



Universal healthcare for all? Māori health inequalities in Aotearoa New Zealand, 1975–2000

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ABSTRACT

Despite establishing a so-called universal, taxpayer funded health system from 1938, New Zealand's health system has never delivered equitable health outcomes for its indigenous population, the Māori people. This article, using a case study approach focusing on Māori, documents these historic inequalities and discusses policy attempts to address them from the 1970s when the principles of the Treaty of Waitangi were first introduced in legislation. This period is one of increasing self-determination for Māori, but notwithstanding this, Māori continued to have significantly shorter life expectancy than the population as a whole and suffered poor health at much higher rates.

Neo-liberal policies were introduced and expanded during the 1980s and 1990s in New Zealand, including in healthcare from the early 1990s. The introduction of the purchaser-provider split in health services and the focus on devolving responsibility to communities provided an opportunity for Māori health providers to be established. However, the neo-liberal economic and social welfare policies implemented during this time also worked against Māori and adversely affected their health.

By analysing attempts to reduce inequity in health outcomes for Māori, we explore why these collective attempts, including by Māori themselves, did not result in overall improved health and increased life expectancy for Māori. There was often a significant gap between government rhetoric and action, and we suggest that a predominantly universal healthcare system did not accommodate cultural and ethnic differences, and this is a potential explanation for the failure to reduce inequities. While this is true for all minority ethnic groups it is even more crucial for Māori as New Zealand's tangata whenua (first people) who had been progressively disadvantaged under colonialism. However, the seeds of ideas around Māori-led healthcare were planted in this period and have become part of the current Labour Government's policy on health reform.

1. Introduction

This article explores the period from 1975 to 2000, which saw the universal health system of New Zealand's first Labour Government under fire and eventually overturned, under the influence of new neo-liberal governments. As Blakely et al. (2005) have argued, New Zealand provides a unique case study as it moved from being a society with one of the highest living standards in the world in the 1950s and 1960s to one in which its wealth was in relative decline compared with other OECD countries by the 1980s and 1990s. At the same time major economic and social changes, resulted in a growing wealth disparity within the country. In this article we consider the impact of the changes on the health of Māori from the 1975 Treaty of Waitangi Act to the New

Zealand Public Health and Disability Act 2000, which effectively ended neo-liberal experiments in the health system. Despite greater recognition of the rights of Māori under the Treaty of Waitangi during this period, Māori continued to have poorer health outcomes and shorter life expectancy than the rest of the population. In fact, the 1990s saw disparities in health between Māori and the rest of the New Zealand population worsen for the first time in the twentieth century.

The impact of the changing health system during this period on Māori has to date been subject to little historical scrutiny. Historians have largely focused on the nineteenth and early twentieth century when considering Māori health (Dow, 1999; Lange, 1999; Durie, 1994). Alistair Woodward and Tony Blakely's *The Healthy Country*, is the exception. They plot social and macro-economic factors including

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employment status, education, income and housing as determinants of health in the post-1980 period and argue that Māori along with Pacific peoples were more severely impacted than the non-Māori non-Pacific population (Woodward and Blakely, 2014, 211). Their study does not, however, directly address government health policies and other initiatives in healthcare.

Mason Durie (Rangitāne, Ngāti Kauwhata and Ngāti Raukawa), a psychiatrist, Māori health expert and Professor of Māori studies at Massey University, has contributed more to the literature on Māori health than any other individual, both its history and contemporary issues, and we draw on his work both as a primary and a secondary source for this article. Durie graduated in medicine in the early 1960s and his career therefore spans the period under discussion in this article, and to the present day. For instance, a 1994 Public Health Commission Report, which argued that the way forward for Māori health was by granting them greater self-determination, extensively cited Durie (Public Health Commission, 1993).

There is a wide literature on inequitable health outcomes for indigenous peoples as a result of settler colonialism which often focuses on the Anglo-settler societies of New Zealand, Australia, Canada and the United States. While the experiences of indigenous peoples varies across time and place in terms of the magnitude of health disparities, the pattern of poorer health outcomes is consistent (Axelsson et al., 2016). There is not the space to provide a detailed summary of the literature on the history of indigenous peoples' health issues but for the purposes of this article, it is most important to emphasize the long-term persistence of health inequalities, as David Jones has done in relation to American Indians (2006), and to locate the origins of these inequities in colonialism as a recent *Lancet* editorial entitled, 'The past is not the past for Canada's indigenous peoples' makes clear (2021). This case study provides a close study of comparatively early attempts by both the New Zealand government and Māori communities to frame the problem of health inequities and find solutions to those persistent inequities.

In terms of the wider body of literature internationally on theories of welfare systems, New Zealand's welfare system from the mid-twentieth century was classified as a Liberal welfare state by Esping-Andersen in his 1990 work, *Three Worlds of Welfare Capitalism*. Esping-Andersen's framework was reclassified by Castles and Mitchell (1993) who categorized New Zealand as a Radical welfare state where citizens' welfare was ensured through protected wage levels. However, many of these protections were dismantled during the period under examination. As Bambra (2007) has argued, these welfare typologies have largely ignored the role of public services, including health systems. Moreover, these frameworks ignore ethnic minorities, and how they were differentially affected by social policy. This is also true of welfare state historians focussing specifically on New Zealand such as Iain Hay and Alexander Davidson. Davidson compared two welfare state pioneers, New Zealand and Sweden, and how the latter survived the economic downturn from the 1970s whereas the former did not. These broad-brush histories of welfare systems appear blind to the parallel story of the history of Māori welfare and health, including Māori attempts to address health issues through local initiatives, the overwhelming structural problems inhibiting those initiatives, and a government insensitive to cultural differences (Hay, 1989; Davidson, 1989). Likewise, Robin Gauld does not address Māori health specifically in his history of New Zealand's health system (Gauld, 2009).

This article draws on documentary historical sources, including a number of significant government reports published during the period 1975 to 2000, government archival sources, published research and a 2018 witness seminar on health reforms in the 1980s. Witness seminars are an innovative form of group oral history, often used to discuss major policy changes or reports, and provide an opportunity for researchers to curate a discussion amongst significant politicians, civil servants and professionals (in this case doctors), thereby accessing views not expressed in other historical sources. By analysing the historical record for this period, we show that identification and acknowledgement of

health inequities was insufficient to solving the issue of inequitable outcomes, that Māori initiatives received insufficient support, and that the increasingly residual nature of the health system, with the extension of user-pays fees into secondary care for instance, in the late twentieth century disproportionately affected Māori.

2. Background

When New Zealand became a British Crown Colony under the Treaty of Waitangi/Te Tiriti in 1840, Māori, the tangata whenua/indigenous people of Aotearoa New Zealand, had lived there for over six centuries. Following formal colonisation and the transition to a self-governing colony in 1852 which left Māori essentially excluded from government institutions since voting was premised on individual property ownership (albeit given some representation following the Māori Representation Act 1867), settlers and the colonial government dispossessed Māori of much of their land, which indirectly affected their health. The Māori population was estimated at 70–90,000 in 1840, declining to 45,000 in the 1890s but then made a come-back, to reach 850,500 (16.7 per cent of the total population) today (Binney et al., 2015; Walker, 2004; Statistics NZ, 2020), meaning that Māori comprise a significantly larger proportion of the population in Aotearoa than other indigenous peoples in former Anglo-settler societies. Despite this dramatic population increase, Māori have, to this day, poorer health outcomes than the majority Pākehā/European population as measured by the standard health indicators such as life expectancy (see Fig. 1).

Definitions and understandings of being Māori have changed across time and between groups. For much of the twentieth century the New Zealand government considered those with fifty percent or more Māori blood to be Māori, although this definition did not equate with Māori understandings of identity and when given the opportunity to self-identify, Māori used their own definition, which was those with Māori ancestry/whakapapa who identify as Māori. This broader definition was included in the 1974 Maori Affairs Amendment Act and so is the definition that was in use by the government for the period under examination in this article (Te Rōpū Rangahau Hauora a Eru Pomare, 2000). At the same time, identifying ancestry to hapū or iwi (sub-tribe or tribe) is more important for many Māori than a broader Māori identity, although about one in five Māori in 1996 could not name their iwi (Robson and Reid, 2001), which demonstrates the prevalence of both individual and collective identities. In terms of health data, Māori are those who identify as Māori, and Māori healthcare organisations are those run by Māori and follow tikanga Māori (practices and values deriving from Māori knowledge).

New Zealand introduced a universal health system in 1938 under its first Labour Government, as part of its universal welfare 'from the cradle to the grave'. This Government argued for social and economic equality for the Māori population. Unfortunately, as will be seen, equality of access did not mean equality of outcome. As was later recognised, New Zealand's universal healthcare system which ignored Māori concepts of health and wellbeing, was never going to deliver equitable health outcomes for Māori. Māori health academics and activists, Papaarangi Reid, of Te Rarawa descent, and Fiona Cram, of Ngāti Pahauwera (Kahungunu) descent, have argued that this is not only because of wider social and economic inequities but because a health system which has been designed for "all New Zealanders" is a system designed for Pākehā/white New Zealanders (Reid and Cram, 2005). In a similar vein, Christopher Mayes has argued that the Australian health system has always been institutionally racist against Aborigines, and that this issue continues to the present day (Mayes, 2020). Mayes asserts that indigenous sovereignty and justice are key to resolving this issue, echoing an argument made by many Māori.

The period from the Second World War saw a major shift of the Māori population from rural to urban areas, as rural poverty and urban job opportunities drove them to cities. In the 1930s only 20 percent of Māori were urban dwellers, but by the 1970s almost 80 percent lived in urban

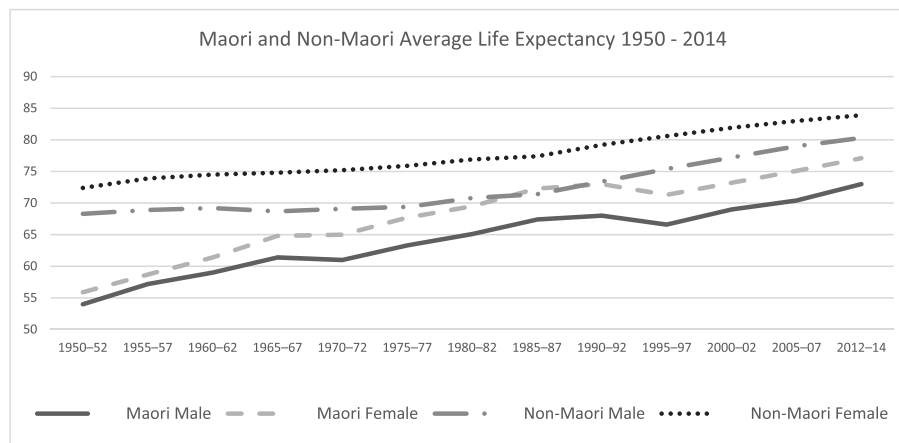


Fig. 1. Statistics New Zealand, Life expectancy by age and sex, 1950-52 – 2012-14, <https://www.stats.govt.nz/information-releases/period-life-tables-detailed-tables>, accessed August 12, 2021.

settings (Pearson, 1990). However, New Zealand experienced an economic downturn from the 1970s, which disproportionately affected those at the bottom of the socio-economic scale, including Māori who were over-represented in low-income households (Cram et al., 2019). At the same time, influenced by the international civil rights movement, Māori began to assert their rights for self-determination/tino rangatiratanga and redress some of their losses under colonisation, including their extensive loss of land. A cultural revival saw Māori asserting their identity through their whakapapa/ancestry, and specifically their iwi (tribal affiliation), gaining confidence as the tangata whenua/people of the land.

An important landmark of this movement was the establishment of the Waitangi Tribunal to hear claims of breaches of the principles of the 1840 Treaty of Waitangi/Te Tiriti, under which New Zealand had become a Crown Colony. Signed in 1840 by Māori chiefs and the British Crown, the Treaty guaranteed Māori the right to tino rangatiratanga (self-determination) and guaranteed citizenship rights. Both are relevant in terms of health, affording Māori the right to design and deliver healthcare in a way that respects their right to self-determination, as was recognised in the late twentieth-century through the new activist movement under which Māori claimed the right to ‘health citizenship’ (Bryder, 2008).

The New Zealand government issued a white paper in April 2021 detailing a comprehensive restructuring of the system including abolishing the twenty District Health Boards founded in 2000 and replacing them with a single entity, Health New Zealand, and establishing a Māori Health Authority with authority and funding to address health inequities for Māori. This is to be done by commissioning Māori-led services and monitoring the overall performance of the health system (New Zealand government, 2021) and legislation implementing these changes, The Pae Ora (Healthy Futures) Act, came into effect on July 1, 2022. Given how wide ranging these reforms are, particularly in terms of addressing health inequities and Treaty principles, exploring why previous attempts to address health inequities have failed, in a country that had traditionally prided itself on providing universal healthcare, is particularly timely (Waitangi Tribunal, 2019). We also see the roots of this new system being planted in the period under discussion, although at that time there was not a political will to institute them.

3. New Zealand’s health system and Māori before the 1980s

While New Zealand’s first Labour Government in 1938 aimed to achieve a universal healthcare system, which was free, complete and accessible to everyone, it fell short of this goal (Easton, 2020). Challenging negotiations with the medical profession meant that the government agreed to general practitioners (GPs) being able to charge

patients a fee, although this was heavily subsidised via a government benefit which covered two-thirds to three-quarters of the cost of a consultation. However, the government contribution did not increase and over time inflation eroded its value, so by the early 1970s patients were covering most of the cost of primary care consultations. The benefit was increased in 1972 and briefly covered approximately half the cost of a consultation, but again inflation quickly eroded its value (Hay, 1989). Secondary care was free at the point of service for all patients, although the British doctor Julian Tudor Hart’s 1971 ‘inverse care law’, that good medical care varied inversely with the need for it in the population served, applied to Māori along with the growing Pasifika (indigenous people of the Pacific Islands) population in New Zealand in the post-war period, even before economic circumstances further hindered access. Moreover, GPs acted as gatekeepers to specialist care and therefore those who could not afford the cost of a GP visit were unable to access secondary care, except via accident and emergency departments. Hospitals were run by elected hospital boards and received funding from the government via the annual ‘Vote: Health allocation’. Over time, governments increasingly applied pressure to boards to run hospitals efficiently and became less willing to accommodate those boards which exceeded their budgets.

As Māori were more likely to live in low-income households, they were less likely to be able to pay directly for the increasing cost of health care, or access private medical insurance, which became available from the 1960s. For those who could afford to access the health system, they were accessing health services that had been designed for “all New Zealanders” which meant Pākehā New Zealanders. As Reid and Cram have argued, “If Māori needs are different from the non-Māori majority then the services designed to meet the needs of the majority may be less appropriate for Māori and may, in turn, increase the likelihood of further disparities. In this way Māori needs and rights to services in New Zealand are marginalised and Pākehā needs and rights for services are privileged” (Reid and Cram, 2005). A Department of Health paper in the late 1960s stated that although there were “no services specifically provided for the Māori people, in practice special consideration is given to their health needs” (Maori Health, 1961). Nevertheless, the dominant trend in the 1960s was ‘integration’, which was effectively assimilation and was promoted by the Department of Māori Affairs (Hunn, 1961).

That the health system ignored the specific needs of Māori undoubtedly contributed to their higher mortality and morbidity rates than other sectors in the population. The extent of these disparities were detailed in Dr Eru Pomare’s 1980 report, *Maori Standards of Health* which covered the period 1955 to 1975. Pomare showed that while there had been a significant reduction in the infant mortality rate during that period as well as deaths as a result of infectious diseases, Māori age specific death rates at all ages were still much higher than non-Māori

and the Māori infant mortality rate was 21 per 1,000 births compared to the non-Māori rate of 16 per 1,000. His research showed an improving situation for Māori, but also a situation where rheumatic heart disease, high blood pressure, cervical and stomach cancers, respiratory diseases and diabetes were each responsible for three times the death rate in the under-65 Māori population than in the non-Māori population (Pomare, 1980).

A Labour government had been elected in 1972, after twelve years in opposition, and published a white paper on the health system in 1974, *A Health Service for New Zealand*, which advocated widespread changes to the system to make it more efficient and equitable (McGuigan, 1974). Despite the paper being over 300 pages long, the word Māori occurred only fourteen times. The paper advocated the introduction of equitable funding and suggested that one factor in its calculation should be to address the higher rate of Māori and Polynesian infant mortality (McGuigan, 1974), but other than this, it did not dwell on the widespread and well-known disparities in health and wellbeing between Māori and the rest of the New Zealand population.

The white paper itself was unpopular amongst those who interpreted it as a bid for making GPs salaried state employees and reducing or removing the role of private medicine, and contributed to Labour's election loss in 1975. The new National Government (the dominant conservative party), which had campaigned against the white paper, established the Special Advisory Committee on Health Services Organisation (SACHSO) to complete a more consultative review of the health system. The main SACHSO committee consisted of nineteen government-appointed members, none of whom were Māori. There is no evidence either within government archives, or in mainstream daily newspapers, that this complete absence of Māori representation was seen as an issue, or even noted, by most of the population. As Durie explained, "[i]t was not until the 1970s that the importance of Māori cultural beliefs and practices to good health outcomes became part of the health agenda" (Durie, 2012). Durie cites two articles published in the *New Zealand Medical Journal* in the late 1970s by himself and Dr David Tipene-Leach as evidence of a change in attitudes which really began to "gain momentum throughout the next decade" (Durie, 2012).

While the intention of the First Labour Government had been to introduce a universal health care system, from the outset the system was never free at the point of access and co-payments for GP services increased over the years. The increasing cost of GP services, the growth of the private sector fuelled by private insurance, and administrative unrepresentativeness meant not only that universal healthcare remained elusive but that certain groups such as Māori were disproportionately affected.

4. Māori cultural revival, the Waitangi Tribunal and Māori understandings of wellbeing and health

The urbanisation of Māori after World War Two made more visible the contrast in wealth and wellbeing between Māori and Pākehā and provided an opportunity for Māori to organise and address these inequities, spurred by new movements of cultural assertiveness and civil rights. Māori experienced the process of urbanisation in a variety of ways. They established culture clubs, urban marae and community centres to support the development of Māori culture in urban settings (Walker, 1992). Urbanisation also shaped the way in which Māori experienced the health system and how the state and the medical profession responded to Māori (Durie, 2012).

Urbanisation provided an opportunity for Māori to organise outside of traditional iwi groups and young Māori began to organise and assert their right to express their cultural identity and demonstrate against racism. Nga Tamatoa, a university-based group founded in Auckland in 1970, challenged many Pākehā New Zealanders' views by stating, "There is no Maori problem, what we have is a problem with Pakehas" (Dunstable, 1992). In 1971 Nga Tamatoa declared Waitangi Day to be a day of mourning for the loss of 63 million acres of Māori land since 1840

(Walker, 1992). The most famous protest of the 1970s, however, was the land march of 1975 led by Whina Cooper of the Māori Women's Welfare League, under the banner "not one more acre of Maori land". The march began in Te Hapua, in the far north of the North Island, and finished in Wellington outside parliament. Cooper was 80 years old at the time, demonstrating that the activism of the 1970s was multi-generational. Regaining land was seen as a key component to improving Māori well-being by protest leaders.

The 1975 Treaty of Waitangi Act was a belated recognition of Aotearoa New Zealand's founding document, The Treaty of Waitangi/Te Tiriti. This treaty had been signed in 1840 by representatives of many (but not all) iwi and representatives of the British Crown. There are two documents – the Treaty of Waitangi in English and Te Tiriti in Te Reo Māori (the Māori language) – and the wording of each differs at crucial points. For many years the Treaty was accorded little significance by the courts and parliament, but in 1975 The Treaty of Waitangi Act was passed which established the Waitangi Tribunal, a quasi-judicial body which was empowered to investigate breaches of Treaty principles that occurred from 1975. Later, in 1985 the Tribunal was granted retrospective jurisdiction which allowed it to consider breaches of Treaty principles dating back to 1840.

The Treaty/Te Tiriti comprised of three articles, all of which have relevance to health and wellbeing. Article One obliges the Crown to provide good government to all citizens, which in a modern context includes the provision of healthcare (Reid, 1999b). Article Two guarantees Māori the control of resources and taonga/treasures that they wish to retain, and it has been argued that taonga includes health and wellbeing. Article Three entitles Māori to the rights and enjoyment of citizenship and equal citizenship has been interpreted to include equity in health outcomes.

New interpretations of the meaning and significance of Te Tiriti led to several Māori health models being developed in the 1970s and 1980s, with perhaps the most well-known being Durie's Te Whare Tapa Whā or the four-sided house which he described as "a view of health which accorded with contemporary Maori thinking" (Durie, 1994). The four sides of the house represent physical health (taha tinana); spiritual health (taha wairua); family health (taha whānau); and mental health (taha hinengaro). This understanding of health was challenging for some who considered this perspective so broad it made it difficult to implement specific policies to improve health or to measure change (Durie, 1994). On the other hand, as Durie highlighted, this broader definition of wellbeing merged well with other changes taking place in health in the 1980s with the community health movement, health promotion and feminist critiques of the medicalisation of childbirth and other areas of health as well as the WHO definition of wellbeing. The 1978 Alma-Ata Declaration stating wellbeing as a basic human right aligned with these goals. By 1988, the New Zealand Board of Health advocated five principles for a national health policy which drew comprehensively from Māori views: holism, empowerment, social and cultural determination, equity of access and devolution and equitable and effective resource use (Durie, 1994).

5. Māori health in the 1980s

What changed between the 1970s and the 1980s which resulted in an increasing government recognition of Māori concepts of health and the need to address health inequities? The push came from Māori themselves, under a receptive social democratic government from 1984 (Durie, 2012). The fourth Labour Government coming to office in 1984 was neo-liberal or free-market driven in economic policy but receptive to modern social movements (such as anti-nuclear, feminism, and Māori rights). One of the earliest developments in Māori health in the 1980s came before Labour was elected to office, the establishment of the National Council of Maori Nurses in Auckland in 1983 following a discussion at a hui (meeting) of Mana Motuhake, a Māori political party founded in 1979. Then in 1984, another hui took place at an Auckland

urban marae (meeting place) sponsored by the Department of Health, which declared Māori health a departmental priority.

The 1984 hui drew on Durie's Te Whare Tapa Wha model, and advocated Māori-led healthcare programmes and initiatives (Hill, 2009). Some attendees expressed concern that a separate system of health provision for Māori could lead to a lowering of standards, further disadvantaging Māori (Durie, 2012). However, recommendations included Māori representation on the newly appointed Area Health Boards (implemented in 1989), teaching of Māori language and culture in all medical and nursing programmes (also implemented), establishing marae-based health initiatives (some were established), along with increasing Māori personnel in health services and establishing formal links between Māori communities and health service organisations (Department of Health, 1984). While not all the recommendations were achieved by the end of the century, the foundations for change were laid and there was a growing acknowledgement that a more diverse health system that integrated Māori-led provision and Māori views was necessary.

Much of the discussion at the 1984 hui was underpinned by a growing body of research on the social determinants of health in relation to Māori. One of the attendees, Neil Pearce, had published a series of articles in the *New Zealand Medical Journal* exploring mortality, social class and ethnicity. He found that eighty percent of excess Māori mortality was not attributable to socio-economic factors alone and that therefore interventions aimed at lower socio-economic groups would not be sufficient to eliminate higher Māori mortality rates (Pearce et al., 1984). Pomare, who was also present, argued that lower health outcomes for Māori were primarily a result of environmental factors, and that primary preventive measures were the solution to this problem. He also highlighted several areas requiring more research (Pomare, 1980; Pomare and de Boer, 1988; Pōmare et al., 1995). The Māori Women's Welfare League's (MWWL) health research unit also issued a report in 1984 drawing on Pomare's findings, and utilising Durie's Te Whare Tapa Wha model and health surveys of Māori women. Their report recommended setting up marae health centres (Murchie, 1984; Hill, 2009; Durie, 2012). The MWWL was a national organisation founded in 1951 and had a long history of advocating on health issues such as immunisation and tuberculosis as well as arguing for better quality housing for Māori, demonstrating that Māori organisations had been actively promoting these issues for considerable time (Harris, 2007).

The official sponsorship of the 1984 hui was indicative of the changes occurring in government, despite the challenges to Pākehā civil servants, some of whom apparently found the experience of going onto a marae (meeting place) "traumatic" (Perkins, 2018). In 1985 the New Zealand Board of Health set up a standing committee on Māori health. In 1986 the Department of Health formally acknowledged the Treaty of Waitangi (Cunningham and Durie, 1999). In 1988 the Māori Health Standing Committee urged the government to "consider the importance of the Treaty of Waitangi as a foundation for the good health of all in Aotearoa" (Standing Committee on Maori Health, 1988).

The 1980s saw the establishment of several Māori-led health programmes. From 1984 mental health services led the way in providing Māori health programmes in secondary care. e.g. Tokanui Hospital (Whaiora) and then Carrington Hospital (Te Whare Hui then Te Whare Paea) (Cunningham and Durie, 1999). Another example of a service for Māori (and Pasifika peoples) which was begun in 1984 was the community-based programme working out of Whaiora marae in Otara (South Auckland) with the aim of demystifying the delivery of healthcare and also to build links between the community and hospital services. Garth Cooper, of Ngāti Māhanga Tainui-Waikato, who was a registrar at Middlemore Hospital at the time and was involved in establishing the programme, recalled that not all Māori approved of a model that also included Pasifika (Cooper, 2018). Although Māori and Pasifika peoples shared similar health problems and lived in similar urban areas, in particular South Auckland and Porirua, some Māori resented being grouped with Pasifika peoples as this classification

ignored their identity as tangata whenua or the indigenous population of Aotearoa New Zealand.

While there were not significant improvements in reducing health inequities in the 1980s, the changes in perspective on Māori health from the Department of Health and government in general were notable. The changes within government had begun in the final years of the National government (1975–84) and increased under the Fourth Labour government (1984–1990). They reflected a gradual change of perspective within government departments, as well as a new generation of politicians entering parliament (particularly within Labour) who were at least nominally more committed to addressing issues of equity and cultural competency. There was a growing emphasis on supporting research in the area, although there was much that was still not being considered. This decade also saw the establishment of several Māori-led health initiatives which played a growing role in subsequent decades.

6. 1980s and 1990s economic and health reforms

At the same time as the growing recognition within the Department of Health of Māori health perspectives and a need to address inequities, the government introduced significant changes driven by neo-liberal or market-driven ideologies (Easton, 2020). These changes are usually dated as beginning in 1984 with the election of the fourth Labour Government, under the direction of its Finance Minister, Roger Douglas, supported by the Treasury. However, the move away from universalism in welfare had already occurred under the previous National government that prioritised spending on those over the age of 60 above other beneficiaries through its new superannuation scheme (McClure, 1998). This disadvantaged Māori, whose population was disproportionately younger than other sectors (see Fig. 1).

While Māori unemployment also began to increase from 1976 with a downturn in the New Zealand economy, difficulties increased for Māori with economic policies introduced by the fourth Labour Government. Corporatisation (often followed by privatisation) of state assets under neo-liberalism resulted in many people losing jobs in areas such as forestry which had been a significant source of employment for Māori. By 1986, 12 percent of Māori men and 17 percent of Māori women were registered as unemployed compared with 4.3 percent of non-Māori men and 6.2 percent of non-Māori women. By 1990, 20.6 percent of Māori were unemployed compared to 7.3 percent of the population as a whole (McClure, 1998) and average Māori household incomes were 20 percent lower than the population as a whole. Two years later, the Māori unemployment figure was 25.4 per cent (Harris and Matutina Williams, 2015).

While the fourth Labour government considered changes to the health sector and commissioned two reports during its time in office – *Choices for Health Care* (Scott et al., 1986) and *Unshackling the Hospitals* (Gibbs et al., 1988) – neither report involved significant input from Māori. *Choices for Health Care* outlined several different ways of funding and organising the health system with different roles for the state, and *Unshackling the Hospitals* advocated a much greater role for the market in the provision of healthcare and argued for a purchaser-provider split. In any case, no substantial changes arose directly from either report. After National's election to office in 1990, however, significant changes were proposed in its paper, *Your Health & the Public Health* (Upton, 1991). Following this, extensive changes were quickly made to the health system with a focus on increasing the role of the private sector and making individuals more financially responsible for their healthcare. Other changes introduced an internal market with a purchaser-provider split, and charges for secondary care in public hospitals were introduced. These major changes had significant consequences for Māori.

The Labour Government had set the changes in process when it made compulsory the transition from traditional Hospital Boards to Area Health Boards, and the new National Government replaced these with four Regional Health Authorities (RHAs). Since 1989 Area Health Boards had included appointed Māori representatives but it was quickly

realised that the new plans outlined in Upton's 1991 paper made no arrangements for guaranteed Māori representation on the various new bodies that were to be created, although a number of Māori were subsequently appointed to many of them (Durie, 1994). Unequal representation across the RHAs meant that each of them took a different approach to satisfying their responsibility to purchase for Māori health gains (Cunningham and Durie, 1999).

While Māori themselves developed health initiatives at this time, one of their biggest challenges was the constant restructuring of the health system, which made it difficult to build partnerships with the various organisations making up the bureaucracy. The move from AHBs to RHAs was particularly frustrating for organisations which had invested a lot of time in building relationships with the former bodies (Durie, 1994). As public health academic Papaarangi Reid explained, "implementation of the principles of the Treaty has been subject to repeated negotiation with ever-changing health bureaucracies" (Reid, 1999b). There was also a lack of consistent policy, and Māori providers were often only offered one-year contracts, with targets and performance management being key features of National's health reforms (Cunningham and Durie, 1999). This made negotiating and working with various arms of the public health system extremely challenging. Despite these challenges, the most notable shift in health provision in the 1990s for Māori was the increasing number of Māori health providers who were able to draw on the experience and expertise that early providers had gained in the 1980s (Cunningham and Durie, 1999). One example of the increasing number of Māori health providers is the 23 Māori health initiatives that were under contract from the Central RHA in 1994/5, mostly in primary care (Cunningham and Durie, 1999).

The introduction of the purchaser-provider split, which allowed for non-public bodies to bid for public funding, appeared to provide an opportunity to Māori to access funds to provide healthcare under a "By Māori, For Māori" banner. Yet, the competitive ethos that underpinned the health reforms could have a negative impact on Māori providers. According to Durie, the competition between iwi "produced tensions and division that, far from creating efficiency, led to a multiplicity of poorly funded, under-resourced authorities with high overheads and an incapacity to grapple with the wide-ranging demands of Iwi development" (Durie, 1994). Those wide-ranging demands included dealing with a highly vulnerable population with poor health statistics.

Urbanisation had led to challenges for Māori in that, while Māori society had traditionally been tribal, and many organisations were built around iwi (tribal) affiliations, urbanisation had resulted in the need for Māori to organise in different ways. The post-war period was by no means the first time Māori had organised across tribal groups, and points to the dynamic and resilient nature of Māori society (Keiha and Moon, 2008). Urbanisation did mean however that many Māori were living far from their iwi, resulting in the need for the establishment of urban Māori organisations and for iwi-based organisations to provide health services to Māori from beyond their own iwi. Te Whānau o Waipareira Trust, an urban Māori authority in West Auckland, was one response, offering comprehensive primary care on a large scale. As Cunningham and Durie noted, "like tribal services, [its] distinctive characteristics grew from [its] close affiliations with Māori networks, [its] cross-sectoral linkages, and [its] ability to reach Māori consensus," (Cunningham and Durie, 1999) suggesting that urban Māori organisations were not dichotomous to tribal organisations but rather another manifestation of tino rangatiratanga/assertion of sovereignty.

Another change in health which was implemented in the 1990s, but outside of the government reforms, was in 1992 when the New Zealand Nursing Council made cultural safety a requirement for all nursing students (Papps and Ramsden, 1996). The concept was developed in the 1980s by Irihapeti Ramsden (Ngāi Tahu and Rangitāne), a trained nurse who also had a degree in anthropology, and it had been advocated by the 1984 Health Department hui. Training in cultural safety involved reflecting on one's own cultural identity and how this shaped one's nursing practice to nurse more effectively an individual or family from

another culture (Papps and Ramsden, 1996). However, the introduction of cultural safety to the nursing curriculum became subject to public debate as it was seen as an example of "political correctness" (Papps and Ramsden, 1996). While cultural safety remained part of the nursing curriculum, the opposition that it faced is indicative of a wider hostility by some Pākehā New Zealanders, often encouraged by the media. Yet it was increasingly normalised as part of training for nurses and other health professionals.

Following the 1996 election, which was the first election to take place under a mixed member proportional (MMP) voting system rather than the traditional first-past-the-post system, the National Party entered into coalition with the New Zealand First Party to form a government. New Zealand First was led by the former National MP Winston Peters (Ngāti Wai), and won 17 seats, including all five Māori electorates. Peters had left the National Party as he was unhappy with the neo-liberal policies it was pursuing, and part of the coalition agreement that he negotiated with National included several changes to the health system. These included the introduction of free GP visits and prescriptions for children under six years old, abolishing the extremely unpopular remaining hospital user charges, the establishment of a Maori Provider Development Programme and a Maori Health Commission, and an increase in baseline funding for the Ministry of Health (English, 1997). Peters was able to capitalise on the significant support he had received from the electorate, but it was also clear that the MMP system had helped increase the number of Māori MPs in parliament with the number of Māori MPs doubling from eight in the 1993 election to 16 in 1996 (the total number of seats had increased from 99 in 1993 to 120 in 1996). This provided a stronger cross-party voice and support for issues of importance to Māori communities.

Despite significant increases in the number of Māori health providers in the 1990s as well as increasing opportunities for Māori to engage with health bodies and influence policy, albeit often in very challenging and ever-changing circumstances, the 1990s was the only decade of the twentieth century in which Māori health worsened (Reid, 1999a). This was no doubt due to the wider context in which the health reforms were taking place and the severe economic consequences that these reforms had for many Māori families (Woodward and Blakely, 2014). Another element of the neo-liberal agenda was to look to individuals to solve their own problems and this often resulted in victim-blaming people for wider public health issues such as obesity, and tobacco and alcohol use (Reid, 1999a). The *Hauora Māori Standards of Health IV* report, covering the period 2000 to 2005 provides extensive evidence of the persistence of health inequities into the twenty-first century. Its findings include that renal failure was 3.5 times more common amongst Māori than non-Māori; that the risk of death for Māori infants was nearly two-thirds higher than for non-Māori; and that deaths from diabetes were nine times more frequent among Māori than non-Māori (Robson and Harris, 2007).

7. 2000 and beyond

With the election of the fifth Labour Government in 1999 and the passage of the New Zealand Public Health and Disability Act 2000, most of the changes implemented in the health system during the 1990s were reversed although there remained a place for Māori primary health organisations. Labour also announced a new "Closing the Gaps" policy to address the health inequities between Māori and the rest of the population. However, this policy was seen by some Pākehā as privileging Māori and the phrase was dropped by Labour in 2001 and replaced with "social equity" but the underlying policy remained and this was criticised in 2004 by the Leader of the Opposition, Don Brash, who argued that it was contributing to racial division and creating two standards of citizenship (Bryder, 2008). In any case, attempts to close the gap between Māori and non-Māori failed, as had previous attempts, and health inequities persisted.

The Waitangi Tribunal is currently conducting the Health Services

and Outcome Inquiry which involves over 200 claims that have been made in relation to Crown breaches of the Treaty in relation to Māori health and outcomes. As this covers such a broad range of issues, the Tribunal elected to hear the claims in three parts. The first, for which a report was issued in 2019, covers the primary health care system since 2000; the second phase which is currently being conducted covers three key areas for Māori health: mental health; disability; and alcohol, tobacco and substance abuse; and the final phase will consider any remaining areas of significance, including historical claims (Waitangi Tribunal, 2019). While the historical claims are yet to be heard, New Zealand provides an interesting example of health being considered in a wider programme of restorative justice to address expropriation from the colonial period to the present. The roots of this process began with giving the Tribunal retrospective powers in 1985 and changing attitudes in the last quarter of the twentieth century, although it took many more years to come to fruition.

In its first report on the health system published in 2019, the Waitangi Tribunal found that Māori health inequities persisted for the first two decades of the twenty-first century and that the primary care framework failed to consistently state a commitment to achieving equity of health outcomes for Māori. It also concluded that Māori primary health organisations were underfunded, the government was not collecting sufficient data to fully inform itself how the primary care sector was performing in relation to Māori health, and in designing the primary care framework, the Crown had not worked in partnership with Māori. The Tribunal also found that Māori were underrepresented across a range of health professions and at the Ministry of Health (Waitangi Tribunal, 2019). These were similar issues discussed in at the 1984 Hui addressed earlier. Considering the Tribunal's report along with a more general review of the health system, the current Labour government has implemented a restructuring of the health system which includes a Māori Health Authority, however the National Party has stated that it will scrap the Māori Health Authority if it wins the 2023 election.

8. Conclusion

New Zealand provides an example of a country where the majority captured the health system and interpreted universal healthcare as meaning healthcare provided for the majority. This arose from the 'colour-blind' universalist principles of the classic welfare state under the First Labour government. As New Zealand became increasingly diverse and with the late twentieth-century civil rights movements, there was an ever-growing awareness of providing culturally appropriate care and providing a health system which produced equitable outcomes for all groups – Pākehā, Māori, Pasifika and Asian peoples. Māori, as the indigenous people of Aotearoa, claimed additional rights through Te Tiriti/the Treaty of Waitangi. To ensure equitable health outcomes, policy makers needed to recognise both cultural diversity and the social determinants of health. Over the course of the last twenty-five years of the twentieth century the New Zealand health system moved from almost completely ignoring Māori to acknowledging Māori perspectives and the need to address health inequities, but little achievement was made in reducing these inequities, and in fact the inequities widened in the 1990s. This gap between acknowledging the problem and effectively addressing it shows both that many of the determinants of health and well-being lay outside the purview of the health system but also perhaps that there was not sufficient political will to address it by either of the major political parties.

The introduction of the purchaser-provider split in health policy in the early 1990s and the focus on devolving responsibility to communities provided the opportunity for many Māori health providers to be established. However, community organisations were often underfunded and were not adequately supported to provide health care to disadvantaged populations. At the same time as these Māori-led health initiatives were being established, the neo-liberal economic and social welfare policies worked against Māori and adversely affected their

health.

This case study of health policy and Māori in New Zealand between 1975 and 2000 shows how, despite a greater consciousness of health disparities and recognition of the different cultural pathways for improving health, without addressing inequities in the wider social determinants of health which stemmed from structural and historical inequalities, and investing in Māori providers to run their own services in a way they considered culturally appropriate, nothing would really change, and indeed the disparities could increase when economic policy cancelled out potential gains through changes to health policy. In this respect New Zealand's two major political parties, Labour and National, were both culpable, both holding power during this period and neither reversing the health trends, although it was under National in the 1990s that the situation deteriorated. Māori-led and controlled healthcare has been proposed in the 2020s, but it was during the last quarter of the twentieth century that the need for such an approach was first mooted and the foundations laid, by both Māori providers and researchers, and broadly accepted by government departments. The 1975 Treaty of Waitangi Act instituted a new era in acknowledgement of Māori rights, although neither government that followed, Labour or National, had the political will to take the new approach to its logical conclusion and give Māori control over the health of their people.

As a study in history, we have not attempted to make definitive epidemiological claims about the causes of health inequities over time. Rather we have charted how the government and other concerned parties conceived of and addressed the problem of health inequities, and how that changed over time. We argue that there was a distinctive sea change in the period 1975–2000 when the Treaty of Waitangi was embedded into official policy. There were impediments along the way to achieving more equitable outcomes, under a neoliberal government intent on market-driven economic and social policies, and structural changes in healthcare, but it was in this period that the idea of Māori-led healthcare services were widely canvassed and accepted – through independent and government-commissioned research, consultation with Māori through hui, and marae-based schemes, for example. These ideas were not realized in the period under discussion, but had their genesis at that time. Whether a Māori-led health system based on Māori cultural beliefs will reverse the health inequities is still to be tested, and the new health system introduced this year is a legacy of the ideas and activism of the last quarter of the twentieth century. That is perhaps the real significance of the period 1975–2000 to Māori health history.

Author statement

Hayley Brown: conceptualization; Methodology; Formal analysis; Writing – original draft preparation. **Linda Bryder:** conceptualization; Methodology; Formal analysis; Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

No data was used for the research described in the article.

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