



Position Statement 24

Ageing and Indigenous Health in Aotearoa New Zealand

Key Points:

1. Communications between different cultures are common in New Zealand (NZ), and common in healthcare situations.
2. A doctor's culture and belief systems influence his or her interactions with patients and this may impact on the doctor-patient relationship.
3. Older Māori in NZ share a particular health background and understanding this may help to appreciate where current health or ill health may have stemmed.
4. The process of colonisation has had a marked effect on the health of Māori in NZ.
5. The Treaty of Waitangi is New Zealand's founding nationhood document, and has important significance for health. The NZ Government has recognised that there are disparities in health in NZ, and also the governmental responsibility to improve health outcomes for Māori
6. Socioeconomic disadvantage explains a considerable proportion of the disparity in health between Māori and non-Māori
7. There have been a number of different models developed for understanding Māori Health, common themes however are spirituality, mental health, physical health, family, language and cultural heritage.
8. The assessment and treatment of Māori can vary compared with non-Māori, and health practitioners should take note of this to allow best care for their patient. Particular examples of this are contained within this position statement.
9. It is important, with consent to involve family and whānau (wider family) in both assessment and treatment.
10. Management for older Māori should include consideration of Rongoa/Māori Medicine and healing, which may incorporate particular medicinal formulations and massage.
11. We support further research into Māori Health and government initiatives to improve the deficit in health of Māori populations compared with the NZ European population.

This position statement represents the views of the Australian and New Zealand Society for Geriatric Medicine. The preparation of this paper was coordinated by Dr Oliver Menzies, Professor Ngaire Kerse and Dr Mere Kēpa and was approved by the Federal Council of the ANZSGM on 16th June 2013. Te Ohu Rata O Aotearoa (Te ORA) – The Māori Medical Practitioners Association – has also reviewed this statement.

Introduction

He aha te mea nui o te ao

What is the most important thing in the world?

He tangata, he tangata, he tangata

It is the people, it is the people, it is the people

Māori proverb

Māori is the name given to the Tangata Whenua / people of the land (Indigenous people) of Aotearoa, New Zealand (NZ).¹ This statement addresses the health of older Māori in NZ. The background and epidemiology of Māori Health in NZ is discussed, followed by practical application in assessment of the older Māori patient.

Communications between people of different cultures is common in NZ, and common in healthcare situations. The effectiveness of these communications can impact health outcomes for patients. The concept of 'Cultural Competence' describes the ability of a medical practitioner to interact with people of different cultures. In their statement on cultural competence in 2006 the Medical Council of NZ (MCNZ) define it as requiring "an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge:

- That NZ has a culturally diverse population.
- That a doctor's culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor-patient relationship.
- That a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding.²

At the indigenous health focussed Royal Australasian College of Physicians (RACP) Congress in 2011 Mason Durie, Professor of Māori Health at Massey University in NZ, noted important patient specific points for practitioners³. These included integrating cultural and diagnostic findings to gain a broad formulation of the problem, and incorporating indigenous concepts and values into the treatment protocols. Collaboration (with families, translators,

cultural advisors, traditional healers) was also emphasized.

One of the primary goals of cultural competence and increasing knowledge of a patient's culture is to improve health outcomes for the patient. The older Māori in NZ share a particular health background, and understanding this history helps to appreciate where current health or ill health may have stemmed from. Older Māori also have different incidences of illness and disease than the general population. Knowledge of these incidences can help in diagnosis. There are further options for management of older Māori which should also be considered, this may include the option of working with a Rongoā / Māori Medicine practitioner.

Some of the cultural commentary in this paper is generalised but Māori patients, like other populations, are diverse and practitioners will need to adapt their approach to individual patients.

Further information on Māori Health can be found in the following useful publications:

1. *Statement on Cultural Competence*. Aug 2006. Medical Council of New Zealand.
2. *Cole's Medical Practice in New Zealand*. 2009. Medical Council of New Zealand. Chapter 5.
3. *Best Health Outcomes for Māori: Practice Implications*. Oct 2006. Medical Council of New Zealand
4. *Statement on best practices when providing care to Māori patients and their whānau*. Aug 2006. Medical Council of New Zealand.

These can be accessed on the MCNZ website via link:

<http://www.mcnz.org.nz/Resources/Standardsandguidelines/tabid/293/Default.aspx>

Background of Māori Health in Aotearoa

Māori people have their own language (Te Reo Māori) and unique culture / Tikanga. Culture can be defined as the ideas, customs, and social behaviour of a particular people or society.⁴ Some people regard Māori culture as haka / traditional Māori war dance, paddling waka / canoe, or particular kai / foods. These are just one small part of Māori culture.

The ancestors of today's Māori arrived in NZ approximately AD 800, arriving in voyaging waka.⁵ The largest social grouping in Māori society is the Iwi / tribe. Iwi may be named after waka, ancestors, places of significance. Iwi are made up of Hāpu / sub-tribes. Traditionally each Iwi and Hāpu have an area of land where they live, where they are from. Such land is known as a Rohe, and the Hāpu or Iwi are the Tangata Whenua / people of the land.

The custom of whakapapa (family history/genealogy), links Māori to whānau / extended family, Hāpu, Iwi, and land. As a result of these relationships a person then has a Turangawaewae (standing place from where one gains the authority to belong) and a Marae / meeting place, and an Urupa / cemetery.

The English speaking NZ European people (Pākehā) have been in NZ since the arrival of Captain Cook in 1769. The contact with this new civilisation had a marked effect on the Māori people and the land. There was the introduction of new diseases, plants and animals, land wars, dispossession of land, and the introduction to alcohol and smoking. Measles, whooping cough, typhoid, scarlet fever, influenza, mumps all took their toll. The land too was not unaffected; pests such as the stoat and possum, and plants such as gorse and blackberry had a large effect on the indigenous flora and fauna. By the early 1900s Māori land ownership constituted "only 17 percent of the country, and a great deal of this was marginal".⁶

On February 6, 1840 at Waitangi in the Bay of Islands, the Treaty of Waitangi was signed between the Crown and the tribes of NZ. Because of the translation into both

Māori and English versions of the treaty, there were some subtle but important differences; however both are regarded as legitimate. This became the NZ nation's founding document. Unfortunately this document was ignored or disregarded in a number of ways since then, and protests against this had little impact, until the establishment of the Waitangi Tribunal in 1975.

All of these things had a devastating effect on the Māori population. At the arrival of Cook the Māori population was variously estimated at between 100,000 and 200,000.⁷ By 1896 the recorded Māori population had reached an all-time low of 42,113.⁸ The situation became so bad that a surgeon in 1846, Dr Isaac Featherston, stated "all we can do is to smooth [the] pillow of the dying Māori race".⁹

Through the early 1900s there was a turnaround in Māori health that was brought about by Māori leadership in health, Māori health promotion, and Māori community and support groups. More recently there were initiatives from Iwi health authorities, urban Māori authorities, and central government. All of this resulted in improved health and longevity for Māori. By 1996 the Māori population had improved to 570,000 from 45,000 in 1901. Life expectancy for a Māori female had improved from 30y in 1901 to 73y in 1996.¹⁰ Disparities in health, however, continued to exist.

The Waitangi Tribunal was established in 1975 to address and attempt to rectify past breaches of the Treaty of Waitangi by the Crown, and since its establishment has ruled on many claims bought by Māori.

The importance of the Treaty in relation to health has been more recently recognised by the Crown. In *The New Zealand Health Strategy* published in 2000, the Ministry of Health states: "central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori will have an important role in implementing health strategies for Māori and that the Crown and Māori will relate to each other in good faith with mutual

respect, co-operation and trust".¹¹ The strategy statement also recognises that there should be "participation at all levels, partnership in service delivery, protection and improvement of Māori health status." The Crown's responsibilities were further recognised in the *NZ Public Health and Disability Act 2000*, which required District Health Boards to "reduce health disparities by improving Health outcomes for Māori" and "to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori".¹²

Te reo Māori me ngā tikanga / Māori language and cultural heritage and understandings influence and guide the Māori approach to illness, wellness and health. Some of the more important concepts to understand include Tapu and Noa.

Tapu can be thought of as a prohibition or sacredness of people, a thing or place (possibly for health reasons). It's 'opposite' is Noa which is a state of free access. These concepts will be discussed further later in this statement.

There have been a number of different models developed for understanding Māori Health, common themes however are spirituality, mental health, physical health, family, language and cultural heritage. In Māori society particular emphasis is placed on spiritual wellbeing, and the health of family and whānau relationships.

Current Health Status of Older Māori

In 2006, 23127 Māori were aged 65 and over, 6.8% of the total population aged 65+.¹³ Between 2011 and 2026, the population of older Māori is predicted to grow by 7.1%, double the growth expected for non-Māori, to 9.8% of the total older population.

The only in-depth exposition about positive ageing for Māori using Mātauranga Māori/Māori knowledge, an

indigenous Māori inquiry paradigm, is a PhD Thesis by Edwards in 2010.¹⁴ Through examination of the literature, interpretation of Mātauranga Māori (42 Māori proverbs) and qualitative interviews with 20 older Māori people, Edwards found that Māori people ageing positively can be characterised by a process dimension; the life-course perspective where "circumstances encountered during life may impact cumulatively and manifest in old age" and outcome dimensions. The overarching outcome domain was taupenui / realised potential, contributed to by several domains including: Tākoha / contribution; Whanaungatanga / connectedness; and tino rangatiratanga / self determination. Potential is different for each older person and realising that potential relates to contribution by Māori collectives and self determination. The values are transformational for health researchers.

One other NZ study included discussions with older Māori which emphasised ongoing contribution to whānau, particularly mokopuna, and ongoing practice of cultural activities.¹⁵ Positive ageing was seen to be ongoing despite the vexed political history of self determination for Māori in NZ.¹⁶ A survey of over 400 older Māori¹⁷ showed that active participation and cultural affiliation were associated with higher standards¹⁸ of health; however, the cross-sectional nature of the study precluded an examination causation; i.e. does better health lead to cultural affiliation or vice versa? Considerable effort in voluntary cultural work was made by older Māori and higher incomes and home ownership were associated with better health status.

Social, economic and environmental factors are proven internationally to impact health¹⁹ and political, cultural and historical factors add to these as recognised factors related to health disparities for Māori in NZ.²⁰ Overall, living standards for Māori are lower than for non-Māori and older Māori are more likely to experience disadvantage and hardship at three to four times that of non-Māori. Older single Māori, mostly women, have

the least material wellbeing.²¹ Lifetime disparities in income continue in old age which contributes to the disparity in longevity between Māori and non-Māori of 8.6 years for men and 7.9 years for women.²² Material well-being is relevant to older Māori; Edwards reported tensions in the relationship between the autonomy of the individual and the duty to whānau, meaning the impact on health is likely to be accentuated.¹⁴⁴ Older Māori are more likely to live in deprived neighbourhoods, eat less vegetables and fruit, and are more likely to be under- and overweight than non-Māori.¹³ Disability affects 24% of Māori aged 65+, with 18% of non-Māori similarly affected. For older Māori little is known about dementia and residential care placement as data is not available.¹³ How, then, are older Māori to age positively, living long lives?

Half of the differences observed in ageing of Māori peoples is due to socioeconomic disadvantage.²³ Other sources of disadvantage in health may relate to social structure, epidemiological factors, and access to health services.²⁴ Māori experiences of health services are gradually changing and younger Māori may be more likely to critique services.²⁴ While exact causes for the differences in ageing are yet to be explained, a greater understanding of the contribution of socioeconomic, cultural, and environmental factors to wellbeing may lead to specific interventions to improve Māori health.

In NZ in 2006, cardiovascular disease (CVD) caused 89% and 58% of deaths of older (65 years and older) non-Māori and Māori respectively.²⁵ Before assuming that non-Māori have higher rates of cardiovascular disease, including those 45 and older gives 96% and 99% for Māori and non-Māori respectively. Māori are therefore dying of cardiovascular causes earlier than non-Māori. For women aged 65 or older, the rate of total cardiovascular mortality was 1742 and 829 per 100,000 population for Māori and non-Māori respectively. Rates of hospitalisation for CVD are high with 10% of older Māori men and 8% of older Māori women being

hospitalised in the 2005 – 2007 period. The morbidity associated with CVD reduces quality of life and increases disability. The Leiden Longevity study showed that over 5 years 32% of the 599 participants reached a composite CVD-endpoint (fatal or nonfatal MI, stroke and death from other CVD causes). Overall 47% died in 5 years, of which 40% died from cardiovascular causes. In one NZ study of Māori aged 75-79 years prevalence of CVD was 67% and subsequent incidence of CVD was 6 cases/100 person-years.²⁶

The second commonest cause of death of older Māori is respiratory disease with an excess of lung cancer and COPD related morbidity. Diabetes and stroke are also in the top 5 causes of death for older Māori.²⁵

The Māori population is ageing faster than those of European descent; the increase in the proportion of Māori aged 65 and over will be greater than for their European counterparts over the next 3 decades.

Assessment of the older Māori patient

General Points

As clinicians will be well aware, understanding a patient's background can help to understand a patient's current presentation. Earlier sections in this article have outlined a background which Māori share. Current health should be interpreted on the background of lower incomes, limited access to medical care and rehabilitation services, cultural alienation, lower standards of health and education. In addition there are higher prevalences of many diseases including metabolic diseases, mental health, ischaemic heart disease, suicide, and cancers. Māori, in most cases, have more frequent and complex health problems at younger ages than their non-Māori counterparts.²⁷

Both the background of Māori health in NZ, and population demographics should be kept in mind in the assessment of older Māori patients. Māori, however, come

from different Iwi (tribes) and diverse cultural backgrounds, and it is important to realise that there is not a 'typical' Māori person. The guidance provided below is a necessary generalisation and therefore some of the points covered may not be appropriate for a particular patient. As a guiding principle, mutual respect and understanding in the therapeutic relationship are a goal, and this may mean incorporating Māori concepts and values into assessment and treatment. Practitioners need to realise that there may be different perspectives in the understanding of disease and the treatment of it. When providing care to older Māori, as the MCNZ statement on cultural competence alludes to, a practitioner should be mindful that their own particular culture can impact on the way that they relate to their patients.²⁸

When assessing patients it is important, with consent to involve family and whānau / wider family in both assessment and treatment. In addition to providing comfort to patients, the presence of whānau members at consultations can lead to improved care by providing additional background information during the medical history. In addition whānau can help patients to understand and remember instructions, and assist patients in carrying out treatment plans.²⁹

In lieu or in addition to whānau, Kaumātua / elder Māori are often employed in conventional services as cultural advisors and advocates, and it may be helpful to have one of these people present during certain assessments and discussions.

Over years there has been an increased urbanisation of Māori, but a significant proportion of older Māori still live in rural locations, and may only attend larger population centres when they have to. Older Māori may be living distant to their Rohe / tribal area, so may not have as many traditional supports available from local Iwi or Marae. Older Māori may have grown up in rural locations, and have children that have moved to larger cities for employment reasons. Alternatively, they may have been forced to move and

live with their children in larger centres as they become more frail.

In interacting with Māori patients, practitioners should be aware of Tikanga Māori, that should be thought of as principles, values, proper conduct and traditions. The principles include:

- Mana / respect and dignity
- Wairua / the spirit that lives on after death
- Tapu / prohibition or sacredness of a thing or place (often for health reasons)
- Noa / a state of free access (or 'the opposite' of tapu)
- Whanaungatanga / kin relations, family and interpersonal relationships

Tapu and noa are principles of special significance in health. One particular example is in the case of a Māori patient's death, the tupapako / body and room that the body is in becomes tapu. Food and drink, which is noa / common, should be kept separate and staff bringing drinks or food in to the family should be avoided.

A more marked example of illness behaviour in relation to tapu is the concept of Mate Māori. This is ill health related to a transgression against tapu. It is important therefore to ask your patients what they feel the cause of their illness is due to. Professor Mason Durie, Professor of Māori Research at Massey University, New Zealand, describes Mate Māori as referring to "a cause of ill health or uncharacteristic behaviour which stems from an infringement of tapu or the infliction of an indirect punishment by an outsider. The prevalence of Mate Māori has never been recorded although there are published accounts of isolated cases of the condition and its management. It may take several forms, physical and mental, and various illnesses not necessarily atypical in presentation may be ascribed to it".³⁰

Older Māori may feel negatively toward hospitals, and this may result in late presentation to their GP or medical centre.

There was an early belief, now fading, that hospitals were primarily “places where people die”.³¹ Hospitals also create restrictions on visitors and visiting hours, whereas Māori are accustomed to whānau and friends being present when they are unwell.

History taking

Whakapapa / knowledge of belonging to a people and a place, is an important conversation among Māori. Talking and making connections is important in building a relationship of trust and respect. As an introduction the practitioner may wish to introduce something of their own background, which may set their patients at ease and facilitate information in return from patients. Talking about ethnic background can also help to open discussion, assessing where patients come from, both culturally and geographically.

In taking a medication history from older Māori, additional information to ask about includes Māori health treatments such as Rongoā / Māori medicine and mirimiri / a form of massage. Further detail on these is given later. Practitioners are encouraged to be supportive or at least tolerant of an older Māori patient's preference for treatment, as long as they are not resulting in harm.

Older Māori are often referred to as Kuia / older woman or Kōroua / older man. Kuia and Kōroua may have important commitments in their Marae or Iwi (tribe). The kaumātua are often called upon to give speeches, lead Karakia / prayer and preside over important occasions. Kuia often have important roles in Waiata / singing, Karanga / calling visitors onto a Marae, and supporting whānau and family. Sometimes these commitments can be significant. More often (than European) older Māori live with or close to relatives and are involved in caring for mokopuna / grandchildren. In return the kaumātua may receive support from younger generations.^{32, 33}

Whanaungatanga / kin relations are an important support relationship for older Māori.

Community support can come in a variety of different forms. There may be support from family and whānau. There may also be support from the local Marae Committee. Other avenues of support are the local urban Māori health authorities, Māori Women's Welfare League, and Rūnanga (Tribal Authorities).

Spirituality is an important factor in the health of Māori. In taking a history from older patients, enquiry about spiritual or religious beliefs is often left out, but is important for older Māori patients.³⁴ If this enquiry serves to gain no useful information for the enquirer, it at least acknowledges that this is an important aspect in health for older Māori patients.

Financial considerations are generally more important for Māori elders than their European counterparts because of their on-average poorer economic status.

Examination

Practitioners need to be aware of the beliefs of tapu / sacredness in relation to the body.

When examining older Māori patients, be careful to pay particular deference to the head, as this is regarded as tapu. Placing one's hands on the head of older Māori people should be avoided if possible, and if you do, obtain verbal consent before doing so.

Sitting on a bedside table or in a place where patients have their meal served should also be avoided, as this renders the surface unclean, and not able to be eaten from. Similarly, Māori may feel uncomfortable if pillows used under their legs or around their buttocks are afterwards offered to them to put under their head.

Cognitive assessment instruments in common use such as the Folstein Mini-Mental Status examination have not been validated in the Māori population. The need for culturally specific tools has been

previously recognised, and has led to the development of the Kimberly Cognitive Assessment Tool in Australia.³⁴ The Rowland Universal Dementia Assessment Scale (RUDAS) cognitive assessment tool also has less cultural bias in use.³⁵

Management

Be aware that illiteracy rates are higher for Māori, so take care with simply relying on written instructions.

When deciding on management, bear in mind that there are specific community supports that are available for Māori. If there is a Māori social worker or health worker available, they can be invaluable in assisting with service planning and support in the community.

When body parts or tissue will be removed and/or examined, be sure that Māori patients are consulted before the examination. In addition, consultation about the final disposal of that material is required.³⁶

Special situations

Palliative Care of older Māori is a particularly important area. Health providers should be aware of the Māori need in relation to presence of family around the time of death. If the death occurred in hospital, prompt removal of the Tupapako / body to a whānau's house or marae will be appreciated greatly by whānau.

In nearly all Māori families, a death will be an occasion for family, whānau and wider relations to gather together to perform the customs of farewell. The tangihanga / funeral and grieving process will be held over several days. It may take place at the deceased person's home or a family member's home, but more commonly it is held on a marae. Anything that delays tangihanga can create strong feelings of resentment within the whānau, and therefore a clear explanation of any necessary delays should be provided by the health practitioner.³⁷

Role of Māori Medicine

Traditional Māori healing has developed from Māori cultural traditions over generations. It is a system of healing which is holistic in its approach, and has spiritual, as well as physical, social and medicinal based aspects.

In modern times there are 3 main modalities of treatment that patients may use: Rongoā (Māori Medicine), Mirimiri (massage), and Karakia (prayer).

Traditionally the Tohunga / Healer was the practitioner whose role it was to administer healing. Some Māori, particularly older Māori, may consult a Tohunga or Rongoā practitioner prior to seeing a medical doctor. Medical practitioners should try to work with rather than against traditional healers, however if you feel their management is harmful then it is important that you share those concerns with your patient. A relevant reference is the MCNZ's statement on complementary or alternative medicine.³⁸

All Iwi now have health committees, and more than 65% have contracts for the development of health services, including mental health services. Elders may be employed in 'conventional' services as cultural advisors.

It is important to entertain the possibility of incorporating traditional healing principles into 'conventional' care, and Māori traditional healing practitioners would generally welcome working with doctors on a shared treatment plan.

Rongoā / Māori Medicine and Healing

refers to the traditional medicinal formulations derived from plants, and healing. Rongoā is used for a variety of different diagnoses. Traditional remedies often targeted common ailments such as toothache, intestinal problems and skin conditions such as boils, cuts and other injuries.

The particular Rongoā employed for a problem may vary according to Rohe, Iwi,

and Hapu. This has been attributed to cultural tradition and a long history of oral transmission of knowledge.³⁹

In more recent times the Ministry of Health has set standards for Rongoā Māori Practitioners and practitioners have welcomed this.⁴⁰

In the 2008 report "The future of Rongoā Māori: Wellbeing and Sustainability" the Ministry of Health has recognised the importance of providing other options for health treatment, and the development of the Rongoā practitioner workforce.⁴¹ Funding for Rongoā Māori has steadily increased and in 2008, the NZ Ministry of Health administered 16 Rongoā Māori contracts with providers throughout the country.

Mirimiri is massage, Māori physiotherapy. Mirimiri can be useful in alleviating discomfort in arthritis and other musculoskeletal complaints. It may also be useful at relieving stress or tension, and symptomatic treatment of pain. In an unpublished audit of 20 patients using a Mirimiri practitioner in 2005, Lisa Gregg and colleagues found that 71% of patients derived subjective benefit from visiting a Mirimiri practitioner.⁴²

Karakia is prayer. Māori believe that the Wairua / spirit that lives on after death is integral to Māori people's wellbeing and health. Many Māori regard karakia as an important way of maintaining health of the wairua. Karakia may be especially useful for treating Mate Māori.

Māori in Australia

In 2006 the NZ resident Māori population estimates by Statistics New Zealand was 624,300.⁴³ Australian census data put the number of people with Māori ancestry living in Australia at 92,918 in the same year. Due to various issues with data collection, a more accurate estimate has been suggested as 126,000.⁴⁴ From 2006 to 2011 the Māori ancestry population recorded by the Australian census grew to 128,434, an increase of 38%. It has been suggested the actual figure is probably at

least 150,000.⁴⁵ Comparing with Statistics New Zealand data Māori in Australia represent around 1 in 5 of all Māori.

Queensland and New South Wales represent states with the highest population of Māori. Western Australia is fast catching up where the Māori population rose 86% between 2006 and 2011.⁴⁵

From 2002–2011 there were 8,450 Māori children born in Australia and 3,728 of these were recorded as not having Australian citizenship.⁴⁵ Not having citizenship entails having a very limited access to welfare payments and services, and tertiary education loans. Tertiary education is required to be paid at international student rates. It is useful for the medical practitioner to recognise this vulnerability when treating the Māori patient in Australia.

There is a difficulty for Iwi organisations in keeping in contact with members living outside of their Rohe / tribal area. One initiative aimed at addressing this is the Tuhono Trust: www.tuhono.net.

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