

“The Treaty of Waitangi & Māori Health”

Key Note Address by Ria Earp, Deputy Director-General, Māori Health, Ministry of Health NZ at

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Mihi

E ngā tangata whenua, e ngā mana, e ngā kārangatanga maha ō waenganui i tēnei huihuinga tangata, tēnā koutou katoa! Tēnā koutou i runga i ngā mate i mauria mai, i ngā tipuna i uwchia mai, i ngā take nunui i whakatakoto mai. Nā reira, tēnā anō tātau katoa!

Introduction

I acknowledge the people of this land, and pay respects to the *Eora nation* and the uniqueness of their relationship to this region. And I greet all of you who have gathered here today, bringing with you: your *whakapapa* – ancestry and ancestors; your *mātauranga* – your knowledge & experience; and your *kaupapa* – your issues and perspectives.

For Māori, it is important to make these acknowledgements before launching into any discussion of the issues of the day. It reminds us that we are human beings with a set of social connections to others, and that we are part of the larger environment and a world which connects us and brings us together. It is appropriate to think of ourselves as both individuals and belonging to a wider grouping, because at the heart of today’s discussion are some of the inherent tensions between the concepts of individual rights, privileges, and responsibilities and group or collective rights and issues. I want to return to some of these tensions later in the presentation.

We Māori have a *whakatauki* – proverbial saying – which states:

“Nā tōu rourou, nā taku rourou, ka ora te manuhiri”

[Literally, this saying is translated as: “*With your food basket and my food basket, we will cater for our guests*”]. In the context of this conference this saying can be translated as-

With your contribution and with my contribution, we will cater for our needs.

In the short time I have I hope to contribute to the thoughts for the day, from the perspective of a New Zealand senior public servant. I certainly do **not** consider that we in Aotearoa have all the answers which apply to your situation in Australia.

Setting the scene historically

The Treaty of Waitangi is often referred to as the founding document of Aotearoa/New Zealand. The Treaty provided a basis for European colonisation, recognising the interests of both Māori tribes and individuals and the early, and subsequent, settlers. Thus, the Treaty recognised that there were peoples living on the land, with their own rights. Unlike Australia, New Zealand was incorporated into the British Empire by negotiation rather than a declaration of *terra nullus*.

The Treaty of Waitangi, signed in 1840, was a ‘deceptively’ simple document, consisting of a preamble and three articles. The Treaty was signed in two languages, although discussions were, not surprisingly, almost exclusively in *te reo Māori* – the Māori language. While there is less debate around the third article in these two versions (ie the conferment of British citizenship), there has been significant debate (by both Māori and Government) around the first two articles, particularly the relinquishment of ‘sovereignty’ in return for ‘ownership of key assets’. We could take all day discussing the finer points of these matters, (and we frequently do), but the main points for me are that the Treaty:

- was about negotiation **not** force;
- recognised that there were two parties to the agreement;
- is a relatively concise document;
- is written in two languages (and not surprisingly these versions differ in meaning); and
- has come to be regarded as the founding document for New Zealand.

The Treaty of Waitangi remained largely ignored, and only given ceremonial recognition, until relatively recent times.

1975 – a watershed year for the Treaty

1975 was a watershed year for recognition of the Treaty. In 1974, the then Labour Government passed the Treaty of Waitangi Tribunal Act, which established the Waitangi Tribunal the following year.

Since 1975, successive governments have built on and developed the overall response to Treaty responsibilities. These can be summarised as follows:

- the establishment of the Waitangi Tribunal;
- direct negotiations with Māori tribes and organisations to address historical and current Treaty breaches;
- the development of specific Treaty and Māori policies within government portfolio sectors;
- the development of service specifications and standards which address Māori development aspirations, cultural values, inequalities and socio-economic indices;
- the incorporation of specific provisions into legislation; and
- significant work in relation to routine and effective consultation with Māori.

Another key feature of the legislation which took effect in 1975, was the reference in the legislation to the “principles of the Treaty of Waitangi”, which were to be outlined by the Waitangi Tribunal.

The principles of the Treaty have come to be a major focus on Government policies and practices, especially from the 1980s onwards. The focus on principles, rather than the text of the Treaty, has not been viewed by either Māori communities or the Government-of-the-day, in the same way. This relates to the debates about the meaning of the articles themselves (given that the two language versions have different interpretations) and the importance of the articles as opposed to the principles. However the principles do offer a way to bring the intent of the Treaty into the modern context and provide scope for developments especially in social policy arenas.

Treaty principles

Treaty principles were initially developed by the Waitangi Tribunal and through subsequent decisions of the Court of Appeal and the Privy Council. In 1987, the

Royal Commission on Social Policy outlined three major Treaty of Waitangi principles, which the Commission saw as integral to the future development of social policy (including health policy) and social services. These were as follows:

- **Partnership:** the Treaty was a compact between the Crown and Māori, which required its partners to act in good faith with each other;
- **Participation:** the Treaty required that each partner was able to participate in the affairs of the nation; and,
- **Protection:** there was an obligation on the Crown to actively protect Māori interests.

Māori health policies

Treaty principles have come to form integral considerations in the development of Māori social policy and strategy setting by Government particularly from the late 1980s onwards. This was supported by “mainstreaming” policies which sought to ensure that all Government agencies took up their specific and collective responsibilities to address Māori issues within their sectors.

For most of the 1990s, Government departed from the approach of directly recognising Treaty responsibilities in Māori health and social policy. However, Māori health policies developed during this period, are acknowledged as significant. They set specific approaches that saw a rapid increase of Māori workers and providers in the health sector. In the absence of specific Treaty references, these changes were built on the premise that Māori health disparities were unacceptable and that Government and its agencies, needed to actively address this situation.

In fact, Māori health policies developed during this time were broadly in line with Treaty principles. This included; the need for Government to act in good faith, to increase overall Māori participation in the health sector, and to actively protect Māori health. So, while there was an absence of direct Treaty references in central government policies (apart from Government accepting that “the Treaty was the founding document”), there was nonetheless, the incorporation of specific Māori health policies. These policies broadly fell within a Treaty framework, and in some regions, local “treaty based” partnerships had been entered into by regional funders.

The new Government in 1999, came determined to act on its manifesto to bring structural changes to the health and disability sector of New Zealand. This provided an opportunity to review the Maori developments in the sector and led to the incorporation of specific Treaty of Waitangi references in new health legislation and to refocus Māori health policies.

The fact that the new legislation proposed a Treaty clause, was one of the more controversial aspects during the submissions on the Bill, and even though it is now clearly in the Act, it may well continue to be raised as a controversial issue. The social and political context of such changes in legislation is important.

So what does the New Zealand Health and Disability Act 2000 actually state?

Part 1: Clause 4

In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Maori, Part 3 [on District Health Boards] provides for mechanisms to enable Maori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

The Treaty principles (rather than the Treaty itself) is the key to this clause. The principles, which we in the sector refer to as the “three ps”- partnership, participation and protection - are woven indirectly into the clause, ie they are not defined in the Act. These principles were derived from the Royal Commission’s work rather than the work of the Waitangi Tribunal or the courts.

The Treaty clause is clearly framed around improving Māori health (the ‘protection’ principle), it refers to the contribution of Māori to decision-making (the ‘partnership’ principle) and the contribution of Māori in the delivery of services (the ‘participation’ principle). The legislation contains other requirements which also reinforce the principles, such as the responsibilities of District Health Boards in Māori workforce and provider development.

These concepts are contained in more detail in the Māori Health Strategy, He Korowai Oranga, released two years later (in 2002) after extensive consultation. The principles articulated by the Royal Commission on Social Policy, have been refined and defined more specifically to health and disability sector.

Partnership: Working together with iwi, hāpu, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services

Participation: Involving Māori at all levels of the sector, in decision-making, planning, development and delivery of health and disability services

Protection: Working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices

These concepts have been in the NZ health sector over the last decade and are now the focus points for driving Māori health development.

The inherent tensions in a Treaty approach

Before concluding on the potential benefits of using a Treaty framework in health, I would also like to raise the issues of the inherent tensions in using a Treaty approach. Professor Mason Durie brings an interesting perspective as a Maori health professional (a psychiatrist), a respected academic (the Head of the School of Maori Studies, Massey University) and a highly regarded leader for Maori development. He has in recent years articulated the tensions surrounding the concept of “indigeneity”. In a speech to the New Zealand Public Service Senior Management Conference in 2000, he made the following astute observation around the tension of individual versus group rights:

“In the absence of a clearly articulated constitutional position, there is a dilemma for the state.... how can citizenship be reconciled with the rights and expectations of indigenous peoples without compromising notions of even handedness and social justice?”

In a more recent presentation in 2004 on ‘Public Sector Reform, Indigeneity and the Goals of Māori Development’, Mason Durie developed this theme further:

“Despite growing world-wide recognition of indigenous peoples as distinctive populations within nations, states are often ambivalent about creating options that could appear to favour them over other populations within a nation...and assertions of rights based on being indigenous is sometimes seen as contrary to the democratic principles of equality.”

I consider these quotes important in that they not only highlight some of the inherent tensions in the debates on the Treaty, but they also acknowledge that the general public become a critical part of the debate. And they are often overlooked. There is a tendency to view the Treaty debate as the domain of the indigenous peoples and the state.

However a general antagonism by the ‘public’ to any perceived “indigenous developments” which may be considered to ‘favour’ the indigenous group over other segments of the national population, can quickly undermine a government’s desire to maintain a such a position. In other words, any stand which articulates benefit to the indigenous group, also needs to be perceived by the wider population as a benefit to the nation, or at least understood within the context of ‘need’. This I would suggest is one of the biggest challenges facing us in the Treaty debate.

How does the Treaty help the improvement of Māori health?

I want to outline my personal views on how a Treaty framework can be considered as a contribution to the improvement of Māori Health.

Firstly, the Treaty was an “enabling document” – it recognised two parties and provided a basis for on-going discussions.

Secondly, the Treaty provides a framework for action, which requires the involvement of **both** the Government and Māori – that is, it is a joint process.

Thirdly, the Treaty provides a framework from which to consider Māori health improvement within wider Māori development. A Treaty approach is holistic – it does not artificially displace key parts of Māori development from others. The Treaty also allows for the alignment of actions in Māori health policy to Māori community development activity in other areas (such as economic, land and cultural development). Arguably, a Treaty approach can be aligned with broader community development models such as those advocated by the WHO and the Ottawa Charter.

Fourthly, a Treaty approach allows the development of frameworks for action which can take a more holistic approach to not only health, but includes those wider determinants of ill health (e.g. housing, education, income and justice). This is supported by more recent Māori health research which indicates that socio-economic status (while a significant indicator), by itself, does not account for

Māori health disparities. Further, this approach also recognises that improvements are not just about services *per se*, but about addressing systemic issues where they exist, such as reducing inequalities.

Finally, while better services, increased workforce and a better health sector will improve Māori health to some degree, the Treaty provides a framework for measuring how this improved health contributes to Māori indigeneity, development and overall well-being (rather than ill-health).

Conclusion

The Treaty remains a key focus for Māori wanting to address their issues with Government in health and other areas. Current negotiations around the position of the Treaty can be sourced to the original discussions prior to the Treaty being signed – that is, the Treaty was about recognising its parties, their desires and their shared interests. These negotiations have waxed and waned particularly in recent years, nonetheless, the Treaty is a reminder that negotiation is far better than conflict.

Māori communities, Government and society will continue find Treaty responsibilities a challenge and will continue to provide different perspectives on what those responsibilities entail. However, the place of the Treaty within any constitutional discussion and within New Zealand history is undeniable.

***“Ko te pae tawhiti, whāia kia tata.
Ko te pae tata, whakamaua kia tīna!”***

“Seek those distant horizons and cherish those you attain!”