MASSEY UNIVERSITY

TE MATA O TE TAU LECTURE SERIES 2009

'THE PAERANGI LECTURES'

MĀORI HORIZONS 2020 AND BEYOND.

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PAE ORA

Māori Health Horizons

Mason Durie

7 July 2009

PAE ORA: MĀORI HEALTH HORIZONS

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The Paerangi Lectures

Pae Ora: Māori Health Horizons is the second of three *Paerangi Lectures*. It will consider the broad approaches to Māori health over the past two decades and the gains that have resulted. But like the other two lectures *Pae Ora* is primarily positioned in the future, and contemplates the consequences of global, local, environmental, and family determinants on Māori health. In the first lecture, *Pae Matatū Sustaining the Māori Estate*, the rapid growth of the Māori asset base was seen as a positive development but one that would demand expert governance and management to ensure that future generations could enjoy the full benefits of their entitlements. Questions relating to the transfer of assets from one generation to another were raised and the importance of future proofing as a way of protecting the interests of future generations was explored. Balancing short term gains against longer term benefits was seen as a serious governance challenge. The major conclusion, however, was that the Māori estate would grow in both size and diversity; it would include customary resources such as land, tradable assets including real estate and shares in international companies, and cultural heritage typified by marae and te reo Māori.

The third lecture, *Pae Mana: Waitangi and the Evolving State* will focus on the relationship between Māori and the Crown in a post-settlement environment. It will raise questions about the constitutional position of Māori beyond 2020, the relevance of the Treaty of Waitangi as a platform for forward development rather than as a vehicle for redress, and the ways in which indigeneity will, or will not, be valued in the future. The implications for Māori if New Zealand were to become a republic will be discussed in the context of Aotearoa as an evolving democracy in the South Pacific with longstanding links to Pasifika and strong trade and diplomatic relationships with Asian economies.

Meanwhile without ignoring the recent past, *Pae Ora* explores the future, moving in similar directions to the other two lectures. Having emerged from a twenty-five year period of Māori health transformation, *Pae Ora* explores possible directions for the next quarter century. In a future environment where technological innovation, demographic transitions, unexpected catastrophes and epidemics, will interact with indigenous aspirations and strengthened Māori capability, outcomes will be difficult to predict. Yet despite the uncertainties ahead and the rapidly changing nature of New Zealand society, *Pae Ora* concludes that Māori health will be a function of Māori determination and Māori know-how. Whānau will make the most significant difference to Māori health and wellbeing, and Whānau empowerment will be shaped by access to quality information and advice, necessary resources, healthy living, a sense of self control and self determination, and a conviction that the future can be created, not simply endured.

Foundations for Change

Although *Pae Ora* is primarily focussed on 2020 and beyond, strong foundations for change have been laid over the past twenty-five years and have resulted in major transformations. Large scale societal transformations do not occur often and when they do happen they are often quickly absorbed by societal institutions so that later generations perceive them as longstanding norms. In addition the full impact of a transformation can be overshadowed by crises of the day which leave little room for reflecting on change over time. Any suggestion of a transformation in Māori health over the past quarter century, for example, might be challenged by the known widespread prevalence of type II diabetes or the high levels of drug abuse among young people, or excessive mortality rates for cancer. Disparities in standards of health between Māori and non-Māori indicate that for almost all diagnostic categories, including mental disorders, injuries, and disabilities, the Māori rate exceeds that of non-Māori by two or three times (Robson, Harris 2007). However, despite the unacceptably high disparities, Māori and non-Māori comparisons do not accurately reflect progress made by Māori over time. Benchmarking Māori health gains solely against non-Māori standards of health assumes that Māori health is best understood by reference to a national statistical norm. To provide a comprehensive picture of change and its significance other indicators are also necessary. Health cannot be totally understood by a comparison of categories of illness or disease across ethnic groups; the comparative approach needs to be balanced by a temporal approach that views Māori health through a Māori lens relying neither entirely on non-Māori prevalence rates or diagnostic categories.

Signs of a new approach to Māori health had emerged in the 1970s (Durie, 1977), but the signals were especially strong in 1983. In its first major report, the Waitangi Tribunal released findings on the Motunui River claim (Waitangi Tribunal 1983). Fears that a new petrochemical plant would increase pollution of the river and fishing reefs led to a case against the Crown, as the architect of 'Think Big' industrial development projects. A Māori environmental ethic, hitherto largely unknown to most New Zealanders, formed the basis for a recommendation that land-based disposal of waste should be pursued ahead of water disposal. The Tribunal had drawn attention to the link between industrial development and environmental sustainability at a time when a New Zealand green conscience had yet to form. Further, embedded in the Motunui Report was also a finding that cultural values were integral to both environmental and human wellbeing.

In the same year legislation was passed to establish the New Zealand Board of Health. Although disestablished within a decade, the Boards Māori Standing Committee had meanwhile proposed that Iwi could be effective champions for Māori health. The prospect that tribal leaders might involve themselves in health seemed unlikely then but the Board supported the proposal and forwarded it to the Government as a strong recommendation (Standing Committee on Māori Health, 1987). Meanwhile at a Young Peoples Hui held at the Raukawa Marae in Otaki, in 1983 too, a four part Māori perspective of health, later known as Whare Tapa Wha, was introduced and endorsed as an approach that was relevant to Māori and to rangataghi (Winiata, 1984).

Another sign of change also emerged in 1983 when Whaiora was established. Located within the large Tokanui psychiatric hospital, Whaiora introduced Māori approaches to treatment and care adding a cultural dimension that had been totally lacking in the formal health services and arguing that health outcomes would be improved if the cultural context for service delivery were relevant to consumers (Rankin, 1986).

But the clearest indications of change became evident the following year in 1984. First, the Hui Whakaoranga was held at the Hoani Waititi Marae in West Auckland. Organised by a fledgling Māori health unit within the Department of Health, and led by Dr Paratene Ngata, the event was the first national Māori health hui in modern times (Steering Committee, 1984). In addition to Departmental representatives, health specialists, hospital board members, and Māori health professionals, the participation of tribal elders and Māori community leaders injected a fresh dimension to the discussions. By the end of the three day conference, three directions had been endorsed: the incorporation of Māori health perspectives into the delivery of health programmes, increasing the professional Māori health workforce, and developing Māori health provider organisations.

The second significant event in 1984 was the Hui Taumata; a Māori Economic Summit held shortly after the election of the Fourth Labour Government. Again, Māori leaders urged the Government to adopt a positive approach to Māori development by fostering Māori economic capability, tribal delivery systems, and the revitalisation of culture, especially te reo Māori. Both the Hui Whakaoranga and the Hui Taumata had moved in the same direction, away from a total reliance on the state and towards self management and self determination, aspirations that were to be increasingly captured by the concept of tino rangatiratanga.

Measuring Progress 1984 – 2009

There are a number of ways to assess the results of Māori health policies and programmes initiated in 1984 and implemented over the following 25 years. They include measures of life expectancy, levels of health awareness, the dissemination of Māori health knowledge, Māori participation in the health sector, and Māori health leadership.

Life Expectancy

Importantly over the past 25 years there has been a significant increase in Māori life expectancy. In 1985 Māori men could expect to live for 68 years and Māori women for 72 years (Pool, 1990, pp. 190-3). But by 2007 Māori life expectancy had increased to 70.4 years for males and 75.1 years for females (Statistics New Zealand, 2009), increases of 2.4 years and 3.1 years respectively. Moreover, whereas the difference between Māori and non-Māori life expectancies was increasing during the 1980s and 1990s (Ajwani et al 2003), by 2002 there were signs that the gap was narrowing (Ministry of Social Development, 2006, pp 24-25). For all New Zealanders in the years 2006-2008 a newborn girl could expect to live to the age of 82.2 years and a boy to 78.2 years.

Māori Health Awareness

Measuring the health status of Māori individuals is one measure of health but given the developmental thrust of the past twenty-five years, and the time lag between laying foundations and realising the full benefits, other indicators are also useful. An important indicator for example is health awareness and the inclusion of health as an item on the Māori agenda. Prior to 1984 fewer that five Iwi included health as part of tribal business. For the most part health had been regarded as a function of health professionals, hospital boards, and the government. In contrast all Iwi now regard health as a high tribal priority and most have developed health programmes delivered by their own people. Iwi health interests are evident in environmental initiatives, marae health policies, and programmes such as marae smoke free, sport and exercise programmes, health governance, and the provision of health services. Within urban Māori communities the delivery of health services has assumed an even higher priority; early intervention for child health, mental health services, cancer care navigation and support, and walk-in clinic services are offered as part of a wider package of care for whānau (Te Whānau o Waipareira Trust, 2008).

Māori Health Knowledge

A third measure of progress is the extent to which Māori knowledge is incorporated into accounts of health generally. Building on the Māori perspectives introduced in 1983/84, knowledge based on Māori understandings and Māori world views has become integral to treatment protocols, assessment procedures, measures of outcome, and frameworks for analysis. Not only has Māori knowledge become incorporated into practice but it has also become part of the health curriculum in universities, polytechnics, and wānanga. Moreover, the establishment of six Māori health research centres since 1993, all employing Māori methods alongside conventional approaches, has demonstrated the relevance of Māori knowledge to understanding contemporary health problems. By the same token, a Māori nursing programme instituted in 2009 aims to train nurses to work effectively with Māori using a mix of Māori and universal methods and theories.

Māori Participation in Health

The most obvious measure of progress, however, has been growth in the Māori health workforce and the parallel growth in the number of Māori health providers. In 1984 there was one Māori health non-government organisation (NGO); by 2009 there were more than 270 delivering a wide range of programmes in mental health, child health, health promotion, disability support, midwifery, and public health.. The number of Māori health professionals has similarly shown a spectacular increase. Between 1984 and 2009 the number of medical practitioners has increased from around 50 (0.5 percent) to over 250 (three percent); from 4 dentists in 1984 there were some 48 in 2009; and from almost none 25 years ago there were more than 300 Māori addiction workers (20 percent) in 2009. The phenomenal increase in the number of Māori health support

workers, community health workers, health professionals and cultural advisors has created a total workforce that has already revolutionised New Zealand's health sector.

Māori participation in health policy, health governance and health management has also increased over the past quarter century. Māori representation on district health boards (DHBs) has largely been achieved through Ministerial appointments as part of a policy that recognises Māori health as a Government priority. At both national and local levels, Māori participation in health policy formulation and policy implementation has been evident at senior management levels. In contrast to 1984 when no hospital boards employed Māori health managers, in 2009 Māori health management is strong in both DHBs and NGOs.

Māori Health Leadership

A fifth measure of progress, related to Māori provider development, can be seen in the network of Māori health leadership. Large numbers of older Māori men and women have entered the health sector ready to play vital roles as advocates, conduits for tribes and communities, supporters for staff, and advisors on matters of tikanga and human ethics. Not only do Māori health providers now employ kaumatua as key members of the team, but district health boards, community programmes and government departments have similarly engaged kaumatua to effect better links with Māori communities and to provide advice on the implementation of Māori health policies and programmes. In addition the establishment of Māori professional organisations such as Te ORA (Māori Doctors Association), Te Kaunihera (Māori Nurses), and Nga Maia (Māori Midwives) has provided practitioners with coordinating and advocacy functions at a national level.

The Twenty-five Years Ahead

Reviewing the past twenty-five years may seem peripheral to a discussion about the future. But there are two reasons for looking back in time. First, the gains made since 1984 have established the foundations upon which the next set of transformations will unfold. Although the directions will predictably shift to meet changing circumstances, it is unlikely that future policies or programmes will be revolutionary. Instead a process of incremental radicalism will build on past successes to take Māori on a journey towards 2035. Second, among those who attended the Hui Whakaoranga in 1984, few if any would have been able to predict the transformations that have occurred. In that respect, forecasting the twenty-five years ahead, and the implications for Māori health and wellbeing will defy accurate prediction.

Yet, despite the challenges of anticipating Māori health over the next 25 years, the future can be explored using a set of tools that include the analysis of past trends, statistical modeling, life course epidemiology, and scenario development. Demographic projections for example have a reasonably high level of certainty; the Māori population will increase at a relatively fast rate - there will be some 800,000 by 2051 as well as 200,000 or more living overseas. By 2051 about

one-third of all New Zealand children will be Māori but the percentage of men and women over the age of sixty-five years will increase from four percent in 2006 to thirteen percent in 2051.

Life course epidemiology predicts the future health status of populations by estimating the long term consequences of disease and injury. Otitis media in infancy for example increases risk for hearing and learning disability throughout life and conduct disorders in childhood increase risk of serious offending in adolescence and early adulthood. The longer term effects of smoking in adolescence are well known and include cancer, heart disease, and hypertension. Obesity in childhood will often result in diabetes later in life just as diabetes in the third and fourth decades will increase the risk of heart disease, poor vision and renal disorders in the fifth and sixth decades. Given current standards of Māori health, life course epidemiology could suggest that the burden of disease will be high and that the larger older Māori population will have high health needs. Much will depend, however, on the effectiveness of intervening action. Progression along a downhill pathway is by no means inevitable; while early interventions will have the greatest prospect of lengthening life and avoiding disability, interventions later in life can still reverse a pattern of progressive incapacity.

Scenario construction provides another vehicle for steering a course into the future. Typically, scenarios navigate between emerging trends and patterns as well as allowing for the intrusion of the unexpected. They take into account global trends and impacts, environmental patterns such as climate change, national and international economies, new technologies, the aspirations of individuals and collectives, and human capabilities such as levels of education, fluency in language and skill sets. Two scenarios illustrate the ways in which future situations can be portrayed according to different sets of circumstances; both are centred on whānau and whānau health but respond to different triggers and lead to diametrically opposite conclusions.

Scenario 1 Whānau Ora

> In the first scenario, by 2035 whānau have become beneficiaries of Treaty of Waitangi settlements. The *Treaty of Waitangi (Whānau Vesting) Act 2014*, required that trustees who were managing settlement funds, make specific provisions for whānau. By 2035 young people, rangatahi, are performing above average at school, they are engaged in postgraduate tertiary education studies and are ready to compete in global markets. Whānau adults are employed in meaningful occupations, are wealthy compared to other New Zealanders, and are as active in civic and national endeavours as they are in marae and community organisations. Close family connections are maintained using state of the art technology to communicate within New Zealand and across the globe. Whānau are effective

carriers of values and culture, are models for lifestyle, portals to community, gateways to te ao Māori, guardians of landscape, and viable economic units.

Whanu health and wellbeing in 2035 reflects healthy lifestyles and whanau capability. By age two years immunisation uptake rates exceed 90 percent and there is a 90 percent uptake of the fourth generation vaccines for cancer of the breast, cervix and prostate. Whanau are guided as much by tikanga as by the latest findings posted on electronic health research bulletins and, as collectives they categorically reject alcohol and drug abuse. Over 80 percent of whānau households have personalised on-line health management programmes and maintain full responsibility for their own health records. As shareholders in Hauora@globe they have access to up-to-date health information together with cultural approaches to dealing with health risks; they supplement on-line information by calling on a range of health providers for advice and annual computerised health checks. Life expectancy for men is 80 years and for women it is over 85 years.

Scenario 2 Whānau Rawakore

In contrast to Scenario 1 where whanau have prospered, scenario 2 describes a situation where whanau have become impoverished.

By 2035 it was clear that the 2008 economic recession was not to be short-lived. Whānau have borne more than their fair share of the brunt and have increasingly narrowed their activities to focus on survival. Home ownership has fallen to less that 20 percent and most whānau are renting substandard houses in greater Auckland and Bay of Plenty cities. Their lack of voice in city affairs has left them powerless to have their plight recognised and addressed. They live in high risk neighbourhoods, have unemployment rates over 18 percent, try and survive on Government subsistence allowances, and are forced to endure trapped lifestyles. Most young people have had negative experiences at school with low achievement, fewer that 40 percent passing the Global Tertiary Entry Examination, instituted in 2016. Aggravating their situation has been the disastrous collapse of the Māori economy when the Oceanic Fish Epidemic (the OFE) of 2021

grossly depleted fishing stock forcing the newly established Iwi Fisheries Co-op. into receivership.

Whānau health and wellbeing has been correspondingly affected. Nutrition is poor, recourse to alcohol, tobacco, and drugs is high, health care occurs on a crisis-by-crisis basis, and a failure to immunise led to an epidemic of diphtheria in 2030. Moreover, new versions of old diseases have emerged; the prevalence of *tuberculosis strain 26* is thought to be exceptionally high. *Strain 26* has now been linked to climate change and has so far been resistant to all therapeutic agents. By 2035 Māori life expectancy has actually fallen to 68 years for men and 73 years for women, the same that it was in 1985.

Whānau Health and Wellbeing 2020 and Beyond

Although both scenarios are possible, neither is highly probable and there would be little debate that Scenario 1, 'Whānau Ora', is desirable whereas scenario 2, 'Whānau Rawakore', is totally undesirable. The purposes of introducing the scenarios, however, were first to highlight how global, political, economic and technological change can impact on whānau with consequences for health and wellbeing; and second to demonstrate that the future cannot be easily predicted. Because cultural, social and economic functions are inter-related, policies and programmes that appear to be whānau neutral can have implications for whānau health many years later.

Yet even if Māori fortunes in 2035 cannot be clearly envisaged, it does not follow that the future will be unresponsive to Māori interventions or that the future cannot be actively shaped. In that respect it is possible to distinguish between 'future takers' and 'future makers'.

'Future takers' accept that the future will bring what it will bring; the agents of change are considered to be so far removed from local control that Iwi and Māori communities feel powerless to change what will be. They might be ready to respond to change but not to direct change. 'Future makers' on the other hand actively engage with the future; they look for signs of change and then create future spaces where hopes and opportunities can flourish, offsetting potential liabilities. Rather than responding to change, 'future makers' will lead change. 'Future makers' identify what is possible and work to make it happen.

However, Māori future making is seriously constrained by two frameworks that tend to dominate practiced: crisis intervention and sectoral division. Crisis management, whether in response to health incidents, household income, inadequate housing or school truancy, is important and requires expert assistance. But by itself crisis management does little to take whānau towards sustainability or into the future. Whanau who are overwhelmingly immersed in immediate predicaments, lack both the energy and the will to look outwards beyond the crisis and into the

future. The same can be said for those who provide services to whanau. A combination of heavy caseloads, coupled with never-ending problem solving, inadvertently aggravate a climate of crisis that comes to characterise whanau in contemporary times. Crisis intervention, however, need not be a deterrent for positive development. Instead a crisis that is well managed can serve to accelerate development if the intervention tools are used to reinforce existing strengths and build new skills.

Sectoral divisions have a similar deterring effect. Addressing a health problem for example, with little attention to other dilemmas that may be even more pressing, introduces a skew into whānau dynamics that may mask barriers to positive development. Sectoral interventions frequently unbalance whānau priorities and hierarchies by focussing on one aspect of whanau life that in the order of things, may be relatively unimportant to the whānau even if it is of great interest to a health worker.

Future making, at least in respect of whānau, requires both a long term plan and a holistic approach.

Planning Healthy Whānau Futures

A long term plan, however, requires the identification of desirable outcomes that will be relevant to whānau and attainable in the future. The task then is to plot a course that will lead towards those outcomes. Enough is already known about Māori health and wellbeing to identify the key functions that whānau might play in order to maximise gains in health and increase levels of wellbeing; desirable outcomes can be measured against those functions. A focus on whānau functioning as key to Māori health and wellbeing assumes that whanau will be the single most influential agent in shaping Māori potential and providing dependable social networks. The fact that families may be dysfunctional does not reduce the prospects of whānau to enhance wellbeing in ways that defy societal agencies. Nor does the changing nature of whānau necessarily disqualify them from key roles in the future. Trends already indicate that by 2035 whānau will be more mobile, more blended, more complex and more dispersed. But they will also be able to utilise new technologies that will shrink the distance between them, lend greater accuracy to the transfer of information, including health records and cultural knowledge, and give access to opportunities across the globe. Diversity, mobility, and dispersal will be offset by enhanced communication and reduced alienation.

Carriers of culture

Models of lifestyle

Portals to community

Gataways to te ao Māori

Guardians of landscape

Economic units

Whānau Health Risks

Health Risks

Lifestyle

Socio-economic stressors

Compromised health status

Disabilities of age

Injury & accidents

Diabetes

Cancer

Health Potential

Growing population

Youthful vitality

Participation in early childhood and tertiary education

More older Māori

Higher participation in

te ao Māori

Distributed health leadership

The 25 Years Ahead

- What outcomes should be sought?
- What interventions will achieve those outcomes ?
- What are the implications for Māori health managers ?

Scenario

- More numerous

- Well educated, high educational achievement
- Engaged in te ao Māori
- Participating fully in wider society
- Employed in meaningful occupations and/or professions
- Wealthy, beneficiaries of iwi investments & Treaty settlements
- Well adapted to modern environments
- Wise users of technology

The Transformation

- 90% uptake of immunisation by age 2 years
- 90% uptake of vaccinations for ca breast, cervix, prostate
- BMIs within 'safe' range for 80% of whānau
- Lifestyles that are compatible with tikanga
- Widespread rejection of drug/alcohol/tobacco abuse
- 90% enrolment in approved primary health schemes
- Personalised on-line health programmes in 80% homes
- 80% uptake of annual health reviews for all age groups
- Life expectancy of 79 yrs for men and 85 yrs for women
- Choice as to health advisors

Making it Happen

- It takes a generation (25 years) to effect transformations
- Can Māori health leaders introduce programmes and practices to shape the longer term (25 years) future for whānau health?
- Is there a case to initiate shifts in broad directions?

Shifts in Direction

- Justification for a Māori health framework

- Operational conventions
- The focus for Māori Health Development

Justification for a Māori Health Framework

The Operational Conventions for Māori Health

The Focus for Māori Health Development

Shifting Direction

Transformation complete

In 2033 Whānau will be empowered to:

- care for their own people
- manage their own health
- access health information
- evaluate health information
- recognise signs of pre-disease
- seek advice as appropriate
- adopt lifestyles that minimise risks to health

Tasks for the Health Leadership

1. Shift from disease focus to a wellness focus
2. Develop programmes that will enable whānau to engage with personalised online health planning
3. Bridge the divide between sectors, between economic and social polices, and between primary and secondary health care
4. Build capability in whānau health promotion
5. Develop quality primary health care arrangements for all whānau
6. Transform health care into health empowerment

The Years ahead

The future is not something we enter.

The future is something we create

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The 25 Years ahead

- Will there be a **transformation**?
- Or simply a repetition of the past 25 years ?
- **incremental radicalism**
- or system re-alignment ?

Future takers

- Accept the future for what it brings
- 'Powerless to change what will be'
- Ready to **respond** to change

Future Makers

- Shape the future by reading the signs
- 'Determined to create future spaces'
- Ready to **lead** change

Twenty-five years out from 2008

How will whānau fare?

Will whānau be able to exercise their key roles and functions?

What will determine whānau wellbeing, health, wealth, and vitality?

Methodologies for exploring the future

- Past Trends
- Statistical modelling e.g. demographic projections
- Life-course epidemiology
- Scenario development

Life Course Epidemiology

- Health incidents in earlier years will impact on whānau health profiles in later years

- Māori ‘health futures’ are largely a function of current health experience

Māori Health Futures

- Otitis media in infancy increases risk for hearing and learning disability throughout life
- Conduct disorder in childhood increases risk of serious offending in adolescence and early adulthood
- Rheumatic fever in childhood increases risk of heart disease in 4th decade
- Smoking in adolescence increases risk for cancer, heart disease in 4th, 5th and 6th decades
- Obesity in childhood increases risks for diabetes in adulthood
- Alcohol & drug misuse in early adulthood leads to liver, heart, circulatory, mental disorders in later years
- Diabetes in 3rd or 4th decade increases risk of heart disease, poor vision, renal disease in 5th and 6th decades

Scenario Development

- Globalisation
- Climate change
- The economy
- Govt. policies
- Information, CIT, technology
- Indigenous aspirations
- Increased Māori capability – larger population, more, kaumatua, range of skills, fluency in te reo
- Greater diversity – ethnic, occupations, locations

Planning Whānau Futures

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