

**Replacing medical and social models of disability by a communities-based model
of equal access for people of differing abilities: A Māori perspective**

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Abstract

I argue here that although the social model of disability which currently prevails in New Zealand is preferable in many ways to the earlier medical model, it is nevertheless based on a largely uni-dimensional concept of society and continues an established tradition of negativity, one that is evident in the ongoing use of the word ‘disabled’ itself by those who subscribe to the social model. I argue here that the social model of disability should be replaced by a communities-based model of equal access for people of differing abilities, one that is, in the New Zealand context, informed by a further developed Māori model of health and wellbeing proposed by Mason Durie, *Te Whare Tapa Whā*. This mode is designed in such a way as to accommodate difference and diversity. In the discussion of different models, I use the words ‘disabled’ and ‘disability’; in other contexts, I replace ‘disabled people’ by ‘people of differing abilities’.

Introduction

In the thousands of years of human existence before 1800, life for most exceptional people appears to have been a series of unmitigated hardships. The great majority of disabled persons had no occupation, no source of income, limited social interaction and little religious comfort. Conspicuously abnormal persons were subjected to superstition, myth and fatalism-especially fatalism. Their lives were seriously limited by widely held beliefs and superstitions that justified the pervasive prejudice and callous treatment.

M. A. Winzer (1997, p. 76). *Disability and society before the eighteenth century: Dread and despair*.

In terms both of policy and policy implementation, disabled Māori are often treated less favourably than disabled non-Māori in that they and their whānau are obliged to accept approaches to provision that are often inconsistent with their cultural beliefs and social practices. The issue of appropriateness, and, therefore, equity of provision clearly needs to be addressed. However, in the absence of an accepted Māori model of disability, there is no obvious way of doing this. One possibility, however, is to determine whether there is an existing Māori model of health and wellbeing, or a Māori model that can be applied to health and wellbeing, that could underpin policy and policy implementation as it relates to the provision of equal access to communities for people of differing abilities.

The medical model of disability

A number of different models of disability, each of which objectifies and stigmatises, have had a profound effect on the lives of disabled people. One of these is the

medical model, a model that views disability in medical rather than social terms, one that continues to have a profound influence on treatment and the allocation of resources in New Zealand in spite of the fact that it is no longer the preferred model.

The beginning of the medicalisation of disability can be traced to the effects of industrialization and urbanization on community structures and, in particular, to the dissolution of those cottage-based industries that provided a context in which disability could be accommodated. With the growth of urbanization and industrialization, disability increasingly came to be seen as a problem, one that needed to be labeled, categorized and controlled through segregation and institutionalization. Gooding (1994, p. 18) discusses the medicalisation of disability in terms of a shift of power:

The medicalisation of social 'problems' as a form of control has been powerfully analysed by writers such as Foucault and Illich. By 'medicalisation' I mean that the perception that disability is first and foremost a problem of individuals, with the corresponding power that gives to the medical profession over disabled people's lives. Whilst medical intervention can be entirely appropriate, for example in the treatment of a medical condition or the diagnosis of an impairment, it undoubtedly extends to a ridiculous degree. . . . The medical profession came to hold great power over disabled people's lives, both within institutions and outside them, through their function as gate-keepers of the welfare state.

The medicalisation of disability is reflected linguistically. In fact, evidence that this model is still alive and well in New Zealand can be found in the language that surrounds disability. Thus, for example, a disabled person may be deemed 'unfit' for work. Under such circumstances, they must succumb to the medical scrutiny of a government approved doctor in order to receive an 'invalid benefit'. Language of this type stereotypes and stigmatises disability at the same time as perpetuating a medical model that has also, appropriately, been referred to as a deficit model. People with disabilities are frequently forced to rely for their basic needs on charity and/or on a source of funds that is often conceptualized as a form of charity (not money derived from tax, but 'taxpayers' money'). Thus, Blaxter (1976, p. 2) notes the way in which people have been, and continue to be, valued in terms of whether or not they contribute directly to the economy:

Ever since the days of the Poor Law, these two principles of social policy have been to some extent separate: a division has existed between those 'outside' the economic system, to whom only charity is owed, and those who are economically active and potentially viable, whom society must help in its own interest and as a matter of social justice.

Although a New Zealand Disability Strategy (2001) which advocates a social model of disability has been in place since 2001, it remains the case that people with disabilities can qualify for a 'welfare benefit' only by subjecting themselves to a process of medical assessment. As Shakespeare and Watson (1997, p. 268) note, medical sociology continues to have difficulty with a non-medical model of disability:

Medical sociology is another discipline that appears to have problems accepting or working within the social model; emphasis is placed squarely on the experience of chronic illness and disability, individualising the experience.

Furthermore, there is evidence that society at large simply does not accept the consequences of the non-medicalisation of impairment, particularly of intellectual impairment. Wherever attempts are made to set up community-based facilities, there are likely to be objections of the NIMBY (not in my back yard) type.

The social model of disability

Oliver (1983, p. 17) defines impairment as 'individual limitation' and disability as 'socially imposed restriction' and Finkelstein (1981) demonstrates that if the physical and social world were to be adapted for wheelchair-users, their disabilities would disappear and able-bodied people would become disabled. It is perspectives of this type that underlie the social model of disability. However, as Swain et al. (1993, p. 15) observe, that model does not necessarily result in the enfranchisement of people with disabilities:

Criticism of the medical model has led to changes, and there are increasing signs that services are moving away from medical control provided by the health service to social and welfare interventions provided in community services. The problem is, however, that this shift does not necessarily result in disabled people having greater control of their lives. On the contrary, community-based service providers generally have a wider perspective than their medical colleagues in identifying areas of disabled people's lives for their professional assessments and interventions. This may leave very little for disabled people to do without feeling that an expert is waiting in the background to intervene. In this respect experts are often encouraged to see the lives of disabled people in terms of problems to be solved and their role as providing solutions.

In the USA and the UK, the disability movement began to call for the de-medicalisation of disability in the 1970s. In the 1980's, Finkelstein (1981) began to question the medical/deficit model of disability as an appropriate theoretical framework, and in the early 1980s, Oliver (1983) developed the work of Finkelstein and others into a social model, one that has had a direct impact on the New Zealand Disability Strategy (2001).

A fundamental aspect of Oliver's social model of disability is the concept of separating impairment from the individual and placing responsibility for providing access with society with society itself. The definition of disability within the context of this model has three main elements: the presence of an impairment; the experience of externally imposed restrictions; and self-identification as a disabled person (Oliver, 1996, p. 5). It is interesting to note that Oliver uses the term 'disabled person' as opposed to the term 'person with a disability', arguing that language has an important role to play in determining one's place within society. However, whereas 'person with a disability' places personhood in initial position, 'disabled person' places disability in initial position. The central issue is, however, not the positioning of these two descriptors, but the very fact that one of them (disabled/ disability) is inherently negative (dis). One possible approach to resolving this dilemma is the approach that

has been taken by deaf people who, instead of accepting negative labels, have insisted on being treated as a group of people with a distinct cultural identity, one that has its own language(es), its own beliefs and its own values. In this way, they refuse to accept the imposition of what Charlton (2000, p. 25) sees as a negative sense of identity:

The modern world is composed of thousands of cultures, each with its own ways of thinking about other people, nature, family and community, social phenomena, and so on. Culture is sustained through customs, rituals, mythology, signs and symbols, and institutions such as religion and the mass media. Each of these informs the beliefs and attitudes that contribute to disability oppression. These attitudes are almost universally pejorative. They hold that people with disabilities are pitiful and that disability itself is abnormal. This is one of the social norms used to separate people with disabilities through classification systems that encompass education, housing, transportation, health care and family life.

Limitations of the social model of disability

In 2001, the New Zealand Disability Strategy (NZDS) was created and the social model began to be incorporated into disability policy and disability service provision. There are, however, two critical issues that need to be addressed. First, does the acceptance of a social model have any real positive impact on people's lives? Does the social model accommodate cultural difference and diversity? The answer to the first of these questions must be a cautious affirmative. Although a number of practices in New Zealand continue, notwithstanding official endorsement of a social model, to be based on the medicalisation of disability, there have been changes, most notably in the area of community-based care. A social model can have a positive impact on people's lives to the extent that it shifts the onus of responsibility for providing access to society itself. The danger is, however, that society will itself be conceived of in uni-dimensional terms. Since societies are made up of people, and since people who identify with different community groups do not necessarily have the same values, it is important that any social model should aim to provide access not just to some nebulous concept of society at large, but to all of those social groupings that play a role in conferring a sense of identity on an individual. It is also important that the negative concept of *disability* should be replaced by a positive concept of equal access for all, whatever their differing abilities are. Thus, in the words of Swain et al. (1993, p. 86):

The experience of physical impairment is similarly constructed, as indeed is its incidence, which varies across societies and also within societies according to class, race, gender, occupation and geographical location. An individual's experience of a particular impairment must be placed within its social context. For instance, the actual course of a condition such as multiple sclerosis will be influenced by socio-economic factors, and the experience of associated impairments for example loss of mobility or sight, will depend on factors such as an individual's economic resources and available services, all of which interact with other social constructs (class, race and gender in particular).

I believe that the social model of disability should be replaced by a communities-based model of equal access for people of differing abilities. This would involve

taking account of people's differences, including those differences that relate to ethnic and cultural affiliation. My aim in the next section is to examine three Māori models of health and wellbeing to determine whether they have anything to offer in relation to the development of the type of model I propose here.

Exploring three Māori models of health and wellbeing: *Te Whare Tapa Whā*, *Te Wheke* and *Ngā Pou Mana*

Te Whare Tapa Whā

Te Whare Tapa Whā, a model of health and wellbeing designed by Professor Mason Durie, is the most commonly cited in Māori health and development policies. This model was presented by Durie (1994, p. 70) at a health hui in Palmerston North in 1982 where he compared its four key dimensions, the dimensions that give it strength, solidity and symmetry and that ensure a balance of individual and community, to the four walls of a *whare* (house). The four dimensions are:

- *taha wairua* (the spiritual dimension),
- *taha hinengaro* (thoughts and feelings),
- *taha tinana* (the physical dimension); and
- *taha whānau* (family).

Te taha wairua is generally seen by Māori as being critical to good health. *Wairua* provides the spiritual link, through *whānau* and the environment, to health and wellbeing. A lack of spiritual awareness is held to leave the body and mind open to illness. Without *wairua*, a person cannot be whole. *Wairua* is a fundamental aspect of identity. It is not necessarily linked in any way to formal religious observance. In providing a link to *whānau*, *tīpuna* and the environment, *wairua* provides an understanding of the link between past, present and future, a link to others and to tribal lands and to that which is important for one's identity and sense of wellbeing (Durie, 1994, p. 70).

Te taha hinengaro focuses on the mind, encompassing expression and thought. Since thought and expression arise not only out of experience, but also out of response to experience, they will be in harmony to the extent that the mind is in tune with experience. Illness, disability and disease can, therefore, arise out of a lack of harmony in the environment or a lack of harmony between the environment and response to the environment. When the environment is sick, the body is therefore at risk.

Te Taha tinana (the physical dimension - bodily health) is something that is central to non-Maori models of health and wellbeing. There is, however, an important difference. For Māori, the concepts of *tapu* and *noa* are fundamental. Some body parts such as, in particular, the head are *tapu* (sacred); others *noa* (non-sacred). This raises issues associated with, for example, the type of treatment that is available in head injury units. Everyday functions such as eating, drinking, sleeping and defecating must be in tune with the environment, and rituals accompanying these functions provide an important reminder of the need to maintain this harmony in order to achieve, and maintain, wellbeing (Durie, 1994, p. 72). Feeding and washing require different spaces because of the different nature of the objects used. Thus, for example, towels used for washing the body are washed separately from towels which

are used for washing or drying dishes. Food can remove *tapu* and induce *noa* especially when it is associated with the *tinana* (body). This is important in that the body is *tapu* (the head being the most *tapu* aspect to the body). Placing food above the head breaks the *tapu* of the head over which it is placed. Placing a bedpan on a table beside food induces *noa*. There are, therefore, issues for Māori in relation to hospitalisation and institutional care, including the type of care that is provided in rehabilitation centres.

The fourth dimension is *te taha whānau* (family/ extended family). This is a very significant dimension for Māori and one that involves identity and sense of purpose. For Māori, inter-dependence is more important than independence, and community service is more significant than occupational status. Thus “personal identity derives as much if not more from family characteristics than from an occupation or place of residence” (Durie, 1994, p. 73). Māori are therefore particularly affected by a paradox that lies at the core of Western approaches to disability care, one that emphasises the value of independence at the same time as directing funding largely to institutions rather than *whānau*, thus ensuring that many disabled people have no option but to become dependent upon institutional care, something that can pose a threat not only to ongoing *whānau* connection, but also to the possibility of making a contribution to the community and, in this way, establishing a sense of purpose. Cut off from *whānau* and community, Māori can rapidly lose that sense of identity and purpose that are fundamental to wellbeing. For those who manage to avoid institutional care, or for whom no institutional care is available, inter-dependence is generally not an option. Instead, they are generally encouraged towards a type of ‘independence’ that frequently involves isolation and exclusion.

Te Wheke

Another Māori model, one that relates primarily to wellbeing within an educational context, but one that can be extended to include health, is *Te Wheke* (the octopus). This model, discussed by Rose Pere (1985) at the Hui Whakaoranga in 1984, looks at Māori wellbeing largely from a *whānau* perspective. The body and head of the octopus symbolise the family unit; each of the eight tentacles symbolises a dimension of life; the connectedness of head, body and tentacles is fundamental to wellbeing, the eyes representing the *waiora* or wellbeing of the person as a whole. The eight dimensions symbolised by the eight tentacles are: *Wairuatanga*; *Tinana*; *Hinengaro*; *Whanaungatanga*; *Mana Atua ake*; *Mauri*; *Whatumanawa*; and *Hā a koro mā a kuia mā*.

Wairuatanga refers to spirituality. Pere describes *wairua* as involving both feelings and responses, feelings and responses that relate to forces that are beyond the physical realm. Maintaining good health involves sustaining and nourishing one’s spiritual dimension (Pere, 1985, pp. 7 – 8)

Tinana is the physical dimension. Taking care of the body is an important aspect of the maintenance of good health. Thus, in the words of Love (2004, p. 61), *tinana* is a dimension with many different aspects:

Aspects of this dimension include adequate nutrition, shelter, clothing, exercise, experience of physical contact, pleasure and pain. Māori society provides a number of avenues for physical expression of the spiritual,

emotional and cognitive aspects of people with situations. Haka and waiata provide for the physical expression of a range of emotions, thoughts and desires. Karanga and Whaikorero provide for the physical and verbal expression of wairua, acknowledgement of whakapapa connections, the pain of losses, and the kaupapa that brings people together. In performing karanga and whaikorero, men and women are physically connected to, and stand between papatuanuku and Ranginui. They stand on the earth that their ancestors stood on, breathe the air and view the skies their ancestors knew. Alternatively inside a whareniui, people are surrounded by physical representations of the ancestors and the history of the home people. The spirit of those who have gone on may be felt and acknowledged within the ancestral house. The house itself is often the embodiment of a tupuna, so people are symbolically contained within the body of the ancestor.

If disabled people are disconnected from *whānau*, they are also disconnected from those communal activities and locations that allow for physical expression of the spiritual.

Hinengaro is the emotions and feelings. As such, it is directly associated with the mind. In discussing Pere's reference to *hinengaro*, Love (2004, p. 67) makes reference to its literal meaning:

The literal meaning of *hinengaro* is the hidden lady or female element. The term is commonly understood as referring to the mind, intuition and source of thoughts, perceptions and some emotions. Pere (1988, 1991) associates this dimension with cognitive activities, higher level emotion and intuition.

Just as the female element is described as 'hidden', so feelings and emotions may be 'hidden'. If they are revealed at all, it may be that they are revealed indirectly, through stories and symbols. Western models of disability have a tendency to focus on physical realities rather than on mental representations of these realities. Where mental representations *are* investigated, there is a tendency to seek direct disclosure. For Māori, this can create particular difficulties since direct disclosure of feelings and emotions can be inconsistent with the hidden nature of *hinengaro*.

Whanaungatanga relates to *whānau* and involves that sense of obligation and reciprocity that arise out of connectedness. Pere (1985, p.12) discusses *whanaungatanga* in the following way:

[*Whanaungatanga*] is based on ancestral, historical, traditional and spiritual ties. It forms that strong bond that influences the way one lives and reacts to his/her kinship group, Māori people generally. It is the area where one's aroha (the concept of giving, caring, sharing) is tested to the fullest extent. It is an area that poses many challenges for an individual who has to live in and out of two worlds – one that is basically Polynesian and one that is basically Western. Whatever affects the kinship group, whether it be positive or negative, affects the individual, there are certain inbuilt obligations that the individual feels towards the group.

Mana Atua ake (commonly referred to simply as ‘mana’) involves a combination of respect and authority. It is something that is not accorded by virtue of ancestry alone. Nor is it something that is associated directly with any particular qualifications or occupation. It must be earned through service. Since *mana* is associated with *atua* (higher being), it necessarily has a spiritual dimension. Thus, service and spirituality are linked, and both are linked to wellbeing. Depriving someone of any opportunity to serve is also to deprive them of an important aspect of wellbeing.

Mauri, the life force inherent in all things, is fundamental to wellbeing. Pollution of the environment is therefore an attack on wellbeing, as is any attempt to undermine the link between self, others and the environment.

Whatumanawa is similar to *hinengaro* in that it is an expression of emotion. The difference between the two is that *whatumanawa* involves not only feelings, but their symbolic expression through community art forms such as *haka* and *waiata*. To be deprived of community is to be deprived of access to the communal expression of emotion and, hence, to be deprived of an important aspect of wellbeing.

Hā a koro mā a kuia mā is literally translated as ‘the breath of life from forebears’. Central to this is the concept of continuity, one that is expressed in many different ways, in, for example, weaving, in carving, in song, and in oratory. To be separated from *whānau* is to be denied access not only to our immediate links with community, but also to be denied access to communal ways of celebrating the continuity and connectedness of life.

Ngā Pou Mana

In 1988, the Royal Commission on Social Policy, in *Ngā Pou Mana*, presented a model in which the foundations of social policy and social wellbeing were presented as four pillars or supports, four inter-related pre-requisites: *mana*, cultural integrity, a sound economic base, and a sense of confidence and continuity. In outlining four things considered to be fundamental to social wellbeing, it provides what could also be seen as a model of a health and wellbeing. These four things are:

- family (*whanaungatanga*);
- cultural heritage (*taonga tuku iho*);
- the physical presence (*te ao turoa*); and
- an indisputable land base (*tūrangawaewae*)

One of the things that might seem, initially at least, to make this model different from the two discussed earlier is the emphasis on the environment signalled in the inclusion of cultural heritage (*taonga tuku iho*). Its inclusion may have been influenced by Waitangi tribunal decisions relating to the claims associated with the pollution of tribal waterways, decisions which acknowledged the fact that a clean environment is important for wellbeing (Royal Commission on Social Policy, 1988, Vol. 1). In fact, however, the inclusion of *taonga tuku iho* does not make this policy inconsistent with the other two. The first - *Te Whare Tapa Whā* – includes *taha whānau*; the second – *Te Wheke* - includes *whanaungatanga*. Any inclusion of reference to *whānau* presupposes the inclusion of *whakapapa*, and *whakapapa* includes the environment.

Comparing the three models

Durie (1994, p. 77) provides a table in which the three Māori models that have been introduced are compared. A critical issue is whether these models are consistent with frameworks that have been proposed in other contexts, frameworks that relate specifically to disability such as, for example, the psycho-social, trans-cultural ethnic validity framework first proposed by Tyler (2001).

Looking at *Te Whare Tapa Whā*, *Te Wheke* and *Ngā Pou Mana* in the context of a psycho-social transcultural ethnic validity framework

In introducing what he refers to as a psycho-social trans-cultural ethnic validity framework, Tyler (2001, p. 26) argues as follows:

Using scientifically based models and methods is a powerful way of figuring out the generality of psychological laws and of individual and cultural beliefs, and the significance of historical events. It can also identify the value bases and empirical strengths and limitations of alternative approaches to human endeavours. . . . In basic areas, phenomena have been studied apart from their history or context, or both, in controlled laboratory settings. This approach has been considered to provide unbiased value free, and therefore more legitimate, truths. In contrast, psychologists in applied areas have explicitly and directly been concerned with the value (however measured) of specific effects and, even more directly, with accepting responsibility for producing those effects. Until recently, both frameworks assumed that people's lives developed within a universal, homogenous context and an evolutionary perspective with regard to sociocultural and individual differences.

The psycho-social trans-cultural ethnic validity framework (often referred to simply as the 'ethnic validity framework') provides a way of taking account of ethnic identity in disability models. As Durie (1995, p. 1) notes, there are some common factors, such as socio-economic status and urbanisation, that have had a direct impact on Māori wellbeing. Nevertheless, Māori identity and Māori lifestyles are diverse (p. 15):

Far from being homogenous Māori individuals have a variety of cultural characteristics and live in a number of cultural and socio-economic realities. The relevance of so-called traditional values is not the same for all Māori, nor can it be assumed that all Māori will wish to define their ethnic identity according to classical constructs. They may or may not enjoy active links with hapū or iwi, or other Māori institutions yet they will describe themselves as Māori and will reject any notion they are 'less Māori' than their peers.

This raises an important issue so far as models for health and wellbeing or disability are concerned. Clearly, such models need to be conceptualised and expressed in ways that accommodate difference and diversity, ways that involve the creation of more, rather than fewer, options. Otherwise, there is a danger that those who are intended to benefit from them will, instead, be trapped within them. From this perspective, the inclusion of reference to, for example, *wairua* (included in both *Te Whare Tapa Whā* and *Te Wheke*) seems wholly appropriate since, although it is imbued with particular

significance for Māori, it does not specify a particular set of beliefs. The same could be said for *tinana*, *hinengaro* and *whānau* (also included in both *Te Whare Tapa Whā* and *Te Wheke*). However, it could be argued that *mana Atua ake*, *mauri* and *whatumanawa* (included in *Te Wheke*) are much more specific in terms of beliefs and that *ha a koro ma a kuia ma* (also included in *Te Wheke*) is, in fact, necessarily included in the concept of *whānau*. So far as *Ngā Pou Mana* is concerned, there are three components in addition to *whānau* (*whanaungatanga*). These are *taonga tuku iho*, *te ao turoa*, and *tūrangawaewae*. So far as allowing for difference and diversity is concerned, *hinengaro* would appear to be preferable to the more specific *te ao turoa*. Furthermore, it could be argued that although *taonga tuku iho* and *tūrangawaewae* are fundamental to the health and wellbeing of Māori in a general sense, they are not directly relevant to policy issues relating to disability: it would be difficult to determine what the implications of including them would be in relation to the establishment and implementation of a differing ability policy. This leaves us with the question of whether reference to the four remaining dimensions - *wairua*, *hinengaro*, *tinana* and *whānau* - is adequate to provide a framework or model for disability policy and disability policy implementation that can genuinely accommodate the needs and preferences of Māori. If a model or framework that is intended to guide policy-making and policy implementation is to be of any real value, it must include specific indicators in terms of which successful application can be judged. These effectiveness criteria should take personal preference into account. It is not my intention here to outline precisely what these effectiveness criteria should be. However, I provide below one example of a possible general effectiveness criterion (relating to all four strands of the model) and two examples of possible effectiveness criteria that could be associated with each of the four strands of the model.

Possible general effectiveness criterion: *Taha Whānau, Taha Wairua, Taha Hinengaro*

- government grants should be available to all *whānau*-centred locations, such as marae, so that equal access is assured for people of differing abilities.

Possible indicators: *Taha Whānau*

Where the person involved prefers to be located with *whānau*:

- the same level of funding as would be available in the case of institutional care is available to *whānau*;
- alterations to the home of any *whānau* member with whom the affected person chooses to reside should be such as to produce at least the same level of facilities as would be available in the case of institutional care.

Possible indicators: *Taha Wairua*

- staff members of all care facilities should be trained to understand and respect practices that relate to spirituality;
- care facilities should provide ready access to places of religious observance and/or ensure that appropriate spaces are provided within the care facility for religious observance;

Possible indicators: Taha Hinengaro

- affected persons should be given as much information as possible about the choices available to them and should be given the time and advice necessary for them to make appropriate decisions about their own lives;
- those in institutional care should, wherever possible, have the right to make decisions about their environment and to contribute to the care and maintenance of that environment by, for example, contributing to the choice of plants, decorations and furniture.

Possible indicators: Taha Tinana

- staff members in care facilities should be trained to understand and respect cultural practices in relation to, for example, washing, eating and expelling waste;
- the preferences of affected persons in relation to personal dignity and personal privacy should be respected.

Towards a communities-based model of equal access for people of differing abilities

The Maori value system has the flexibility to accommodate variation . . . if we know the principle, we can make adjustments.

(Epu Huritai as cited in Metge, 1995)

The concepts of *wairua*, *hinengaro*, *taha tinana* and *whānau* could underpin the development of a New Zealand-centred communities-based model of equal access for people with differing abilities. They would be directly relevant to such a model precisely because they support the view that the individual with an impairment is a person first, their impairment being a secondary consideration in relation to their identity. By removing the deficit language and embracing the term ‘differing abilities’, we can also ensure that this model can be applied in a variety of different contexts.

Ensuring the well-being of people through attention to *wairua*, *hinengaro*, *taha tinana* and *whānau* involves respecting them as people and treating them as part of their community. It removes the emphasis on ‘impairment’, ‘illness’, and ‘disability’ that continue to imbue the medical model and that also continue to haunt the social model.

Although the social model shifts responsibility for ensuring that individuals of differing ability are provided with adequate and appropriate access to all aspects of society from the individual to society itself, it remains the case that people of differing abilities continue to be required to identify with some medically diagnosed condition and are seen as being provided with special ‘services’ or ‘support’ rather than, as is the case for all other individuals, having an expectation of being provided, by right, with whatever is necessary in order to live full and productive lives.

A New Zealand-centred communities-based model would be focused on the unique framework that exists within New Zealand. It would involve an holistic approach to the provision of culturally appropriate services for all New Zealanders and New

Zealand residents and would, necessarily, be adaptable to different social and cultural contexts, taking into account the needs not only of Māori, but also of people of other ethnicities and cultural affiliations, of the needs of women, men, children and rural-dwellers as well as urban-dwellers.

In summary, I believe the concepts of *wairua*, *hinengaro*, *taha tinana* and *whanau*, supplemented by effectiveness indicators, can provide the underlying concepts for the development of a New Zealand-based communities-centred model, a model that is capable of providing equitable (possibly even equal) access for people of differing abilities. Adopting such a model would be unlikely to change attitudes in the short term. Nevertheless, it has the potential to challenge existing myths about impairment and to remove at least some of the barriers that currently prevent people of differing abilities from participating fully in our communities.

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