

# ORANGA KAUMĀTUA: PERCEPTIONS OF HEALTH IN OLDER MĀORI PEOPLE

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## Abstract

This paper explores some of the opportunities for Māori health uncovered by recent developments in the measurement and analysis of health-related behaviours. It presents the findings of a survey incorporating Short Form 36™ (SF36™) of more than 400 older Māori, many considered kaumātua (respected older Māori men and women). The findings identify important cross-links between health and other factors contributing to health, indicating that higher standards of health are strongly associated with active participation and cultural affiliation, home ownership and higher incomes. Low income appears to be generally associated with poorer health, and it seems that older Māori may have less opportunity to supplement their income compared with other New Zealanders in the same age groups. In this paper the risks and protective behaviour of the participants covered the breadth of the social policy sector, and underline the need for long-term policy planning. Provision for Māori retirement is a matter that iwi (tribe), hapū (sub-tribe or clan) and the state should consider. Older Māori will continue to rely heavily on state provision. High home ownership is less likely among the next generation of older Māori, and many will have known long periods of unemployment. Long hours of voluntary work are not atypical, and there may be a case for recognising those efforts. As dependency ratios change with a larger proportion of older people, policies should also be revised to assure that potential at *both* ends of the life cycle is fulfilled.

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## 1 Acknowledgments

Te Pūmanawa Hauora would like to acknowledge those individuals and organisations who supported the Oranga Kaumātua Study in 1996–1997. Most importantly, our thanks go to those kaumātua who participated in the study. The research would not have been possible without their support. It is our hope that this report will benefit present and future kaumātua. We are grateful to those individuals and organisations who worked on our behalf in the regions; in particular the regional coordinators, interviewers, administrators, iwi, and Māori community organisations. Thanks to the health service provider representatives and Regional Health Authority representatives who agreed to be interviewed. We also acknowledge the support of Te Puni Kōkiri, the Ministry of Health, the Health Research Council of New Zealand, and Massey University.

## INTRODUCTION

Recent developments in the measurement and analysis of health-related behaviours have brought about new understandings regarding the application of health assessment tools such as SF36<sup>TM2</sup>, and have provided public health professionals with new ways of considering people's health (Salmon et al. 1999, 2000, Scott et al. 2000, Silburn et al. 1996, Waters et al. 2000, Zubrick et al. 1995, Zubrick et al. 1997). These tools may also provide new ways to improve health (perhaps using the health determinants approach of social epidemiology) and monitor changes.

The implications for determining self-assessed health status and the notion of risk behaviours will be discussed in this paper and reviewed at the conclusion. The case study is a window through which we may observe and understand health-related behaviour, the notion of cultural norms and social values, and how health states may be interpreted.

## WORLD VIEWS

Understanding and recognising different world views can help us do better social policy by understanding where our world views share the same perspective and where our perspectives diverge. Patton (1990) suggests that it is important to match world view and competencies to the context of the research. The context in which we understand research is also important, as theory located in the Māori world that seeks to meet Māori needs is entirely sensible to Māori (Royal 1998). This is especially consistent with contemporary Māori structures, and leads to the development of new approaches to health that make sense to Māori (Durie 1998).

This paper considers the health and wellbeing of a selected group of older Māori in a mixed-methods research project.

## AIMS OF THE PAPER

This article uses a case study, Oranga Kaumātua, a study of Māori people aged 60 years and over undertaken by Te Pūmanawa Hauora, to outline a range of issues relating to the risk and protective behaviours of older Māori. Its aims are to:

- discuss health-related behaviours
- consider cultural norms and social values for a group of Māori
- describe preferences for health states.

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2 The SF36<sup>TM</sup> Health Survey questionnaire is a validated instrument used to assess health status. Developed in the United States, it was tried and tested by the Midland Regional Health Authority in 1994 and used in the New Zealand Health Survey (Ministry of Health 1999). Te Puamanawa Hauora is a registered user of the SF36<sup>TM</sup>.

The health and wellbeing of older Māori have been considered by some public health professionals from a narrow perspective in which Māori are seen to be the same as other older people. From this conservative perspective, older Māori are, in fact, invisible. It could be argued that considering the needs of older Māori is a radical departure from a conservative public health world view.

The aims of this study were to:

- gauge the economic circumstances of older Māori
- ascertain their health status
- measure the level of minor and major disability for older Māori
- identify policy implications for Māori and the Government.

## OLDER MĀORI

The Māori population is youthful, with a median age 10 years younger than the New Zealand population as a whole (Statistics New Zealand 1998). Although youthful, the Māori population is also ageing, due to a combination of increasing life expectancy and decreasing birth rates. Therefore, both the proportion and the numbers of older Māori will increase significantly over the next 20 to 30 years. During this time, older Māori will be confronted by many changes, including changes to whānau structures, the provision of health care, and the way in which government agencies provide for all its older citizens. Assumptions about the traditional role of older Māori in Māori society, or in New Zealand society generally, will not fit for all Māori. Nevertheless, older Māori will be increasingly relied upon when traditional Māori resources are required. Accurate information about the range of actual situations of older Māori is essential for future health planning.

This paper recognises that older Māori do not live in isolation from other systems and developments. Policies and programmes emanating from government, iwi and the communities in which they live influence the circumstances of older Māori.

Oranga Kaumātua is, in part, an exploration of the interaction between older Māori and their whānau (family). Rather than presuming that illness, disability or hardship are the key determinants of wellbeing in old age, the underlying philosophy of the study is that older Māori are able to pursue fruitful lives and occupy valuable roles, largely because of their many years of experience (Te Puni Kōkiri 1997). This approach is consistent with Government policy for Māori public health as outlined both in *He Matariki* (Public Health Commission Rangapū Hauora Tūmatanui 1995) and, most recently, by *He Korowai Oranga: The Māori Health Strategy* (Minister of Health 2002), and takes a positive view towards ageing.

## THE STUDY

### Sampling

Kaumātua were recruited through iwi and Māori community networks. The sample selection was biased towards older Māori who were more likely to participate in traditional or customary Māori society. In the sense of statistical generalisability to all older Māori, this case study falls short of being “representative”. Nevertheless, the sample size of 429 older Māori men and women makes the study one of the largest research projects involving older Māori: study participants account for nearly 1.7% of all Māori aged 60 years and over. For this reason, the study is important because it considered the needs of a significant proportion of an age group who are important to contemporary Māori society.

### Measuring Health-Related Behaviours

The kaumātua questionnaire was designed to collect information on demographic and cultural factors, whānau interaction, views on ageing, sickness and disability, health service utilisation and lifestyle factors. Questions regarding cultural values and household composition used in the questionnaire were developed and tested for the longitudinal study of Māori households *Te Hoe Nuku Roa* (Te Hoe Nuku Roa 1999).

The Short Form 36 (SF36™) was incorporated into the questionnaire to assess the health status of older Māori and to enable comparisons with other studies. SF36™ is a 36-item questionnaire that can be self-completed or delivered by an interviewer, and was developed during the Medical Outcomes Study to measure generic health concepts relevant across age, disease and treatment groups (Medical Outcomes Trust 1994). The Australia/New Zealand version was used in New Zealand during the health needs assessment carried out by Midland Health Authority (Kokaua et al. 1995).

A bilingual version of SF36™ (Māori and English) was developed by the research team at Massey University (Te Puni Kōkiri 1997) and, combined with a set of show cards, allowed participants the choice of being interviewed in either Māori or English, or a mixture of both.

### Recruitment

Regional hui (meetings) were held to present details of the study to local communities, to provide opportunity for discussion, and to seek support and participation. All the 10 regions approached were keen to participate, and were invited to nominate a coordinator for their region. The coordinators played a key role in liaison between the

research group at the School of Māori Studies at Massey University (Te Pūmanawa Hauora) and the local community.

### Interviewers

The first 10 regions approached readily agreed to take part in the research project after a hui in each region. Bilingual interviewers, nominated by their region, worked with regional coordinators (also from each region) to identify and recruit older Māori into the study. Many of the interviewers were “peer interviewers” because kaumātua also took part in the research project as interviewers.

Regional coordinators, interviewers, Māori community groups and iwi were supplied with information brochures to distribute to local older Māori. The brochures provided details of the study and invited older Māori to participate in the research. Participants recruited for the study were interviewed face to face. These interviews took approximately one-and-a-half hours. A small gift of food was offered as koha (a traditional gift) at the completion of the interview.

### CASE STUDY FINDINGS

The results of the 10 regions were reported in a customised report to the region. This report compared the data gained from those interviewed in the region with the rest of the participants in the survey. There was some variation in the responses from the regions. However, variation in data in most cases was not statistically significant (using a significance level of  $p < 0.05$ ; that is, less than 5% chance of a random event).

#### Te Aō Māori: Cultural Identity, Roles and Demands

Almost all (98%) respondents identified their iwi and 85% identified their hapū. Most respondents (84%) were able to speak the Māori language, and when asked to identify their first language 23% cited Māori, 37% cited English and 40% cited both English and Māori. Older Māori respondents identified a number of situations where they always spoke the Māori language: with other older Māori (42%), at marae (a place for traditional gathering by Māori) (36%), at hui (31%), and around children (22%). These cultural identity responses were similar to the findings by Te Hoe Nuku Roa (1999) and the Māori Language Survey (Te Puni Kōkiri et al. 1995).

Most (85%) respondents indicated their people thought of them as *kuia*<sup>3</sup> or *koroua*<sup>4</sup>. When asked if they enjoyed their role as *kaumātua*, almost half (47%) of the respondents said “always”, and 29% said they enjoyed their role sometimes or often. A small group of respondents (4%) seldom or never enjoyed their role as *kaumātua*; 20% either did not know or chose not to respond.

The majority of respondents (68%) were involved in *marae* activities, mostly in a supportive role. Older Māori often cited poor health as a reason for non-involvement in *marae* activities. Distance, lack of transport and loss of interest were less frequently cited.

### Whānau Roles and Interaction

In general terms, older Māori were regularly involved in *whānau* matters, as most of the respondents (73%) had at least weekly contact with their *whānau*. However, 12% had contact less often than every six months.

Seventy-eight per cent of respondents provided care for their *whānau*. Of those respondents, 90% cared for children, 80% cared for sick *whānau* members, 44% cared for disabled *whānau* members, and 46% for older *whānau* members.

The respondents were asked if they received care from *whānau*. Most respondents did, but seldom for long-term illness. Respondents were asked if their *whānau* assisted them in other ways. Of those that indicated “yes”, assistance was most often in the form of accommodation, transport or financial matters.

### Attitudes to Ageing

For most of the respondents, older age was seen as a time of increased opportunities to follow their own interests. When asked about sources of worry, the respondents most frequently indicated that they were not concerned about accommodation, independence, personal mobility, transport, leisure time or *marae*. However, they were sometimes worried about health (29%), and one-third of respondents were very concerned about financial matters.

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3 A respected older Māori woman.

4 A respected older Māori man.

## Income

The economic position of older Māori is determined by income from paid employment, accumulated resources, inherited wealth, assistance from whānau and access to social welfare payments. In this study, only 13% of respondents were in paid employment, usually on a part-time basis. Most respondents (79%) received a social payment (Guaranteed Retirement Income and Sickness Benefit), and 29% received income from Māori land.

The majority of the respondents (68%) earned less than \$20,000 per annum. Only 36 respondents (9%) had an income over \$20,000 per annum. Ninety respondents (23%) did not know or chose not to specify their income.

## Planning for Retirement

Respondents' financial arrangements for later years tended to depend on state provision. The majority of the respondents (76%) relied on Government Superannuation, with an additional 12% having savings, and 4% on private superannuation. Some respondents (8%) had made no other financial arrangements for their later years, relying solely on Government Superannuation. The majority of the respondents (87%) did not have medical insurance.

## Self-Perceived Health Status

In this study, health was scored using the SF36™ schedule. This brief instrument for measuring health status enables physical health, mental health and social functioning to be assessed. As expected, older Māori experience decreasing mobility and physical agility with increasing age (Table 1). Physical functioning and overall health status decrease with age, and there is increasing bodily pain. Mental health and social functioning scores did not appear to change significantly with age (Table 1).

Most respondents reported at least "Good" general health. There was no significant difference in general health between older men and older women (Table 2).

The self-reported health status of older Māori was scored from responses to the SF36™ section of the questionnaire. The general health status of the older people interviewed differed only slightly between the sexes. The health status of older Māori shows a decrease in component score for physical function and vitality as age increases. As age increased in this sample, older Māori were more likely to rate their own health as poorer than it was in the previous year, as indicated by the decrease in the "health transition" component.

Table 1 Self-Assessed Health Score: Mean Component Score for Age Groups

Health Status Component	Under 60 years	60–64 years	65 years and over
Physical functioning	46.1	71.4	54.7
Role: physical	55.4	69.9	59.3
Bodily pain	63.4	84.0	75.6
Social functioning	57.1	84.3	75.8
Role: emotional	61.9	76.8	78.5
Mental health	57.1	81.5	79.3
General Health	50.2	69.1	63.8
Vitality	40.0	66.8	60.9
Health transition	2.8	2.6	2.8

Note: all figures are transformed scores (range 0–100), except "Health transition", which uses raw scores (0–5).

Table 2 Self-Perceived General Health

General Health (%)	Excellent	Very Good	Good	Fair	Poor
All respondents	13.7	27.1	26.2	27.6	5.4
Older men	12.7	30.4	24.1	27.8	5.1
Older women	14.3	24.8	27.8	27.4	5.6

Decrease in vitality and physical function between the under-60-years age group and the 60-to-64 age group is consistent with the higher proportion of this group reporting lower health scores (Table 3) and a higher proportion of self-reported disability. The under-60-years age group of people reported much disability and were all eligible for state assistance (qualifying for the Sickness Benefit).

Table 3 SF36™ Score for Physical Function, Vitality and Health Transition: Mean Scores (standard error in brackets)

Health self-assessment components	Under 60 years	60–64 years	65–69 years	70–74 years	75 years and over
Physical function	46.1 (7.9)	71.4 (2.7)	61.4 (3.2)	58.7 (3.0)	39.5 (3.7)
Vitality	40.0 (6.4)	66.8 (2.2)	62.1 (2.3)	63.3 (2.4)	57.7 (2.7)
Health transition	2.79 (0.28)	2.64 (0.11)	2.75 (0.11)	2.67 (0.11)	2.96 (0.12)

People over the age of 60 experienced decreasing physical function and vitality consistent with trends indicated in Table 3, where there is a general trend of increased reporting of low-health and mid-health status among older men and older women from the age of 65.

### Health Risks and Preventative Care

The study measured the use of tobacco and alcohol by older Māori. Only 27% of older Māori smoked cigarettes regularly. However, 43% of older Māori who did not smoke



had smoked at sometime in the past. A range of reasons was given for discontinuance, including cost, poor health and medical advice. Fewer than half (46%) of older Māori reported they drank alcohol: of those who did, 3% were heavy drinkers, 59% were moderate drinkers and 36% rarely drank.

The level of participation of older women in health prevention programmes was sought. Thirty-seven percent had regular cervical smears, while an additional 25% had had at least one cervical smear previously. Similarly, 38% of kuia had had regular breast examinations, and a further 12% reported an examination sometime in the past.

Of the older men, 25% reported experiencing potential prostate-related problems, while 64% said they had not experienced these problems and 10% did not know.

#### DISCUSSION: HEALTH STATUS AND OTHER VARIABLES

Using the SF36™, 27.6% of the respondents described their health as fair and 5.4% as poor. Compared with the preceding 12 months, 19% described their current health as worse than it had been, 28% thought there had been an improvement in their health, and half reported no change over the 12-month period. Older Māori seem to have an optimistic view of their own health when compared with self-reported levels of morbidity.

The measure of cultural identity in this study incorporates levels of marae participation, the use of Māori language, access to Māori resources (such as land) and involvement with whānau. Nearly 70% of older Māori in this study were active marae participants. When kaumātua activity on marae was compared with overall health scores, statistically significant differences were noted: older Māori with the lowest health scores (i.e. the worst health) were less likely to have any current involvement on marae when compared with older Māori showing high health status.

*“The role of kaumātua/kuia is very demanding on one’s time and health: long hours spent at tangihanga and marae meetings.” (74-year-old respondent)*

For the 30% who enjoyed ownership of Māori land, including financial benefits, there was no apparent correlation with health status. This cautions against any assumption that land will automatically cushion against poor health, although Māori landowners may be in a somewhat better position to cope with the costs of poor health than those whose income derives entirely from a social payment.

There was a relationship between self-assessed health status and Māori language use and competency. This relationship was strongly influenced by where the responders lived. The lower health status of those urban responders who spoke te reo Māori

(Māori language) as their first language may be a reflection of the lack of access to Māori language health information, or of the greater demands placed on them by virtue of their ability to speak Māori. While kaumātua were able to carry out their duties – duties that required physical as well as mental stamina – they reported relatively good health. When kaumātua were no longer able to carry out their duties, they reported declining health with increasing age, and associated with their declining health was poorer emotional wellbeing. It is difficult to determine whether declining health brought about poorer emotional wellbeing and less participation in this cross-sectional case study.

“As guardians of te reo Māori, ngā tikanga<sup>5</sup> and ngā iwi, hapū, and whānau, kuia and kaumātua have demands placed upon them which have no equivalent in Pākehā<sup>6</sup> society.” (74-year-old-respondent)

As already noted, two-thirds of respondents had a positive attitude towards their own health, and considered they were regarded favorably by their people as kaumātua. Lower health status was evident in those older Māori who seldom or never enjoyed the kaumātua role, but otherwise health status did not impact significantly on perceived role satisfaction.

## CONCLUSIONS

This case study represented the views of a sample of older Māori with a more traditional or conservative profile, and is therefore biased in favour of Māori who are integrated into either tribal society or urban Māori networks. On the other hand, the respondents represent almost 2% of the eligible Māori population and reflect wide regional as well as urban, rural and metropolitan mixes. The age distribution of the sample yields proportionately more Māori in the older age groups (70 years and older, 45% of the sample). Notwithstanding these limitations, it is nonetheless the largest study of its kind.

### Self-Assessed Health Status

Kaumātua present an optimistic assessment that is belied by actual morbidity and premature mortality. Data from the Health Survey of New Zealand (1995–1996) suggested that older Māori considered health in terms different from the assumptions made by the designers of SF36<sup>TM</sup> (Scott et al. 2000). While the suitability of SF36<sup>TM</sup> seems assured from the participants' responses to the questionnaire, more work is required to be confident that the data collected thus far are a fair and accurate reflection of their health status. This work is under way and will be published in the near future.

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5 Māori lore and traditions.

6 People who are not Māori.

## Role of Kaumātua

“Kaumātua” is a functional term rather than an indication of age. Positive views of ageing are reported by older Māori, and regardless of occupation or retirement there is active participation within Māori society. The role most older Māori adopt is active, insofar as contributions at both whānau and community levels are valued. In return, older Māori are afforded respect and assistance. Integral to this mutually beneficial relationship is the leadership role expected of kaumātua; it appears to be based less on chronological age than on the nature of the contribution.

The findings of this study confirm the importance of the marae and the whānau as areas where positive roles can develop for older Māori.

## Cultural Identity

As expected, with the participants’ high levels of involvement in Māori institutions such as the marae and whānau, the respondents identify strongly as Māori, whose role is to carry their culture within their own communities. Almost all respondents were strongly in favour of increasing te reo Māori competency and use among younger members of the whānau. Demands placed on older Māori can often be traced to their competence with the language and expectations that they will teach others. Some older Māori feel burdened by the responsibilities that increase with age.

There was little indication in the study that older Māori are indifferent to the significance of a Māori identity – quite the reverse. For future planners, however, a major consideration will be the readiness of older Māori to step into the role of kaumātua, as the cultural custodians and marae leaders.

The key to the participation of these older Māori in Māori society was their knowledge of the community and their acceptance by others. Urbanisation has created physical distance that may well act as a deterrent for some kaumātua to exercise this role unless other arrangements, such as hapū wananga (institutions of Māori learning) in towns and cities, are included in iwi policies.

## Whānau

Whānau relationships are typically close. Respondents indicated they were reliant on help from their whānau, and they in turn provide help and assistance to their whānau (family). This level of reciprocity contributed to an intergenerational understanding, and provided a sense of satisfaction among older Māori.

This means that consideration must be given to strengthening whānau to avoid further fragmentation and alienation. whānau circumstances are rapidly changing, and if older Māori are to remain involved and to continue to play essentially positive roles, active policies for whānau development are needed.

### Risk and Prevention

The roles that older Māori are expected to undertake are both a risk and a benefit to their health and wellbeing. The balance of risk and benefit is determined by the demands placed on this vital and skilled group of people. Older Māori face a variety of challenges, but also contribute actively to the life of their communities. The complex relationships with whānau and iwi, the shared intergenerational responsibilities, the interface with the health sector, economic concerns, and access to social services and the mainstream generally, have implications for Māori development.

Wide, cross-sectoral planning is required to guarantee older Māori a positive place in society and reduce the impact of age-related disabilities. Iwi have a definite policy and planning function at regional level, and should be well placed to bring the strands of their communities together and weave the threads to moderate the impact of ageing on older Māori and their whānau.

At the same time, there is an obvious and ongoing role for the state. The needs of current and future older Māori must be acknowledged in the development of Government policy. The focus must recognise the health needs of our older Māori, and the impact these needs have on the participation of kaumātua within Māori society.

Kaumātua are crucial to the preservation of our taonga (treasures) for future generations and, most important, we must look after our older Māori, for they are a taonga for us all. The risk to the health and wellbeing of Māori society is the premature loss of kaumātua. Preventative strategies need to take a broader approach than the current narrow public health focus and practice, and account for the social needs of older Māori. Strategies must encompass a positive view of ageing and an active involvement in a cultural context consistent with the role of older Māori. Because of the clear relationship between participation in the business of the marae that provides many roles for older Māori, and self-reported good health, this positive view of ageing provides a mechanism for maintaining some level of resilience in an otherwise at-risk population.

New policies that address the health and wellbeing of Māori and whānau reflect the changing demands on Government. Further research is required to provide evidence for the benefit, or gain, from changes of policy, as well as for the integration of health with other social policy, as indicated in *He Korowai Oranga* (Minister of Health 2002).

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