Te hauora Māori i mua – history of Māori health

by Raeburn Lange

Māori communities were ravaged by the arrival of European diseases such as measles and influenza. With the rapid loss of their land, displaced tribes struggled to survive. In the 20th century things improved, but in the 2010s Māori life expectancy was still seven years less than that of Pākehā.

Pre-European health

Healthy people

In pre-European times, Māori were tall and muscular, even by today's standards. Their average life expectancy of around 28–30 years seems low. But when European explorer James Cook arrived in New Zealand, the populations of both France and Spain had a life expectancy below 30 years.

Early European visitors often described Māori as a fit and healthy people. They led active lives, and many of the infectious diseases common in other parts of the world were unknown to them. However they were probably affected by pneumonia, tetanus, gastroenteritis, arthritis, rheumatism and various skin diseases.

Bracken fern root was an important staple for many iwi. Eating this increases the chance of cancer. The fibrous Māori diet meant people tended to wear their teeth out, which over time led to malnutrition, disease and death.

Beliefs about ill health

Māori medical treatment was closely linked to religious beliefs and practices. People became ill when they offended the gods, or violated the tapu associated with the supernatural world. Scientific ideas about hygiene and infection were little understood anywhere in the world. Nevertheless Māori belief in tapu played an important role by guiding practices for sanitation and water supply. For example, the turuma (latrine) was a separate space in Māori villages. Tapu also affected childbirth and death ceremonies, ensuring healthy practices. Tapu limited contact with the dead, which helped prevent the spread of disease.

Healing practices

Illness was treated by karakia and rituals, and also by rongoā rākau (medicinal plants), physical massage, and the use of water for sprinkling or immersion. Central to healing was the tohunga, an expert and a spiritual and religious leader. The emphasis was on finding the cause of the illness, and getting rid of the spirit or dealing with the transgression responsible for it, rather than on patient care. The spiritual dimension in the treatment may have aided recovery. Some maladies were seen as mate tangata (human in origin) rather than mate atua (divine in origin) and were treated more pragmatically – cuts were sewn up with muka (flax fibre), broken bones were bound with splints, and boils were incised and squeezed.

Health devastated, 1769 to 1901

Diseases

When Europeans first arrived in New Zealand Māori had no immunity against many of the virulent diseases they brought with them. Some of the worst diseases, such as yellow fever, cholera, malaria and typhus, never arrived. Smallpox and plague were quickly contained on the rare occasions they were identified.

However significant diseases were brought, including venereal infections, measles, influenza, typhoid fever (enteric fever), dysentery and tuberculosis. Venereal diseases such as gonorrhoea and syphilis were first introduced during James Cook's voyages around New Zealand, and had an effect on birth rates through sterility and stillbirths. When epidemics affected Māori, the phrase 'tokotoko rangi', or 'spear from heaven', was applied to such calamitous visitations of disease.

Early 19th century

From around 100,000 in 1769, the Māori population had declined by 10–30% by 1840. This was largely due to introduced diseases, and the effects, direct and indirect, of the musket wars, including dislocation from lands that were important for agriculture and provided access to mahinga kai (food resource areas).

Diseases had a significant impact on some tribes, but there were factors limiting their spread during this period. Māori had small, low-density, dispersed populations, so infections tended to be localised. Only certain iwi had close contact with Europeans, with many having only peripheral contact.

Dislocation and disease, 1840 to 1901

Between 1840 and 1891 disease and social and economic changes had serious negative effects on Māori health, and a significant impact on the population.

Tribal dislocation from the traditional Māori environment was brought about by the New Zealand wars and the large-scale land confiscations that followed. There was widespread loss of land through purchase and the operation of the Native Land Court, and new patterns of land use and economic activity. Māori changed housing styles, water supplies, sanitation and diet. These affected standards of health, usually for the worse.

Very large increases in the European population during this period meant Māori across the country were continuously exposed to new diseases. Many Māori children died in their first year of life, often from pneumonia and respiratory infections. In addition, many adults and older children suffered from epidemics of viral disease and typhoid fever, as well as from tuberculosis, a chronic disease that often ended fatally. Relatively high death rates combined with low birth rates saw a rapid decline in the Māori population betwen 1840 and 1878, with a slower decline from 1878 to 1891. Between 1840 and 1891 the Māori population may have halved. The population continued to decline until the century was nearly over

Early health services for Māori

There were humanitarian responses to Māori health decline. The earliest providers of medical care were the missionaries. Government hospitals for Māori were set up in a few places in the 1840s.

As the non-Māori population grew, hospitals became increasingly Pākehā-dominated institutions, built and administered by the local settler communities. Many Māori were suspicious of hospitals for cultural reasons, and were also deterred from entering them by fees. From the 1840s the government subsidised a number of doctors (native medical officers) to provide medical care for any Māori who could not afford to pay for treatment.

Sometimes officials organised emergency responses to epidemics. Sporadically there was vaccination against smallpox. Teachers in native schools were given medicines to treat pupils and their families. Education official James Pope wrote a handbook entitled Health for the Maori, which was translated into Māori and became widely used.

‘A dying race’

Many Pākehā spoke of Māori as a ‘dying race’. They regarded the passing of the race as inevitable, with some saying that under irresistible natural laws a stronger race would always displace a weaker one. But in 1891 Māori MP James Carroll said, ‘I am forced to the conclusion that it is a mistaken theory that the Native Race will rapidly decrease.’[1] In fact the Māori population may already have begun to increase at that time.

Survival of traditional medicine

While many Māori accepted European treatments, traditional Māori health practices persisted. Māori combined elements of the two systems according to the circumstances. Traditional health practices were helpful in many cases, but were often ineffective against new diseases. Patient safety was sometimes endangered when harmful treatment was given, or when potentially beneficial treatment was opposed or delayed.

Footnotes

- Quoted in Richard Boast, Buying the land, selling the land: governments and Māori land in the North Island 1865–1921. Wellington: Victoria University Press and Victoria University of Wellington Law Review, 2008, p. 167. Back

Health improves, 1900 to 1920

In the 20th century, Māori population numbers increased considerably. This was an impressive demographic recuperation. In addition to an increasing resistance to common introduced infections, an important factor was a vigorous health campaign mounted by Māori and by the government in the early decades of the 20th century.

Māori health development

Young Māori activists, many of them former students of Te Aute College in Hawke's Bay, pushed for improved health practices in Māori settlements around the country, and advocated greater use of the available health-care services and facilities. From the late 1890s they worked through the Te Aute College Students Association (later known as the Young Maori Party), led by Apirana Ngata and others. Many influential chiefs and elders lent their support.

Soon this movement became closely associated with innovative Māori health measures adopted by the government. The new Public Health Department established in 1900 included a Māori section headed by Dr Māui Pōmare, who was appointed native health officer. Until he resigned in 1911 to enter Parliament, Pōmare travelled around the country, inspecting Māori settlements and giving advice, instruction and encouragement to local leaders to improve sanitary and public-health conditions. For some years he had the help of an assistant native health officer, Dr Te Rangi Hīroa (Peter Buck).

Maori Councils Act

Under the Maori Councils Act 1900 Māori councils and local marae committees were elected in almost every Māori district. Health improvement was one of their most important functions. A number of influential Māori were appointed to government positions as native sanitary inspectors, to assist the health work of the councils. The Māori councils did their best work in their first decade, after which most struggled to continue, largely due to inadequate financial resources.

Native health nurses

Native health nurses, both Pākehā and Māori, were appointed to the Māori nursing service set up by the government in 1911. A precursor of the public health nursing service of later times, this branch of the Health Department had the strong support of Māori health advocates such as Pōmare, Te Rangi Hīroa and Ngata. The service concentrated on community health work in Māori settlements, many of them remote and without easy access to doctors.

Government health support

During this period the government continued to subsidise doctors as native medical officers in Māori districts, and to supply native school teachers with medicines for their pupils.

More hospitals were built. They were only partially government-funded, and because of a perception that Māori landowners did not contribute their fair share of rates, there was a tendency for hospital administrators to resent having to admit Māori patients.

Many Māori were suspicious of hospitals, and found them unsympathetic to Māori cultural practices and values. A move at this time to establish Māori hospitals was unsuccessful.

Continuing ill health

Although levels of immunity to new diseases had increased, and death rates were dropping, poor economic circumstances and unsatisfactory living conditions still made many Māori susceptible to ill health.

There were still frequent local typhoid outbreaks, and tuberculosis continued to ravage Māori communities. In 1913 there was a widespread smallpox epidemic which resulted in some Māori deaths. Many Pākehā died in the influenza pandemic of 1918, in which millions of people died all over the world, but Māori were even worse hit. It is estimated that 5% of the Māori population died, a death rate more than eight times that of Pākehā.

Survival of traditional healing practices

Traditional health practices were still very common in all Māori areas. In some districts people were reluctant to participate in any modern health programmes, particularly those associated with the government. This was the case in Taranaki and Waikato, following land confiscations after the 19th-century wars. In the Urewera, too, the prophet Rua Kēnana chose to work to improve health independently of the government and the Māori councils.

Tohunga Suppression Act

Complaints were often made by health officials and others that tohunga were endangering rather than enhancing Māori health. In 1907 the Tohunga Suppression Act was passed, with the support of several Māori leaders and politicians. It was intended to counter what was regarded as the harmful side of the tohunga's work. Although this legislation was not an outright assault on all aspects of traditional healing practices, it reinforced the idea that 'tohungaism' was an undesirable activity. Not many prosecutions were made under the act, however, and tohunga continued to practise.

Slow progress, 1920 to 1945

Health conditions

From the 1920s to the 1940s the Māori population increased rapidly, reaching 115,646 in 1945. However Māori health continued to lag far behind that of non-Māori.

The first systematic study of Māori living conditions, in the 1930s, revealed that a high proportion of the population were living in houses of a poor standard, often with overcrowding, polluted water supplies and unsatisfactory sanitary facilities. In 1934 official statistics indicated that the Māori death rate was more than double that of non-Māori. An East Coast study in 1935 showed the mortality rate for Māori suffering from tuberculosis was around 10 times the rate for Pākehā. The disparity was about the same in 1947. In this period tuberculosis was the single largest cause of death among Māori. The Māori death rate from typhoid fever was falling, but in 1937 it was still nearly 40 times the Pākehā rate. Infant mortality was much higher among Māori than in the non-Māori population. In 1938 it was four times higher.

Efforts to improve Māori health

When the Department of Health was restructured in 1920, in the aftermath of the influenza epidemic of 1918, it included a Division of Maori Hygiene, headed at first by Te Rangi Hīroa, and later by another Māori doctor, Edward Ellison.

In 1931 the division was abolished and oversight of Māori health was included in the general responsibilities of the department. Te Rangi Hīroa helped to revive the Māori councils (renamed Māori health councils), and they continued their work until 1945.

Government expenditure on health

Politician Apirana Ngata continued to fight to improve Māori health in the 1920s and 1930s. Māori doctor Māui Pōmare was minister of health from 1923 to 1926.

Government expenditure on Māori health increased greatly in the 1930s. A programme for controlling tuberculosis in Māori communities was implemented on

the East Coast, and then extended to other districts. Inoculation against typhoid was introduced to Māori districts early in this period, with a focus on schoolchildren. Typhoid became uncommon.

A scheme for improving Māori housing was introduced under the Native Housing Act 1935, although not many new houses were built under this scheme until after the Second World War. Another Māori health initiative was a project for installing modern pit privies, which the government, pushed by Ngata, implemented in 1938.

Nurses and hospital births

The number of native health nurses (known as district health nurses from 1930, and public health nurses from 1952) increased, and they gave added emphasis to preventive work and to mothers and children. Most Māori births were assisted by relatives or traditional attendants until the 1920s. The Department of Health encouraged hospital births in an effort to reduce the gap between Māori and non-Māori maternal mortality rates. By 1937, 17% of Māori births took place in hospital. This proportion increased rapidly after maternity care became free in 1939. By 1947 about half of Māori births took place in hospital.

Hospitals and cultural barriers

There is little evidence of any conscious or deliberate effort to lessen cultural barriers and make hospitalisation an experience more congenial to Māori in the 1920s and 1930s. Nevertheless, increasing numbers of Māori were now willing to enter hospital. Fees were a barrier to admission, but in 1939, under the Social Security Act 1938, hospital admission was made free for all patients. The act also introduced universal medical benefits, in 1941. All citizens could now see a doctor at little cost, although in rural districts where many Māori lived there were sometimes few resident practitioners.

Changing health, 1945 onwards

In the later 20th century the Māori population continued to increase, especially in the 1950s and 1960s, and increasingly Māori moved from rural to urban areas.

Health conditions

After the Second World War a tuberculosis campaign began to bear fruit among Māori. From the early 1950s decreasing rates of tuberculosis incidence and mortality were recorded, particularly when Māori were immunised against it. In 1964 the Health Department stated that tuberculosis was no longer a significant cause of death among Māori.

Māori infant mortality fell steadily from the late 1940s, although in the early 21st century it was still higher than the non-Māori rate.

Typhoid outbreaks were rare by the 1950s.

Comparisons

In overall health status the Māori population continued to lag behind the non-Māori population. In a 1960 study the Māori mortality rate was still about twice that of non-Māori, with the greatest gap seen in the years of infancy and childhood. Māori were affected more than non-Māori by degenerative conditions such as diabetes, cancer, heart disease and stroke, which had not been much in evidence before. Lessening impact from infectious disease was offset by increasing impact of non-communicable illnesses. High rates of sickness and death from degenerative conditions were still being recorded at the end of the 20th century.

Disparity

Though the gap was closing in the 21st century, clear heath disparities remained. In 2012–14 Māori life expectancy at birth was 6.8 years lower than non-Māori for women and 7.3 years for men. In the 2010s Māori men were almost three times as likely as non-Māori men to die of lung cancer; Māori women were over four times as likely as non-Māori women. Māori died from heart disease at more than twice the rate of non-Māori. Māori were twice as likely to have diabetes as non-Māori, and diabetes complication rates were also higher. Despite great improvements, and a significant rise in life expectancy, Māori were still worse affected than non-Māori by almost every known health condition.

Factors in disparity

Continuing disparities between Māori and non-Māori in the areas of employment, income and education were an important factor in health inequalities. Housing conditions played a part too. Lifting the standard of Māori dwellings, especially in rural areas, was a slow process. The official housing programme was faced with the problem of keeping up with the rapid increase in the Māori population, which meant that overcrowding persisted even when large numbers of new houses were built. The problem of substandard housing had not been entirely eliminated.

Māori and the health system

With so many families moving to towns and cities, Māori had better access to health facilities. But barriers of cost and culture were often still present. The government's public health programmes continued to target Māori communities when distinctive needs were identified, and this had a considerable impact on Māori health status.

Hospitals were fully funded by the government from 1957, removing the perception that Māori did not contribute enough to hospital costs through the local authority rating system. By 1959 the proportion of Māori births occurring in hospital had risen to about 90%, and the figure continued to rise. There have been Māori doctors,

nurses and other health workers for more than a century – in greater numbers in the early 21st century. But Māori are still under-represented in the health workforce at all levels.

Attitudes to health

In the second half of the 20th century the government began to take a more bicultural approach to Māori health needs, partly in response to Māori demands for greater involvement in issues concerning their health. The new trend intensified in the 1980s. It included enabling Māori to participate more in the planning and implementation of health programmes, and making greater acknowledgement of distinctive Māori values and practices in the health area.

Te Hui Whakaoranga (the Maori Health Planning Workshop) held in Auckland in 1984 was a landmark in this change. Soon marae-based health schemes and other Māori health providers began to emerge, offering medical care 'by Māori, for Māori'. The government publicly committed itself to ending the disparities between Māori and non-Māori health.

Traditional medicine

Māori still retained many of their traditional ideas about health. Officials in the health sector gradually developed a greater understanding of Māori approaches to health and sickness, and government policies showed a greater acceptance of these approaches and their value for health care. Tohunga still practised in many Māori communities, and Pākehā were increasingly willing to view their work more positively. The Tohunga Suppression Act was repealed in 1962. Twenty years later the health authorities began to show a willingness to accept traditional healing practices as complementary to Western medicine, and even to recognise tohunga and incorporate their work into the mainstream health system.

External links and sources

More suggestions and sources

Davidson, Janet. The prehistory of New Zealand. Auckland: Longman Paul, 1987.

Dow, Derek A. Maori health and government policy 1840–1940. Wellington: Victoria University Press, 1991.

Lange, Raeburn. May the people live: a history of Māori health development 1900–1920. Auckland:

Auckland University Press, 1991.

Pool, Ian. Te iwi Māori. Auckland: Auckland University Press, 1991.

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