Maori Health and Heaton Rhodes as Minister of Public Health, 1912–1915

ONE OF THE MOST REMARKABLE transitions in New Zealand history is the recovery of the Maori population from its 1896 nadir, and its growth thereafter, despite the temporary setback of the 1918 influenza pandemic. Two recent books on Maori health development and government policy greatly enhance our understanding of the crucial first two decades of the twentieth century in Maori health, despite the patchiness of surviving Health Department archives prior to 1920. However, neither author was aware of the existence of a highly relevant and interesting body of primary evidence for the years 1912–1915 in the Manuscripts Department of the Canterbury Museum, namely, the outward letterbooks of R. Heaton Rhodes as Postmaster-General and Minister of Public Health. Maori health issues occupy a small but significant part of the health correspondence in these volumes, which throw new light on each of the major themes addressed by Derek Dow and Raeburn Lange in their recent books. Though Heaton Rhodes could not be regarded as an outstanding Minister of Health, and his term of office was too brief to have much impact on Maori health, his letterbooks are informative and often revealing of attitudes towards Maori health among politicians and medical practitioners in the period of the first Reform government.

Who was Heaton Rhodes, and how did his ministerial letterbooks finish up in the Canterbury Museum instead of in the National Archives? Described in the Dictionary of New Zealand Biography as a 'lawyer, runholder, stock breeder, politician, horticulturalist, philatelist, philanthropist', Robert Heaton Rhodes (1861–1956) was the namesake eldest son of an early pioneer of Canterbury, and has been termed the province’s ‘outstanding public figure’ of the twentieth century. His uncle, the whaling captain William Barnard Rhodes, first visited Banks Peninsula in 1836 and was one of the earliest Europeans to describe the swampy site of the future city of Christchurch. ‘Barney’ Rhodes returned in 1838 to land Canterbury’s first herd of cattle near Akaroa, and to purchase land from Ngai Tahu. He then summoned his younger brothers, Robert and George, to manage his sheep runs on Banks Peninsula while he took up residence in Wellington, prospering as a successful merchant and land speculator. When the first four ships of the Canterbury Association arrived at Lyttelton in December 1850, the Rhodes brothers supplied the settlers with fresh meat and vegetables from their farm at Purau.

Heaton Rhodes was born at Purau in 1861, in Canterbury’s first stone homestead, built by his father in 1854. Though proud of his Yorkshire ancestry,
he was prouder still of being a first-generation Cantabrian. His earliest impressions of Purau included meeting groups of Ngai Tahu at their seasonal settlement near the beach, and watching the Maori shearsers his father hired from Rapaki near Lyttelton. From childhood he could understand and speak a little Maori, and throughout his career showed a sympathy and liking for Maori living in his electorate, which was warmly reciprocated. Sadly, the family had to leave Purau after George’s untimely death in 1864 broke the brothers’ partnership, although they returned every year for the shearing. All the Banks Peninsula runs finally had to be sold, but with the proceeds Heaton’s father built a grander house at Elmwood in Christchurch and, with shrewd land speculation, became one of Canterbury’s richest men in the 1870s.5

After education in Switzerland and at Hereford Cathedral School, Heaton Rhodes completed a law degree at Oxford University, but never practised. His father’s death in 1884 made him probably the wealthiest bachelor in New Zealand, with an income averaging £7000 a year. After his return from Oxford he joined the Canterbury Yeomanry Cavalry, rising slowly through the ranks to become Lieutenant in 1896 and Captain in 1902. He was also a leading polo player and top goal-scorer for the Christchurch team which won the first Savile Cup in 1890 and held it for the next three years. After his marriage in 1891 he bought land near Tai Tapu (part of his father’s old Ahuriri run) and in 1895 built an impressive wooden mansion there, which he named Otahuna. He then became a gentleman-farmer, importing New Zealand’s first herd of Norfolk red-poll cattle in 1898. (The shearing at Otahuna was always done by Maori from Rapaki; Rhodes thought the Australian contract gangs were too rough with the animals.) His love of trees and flowers led to the creation of a spectacular garden at Otahuna, which became famous for its massed daffodils. Heaton Rhodes was president of the Canterbury Horticultural Society from its inception in 1903 until his death in 1956.6

He entered politics in 1899 as MHR for Ellesmere, an electorate which then included most of Banks Peninsula. After active service in the South African War in 1902, he became Opposition chief whip for his leader, William Ferguson Massey, and though he was no great orator in the House, his transparent honesty and ‘great charm of manner’ made him an ideal behind-the-scenes mediator and committee member. In 1911 he commanded the New Zealand Contingent at the coronation of King George V in London, and in 1912 he was made a Knight of Grace in the Order of St John in recognition of his philanthropic work for the Order in Canterbury. Rhodes and his wife Jessie were close friends and supporters of Nurse Sibylla Maude and her district nursing scheme, the first in New Zealand, and for most of his adult life he was chairman of the Rhodes Memorial Convalescent Home in Christchurch, so he had first-hand knowledge of hospitals and health issues.7

As Massey’s chief whip and the senior Canterbury MP, Rhodes could not be overlooked for the first Reform cabinet when Massey took power in July 1912. He replaced Harry Ell as Postmaster-General (overshadowed by Sir Joseph Ward’s long tenure of that office) and became Minister of Public Health and Hospitals, presumably in recognition of his philanthropic work with St John.8 This first Massey cabinet was one of the strongest and most talented in New
Zealand’s political history. Six of the nine had university degrees. Massey imposed greater unity on his cabinet than Ward, or even Seddon in his last years, and they stuck together as a team, respecting each other’s talents. Massey’s deputy was James Allen, a clever if rather dour Dunedin businessman, whose portfolios of Finance, Defence and Education neatly reflected his interests and expertise. Massey’s closest adviser and leader of the Legislative Council was the brilliant lawyer F.H.D. Bell KC (later Sir Francis Bell). As W.J. Gardner remarks, this first Reform government was really a Massey-Bell ministry. Massey, Allen and Bell formed the decision-making core, but they shared the inner circle with other strong personalities: William Herries as Minister of Railways and Native Affairs, Alexander Herdman as Attorney-General and Minister of Justice and Police, and Francis Fisher, the ministry’s most forceful and effective debater next to Massey. Conversely, William (‘Wakky’) Fraser was an elderly Minister of Public Works, an old friend of Massey’s, while Maui Pomare as Representative of the Native Race is said to have snored his way through the more tedious cabinet meetings. Rhodes was the seventh-ranked minister, junior to all except Pomare and Bell, who, despite his close relationship with Massey, had a low official ranking.9

Health was a lesser priority for this first Reform cabinet than land reform and Herdman’s 1912 Public Service Act, but industrial and labour issues soon overshadowed all else with the worsening Waihi miners’ strike of 1912 and the 1913 waterfront dispute. Left-wing historians have criticized Massey’s government for its heavy-handed response to these disputes, though most farmers and the urban middle class at the time probably welcomed the government’s firm stance.10 The outbreak of the First World War in 1914 gave Massey a host of new problems undreamt of in 1912, and pressure soon mounted for a government of national unity. After an inconclusive general election, Sir Joseph Ward demanded parity in cabinet seats, and finally got it in August 1915, so someone had to step down from Reform. That someone was Heaton Rhodes. He was promptly sent off to the Middle East as a special government commissioner and won a great deal of public approval for his investigation of hospital conditions for New Zealand soldiers wounded at Gallipoli.11 Like most people, he probably expected the war to be over within a year or two and that he would soon be back in cabinet; he presumably kept his ministerial letterbooks for this reason, and because there was a scattering of electoral and personal correspondence in them. He spent the rest of the war in London as New Zealand’s Red Cross commissioner, and only returned to cabinet in July 1920 as Minister of Defence (now as Sir Heaton Rhodes). The letterbooks remained at Otahuna, forgotten, until his death in 1956. His trustees later deposited them in the Canterbury Museum.

Government policy towards Maori health before 1912 was complicated if not compromised by confusion over funding and administration. Since the establishment of the Department of Public Health in 1900 approximately £3000 a year had been allocated to Maori health from the £7000 provided in the Native Civil List, unchanged since 1852. This sum was paid by the Justice Department, which administered the Native Civil List, but friction occurred between Health and Justice officials over its use. When T.W. Fisher became Under-Secretary of
the Native Department in 1907 he found that expenditure on Maori health had risen to nearly £5600 a year, and immediately recommended cuts of £1300. The Native Civil List grant had been supplemented by an equal amount from the Health vote, but government retrenchment in 1911 reduced the allocations to Maori Councils even as they were being given greater responsibility for Maori health. The salaries of Maori health inspectors were likewise reduced. In that same year, the Deputy Chief Health Officer, Dr Joseph Frengley, noted that outbreaks of infection in Maori settlements were dealt with by a bewildering variety of agencies, including the Health Department, police, county councils, Native Department nurses, Maori Councils and subsidized Native Medical Officers. The promising collaboration of Maori Councils with Dr Maui Pomare as Native Health Officer in 1901 and Dr Peter Buck as his assistant in 1905 had run out of steam, or rather money, and by the end of 1911 both Maori doctors had left the Health Department for Parliament. At least some of the administrative confusion was resolved in 1911 when Maori health was transferred from the Native Department to the Health Department, but its funding remained low.12

The key issues in Maori health facing Heaton Rhodes as the new Minister of Public Health in 1912 all related to underfunding. His most urgent priority was the reorganization of the Native Medical Service, to ensure that a limited number of nurses were distributed to areas of greatest need. His next most urgent problem was the difficulty of attracting general practitioners to serve as Native Medical Officers and attend ‘indigent’ Maori. Related to this was the problem of Maori access to public hospitals. Some hospital boards refused to admit Maori with infectious diseases, and others insisted that since Maori did not pay rates they were not entitled to hospital beds. Looming behind these immediate problems was the bogey of poor sanitation in Maori settlements. Pakeha fears about the spread of disease from such settlements to the general population were often exaggerated, but were not entirely without foundation. Typhoid was still prevalent in many Maori districts, as well as in smaller towns and Pakeha farming districts. A growing concern in this period was the spread of tuberculosis from Maori settlements. In addition to these issues, Heaton Rhodes had to deal with the crisis of the 1913 smallpox epidemic in the upper North Island, the worst public health crisis for Maori before the much more deadly ‘Spanish’ influenza pandemic of 1918.13

The Rhodes letterbooks cast light on all of these issues, and furnish fresh evidence not found in other sources. They are especially revealing of official attitudes towards Maori health, and of racial attitudes among some politicians and medical practitioners at this time. Volumes 1–22 cover the period 11 July 1912 to 6 August 1915, and comprise outward correspondence from Rhodes as Postmaster-General and Minister of Telegraphs, Minister of Public Health and Minister in Charge of Hospitals and Charitable Aid, Mental Hospitals and the Tourist and Health Resorts Department. Altogether these volumes contain approximately 2500 letters and verbatim proceedings of 315 deputations. Post and Telegraph matters account for just over half of all deputations (52.6%) while Health accounts for only a third (35%). The remaining deputations concern Tourist and Health Resorts (6.6%), local electorate matters and (after August 1914) wartime censorship. Some of the Health Resort deputations Rhodes met
at Rotorua and Te Aroha were concerned with water supply and sewage disposal, and should be counted with Public Health. Letters and deputations on health matters total 224 significant items, leaving aside routine acknowledgements, and Maori health issues appear in about a third of these. It must be remembered, of course, that not all Health Department correspondence required the minister’s signature. Dr Thomas Valintine as Chief Health Officer would have dealt with the bulk of the routine correspondence, though its survival in the pre-1920 Health Department archives is, at best, incomplete. It must also be noted that Maori health occupied only a very small place in Heaton Rhodes’s wide range of extra-Parliamentary interests.

The provision of Native Medical Officers (NMO) had begun in a small way in the 1860s and was an attempt to prevent high mortality among Maori by placing medical assistance within the reach of even the poorest. By 1900 there were fewer than 30 NMOs, and they were thinly spread, especially in the North Island where most Maori lived. Remote districts with low population density were least likely to have subsidized medical care. When Heaton Rhodes became Minister of Public Health the system was widely regarded as patchy and inequitable, but better than nothing.

Both Dow and Lange refer to the problem of providing subsidies for general practitioners acting as NMOs. This issue also looms large in the letters and deputations relating to Maori health in Rhodes’s letterbooks. Dow refers to the situation of John Somerville of Wairoa, Hawke’s Bay, whose £30 for 175 cases in 1909 averaged 3s.5d. per visit; he was the second-busiest NMO next to Dr Davis of Waiapu. By 1912 Somerville was getting £35 a year. On 27 September that year Heaton Rhodes received a deputation from Mohaka complaining about Somerville’s work. Mohaka was a coastal settlement 20km west of Wairoa comprising about 200 adults and almost as many children. Their complaint was that Somerville ‘was of very little service’ beyond a ten-mile radius of Wairoa, where he lived, and Mohaka was a little too far for him to come willingly. The deputation wanted a trained nurse in the district, ‘as soon as possible’, in preference to a subsidized medical man. Rhodes told them that he had asked the Chief Health Officer for a report on every district where a subsidy was paid for medical aid to Maori, and that he had ordered a reorganization of the Native Medical Service.

At least Maori in Wairoa and its district had an active doctor who earned his subsidy. Elsewhere it was not so easy to attract effective NMOs. In November 1912, while visiting Waiuku with Massey, Rhodes received a deputation led by John McGavin, a former Native School teacher, complaining that the local Maori population lacked a medical officer. Dr Monck had been offered £25 a year but had declined, and Dr Howden would not do the work for less than £50 a year. Rhodes replied that he was getting a report on the whole question of subsidized medical attendance for Maori, and would send his decision through Massey as the local MP. By contrast, Pakeha settlers in remote rural districts had greater resources with which to attract medical practitioners. In February 1913 Rhodes heard that Whangamomona wanted a doctor, the nearest being at Stratford (50km distant). A medical association had been formed with 100 members, and had already collected £120, but they needed a government subsidy to reach the
required salary of £400. Railway workers on the new line were willing to subscribe sixpence a week towards this sum. The Stratford Hospital Board had offered a nurse, but the settlers preferred ‘a medical man to start with’ — a complete reversal of the preference of Maori at Mohaka.  

Though details are scanty in the letterbooks, a reorganization of the Native Medical Service was announced in May 1913, so that when Pomare forwarded a request for medical attendance from Maori at Spring Creek in Marlborough, Rhodes was able to give him a list of doctors in Blenheim, Havelock and Picton who had been reappointed as NMOs in their respective districts.

One of the first deputations Rhodes had received about Maori health, on 20 September 1912, comprised Tame Parata (MHR for Southern Maori, 1885–1911) and his son Taare (Charles), who had succeeded him as member for Southern Maori. The latter had reminded the government in the House earlier that month that its predecessors had pledged to give free hospital and medical services to Ngai Tahu, but this had never been fulfilled, and he claimed that recently ‘the doctors had been very careless in connection with their attendance on the Natives’. Rhodes replied that he was aware that free medical assistance had been given to Ngai Tahu in the past, and that he was in the process of reorganizing the work of NMOs. This delegation was obviously in response to his request for more detailed information, and gives a snapshot of Maori perceptions of deficiencies in the Native Medical Service in the South Island.

Parata pointed out that in the far south, at Riverton and Colac Bay, there was no current NMO; at Puketeraki (near Waikouaiti), a settlement with about 60 Maori, the local doctor demanded fees for attendance on Maori and some patients preferred to go by train to Dunedin Hospital for treatment and medicines. At Moeraki, the local NMO (Dr Howden) complained that his £50 subsidy was not enough to cover distant calls, and Morven had lost the services of Dr Barclay at Waimate, who likewise found that his subsidy did not cover his expenses, nor the cost of medicine for Maori patients. Parata suggested that the Oamaru doctor who attended the Maori settlement near the Waitaki River bridge might be persuaded to travel the extra six miles north to Morven. At Temuka, Dr John Hastings asked Maori patients at the Arowhenua pa to pay for their medicines in advance. At Little River, Dr Cook demanded fees from Maori families he thought could afford them. Quite apart from the specific complaint by Ngai Tahu that they had been promised free medical attendance, there was obviously a great deal of variation between NMOs on the question of charging fees to Maori patients.

This question remained unresolved during Rhodes’s time as Minister of Public Health. Valintine’s predecessor as Chief Health Officer, James Mason, had insisted that Maori should pay for a doctor’s attendance if they could afford it; the NMO subsidy was intended to cover those who were described by T.W. Fisher as ‘indigent natives’. Yet Valintine told Dr Mercer of Kaeo in January 1913 that if he accepted a subsidy he had to treat all Maori in his district, regardless of their financial situation, and as late as 1919 Dr Chesson, District Health Officer for Canterbury, remarked that Hastings at Temuka was quite within his rights in refusing treatment to Maori who could afford to go to a private hospital in Timaru.
When Rhodes became Minister of Public Health only one of the NMOs was Maori. Dr Tutere Wi Repa had graduated from the Otago Medical School in 1908 and taken up a position as house surgeon at Gisborne Hospital, a position which was abruptly cancelled. Since then he had struggled to make a living in general practice at Te Karaka, near Gisborne. He came to see Rhodes on 9 July 1913, seeking a larger subsidy to work in the Te Araroa district. Wi Repa told Rhodes that the district held about 500 Maori and 200 Pakeha, with the nearest doctor at Waipiro, nearly 50km to the south. In 1913 this was one of the most isolated of all Maori settlements on the East Coast, lacking good roads let alone a railway. The sea was still the best highway. Wi Repa told Rhodes about his abortive appointment to Gisborne Hospital, which had been arranged by Valintine, 'but when they discovered that I was a Maori they dismissed me'. This episode obviously rankled, and made Wi Repa bitter and suspicious towards Pakeha officialdom for the rest of his life. Rhodes was glad to help him make a fresh start in a district desperately in need of a resident NMO, and Wi Repa moved to Te Araroa with a subsidy of £100 a year, and remained there until he died in 1945.

Taare Parata came to see Rhodes in August 1913 with a complaint about lack of medical attendance on Maori near Kaikoura. Though the pa was only a mile from the township, the NMO refused to attend Maori cases without payment and in a recent typhoid outbreak six or seven children had died within a few weeks, causing much alarm among Pakeha residents. In serious cases, Parata insisted, the doctor should attend Maori cases regardless of fees. He reminded Rhodes that the land purchase agreements in Otago and Canterbury included provision for medical attendance and hospitals for Maori: 'In the whole of the South Island he did not think that more than three or four Natives were in a position to pay doctors' fees. When the land was divided up there was very little for each'. Rhodes promised to see what could be done to improve medical attendance in Kaikoura.

This example touches on the vexed problem of sanitation in Maori settlements and Pakeha fears about the spread of disease. The reluctance of some NMOs to attend Maori typhoid cases may be explained by their fear of spreading infection. The usual response to outbreaks of typhoid in Maori settlements was to isolate cases as far as possible in separate 'fever camps'. Most of the handful of qualified Maori nurses in this period were put in charge of such camps, especially on the North Island's East Coast. Akenehi Hei, the first Maori registered nurse, contracted typhoid and died in November 1910 after nursing her own relatives at Gisborne. Heni Whangapirita, the second Maori registered nurse, worked in the typhoid fever camps on the East Coast in 1911, before leaving the service to marry T.H. Reedy. In 1912 Apirana Ngata came to see Rhodes, seeking government compensation for two Native School teachers, Miss Byles and Miss Baigent, who taught at Whareponga for several years and who were just about to leave when typhoid fever broke out. They stayed for six months, nursing the Maori community, and spent all their savings since they received no further income from the Education Department. Rhodes promised to reimburse them by matching whatever sum could be raised by local subscription up to £25.

A deputation in August 1913 blamed tangi for spreading typhoid in the Kawhia
district, but in the course of a later deputation Rhodes expressed the opinion that typhoid was widespread there because the district was low-lying and the water supply was ‘not good’. Improving the quality of water supplies to Maori settlements was certainly the most effective way to reduce the incidence of typhoid, but Pomare had found as early as 1903 that Maori custom and lack of finance made sanitation and water supplies very difficult problems to solve. The government had provided metal water tanks on request to a few settlements from 1899, but this practical solution was too expensive to implement on a larger scale. Some progress was made where local Maori leaders took the initiative to ask for government help. In August 1913 Rhodes, as local MP, was able to help get a piped water supply extended to Rapaki from Lyttelton. Improved housing, sanitation and water supplies form a large part of the explanation for Maori population increase after the 1895 census, but there was still much room for improvement even in the 1930s.

Typhoid cases admitted to hospitals always caused alarm among the Pakeha community. An outbreak of typhoid at Kerepehi late in 1912 resulted in 12 Maori cases being admitted to Thames Hospital, stretching its meagre resources. Six cases were put in the ‘consumptive shelter sheds’, but if any more patients came in, the hospital board chairman (W.J. McCormick) warned Rhodes on 13 December 1912, they would need to open a temporary hospital. Pomare had even suggested using tents. McCormick’s comments illustrate the dilemma facing local hospital boards: ‘The patients were getting over the trouble, but Maoris were careless and sometimes stopped in boarding houses when they had the fever on them. When the Sanitary Inspector visited the district the patients were found lying all over the place. These people did not pay hospital and charitable aid rates and yet the Board had to take them in. Another epidemic like that might cripple the finances of the Board.’ Rhodes recognized that the problem of Maori admissions to hospitals was mainly financial, but he also asked for a special report on the water supply at the pa, because this was usually the source of typhoid outbreaks. It is noteworthy that Kerepehi also suffered badly in the 1918 influenza pandemic, and that the Thames Hospital Board at first refused to admit any Maori cases until the District Health Officer and the District Nurse insisted that the worst cases urgently needed hospital care.

Pakeha reported that Maori living conditions varied enormously. Some pa were kept scrupulously clean and tidy, but others betrayed their insanitary conditions by their smell. An example of the latter came to the notice of the Minister of Public Health from Dr F.M.G. Britten who told him that one Maori pa at Te Puke had no proper drainage and the people ‘were living in a mass of filth’. He claimed that disease was spread from such settlements to the general population by Maori visiting European shops and handling the goods there. Even stronger views were expressed in the course of a deputation in October 1913, just after the smallpox epidemic, by Dr F. Wallace Mackenzie of the Otaki Hospital Board. Having worked among the district’s Maori population during the epidemic, he had no hesitation in saying that ‘their style of living was bad and was a great danger to the State’. He warned that if an epidemic of cholera were to break out, it would wipe out the Maori population ‘and probably many of the whites’. He regarded typhoid as far more dangerous than smallpox,
and said that it was very prevalent in the Kawhia district. Rhodes asked him what he thought should be done. Mackenzie replied: 'all the Maori pahs burned down and each man given fifty acres of land'.

As an alternative model, Mackenzie cited Sir George Grey’s Kawena settlement on the Wanganui River, where ‘every man was his own landlord, the people were clean and good’, and when he visited the settlement he could not find a single sick person. ‘Give each Maori a bit of land and he would work,’ Mackenzie added, but when the land was owned collectively none would work: ‘Unless they had a real good man in the pah they played all day and did not care what water they drank’. Rhodes agreed with him, and said that Maori in Horowhenua county ‘had become lazy’, so that their pa were insanitary and it was difficult to get them to keep their settlements clean. Rhodes added that he had ‘always been an advocate of individualization of Maori titles’, but added that there were ‘many difficulties’ in the way of achieving this.

Earlier in the discussion, the chairman of the Wellington Hospital Board, Rev. W.A. Evans, had drawn attention to the heavy workload and transport problems of the Maori nurse located at Otaki. He claimed that the Maori settlement at Levin was ‘practically neglected’ for lack of transport. The board had agreed to pay for the nurse’s lodgings at Levin, but none could be found at a reasonable rate. Though the government paid her salary, the board had to pay her expenses, and conveyance by buggies to the various pa in the district would cost an extra £75–100 a year. There was undoubtedly a great need: the nurse had made 1850 visits in the Otaki, Waikanae and Manakau districts but could not reach more remote settlements.

Evans questioned whether the government had anticipated the ‘immense amount of work’ to be done by nurses in Maori districts, and whether the funding was adequate. Mackenzie believed there was a fund of £7000 a year available for Maori health, but Rhodes replied that his department only got £3000 with a small extra amount from the Public Trustee. Valentine suggested that the wealthier Maori of the district should pay the transport costs for poorer Maori.

Rhodes was reluctant to make an exception over the Otaki nurse’s travelling expenses. The government paid her salary and gave her a free rail pass. All other hospital boards paid the travel expenses of their nurses. He thought that when Maori wanted the nurse they should provide transport for her. Evans pointed out that the real problem was the great poverty of the Otaki Maori, to which the Minister tartly responded, ‘But if there is a race meeting they can find buggies to go in’. Evans replied that those who went to race meetings in buggies were not those in need of the nurse. Rhodes finally agreed that, on the whole, Maori were very good at reporting cases of sickness, and at following the nurse’s instructions, and promised to find out whether the Maori Health Service was entitled to a larger amount from the Civil List. Since there was no change in the grant, it must be assumed that his enquiries were fruitless.

What the Minister of Public Health saw as ‘laziness’ among the Maori community at Otaki would now be explained as the apathy and hopelessness resulting from extreme poverty, land loss and culture-clash. Pakeha perceptions of Maori living conditions at this time were rarely free from elements of moral disapproval and cultural misunderstanding. Mackenzie’s impression that some
Maori ‘played all day and did not care what water they drank’ is an example of the latter. Practising haka and singing waiata might have seemed like ‘playing’ to the uninformed Pakeha observer, but were vital for the transmission of customs and cultural values in a Maori community. (Maori might have held similar views about Pakeha festivals involving processions and brass bands as so much ‘play’.) As for water supplies, unless a settlement had a piped water supply, the women fetched water daily from designated sacred places (wai tapu), and may not have been aware of any contamination by effluent further upstream. A large part of Maori grievance over land loss involved the casual disregard of many Pakeha settlers for sacred Maori sites in the landscape.

In the course of this same deputation the Otaki Hospital Board chairman, B.R. Gardener, urged compulsory registration of Maori births and deaths as a key step towards control of tuberculosis. He was certain that the real death rate from TB among Maori was far greater than the Health Department believed. The campaign against TB was already costing hospital boards ‘a great deal of money’, but he feared it would be wasted unless better records were kept. Follow-up reports on patients leaving sanatoriums ‘should be insisted upon’, and notification made of TB patients moving from one district to another. The children of consumptive parents should be examined immediately, and checked every six months, possibly saving the country ‘thousands of pounds’ by early detection of new cases.

Registration of Maori births and deaths was a step in the right direction and in time would provide valuable statistical benchmarks for improvements in Maori health.

Tuberculosis remained a long-term Maori health problem well after the crisis of the 1913 smallpox epidemic had passed, yet official discussions of TB often omitted its Maori dimension. The 1912 conference on tuberculosis, opened by Heaton Rhodes as Minister of Public Health on 22 October, appears to have completely ignored Maori, even though some doctors regarded local pa as sources of infection in the community. Dow has drawn attention to one exception to the prevailing official neglect of TB among Maori before the 1920s. In 1912 Dr George Blackmore, medical superintendent of the Cashmere Sanatorium, and Dr A.B. Pearson, bacteriologist at Christchurch Hospital, were sent to investigate the incidence of TB at Tuahiwi, the largest Maori settlement in North Canterbury, near Kaiapoi. They recommended a trial of weekly tuberculin injections, but this proved too expensive for wider application, despite
promising results, and the outbreak of war in 1914 put a stop to all such initiatives, for lack of money. On 4 January 1915 Rhodes met a deputation from the North Canterbury Hospital Board, led by Blackmore, to discuss Maori health in Canterbury. He began by pointing out that he still had only about £3300 to provide for all Maori medical attendance throughout New Zealand. By this time there were newly subsidized NMOs at Little River, Leeston and Southbridge, but, he reminded them, 'there are very few Maoris in the South Island and it is difficult to make the amount go round'. The board chairman, Frederick Horrell, said conditions had been 'very bad' at Tuahiwi until a nurse was appointed about two years ago, and then things had improved, but she had since left and things had 'gone back again'.

Blackmore confirmed that the nurse at Tuahiwi had done 'quite remarkable work'. She inspected each dwelling and made sure that the children did not spread infection. About half of the school children had TB. She discovered that one way the disease was spread was thanks to the craze for American chewing gum; in one family, every member had caught TB from exchanging chewed gum. Blackmore said he had last examined the children about two years previously, and when he examined them again recently he found no disease in those treated with tuberculin injections: 'The whole aspect of the school was changed completely'. The Education Department had built shelters for infected pupils, and the teacher had been instructed in giving tuberculin to the children.

Maori at Tuahiwi had been 'so impressed with the importance of preventing the disease from spreading that other Maoris suffering from tuberculosis were not allowed to come into their pah'. There had clearly been a great improvement at Tuahiwi. But, Blackmore added, many TB cases still remained at Rapaki and Little River. They needed another nurse who could visit these places regularly. Rhodes must have felt pleased when he told this deputation that the Health Department had found a suitable nurse, and that she could start straight away: 'I shall see that there is no delay in the matter'. With the coming of war in 1914 and the departure of doctors and nurses to join the war effort, the problem of finding suitable doctors to act as NMOs grew more difficult. The Rhodes letterbooks cast a little more light on one example cited by Dow of Maori reluctance to use an appointed NMO. This was the unfortunate Dr Alfred Story in the Bay of Islands.

A deputation received by Rhodes on 16 April 1915 from the Bay of Islands Hospital and Charitable Aid Board told him that Story was employed by the Whangararoa Medical Club and that he refused to attend non-members. The board held that because a government subsidy was paid, he should attend anyone in need in the district. If they could not pay, he could ask the board for the fee. Rhodes, however, pointed out that this was not a subsidy but a direct grant to the Whangararoa Medical Association. Then the board's real grievance emerged. Story had been employed by the board but had proved 'unsatisfactory', and the board refused to reappoint him. Then, 'to our intense surprise', said chairman T.M. Lane, he got an appointment at £100 a year to attend the Maori population. Yet Maori did not want him either, claiming that he was not on the medical register, and that he had a German wife and they were afraid that he would
poison them. In Story’s defence Rhodes said, ‘He has done some very good work. He makes no pretence of being registered’. He then asked, ‘Does he drink?’ and Lane replied, ‘I think he takes morphia’. The board’s main objection was that so long as Story remained, the board could not appoint another doctor to the district. Obviously, the hospital board wanted to appoint the NMO, but Rhodes and Valentine would not give up the Health Department’s independent control of the NMOs. Rhodes thought this case was a matter for the Medical Board to investigate rather than the Health Department. Apart from illustrating the tug of war between the Health Department and hospital boards for control of NMOs (a struggle which lasted until the 1980s), this episode also reflects the acute shortage of qualified medical practitioners in rural areas during the First World War.

Medical Registration was one of Rhodes’s more successful pieces of new legislation in his brief term as Minister of Public Health. Joseph Ward had prepared a Medical Practitioners Bill soon after the establishment of the Health Department in 1900, and every Minister of Public Health since then had tinkered with it, but it was thanks to Rhodes’s quiet behind-the-scenes diplomacy and his willingness to amend it in committee that the bill was finally passed in 1914. Its most distinctive feature was that each member of the Medical Board should be a registered medical practitioner; this was not the case with Britain’s General Medical Council, which always included government appointees. New Zealand’s doctors could now feel assured that they had full control of their own professional standards, and in gratitude for his handling of the bill they elected Heaton Rhodes an honorary member of the New Zealand branch of the British Medical Association, a rare privilege for any Minister of Public Health.

Rhodes’s handling of the 1913 smallpox epidemic is more fully reported in Parliamentary Debates and the newspapers than in the Rhodes letterbooks, but the latter occasionally add some details not found elsewhere. In a letter to his cousin Arthur, dated 23 August 1913, Rhodes explained that he could not get away from Wellington because ‘nearly the whole of my time is taken up with smallpox matters’. The smallpox epidemic dominated newspaper headlines in July and August 1913, competing with reports of overcrowding in mental hospitals. Inevitably the newspapers repeated some of the more colourful rumours circulating about smallpox, adding to fears that it could sweep through the Pakeha population as well. Rhodes was quick to refute rumours that people had had to have their arms amputated after adverse reactions to smallpox vaccination, just as he denied rumours that he was considering isolating Auckland. Questioned by a reporter in Wellington, Rhodes said, ‘I never suggested it. The papers might have, but I can’t help what the papers say.’

Cabinet had considered isolating the South Island, but health officials were confident that travel restrictions on Maori would confine the epidemic to the upper North Island. Passengers on the Wellington–Lyttelton ferries were advised to have vaccinations, and Rhodes set a good example by being vaccinated himself. With hindsight it is clear that the Health Department underestimated the severity of the epidemic in Northland, but it would be unfair to accuse Rhodes or his officials of neglect or inadequate response. On the basis of the information filtering through to them, especially from Dr Peter Buck (Te Rangihiroa) and
Dr Pomare, their responses were prompt and appropriate. They sent a large team of vaccinators to Northland, later reinforced by a group of fifth-year medical students from Otago University. Rhodes made several public statements about Maori willingness to be vaccinated and noted that their willingness to comply with travel restrictions was greater than that of most Pakeha.48

Rhodes was careful to investigate complaints of neglect from Maori settlements. In early September 1913 a newspaper reported that a group of Maori in the Waikato had asked the Hamilton Borough Council for assistance, claiming they had no food, no money, and much sickness because of the Health Department’s travel restrictions. Rhodes immediately sent a telegram to Dr Douglas at Hamilton Hospital, asking him to investigate. Douglas visited the pa and found it was all a joke: the ‘idle Maoris’ who had signed the petition merely laughed, and were ridiculed by other Maori. There was no smallpox, and no starvation at the pa. Douglas reported that the Waikato was ‘clear’, there had been no fresh cases for ten days, and all other Maori settlements had been only too anxious to help the health officials. Rhodes wrote privately to Douglas to thank him for his report: ‘the letter was a great relief to me’.49

Travel restrictions on Maori remained in place long after the smallpox epidemic had abated. Apirana Ngata led demands for the restrictions to be lifted, pointing out that the shearing season was about to start, and that Maori shearing gangs needed to travel in order to earn their living. Rhodes replied that the restrictions only applied to Maori who did not have a vaccination certificate; the shearsers could easily get vaccinated and then obtain permission to travel. There had been scattered reports of railway guards refusing to allow Maori to board trains even when they had certificates, but Rhodes said he could not help it if such individuals chose to ignore the regulations.50

Travel restrictions were finally lifted in early December 1913, when Rhodes made a statement in the House declaring the country ‘practically clear’ of smallpox. He spoke of the readiness with which Maori had complied with Health Department directives, and ‘the dignity with which they submitted to measures which they must have regarded not only as harsh but, at times, as almost unjust’. He then thanked by name all the medical students who had volunteered to help, and paid special tribute to Buck, as well as the officers of the Health, Police and Education departments who had helped ‘stamp out’ the epidemic. Pomare said that he had spent ten days helping his people during the epidemic and had found the Health Department’s men working so efficiently that there was no need for his services.51

Rhodes handled this major crisis in Maori health surprisingly well. Rather than sit back and wait for his officials to deal with the epidemic, he had adopted a ‘hands-on’ approach, ordering the Chief Health Officer to go and investigate the situation in two different parts of the North Island, and making a direct personal approach to the Otago Medical School to seek volunteer vaccinators for Northland. His predecessor (and successor) as Minister of Public Health, George W. Russell, who was his most frequent critic from the Opposition benches, congratulated Rhodes on his department’s effective response to the crisis.52 Rhodes’s example may have lingered in Russell’s mind, encouraging him to adopt the same approach during the 1918 influenza pandemic.53
Maori health almost disappears from the Rhodes letterbooks after the 1913 smallpox epidemic. The outbreak of war and the general election of 1914 gave ministers other things to think about, and Rhodes faced a different health crisis in 1915 with a serious outbreak of ‘cerebro-spinal fever’ (probably meningitis) at Trentham Military Camp in June and July, in the midst of separate epidemics of measles and influenza. Altogether there were 26 deaths among over 2000 cases from these three causes. (This compares with 55 Maori deaths from over 2000 cases in the 1913 smallpox epidemic.) In contrast to the plaudits Rhodes and his officials received for their handling of smallpox, the newspapers were highly critical of their handling of the Trentham Camp epidemics, one Auckland paper demanding the immediate removal of Rhodes and senior Health Department officials. Opportunistic politicians such as Dr H.T.J. Thacker were quick to jump on the bandwagon, but Rhodes capably defended himself and his officials, showing that everything possible had been done in the time available.

Apart from pushing for a reorganization of the cash-strapped Native Medical Service in 1913 and his surprisingly capable handling of the smallpox epidemic, Rhodes could not claim any spectacular successes or major new initiatives in Maori health during his brief tenure as minister. He was a diligent administrator, earning the reputation of being the first minister at his desk every morning, and he defended his department effectively in the House, but he failed to obtain any significant increase in funding for Maori health before the advent of war in 1914 put a cap on government spending and caused serious retrenchment in the Native Medical Service.

Rhodes probably had more interest in Maori health than anyone else in Massey’s first cabinet apart from Pomare, but on wider Maori issues he appears to have deferred to William Herries as Native Minister. In Opposition, Herries had been a strong advocate of individualization of Maori titles, and in government he restructured the Native Department into a land purchase department. He denigrated Maori councils and Maori land boards, and between 1911 and 1920 over two million acres of Maori land were alienated. There is no evidence that Rhodes ever disagreed with his party’s Maori policies. As MP for Ellesmere, Rhodes maintained a cordial relationship with Maori in his electorate, who had presented him with a rare whalebone mere on his departure for the South African War in 1902. In 1941 he paid for the carving at Rotorua of a new altar for the little Maori church at Onuku, near Akaroa, to mark its centennial. Yet it must also be remembered that Rhodes belonged to a generation that believed the Maori were a dying race. His cousin Arthur (mayor of Christchurch in 1901) had named his children Mairehau and Tahu in that brief naming-trend among Pakeha in the 1890s to preserve the memory of New Zealand’s dying native race. (Rhodes had no children of his own.) While Rhodes appears to have been sympathetic to Maori health needs and tried to do what he could with limited resources, he does not appear to have had the necessary political clout in the first Massey cabinet to increase those resources.

Rhodes’s support for the individualization of Maori land titles suggests that his approach to Maori health problems lay along the path of detribalization and assimilation — in short, Europeanization. The more like Pakeha they became, the healthier Maori would be. There is little doubt that such attitudes of
paternalism and racial superiority were prevalent not only among the members of Massey's first cabinet but also among most of the Health Department's officials before 1920. Yet, as Lange's book has shown, Maori were perfectly capable of reforming themselves in order to improve their health, and only needed better means with which to do it. Some help was better than none, and Lange recognized that the recovery of the Maori population after 1900 owed at least as much to government assistance as it does to Maori self-help.59 However, the evidence of the Rhodes letterbooks tends to support Lange's general conclusion that Maori health was a low priority for successive governments in the years 1909–1919. Buck and Pomare left the Health Department to enter Parliament, and the position of Native Health Officer remained vacant from 1911–1919. Their promising initiatives of the early 1900s, in collaboration with Maori councils and teachers in Native schools, had been frustrated by government indifference and underfunding by both Liberal and Reform cabinets. While Herries was Native Minister (from 1912–1921) land issues predominated in cabinet discussions concerning Maori, and very little attention was paid to Maori councils or Maori health.60 An opportunity was lost, and Heaton Rhodes as Minister of Public Health must share some of the responsibility for the first Massey cabinet's failure to fund Maori health reforms on a larger scale.
NOTES


2 Canterbury Museum, Manuscripts Department, 45/58, Outward Letter Books of Sir R. Heaton Rhodes, 1912–1915, 27 vols (hereafter CM 45/58); Miscellaneous press clippings, 1890–1927, 6 vols and 3 boxes. Volume 23 (marked ‘Private’) has estate and electorate correspondence; volume 24 concerns the Canterbury Yeomany Cavalry; volumes 25–27 contain newspaper clippings.


11 Canterbury Museum, Manuscripts Department, ARC 1993.33, Diary of Lt. Col. R.H. Rhodes on his mission to the NZEF in Egypt, Malta, Mudros and Gallipoli, 1915–16, 6 vols.


14 See Lange, p.332.


17 CM 45/58, Vol.6, p.135.

18 *Press* (Christchurch), 13 May 1913; CM 45/58, Vol.8, p.33.

19 CM 45/58, Vol.3, p.238; *New Zealand Parliamentary Debates (NZPD)*, 1912, 161, p.27; Lange, pp.71–72 suggests that Ngai Tahu did well out of the NMO system, but the evidence of the Rhodes letterbooks indicates continued dissatisfaction. This helps to answer one of the questions posed by Philippa Mein Smith in her review of Lange and Dow, NZJH, 34, 1 (2000), p.177.


22 CM 45/58, Vol.9, p.86; Lange, p.178.


24 Lange, p.170–2.


26 CM 45/58, Vol.10, p.77.

27 CM 45/58, Vol.12, p.22.

28 CM 45/58, Vol.10, p.13; see also Lange, pp.75, 153–4.
29 CM 45/58, Vol.6, p.3.
32 CM 45/58, Vol.12, p.18.
33 CM 45/58, Vol.12, p.20.
34 CM 45/58, Vol.12, pp.15–16.
35 CM 45/58, Vol.12, p.21. For the Civil List allocations for medicines and doctors’ subsidies, see Lange, p.271. The amount remained steady at about £3000 p.a. between 1912 and 1918, but the total expenditure each year fell far short of the £7000 allocated.
37 CM 45/58, Vol.12, p.20.
38 Lange, p.238.
39 Rice, Black November, p.104.
40 Dow, Maori Health, p.143.
43 CM 45/58, Vol.19, p.64.
44 Dow, Maori Health, p.120; CM 45/58, Vol. 20, pp.104–8.
47 Dominion (Wellington), 14 July 1913; CM 45/58, Vol.27, f.34.
50 NZPD, 1913, 164, p.654.
51 NZPD, 1913, 167, pp.1150–2. See also Day, p.198.
52 NZPD, 1913, 167, pp.1152–4.
53 Rice, Black November, pp.54–5.
54 Maclean, pp.399–405.
56 C.A.C. Hardy, MP for Selwyn, in Lyttelton Times, 15 September 1916.
58 Press, 3 May 1941.
59 Lange, p.268.
60 Lange, p.196.