pandemic.[29] [30]

Access to Primary Health Care

Primary Health Care in New Zealand is, in the main, run as a subsidised private business. As a result, the costs to whānau are significant and a major barrier to access for low-income communities such as Māori.

Access to Primary Health Care services are key factors in disparities and, although accurate data is hard to obtain, the 1917/18 New Zealand Health Survey reports that 27.4 percent of Māori under 14 years report experiencing unmet need for Primary Health Care, compared to 19.4 percent of non-Māori under 14-year-olds. For those over 14, the figure rises to 38.0 and 27.4 percent respectively.[31]

Socioeconomic determinants of health

Similar patterns exist in intentional and unintentional injuries, disability, and other major health conditions.[32] The comprehensive and persistent extent of disparities and the exacerbating impact of poverty and poor access to health services for Māori is consistent across all health conditions.

For this reason, it is pointless to outline the much-quoted evidence of lifestyle risks as these are reflected in the outcomes and the socioeconomic determinants of health. There is overwhelming evidence that poverty and exclusion suffered by people of colour lead to poor health outcomes; and while smoking, drug consumption and poor diet are proximal causes

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[26] Durie, M. (1994). *Whaiora.* Oxford University Press.

[27] Rice, G. (2017). *Black Flu 1918.* Canterbury University Press.

[28] https://www.auckland.ac.nz/en/news/2022/03/29/rheumatic-fever-time-to-stamp-it-out.html.

[29] Wilson, N., Barnard, L.T., Summers, J.A., Shanks, G.D., & Baker, M.G. (2012). Differential mortality rates by ethnicity in three influenza pandemics over a century, New Zealand. *Emerging Infectious Disease, 18*(1), 71-7.

[30] Khieu, T.Q.T., Pierse, N., Telfar-Barnard, L.F., Zhang, J., Huang, Q.S., & Baker, M.G. (2017). Modelled seasonal influenza mortality shows marked differences in risk by age, sex, ethnicity and socioeconomic position in New Zealand. *The Journal of Infection and Public Health, 75*(3), 225-233..

[31] https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics

[32] Ibid.

of many illnesses suffered by the poor, the underlying distal determinants of health are poverty, racism and exclusion.[33] [34] [35]

Conclusion

Māori health is a wicked problem. Its roots are colonisation, but each generation has faced new challenges that compound the disadvantage that the loss of their land and all the resources it held for them.

The impact of colonisation on Māori is like that of indigenous and minority populations all over world. All peoples whose lives and lifestyles were shattered by the European colonisation of the 18-20th centuries have been denied civil rights and lost most of their resources and made second class citizens in their own lands.

The settler state was created in the wake of te Tiriti o Waitangi and acted largely in direct breach of it – and only begun to consider the obligations of te Tiriti after the Treaty of Waitangi Act of 1975. This has led to significant change in direction and has given Māori the opportunity to reclaim the rights guaranteed by te Tiriti.

In health this has included the development of Māori health services and, while these services have struggled for recognition and adequate resourcing, they reflect the aspirations of Māori to shape their own destiny. The Pae Ora (Healthy Futures) Act of 2022 has created Te Aka Whai Ora (Māori Health Authority) that gives greater recognition of that aspiration – and time will tell how the Crown will honour its obligation.

It is important to understand our history to be able to heal its wounds and while it is difficult to confront the past we can only move past this history when we truly understand it. We must have the courage to learn from the past and the courage to take the opportunities to heal these wounds.

[33] Lynch, J.W., Kaplan, G.A., Salonen, J.T. (1997). Why do poor people behave poorly? Variation in adult health behaviours and psychosocial characteristics by stages of the socioeconomic lifecourse. *Soc Sci Med, 44*(6), 809-19..

[34] Blakely, T., Carter, K., Wilson, N., Edwards, R., Woodward, A., Thomson, G., & Sarfati D. (2010). If nobody smoked tobacco in New Zealand from 2020 onwards, what effect would this have on ethnic inequalities in life expectancy? *New Zealand Medical Journal*, 123(1320), 26-36.

[35] Blakely, T., Fawcett, J., Hunt, D., & Wilson, N. (2006). What is the contribution of smoking and socioeconomic position to ethnic inequalities in mortality in New Zealand? *Lancet, 368*(9529), 44-52.