"SICK UNTO DEATH"

BARRIERS AND FACILITATORS TO

PRIMARY HEALTHCARE

FOR MĀORI

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ABSTRACT

This qualitative study examined the barriers and facilitators that influenced access to and engagement with primary healthcare amongst a purposively selected Maori sub-sample from the Christchurch, New Zealand, cohort of the Hauora Manawa Study which is comparing heart disease amongst two diverse Maori communities (in Wairoa and Christchurch) with a non-Maori group in Christchurch. There was found to be a highly complex and multidimensional relationship between skin colour and/or social-ascription as Maori, and age, gender, and spatial and social-class location.

The integration of Bourdieu's Theory of Practice (1977) and Shim's (2010) conceptualisation cultural health capital into a context-specific analytical framework was instrumental in mediating the dichotomous relationship between subjective patient experiences and objective institutional arrangements, including policies, practices and the relative power imbalances in a highly differentiated, racialised society. Access barriers regarding the reduced ability to maintain continuity of care with a known practitioner, since the restructuring of New Zealand's primary health sector at the turn of the century, represents the disjuncture between contemporary policy objectives and clinical encounters with predominantly non-Maori practitioners. Recognition of skin colour and/or self-defined social-ascription becomes a determinant of potential or realised exposure to differential treatment and/or utilisation patterns.

Age and gender reflect the history, context, and tempo of demographic change precipitated by rapid Maori urbanisation from the 1950s-1960s. Lifecourse access to healthcare appears to condition pre-reflexive acceptance of Western medical care. In contrast, adult access (except in cases of medical emergencies) and/or gender-specific differences, reflective of the belated medicalisation of Maori childbirth and concomitant childrearing responsibilities, require clinical encounters conducive to overcoming heterodoxical beliefs occasioned by childhood dependence on traditional medicine. Notwithstanding increased intermarriage and access to societal infrastructure in the urban milieu, the transgenerational normalisation and entrenchment of the racialised social-class destination of Maori impedes equitable access to financial, symbolic cultural, social, political and cultural health capitals. Dominant group cultural capital is permanently
marked by the class, social and ethnic origins of its acquisition, and the differences in ability to accrue cultural health capital appears to reflect the cumulative and interconnected relationship between broader inequities that pervade all aspects of social structures, institutions and social life.

In the modern healthcare landscape, conditioned by healthism and concomitant expectations that patients assume greater management of, and have proactive dispositions towards, personal health and risk behaviours, accrued dominant cultural health capital has currency. Familiarity with biomedical concepts and language, verbal and nonverbal competencies, including health literacy, together with the interactional capacity to engage with health professionals and navigate care pathways constitutes an advantage. Barriers and facilitators to primary care access are not only conditioned by provider dispositions and bias, both intentional and unintentional, but indirect and symbolic, direct and material manifestations of colonial relations.

Equitable Maori access to and engagement with primary healthcare requires the government, institutions, their representatives, and citizens to recognise the relationship between colonial power relations and societal, not individual, responsibility for interethnic disparities in health and other outcomes.
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CHAPTER ONE: INTRODUCTION

Papaarangi Reid ... gave a stunning portrayal of how indigenous populations see the way power shapes health. There is more than one truth, she argued. Which truth you choose depends upon the scene (the data) you have before you, your own particular position when viewing that scene, the values you bring to your point-of-view, and the way your interpretations of the scene are informed by the society in which you live .... (Population Health Congress, Adelaide, Australia, Part 1) (cit. Horton 2012 The Lancet Editorial).

Introduction

The reduction and elimination of disparities in New Zealand between Māori and non-Māori health outcomes is now a national priority, and primary healthcare is one of the mechanisms through which the government intends to redress disparities in life expectancy, mortality and morbidity indicators (Ministry of Health 2010c). Notwithstanding that disparities in health outcomes have persisted since the time of European colonisation, the abrupt widening of differences in Māori and non-Māori life expectancy that followed the neo-liberalism of the 1980s and 1990s (Ajwani, Blakely, Robson & Bonne 2003) stimulated health sector reforms. Initial attempts to implement equity and social policies based on the Treaty of Waitangi provoked public outrage, and the Labour Government policy of Closing the Gaps was abandoned within six months, along with the long-standing political consensus that Māori represented a "special target group" (Humpage 2006, p. 231).

1 Efforts to reduce interethnic disparities focused on retreating from the competitive model (Gauld 2003, p. 208) to a more population health focused approach (Tobias, Blakely, Matheson, Rasanathan & Atkinson 2009). The re-emergence and disproportional incidence amongst Māori of Third World diseases (M. G. Baker et al. 2012) has focused attention on the nation's comparatively poor performing health system compared to other high income countries, a disparity directly linked to the social determinants of inequality (New Zealand Medical Association 2011, p. 1).

1 In late 1999, the newly elected center-left Labour-Alliance Coalition's policies were explicitly directed towards ameliorating increased interethnic social and health inequities precipitated by fifteen years of neo-liberalism. The Government nonetheless endeavoured to reduce health disparities between Maori and non-Maori. Health sector reforms were justified based on the need to redress the negative effects of the competitive model, in part by ensuring "democratized, locally controlled decision-making over planning, resource allocation and services configuration" (Gauld 2003, p. 208).
As Donabedian (1966, p. 694) long ago noted, health outcomes validate the effectiveness of healthcare provisions; within the context of a paucity of research on the impact of the restructuring of primary healthcare (Ross & Kenrick 2011), and qualitative research into the determinants of health inequities, the purpose of this research is to provide a sociological analysis of barriers and facilitators that condition Māori access to and engagement with modern primary healthcare provisions. The association between socioeconomic status and access to primary healthcare in New Zealand is well documented (Jatana & Blakely 2008; Jatana & Crampton 2009a; Jatana & Crampton 2009b; Jatana, Crampton & Richardson 2011; Schoen & Doty 2004). Other barriers are financial constraints (both direct and indirect) vis-à-vis consultations, prescriptions (Jatana, Crampton & Norris 2011), and travel and associated costs, and patient assessments of whether care represents "value for money" (Jansen 2009).

Interethnic disparities have also been attributed to racism, as Māori health inequality persists, even after controlling for deprivation and health need (Baxter 2002; J. Carr, Robson, Purdie & Workman 2002; Cormack, Robson & Purdie 2005; Ellison-Loschmann & Pearce 2006; Ministry of Health 2010c; Schoen & Doty 2004; Sporle, Pearce & Davis 2002; Westbrooke, Baxter & Hogan 2001). For example, Māori rates of amenable deaths are 27% to 34% higher than non-Māori males and females respectively (Tobias & Yeh

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2 In New Zealand the determinants of health are measured by socioeconomic position (based on individual factors including education, employment, income levels, home ownership, household crowding) in conjunction with deprivation, an area-based measure of socioeconomic position (Howden-Chapman & Tobias 2000). The NZDep has since 1991, extracted deprivation-related data from the national census based on meshblocks (small geographic units defined by Statistic New Zealand). Deciles 1-2 indicate the less need whereas Deciles 9-10 indicate the greatest need. The NZDep1996 revealed 3 "gaps" between Māori and non-Māori (Reid Robson Jones 2000). First, a "distribution gap" as 56% of Māori resided in the 3 most deprived of the 10 decile areas; second, an "outcome gap" showed different health outcomes for Māori even after controlling for deprivation; and third, the "gradient gap" (the relationship between ethnicity and increasing deprivation) implied that the effect of increasing deprivation compounded risk for Māori but not Pakeha, thereby highlighting the independent effect of ethnicity (Reid, Robson & Jones 2000). Although measurements included in the NZDep Indexes better reflect of the heterogeneity of Māori society than those based solely on social class (Nazroo 2003), they nonetheless failure to capture all dimensions of deprivation, particularly the cumulative effect of intergenerational disadvantage resulting from colonial and neo-colonial policies and practices as well as the life-course effect accrued through ongoing marginalisation (Davey Smith 2000).

3 As Andersen and colleagues (1983) note the concept of access implies potential and realised access and is also affected by both the health consumer and the system: "The characteristics of individuals ...(such as age, insurance coverage and health status) reflect the probable or potential levels of access to medical care; utilization and satisfaction may be more appropriately considered objective and subjective indicators, respectively, of actual or realized access to services. The potential of individual entry to the health care system is influenced by structural characteristics of the delivery system itself and the nature of the wants, resources, and needs that potential consumers may bring to the care-seeking process. The realization of entry is reflected in a population's reported rates of utilization and in subjective descriptions of the care eventually obtained."
Disparities cannot be fully accounted for by socioeconomic inequalities or explained by biological or genetic differences (Howden-Chapman & Tobias 2000; Reid et al. 2000). Moreover, data relating to general practice utilisation and ethnicity is incomplete and not routinely available (Cormack et al. 2005; Jansen 2009).

In this study Pierre Bourdieu’s Theory of Practice (1977) and Shim’s (2010) conceptualisation of cultural health capital are integrated into a context-specific theoretical framework to explore the relationship between colonial and neo-colonial relations, various forms of capitals and primary healthcare practice. Bourdieu’s Theory of Practice posits that practice is the outcome of the relationship between habitus, 4 capitals and interrelated institutions or social fields (Maton 2008, p. 49) across time and space. Accordingly, the determinants of inequality reflect the subjective consequences of structural arrangements (Swartz 1997, p. 97) and the relationship between patients and the institution of health and its agents vis-à-vis policies, practices and relative positions within a highly differentiated, racialised society.

This thesis focuses primarily on non-financial barriers, as gaining access to the health system does not ensure access to appropriate quality services or guarantee equal treatment (Geiger 2003; Krieger 2003; van Ryn & Fu 2003). The Ministry of Health (2002a) recognition of implications of the legacy of colonisation and attendant racism 5 corresponds with mounting national (Ministry of Health 2010c; Robson & Harris 2007) and international evidence (Geiger 2003; C. Jones 2000; Nazroo 2003; van Ryn et al. 2011; van Ryn & Fu 2003; D. R. Williams 1997b) that these factors remain fundamental drivers

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4 According to Karlsen and Nazroo (2002, p4), what “individual decisions about who we are and our lifestyle choices, while appearing to be unbounded and, therefore, solely a consequence of agency, are, in reality, made within social constraints, what Bourdieu terms ‘habitus’ (1977). The theory of habitus explores the way in which symbolic representations influence behaviour through: a whole body of wisdom, sayings, commonplaces, ethical precepts (‘that’s not for the likes of us’) and, at a deeper level, the unconscious principles of the ethos which . . . determines ‘reasonable’ and ‘unreasonable’ conduct for every agent (1977: 77). Thus Bourdieu argues that while social practice has some purpose and practical intent for the individual, these goals are located within an individual’s own experience of reality, which is related to who and what they are and is, therefore, at least partially, externally defined. Bourdieu argues that the only means of expanding this sphere of ‘reasonable’ behaviour is through increasing the lifestyle choices available, via forms of ‘capital’, which are also delimited by social position. So, attempts by social groups to define and appropriate their own lifestyle will also be restrained and influenced by the social structure and wider society” (Karlsen & Nazroo 2002, p. 4).

5 Harris et al. (2006a; 2006b) found that self-reported experiences of racial discrimination were significantly associated with a greater likelihood of reporting poor or fair self-rated health, lower physical function, lower mental health; smoking, and cardiovascular disease; these authors also found that both deprivation and experiences of perceived racial discrimination contributed to inequalities in health outcomes and that most of the disparities in health outcomes accessed could be attributed to a combination of deprivation and discrimination.
of health inequities. The ideology of racism is fundamental to the process of colonisation, which is dependent on transference of all assets and resources from the colonised to the colonisers, and the dehumanisation of indigenous peoples (Churchill 1994). Moreover, Shim's conceptualisation of cultural health capital has relevance within the current context of healthism, where health status is attributed to individual responsibility for the management of health risks and risk behaviours. Shim (2010, p. 6) posits that patients require various distinctively cultural skills and competencies, and that the ability to "display an enterprising and proactive disposition, a fluency in biomedical concepts and language, bureaucratic know-how, and an interactional agility with authoritative experts" is advantageous in successfully navigating the complexities of the modern healthcare landscape.

This qualitative research is undertaken amongst a Māori sub-sample of the Christchurch cohort of the Hauora Manawa Community Heart Study (Hauora Manawa Study). The broader Hauora Manawa Study is documenting and comparing heart disease and cardiovascular risk factors amongst three randomly selected population groups (n=244); two diverse Māori communities (Ngati Kahungunu in rural Wairoa and Mana Whenua in urban Christchurch), and a non-Māori group in Christchurch, aged between 20 and 64 years. This study purposively selected a sub-sample (n=45) of Māori from the Christchurch cohort (aged between 24 and 64 years) to ensure maximum diversity of self-reported perceptions and/or experiences of primary healthcare characteristics of the heterogeneous composition of Māori. Kaupapa Māori principles, consistent with the "for, with and by Māori" approach of the broader study (Pitama et al. 2011, p. 249) guided, and were loosely integrated into, methods of data collection and interpretation.

The Bourdieusian concept of epistemic reflexivity (Bourdieu & Wacquant 1992, p. 36; Swartz 2002), which demands attentiveness to the personal habitus, dispositions and practice of the researcher as potential sources of bias (Bourdieu & Wacquant 1992), guides this research. Moreover, as a Māori researcher, the method and processes of data collection employed in this thesis (control, challenge, culture, connection, change and credibility) (Kerr undated, p. 5) correspond with the principles of Kaupapa Māori research, consistent with the overarching philosophy of the parent study. Ethics approval for this research is covered by approval granted to the Hauora Manawa Study from the Multi-region Ethnics Committee.
Research Question

This thesis has sought to answer the overarching question of what the barriers and facilitators to primary healthcare are by exploring the specificities of how Māori describe their experiences of access and engagement within the context of a highly differentiated, racialised, colour-conscious, neo-colonial society.

Notwithstanding conceptual difficulties in defining access, the American Institute of Medicine's definition, "the timely use of affordable personal health services to achieve the best possible health outcomes," has wide-spread acceptance (Millman 1993). A salient characteristic of this definition is that both service utilisation and health outcomes measure whether access has in fact been realised. Proof of access of service utilisation relative to need distinguishes the components of initiation and continuation, potential or actual entry indicates individual or population use of a service if required whereas gaining access refers to initiation of the process of service utilisation (Aday & Andersen 1974). Within the context of this study, participants' self-reported barriers and facilitators to realised, quality 6 access encompass the components of disposition, 7 affordability, accessibility and acceptability of care (Aday & Andersen 1974; Arah, Westert, Hurst & Klazinga 2006); the latter emphasises the salience of doctor-patient relations and the rights of patients to be treated with consideration and respect, informed of treatment options, and involved in the decision-making process (Donabedian 1990).

\[6\] The difficulty of defining quality healthcare has long been acknowledged (Maxwell 1984) with over 100 definitions of quality identified in 1990 (Lohr 1991). While recognising the context-dependent nature of quality and the possibility and legitimacy of multiple formulations (depending on different positions and responsibilities within the health system), Donabedian (1988, p. 1743) defined quality healthcare as “that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts.” The phrase “measure of patient welfare” is indicative of the recent emphasis on patients’ subjective measures of outcome over and above the conventional objective physician determined outcome indicators (Blumenthal 1996, p. 892). The New Zealand Health Sector defines quality as “the degree to which the services for individuals or populations increase the likelihood of desired health outcomes and/or increase the participation and independence of people with a disability, and are consistent with current professional knowledge (adapted from Lohr 1990)” (Ministry of Health 2003, p. 2). Thus, quality care incorporates both technical excellence and responsiveness to the values and preferences of individual patients, measurable by the extent to which their expectation of care have been satisfied (Blumenthal 1996; Raymont 2008).

\[7\] Disposition refers to the propensity for an individual to access healthcare which is influenced by demographic, social structural characteristics and attitudinal-belief variables (Andersen & Newman 2005).
Health equity and rights to healthcare

The Ministry of Health (2003, p. 10) defines access and equity as "the extent to which people are able to receive a service on the basis of need and likely to benefit, irrespective of factors such as ethnicity, age, impairment or gender." Despite the interconnectedness of access and equity, in that the latter involves the "fairness in the distribution and its benefits among a people" (Arah et al. 2006, p. 11) and "its effects on health" (Donabedian 1990, p. 1115), Maxwell (1992, p. 174) proposes the necessity of independently assessing both concepts as "systematic, if largely unconscious, bias in most public services against minorities that goes far beyond access."

Health equity entails "the absence of systematic disparities in health (or in the determinants of health) between different social groups who have different levels of underlying social advantage/disadvantage -- that is, wealth, power, or prestige" (Braveman & Gruskin 2003, p. 254). The governance assumed under the Treaty of Waitangi surely guarantees Māori "good governance; surely fair, just and ethical governance" (Reid 2011, p. 3). Equitable Māori access to health is a fundamental human right, and interethnic health inequities breach international conventions to which the New Zealand government is a signatory.\(^8\)

The right to the "highest attainable standard of health" was embodied in the 1946 World Health Organisation Constitution (1946, p. 1); human rights were specified in the Universal Declaration of Human Rights (1948), and extended in the Universal Declaration of Human Rights (1966), the International Covenant on Economic, Social and Cultural Rights (1966) and the International Covenant on Civil and Political Rights (1966), imposed legally binding obligations on governments that are party to these agreements (E. Curtis et al. 2010, p. 320). Moreover, the New Zealand government has obligations under The International Convention on the Elimination of all Forms of Racial Discrimination (1965),\(^9\) and the United Nations Declaration on Rights of Indigenous Peoples.\(^{10}\) The principles of action for achieving health equity, defined by the World Health Organisation's

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\(^8\) "The right to health, like all human rights, imposes governmental obligations: to respect (not to interfere with the enjoyment of the right to health); to protect (to ensure that third parties do not infringe upon the enjoyment of the right to health); and, to fulfil these rights (to take positive steps toward the right to health)" (E. Curtis et al. 2010, pp. 320-321).

\(^9\) Under Article 5, governments are obligated to: ... to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of... the rights to public health [and] medical care (Office of the High Commissioner for Human Rights, pp. 220-222).

\(^{10}\) Article 24(2) states: "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realisation of this right" (United Nations 2007, p. 9).
Commission on Social Determinants of Health, include "(a) improving the conditions of daily life, (b) tackling the inequitable distribution of power, money and resources and (c) measuring and understanding the problem and assessing the impact of any actions" (E. Curtis et al. 2010, p. 319). The World Health Organisation statement that health inequities exist where "systematic differences in health are judged to be avoidable by reasonable action" (2007, p. 26) was reaffirmed in the Rio Political Declaration on Social Determinants of Health (2011).

Although redressing interethnic health inequities is primarily a human rights issue, the New Zealand Medical Association's (2011, p. 4) recognition that "economic growth should not be viewed as a sole measure of a country's success and ... the fair distribution of health, well-being and environmental and social sustainability are equally important goals" underpins the promotion of "proportional universalism in all social policies." Thus, the concept of *vertical equity* (unequal, or preferential, treatment for unequals) that acknowledges the potential of Māori to make the greater health gains (New Zealand Medical Association 2011) corresponds with the most "cost efficient use of health dollars" by maximising health gains (or minimisation of harm)" (Reti 2002, p. 305).

Notwithstanding the myth of New Zealand egalitarianism, colonial relations continue to obstruct social equity between Māori and non-Māori. More than 150 years ago, Rudolf Virchow\(^\text{11}\) observed that "the improvement of medicine would eventually prolong human life, but improvement of social conditions could achieve this result now and more rapidly and more successfully"; Virchow also stated that "physicians are the natural attorneys of the poor, and the social problems should largely be solved by them" (cit. Pincus 2004, p. 225). In America, despite gradually increasing acknowledgement and condemnation of racial inequities in care on the part of medical leadership and stakeholders in healthcare provision over the past fifteen years, "there has been very little actual progress towards eliminating racial inequities in medical care" (van Ryn et al. 2011, pp. 201-202). In New Zealand, Reti (2002, p. 305) acknowledges that while not all doctors are persuaded by "rights" guaranteed under the Treaty of Waitangi, Māori health inequities are contrary to the "fundamental principle of medical ethics, distributive justice."

\(^{11}\) Rudolf Virchow (1821-1902) was the founder of modern cellular pathology, considered to be the cornerstone of the biomedical model.
Outline of chapters

Chapter Two of this thesis presents a chronological overview of the relationship between racism, rights, rhetoric and resentment, and the determinants of inequality that mark Māori from the general population. Notwithstanding rights guaranteed under the Treaty of Waitangi, the exercise of power through complex and intertwining forms of racialised domination has enduring and cumulative implications for Māori health. Differential access to, and the volume and composition of capital(s), has occasioned interethnic disparities in life trajectories (Weininger 2005, pp. 149, 153). Moreover, the contemporary efficacy of symbolic violence, and the peculiarities of national expressions of racism, has resulted in the politics of difference transmogrifying indigenous rights into privilege, despite stark disparities in health. Chapter Three similarly provides a chronological overview of the relationship between politics, policies, power and Pākeha privilege by contextualising the relationship between the power of the New Zealand state and its institutions, since its inception in 1852. This relationship manifested in responses indicative of the interconnected discourses of the state and social policy, and of the state and "the risks to the health of society and individuals" Belgrave (2008, p. 70).

Relevant national and international literature pertaining to factors that condition primary healthcare access at the levels of the health system, the healthcare process, and the patient and/or population (Mandelblatt, Yabroff & Kerner 1999; Robson & Harris 2007; B. D. Smedley, Stith & Nelson 2002) are reviewed in Chapter Four. Chapter Five positions Māori health and social disparities within methodological and theoretical frameworks used in this research, and outlines the methods employed in the selection, analysis and interpretation of quantitative data collected from a Māori sub-sample of the Christchurch cohort of the Hauora Manawa Study.

The findings of this research are presented in three chapters. Chapter Six outlines the relationship between the spatial and/or class-specific location of the primary habitus, the nature of capital(s) accrued, and childhood access to primary healthcare in the post-World War Two period; concomitantly it considers the relationship between childhood experiences and adult dispositions (habitus) towards current access to and engagement with modernised primary care services. Moreover, this chapter emphasises variations in the overall volume and the composition of capital(s), accrued over time (Wacquant 2006, p. 7).
Chapter Seven explores a similar relationship but focuses on gender- and age-specific conditioning of habitus, and adult dispositions towards contemporary care. Chapter Eight focuses attention on the implications of social classification as Māori and/or non-Māori as a determinant of access to, and engagement with, predominantly non-Māori healthcare providers, and the impact of colonial relations on the accrual and deployment of Western cultural health capital.

The discussion in Chapter Nine positions the complex and multifaceted relationship between colonial relations and cultural health capital, Māori access to and engagement with healthcare within the context of the cumulative legacy of state power to naturalise systems of classifications that are produced, and reproduced, "by securing the misrecognition, and the recognition, of the arbitrariness upon which they are based" (Bourdieu 1977, p. 164).
CHAPTER TWO: RACISM, RIGHTS, RHETORIC AND RESENTMENT

The Treaty is all about prior ownership. The Treaty recognises that we as Māori were not simply found. Abel Tasman or Captain Cook did not find us. We were never aware that we were lost. We had no need to be found. The Treaty recognises that in exchange for settlement rights, the natural rights of the original occupants would be respected and upheld.... [N]or is the Treaty about privilege. It is no privilege to keep one's properties. That's a right. The Treaty is about 'just rights and properties'. Those are the words of the Treaty. The only privilege accorded by the Treaty was the right of European settlement. Without the Treaty, there was no such right. The Treaty is about the most basic principles of justice and law (Chief Judge E. Durie 1989).

Introduction

The creation of the state in 1854 and control of economic structures, political and legal systems produced policies and practices that privileged European settlers and their descendants. After the Second World War, nation-building and survival ¹² compelled a unification of "the material, the territorial and the symbolic order," based on the "dispossession of indigenes, the incorporation of more recent waves of immigrants and the transposition of an ethnic core of British memories, myths and institutional forms to the South Pacific;" however, achieving a sense of national identity was problematic as New Zealanders shared a geographic space but not history (Pearson 1991a, pp. 205, 211). Governor Hobson's oft-quoted phrase He iwi tahi tatou - We are all one people, ¹³ together with the ideology of harmonious "race relations" created a veneer of nationhood (Belich 1986, p. 298). The recent reframing of Māori rights as racial privileges by the New Right

¹² The modern nation is "a named community of history and culture, possessing a unified territory, economy, a mass education system and common legal rights;" nation-building and survival requires an "ethnic core....a sense of continuity, shared memories and a sense of common destiny - a collective cultural identity" (Pearson 1991a, p. 197).

¹³ Anthropologist, Joan Metge (2004, August 11) provided the following alternative translations for the phrase used at the time of the signing of the Treaty of Waitangi in 1840: "We two people together make a nation" or "We many peoples together make a nation."
has perpetuated Pakeha resentment. As American sociologist William Thomas (1863-1947) famously commented: "If men define situations as real, they are real in their consequences" (Dictionary of Sociology 2009, p. D3).

This chapter is structured in four sections. Section One presents a chronological overview of the historical foundations and contemporary social origins of racism (Davey Smith 2000, p. 1696). Sections Two through Four contextualise the policies employed by the state from the nineteenth century until the present to incorporate, manage and control Māori, and strategies deployed to defuse crises, by reorganising economic, political and civil relations that produced and reproduced the determinants of inequity between the dominant Pakeha majority and the Māori minority (Kelsey 1991, pp. 108-109).

Section One Racism(s)

The pseudoscientific concept of "race" as "the principal lens" through which Māori/European relations were viewed (Wetherell & Potter 1992, p. 124), rationalised the dispossession and dehumanisation of Māori on the basis of racial superiority (Bhopal 1998; Garner 2010; Robson 2004, p. 13; D. R. Williams 1997a). Despite the lack of definitional consensus on the meaning of "race," cultural categorisations of Māori and Pakeha as groups and individuals with specific, natural and innate characteristics (Garner 2010, p. 11) provide a "justificatory scheme for social inequality" where, for example, common sense Māori phenotypes represent a marker of "human evaluation that signals a wide variety of beliefs about inherent differences that are intimately connected with believed or imputed cultural distinctions" (Pearson 1991a, p. 195). Historical power relations resulted in the racialisation\(^\text{14}\) of access to societal resources, goods and services, including healthcare (C. Jones 2001a) and the naturalisation of "race relations" by extricating them from "the realm of historical explanation" (Pearson 1991a, p. 195).

Forms of racism

Racism "cannot be taken as a given feature of a society" (Davey Smith 2000, p. 1696), as its manifestations change in both "form and context ... over space and time" (Pearson 1991a, p. 195) according to the regional specificities of particular nation states. Racism

\(^{14}\) Despite the lack of definitional consensus, within the context of this thesis, racialisation is conceptualised as "... something detrimental that is done to others as part of a power relationship" (Garner 2010, pp. 19-20).
also operates in tandem with deficit theory, which similarly evolves with nascent variants emerging and superseding older variants once their scientific or ideological basis have been discredited (Valencia 1997; Valencia & Solorzano 1997).

Racism is experienced almost exclusively by ethnic and/or coloured minorities and constitutes a powerful determinant of health inequities (Davey Smith 2000). The Jones Model is a widely recognised framework that conceptualises the three levels of racism that produce health disparities. Jones (2000, p. 1212; 2001b, p. 300) defines institutional racism as "differential access to the goods, services, and opportunities of society by 'race'. It is structural ... codified into institutions, custom, practice and law so there need not be an identifiable perpetrator;" institutional racism commonly manifests as "inaction in the face of need," with disparities in material conditions (such as education, housing, employment and medical care) and access to power (information, resources and voice).

Personally-mediated racism refers to "differential access to societal goods, services and opportunities because of prejudicial "assumptions about the abilities, motives, and intentions of others" and discriminatory "actions toward others according to their race" (Jones 2000, p.1212-13). Personally mediated racism (both intentional and unintentional) encompasses "acts of commission as well as acts of omission" that manifest as "lack of respect, suspicion, devaluation, scapegoating, and dehumanization;" the impacts on health include "the stresses of everyday racism and differential treatment within the health care system" (C. Jones 2001b, p. 300). Internalized racism is defined as "acceptance by members of the stigmatised races of negative messages about their own abilities and intrinsic worth" that manifest in the "embracing of 'whiteness,' self-devaluation, and resignation, helplessness, and hopelessness" and engaging in health-damaging behaviours (C. Jones 2001b, p. 300).

Moreover, within the context of a colour-conscious society, the relationship between "whiteness" and social and legal status, rights, privileges and power is receiving increasing recognition (Fine 1997; Robson 2004). For Fine (1997, p. 58), the institutional management of "colour" is reinforced through complex institutional processes that confer cumulative benefits. First, the production of "whiteness," like all "colours," is relational, partially resulting from institutional arrangements where "race" (or ethnicity) is not merely managed, but created and reinforced; second, the ascribed value of colour occurs within a
"symbiotic relationship where 'whiteness' becomes a 'natural' proxy for quality, merits, and advantage", and "colour" epitomises deficit or "lack;" and finally, the internalisation of racial discourses influences individual perceptions of Self and Others (Fine 1997, p. 58).

**Modern manifestations of racism**

Since the 1970s, new manifestations of modern racism (McConahay 1983), symbolic racism (Sears 1988), discourses of racism (Wetherell & Potter 1992), and aversive racism have emerged. Modern and symbolic racism(s) focus on political conservatism; in contrast, aversive racism (Gaertner & Dovidio 1986) describes "a subtle form of bias typically expressed by well-intentioned, liberal [and] well-educated individuals" (Hodson, Dovidio & Gaertner 2004, p. 120). Aversive racists are "most likely to express prejudice and discrimination under conditions of situational ambiguity, when the attitude and behavior that disadvantages blacks can be attributed to causes other than prejudice or can be justified along nonracial lines;" furthermore, because aversive racism is "less recognisable as prejudice against another group, bias may often be expressed more in terms of pro-group bias and anti-group bias" (Hodson et al. 2004, p. 120). As the practices and normal cognitive biases that inform negative feelings of aversive racists "exist 'under the surface' of consciousness and conflict," subsumed by the more "deliberative and consciously held beliefs regarding the positive value of equality and justice among racial groups," aversive racism is a "subtle, albeit in insidious, form of racism" that facilitates a non-prejudiced view of self (Hodson et al. 2004, p. 120). In healthcare contexts, Van Ryn and Fu (2003, p. 2) argue that the behaviours of providers may be influenced by societal messages with respect to individuals' "fundamental value, self-reliance, competence and deservingness," and may result in the unintentional communication of lower expectations to patients on the basis of "race," income, class and education than are conveyed to their more privileged counterparts.

*Racism* as a manifestation of the broader phenomenon of oppression is intrinsically linked to the concept of privilege (Paradies 2006b). *Racial discrimination* reflects:

the behavioural or institutional expression of racist ideology ... a social structured and sanctioned phenomenon, justified by ideology and expressed in interactions, among and between individuals and institutions, intended to
maintain privileges for members of dominant groups at the cost of deprivation for others (Krieger 2000, p. 41).

Although *racial discrimination* is operationalised in various types and forms by different agencies in different domains, the role of the state is fundamental in redressing the "the totality of ways in which societies foster discrimination" (Krieger 2001, p. 41). Manifestations of *racial discrimination* encompass *institutional* (or organizational) *discrimination* embedded in policies or practices of state or non-state institutional structures as well as *interpersonal* (or individual) *discriminatory* interactions between individuals that are usually directly perceived, regardless of whether individuals are acting in institutional roles or as public or private individuals. *Interpersonal discrimination* may cause internalised oppression, as members of stigmatised groups may accept their subordinate status and related unfair treatment as "deserved," and thus non-discriminatory (Fanon 1967; Krieger 2000, p. 57). In all instances, "the perpetrators of discrimination act unfairly towards members of socially defined subordinate groups to reinforce relations of dominance and subordination, thereby bolstering privileges conferred to them as members of a dominant group" (Krieger 2001, p. 41).

**Section Two Amalgamation and assimilation**

At the time of the signing of the Treaty of Waitangi in 1840, neither the state nor the nation existed (Pearson 1991b), but *racism* - the core component of the British national and Victorian cultural baggage had already been imported at the time of contact between Māori and British imperialists. Māori had migrated to Aotearoa from eastern Polynesia in a series of epic canoe voyages between 700 and 1200 years ago (R. Walker 1990). In 1642, the Dutch explorer, Abel Tasman, recorded the first contact with Māori during an unhappy encounter with tribes at the northern tip of the South Island. The arrival of James Cook in 1769 "triggered the first wave of imperialism and the subsequent arrival of sealers, traders, and whalers" (Anderson et al. 2006, p. 1777). Pre-contact Māori society is recorded as having "functioning social, political, cultural and economic systems .... that supported population growth, not just survival;" the adequacy of these systems is indicated by the estimated average life expectancy of approximately 28-30 years for both Māori and their European counterparts (Reid & Cram 2004, p. 36).
The fatal impact of contact

Māori contact with Europeans epitomises the deleterious impact of introduced diseases and disruption that Western imperialism and colonisation wrought on indigenous peoples. A "combination of musket warfare, disease and starvation" (Durie 1996, p. 1) contributed to the reduction of the population from an estimated 200,000 (pre-European contact) to 42,1113 (1896 census) (see Table 1). Initially contact was restricted to particular coastal tribes with small, low density, dispersed populations that served to localise infections (Lange 2011). Furthermore, "New Zealand's vast girdle of ocean was a partially effective natural quarantine;" the importation of disease moderated by the four month passage from Europe and similarly, as whalers arrived after extended periods at sea, the sick had either died or recovered en route (Belich 1996, p. 174).\(^{15}\)

Contagion was also moderated by traditional social, political, cultural and economic systems, including public health practices (Reid & Cram 2004, p. 4). Eighteenth century commentators praised the standard of Māori health. In 1769, Joseph Banks (on Cook's *Endeavour* ) noted: "Such health drawn from so sound principles must make physicians almost useless" (cit. Salmond 1991, p. 279). John Savage in 1805 predicted that: "Neither the appearance or accounts of the natives indicate the prevalence of disease [yet] ... in a few years how great the change [will be] ... in no respect resembling the hardy inhabitants previous to their contact with civilised man," supporting the hypothesis of the "Fatal Impact" of European contact (Belich 1996, p. 174).\(^{16}\)

According to Belich (1996, p. 173), "fatal impact through disease is an immensely powerful fact in culture-contact history, and an equally powerful fiction." The factual aspect is that people inhabiting long-isolated regions were "virgins" to the majority of diseases that contaminated the Old World. Before Louis Pasteur pioneered the

\(^{15}\)Despite increased early nineteenth century tribal interaction, Belich (1996, pp. 175-176) estimates that the Māori population did not form a single interactive epidemiological population until the 1850s, although proximity to Sydney may have resulted in the formation of a single Australasian epidemiological population of sufficient magnitude to sustain some endemic diseases, such as influenza, by the 1830s.

\(^{16}\)During his visit to New Zealand in 1835, Darwin commented with respect to the Māori depopulation that "there appears to be some...mysterious agency generally at work. Wherever the European has trod, death seems to pursue the aboriginal.... The varieties of man seem to act upon each other; in the same way as different species of animals- the stronger always extirpating the weaker" (Lange 1999, p. 57). However, "Darwin's ideas regarding the evolution of the animal species through a process of struggle and natural selection, as presented by him in *The Origin of the Species* (1859), were specifically applied by him to humans in his next book, the *Descent of Man* (1897).... But it was Herbert Spencer who had popularised his ideas, blending Darwin's biological evolution among the animal species with a sociocultural theory of struggle for survival among the 'races'" (Ballara 1986, pp. 173-174).
bacteriological revolution in the mid-nineteenth century, ignorance underpinned European speculation that they were biologically superior because of relative immunity to pox and pestilence. The mythical aspect is the transmogrification of this phenomenon into what was seen as the "irrevocable laws of the Nature of Providence .... Fatal impact thinking became a force in itself, exaggerating the inevitability" of the extinction of the indigenous population (Belich 1996, p. 173).

The civilising and christianising mission

Fatal Impact theory was influential on missionaries' reports of the disease-induced reduction of the Māori population (Belich 1996). The mission doctor Samuel Ford, for example, considered the death toll of 19 of 800 people afflicted with influenza and tuberculosis "very great" and proof of imminent Māori extinction (cit. Belich 1996, pp. 174-175). Similarly, the prevalence of venereal disease, introduced during Cook's voyages (Lange 2011), was overstated. One missionary claimed that "49 out of 50 Māori women were sufferers" (cit. Belich 1996, p. 175). In contrast, observers denied that syphilis and gonorrhoea were widespread among Māori. In 1821, Dr Fairfowl claimed that venereal disease "has not spread much among them, as they strictly taboo the infected persons;" later, in 1828, the artist Augustus Earle noted that while many Māori were afflicted by introduced diseases, they seldom died (Belich 1996, p. 175). Significantly, by the late 1830s there were indications that Māori were becoming immune to some diseases (Belich 1996).

To the missionaries, Māori illness represented the "inevitable consequence of immorality or sin" (Durie 1994, p. 33) (Durie 1994, p. 33). The significant numbers of Māori converts in the 1830s, after the Musket Wars (1820-1835) ended, were urged to demonstrate greater commitment to their new found faith to placate "the superior power and anger of the European God" who was punishing them "for their wickedness in clinging to their own beliefs" (Ballara 1986, p. 83). While conversion to Christianity resulted in the acceptance by some Māori that epidemics symbolised a visitation from God (Durie 1994, p. 33) (Durie 1994, p. 33), traditional beliefs were retained, in part because of the correspondence between Christian teachings and belief in spiritual forces (Lange 1999, p.

17 Missionaries faith in the common origins of man, all of whom descended from Adam and Eve, was not equated with the equality of human races but rather the monogenist belief that differences in the appearance of human types reflected "the 'Fall from Grace' and subsequent 'degeneration' as sufficient explications for dehumanized status of some races" (A. Smedley 1993, p. 243).
45). Notwithstanding the divergence of opinion vis-à-vis the origins of man, both monogenists and polygenists agreed on the inferiority of dark "races" and the superiority of "white races" (A. Smedley 1993). The missionary influence is considered to have been comparatively benign, as fundamental to their civilising mission was the anticipated social and political incorporation of Māori into the nascent colonial society (Lange 1999, p. 61).

Māori contact with Western culture transformed the traditional social, political and economic arrangements, thus establishing the pre-conditions for infectious disease. By the 1820s, tribes in close proximity to Europeans determined to avail themselves of the trading, educational and employment opportunities, and began to disregard the centuries of traditional knowledge and practices that had evolved (Durie 1994, pp. 35-36). As chiefly authority waned, the customary practice of tapu\(^{18}\) was ignored, and with it long established prohibitions and observances that had previously protected standards of health (Lange 1999, p. 20). Vulnerability to disease was enhanced by relocating from hilltop kainga to coastal areas where new pa were constructed without public health amenities, such as potable water, sanitation and effective drainage (Durie 1994, pp. 35-36). Susceptibility to disease was exacerbated not only by damp, poorly ventilated, overcrowded living conditions, but also excessive consumption of tobacco and alcohol, the latter symptomatic of cultural maladjustment (Lange 1999, p. 26).\(^{19}\) Dr. Turbott noted that changing preferences and sources of food caused the "essentially sound" traditional diet to become superseded by one excessively high in carbohydrates (Lange 1999, p. 20). By the late 1800s, potatoes and flour constituted the basic source of nutrition for many impoverished Māori communities (Durie 1994, pp. 34-36).

**From contact to contract**

In 1840, seventy years after Cook's voyages, Māori entered into a contract with the British Crown. Māori, as the majority population who were heavily armed, highly skilled musketeers and actively engaged in a dynamic emerging national and international economy, did not sign the Treaty of Waitangi from a position of weakness or a need for protection (Belich 1996; Reid & Cram 2004). On the contrary, the numerical superiority of Māori, their relatively dense habitation of coastal areas coupled with challenging

\(^{18}\) Tapu is a "state of sacredness which protects and nurtures tribal resources" (Tapsell, Thomson & Hughes 2008, p. 69).

\(^{19}\) Notwithstanding reports by Gluckman (1974), the Māori response to the introduction of alcohol was diverse in consumption and aversion (Mancall, Robertson & Huriwai 2000).
geographic terrain, made military subjugation by the British both impractical and inexpedient.\textsuperscript{20} Nor did The Treaty of Waitangi represent a unique development in Colonial Office policy arising from prevailing humanitarian ideals of limiting the fatal impact of erstwhile colonial enterprises (Orange 1987; Sorrenson 1991).\textsuperscript{21} Mounting pressure was exerted by powerful private interests, capitalist imperialists with influential connections in the Colonial Office, who perceived New Zealand to be ideally suited to colonisation (Belich 1996).\textsuperscript{22} Established racist ideologies justified the exploitation of non-European countries, particularly in those with temperate climates, to further the economic development of Britain (Miles 1982 cit. Wetherell & Potter 1992, p. 22).\textsuperscript{23}

Nonetheless, the Treaty reflected colonial patronage and was, to some extent, motivated by concerns over Māori health and well-being (Durie 1998b; Durie 2004; McKenzie 2010). In 1832, the British Resident, James Busby, informed the Colonial Office of the "miserable conditions of the natives" that "promised to leave the country destitute of a single aboriginal inhabitant" (Kingi 2005, p. 3). Busby's dispatches continually emphasised Māori vulnerability to the "evils' of ad hoc British settlement" (Durie 1998b, p. 81). Following the 1837 influenza epidemic, the missionary surgeon, Samuel Ford, was persuaded of the imminent Māori extinction (Durie 1994). In the post-abolitionist milieu, humanitarian influences within the Colonial Office rendered the wanton destruction of indigenous populations, such as had occurred in the Americas, increasingly unpalatable (McKenzie 2010; Salesa 2001). Collectively, these factors contributed to the ultimate acceptance of the "fatal necessity" of formal British intervention (Belich 1996, p. 182).

\textsuperscript{20} Furthermore, Northland tribes were also somewhat au fait with British contracts, having recently added final signatures to the 1835 Declaration of Independence (Mikaere 2008; Reid 2011).

\textsuperscript{21} On the contrary, the 1837 Report of the House of Commons Committee on Aborigines prophetically stated "that it was 'inexpedient' to enter into treaties with aboriginal peoples who could too easily be disadvantaged by 'the ambiguity of language' of such treaties and 'the superior sagacity which the Europeans will exercise in framing, in interpreting, and in evading them'" (cit. Sorrenson 1991, p. 15). Thus, while the 1837 Report may have reinforced a measure of urgency in protecting Māori rights, the Treaty reflects long-established colonial policy and a typically pragmatic Colonial Office "response to yet another crisis on a far-flung imperial frontier" (Sorrenson 1991, p. 29).

\textsuperscript{22} Moreover, "the crisis in capitalism experienced in Britain from 1830 to 1850" provided an added impetus; a settler colony would provide a solution to Britain's "surplus population" and escalating "social unrest" (Miles & Spoonley 1985 cit. Wetherell & Potter 1992, p. 23).

\textsuperscript{23} For example, the prediction of Scottish surgeon, Robert Knox (1791-1862) boded ill for the indigenous inhabitants of Antipodes: "Already, in a few years, we have cleared Van Diemen's Land [Tasmania] of every human aboriginal; Australia, of course, follows, and New Zealand next; there is no denying the fact, that the Saxon...has a perfect horror for his darker brethren. Hence the folly of the war carried on by the philanthropists of Britain against nature" (Curtin, 1971 cit. Ballara 1986, p. 174).
The Māori text of the Treaty of Waitangi,\(^{24}\) signed by over 500 chiefs compared to the thirty-nine who signed the English text (Orange 1987), guaranteed the continued expression of tino rangatiratanga (chieftainship) in exchange for kawanatanga (or governance), primarily perceived in terms of the imposition of controls on settlers (Reid & Cram 2004). Accordingly, the Treaty assured Māori self-determination together with access to the benefits of the emerging nation, including Western science, technology and "knowledge power" to augment their own traditions (Simon 1992). However, Article One of the English text is accepted as authorising the cession of sovereignty,\(^{25}\) though the rationale of Māori willingly and knowingly ceding ultimate power to the British has long been contested. While the Crown equated government with "a Westminster-style Parliamentary sovereignty and English common law" (Kelsey 1991, p. 111), the transliteration of kawanatanga in the Māori text failed to convey the extent of power and authority sovereignty entailed.\(^{26}\)

In Article Two, both the Māori and English versions reflect the Colonial Office's instructions and unequivocally guaranteed Māori protection of physical and human resources, including health.\(^{27}\) Article Three conferred equal rights on Māori, indicating their "political and ideological incorporation through the granting of British citizenship" (Pearson 1991a, p. 204). Although the Colonial Secretary's instructions to Governor Hobson emphasised paternalistic concerns vis-à-vis Māori health and welfare, no reference was made to the incorporation of Māori into the colonial administrative structure, or to the

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\(^{24}\) Although the Māori text represents a department from established precedent, the three articles of the English text closely resemble earlier treaties, particularly the British-Sherbo agreement negotiated with the tribal rulers of Gambia in 1825 (Sorrenson 1991).

\(^{25}\) By 1847 the evangelical influence at the Colonial Office ended when Earl Grey and the Whig Party assumed power; the Whigs together with New Zealand settlers were "influenced by Vattel's approach to sovereignty emphasising the European-style nation state and lack of indigenous people's rights, and by Locke's view on property rights and the use of 'waste-lands' (i.e. lands that were 'wild', being uninhabited or uncultivated)" (McKenzie 2010, p. 27).

\(^{26}\) "Kawanatanga' was well chosen by the missionary translators; Sovereignty or 'rangatiratanga' is not conditional. Although 'Kawanatanga' is a coined word it was known to Māoris [sic] from the Bible. Pontius Pilate was the 'Kawana' of Jerusalem but his authority was not the supreme authority of Caesar or God" (Reid 2011, p. 3; Waitangi Tribunal 1985). Furthermore, the Orakei Report (1987) explains that "'Kawanatanga'...likely meant to the Māori, the right to make laws for peace and good order and to protect mana Māori." Notwithstanding the semantics of language, sovereignty imposed a concomitant responsibility on the Crown to provide good governance, which is "fair, just and ethical...a critical expression of [which] is equity" of access to societal resources (Reid 2011, p. 3; Waitangi Tribunal 1987).

\(^{27}\) "They must not be permitted to enter into any contracts of which they might be the ignorant and unintentional authors of injuries to themselves. You will not for example, purchase from them any Territory the retention of which by them would be essential, or highly conducive, to their own comfort, safety or subsistence. The acquisition of Land by the Crown for the future Settlement of British Subjects must be confined to such districts as the Natives can alienate without distress or serious inconvenience to themselves" (Normandy 1839).
development of any type of Māori government (Hayward 2003a). Additionally, Hobson's dismissal, in the name of expediency, of the Colonial Office stipulation that "free intelligent consent" be obtained from Māori (Colenso 1890, pp. 32-33) created very different expectations for both parties.

Even so, the colonisation of New Zealand was supposed to be different from the established Imperial norm. The combination of "a superior kind of 'native' and a better planned and organized settlement" could redeem Britain's colonial reputation as a Christian coloniser with the Treaty ensuring enlightened attempts to "govern the New Zealanders, without destroying them" (Salesa 2001, p. 16). Colonisation would, "some went so far as to say, secure the lives and property of Māori..." (Salesa 2001, p. 20).

**The New Zealand Constitution Act (1852)**

The formation of the state in 1852 under the New Zealand Constitution Act endorsed the coercive assimilation of Māori to create a semblance of cohesion (Pearson 1991a, pp. 204-205).\(^{28}\) While the Treaty per se was motivated by the dual, albeit irreconcilable, agendas of humanitarianism and colonisation,\(^{29}\) the Settler Government was not (McKenzie 2010). The inauguration of what was termed *Responsible Government* typifies the determination that "settler societies display...towards political autonomy from the imperial metropole and [their desire to] seek unimpeded action against the colonised" (Lian 1990 cit. Pearson 1991a, p. 197). State institutions aggressively pursued the redistribution of resources, particularly land, fundamental to the viability of a "white" settler colony; the separation of Māori from their economic base was executed through military subjugation and legal dispossession. In 1859, the Premier, Henry Sewell,\(^{30}\) noted that the settlers, "outnumbering the Māori[s] and stronger in a greater degree than the proportion of numbers, would not suffer their progress to be checked by an inferior race. They would, if necessary, take the land; the Māori[s] would resist and be crushed or exterminated" (Sinclair 1974 cit. Ballara

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\(^{28}\) Assimilation, instituted as official policy of state until the mid-twentieth century, was premised on a fundamental belief in Western cultural and racial superiority and the existence of a system of shared Western beliefs, values and "codes of behaviour into which All should be assimilated" (Mullard 1982, p. 121).

\(^{29}\) Orange (1987, p. 30) states that although "Normanby's instructions recognised Māori independence, (even a sovereignty or sorts); he had to negate it to allow for British colonisation while regretting its inevitability. He had to show that justices were being done to the Māori people by British intervention, even while admitting that such intervention was nevertheless unjust."

\(^{30}\) Henry Sewell (1807-1879) was a prominent nineteenth century politician who campaigned strongly for self-government. He is generally regarded as having been New Zealand's first Premier, having led the Sewell Ministry in 1856.
1986, p. 60). The alienation of Māori land and attendant destruction of economic structures, is a basic cause of contemporary Māori deprivation (Department of Social Welfare 1998).31

In 1877, legal imperialism supported the colonial imperative (Kelsey 1991). Chief Justice Prendergast declared the Treaty a "nullity" because there was "no Māori capable of ceding sovereignty."32 Prendergast's description of Māori as "savages," "barbarians" requiring "paternalistic or alternatively, repressive measures in response to their believed barbarism" is not only indicative of rabid colonial racism but reinforces the mythological basis of harmonious "race relations" (Spoonley 1993, p. 8).

Social Darwinism

From the mid-1860s, the colonial imperative received the scientific and moral endorsement of Social Darwinism, with Herbert Spencer's adaptation to humans of Darwin's theory of survival of the fittest within the plant and animal kingdoms. Dr Isaac Featherston's prediction, in 1846, that "a barbarous and coloured race must inevitably die out by mere contact with the civilized white race" (Durie 1994, p. 31), is indicative of the racial and national attitudes characteristic of the Victorian ethos (Belich 1986, pp. 298-304). In contrast, from the mid-1860s, Social Darwinism rationalised the thriving "white" settler immigrant population and decreasing Māori population as a natural outcome, determined by "unchangeable laws on which human progress depended" (cited in Lange 1999, p. 57).33

In 1882, Dr Alfred Newman, in "Express[ing] his satisfaction at the rate of Māori depopulation" (Ballara 1886, p. 83), noted that "this unavoidable process was scarcely subject for much regret...they are dying out in a quick, easy way, and are being supplanted

31 The seminal report, Daybreak - Puao-te-Ata-tu, noted that: "By the 1850s Māori tribes owned and operated most of the coastal shipping in the North Island. By 1858 there were 53 Māori vessels of more than 14 tons registered in Auckland alone. They supplied the local market with almost all its produce and maintained a considerable export trade to Australia and the Pacific. The cargoes they carried were Māori grown....This Māori enterprise was so successful that it could, ultimately, only be defeated by war, defeat and the imposition of Pakeha institutional structures. Those Land Wars are seen by Māori as a conscious attempt to exclude the Māori from the emerging Pakeha economy. 'Rebellion' was merely the pretext" (Department of Social Welfare 1998, pp. 62-63).
32 Prendergast's ruling in the Wi Parata v the Bishop of Wellington was accepted by the courts until the passage of the 1975 Treaty of Waitangi Act (Spoonley 1993, p. 8).
33 For example, in 1867, Dr Ferdinand von Hochstetter stated: "The Māoris [sic] look forward with fatal resignation to the destiny of the final extinction of their race. They themselves say, 'As clover killed the fern, and the European dog the Māori dog, as the Māori rat was killed by the Pakeha rat, so our people also will be gradually supplanted and exterminated by the Europeans" (Sorrenson 1977 cit. Wetherell & Potter 1992, p. 124).
by a superior race" (Lange 1999, p. 59); the missionary James Buller commented in 1878: "With man, the wish is father to the thought" (Lange 1999, p. 60).

The advent of Social Darwinism was timely for the colonists. The central tenet of Fatal Impact (the inevitable victory of the "race" possessing higher mental and military faculties) had been severely challenged by initial Māori triumphs over the British during the New Zealand Wars (Belich 1986, p. 298). The victory of "unplanned, disorganized Māori savagery" over superior, rational and civilized British military strategy was ultimately reinterpreted as the inevitable defeat of a "courageous and chivalrous" group of one of the finest native "races"; this version of events obscures "one of the most efficient and effective resistance efforts ever mounted by a tribal people against European expansion," where superior material resources rather than superior mental facilities ultimately triumphed (Belich 1986, pp. 298-299).

**The demise of a "Noble Race"**

In the 1880s, with substantive European sovereignty achieved, increasingly diverse attitudes towards Māori manifested in public discourse and popular culture. Expressions of rampant racism became moderated by "suppressed undertones of guilt" with the re-emergence of "the noble race" in popular culture (Lange 1999, p. 63). Governor Lord Glasgow's (1822-1878) depiction of Māori as "the noblest race the British nation has come into contact with" (cit. Lange 1999, p. 60) was expressed after Māori retained only one sixth of their original estate (much of it marginal land in remote areas); the Validation of Invalid Land Sales Act (1894) had legitimised any misappropriation of Māori land, and as Table 1 illustrates, the population had reached the precariously low nadir of 42,113 by 1896 (Durie 1998b, p. 85).

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34 Newman was challenged by members of the audience in the Wellington Philosophic Society and later he himself would express more sympathetic views regarding the plight of Māori (Lange 1999, pp. 58-59).
35 These wars were, until the 1970s referred to by historians and are still called by many others, the "Māori Wars," despite being caused by European aggression designed to acquire land and implement substantive sovereignty (Ballara 1986, p. 60).
36 For example, A. A. Grace's *Tales of a Dying Race* (1901) and C. G. Goldie's paintings *The Last of her Tribe and A noble relic of a Noble race*. 
Table 1: Māori and non-Māori population and land ownership Source: Durie (1998c, p. 62)

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Māori Populations</th>
<th>Non-Māori Population</th>
<th>Land owned by Māori: ha</th>
</tr>
</thead>
<tbody>
<tr>
<td>1800</td>
<td>150,000</td>
<td>2,000</td>
<td>26,709,342</td>
</tr>
<tr>
<td>1820</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1840</td>
<td>100,000</td>
<td>2,000</td>
<td>26,709,342</td>
</tr>
<tr>
<td>1852</td>
<td>59,700</td>
<td>55,762</td>
<td>13,770,000</td>
</tr>
<tr>
<td>1860</td>
<td>79,000</td>
<td></td>
<td>8,667,000</td>
</tr>
<tr>
<td>1874</td>
<td>49,800</td>
<td>295,184</td>
<td></td>
</tr>
<tr>
<td>1878</td>
<td>47,800</td>
<td>410,207</td>
<td></td>
</tr>
<tr>
<td>1881</td>
<td>46,750</td>
<td>487,280</td>
<td></td>
</tr>
<tr>
<td>1886</td>
<td>43,927</td>
<td>576,524</td>
<td></td>
</tr>
<tr>
<td>1891</td>
<td>44,177</td>
<td>624,474</td>
<td>4,487,000</td>
</tr>
<tr>
<td>1896</td>
<td>42,113</td>
<td>701,101</td>
<td></td>
</tr>
<tr>
<td>1901</td>
<td>43,143</td>
<td>772,719</td>
<td>2,890,000 (1911)</td>
</tr>
</tbody>
</table>

Māori were distinguished as having more desirable qualities, including higher mental acumen, compared to other "non-white races." The Hon. William Pember Reeves remarked that: "The average colonist regards a Mongolian with repulsion, a Negro with contempt, and looks on an Australian black as very near a wild beast; but he likes the Māoris" (Ballara 1986, p. 55). "Are we not then worth saving? or must we be doomed by your civilization [?]" one Māori enquired (cit. Lange 1999, p. 233). Notwithstanding the rhetoric, self-interest underpinned Pakeha ambivalence.\(^37\)

"Māori survival - a monument to Pakeha justice"

European belief that Māori were dying as a matter of course because they were an inferior "race" were challenged by concomitant advances in scientific understanding of disease

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\(^37\) For example, a newspaper editorial candidly noted: "The great body of the Europeans throughout the colony now regard the natives with indifference....They look upon them as an obstacle to the spread of settlement and...a drawback to the colony" (Auckland Star, 1882 cit. Ballara 1986, p. 75).
causation and "a pragmatic desire to ensure that history would have nothing to reproach them with" (Ballara 1986, p. 83). In 1882, the surgeon and geologist, Sir James Hector, disputed that the Māori depopulation was "attributable to any law of nature" (Lange 1999, p. 63); later, in 1900, politician Sir Robert Stout declared that the demise of Māori would bequeath "a legacy of shame to future generations" (Lange 1999, p. 63). The preservation of the "race" would, however, reflect Pakeha benevolence and provide a "perpetual monument to the justice and enlightening of the methods employed towards them" (Lange 1999, p. 59). However, a formative reason for the British colonists treating Māori "more kindly than any other native race" (Ballara 1986, p. 60), particularly when compared with the brutality exhibited by their Australian counterparts towards the Aborigines, was Māori military expertise. So called Pakeha benevolence reflected the pragmatic reality that "when they tried [to attack], they got killed" (Belich 1986, p. 304).

The publication of The Aryan Māori in 1885, positing commonality of Māori and European ancestry, provided a timely and convenient antidote to the legend of "the dying Māori" (Belich 1986, p. 298) and the need for the humanitarian provision of palliative care (Lange 1999, pp. 61-64). The flattering ascription of Māori as Semite, in contrast to other coloured people as Hamites, was partially attributable to skin colour; Māori colouration was equated with that of people inhabiting the northern coast of the Mediterranean (Sorrenson 1979 cit. Ballara 1986, pp. 53-54). Both colonists and European idealists, the latter preferring to avert Māori extinction, were resolute in their determination to establish a homogeneous society.

A "White New Zealand" would be preserved by restricting immigration (Ballara 1986, p. 54); Māori incorporation into the "one race, one culture society," was based on the fabrication that: "he was not brown at all, but merely dark white. He was a 'long lost brother' of Caucasian ancestry. Any undesirable characteristics and coloration could be attributed to races 'in his blood' of miscenegenation with an inferior, darker species, the

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38 According to Ballara (1986, p. 109): "In 1897 it had been necessary to issue an order to prevent police from shooting at aborigines until after they had been attacked by them."

39 Ballara (1986, p. 54) states that: "Whether by culture or physical means, the absorption of the Māori people by elimination of their separate characteristics was an overriding aim of...colonial society. New Zealand was to be the possession of one race with one culture...[and] avoid the evils imposed on Australia...which 'necessitated' the importation of 'coloured' labour.... [and also] avoid the situation of South Africa, where a comparatively small European population was situated in the midst of a large resident and migrant Africa majority...[T]he dilemma of the United States of America was even worse, what with its population of Negro ex-slaves, and its open door policy on immigration."
Melanesian Moriori" (Ballara 1986, p. 54). The excesses of rabid Anglo-Saxon racism were directed towards the Chinese, whose residence could be debarred, whereas the Māori population "had perforce to be retained" (Ballara 1986, p. 56).

**Population recovery**

At the turn of the century, the confident European expectation that they would "become the sole heirs of 'this splendid inheritance' by default," was invalidated when, in 1896, the rate of Māori births exceeded that of deaths (Ballara 1986, p. 86). Initially attributed to defective methods of processing census data, by 1910 the growth in the Māori population was unequivocal (Ballara 1986). Thereafter, blame for the disproportionately high rates of Māori mortality shifted to the cultural explanations of their inferior living standards and obstinate refusal to relinquish primitive and degraded communal ways and emulate the superior Pakeha economic and social practices. The rationale for acquiring the unproductive, communally-owned land of the "dying race" transformed into the "white man's burden" of ensuring Māori exposure to the superior mode of Pakeha living (Lange 1999, pp. 61-64).

Collectively, myths about the New Zealand Wars and Māori superiority among native peoples and their Aryan origins, formed the basis of legendary "race relations" and reinforced the viability of Māori civilisation through assimilation (Belich 1986, pp. 298-304). Assimilation would not, however, be on an equivalent basis. Following the introduction of the old age pension (1898), Māori, although technically eligible, were generally excluded, with Māori pensioners receiving two-thirds of the pension of Pakeha. Moreover, the policy of assimilation mandated that Māori "become absorbed, blended, amalgamated, with complete loss of Māori culture" into European society (Hunn 1960, p. 15), and their desire to eradicate difference entailed "the demise of Māori language, culture, and world-views" (Johnston 1998, pp. 90, 124).

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40 Moriori are recognised as the indigenous people of the Chatham Island group which is located 800 km south-east of mainland New Zealand. While once believed to be Melanesian, they are now considered to share the same Polynesian ancestry as Māori. Current research estimates that they migrated from the mainland around 1500. [http://www.history-nz.org/moriori.html](http://www.history-nz.org/moriori.html). However, as Ballara (1986, p. 57) notes: "The fact that no non-Polynesian people called Moriori lived in New Zealand was established early in the twentieth century by archaeologists even if their findings did not receive popular acknowledge; the myth of the Moriori was still being taught in schools and accepted as fact by many New Zealanders in the 1970s.

41 For example, in 1900, a New Plymouth magistrate stated: "The amount of 18 pounds which is a mere subsistence to an aged European is far too large a revenue for an aged Māori" (cit. Maharey 2000).
The Social Security Act (1938)

The Great Depression or *poharatanga* (1930-1939) disproportionately impacted on Māori (Rankin 1995 cit. Nikora, Hodgetts, Carlson & Rua 2011, p. 94). Despite regional variation and differences in statistical data, by 1939, according to historian Michael King, three quarters of all Māori adult males were registered as unemployed (cit. Bryder 2001, p. 78). It was more difficult for Māori to qualify for state relief, and when successful, they were paid less than their Pakeha counterparts.\(^{42}\) The introduction of universal welfarism under the Social Security Act (1938) provided conditional relief for Māori poverty, as the statutory provision of "discretionary powers" permitted the reduction of benefits perceived as "not necessary for the maintenance of the beneficiary" (McClure, 1998 cit. Robson 2004, p.39), and this discretion was punitively applied to Māori. In the 1940s, 80% of Māori were excluded from benefits received by their Pakeha counterparts, and those deemed eligible received less; "Māori beneficiaries were subjected to racist scrutiny, judgement and supervision while Pakeha beneficiaries remained free from observation" (McClure, 1998 cit. Robson 2004, p. 39). It was not until the 1950s that official Māori equivalency in age, widows' and invalids' benefits was achieved in incremental stages after Māori protest and public acknowledgement of the contribution of the Māori War Effort Organisation, and the exorbitantly high "price of citizenship,"\(^{43}\) paid in blood, by men in the 28th Māori Battalion (Robson 2004, p. 39).

Discretionary powers, however, remain an entrenched determinant of inequity. For example, in 1986, 88% percent of eligible Māori received national superannuation compared with 96% of Pakeha (McClure, 1998 cit. Robson 2004, p. 39). Barriers to Māori accessing Accident Compensation Corporation (ACC) benefits have also been identified (Te Puni Kokiri 1997); notwithstanding that ACC has reported addressing some barriers to Māori access (Te Puni Kokiri 2001), current data reflects continued under-claiming by Māori relative to expected rates (Jansen 2009), particularly in the context of greater

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\(^{42}\) The justification for reducing Māori benefits was based on their presumed communal living and ability to subsist off the land; however, as the MP Eruera Tirikatene reported in 1940, Pakeha living at Ratana pa received the full benefit, while Māori residents were paid a reduced benefit (Easton 2010).

\(^{43}\) In *The price of citizenship : Ngarimu V.C.* (1943) Sir Apirana Ngata (1874-1950) describes the Māori contribution to New Zealand’s forces in World Wars One & Two. During World War Two, the War Effort provided a temporary reprieve from state policy of "destroying the beastly communism of the tribe" (Richmond 1880), by restoring "the ancient characteristic of tribal leadership now so vitally essential to the successful prosecution of the Māori war effort" (Colonial Hemphill cit. Department of Social Welfare 1998, p. 68) ultimately stimulated a pan-tribal political resurgence during the 1970s and 1980s (Pearson 1991a, p. 206).
vulnerability to work-related injuries and fatalities (McCacken, Feyer, Langley, Broughton & Sporle 2001). Despite Māori and Pasifika communities having the lowest income levels (Hackwell & Howell 2002), research by Howell & Hackwell (2003, p. 8) identified alarming ethnic disparities in receipt of the supplementary assistance benefits, with 7.4% of children of Pakeha beneficiary households receiving the Disability Allowance, compared with only 3.2 percent of Māori and 1.9% of Pasifika children.

**Section Three Formation of the nation-state**

The coincidence of nation and state in the post-World War Two milieu ended the informal segregation of Māori and Pakeha (Pearson 1991a, pp. 204-205) that had persisted since the Wars of the 1860s (Ballara 1986). A New Zealand rather than British national identity emerged, although immigration remained predominantly British 44 (Pearson 1991a, pp. 204-206). Universal welfarism and Pakeha respect for the Māori sacrifices during the war created a greater sense of national cohesion; however, "tensions remained between a universalising trend towards nationhood and the particularisms of aboriginal status" (Pearson 1991a, p. 206).

In the post-war period there was growing Pakeha resentment over the perceived "privileges' enjoyed by the Māori people" (Ballara 1986, p. 114); accordingly, achieving social and economic equality required Māori to "renounce all claims for special benefits and privileges ..." (Ausubel 1958, p. 241). In 1947, the future Prime Minister (1949-1957), Sidney Holland, rhetorically asserted that Māori "enjoy many advantages; they enjoy special legislation; they enjoy special protection .... While these conditions obtain there cannot be equality of Māori with Pakeha" (cit. Ballara 1986, p. 114). A privilege deeply resented by many Pakeha was, and remains, the allocation of four of the 70 parliamentary seats to Māori (when population parity required 16) under the Māori Representation Act (1867). The perception that these seats afford Māori an unfair advantage vis-à-vis a Māori vote counting for more than a European vote (Ballara 1986, p. 114), is without basis. For example, although the Māori seats held the balance of power in 1940 and 1957 few

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44 Eighty five per cent of immigrants to New Zealand were British between 1947 and 1958.
concessions were gained; and Māori seats were not subject to the formula that has increased the number of general seats (Spoonley 1993, p. 75). 45

New forms of racism

The coexistence of Māori and Pakeha in the urban milieu, and the incorporation of Māori (and Pasifika peoples) into the emerging nation (Pearson 1991a, pp. 204-205) produced new and more public forms of state-supported racism (Spoonley 1994). In 1958, the visiting psychologist, David Ausubel, found the racist attitudes of Pakeha comparable in many respects to those of his fellow "white" Americans. Despite the relative legal and extra-legal equality enjoyed by Māori, racial equality was, Ausubel (1958, p. 234) argued, "as much a state of mind as it is a state of law. It largely inheres in the extra-legal attitudes and conduct of people." The ubiquitous claim of mythical racial equality was, Ausubel (1958, pp. 235-236) 46 found, contradicted by racial discrimination, as "the difference in skin colour has come to symbolise all of the social, economic and cultural differences at present separating two peoples."

Unadulterated myth underpinned "the frequently declared acceptance of the Māori as a blood brother in a homogenous Caucasian society, save for those traces of 'lower' blood inherited from the 'Moriori'" (Ballara 1986, p. 98). The reality was a colour bar in twentieth century New Zealand, "characterised by its informality" (Ballara 1986, p. 103), which manifested in multiple legal and extra-legal discriminatory practices across multiple domains including "housing, hotel accommodation, employment, credit, and ordinary social interaction" (Ausubel 1958, p. 241). For example, under The Sales and Spirits Ordinance (1847), Pakeha were afforded sole control of the distribution of alcohol

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45 However, since the introduction of mixed-member proportional system (MMP) in 1996, the number of seats rose increasing to seven in 2008 (Sparrow 2010, p. 7).

46 Ausubel (1958, pp. 236-238) identified categories of Pakeha prejudice: first, the almost unanimous, stereotypical portrayal of Māori as "lazy, shiftless, unreliable, improvident and happy-go-lucky human beings." Second, the widespread patronizing rationalizations of the natural suitability of Māori to "sport, warfare, road work, tractor driving, shearing and freezing [work]" contrasting with any employment demanding "sustained effort, initiative or intellectual ability," considered to be beyond Māori capability. The exceptions, intellectuals such as Sir Peter Buck, were rationalised by the "considerable quantity of white blood" coursing through their veins. Third, acceptance of Māori was conditional upon absolute conformity to European values and standards, reflecting the axiomatic superiority of European culture and the juxtapositioning of assimilation with reversion to stone-age culture. Fourth, Ausubel argued there was total Pakeha indifference towards Māori welfare. However, miscegenation provoked the greatest anti-Māori prejudice: "[The Pakeha] will either tell you that it is a sin against the laws of God, man, and nature or will claim that negative community attitudes and racial differences in standards of behaviour invariably preclude success in mixed marriages" (Ausubel 1958, p. 239).
(Mancall et al. 2000) until the Licensing Amendment Act (1948) repealed the prohibition of Māori alcohol consumption in public bars (Bramley, Broad, Harris, Reid & Jackson 2003, p. 5). Nevertheless, the legendary coexistence of Māori and Pakeha living "in unprecented harmony and tolerance" (Ballara 1986, p. 99) was so entrenched in the public and official psyche that in 1959 the incumbent Prime Minister, Walter Nash, employed the rhetoric that New Zealand's "race relations": "set an example to all nations and was one which had stood the test of time" (Ballara 1986, pp. 99-100).

Māori urbanisation and the "Long Boom" (1950-1966)

The rural exodus of Māori was, arguably one of the most rapid processes of urbanisation undergone by any indigenous people in the world (Shields, Bishop & Mazawi 2005). Whereas in 1936, 90% of Māori were rural, by 1976, 76% were urban based, with almost one quarter residing in Auckland (Spoonley 1993, p. 13). The destruction of traditional economic structures produced a Māori proletariat now required to service the labour needs of emerging Fordist47 industries in urban centres; Māori (and Pasifika peoples), as replacement labour for the "upwardly mobile Pakeha working class," formed an ethnically distinct, residentially-segregated section of the working class (Pearson 1991a, p. 206). Despite evidence of Māori disadvantage, the overall economic buoyancy of the "Long Boom" (1950-1966) created a "semblance of national social cohesion" (Pearson 1991a, p. 207) when Māori employment levels were higher than those of non-Māori (Te Puni Kokiri 1998, p. 14).

Integration

The policy of integration in 1960 reflects state pragmatism vis-à-vis managing the demographic revolution created by the urbanisation of Māori, changing global power relations and the increasingly heterogeneous composition of Western democracies. The policy objective remained "the elimination of the minority culture which was so disturbing to European colonials who were seeking to reproduce their mother culture, safe and familiar in a Polynesian Pacific environment" (Ballara 1986, p. 91). Hunn's (1960, p. 15) definition of integration was: "To combine (not fuse) the Māori and Pakeha elements to

47 Fordism is "based on mass production, while post-Fordism is characterised by high degree of flexibility in terms of both production and supply of labour. Technology means less reliance on semi and unskilled labour, and if low-cost labour is required, then production is located in those countries where labour is cheap and unionised" (Spoonley 1994, p. 93)
form one nation wherein Māori culture remains distinct." The cultural superiority inherent in the policy of assimilation was to be replaced with the "...more liberal concept of cultural tolerance" (Mullard 1982, p. 125), conditional upon the maintenance of societal harmony (Smithies & Fiddick 1969 cit. Grillo 1998, p. 117) and the retention of asymmetric power relations (Johnston 1998, p. 110).

The Hunn Report (1960) signalled the official ascendancy of cultural deficit explanations of disparities in social indices, whereby responsibility for the cycle of deprivation was attributed to "all aspects of Māori life, personality, home circumstances, family size, economics and educational achievement" (Simon & Smith 2001, p. 307). Hunn (1960, p. 78) minimised the effect of racial discrimination: "the faint traces...are truly minimal and nothing to worry about ... [what] does exist is obviously not racial but social." Māori socioeconomic disadvantage, educational underachievement, and poor health status became inextricably linked to Māoriness; cultural difference, in particular, became a term synonymous with cultural deprivation: Māori were not only culturally different, but also culturally deprived (Johnston 1998).

In their analysis of the Hunn Report, Wetherell and Potter (1992, pp. 125-128) distinguish between the influence of earlier Victorian racial interpretations and the new "culture" variable.48 Māori were portrayed as being on an evolutionary journey, the endpoint of which marks the commencement of integration and their ultimate assimilation into Pakeha culture (Wetherell & Potter 1992, p. 126). Hunn's portrayal of the inevitability of the advanced superior "white" civilisation subordinating the retarded and primitive Māori culture is consistent with earlier racist doctrines; however, it differs in that the Pakeha mode of life is represented as modern rather than simply racially superior, which was characteristic of Victorian thinking (Wetherell & Potter 1992, p. 127). The Pakeha mode of living as the epitome of modern life, common to advanced people had to be adapted: it could no longer be ascribed exclusively to Europeans as Post-World Japanese economic progress demanded inclusion (Wetherell & Potter 1992, p. 127).

48 The polygenist influence is apparent with the description of Māori as a "virile race" (Hunn, p. 17) and the "integrating [of] the two species of New Zealanders" (p. 14); the Social Darwinist perspective manifests in the proposed single national culture, overwhelmingly comprised of Pakeha cultural values combined with tokens of "only the fittest elements" of Māori cultural relics that had "survived the onset of civilisation" (p. 14).
Economic Crisis (1973-1974)

The Oil Crisis in 1973-74 ended the international post-war economic boom of the 1950s and 1960s (Ongley 1991, p. 19), which had defused interethnic inequalities and injustices within New Zealand society. Figure 1 illustrates rising levels of unemployment, ultimately responsible for creating a "more public and significant racist discourse" (Spoonley 1994, p. 87).

Figure 1: Registered unemployed and notified vacancies, 1946-89 Source: (Ongley 1991b) - Nga Take pg 17-36

Māori and Pasifika peoples became problematised as two "races" (Miles, 1989 cit. Spoonley 1994, pp. 86-87) that were "posing a racial threat" (Spoonley 1993, p. 13). Their urban presence connected with emerging social and economic problems, law and order issues (particularly gangs and rapes), and urban malaise as well as "competition for resources such as health care" (Spoonley 1994, pp. 86-87). The introduction by the state of racist measures targeting migrants represents the typical response of most capitalist countries in times of economic crisis (Spoonley 1994, p. 87). While Pasifika peoples were
targeted and deported as "overstayers," the Māori response precipitated the evolution of "ethnic nationalism" (Spoonley 1993, p. 13).

**Multiculturalism (1974-1984)**

The ostensible adoption of multiculturalism corresponded with other state responses to immigration and the changing ethnic composition of Western societies. The resurgence of Māori politicisation sanctioned "cultural diversity as a central aspect of society" (Tait 1988, p. 76) without acknowledging the indigenous status of Māori; the concept of culture rather than "race" was pragmatically adopted as an alternative discursive strategy to maintain social control (Wetherell & Potter 1992, p. 128). While multiculturalism differed from integration in that cultural difference was to be "valued" rather than simply "tolerated" (Johnston 1998, p. 129), the policy simultaneously allowed for Māori disparities to be extricated from "a Treaty framework into an arena where Māori [became] one of a number of competing minority groups" (Reid et al. 2000, p. 45).

**The Waitangi Tribunal**

The establishment of the Waitangi Tribunal in 1975\(^{49}\) reflects state legerdemain in pacifying increasingly militant Māori protests (Poata-Smith 1997) by incorporating subordinate interests while preserving the powers of the hegemonic block (Havemann & Turner 1994, p. 168). The Treaty of Waitangi Act (1975) requires the Tribunal to give equal weight to both language versions of the Treaty in contravention of the rule of *Contra Proferentum*, which in Treaty jurisprudence recognises the primacy of the version in the indigenous language (Reid & Cram 2004, p. 10). The Tribunal's jurisdiction was limited to investigating contemporary Crown breaches of the Treaty from 10 October 1975, and making recommendations to the government regarding recompense (Hayward 2003b). However, the increasingly militant Māori political resurgence demonstrates that the state "can also be a site of resistance as well as oppression" (Pearson 1991a, pp. 197-198).

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\(^{49}\) 1975 Treaty of Waitangi Act
Section Four Biculturalism, the New Right and New Racism

The adoption of biculturalism\(^{50}\) in 1984 reflects state hegemony in maintaining the status quo through national harmony and mutual acceptance of cultural differences. While the formation of the nation-state after World War Two had undermined "the complexities of indigenous social, economic and political life," the remnants of Māori autonomy established the preconditions for the emergence of "pan-tribal social movements" (Pearson 1991a, p. 198).


In 1984, the newly elected Fourth Labour government faced two contradictory crises. The first, the crisis of capitalism, was addressed by the introduction of "liberal economics and ideology" and a move away from the Keynesian welfare state by reducing expenditure and interference in the market place (Kelsey 1991, pp. 108-109).

Second, the state responded to the "crisis of constitutional legitimacy as increasing numbers of Māori militantly reasserted their political and economic rights under the Treaty of Waitangi;" this was done by implementing "a Treaty policy which sought to defuse and pacify Māori demands without disrupting the fundamental economic and political structures of the colonial-derived state" (Kelsey 1991, pp. 108-109). The policy of biculturalism, together with extending the jurisdiction of the Waitangi Tribunal jurisdiction back to 1840, represented the Fourth Labour government's dual appeasement approach to increasing Māori political unrest (Poata-Smith 1997). State acknowledgement of the indigenous status of Māori was not accompanied by any concomitant devolution of power (Johnston 1998, p. 11).

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\(^{50}\) Biculturalism reflected state recognition of Māori ethnicity - a community possessing what Smith (1989) defines as the six attributes of believed or actual connectedness: "a common name for a population...; a set of myths of common origins and descent for that population; some common historical memories of things experienced together; a common 'historic territory' or 'homeland', or an association with one; one or more elements of common culture - language, customs or religion; and finally a sense of solidarity among most members of the community" (cit. Pearson 1991a, p. 196). Ethnic groups have "(a)... priority in time with respect to the occupation and use of a specific territory; (b) voluntarily perpetuates its cultural distinctiveness; (c) self-defines as a distinct collectivity and is recognised as such by other groups and state authorities; and (d) has an experience of subjugation, marginalisation, dispossession and exclusion or discrimination" (Kenrick & Lewis 2004 p. 5 cited in Barber 2008, p. 142).
The Treaty of Waitangi Amendment Act (1985)

While the extension of the jurisdiction back to 1840 broadened the "ambit and resources of the Waitangi Tribunal" (Spoonley 1994, p. 96), its "powers remained purely recommendatory," reflecting the lack of intent to place "key economic resources in Māori hands" (Kelsey 1991, p. 115). Moreover, the Court of Appeal's 1987 decision which involved redefining the Treaty in terms of principles, rather than the articles, reinforced the legitimacy of the state and the Crown's exercise of governance, while simultaneously circumventing "the implications of tino rangatiratanga in the Māori text by adopting the key elements of sovereignty in the English text" (Kelsey 1991, p. 111).

Thus, Māori rights with respect to health and well-being were transformed into the three principles (participation, protection and participation) by the Royal Commission on Social Policy (1987). These principles are, however, inherently problematic, in terms of definition, interpretation, scope, measurement, and enforcement (Kelsey 1991, p. 127). Partnership is derived from the original Treaty Partnership, and from a health perspective mandates the inclusion of Māori in "the design of health legislation, policies and strategies" (Kingi 2005, p. 11), but fails to clarify the crucial issue of asymmetric power relationships (Reid & Cram 2004, p. 11). Protection emphasises the Crown's duty to actively protect Māori interests and ensure an equitable standard of health and well-being (Kingi 2005, p. 11). Significantly, as Reid and Cram (2004, p. 11) assert, protection "signals Māori need and engenders paternalistic responses from agencies rather than giving a clear message about the agencies' need to protect Māori rights." Similarly, participation indicates the rights of Māori to engage with the Crown without clarifying the level or extent of engagement.

The impact of neo-liberal reforms

The Māori socioeconomic landscape was devastated by post-Fordism and the neo-liberal reforms implemented during the period 1984-1999. Three reports, He Kakano: A Handbook of Māori Health Data 1993-94, Hauora: Māori Standards of Health III: A

51 Despite the settlement of claims, as noted by the United Nations Special Rapporteur: "the overall land returned by way of redress through settlements is a small percentage of the land claims, and cash paid out is usually less than 1% of the current value of the land. Total Crown expenditure on the settlement of Treaty breach claims over the last decade (approximately NZ$ 800 million) is about 1.6% of the government budget for a single year" (United Nations 2006, p. 8).

52 Te Puni Kokiri 1993.
Study of the Years 1970 to 1991\textsuperscript{53} and Our Health Our Future 1993\textsuperscript{54} illustrated the relationship between inter-ethnic health disparities, unemployment, and socioeconomic status. The segregation of Māori into Fordist industries as semi- or unskilled labour increased Māori vulnerability to the economic restructuring and minimalisation of the welfare state (Fleras & Elliot 1996, p. 100; Poata-Smith 1997). The 1987 New Zealand Class Structure Project found 45% of Pakeha were classified as working class compared with over 72% of Māori (Loomis 1991, p. 38). Table 2 depicts the levels of post-Fordist Māori redundancies responsible for creating a Two-Nation Cleavage (Jessop 1989), differentiated by "a core-workforce, skilled and well paid, and a marginalised group of [primarily non-European] workers whose locality or industry can no longer provide jobs" other than occasional, poorly paid temporary work (Spoonley 1994, p. 93).

Table 2: Unemployment as percentage of full-time labour force

Source: (Spoonley 1994, p. 94).

<table>
<thead>
<tr>
<th></th>
<th>Unemployed as a Percentage Full-time Labour Force</th>
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<tbody>
<tr>
<td></td>
<td>1986 %</td>
</tr>
<tr>
<td>Māori</td>
<td></td>
</tr>
<tr>
<td>15-64 years</td>
<td>12.1</td>
</tr>
<tr>
<td>15-24 years</td>
<td>19.9</td>
</tr>
<tr>
<td>Non-Māori</td>
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<td>15-64 years</td>
<td>3.8</td>
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<td>15-24 years</td>
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The Nationhood Speech (2004)

By the late 1980s, the state had reasserted control of Māori nationalism, and a substantially weakened Waitangi Tribunal was diverted to the periphery of the settlement process (Kelsey 1991; Spoonley 1994). Increasingly the government position aligned more closely with the dominant New Right politics; as a result, by the late 1990s, the commonsense understanding of racism as a form of discrimination was inverted (Spoonley 1994, p. 82). Don Brash, the new leader of the opposition National Party, adopted the "new racist"

\textsuperscript{53} Pomare et al. 1995.
\textsuperscript{54} Public Health Commission 1993.
tactics employed by Far Right extremists (Barber 2008, p. 143). In contrast to Britain, France and the United States, where the majority populations are portrayed as victims of immigrant racism caused by the refusal of immigrants to adopt the host's culture, the deployment of new racist strategies against an indigenous population is "relatively unique" (Barber 2008, p. 143). Brash's Nationhood speech, in 2004, was a "watershed event in the health inequalities debate," attacking government policies targeting Māori socioeconomic disadvantage (and redressing historical breaches to the Treaty of Waitangi) as unfairly privileging Māori on the basis of "race" not need, promising that National would remove "race-based" funding (Matheson & Dew 2008, pp. 10-11).

Brash's speech ended the consensus whereby the major political parties (National and Labour) acknowledged the rights of both indigenous and non-indigenous populations and the quasi-legal status of the Treaty of Waitangi. Political analysis had identified "race relations" as the issue most likely to influence voters' party allegiances by "building on the groundswell of resentment towards Māori 'privilege'" (Barber 2008, pp. 142-144) that followed the Labour-Alliance Coalition's Closing the Gaps (2000) policy. The immediate post-speech response was a 17 point increase in opinion polls for National, with strong support from males and the working class (Matheson & Dew 2008, p. 11). As Johansson (2004, p. 122) argues, Brash talks "almost absurdly, given the disparity between Māori and Pakeha outcomes on any number of social indicators." Nevertheless, public opposition was "legitimated as opposition to racism," by reframing racism as privileging the minority over a majority (Barber 2008, p. 151). The discourse of "race" had provided the legitimating ideology. Biculturalism implicitly recognises the association between a colonial legacy, contemporary Māori disadvantage, and the justification of political demands for ameliorative action. However, as Barber (2008, p. 143) notes, by portraying indigenous rights as "race based rather than 'ethnicity or culture' based, the rhetoric of 'race' elides arguments about cultural heritage and cultural identity, and allows those policies that take such factors into consideration to be attacked as 'racist'."

The public's positive response to the Brash speech is indicative of multiple societal factors: first, there is general ignorance of colonial and Treaty history (Reid 2011); second, geographic isolation from the extremes of twentieth century racial violence means that the population is:
somewhat naïve as to the true invidiousness of racial rhetoric...[The] Race Relations Act [1971] ...outlaws...discrimination [and] in the egalitarian culture of New Zealand society, with its self-belief that all are equal and that everyone should get a 'fair go', this narrow perception of racism means any government's actions perceived as favouring one group are suspect (Barber 2008, p. 143).

Third, the recurring motif of Pakeha self-interest (Dow 1995, p. 31) underpins measured public acceptance of symbolic recognition of Māori ethnicity and Treaty rights, but deeply entrenched public resistance to any resource-specific allocations to Māori (Sibley & Liu 2004, p. 88), such as Treaty claim settlements made during the 1990s under the Fourth National government (Humpage 2006). Finally, as Johansson (2004, p. 125) states: "The fact that Brash's evidence for 'privilege' was frequently anecdotal and remarkably thin when compared to every social indicator reveals how emotion, when stimulated, can swamp reason, especially when saliency about race issues is high." More recently, The Dominion Post, in contrast to the Weekend New Zealand Herald, refused to print an ACT 55 Party advertisement designed by John Ansell with the slogan Fed up with pandering to Māori radicals? Clarke's (2011) blog reports that prior to his resignation, Ansell commented:

These guys [Māori] have gone from the stone age to the space age in 150 years and [they] haven't said thanks. That's the nature of the thing. In the Māori world, if one tribe conquers another you eat the guys eyeballs. The Brits were pretty civilised by that standard.

Ansell's reference to "white cowards" allowing the "Māorification of the country" provoked widespread criticism from the Race Relations Commissioner and the leaders of all other political parties (B. Clarke 2011). Māori ethnicity still remains vulnerable to the vagaries of contemporary politics. In 2008, within months of being elected, the centre-right conservative National Government announced funding cuts to a range of social welfare programmes; at the same time, however, ethnicity remains a "worthy" marker of "marginality" with the potential to be "presented as redistribution injustices that can mar the 'efficiency' and 'effectiveness' of neoliberal capitalist structures" (Simon-Kumar 2001, p. 84).

55 Association of Consumers and Taxpayers.
Chapter Summary

This chapter has reviewed the relationship between colonial and neo-colonial practices, together with attendant racism(s), in the production and reproduction of the basic causes of the determinants of inequity. Chapter Three contextualises the relationship between politics, power, policy, and privileged access to healthcare. In the final analysis politics is, as Virchow long ago stated, "public health in the most profound sense" (Taylor & Rieger 1985 cit. Navarro & Shi 2001, p. 490).
CHAPTER THREE: POLITICS, POWER AND PAKEHA PRIVILEGE

In any period, health policy is subject to wider policy objectives. Historically these policy objectives [in New Zealand] have included encouraging self-reliance; strengthening the [European] 'race'; providing security for families; and participation for citizens or rights for consumers. The realisation of any of these objectives has been constrained by economic challenges, the objectives themselves reflect the social and economic conditions of the period (insertion added Belgrave 2008, p. 69).

Introduction

Health policy cannot be separated from its political and social context, and according to Belgrave (2008, p. 70) responds to "two interconnected but distinct discourses;" the first involves the relationship between the state and social policy, and the second, the relationship between "the risks to the health of society and individuals." However, the state is "not a neutral agency benignly reflecting pluralistic social democratic interests ....[but] rather it is a set of institutions that both reflects and manages the balance of power in its role as a system of domination" (Pearson 1991a, pp. 197-198). Since its inception in 1852, colonial and neo-colonial state control of the health system has produced policies and practices that, despite attempts to improve Māori health, have disproportionately privileged the health outcomes of Pakeha.

This chapter is chronologically structured in three sections. The first outlines nineteenth century policy responses (and attendant racist rationalisations) vis-à-vis the impact of colonisation on Māori health that evolved from colonial patronage and humanitarianism. While in the late nineteenth century Māori were seen as a "dying race,"56 when by the turn of the century Māori births overtook rates of death (Ballara 1986, p. 86), their survival was seen to pose a health risk to Pakeha because of the indiscriminate nature of infectious

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56 "The Māori population continued its downward spiral in the wake of the Treaty of Waitangi in 1840, reaching a low of about 42,000 in 1896. Population decline and racist ideologies combined to fuel forewarnings about Māori extinction. In 1856 physician and politician Dr Isaac Featherston said it was the duty of Europeans to 'smooth down ... [the] dying pillow' of the Māori race" (Ballara 1986, p. 86).
disease was both recognised and feared (Belgrave 2008, p. 72; Durie 1994). Section Two outlines evolving twentieth century policies: the public health concerns and the bureaucratisation of health in 1900; the introduction of universal healthcare in 1937; and, as advances in medical and scientific innovations made state-subsidised provisions increasingly unaffordable, the implementation of neo-liberal policies that culminated in greater "marketisation [and] managerialism than in any other state funded system in the world" (Easton 2002). The final section describes twenty-first century policy responses to the deleterious effect of neo-libertarianism on a national health system now ranked poorly by the World Health Organisation (Gauld 2003, p. 211). Moreover, this chapter charts the emergence of counterintuitive Pakeha fears that Māori have received preferential treatment vis-à-vis rights.

Section One - Nineteenth Century Māori Health Policy

In 1840, the Colonial Office objective of governing the "New Zealanders, without destroying them" (Salesa 2001, p. 16), represented a significant departure from the conventional norm. Limited ad hoc medical services were provided to a receptive, albeit somewhat skeptical, Māori population by a minimal number of colonial surgeons (Dow 1999, pp. 28, 35). Although Māori were aware that the diagnostic powers of Western medicine did not correspond to efficacy of treatment (Salesa 2001, p. 22), the ineffectiveness of traditional cures to combat introduced diseases provided an added impetus to engage with European healthcare.\(^57\) From 1846, Western medical provisions were augmented by a system of state subsidised doctors and Native Medical Officers.\(^58\) As the "scientific intellectuals" of the time, early colonial doctors performed multiple roles as "colonial agents, mediators and healers" (Salesa 2001, p. 15). The lack of success in treating disease or stabilising the size of the Māori population motivated some doctors to become physicians of a new Māori "body politic," diagnosing "problems with Māori 'life', essentially as other kinds of pathogens" (Salesa 2001, p. 23). Doctors' professional endorsement of contemporaneous "race-science" served as scientific validation of this "tool of empire," legitimising colonial policy and depersonalising settler culpability (Lange

\(^{57}\) Initially, missionaries, private individuals and philanthropist doctors also played an important, albeit unofficial, role in rendering care to Māori (Dow 1999, p. 18; Lange 1999, p. 83).

\(^{58}\) In 1885 there were 15 subsidised doctors and dispensers; 13 in 1890; 26 in 1896 (Lange 1999, pp. 71-72). Dow (1999, pp. 46, 71-72) argues that as approximately 20% of doctors in 1866 were officially appointed to care for Māori, this confirms the existence of a state subsidized medical scheme; however, he concedes that despite significant increases in the number of doctors from the 1860s, they failed to keep pace with Pakeha population growth.
1999, p. 59). Other doctors focused on establishing a hospital system in response to the Colonial Office directive that hospitals were a rare government institution that was both "useful to colonists and beneficent to Māori" (Salesa 2001, p. 18).

In 1848, Governor Grey notified the Colonial Office of his endeavour "to introduce a tolerably efficient system of medical attendance into those portions of this colony which are most densely inhabited by natives" (cit. Dow 1999, p. 38), the provision of which Grey believed was a "matter of paramount importance to the native race" (1852 cited in Dow 1999, p. 35). By 1850, the four existing hospitals (Salesa 2001, p. 17) provided surgical, clinical and outpatient treatment for Māori able and willing to seek treatment (Dow 1999, pp. 27-35), consistent with Dr FitsGerald's belief that hospitals were "... a powerful engine for gaining an influence over the Native Mind," and that "... Doctors devoted to their Profession were some of the best civilizers of Savage Races" (Salesa 2001, pp. 17, 18).

Constitution Act (1852) and "Responsible" Settler Government

The New Zealand state was created in 1852 by The Constitution Act. For Māori, the institution of Responsible Government by settlers in 1854 was an oxymoron. The sudden influx of large numbers of European migrants undermined the political, social, and economic circumstances of Māori (Durie 2004, p. 5). "Race-science" and the laissez-faire philosophy of minimal state-subsidised provisions rationalised colonial inaction in the face of the predicted extinction of Māori (Belich 1986; Durie 1998c; Lange 1999) (see Table 1). At the same time, the Native Department (1861-1893), responsible for Māori health (Luxton 2008, p. 6), was antithetical to realising its primary objective of alienating Māori land (Dow 1999, p. 15). By default the Education Department made the greatest contribution to Māori health (Lange 1999, p. 75), with native school teachers (poorly paid,

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59 The underlying motives for such provision by the Colonial Office remain a subject of debate. Despite the lack of incentive to construct hospitals for the small settler population in the emerging colony, the treatment of indigent poor in charitable hospitals had, by the 1840s, became an established norm in metropolitan Britain (Dow 1999, p. 23). Belgrave (1985, p.212) challenges the proposal that similar provisions in New Zealand represented technological "tools of empire" designed to amalgamate Māori without the need for military subjugation, countering that "the lack of segregation between Pakeha and Europeans was an indication of the degradation associated with admission rather than enlightened attitudes towards race" (cited in Dow 1999, p. 27).

60 An advocate of Māori Health, Fitzgerald was Head of Wellington Hospital in the 1850s.

61 Notwithstanding that The Civil List fund of £7,000 per annum for "native purposes" financed the NMOS, this funding was a source of Pakeha contention, parsimony and misappropriation, provisions were unevenly distributed, ever-changing, and paltry given escalating rates of Māori illness (Lange 1999, pp. 72, 83).

62 This policy has been extensively documented by Butterworth 1989 and Walker 1990.
commonly uncertificated and without medical training) dispensing pharmaceuticals amongst pupils and communities (Dow 1999; Lange 1999, pp. 75-82).\(^{63}\) Significantly, it was the Inspector of Native Schools, John Pope (1880-1903) who authored the widely circulated *Health for the Māori* (1884), which expounded the virtues of Pakeha medicine and the evils of traditional health practices (Lange 1999, pp. 76-79).

**Māori Hospital Access from the 1860s**

From the 1860s, the accessibility, availability, affordability, and acceptability of hospital care for Māori reduced (Consedine 2007)\(^ {64}\) as the expanding hospital system responded to the needs of a rapidly expanding Pakeha population (Dow 1999, pp. 57-71). The Land Wars (1863-1872) and Māori resistance to the alienation of their lands hardened racial prejudice (Belich 1986); by 1864, Māori willingness to subject themselves to Western medical care had declined (Dow 1995, p. 32). Although technically entitled to charitable admission on an equivalent basis to Pakeha (Lange 1999, pp. 233-234), (under the Hospital and Charitable Institutions Act 1885), the refusal of local hospital boards to admit Māori was rationalised by Māori inability and/or refusal to pay (Dow 1999, pp. 60-61).\(^ {65}\) Moreover, less than half of the thirty-eight institutions were located in close proximity to Māori districts.\(^ {66}\) Increasingly, Māori perceived hospitals as Pakeha institutions; resistance to Western medical care was aggravated by doctor-patient dissonance arising from communication barriers, cross-cultural misunderstandings, Eurocentrism, and professional ignorance of Māori concepts, such as tapu.\(^ {67}\) Anxiety over the affordability of treatment

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\(^{63}\) This responsibility continued into the 1930s (Lange 1999, pp. 178-179).

\(^{64}\) Hospitals were managed by provincial governments (1852 to 1876) and central government (1877-1885) (Dow 1999, p. 60).

\(^{65}\) The Boards' attitude was underpinned by the resentment over the exemption of Māori land from rates which contributed to provincial hospital levies (Lange 1999, p. 36).

\(^{66}\) No hospitals existed in Waikato until 1889; North Auckland, 1908; King Country 1909, Urewera until the mid-twentieth century (Lange 1999, pp. 36, 53); half the hospitals established from 1861-1990 serviced the goldfields (Dow 1999, p. 66).

\(^{67}\) Buck and Gluckman identified issues such as the careless disposal of bandages containing body material and doctors adopting a Eurocentric approach, refusing to explore Māori cultural beliefs (Lange 1999, pp. 36-38). In the 1960s Dr Gluckman wrote a thesis aimed at helping "the intending Dr [to] understand... [the] effects of European culture contact and specific diseases upon Māori." Gluckman maintained that "the history of Māori medicine in New Zealand is of interest not only for its facts but more importantly for the moral lessons and implications" (Bryder & Dow 2001, p. 4). Gluckman employed statistics from the 1960 New Zealand Official Yearbook as evidence that Māori health issues had yet to be resolved (Bryder & Dow 2001, p. 4).
often resulted in refusal to be hospitalised and recourse to the tohunga;\textsuperscript{68} belated access reinforced perceptions that hospitals were places where people went to die (Lange 1999, pp. 36-42), which ironically accorded with contemporaneous European prejudices and fears of hospitalisation (Lange 1999, p. 44).\textsuperscript{69}

**Diseases of poverty, colonisation and racism**

Diseases of poverty - or of colonisation and racism - aggravated rates of Māori mortality (Robson 2008, p. 30).\textsuperscript{70} Concurrent coping strategies included excessive alcohol and tobacco consumption and the abandonment of the traditional health practice of isolating the sick (Durie 1998c; Marrone 2007). However, racist responses to ameliorating infectious disease in the two populations exacerbated Māori rates of mortality and morbidity. Pulmonary tuberculosis (TB) - *The Great White Plague* (Pomare cited in Lange 1999, p. 30) would remain a major and persistent cause of death.\textsuperscript{71} Despite the availability of a mid-twentieth century preventative cure (Dow 1999, p. 86), Māori mortality rates in the 1930s and 1940s were 10 times that of Pakeha (Dow 1995, p. 134); sporadic eradication campaigns (the last in 1964) meant that TB remained uncontrolled among Māori until 1975 (Durie 1998c, p. 61).\textsuperscript{72}

Similarly, smallpox, despite the availability of an efficacious mid-nineteenth century treatment,\textsuperscript{73} disproportionately affected Māori. While Dow (1999, pp. 48-56) argues that smallpox eradication in the nineteenth century (the only "purely preventative" government Māori health initiative (Lange 1999, p. 83)) counteracts allegations of official negligence

\textsuperscript{68} "Priests were known as tohunga. Māori scholar Te Rangi Hiroa (Peter Buck) suggested that the term derives from tohu, meaning to guide or direct. Ngāpuhi elder Māori Marsden suggested tohunga comes from an alternative meaning of tohu (sign or manifestation), so tohunga means chosen or appointed one. The term tohunga is also used for an expert in a particular field" http://www.teara.govt.nz/en/nga-karakia-a-te-Māori-traditional-Māori-religion/2.

\textsuperscript{69} Nineteenth-century British hospitals were charitable institutions, providing treatment to indigent poor; medical treatment for their affluent benefactors was received in their homes (Dow 1999). Florence Nightingale, pioneer of the concurrent nursing revolution had determined that proximity to a military hospital during the Crimean War was the key determinant of regimental mortality, with death commonly resulting from post-care infections rather than wounds sustained on the battlefield (Maxwell 1984, p. 1470).

\textsuperscript{70} Kuntz (1994) attributes the severity and extent of the indigenous population collapse in New Zealand and Hawaii to the dispossession of their lands, as landlessness not only causes poverty but increases susceptibility to associated diseases including overcrowding and malnutrition (Reid & Cram 2004, p. 8).

\textsuperscript{71} Contagion had been unwittingly fostered by missionaries who, determined to subvert traditional beliefs, encouraged spitting, an anathema to pre-Christian Māori (Durie 1998c, p. 33).

\textsuperscript{72} In 2005, rates of TB among Māori are 12 times higher than those of non-Māori Pakeha (Oh 2005, p. 2).

\textsuperscript{73} In 1796, the successful use of cowpox vaccine by Jenner in the protection humans against smallpox was announced (Dow 1999, p. 50).
in controlling communicable diseases, \(^{74}\) Māori were, in spite of their greater willingness than Pakeha to be vaccinated, excluded from the compulsory vaccination clauses in the 1872 Public Health Act (Lange 1999, p. 74). While Pakeha immunization rates improved in the 1877-1880 period (Dow 1999, p. 84), the vaccination of Māori for smallpox was reinstated by Dr Maui Pomare in 1900. Similarly, typhoid fever - the "filth" disease - also remained largely unchecked amongst Māori because of official apathy, parsimony, victim-blaming, and government refusal to implement sanitary improvements in impoverished Māori communities (Dow 1999, pp. 87, 140-143). The incidence of typhoid finally began to decline after the biannual vaccination of Māori school children in the late 1920s (Dow 1999, p. 192); nevertheless, in 1937, Māori mortality rates remained almost 40 times higher than those of non-Māori (Lange 2011).

**Pakeha self-interest and Māori resolve**

By the beginning of the twentieth century, the government, motivated by the desire to protect the Pakeha population, endorsed a measured partnership with Māori to provide vital health initiatives. Deliberation on the expediency of alleviating appalling rates of infectious disease among Māori became increasingly oppositional: "dying pillowers' such as Dr Alfred Newman and Archdeacon Walsh ... regarded the demise of the Māori race as inevitable,"\(^{75}\) whereas the Young Māori Party\(^{76}\) and reformers such as John Pope deemed the situation grave but not irreversible (Dow 1999, p. 84). Notwithstanding the small but notable group of Pakeha health reformers, the prevailing attitude attributed the Māori health crisis to their disinclination "to heed within the realms of civilization;" the government, similarly opposed to direct action, exhorted Māori to improve (Lange 1999, p. 69). However, the Young Māori Party's determination to reverse the status of Māori health fortuitously aligned with Pakeha self-interest. The fear that bubonic plague was harboured by Māori communities and would threaten the viability of European society, provided the impetus to improve Māori health (Belgrave 2008, p. 72; Dow 1999; Lange 1999, p. 232).

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74 Smallpox vaccination was terminated by the Native Department in 1865 to reduce expenditure, and the payment of Māori Health Officers was not authorized until the 1871 Vaccination Act (Dow 1999, pp. 53-54).
75 "Dying Pillowers" subscribed to the belief that the duty of Europeans was to "smooth down ... [the dying pillow] of the Māori race, the statement made in 1856 physician and politician Dr Isaac Featherston, quoted by Peter Buck (Te Rangi Hīroa), "The passing of the Māori." Transactions and Proceedings of the Royal Society of New Zealand 55 (1924), p.362.
76 The Young Māori Party was established in 1909, by former students of Te Aute College to improve the position of Māori; members strove to gain public acceptance, ultimately gaining both Pakeha favour and practical support for their objectives (Lange 1999, p. 266).
Section Two - Twentieth Century Health Policy

Public Health Act (1900) "Te Pire Kiore - The Rat Bill"

Public fear "that the people be plagued" (Dow 1995, p. 42) was the catalyst for establishing the Department of Health under the Public Health Act (1900) (Belgrave 2008; Dow 1999) with the infrastructure and authority to mount an effective public health campaign (Lange 1999, p. 137). Simultaneously, the state responded to persistent Māori agitation for self-government (Lange 1999, p. 140) and accusations of "genocidal policies" (Durie 1994, p. 42) with two distinct approaches: first, by officially endorsing the establishment of Māori Councils (also under the 1900 Public Health Act) and second, by appointing Maui Pomare (c. 1875-1930), "by reason of his nationality," (Dow 1995, p. 57) as the first Māori Medical Officer (Durie 1994, p. 43). In 1905, Peter Buck, Te Rangi Hiroa, (c. 1877-1951) also joined the Department. The remarkable accomplishments of these two Māori doctors was, in part, achieved by utilising tribal leadership in Māori communities (Durie 1998c, pp. 44-45), following the passage of the Māori Councils Act in 1900.

Māori Councils Act (1900)

The Māori Councils Act represented a temporary counter-hegemonic response to demands for greater autonomy, albeit within a legitimate constitutional arrangement; the nineteen elected Māori Councils appointed inspectors to enforce sanitary regulations in community housing and water supplies (Durie 1994, p. 42). The separate administration of Māori health was, however effective, transitory (Te Puni Kokiri undated, p. 31). Public opinion was critical and derisive of differential treatment of Māori, stereotyping native administration as "futile, farcical and a travesty," positing "sanitation and Māori" as polar and irreconcilable opposites (Lange 1999, p. 230). In 1906, the Native Department

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77 Pomare was Minister of Public Health 1923-1926 (Lange 1999, pp. 185, 256-257).
78 After leaving the Department in 1909, Buck became an MP (1909-14), fought in WWI, and in 1919 became Native Health Officer, filling the position vacated by Pomare in 1911 and attending to victims of the 1918 influenza epidemic; thereafter Buck pursued an anthropological career (Lange 1999, pp. 185, 256-257).
79 On the basis of etiological and epidemiological understanding, McKeown (1976) considers that sanitary reforms alone would not have reduced mortality rates by more than 25% as the majority of significant diseases declined before nineteenth-century advances were made in medical knowledge. "The decline in crude death rates was largely explained by the benevolent 'invisible hand' of rising living standards and increased per capita food consumption, rather than by the advances of 'scientific medicine'. The role of sanitation reform was given second place" (cit. G. W. Rice 1991, p. 85).
80 The Native Department (1861–1893), was reconstituted as the Department of Native Affairs (1906–1989) (Luxton 2008, p. 6).
relinquished responsibility for Māori health to the Department of Health (Te Punu Kokiri undated, p. 31). Three years later, the Māori Councils, in spite of noteworthy accomplishments (including a 70% Māori vaccination uptake) were disbanded (Durie 1998c, p. 43); in response to the lack of government responsiveness to urgent Māori health needs both Pomare and Buck resigned (MacLean 1964). The reduction of Departmental expenditure on programmes undertaken by Pomare and Buck reflect Pakeha ignorance of the value of traditional leadership structures and community collaboration in realising public health objectives (Lange 1999, p. 188).

The imposition on Māori of a monocultural health system is characteristic of institutional racism. A Pakeha workforce of Native Medical Officers and district nurses was recruited to treat typhoid (almost completely eradicated among Pakeha) (Dow 1995, p. 82) and other acute illnesses in Māori communities (Durie 1998c, pp. 42-45). Cognizant of the importance to health of cultural understanding, Buck, Pomare and several Pakeha doctors had promoted the training of Māori nurses (Lange 1999, p. 167). However, the nascent Māori nursing scheme was undermined by hospital resistance to providing training facilities. Furthermore, Hospital Boards, "most unsympathetic to Māori health matters" (Buck cit. Lange 1999, p. 183), assumed greater control of Māori health. Neither Carroll nor Ngata could requisition government support to redress the appalling rates of Māori mortality and morbidity (Lange 1999, p. 194).

**Tohunga Suppression Act (1907)**

The passage of the Tohunga Suppression Act in 1907 was also inimical to ameliorating Māori health: "By outlawing traditional healers, the Act also opposed Māori

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81 By 1909, according to Pomare, the Councils had achieved in a few years what he envisaged would take a quarter of a century (Dow 1999, p. 127).
82 "Between 30-40 were paid a 'subsidised salary' with the right to charge a fee for services rendered as well as for medicines," unsurprisingly, issues arose regarding the level of funding, unpaid fees, the effectiveness of these men in attending to the health and sickness needs of Māori, and Māori acceptance of adherence to Western medical advice (Ngata 2002, p. 299).
83 The incumbent Matron of Thames Hospital exemplified Pakeha refusal to participate in the scheme: "Let them get a Hosp. of their own" (Stewart, 1906 cit. Dow 1999, p. 130). The participation of the few graduate Māori nurses was officially discouraged because of Pakeha reservations about their objectivity when dealing with demands of their own iwi (Durie 1994, pp. 44-45). Following the death of Nurse Hei from typhoid, the scheme was, despite Māori attempts to retain it, largely abandoned. A total of approximately 63 Māori graduated (Dow 1995, pp. 81-84).
84 Sir James Carroll (1857-1926) was a prominent politician of Māori-Irish descent. Sir Aparana Ngata (1874-1950) was also a prominent politician and lawyer of Māori-European descent.
85 In 1908 the passage of the Quackery Prevention Act was designed "to counter allegations of racial discrimination" (Dow 1999, p. 129).
methodologies and the legitimacy of Māori knowledge in respect of healing, the environment, the arts, and the links between the spiritual and the secular" (Durie 1997, p. 34). Despite Pomare's expressed concerns about the efficacy of new tohunga therapies, the practice of dipping TB sufferers in cold water, for example, was not dissimilar to concurrent Western treatment (Durie 1997, p. 34). The survival of tohungaism was symptomatic of the absence of treatment alternatives for a predominantly rural population peripheral to both the concern and catchment areas of Western medical attention (Lange 1999, pp. 35, 49-50). Moreover, the failure of the state to offset the prohibition of tohungaism with alternative medical provisions contributed to the death of approximately four percent of Māori during the 1918 influenza epidemic (Lange 1999, p. 240).

**Public Health Act (1920), "The Flu Act"**

Public fear precipitated by the 1918 influenza epidemic provided the impetus for the restructuring of the Department of Health in 1920. Of the estimated 8,600 fatalities, the Māori mortality rate of 42.3 per 1,000, was greater than seven times higher than that of Europeans (G. Rice 1983) is estimated to be amongst the highest in the world (Dow 1999, p. 145). Paketa self-interest was instrumental in the appointment of Buck as the Director of the newly established Division of Māori Hygiene; however, funding constraints and Eurocentric presumptions of the superiority of Paketa nurses thwarted Buck's efforts to deliver Māori-centered health initiatives through the largely defunct Māori Councils (Durie 1998c, p. 44). Equally disillusioned by state inertia vis-à-vis urgent Māori health needs, both Pomare and Buck entered politics (Dow 1999, p. 124). Departmental restructuring in

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66 While the political intent of the Act has recently been reevaluated by Dow (2001 cit. Bryder & Dow 2001, p. 6), the preponderance of academic opinion consider its purpose was to pre-empt threats to European sovereignty posed by prophets such as Te Whiti and Rua Kenana (Webster 1979 cit. Durie 2004, p. 6). The latter, although supportive of Western technologies and amenities, attracted a sizable following amongst fellow malcontents by challenging Māori subservience to the Crown (Durie 1997, pp. 34-35). Rua Kenana's prophesied departure of all Europeans from New Zealand resulted in his arrest, under a clause "which made it an offence to foretell Māori futures" (Durie 1997, pp. 34-35). In 1916, Kenana was imprisoned for a year, for moral resistance against the police (Durie 1997, pp. 34-35).

67 In 1926, 90% of Māori lived in rural areas, many of which were sparsely populated by Paketa. For example, in 1900 there were no doctors in Rotorua, Wanganui or Napier (Lange 1999, p. 35). The subsequent repeal of the Act in 1962 (under the Māori Welfare Act) signaled belated acknowledgement of the complementary value of traditional healing practices (Lange 1999, p. 262).

68 Figures vary - Rice reports the ratio of ten in contrast to Dow's seven; Māori were not included among the 111 witnesses at the Royal Commission (Dow 1999, p. 145). Hirini (1999, p. 3) states that Māori influenza sufferers were denied treatment: Rice (1988) reports that: "some hospitals imposed a strict colour bar by refusing to admit Māori. Indeed, some towns illegally prevented Māori from entering. In Whangarei, the mayor declared a health cordon whereby Māori could not enter the built-up area. This ban was later revoked for Māori who were able to produce a certificate signed by a doctor" (Keene 1989).
1930 resulted in the abolition of the Māori Hygiene Division and mainstreaming of all health programmes (Durie 2004).

**Segregated infant and maternity care**

Twentieth century initiatives to reduce national rates of infant and maternal mortality instituted racially segregated provisions (Bryder & Dow 2001, p. 7). In 1907, The Royal New Zealand Plunket Society, founded by the outspoken eugenicist, Dr Truby King, was committed to selective breeding and the moral responsibility of "white" women to ensure the viability of the European "race" (Ali 2004, p. 2). Plunket (with 46 nurses in 1920, increasing to 138 by 1940) attended to Pakeha, whereas the Department of Health district (later Public Health) nurses (with 19 nurses in 1918 and 50 by 1940) catered for Māori (Bryder 2001, pp. 69-70). Measures implemented to ensure the "efficiency and future of the Anglo-Saxon race" ⁸⁹ proved extraordinarily successful: in 1910 Pakeha infant mortality reduced from 89 to 62 per 1,000 live births, and with the increased medicalisation of Pakeha childbirth from the 1920s (McBride-Henry & Clendon 2010, p. 7), infant mortality consistently remained below 50 (Bryder 2001, p. 66). In contrast, Pool estimates that Māori infant mortality in the 1906-10 period was 225 per 1,000 live births, reducing to 150-160 by 1926, and 135 in the 1941-45 period (Lange 1999, p. 261).

Māori infant mortality was attributed to multiple factors, including parental ignorance and incompetence (Dow 1999). Pomare and Buck identified ignorance of diet and hygiene; Buck argued that bottle feeding had "slain more than the guns of Hongi" ⁹⁰ (cit Lange 1999, p. 34). Although little is recorded about formula feeding of Māori infants during the 1920s, the practice of giving infants formula was widely accepted amongst Pakeha; despite challenges by some medical practitioners, by the 1940s, the medical professional considered King's "humanised milk" formula was of equivalent nutritional value to breast milk (McBride-Henry & Clendon 2010, p. 7). In 1934, the Governor General, Lord Bledisloe, attributed the nation's low infant mortality rate - "approximately one-half of that in England, and Wales and the United States of America" - to Plunket and its founder (Bryder 2001, p. 67). This achievement was, however, conditional upon the exclusion of Māori mortality, justified by the inaccurate and substandard nature of data (Bryder 2001, p.

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⁸⁹ The 1917 slogan was "Save the Babies' Week"; subsequent child-focused initiatives included the establishment of Health Camps (1919) and the School Medical Service (1921) (Bryder 2001, p. 66).

⁹⁰ The Ngapuhi chief blamed for initiating the Musket Wars which lasted for approximately 15 years following his importation of 300 muskets in 1821.
Notwithstanding subsequent improvements, by 1958 the infant mortality rate was still three times higher for Māori than for Pakeha (54 per 1,000 compared to 19 per 1,000) (Dow 1999, pp. 196-197; Durie 1998c, p. 128). In 1968–9, belated medical attention was directed towards Māori infant mortality rates (almost three times higher than those of Pakeha) as New Zealand’s position on the international scale of infant mortality was deteriorating (New Zealand Medical Journal Editorial cit. Dow 1995, p. 197).

The Commission of Inquiry into Maternity Services (1936-38) found maternity risk amongst Māori women was double that of "white" women, with a high incidence of sepsis (Harte 2001, pp. 88-89). In 1936, Duncan Cook, the Medical Health Officer of Whangarei (with a large Māori population) posited that the underlying cause was a personal rather than a material defect, a "non-awareness of the insanitary and unhygienic conditions so well apparent to the average Pakeha" (cit. Bryder 2001, p. 83). While such sentiments undoubtedly contributed towards discouraging Māori hospital deliveries, the percentage of hospital births increased (17% in 1937 and 50% in 1947), albeit at a slower rate than that of Pakeha (35% in 1920; 68% in 1930 and 87% in 1938) (Harte 2001, p. 89).

Māori health initiatives

Desperation and inaccessibility of health services impelled leaders such as Te Puea Herangi (1883-1952) to establish Māori initiatives. According to Lange (1999, p. 225), Te Puea was "the first leader with the vision, drive and status necessary to challenge the anti-Pakeha attitude that was preventing advances on health front." Her medical clinic at Turangawaewae treated victims of the 1913 smallpox outbreak and influenza epidemic in the lower Waikato; public health campaigns were approached from dual traditional and Western medicine perspectives (Te Puni Kokiri undated, p. 32). Despite working closely with doctors (Durie 1998c, p. 45), Te Puea's aspiration of establishing a marae hospital (M. King 1977, p. 127), as with other similar Māori demands (Lange 1999, p. 42), was stonewalled by monocultural intolerance of any separate system of healthcare (Durie 1998c, p. 45). Forthcoming universalism would, however, afford little immediate relief (Dow 1995, p. 121); for example, in 1936, Dr Harold Turbot reported that more than 25% of Māori illnesses received no medical treatment (Lange 1999, p. 41).

91 Māori deaths were not registered prior to the 1921 Births and Deaths Registration Act; by 1903 only 60% were certified by a doctor or coroner (Maclean 1964 cit. Bryder 2001).
Social Security Act (1938)

In the post-depression era, the enactment of the 1938 Social Security Act by the First Labour Government (1935-1949) was intended to create the world's first national health service (Hay 1989) and end class-based inequalities (Durie 2004). The Eurocentric policy objective was "the idealised social environment of a nuclear family as the means of achieving public good. New health services, with a focus on personal healthcare rather than public health were heavily subsidised and aimed at producing a society of ideal families" (Belgrave 2008, p. 71). The increasing urbanisation of Māori resulted in traditional practices of communal responsibility that protected whānau health and welfare being superseded by the *cult of domesticity*; Māori mothers became isolated in individual households, bearing sole responsibility for child-rearing and domestic chores under the scrutiny of Pakeha, many of whom considered Māori child-rearing practices over-indulgent and inconsistent with concurrent disciplinary norms (Ritchie 2007). Conformity demanded adapting to Pakeha mothercraft, including infant feeding regimes, consistent with the Plunket Society's standardised scientific approach to child and infant care (McBride-Henry & Clendon 2010).

Concomitant advances in medical technology and scientific knowledge enhanced the status of both the medical profession and the hospital; Pakeha self-interest underpinned the "social democratic consensus" (1935-1966) for a tax-funded system to improve life expectancy and reduce the impact of disease (Armstrong 1994, p. 118). However, private sector resistance, particularly from GPs, thwarted the establishment of a universally accessible and state funded national health service (Lovell-Smith 1966 cit. Easton 2002, p. 1). While hospital specialists were receptive to receiving a salary, GPs resolutely opposed the proposed capitation funding, determined to maintain their "entrepreneurial and professional independence" (Belgrave 2008, p. 74). The ensuing compromise, reached in 1941, institutionalised GP monopoly of primary care (Ellison-Loschmann & Pearce 2006) based on periodic consultations, curative not preventative medicine, individual demand and ability to pay (Gauld 2008, p. 96). Although the General Medical Services (GMS) Benefit

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92 According to Belgrave (2008, p. 73): "The doctors, led by the dogged president of the British Medical Association (NZ Branch), J.P.S. Jamieson, were also committed to a form of social security, but preferred a two-tiered system whereby they could charge the wealthy directly. The compromise was a single-tiered and therefore universal system, but one where the private market for primary health care was retained. As a result, plans for population-based system of primary health care were shelved. Expenditure followed the individual patient choice of practitioner and was not directed to those most in need."
covered almost the full cost of the consultation scheme, GPs' prerogative to charge a fee-for-service patient co-payment (Gauld 2008, p. 95) created a "micro-economic market" that afforded state-subsidised care to the more affluent (Belgrave 2008, p. 73).

Post-World War Two Māori Health Standards

In the Post-World War Two period, improving but persistent interethnic health disparities that compelled government action are illustrated in Table 3 (Durie 1998c, pp. 127-128). Moreover, gains in Māori life expectancy and control of infectious diseases that accompanied urbanisation were offset by major interethnic disparities in most disease categories, including degenerative disorders (Durie 1998c, p. 128) resulting from lifestyle changes and psychosocial stress.

Table 3: Māori health status 1950-1959. Source: (Durie 1998a, p. 128)

<table>
<thead>
<tr>
<th></th>
<th>Māori</th>
<th>European</th>
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<tbody>
<tr>
<td>Life Expectancy (1951)</td>
<td>55 years (female)</td>
<td>65 years (female)</td>
</tr>
<tr>
<td></td>
<td>54 years (male)</td>
<td>68 years (male)</td>
</tr>
<tr>
<td>Birth Rate (per 1000) (1956)</td>
<td>45</td>
<td>25</td>
</tr>
<tr>
<td>Infant Mortality (per 1000) (1958)</td>
<td>54</td>
<td>19</td>
</tr>
<tr>
<td>Death rate (per 1000) (1959)</td>
<td>6.61 (under 20)</td>
<td>1.92 (under 20)</td>
</tr>
<tr>
<td></td>
<td>13.09 (over 20)</td>
<td>13.28 (over 20)</td>
</tr>
</tbody>
</table>

Notwithstanding the implementation of Māori-targeted government programmes in the social policy arena (Durie 1998c, p. 99), the two-tiered health system the First Labour Government had endeavoured to circumvent had materialised (Gauld 2009, p. 21). Delayed Māori access to healthcare and the resultant severity of conditions treated were attributed to disproportionately adverse Māori socio-economic circumstance (Davis 1986). Within the urban milieu, despite increased, albeit restricted, access to societal resources, Māori households were disproportionately overcrowded (Statistics New Zealand 2012b). Table 4
illustrates interethnic differences in standards of housing, and potentially a relationship between Māori exposure to diseases, such as otitis media, the lack of medical treatment, and educational disadvantage because of hearing loss (Durie 1998c, pp. 132-133).  

Table 4: Percentage of Homes with Household Amenities (Source: 1956 Census)

<table>
<thead>
<tr>
<th></th>
<th>Percentage of Homes</th>
</tr>
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<tbody>
<tr>
<td>Bath or Shower:</td>
<td>Māori 58</td>
</tr>
<tr>
<td></td>
<td>Non-Māori 92</td>
</tr>
<tr>
<td>Piped Water:</td>
<td>Māori 50</td>
</tr>
<tr>
<td></td>
<td>Non-Māori 87</td>
</tr>
<tr>
<td>Hot-water Service:</td>
<td>Māori 48</td>
</tr>
<tr>
<td></td>
<td>Non-Māori 89</td>
</tr>
<tr>
<td>Flush Toilet</td>
<td>Māori 31</td>
</tr>
<tr>
<td></td>
<td>Non-Māori 80</td>
</tr>
<tr>
<td>Refrigerator</td>
<td>Māori 20</td>
</tr>
<tr>
<td></td>
<td>Non-Māori 56</td>
</tr>
<tr>
<td>Washing Machine</td>
<td>Māori 19</td>
</tr>
<tr>
<td></td>
<td>Non-Māori 58</td>
</tr>
</tbody>
</table>

Social Democratic Consensus in crisis (1966-1984)

At the same time, the economic foundation of the social democratic consensus had diminished. "Britain's entry into the Common Market...the oil shocks, 'stagflation' (declining employment and increasing inflation) and the development of a global market place, subjected New Zealand to a 'double instability', both internal and external" (Armstrong 1994, p. 121). The policy objective of the "ideal family" was superseded by that of the "participating citizen" (Belgrave 2008, p. 76). However, the privileging of the

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93 The seminal report, Whakarongo Mai (1965) first highlighted the severity of Māori hearing impairment. Hearing loss was subsequently identified as one of the ten Health Goals by the Public Health Commission in 1993 (Durie 1998c).
egocentric rights of individuals over exocentric rights of collectives enabled interethnic
group advantage/disadvantage to be redefined as individual difference, with causation
attributed to deficit aspects of Māori "genes, behaviour, circumstances and engagement
with the system" (Reid et al. 2000, p. 44).

Concomitant advances in scientific and medical technologies undermined the fundamental
premise of universalism vis-à-vis the delivery of "a finite quantity" of healthcare (Easton
2002, p. 1). Increasing demand for free hospital services exerted pressure on delivery
capacity. The expanding private hospital sector produced a two-tiered system of access to
non-urgent surgery as people with private medical insurance were treated by state-funded
hospital specialists working in private practice while public hospital waiting lists
lengthened. 94 Private medical insurance, little used since 1938, developed rapidly
(Belgrave 2008, p. 76) and afforded affluent members of society privileged and timely
access to healthcare. 95 The lack of integration between primary and secondary services, the
increasing cost of both primary and specialist care and the difficulty of accessing new
treatments, collectively reinforced the public perception that the health system was
dysfunctional and deteriorating (Gauld 2009, p. 21).

Third Labour Government (1972-1975)

The Third Labour government's White Paper - A Health Service for New Zealand (1975)
acknowledged the need to place greater emphasis on preventative medicine and ensure
primary care access accorded with need rather than ability to pay (Gauld 2009, p. 30).
However, government attempts to negotiate increased GMS subsidies, conditional upon
pre-determined patient charges, once again provoked strong and successful opposition
from the medical profession (Gauld 2009, pp. 52-53). Labour's increasing unpopularity and
subsequent loss of the 1975 election was partially attributed to a concerted anti-
government campaign launched by the medical profession (Bassett 1976 cit. Gauld 2003, p.
203).

94 There were 30,000 people on waiting lists in 1973; 50,804 in March 1987 and 60,448 in June 1989 (Gauld
2009, p. 58).
95 In 1969 there were 25,000 members, increasing to one third of the population in 1985 (Lang 1987, p. 158)
subsequently decreasing between 1990-1998 (Barnett & Lauer 2003, p. 310). However, insurance uptake in a
predominantly publically funded system contributes little to the total health expenditure (only 6% in 1996
when approximately half of the population held some private health coverage (T. Ashton 1999, p. 270).
Third National Government (1975-1984) - the rise of the Libertarian Right

Between 1975 and 1984, National advanced healthcare reforms in collaboration with key stakeholders, including the New Zealand Medical Association. Two Area Health Boards, conceptually identical to those recommended in Labour's 1975 *White Paper*, were piloted in Wellington and Northland regions; the success of these trials resulted in the Area Health Boards Act (1983) which mandated the transition of the twenty-seven existing hospital boards to Area Health Boards (Gauld 2003, p. 203). Interethnic health disparities focused government attention on Māori health development (Gauld 2009, pp. 72-73). Moreover, a study by Smith and Pearce (1984), reinforced by *Hauora: Māori Health Standards 1955-1975* (Pomare 1980), posited that improving interethnic health inequalities was conditional upon the integral involvement of Māori in both service planning and implementation. Concurrent Māori aspirations for greater autonomy coalesced with, and were subsequently manipulated by, proponents of market liberalism, neo-conservatism and rapidly diminishing bipartisan support for Keynesian welfarism (Durie 1998c, p. 148).


The victory of the Labour party in the snap election of 1984 signalled the "transformation of New Zealand politics and public policy" (Gauld 2009, p. 37). The "blitzkrieg approach" (Easton 1994) adopted by the Labour government precipitated the most rapid and comprehensive implementation of radical theory-driven New Right reforms of any country in the world (Lauder, Hughes & Watson 1999, p. 36). Legislative changes initiated general management in hospitals with funding contracts between the government and the fourteen restructured Area Health Boards, including "output-and outcome-orientated accountability mechanisms and a series of population-based health goals" (Gauld 2003, p. 203). In the context of re-emerging neoclassical economics, the impact of exogenous factors, such as structural inequality and racism, the need for state intervention to redress the independent relationship between Māori ethnicity and poverty, and psychosocial stressors that produce lifestyle diseases, were dismissed; the reformers emphasised

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96 Fourteen geographically based, centrally funded Regional Health Authorities providing integrated services for the needs of their populations (Gauld 2003, p. 203).
97 The "elite and close-knit group of technocratic politicians and advisers" (Gauld 2009, p. 39), who captured policy making, according to Gauld (2003, p. 203), "fundamentally reshaped the public sector in accordance with the demands of managerialism, public choice and agency theories." See (Gauld 2009, p. 41) for description of managerialism, public choice and agency theories.
individual culpability, proposing that universal health provisions supported perverse tax payer funded incentives for poor lifestyle choices (Belgrave 2008, p. 78; Hodgetts, Bolan & Stephens 2005).

In 1984, under the guise of biculturalism and formal recognition of the Crown's Treaty obligations, the government launched The Decade of Māori Development (Durie 1998c, p. 100). Māori aspirations of integrating a bicultural perspective of health and realising autonomy through iwi service delivery produced Māori-friendly but not Māori-centered policies (Kiro 2000), subsumed under the general policy approach (Durie 1998c, p. 150). "For the government, devolution was perceived as synonymous with delegation and decentralization, and central authorities talked about tinkering with the existing system by way of Māori add-ons; for the tangata whenua the discourse was about power sharing, parallel development and separate institutions" (Fleras 1991, p. 186). Moreover, biculturalism facilitated "institutional appropriation of Māori knowledge and skills" without concomitant participation or partnership (Durie 1998c, p. 118). Nonetheless, iwi redirected their attempted negotiations with the Department of Health to partnership-building with their respective Area Health Boards (Durie 1998c, p. 149). Inevitably conflicts emerged as Area Health Boards had difficulties acknowledging Treaty obligations and vested interests in retaining Māori services under board control; nevertheless, despite minimal resource allocation and the exclusion of Māori from service planning, some "by Māori for Māori" delivery services materialised (Durie 1998c, p. 149).

In 1989, fourteen newly established Area Health Boards assumed responsibility for operational and public health, with the Department of Health monitoring and evaluating their performance against national requirements (Gauld 2009, pp. 33-35). The atmosphere of uncertainty in the health sector was exacerbated by the divergent agendas of three successive Ministers of Health from 1987–1990 (Gauld 2009, p. 52); under the third, Helen Clark, the 1989 New Zealand Health Charter established targets and goals for Area Health Boards to meet their accountability agreements. However, regional variation in the Area Health Board performance (availability of beds and waiting lists) negatively impacted

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99 In 1987, Puao-te-Atu-tu, a report by the Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare in New Zealand focused attention on institutional racism, highlighting how monocultural policies severely disadvantaged minorities and reinforced that "equitable access was a myth" (Durie 1998c, p. 112).
on Māori. Nationally, reductions in the availability of public hospital beds and durations decreased the Māori average length of stay from 14.3 to 7.1 days (Pomare & de Boer, 1988 cit. Durie 1998c, p. 128). The realisation of the Charter’s targets (such as surgery to correct the disproportionate levels of hearing loss in Māori children under five) and reducing waiting lists was discouraged by the perverse incentives of specialists working in both the public system and the more lucrative private sector (Gauld 2009, p. 71).

Moreover, safety issues resulted from the clash of clinical and commercial cultures (Hornblow 1997); The Health and Disability Commissioner attributed the deaths of eight patients in Christchurch Hospital to "system changes and inadequacies" (Stent 1998). At the same time, the government commissioned two independent reviews: Choice for Health Care and Unshackling the Hospitals. The latter, commonly known as The Gibbs Report, which exerted a profound influence on the forthcoming reforms (Gauld 2009, p. 58), proposed the creation of quasi-markets in health to remediate the "performance failures of a state sector that was non-responsive to … Māori" (Belgrave 2008, p. 78).

**Fourth National Government (1990-1996) - the commercialisation of health**

Following Labour’s defeat, the newly elected centre-right Fourth National Government (1990-1999), contrary to election promises of continuing incremental change, embarked on the most radical restructuring of the health sector in half a century (Easton 2002; Hornblow 1997). The 1991 Green and White Paper - Your Health and Public Health, in marked contrast to the fully tax-funded system proposed in the 1974 White Paper (Easton 2002, p. 1), advocated the privatisation of both the funding and delivery of the public health system. The Green and White Paper signalled the transformation of "both the organisation of health care and the underlying ideology which governed health policy … as the basis for refocusing health services from a public service to a commercial ethos" (Hornblow & Barnett 2000, p. 133). By international standards, the health sector performance during the 1980s contradicted the need for fundamental reform, the health budget was contained,

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102 While per capita expenditure varied little among the four largest boards (5%), Area Health Boards with disproportionately large Māori populations (Northland and Bay of Plenty) spent only 80% of national average per capita (Gauld 2009, pp. 67-68).

103 In 1990 New Zealand ranked 10th in 24 OECD countries decreasing to 16th in 1999 (Gauld 2009, p. 66).
partly as hospital throughput had been increased with substantial reductions in duration of hospital stays and the number of public hospital beds available\textsuperscript{104} (Gauld 2009, pp. 65-69).

Consistent with the commercialist ideology (Easton 2002, p. 3), the Ministerial Taskforce's recommendations \textsuperscript{105} included a purchase-provider split and the establishment of a competitive, quasi-market approach to the provision of health services. During the two-year consultation process, the alleged problem of "professional capture" was circumvented by minimising health sector involvement (Easton 2002, p. 3), resulting in the changes being devoid of "health sector consultation or public mandate" (Hornblow & Barnett 2000, p. 133). A new hospital sector infrastructure was mandated under the 1993 New Zealand Health and Disability Act. Four Regional Health Authorities were established, each responsible for the planning and purchase of appropriate health services, on a commercial basis, for the needs of their populations.\textsuperscript{106} The locally elected health boards were replaced by non-elected government appointees (primarily from the business sector) and boards were accountable to the Minister of Health (Easton 2002, p. 3). The Department of Health (1900-1993) was replaced by a new Ministry of Health. The Ministry funded Regional Health Authorities on a population-based formula (with capped budgets to ensure macroeconomic efficiency), assuming responsibility for monitoring the performance of purchase agreements with both Crown-owned and private providers in a competitive health market (Gauld 2003, pp. 204-205).\textsuperscript{107}

The planned introduction of competition between public and private purchasers to provide consumers with choice of care, through Regional Health Authorities or other (non-government) healthcare plans, quietly disappeared from the agenda (Hornblow & Barnett 2000, p. 133). In 1993, four Regional Health Authorities established PHARMAC\textsuperscript{108} to improve management and reduce government expenditure on pharmaceuticals (Gauld 2003, p. 206). The fourteen Area Health Boards\textsuperscript{109} were reconfigured into twenty-three Crown

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\textsuperscript{104} In the 1987-89 period there were a total of 344 hospitals, 171 public (24,488 beds) 173 private (6,157 beds) (Quin 2009, p. 7), from 1987-89 number of hospital beds decreased 5.4% (Gauld 2009, p. 66).

\textsuperscript{105} The Taskforce was chaired by Rod Carr, a prominent banker and member of the Business Roundtable with no health sector experience; the recommendations were announced on Budget night July 1991.

\textsuperscript{106} The Regional Health Authorities were Northern, Midland, Central and Southern.

\textsuperscript{107} Unlike their predecessors, Regional Health Authorities were technically neutral and no longer afforded public providers privileged access to public monies over similar independent or private providers, which stimulated growth in the private hospital sector (Durie 1998c, p. 145).

\textsuperscript{108} PHARMAC was established under The Health & Disability Services Act 1993.

\textsuperscript{109} Sir Ron Trotter oversaw the reconfiguration. Some Community trusts, primarily those serving local communities, remained as private and independent providers able to contract to Regional Health Authorities.
Health Enterprises. Structured as "for-profit organisations," operating on commercial principles and subject to commercial legislation by boards of government appointees (again primarily from the business sector); these organisations would minimise the vested interests of providers and ensure rational decision-making. Public health services were separated: an independent Crown agent, the Public Health Commission,\(^{110}\) assumed responsibility for contracting with Crown Health Enterprises and other providers (Gauld 2009, pp. 82-84). A Core Services Committee was charged with rationing personal health services provided by the Regional Health Authorities (Gauld 2009, pp. 94-97). However, determining which core services should be offered proved complex and contentious and never materialised; instead the Core Services Committee was "transformed into the National Health Committee, with a different task" (Hornblow & Barnett 2000, p. 133).

For Māori, despite disappointment with the very diluted Treaty clause ultimately inserted in The Health and Disability Act 1993, the government's strategic objective for improving Māori health (Durie 1998c) formed a basis for the development of Māori health initiatives throughout the 1990s.\(^{111}\) Several "by Māori, for Māori" health initiatives were "nurtured" by Regional Health Authorities, with Māori assuming an increasingly central role in the planning and delivery of Māori-centered services (Gauld 2003, p. 206). However, constant changes to policy and personnel created an unstable environment and high infrastructure costs for Māori providers (Durie 1998c). Additionally, Māori representation was problematic; political appointees commonly reflected party loyalty and community standing, often without Māori mandate, whereas iwi representation tended to reflect popular local support and community standing, with appointees potentially inexperienced in Māori health issues (Cunningham & Durie 2005).

During the 1990s, the state signalled the move to capitated funding (based not on visits but on per capita (per head) of population) by the formation of GPs into Independent Practitioner Associations (IPAs) (Quin 2009).\(^{112}\) Following a government funded pilot scheme, Independent Practitioner Associations expanded in "numbers, size, scope, and confidence," developing multiple cost-saving and efficiency driven population-based and

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\(^{110}\) In 1995 the Public Health Commission was decommissioned.

\(^{111}\) For example, in 1993 the National Body of Traditional Māori Healers was established and the Ministry of Health published standards for traditional healing (Archibald 2006, p. 31).

\(^{112}\) In 1996 approximately 30 IPAs existed, the largest PROCARE Health in Auckland had 340 GP members (Quin 2009).
primary care initiatives (Gauld 2008, p. 96). By 2000, when Independent Practitioner Associations had become well-established, (Gauld 2008, p. 96), various small non-profit organisations (NGOs) simultaneously emerged, including trade union supported Community Health Centres (established prior to 1990s) and Māori healthcare organisations. Services were free or co-payments minimal, and funding was on a capitation basis, with GPs receiving a salary (Gauld 2008, p. 97).

By mid-1996, with an election imminent, the dismal failure of the reforms was apparent, and government officials admitted that "the pace of performance improvement since the reforms seems to have weakened" Hornblow & Barnett 2000, p. 134. Increased rates of avoidable hospitalisation during the 1980-97 period (Barnett & Lauer 2003; Dharmalingam, Pool, Baxedine & Sceats 2004) highlighted widening social and ethnic polarisation, and waiting lists for non-urgent surgery increased by 50% (Hornblow & Barnett 2000, p. 133). The introduction of user charges for hospital services in February 1992, designed to reduce health expenditure by encouraging positive health behaviours and timely primary care utilisation, was withdrawn in 1993 due to "public outrage" (Hornblow & Barnett 2000, p. 133). Growing public anxiety coalesced into health professionals, trade unions and community organisations uniting in unprecedented resistance to the reform process (Barnett & Barnett 2004; Easton 1994).

Mixed-member Proportional System

The first-past-the-post electoral system produced one-party governments until the 1996 introduction of a mixed-member proportional system (MMP) produced coalition governments with increased minority party power (Gauld 2008, p. 94). In reality, however, this change:

...has had a marginal impact on political behaviour: coalitions have functioned like their one-party predecessor, the adversarial tradition persists, cabinet remains dominant, and politicians continue to engage in swift change (Gauld 2003, p. 202).

112 By the late 1990s over 70% of GPs had enrolled into the more than 70 IPAs nationwide (Gauld 2008, p. 96).
115 The scheme proved costly not only in terms of public support, as establishing "billing systems cost Area Health Boards $8.012 million" (Gauld 2009, p. 93).
The unicameral system is still dominated by the two major political parties: National (conservative, centre-right) and Labour (social democratic, centre-left) parties. The short three-year electoral process facilitates fast law making as incumbent parties endeavour to distance themselves from the political opposition and make certain that the effects of changes are evident before the next election (Gauld 2008; Miller 2006).

**National-New Zealand First Coalition (1996-1999) and the "Re-reforms"**

Following the first MMP election in 1996, the National-led coalition was reliant on the populist New Zealand First Party. Both parties had campaigned on different health platforms: National on anti-health reform (Hornblow & Barnett 2000, p. 133) and New Zealand First on the need to restore universal access, particularly to the elderly (Belgrave 2008, p. 78). The health system underwent a "re-reform" process (Gauld 2009, p. 137); attention focused on cooperative and collaborative relationships and shifting away from National's former commercialised stance (Easton 2002, p. 4). Support was given to Māori health development and health funding increased, particularly for child and mental health services (Quin 2009, p. 14). However, although free doctor consultations for children under five years produced higher consultation rates and potential reductions in hospitalisation, as the Free Child Health Scheme transferred approximately 70% of cost from families to government (Dovey, Tilyard, Morton, Penrose & Eidler 1999), the middle-classes were disproportionately advantaged (Belgrave 2008, p. 79).

The rehabilitation of Crown Health Enterprises as Hospital and Health Services signalled a retreat from a profit focus towards providing public service; despite the reinstatement of community representation on boards (Quin 2009), the retention of the purchaser/provider split maintained the adversarial contracting environment (Hornblow & Barnett 2000, p.

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117 Advancing the development of Māori providers was part of the 1996 Coalition Government Agreement on Health and as a result, the Māori Provider Development Scheme was introduced in 1997. "The Scheme allocates $10 million per year to Māori providers and workforce development. The number of Māori providers delivering a range of primary health care services has increased from approximately 23 in 1993 to around 286. However, there are relatively few Māori health providers throughout the country and most Māori have no choice but to access mainstream providers, particularly for secondary health care. The Scheme is being reviewed in 2005" (Ratima, Edwards, Crengle, Smylie & Anderson 2005, pp. 7-8). Moreover, while Māori-led health services have succeeded in redressing access barriers for some Māori, their operations are severely curtailed by funding constraints, receiving only 180 million of the 6.6 billion dollar health budget in 2000-01 (Blakely, Tobias & Robson 2005). Thus, the majority of provider interventions are universal and Crown assertions of support for whanau health models are contradicted by the absence of current or proposed comprehensive interventions designed to specifically address Māori access to health services (Cormack et al. 2005).
The centralisation of the four Regional Health Authorities into Hospital and Health Services exacerbated provider discontent regarding the lack of local presence and understanding (Gauld 2009; Hornblow & Barnett 2000). The level of unmet Māori health need was evident in, for example, 1997 rates of Māori hospitalisations for infectious diseases and respiratory disorders that were 40% higher than those of non-Māori (Ministry of Health 1999a). In a five country comparison, Donelon, Blendon et al. (1999) found that only Americans consumers perceived that access to healthcare was worse than that of New Zealanders.

**Māori health and New Right reforms**

Māori health statistics illustrate the tendency for the application of a market strategy to healthcare to worsen existing health inequalities. Figure 2 illustrates abrupt changes from the mid-1980s in the life expectancy gap between Māori and non-Māori. The reduction in interethnic disparities in the three decades of post-World War Two period ended; while non-Māori life expectancy at birth increased during the last two decades at the fastest rate since World War Two, for Māori the increase was minimal (Robson 2004, p. 6).

**Figure 2: Māori & non-Māori life expectancy by gender, 1950-2000 Source:**

(Ajwani et al. 2003, p. 47)
Similarly, infant mortality which had decreased amongst Māori and non-Māori for the last twenty years, widened markedly between 1980 and 1999, with Māori infant mortality rates (9.2 per 1,000 live births) twice as high as non-Māori (4.6 per 1,000) (Robson 2004, p. 10). The latest data confirms that Māori (and Pasifika) women are still more likely than Europeans to have stillbirths and neonatal deaths, and Māori constituted 50% of all teenage mothers whose babies died in the 2007-2009 period (Perinatal and Maternal Mortality Review Committee 2011).\footnote{Despite similar rates of breastfeeding, in the 2004-6 period Māori rates of infant mortality were 1.5 times and rates of Sudden Infant Death Syndrome (SIDS) were 5 times higher than those of non-Māori (Ministry of Health 2010c, p. 49). In 1989 the rate of Māori SIDS reached 9.2/1000 live births; by 1992 the rate decreased to 6.5/1000 compared to less than 2.5/1000 for non-Māori (Durie 1998c, p. 134). Tipene-Leach and colleagues (2000) attribute some differences in SIDS mortality to more effective targeting of non-Māori by the SIDS prevention campaign.}

Despite the greater need, Māori utilisation of primary care decreased (Barnett 2000) because of escalating patient co-payments (Davies 1990 cit. Gauld 2009, p. 65), among the highest in the world (Gauld 2003, p. 204). The provision of cheaper access, through the establishment of a few trade union sponsored centers, had a minimal overall effect (McGrath 1989 cit. Barnett 2000, p. 161). Associated health risks for Māori reflected psychosocial change and included increased psychiatric admissions and drug and alcohol abuse; double the incidence of lung cancer; a higher incidence of communicable diseases (such as meningitis and rheumatic fever); as well as deaths from asthma and SIDS (Durie 1998c, p. 134). As a result, attention increasingly focused on the need to improve Māori representation in the professional health workforce (Barwick 2000; Baxter 2002; Cormack et al. 2005; Cram 2010).

Section Three - Twenty-First Century Health Policy


In late 1999, the newly elected center-left Labour-Alliance Coalition's policies were explicitly directed towards ameliorating increased interethnic social and health inequities precipitated by fifteen years of neo-liberalism. Notwithstanding, the political and public outrage caused by the attempted implementation of equity and Treaty-based social policies, with blatantly descriptive labels, such as Closing the Gaps (Humpage 2006), the government nonetheless endeavoured to reduce health disparities between Māori and non-
Māori. Furthermore, health sector reforms were justified based on the need to redress the negative effects of the competitive model, in part by ensuring "democratized, locally controlled decision-making over planning, resource allocation and services configuration" (Gauld 2003, p. 208). The Ministry of Health resumed responsibility for policy advice, funding and monitoring the health and disability sector. Although public confidence in the health system was low (Donelan et al. 1999), restructuring was nonetheless politically motivated in the absence of corroborating evidence (Gauld 2008, p. 98).

Public Health and Disability Act (2000)

The New Zealand Public Health and Disability Act 2000 was the first social policy legislation to incorporate a clause pertaining to Māori rights under the Treaty of Waitangi (A. F. Boulton et al. 2004). Public fears that Māori would be afforded preferential access to care were allayed as Clause 4 of the Act restricts the Treaty obligation to District Health Boards ensuring Māori involvement in joint planning and shared vision (Durie 2004, pp. 8-9). The policy of separating purchaser/provider functions ended; twenty-one District Health Boards replaced the Hospital Health Services' and assumed responsibility for the purchase and provision of primary, secondary and tertiary healthcare, and of personal and population-based health services to a geographically defined population, in consultation with the community and local iwi. Although District Health Boards are conceptually identical to the Area Health Board system that operated from 1989-1991 (Gauld 2003, p. 208), they have additional legislative responsibilities to improve Māori health (Ministry of Health 2000). Māori participation on Boards of Governance was made mandatory (a minimum of two Māori of the eleven board members, who, if not elected, are appointed by

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119 This followed the abolition of the Health Funding Authority (HFA), established by the previous government.
120 This was the first Act to incorporate the Treaty of Waitangi into social policy legislation, aimed at increasing Māori participation in the health sector "particularly in service delivery, policy development and in prioritising the allocation of resources to Māori health" (A. F. Boulton, Simonsen, Walker, Cumming & Cunningham 2004, p. 36).
121 District Health Boards are funded by the Ministry of Health according to a population-based formula in their geographically defined regions (Gauld 2008, p. 98), ranging in population size from 30,000 to 500,000 (Quin 2009, p. 19).
122 The inclusion of the Treaty statement in the Act (s.4) was considerably diluted compared with the original statement "which had applied to all the agents and organisations referred to in the Bill, including District Health Boards, PHARMAC and the National Health Committee" rather than only to District Health Boards (A. F. Boulton et al. 2004, p. 38).
the Minister)\textsuperscript{123} (Ministry of Health 2000). Further, Boards are legally required to focus on preventative health services and the development of partnerships with local iwi (Gauld 2003, p. 208).

**Primary Health Care Strategy (2001)**

The Primary Health Care Strategy (2001) was intended to deliver comprehensive coordinated primary healthcare to reduce inequalities in health status (King 2001). The emphasis placed on community development and intersectoral work (at both individual and population levels) contrasted with the traditional focus on GP clinical services and a fee-for-service (Abel, Gibson, Ehau, Tipene Leach & Haurua. 2005). This holistic approach was further reinforced in the objectives of *He Korowai Oranga: The Māori Health Strategy xx*, and accompanying action plans: *Whakatataka* and *Whakatataka Tuarua*\textsuperscript{124} (Ministry of Health 2006b) to designed to encompass all aspects of Māori health by affirming Māori approaches to health and disability in order to improve Māori health outcomes. The overall aim of *Whānau Ora* is defined in the strategy as "Māori families that are supported to achieve the fullness of health and wellbeing within te ao Māori and New Zealand society as a whole" (Ministry of Health 2002b, p. iii).

Despite the Associate Health Minister’s (2003) announcement that *He Korowai Oranga: The Māori Health Strategy* represented a "strategic breakthrough," the devolution of power and control, that ostensibly afforded Māori autonomy over their healthcare proved illusory.

**Primary Health Organisations**

The Primary Health Care Strategy (2001) set out the new configuration of primary care arrangements, including the formation of Primary Health Organisations (PHOs). The requirement that members of the public formally enrol with a Primary Health Organisation (PHO) ended the long-standing practice of patronising a single GP or organisation (Gauld 2008, p. 99). Despite the ten year enrolment framework, by October 2004, 91% of the population had enrolled with one of the seventy-five Primary Health Organisations,

\textsuperscript{123} Boards of Governors are comprised of four ministerial appointees, including the Chair, plus seven locally elected appointees. In making an appointment the Minister of Health must endeavour to ensure that Māori membership on the board is proportional to the number of Māori in the DHB’s resident population (Ministry of Health 2000).

\textsuperscript{124} Whakatataka Tuarua aimed to integrate existing and newly emergent initiatives and ensure effective and inefficient use of resources designated to Māori health (Ministry of Health 2006b).
including more than 75% of Māori and nearly 80% of people residing in NZDep deciles 9 and 10 (providing approximately 50% of the population with reduced or low cost services) (Abel et al. 2005, p. 3). Notwithstanding problems with the funding formula, Rice and Smith (2001) acknowledge New Zealand's modest attempt to address this internationally recognised challenge by including variables explicitly designed to reduce health inequalities (Crampton & Foley 2008, p. 145).

The Primary Health Care Strategy mandated the reorganisation of GPs and Independent Practitioner Associations into Primary Health Organisation membership. In contrast to Independent Practitioner Associations (which are owned and operated by the medical profession) Primary Health Organisations are multi-disciplinary, community-based entities encompassing other health professionals (including nurses, Māori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, podiatrists, psychologists and midwives) who also serve the health needs of the enrolled population (Gauld 2008, p. 99). Based on the community non-profit model, Primary Health Organisations are designed to respond to the current policy objectives by focusing on population health gains by planning and developing health-promotion and other primary care health programmes.

Primary Health Organisations were established in July 2002, and supplemental details of funding arrangements and minimal formation requirements were announced (Ministry of Health 2001a), including "governance and service-delivery arrangements: a governing board with a range of primary care practitioners and community representatives; a management and provider structure; evidence (through confirmed enrolments) of a clearly defined patient base; and financial and service-delivery plans" (Gauld 2008, p. 99). However, in order to moderate GP resistance the "community participation imperative" has been diluted in successive policy amendments (Neuwelt & Crampton 2004 in Abel et al. 2005, p. 3). Moreover, funding formula issues have been addressed, so Primary Health

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125 The use of demographic variables as proxies for health care need (Crampton & Foley 2008, p. 145) proved problematic, as access Primary Health Organisations could offer lower fees immediately and arguably attract patients from Interim Primary Health Organisations (Barnett & Barnett 2004). Moreover, "there was not much evidence related to GP use by ethnicity and deprivation, and what evidence did exist indicated that these groups seek care at rates similar to the rest of the population despite being sicker. Hence, even if data could be obtained to support an allocation by ethnicity and deprivation, the resulting formula would cement in place historical inequities and contravene the aim of the strategy" (Crampton & Foley 2008, p. 137).
Organisations with similar demographics and special needs have received similar funding since July 2007.\textsuperscript{126}

In October 2007, very low-cost practices were introduced and were eligible for additional government subsidies, providing free services to children under six and lower charges for other patients (Gauld 2008, p. 99). However, the provision of universal low cost access to primary care, and very low cost access for the most vulnerable populations, remained an unsolved policy issue, underpinned by the risk of middle-class capture of additional funding, and co-payments not being sufficiently low to improve access for the most vulnerable (Hefford, Crampton & Foley 2005, p. 8). Moreover, Labour's strategy of improving access by gaining control of patient co-payments through capitation funding that privileged Primary Health Organisations rather than the pre-existing Independent Practitioner Associations as the structure for delivering primary care (Ministry of Health 2001b) was not successful. Although patient co-payments have been reduced and the range of primary care services has been extended, professional monopoly of primary care remains entrenched, and in the absence of capitated funding, so does periodic curative treatment (Gauld 2008, p. 93).\textsuperscript{127}

**Fifth National Government (2008-present)**

Following the 2008 and 2011 general elections, the Fifth National Government signed Confidence and Supply Agreements with the Māori Party to ensure voting majority for important legislation.\textsuperscript{128} Under the latest agreement, Māori Party Co-Leader, Tariana Turia, was reappointed as Associate Minister of Health and Minister responsible for Whānau Ora (National Party 2011). The inclusive approach to service provisions under Whānau Ora is designed to empower "families as a whole, rather than focusing separately on individual

\textsuperscript{126} Before July 2007, two formulae determined PHO funding by the demographic detail of enrolled populations. PHOs with enrolled high needs populations (50% or more were Māori, Pacific and/or of NZDep deciles 9 or 10) qualified for the larger Access funding while others attracted the lower level Interim funding (Abel et al. 2005, p. 3).

\textsuperscript{127} District Health Boards and an independent Fee Review Committee monitor approximately eighty-two PHOs (Quin 2009, p. 20) and the varying levels of fees charged by different practices. Non-Government Organisations (NGOs), including community and iwi organisations, deliver many support services on a not-for-profit basis (Quin 2009, p. 20).

\textsuperscript{128} Confidence and Supply Agreements were also signed with ACT and United Futures Parties and National has signed a Memorandum of Understanding with Green Party.
family members and their problems" (Te Punu Kokiri 2012). The Ministry’s latest policy, Better, Sooner, More Convenient Primary Care (2009), is designed to provide "better integration between primary and secondary health services, deliver care in a patient-centred and clinician-led way, and be more convenient for patients" (Ministry of Health 2010b, p. 1). Although this policy operates in conjunction with Whānau Ora, the level of Māori health inequities outlined in Tatau Kahukura: The Māori Health Chart Book (2010c) and Korero Mararama: Māori Health Literacy (2010a) remain of serious concern.

The resurgence of Third World diseases in New Zealand and their disproportionate incidence and burden amongst Māori (and Pasifika) identified in the Baker Report (2012) are a serious indictment of health policy. As noted in an editorial in The Lancet, this health crisis challenges "the epidemiological transition theory, whereby development is accompanied by a shift of health burden towards chronic diseases, and [has] enormous implications for health and social policy in New Zealand" (Lim & Mokdad 2012, p. 1080). Baker and colleagues (2012, p. 1118) also identified the need for the Ministry of Health to revisit strategies designed to reduce the incident and burden of infectious disease.

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129 Whānau Ora is, Turia states, "about enabling our families to dream the dream, to bring together the resources that can create their own opportunity to grow" (Te Punu Kokiri 2012). The National-Māori Party Accord identifies three specific measures to support the Whānau Ora approach: 1) A specific annual Whānau Ora appropriation will be developed to improve the reach, capability and effectiveness of Whānau Ora; two, The Government and the Māori Party will actively work towards the establishment of a standalone commissioning agency over the next 12 months; and, third, Whānau Ora will increasingly bring a greater focus on addressing the issues of employment, housing and educational achievement as well as supporting the most vulnerable whanau, including those on low incomes (Te Punu Kokiri 2012).

130 Rates of admission for infectious diseases in Pacific Islander and Māori populations are respectively 2.35 and 2.15 times higher than the for NZ Europeans and other ethnic groups; Between 1989 and 2008, the rate of admission for infectious diseases increased by 72.1% for Pacific Islanders and 49.6% for Māori, with European New Zealanders and other ethnic groups increasing by 40.2% (M. G. Baker et al. 2012).

131 Omran divided the epidemiological transition of mortality into three phases, in the last of which chronic diseases replace infection as the primary cause of death. These phases are:

The Age of Pestilence and Famine: Where mortality is high and fluctuating, precluding sustained population growth, with low and variable life expectancy, vacillating between 20 and 40 years.

The Age of Receding Pandemics: Where mortality progressively declines, with the rate of decline accelerating as epidemic peaks decrease in frequency. Average life expectancy increases steadily from about 30 to 50 years. Population growth is sustained and begins to be exponential.

The Age of Degenerative and Man-Made Diseases: Mortality continues to decline and eventually approaches stability at a relatively low level. The epidemiological transition occurs as a country undergoes the process of modernization from developing nation to developed nation status. The developments of modern healthcare, and medicine like antibiotics, drastically reduces infant mortality rates and extends average life expectancy which, coupled with subsequent declines in fertility rates, reflects a transition to chronic and degenerative diseases as more important causes of death" (Wikipedia 2012).
Chapter summary

This chapter has outlined the complex, cumulative effect of the relationship between the politics, state power, health policies and practices that have privileged the health status of Pakeha. In the contemporary milieu, manifestations of Third World diseases emphasise the relationship between the state and social policy, and the disproportionate burden of incidence amongst Māori "the risks to the health of society and individuals" (Belgrave 2008, p. 70). While Pakeha self-interest represents "a recurring motif of public health activity of behalf of Māori" (Dow 1995, p. 31), perhaps the greatest irony is that when health policy was introduced in 1840, the "critical test of the efficacy of Western medicine [was] the size of the Māori, not the European population; the reverse of places such as India" (Salesa 2001, p. 14). Chapter Four reviews pertinent literature both national and international of potential relevance to Māori accessing and engaging with current primary healthcare provisions.
CHAPTER FOUR: LITERATURE REVIEW

Consumers [patients] have a great deal to say about both the (technical task and an interpersonal exchange), and also about the circumstances under which the task is performed and the exchange occurs. In defining what is desirable or undesirable in the interpersonal exchange or amenities of care, it is consumers, I believe, who should make the decisive contribution. It is their expectations that should set the standard for what is accessible, convenient, comfortable or timely. It is they who tell us to what extent they have been listened to, informed, allowed to decide, and treated with respect. In doing so, consumers express their personal preferences; but they also voice the expectations that particular positions, in particular segments, of particular societies have implanted and nurtured (Donabedian 1992, p. 247).

Introduction

This chapter reviews relevant national and international literature relating to barriers and facilitators that affect Māori access to primary healthcare. The impact of various forms of racism over time and across multiple domains of the lifecourse of Māori and other indigenous and racial minorities is increasingly recognised as a determinant of health and a driver of interethnic and interracial health inequalities (Paradies, Harris & Anderson 2008). Access to primary healthcare is a complex and multidimensional concept which, within the context of this research, is considered at the levels of the health system, the healthcare process, and the patient and/or population (Freeman et al. 2007; Haggerty et al. 2003). Also integrated are elements of Donabedian's (1966; 1988) "structure model," encompassing the variables of the organisational, provider, and patient characteristics, as well as the predisposing, enabling, and needs variables identified in the Andersen model (Aday & Andersen 1974; Andersen 1995; Andersen et al. 1983).

This chapter is structured in three sections. The first briefly reviews the literature and identifies the gaps in the national literature pertaining to the current reconfiguration of primary care instituted under the New Zealand Health and Disability Act (2000). Section Two explores healthcare process-level barriers that impact on Māori access to, and the quality of, healthcare which is provided, almost exclusively, by non-Māori health
professionals. The final section explores individual or patient-level factors, particularly non-financial barriers and facilitators that influence Māori healthcare seekers' predisposition towards, and expectations and utilisation of, healthcare and satisfaction with provisions. Literature for this review has been sourced from a diverse array of sources including government documents, internet databases, academic books and journals. The selection of pertinent data has primarily involved library databases and internet searches, seminal works, literature reviews, and reference lists of printed materials.

**Section One: Health system-level factors**

This section is brief due to the absence of literature specifically addressing the impact of the restructuring of primary health under the Primary Health Care Strategy (2001), and the mandatory patient enrolment with a Primary Health Organisation and/or General Practice rather than a solo practitioner (Ross & Kenrick 2011). Within the context of a racialised, neo-colonial society, barriers to Māori access at the health system-level include the universal, Western approach to healthcare, the disproportionately non-Māori workforce, the monocultural nature of services, and organisational barriers (Bacal, Jansen & Smith 2006; Barwick 2000; Baxter 2002; Cormack et al. 2005; Jansen, Bacal & Crengle 2009; Ministry of Health 2002a). The structure of the healthcare system reflects its European origins, which values individualism and self-advocacy, and privileges people of European ancestry, particularly those of higher socioeconomic status (T. Walker, Signal, Russell, Smiler & Thu iawai-Ruru 2008). Non-Māori are also privileged by disproportionately higher levels of health literacy (Ministry of Health 2010a) and cultural health capital necessary to meet healthcare demands that require increasing levels of patient sophistication (Shim 2010). Organisation barriers include the timing and availability of services, failure to identify and treat people with the greatest health needs, confusion and uncertainty regarding the continuity of care, and the maintenance and follow-up of treatments required (Baxter 2002; Cormack et al. 2005; Crengle 2000; Jansen et al. 2009; Jatana, Crampton & Richardson 2011; Penney, McCleanor & Moewaka-Barnes 2006). While disparities in access to healthcare have been reported across all sectors of the health system, access to emergency services is equivalent for both Māori and non-Māori, which suggests that barriers to access are removed in emergency situations where care is dictated by medical protocol, but re instituted in the post-emergency environment (Jansen & Smith 2006).
A substantial and increasing body of empirical evidence indicates the causal association of institutional racism for widespread inequalities in the quality of healthcare available to racial/ethnic minorities (Harris et al. 2012a; Reid et al. 2000; Robson & Harris 2007; B. D. Smedley et al. 2002; van Ryn & Fu 2003). As noted by Sporle, Pearce and Davis (2002, p. 127):

The persistently high Māori mortality rates, when controlled for social class, indicate that the poor state of Māori health cannot be explained solely by relative socioeconomic disadvantage. The high Māori rate of potentially preventable deaths indicates that the health sector is still not meeting the serious health needs of many Māori.

Changes to the organisation of primary healthcare are designed to reduce and ultimately eliminate interethnic health inequalities by more effectively addressing the healthcare needs of whānau and improving outcomes for Māori with higher needs (Ministry of Health 2001b; Ministry of Health 2002b; Ministry of Health 2006b). The need for institutional change was partially motivated by increased rates of mortality and morbidity that coincided with the implementation of the New Right reforms in the late 1980s and 1990s (Ajwani et al. 2003). Since the enactment of the New Zealand Health and Disabilities Act (2000), research has been conducted with Māori healthcare providers (A. F. Boulton, Gifford & Potaka-Osborne 2009; A. F. Boulton et al. 2004) and users (Cram & Smith 2004; Cram, Smith & Johnstone 2003; Jansen et al. 2009; T. Walker et al. 2008).

However, there is a paucity of research into the impact of organisational change at the primary care interface which mandated patient enrolment with practices rather than specific GPs (Ross & Kenrick 2011). Jatana, Crampton and Richardson (2011, pp. 16-17) found "some support for the hypothesis that people with high health needs have higher mean continuity of care scores;" nonetheless, these authors acknowledge that different attributes of primary care have not been studied to the same extent as in other countries where similar processes of modernisation have been implemented. In Britain, for example, comprehensive studies have been undertaken into the effects of the restructuring of the National Health System since the 1990s (R. Baker 1997; R. Baker et al. 2007; R. Baker, Mainous III, Gray & Love 2003; M. Boulton, Tarrant, Windridge, Baker & Freeman 2006; Freeman 2008; Freeman & Hjortdahl 1997; Freeman, Olesen & Hjortdahl 2003; Freeman, Robinson, Ehrich & Richards 2001; Freeman et al. 2007; Gulliford, Naithani & Morgan
2006; Gulliford, Naithani & Morgan 2007; Guthrie, Saultz, Freeman & Haggerty 2008; Guthrie & Wyke 2006; McWhinney 1975; Mead & Roland 2009; Pereira & Pearson 2003; Sweeney & Gray 1995; Turner et al. 2007; Wachter 2001; Windridge et al. 2004), including barriers experienced by "black" and minority groups (Lakhani 2007).

Section Two: Healthcare process-level factors

At the health process-level increasing attention is being paid to the causal association of racial discrimination and interethnic inequities (Harris et al. 2012a; Harris et al. 2006b; Reid & Robson 2007; Robson & Harris 2007). Barriers to equitable access to quality primary care for Māori include human relations factors (Baxter 2002; Cormack et al. 2005; Crengle 2000; McLeod, Cormack, Love & Salmond 2006) and "cultural fit" issues between Māori patients and predominantly non-Māori providers (Jansen 2009). The role of clinicians in reducing interethnic inequities has been identified (E. Curtis et al. 2010; New Zealand Medical Association 2011) as the impact of "race" and/or ethnicity on clinical decision-making regarding diagnosis and treatment, and is being increasingly well documented (Cooper & Roter 2002; B. D. Smedley et al. 2002; van Ryn et al. 2011; van Ryn & Burke 2000; van Ryn & Fu 2003). For example, the NatMedCa study found that new problem identification, tests, investigations and specialist referrals did not reflect the burden of disease experienced by Māori (Crengle 2007). The unconscious implicit attitudes and stereotypes that non-Māori-doctors and Māori patients hold about each other may be of greater importance in shaping reciprocal attitudes, expectations, and perceptions than either party realises (Jansen et al. 2009), particularly within the current sociopolitical context of healthism where individual responsible for health is attributed to health-risk behaviours (Hodgetts et al. 2005).

The doctor-patient relationship

The doctor-patient relationship is a multifaceted and multidimensional phenomenon that comprises "one of the most complex social relations" (Ong, De Haes, Hoos & Lames 1995, p. 903). The characteristics of both parties are reciprocal. Doctors' behaviour affects patients' self-confidence, motivation, and perspective on their health status and, potentially, their health outcomes (Ong et al. 1995, p. 912; B. D. Smedley et al. 2002; van Ryn et al. 2011); patients' communicative behaviour and personal characteristics exert an influence on doctors (Street 1991). The quality of care delivered at the clinical interface is also
influenced by doctors' socio-cultural characteristics, including their training, cultural competencies, personal beliefs and biases (intentional and unintentional) (Betancourt, Green, Carrillo & Ananeh-Firempong II 2003; Burgess, van Ryn, Dovidio & Saha 2007; Carrillo, Green & Betancourt 1999; Jansen et al. 2009; van Ryn et al. 2011; van Ryn, Burgess, Malat & Griffin 2006; van Ryn & Fu 2003).\footnote{The three mechanisms that influence clinical decision-making are "bias (or prejudice); greater clinical uncertainty; and beliefs or stereotypes influence medical decisions" (B. D. Smedley et al. 2002, pp. 9-11).} In their seminal study based on clinical encounters, Van Ryn and Fu (2003) found that American doctors rated African American patients (compared to "white" patients) as less intelligent; less educated; more likely to abuse drugs and alcohol; more likely to fail to comply with medical advice; more likely to lack social support; and less likely to participate in cardiac rehabilitation.

**New Zealand doctors**

In New Zealand, the attitudes and behaviours of predominantly non-Māori health professions are inevitably influenced (intentionally or unintentionally) by negative neo-colonial messages (Klonoff 2009) vis-à-vis "fundamental value, self-reliance, competence and deservingness" (van Ryn & Fu 2003, p. 249) of Māori patients. The socialisation of both New Zealand and foreign born and trained doctors occurs within the context of a racially-biased media (McCreanor & Nairn 2002a), public ignorance of colonial history (Reid 2011), and a "relatively unique" environment where deficit attributions of interethnic disparities constitute a value source of political capital (Barber 2008, p. 143). Collectively these factors exacerbate professional ignorance and/or limited understanding of the basic causes of Māori health inequities (D. R. Williams 1997a).

**Differential treatment**

Despite the paucity of studies explicitly exploring the differences between providers interactions with Māori and non-Māori patients (Jansen et al. 2009, p. 20), interethnic disparities in the provision of medical care have been identified. In a survey of 25 GPs in the Auckland region, McCreanor and Nairn (2002b) identified deficit explanations (such as non-compliance, socioeconomic deprivation, stereotypical beliefs regarding late presentation, different treatment preferences, and failure to attend follow-ups and/or embrace preventative health practices) to justify disparities and existing provisions. Mcleod et al. (2004) found that subjective decision-making by GPs regarding elective
surgery potentially explain lower Māori rates of referral compared to non-Māori, such as is seen in difference in rates of caesarean sections (Harris et al. 2007). Similarly, Johnstone and Read (2000) identified deficit explanations in a survey of psychiatrists, where 11.3% of respondents (n=28) believed that Māori had a greater biologically or genetically determined predisposition to poorer mental health than non-Māori. Genetic determinism is cogently exemplified by Lea and Chamber's (2007) neo-Darwinian attribution of a Warrior Gene to explain a Māori genetic predisposition towards aggressive behaviour identified in gorillas (Crampton & Parkin 2007; Hook 2009d; Merriman & Cameron 2007; Whittle 2009; Whittle 2010). As Foster and Sharp (2002, p. 844) note:

Although simplistic biological understandings of race and ethnicity associated with the eugenics movement maybe dead, the far more subtle presumption that racial and ethnic distinctions nonetheless capture 'some' meaningful biological difference is alive and flourishing.

Further, the socialisation of many health professionals in accordance with the "protestant ethic or the middle-class value system" has inculcated values such as "an avoidance of overindulgence, a stress on self-discipline ... and a willingness to defer gratification" (Najman, Klein & Munro 1982, p. 1787). Professional socialisation is reinforced by the prevailing philosophy of healthism, where "individual agency is accepted as the primary source of health and the prevention of illness is associated with personal choice and willpower" (Hodgetts et al. 2005, p. 124). However, lifestyle explanations for interethnic disparities in health outcomes "decontextualise[s] behaviour" and facilitate deficit theorising (Blakely, Ajwani, Robson & et 2004, p. 2246). Professional biases with respect to obesity (G. D. Foster et al. 2003) may, for example, detract from the provision of non-prejudicial and equitable care.

**Healthism**

The response of doctors towards Māori represent a significant process-level factor. Notwithstanding that research relating to health-risk factors are complex and mixed within the current socio-political context of healthism where attribution for interethnic disparities in health outcomes is attributed to individual responsible for health-risk behaviours such as obesity, tobacco and alcohol consumption (Hodgetts et al. 2005, p. 124). Inculcation of the healthism ideology may translate into discriminatory practices by health professionals with
respect to the relationship between physical activity and obesity. Although the *New Zealand Health Survey* 2005/2006 found comparable levels of vigorous and moderate physical activity for Māori and non-Māori (Ministry of Health 2010c, p. 93), cultural, socioeconomic and genetic factors have been used to explain Māori rates of obesity that are 43% compared with European/Other 24% (Ministry of Social Development 2010). Metcalf et al. (2000) found that the body weight of Europeans adhered more closely to what is now perceived as an ideal body size in Western societies than Māori. The higher incidence of obesity amongst Māori has been attributed to lower socio-economic status and a Polynesian thrifty genotype as a result of adopting a European diet. However, as Pearce et al. (2004, pp. 1070-1071) state: "It now seems, however, that almost everyone except Europeans may have the thrifty genotype." The thrifty gene hypothesis, Paradies and colleagues (2007) contend, contributed little understanding to complex diseases while perpetuating problematic notions about human differences.

Harris et al. (2012a, p. 413) found no association between experiences of racial discrimination and measures of excess body fat among Māori, and report that findings from limited international research are mixed. Studies reporting a positive association between racial discrimination and obesity (Hunte & Williams 2009; Shariff-Marco, Klassen & Bowie 2010) contrasts with others where no association or an inverse relationship was found (Shelton et al. 2009; Vines et al. 2007). However, Lewis et al.'s (2011) finding that visceral but not subcutaneous fat was significantly associated with discrimination emphasises the need to distinguish between visceral and subcutaneous fat rather than rely on BMI and waist circumference, as the former has greater significance as a marker of cardiovascular disease (Harris et al. 2012a).

With respect to tobacco consumption Robson's (2004) finding that provider bias, manifested in perceptions that Māori smokers had abdicated responsibility for their personal health and a concomitant entitlement to optimal healthcare, is of concern. However, Harris et al.'s (2012b) finding that Māori smoking is positively associated with racial discrimination reinforces increasing international evidence that smoking is a maladaptive coping phenomenon (J. W. Lynch & Kaplan 2000), associated with disproportional societal stresses imposed on marginalised and/or indigenous minorities and migrant populations (Tran, Lee & Burgess 2010; D. R. Williams & Mohammed 2009; D. R. Williams, Neighbors & Jackson 2003). For example, in two studies racial discrimination
was found to be the best predictor of tobacco consumption amongst African American adults (Landrine & Klonoff 2000). Research conducted by Lea et al. (2005) that claimed "Māori are genetically slower nicotine metabolisers compared to Europeans" has been challenged on the basis of sample size and the use of ethnicity as a marker of genetic grouping (S. Hill, Shaw, Harris & Lindberg 2006). However, Robson's (2004) finding that provider bias, manifested in perceptions that Māori smokers had abdicated responsibility for their personal health and a concomitant entitlement to optimal healthcare, is of concern.

Similarly, Harris et al.'s (2012b) finding that hazardous Māori alcohol consumption is positively associated with racial discrimination aligns with reinforces international research (Tran et al. 2010; D. R. Williams & Mohammed 2009). Interestingly, despite the rarity of purely hereditary diseases, a study of alcoholism in New Zealand by Marshall and colleagues (1994) represents a rare example of health related genetic difference. This research found that "the ADH2-2 gene ... believed to protect against alcoholism," while relatively common among Māori, was not found in the Pakeha population; however, as Pearce et al. (2004, pp. 1070-1071) note: "any hypothesised protective genetic factors are, however, offset by socioeconomic, cultural and political factors."

**Biomedicine and psychosocial medicine**

The response of doctors towards risk-behaviours reflects the tension between biomedicine and psychosocial approaches to medicine. van Ryn and Williams (2003, pp. 498-499) argue that neither approach "adequately account for, address, or provide clarity on the role of social and behavioural factors in clinical decision making." Biomedicine is the doctor-centred, evidence-based application of "technical knowledge and professional authority ... [regarding] the best odds, based on trials of various possible treatment options;" whereas the more holistic psychosocial medicine aims to provide individualised patient-centred care, based on the unique circumstances and preferences of the patient who is involved in the decision-making process (Erickson 2007, pp. 4-5). Combining both types of medicine within the consultation process is challenging (Ford, Schofield et al. cit. Erickson 2007, p. 5) and requires effective, interactive doctor-patient communications.

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133 Māori alcohol consumption, while similar to that of non-Māori, is potentially more hazardous (Bramley et al. 2003), characterised by the likelihood of drinking less often but in greater quantities on a typical occasion. Māori binge drinking is consistent with the behaviour of other colonised indigenous minorities (Brady 2000).
Published guidelines and performance measures

The disconnect between the evidence-based medicine and the tenets of culturally competent, patient-centred care is complicated by the lack of clarity about the specific function of social or behavioral factors in guidelines or performance measures (van Ryn & William 2003, p. 500). Provider discretion constitutes a pathway that potentially affects clinical decision-making as beliefs about individual patients may be overshadowed by their ethnic/minority group characteristics. By way of example, blood tests (including lipids and serum glucose) for Māori were found to be ordered less frequently than for non-Māori (Crengle, Lay-Yee, Davis & Pearson 2005), despite higher incidence of heart disease (Crengle 2007; Gentles et al. 2006).

Doctors may also prescribe different treatment regimes and communicate lower expectations to minority patients than they convey to their more privileged counterparts (B. D. Smedley et al. 2002; van Ryn & Fu 2003). Differences have been identified in the treatment of depression (Arroll, Goodyear-Smith & Lloyd 2002; Crengle 2007), including lower rates of prescribed antidepressant medication for Māori compared to non-Māori (D. R. Thomas, Arlidge, Arroll & Elder 2010).

The seminal report, Unequal Treatment, stated that "a pragmatic balance must be sought between the advantages and limitations of guidelines, such as the tension between the goal of standardisation versus the need for clinical flexibility" (B. D. Smedley et al. 2002, p. 16). Nonetheless, in contrast to physiological indicators, doctors receive negligible training and "have less time to assess patients on social and behavioural characteristics ... [thus] guideline-adherent decision-making is frequently dependent on the quality of communication" (van Ryn & William 2003, p. 500). However, communication barriers within non-concordant relationships are well recognised. For example, GPs attributed lower Māori rates of diagnosed depression to the reluctance of many Māori to discuss personal health issues because of the stigma attached to mental health (D. R. Thomas et al. 2010).

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134 Other problems with risk management guidelines with respect to Māori include the original Framingham Heart Study (based on data from a largely-white middle-class North American population) was found to over-estimate risk for Pakeha and under-estimate risk for Māori (Riddell et al. 2010).
Doctor-patient relations

While communication is fundamental to all relationships (Cooper, Beach, Johnson & Inui 2006, p. S22), effective doctor-patient communication is crucial to establishing a positive inter-personal relationship, exchanging information, and making treatment-related decisions (Ong et al. 1995). Recent expressions of public dissatisfaction with the medical profession are, in large measure, attributable to suboptimal clinical communications rather than clinical competence (Simpson et al. 1991). While New Zealanders generally value their doctors' communication and relationship skills and remain loyal, unless professional attitudes or behaviours become unacceptable (Kerse et al. 2004; Nicholls & Jaye 2002), doctor-patient interactions are nevertheless simplified by a commonality of ethnic backgrounds, unimpeded by group differences in communicative ability and style (C. M. Ashton et al. 2003). New Zealand doctors report lower levels of rapport with Māori than with non-Māori patients (Crengle 2007; McCleanor & Nairn 2002b). Māori, however, perceive that establishing a rapport is crucial; rapport-building provider characteristics include "the doctor taking time to listen, using understandable language, taking an interest in whānau health history, and engaging with the patient to deliver a collaborative style of healthcare" (Cram et al. 2003, p. 4). Although Māori are more likely to discuss personal feelings with a known GP (D. R. Thomas et al. 2010), the concept of rapport is culturally bound and non-Māori doctors may make erroneous assumptions about having successfully established relationships with Māori patients (Walker et al. 2008).

International research attributes difficulties in cross-cultural, inter-personal interactions to the behavioural differences of majority group doctors towards "white" and ethnic minority patients. In their literature review, Schouten and Meeuwesen (2006a) found these differences primarily involved doctors' affective and instrumental verbal behaviour, with the preponderance of studies finding that doctors, when communicating with ethnic minorities, exhibited decreased empathy, less affective behaviour and engaged in less social talk and partnership building (Cooper et al. 2003; Hausmann et al. 2011; Hausmann, Kressin, Hanusa & Ibrahim 2010; Johnson, Roter, Powe & Cooper 2004). According to Hall and colleagues (1998, p. 73) social conversation is more "symmetrical and fraternal" than medical dialogue and thus potentially reinforces a patient's sense of value as a human being, rather than being "simply an anonymous 'case' or a set of symptoms." In the United States, doctors' communications were found to be more "narrowly biomedical" (Roter et al.
1997) more verbally dominant and less patient-centred (Johnson, Roter, et al. 2004) when interacting with African American compared to "white" patients. Thus, cross-cultural training is widely advocated as the panacea to enhance communicate between majority group doctors and minority group patients (B. D. Smedley et al. 2002; Tucker et al. 2003).

Cultural competency training

In order to redress Māori health disparities, the acquisition of cultural competency skills may be equally as important as practitioners' clinical skills (Jansen & Sorrenson 2002). The Medical Council of New Zealand (2006) states that cultural competence "requires an awareness of cultural diversity and the ability to function effective, and respectfully, when working with and treating people of different cultural backgrounds." Practice accreditation with CORNERSTONE is designed to ensure fulfilment of doctors' legal and professional obligations to provide culturally competent care to Māori patients (The Royal New Zealand College of General Practitioners 2009). The Royal New Zealand College of General Practitioners state that "once appropriate standards are developed, registration authorities must ensure that providers perform in the appropriate manner" as professionals' self-evaluation of competency has proven to be ineffective (Bacal et al. 2006, p. 308).

Similarly in New Zealand, teaching cultural competency skills to medical undergraduates presents challenges, particularly "managing the 'hidden curriculum' .... [a]s senior practitioners' discourse or professional practice may be at odds with the principles underpinning Māori health teaching. This hidden curriculum can have a powerful influence on students' learning and ultimately on their practice" (R. Jones et al. 2010, p. 6). van Ryn

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135 Similarly, Schouten and Meeuwesen (2006b) found that Dutch patients were both more assertive and participatory in clinical encounters than their non-indigenous counterparts; significantly, this research found that GPs' affective verbal behaviour was positively associated with both patient participation and patient satisfaction. In intercultural consultations Dutch GPs communicate less with patients than during intracultural consultations (Schouten, Meeuwesen & Harmsen 2009), and receive different, less familiar and less egalitarian conversational clues from ethnic minority patients than from Dutch patients; these different outcomes were underpinned by cultural perceptions of greater doctor-patient power imbalances (Meeuwesen, Tromp, Schouten & Harmsen 2007).

136 The Health Practitioners Competency Assurance Act (2004) is expected to "improve integration of cultural and clinical competence [leading] to better outcomes through improvements in communication, acceptability of treatment, adherence to treatment plans, and through measures of doctor performance in delivery of services to Māori" (Bacal et al. 2006, pp. 307-308). Approximately 80% of all general practices are registered with the CORNERSTONE programme and that 629 are now accredited against Aiming for Excellence (Royal NZ College of General Practitioners 3 August, 2011).

137 In America, van Ryn and colleagues (2011, pp. 206-207) found that exceptions notwithstanding, the majority of "white" physicians are low in explicit and high in implicit prejudice and acknowledge the difficulties involved in changing the behaviours of doctors with "high levels of explicit bias."
et al. (2011, p. 207) report that two sociopolitical orientations have utility in predicting explicit biases amongst medical students: Social Dominance Orientation (SDO) and Medical Authoritarianism (MA), a health-context specific offshoot of Right Wing Authoritarianism (RWA).\textsuperscript{138} Unfortunately, MA, which predicts the propensity of students' "to stereotype and make negative attributions about patients from stigmatised groups ... appears to increase over the course of medical education" (Merrill et al. 1995 cit. van Ryn et al. 2011, p. 207).\textsuperscript{139}

Cultural competency acknowledges and accepts variation in patients' sociocultural health beliefs, medical practices, attitudes towards medical care, and levels of trust in doctors and the healthcare system, as well as differences in patients' thresholds for seeking care, ability to recognise and articulate symptoms, and levels of integration of 'medical culture' into their explanatory models (Bacal et al. 2006; Betancourt et al. 2003; Carrillo et al. 1999; Penney et al. 2006). However, the extent to which cultural factors can be implicated as causes of interethnic disparities in health outcomes remains a source of contention. Culture is defined by the Institute of Medicine as an "integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups" (Cross, Bazron, Dennis & Isaacs 1989).\textsuperscript{140} Culture is also, according to Carrillo et al. (1999, p. 829), shaped by factors that include "proximity, education, gender, age and sexual preference." Accordingly, some writers propose that cultural competency should be considered an inherent aspect of all healthcare provisions. This would redress the prevailing tendency to "exoticise culture... as a factor affecting the care of racial-ethnic minority populations rather than as a dynamic set of factors that have a pervasive influence on important aspects of all individuals' everyday experiences" (Hernandez, Nesman, Mowery, Acevedo-Polakovich & Callejas 2009, p. 1049). Moreover, Saha (2006, p. 203) argues that identifying cultural incompetence and cultural discordance as important causes of interethnic disparities in healthcare (particularly in the absence of

\textsuperscript{138} SDO represent the degree to which people value hierarchically structured relationships among social groups, such as dominance of Whites over Blacks; RWA reflects the level of belief in traditional authority structures (van Ryn et al. 2011, p. 207).

\textsuperscript{139} In a New Zealand study that measured the effects of RWA and SDO on university students and members of the general public, Sibley and Liu (2004, p. 88) found deeply entrenched resistance to any resource-specific allocations to Māori.

\textsuperscript{140} Smedley et al. (2002, p. 19) identify the three conceptual approaches in Cross-Cultural Education those focusing on attitudes (cultural sensitivity/awareness), knowledge (multicultural/categorical approach), and skills (cross-cultural approach).
substantive corroborating evidence) represents a "leap of faith" attributable to the widespread conflation of culture with "race" and ethnicity.

Nevertheless, there is increasing international acceptance that cultural competence or cultural sensitivity should become an integral part of medical training and that the skills of many majority group doctors should be enhanced. However, while culture is an adaptive system of meaning which people share that "can be taught and reproduced" (Wachtler, Brorsson & Troein 2006, p. 111), the acquisition of such skills is neither straightforward nor a likely panacea for solving interethnic health disparities (Brach & Frasier-Erector 2000; Ferguson & Candiby 2002; Napoles-Springer, Santoyo, Houston, Perez-Stable & Stewart 2005). In their reviews, Ferguson and Candiby (2002) and Desiree, Lee-Ray, Gomez, Bereknyisi & Braddock (2010) found no evidence that demonstrated improved outcomes through formal medical training in cultural competency. However, Desiree and colleagues (2010) found three studies that reported beneficial rather than harmful effects.

Moreover, the tendency of cross-cultural curricula to adopt a "categorical and potentially stereotypic approach," that essentialises the characteristics of patients of specific cultures as a unilateral set of unifying traits, is problematic (Carrillo et al. 1999, pp. 829-830). This "essentialising" of cultural attributes (Wear 2003, pp. 550-551) disregards the heterogeneous reality of contemporary cultural groups and wide variation in levels of acculturation of group members and renders the teaching cultural competency is not only difficult, but potentially counterproductive (Carrillo et al. 1999). Additionally, the increasingly multicultural composition of Western democratic societies, and the evolving cultural profiles of the major urban metropolis, as dominant minority cultures change with successive waves of migrants, renders it impossible for doctors to be familiar with aspects of all the cultural groups they are likely to encounter in clinical settings. Napoles-Springer and colleagues (2005) propose that patient training programmes (successfully utilised to increase shared decision-making among dominant groups) could be modified to specifically address the needs of cultural minorities; these authors also emphasise the need for physicians to exhibit greater sensitivity and flexibility towards the use of complementary/alternative medicine amongst all ethnic groups.
Alternative providers

Bazargan and colleagues' (2005) findings that self-reported discrimination was the strongest predictor of alternative provider utilisation has relevance to Māori health because of the continued use of rongoa and the revitalisation of traditional healing practice (Cram et al. 2003; R. Jones 2000b). In a qualitative study of traditional Māori healers, Jones (2000a, p. 19) found that practitioners attributed many "ostensibly physical problems ... [to] spiritual, psychological and family issues." Jones (2000c, pp. 107-108) argues that as Māori frequently consult both traditional healers and Western practitioners simultaneously (often without either practitioner knowing of the other's involvement), the potential exists for unwanted pharmacologic interactions as well as issues involving conflicting advice. Furthermore, Ngata and Pomare (1992, p. 43) identified the need for professional appreciation and acknowledgement of the "functioning of the Māori whānau (family) system ... [as] extensive intermediary consultations with family, elders [as well as] traditional healers may take place before a patient seeks Western medical care." Significantly, these authors (1992, p. 46) highlight the need for professional empathy and understanding that: "[u]rbanisation in search of work, unemployment, poor educational attainement and alienation from one's tribal roots, language and traditional support systems have contributed to the breakdown and dysfunction seen in many whānau and individuals."

Thus, cultural competency requires changes "in the culture of medicine itself" (Ring & Brown 2003, p. 405). Acquaviva and Mintz (2010, pp. 702-703) forcefully argue that medicine represents the last "bastion of overt racial profiling" in America in that the visual determination of patient "race" is a crude attempt to "determine phenotypic congruence with a socially constructed taxonomy;" the practice of subjective visual assessment, routinely recorded in patient histories, and taught to medical students as a determinant of risk of certain diseases, "falsely legitimises race as an essential factor in diagnosing and treating patients." Ironically, "the physician [too] is a victim of racism, prejudice, or profiling based on appearance" (Sapien 2010, p. 582).

Notwithstanding concerns previously mentioned, culturally competent practice has important ramifications for enhancing the quality and acceptability of care across racial/ethnic divisions. Studies in the United States have found that minority patients in racially discordant relationships received less patient-centred communication (Cooper-
Patrick, Gallo & Gonzales 1999; Peek et al. 2010), especially if being treated by "white" doctors (Cooper-Patrick et al. 1999; Cooper et al. 2003; Johnson, Saha, Arbelaez, Beach & Cooper 2004; Saha, Arbelaez & Cooper 2003). African American and minority patients are less involved in participatory decision-making (S. H. Kaplan, Greenfield, Gandek, Rogers & Ware 1996; Ngo-Metzger et al. 2006; Peek et al. 2010), and receive less information overall (C. M. Ashton et al. 2003; Ngo-Metzger et al. 2006). Such inequities reinforce the significance of patient-centred care in reducing disparities in quality of care delivered to racial and ethnic minorities.

**Patient-centred care**

Patient-centred care is defined by the Institute of Medicine (2001, p. 3) as that which is "respectful of and responsive to individual patient preferences, needs, and values," and which relates to "the degree to which a system actually functions by placing the patient/user at the centre of its delivery of healthcare." Patient-centred care represents an egalitarian approach that facilitates greater patient expression of their "symptoms, feelings, thoughts and expectations" (Henbest & Stewart 1990 cit. Ong et al. 1995, p. 911), thus promoting a "'whole person' model that recognises the larger context in which patients live and function" (Kizer 2002, p. 118).\(^\text{141}\) Although some patients place higher priority on the technical quality of care and provider continuity (Cheraghi-Sohi et al. 2008), research found that providers' patient-centred interactive communication style promotes positive health outcomes including patient compliance, functional status, better health and increased efficiency of care (Arah et al. 2006; Bauman, Fardy & Harris 2003; Mead & Bower 2002; O'Malley & Forrest 2002; Ong et al. 1995; Roter et al. 1997; Stewart 2001; Stewart et al. 2000; Weston 2001). In a seminal British study, Little, Everitt et al. (2001) found that patient-centred care was perceived as a marker of quality, associated with patient satisfaction, symptom relief and the utilisation of fewer healthcare resources. However, most doctors are "either patient-centred or not but rarely somewhere in the middle" and differences in the responsiveness of individual doctors towards their patients will inevitably manifest (Morgan 2003 cit. Erickson 2007, p. 10). Studies have identified deficient patient-centred communications (particularly amongst "white" doctors) when

\(^{141}\) While not explicitly identified as a quality dimension for the New Zealand Health and Disability system, patient-centredness is nonetheless emphasised by the central positioning of the patient/whanau and the reference to the Treaty of Waitangi principles of partnership, participation and protection in the framework (Seddon 2006, p. 4)
interacting with minority patients (Cooper et al. 2003; Saha et al. 2003), in both subjective and objective measurements (Cegala & Post 2006).

**Practitioner responsiveness**

Responsiveness is, according to the World Health Organisation\(^{142}\) "a system that treats people to meet their legitimate non-health expectations" (2000 cit. Arah et al. 2006, p. 9). Meeting the realistic wishes, desires and expectations of patients and their families (Donabedian 2003) represents a "paradigm shift" in the doctor-patient relationship during the past thirty years (Moumjid, Gafni, Bermond & Carrere 2007). Increasing patient demands for autonomy or sovereignty and "choice and control over medical decisions" (Emanuel & Emanuel 1992, p. 2223) requires that paternalism is transformed into partnership\(^{143}\) (Charles, Gafni & Whelan 1997; Cooper et al. 2003; Coulter 1997; Deber 1996; Elwyn, Edwards & Kinnersley 1999; Emanuel & Emanuel 1992; Moumjid et al. 2007; Ngo-Metzger et al. 2006; Weston 2001).

**From paternalism to shared decision-making**

In terms of ideal doctor-patient model, the traditional Paternalistic Model is situated at one end of the treatment decision-making continuum and involves the authoritarian doctor controlling the encounter and the passive patient is simply obliged to comply with the recommended medical regime for the diagnosed illness (Charles, Whelan & Gafni 1999). The Informed Model (reflecting patient autonomy or consumer sovereignty) is positioned at the opposite end, where the doctor's responsibility is restricted to communicating all relevant treatment options and their associated risks/benefits to the expert patient (Elwyn 2006), who subsequently makes an informed decision (Charles, Whelan, et al. 1999). Centrally positioned on this continuum is the Shared Model which is characterised by the formation of a partnership, where a two-way information exchange results in the patient's treatment preferences being integrated into the decision-making process (Charles et al. 1997). However, shared decision-making requires professional encouragement (Braddock, Edwards, Hasenberg, Laidley & Levinson 1999), practitioner predisposition, and the requisite skills (Towle & Godolphin 1999).


\(^{143}\) "A partnership between a patient and clinician is a union that recognises and values the unique perspective, knowledge, and opinion of each participant" (Cooper et al. 2006, p. S22).
Shared decision-making

Although conceptual definitions remain poor (Makoul & Clayman 2006; Mounjed et al. 2007), shared decision-making is now considered to be "the crux of patient-centred care" (Weston 2001, p. 438). The foremost models of Charles et al. (1997), Towle & Godolphin (1999), and Coulter (1997) similarly define shared decision-making as a bi-directional information exchange during clinical encounters that involves doctor-patient participation in the final decision. Conceptual refinements of the shared decision-making model include equipoise, reflecting the commonplace reality that best practice often fails to identify a single treatment option as superior (Gwyn & Elwyn 1999), and the notion of implicit rather than explicit patient participation in weighing risk-benefits, especially in long-term illness (Elwyn, Edwards & Kinnersley 2000). Deber (1994, p. 426) distinguishes "problem solving as the search for the single 'correct' solution...[and] decision making...where a choice must be made from among several alternatives, often involving trade-offs of harms and benefits." Challenges resulting from practitioners' interpersonal skills and information necessary to executive shared decision-making underpins its very limited success (Edwards & Elwyn 2006). Nevertheless, shared decision-making represents "a mechanism to decrease information and power asymmetry between doctors and patients by increasing patients' information, sense of autonomy and/or control over treatment decisions that affect their well-being" (Charles et al. 1997, p. 682). In cross-cultural clinical encounters, advantages may accrue when family and friends are involved in the decision-making process (Charles, Gafni, Whelan & O'Brien 2006).

Information sharing

The exchange of information is a fundamental component of the doctor-patient interaction. The doctor requires information to formulate a diagnosis and treatment plan, and the patient needs information to understand the nature of the illness and treatment options, and that the condition is accepted and being seriously addressed by the doctor (Ong et al. 1995, p. 904). Inadequate exchange of information constitutes the most common source of patient dissatisfaction (Coulter, Parsons & Askham 2008) as doctors consistently underestimate both the amount of information and level of involvement (particularly the former) (Ong et al. 1995). Torke, Corbie-Smith and Branch (2004) found "white" doctors failed to address these needs amongst African Americans patients. Peek et al. (2008, p. 450) found that African American patients wanted to share information rather than share
decision-making and considered that non-adherence was "an acceptable mechanism to express control and act on treatment preferences."

Further, socio-demographic variables, such as illness, age, education, social class and smoking status are not useful predictors of desired level of involvement (Elwyn et al. 1999; Frosch & Kaplan 1999; McKinstry 2000). McKinstry (2000) found that the majority of smokers, despite being from lower socioeconomic backgrounds, preferred to participate in decision-making, possibly in response to negative experiences of previous consultations dominated by authoritarian doctors. Patients actively communicate exert a positive effect on doctors' communicative behaviour by articulating their beliefs about health (explanatory models), preferences, concerns, and expectations of care and by asking questions (S. H. Kaplan et al. 1996; Street 1991; Street, Voigt & Geyer 1995). Overall, in comparison to their passive counterparts, active patients, who tend to be younger, (Coulter 1999) "white" and educated (Gordon, Street Jr., Sharf & Soucek 2006; Street, Gordon, Ward, Krupat & Kravitz 2005), receive more information (Street 1991), have a stronger sense of control over their personal health, are more adherent with treatment (Stewart 2001), and are more satisfied with the care received (S. H. Kaplan et al. 1996; Ong et al. 1995; Roter et al. 1997).

Shared decision-making is, however, largely dependent upon the doctors' willingness and ability to create an environment conducive to patients feeling sufficiently comfortable to reveal and discuss their treatment preferences (Charles et al. 1997; Frosch & Kaplan 1999). A hybrid model of decision-making often evolves as individual patients differ considerably in their ability and desire to participate in, and the extent of communication necessary to arrive at, a treatment decision (G. Clarke, Hall & Rosencrance 2004). The training of many older doctors to be paternalistic exacerbates difficulties in accepting patients as equal partners, "experts in their own experience of disease and their preferences" (Weston 2001, p. 438). Doctors' participatory decision-making styles are influenced by their backgrounds, practice volume, level of professional autonomy (S. H. Kaplan et al. 1996), preparedness to relinquish the power and ability to communicate risk. Say and Thomson (2003, p. 543)
emphasis that "risk is a complex phenomenon" which many patients (and doctors) find difficult to comprehend, with errors commonly relating to different types of biases.\textsuperscript{144}

Barriers to shared decision-making commonly cited by doctors include cost containment strategies and time constraints (Charles et al. 1997; Coulter 1997; Stevenson, Barry, Britten, Barber & Bradley 2000), with respect to the latter, variations in consultations times are considerable. New Zealand research has identified shorter duration of consultation time for Māori compared to non-Māori patients (mean=13.7 vs. 15.1 minutes) (Crengle 2007) which, as Jansen et al. (2009, p. 21) note, may contribute to stereotyping as "time pressures and uncertainties that providers face when assessing patients or making treatment decisions can cause providers to incorporate implicit assumptions into their recommendations." In the British National Health System, 10 minutes is an accepted norm; in 1997 the average consultation was 9.4 minutes over an average of 5 visits, totalling 47 minutes per year, which according to Gray (1998) represents a significant amount of time, especially as family medical care tends to build up over multiple consultations. In America, Kaplan and colleagues (1996) found that consultations of less than 18 minutes resulted in less effective patient information seeking and that doctors' cost-containment strategies that reduce time with patients may result in suboptimal outcomes; more time spent with a patient increased patient satisfaction, especially when time was invested in explaining the rationale of treatment decisions. One study found no time difference in race-concordant consultations in Anglo-American and Spanish-American patients (Johnson, Roter, et al. 2004), whereas Cooper et al. (2003) found that race-concordant visits were approximately 2 minutes longer than non-concordant visits, and patients rated doctors as more participatory regardless of the communication that transpired. Roter et al. (1997) found that focusing on psychosocial issues did not result in significantly longer consultation times. No association

\textsuperscript{144} "Following a comprehensive analysis of data, the American DECISION Study found that although patients perceive themselves to be informed participants in medical decisions, their recall of the important factual information deemed critical to decision-making was found to be lacking. Furthermore, what patients described as 'participating' often equated to assenting to recommendations of their physicians without much discussion in the way of options or weighing of risks and benefits. Disturbingly ... investigators also found inferential evidence of racial bias in the manner in which African American patients were informed and invited to participate in certain clinical decisions" (Braddock 2010, p. 5S).
was found between physician productivity and patient-centred communication or shared decision-making (Wood et al. 2009).

**Explanatory models of sickness**

Inconsistencies in explanatory models of *sickness* represent a potential barrier for Māori at the clinical interface. Patients' explanatory models of *illness*, encompass beliefs about the nature of *sickness*, its cause, severity, prognosis and preferences for treatment, and frequently vary with the doctors' explanatory model of *disease*. As Kleinman, Eisenberg and Good (2006, pp. 140-141) state: "modern [Western] physicians diagnose and treat diseases (abnormalities in the structure and function of bodily organs and systems), whereas patients suffer illness (experiences of disvalued changes in states of being and in social function)." In sum, explanatory models represent vitally important drivers of doctor and patient behaviours, implicit in doctors' diagnosis and therapeutic plans and patients' decision to adhere to the recommended treatment regime (C. M. Ashton et al. 2003). Even when both parties come from similar sociocultural backgrounds, the patient's acceptance of the doctor's biomedical solution still has to be negotiated (Kleinman, Eisenberg & Good 1978). The wide diversity of sociodemographic, sociocultural and historical experiences of Māori patients and their whānau, and the acceptance by some of traditional practices incompatible with the established medical practice, serve to reinforce the necessity of professional acknowledgement and exploration of diverse Māori perceptions of illness (Durie 1998c; R. Jones 2000b; Ngata & Pomare 1992; Tapsell et al. 2008).

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145 Nonetheless, as Fiscella and Epstein (2008, p. 1843) argue: "During 15-minute visits, physicians are expected to form partnerships with patients and their families, address complex acute and chronic biomedical and psychosocial problems, provide preventative care, coordinate care with specialists, and ensure informed decision-making that respects patients' needs and preferences. This is a challenging task during straightforward visits, and it is nearly impossible when caring for socially disadvantaged patients with complex biomedical and psychosocial problems and multiple barriers to care."

146 Modern Western medicine has transformed from a holistic to a reductionist approach to patient care; the widespread professional adoption of, and acquiescence to, the biomedical model frequently results in the failure to include the psychological, social, cultural, and physiological contexts, as originally proposed by Hippocrates (Pirbhai 2003). As Taylor (2003, p. 559) states: "Physicians' medical knowledge is no less cultural for being real, just as patients' lived experiences and perspectives are no less real for being cultural." British researchers found that in contrast to "whites", the explanatory models of African-Caribbeans and Bangladeshis were frequently informed by social or supernatural factors, rather than biological understandings (McCabe & Priebe 2004). Culturally sensitive clinical practice was essential to addressing this dissonance (Bhui & Bhugra 2002), and often proved useful in understanding unexplained medical symptoms (Sumathipala et al. 2008).
Section Three: Patient-level factors

The relationship between experiences of racial discrimination in the health sector and other domains is receiving increasing national and international attention as a barrier to healthcare utilisation (Harris et al. 2012a; Harris et al. 2012b). Other individual determinants of healthcare utilisation that affect the care-seeking behaviours of patients are comprised of predisposing, enabling and need components (Andersen et al. 1983, p. 50). These attributes are considered mutable if amenable to policy directives (for example, insurance status and education); conversely, immutable characteristics encompass sociodemographic and sociocultural factors (Aday & Andersen 1974). At the patient-level, factors include demographic characteristics, socioeconomic position, resources and contexts, the effects of stress and other psychosocial factors (J. Lynch, Davey Smith, Kaplan & House 2000; Mandelblatt et al. 1999; Ministry of Health 2002a; A. J. Thomas, Eberly, Davey Smith, Neaton & Stamler 2005; D. R. Williams et al. 2003). Individual-level characteristics encompass health-related knowledge, attitudes, behaviours and preferences; relationships with and ability to engage with health professionals; and understanding of and familiarity with healthcare processes, all of which may reflect the cumulative, transgenerational effects of colonisation, marginalisation and discrimination (Reid & Robson 2007; Robson & Reid 2001).

Predisposition to seek medical care

The propensity of Māori to utilise health services prior to the onset of illness episodes is affected by discriminatory treatment in healthcare (Harris et al. 2012b) immutable demographic factors (the biological imperatives of age and gender which indicate the likelihood for need of health services), as well as social "givens" (Andersen et al. 1983, p. 50). The latter incorporates education, occupation and ethnicity variables, as well as a multitude of factors relating to social networks, social interactions and culture that reflect an individual's status in the community, ability to command the resources necessary to address health issues and the environmental health of the community (Andersen 1995). Immutable factors also encompass genetic factors and physiological characteristics (including mental dysfunction, cognitive impairment and autonomy) (Andersen 1995). Mutable factors considered amenable to short-term policy change include values and preferences with respect to health and illness, general healthcare beliefs and attitudes,
knowledge and sources of healthcare information, and stress and anxiety about health (Aday & Andersen 1974).

The predisposition to seek care is determined by *illness behaviour*, which, Mechanic (1986, p. 1) states, involves the way in which people:

Monitor their bodies, define and interpret their symptoms, take remedial action, and utilise sources of help as well as the more formal healthcare system. It also is concerned with how people monitor and respond to symptoms and symptom change over the course of an illness and how this affects behaviour, remedial actions taken, and response to treatment. The different perceptions, evaluations of illness have, at times, a dramatic impact on the extent to which symptoms interfere with usual life routines, chronicity, and attainment of appropriate care and cooperation of the patient in treatment. Variables affecting illness behaviour usually come into play well before any medical scrutiny and treatment.

A fundamental premise of the *illness behaviour* model is that illness and the illness experience are produced by sociocultural and social-psychological factors, regardless of their genetic, physiological or other biological sources (Mechanic 1986). *Illness behaviour* is a "normative experience governed by cultural rules," determined by "approved" ways of being ill, which may reflect distinct cross-cultural and historical variation in coping strategies across ethnic, class, and family boundaries (Kleinman et al. 2006, p. 141). Accordingly, while the "magnitude, severity, persistence and character of symptoms" influence and determine the boundaries for personal and social definitions, significant inconsistencies exist in perceptions of illness and the interventions and support mechanisms that are considered and utilised (Mechanic 1986, p. 1).

Gribben (2005, p. 5) attributed the low predisposition of some Māori to access primary care to "transient lifestyle, conflicting priorities, beliefs and values/concepts of GP, existence of costs and debts with provider, [and] fear of being identified," elderly Māori and gang families were found to be especially vulnerable to these barriers. A small minority of Māori experienced "extreme discomfort ... in a traditional primary care setting," such that the doctor-patient interaction was perceived to be so stressful that the
"exchange of sensitive information [was] impossible" (Gribben 2005, p. 6). Other Māori perceived that their physical appearance (for example, tattoos and rough clothing), coupled with "past difficulties in the relationship between services and individuals, mental health issues, social skills problems and the incongruity between seeking health care and the male macho image" rendered the service inaccessible (Gribben 2005, p. 7). Jansen and colleagues (2009) reinforce the "macho" image and learned stoicism as barriers to Māori engagement. Notwithstanding that "hard to reach" Māori are heterogeneous, and some restrict use of primary care to trauma but disengage for preventative care, Gribben (2005, p. 23) concludes that for a subgroup, assuming a willingness to engage with health services "might be assuming too much."\(^{147}\)

However, Māori care seeking behaviours reflect the corollary of exogenous factors, imposed by policies and practices of state, and the pernicious and pervasive effects of racism over time and across multiple domains (Harris et al. 2012a). The illness behaviour of many Māori may reflect historical trauma associated with colonial and neo-colonial processes (Reid & Cram 2004; Reid & Robson 2007) negative whānau perceptions and/or experiences of providers (Cram & Smith 2004), and diffidence and apathy towards personal healthcare (Jansen et al. 2009) characteristic of marginalised individuals.

**The enabling component**

The enabling component represents the means available to individuals to obtain healthcare and encompass mutable factors (income, insurance, structure and convenience of accessing a regular source of care), as well as immutable factors relating to the community of residence (Andersen 1995; Andersen et al. 1983). Overall, Māori in comparison to non-Māori have lower family incomes (Robson, Cormack & Purdie 2010) and lower levels of private health insurance coverage, irrespective of socioeconomic status (Te Puni Kokiri 2000). Jatrina and Crampton (2009b) confirm earlier research that financial barriers continue to prevent Māori access to needed primary care (Barnett 2000; Barnett & Coyle 1998; Malcolm 1996) despite the availability of low cost provisions Gribben (2005, p. 5) . As noted in Chapter Three, the provision of universal low cost access to primary care, and very low cost access for the most vulnerable populations, remains an unsolved policy issue,

\(^{147}\)According to Raymont (2008, p. 29), factors that: "militate against appropriate use of primary health care services can be subsumed into the idea of social distance. Those who do not use services are distanced from them by culture, disadvantage or lack of information. Many [Māori] may be closely connected to their own social group, but this may be itself distanced from health care services."
underpinned by the risk of middle-class capture of additional funding and co-payments not being sufficiently low to improve access for the most vulnerable (Hefford et al. 2005).

The need component

The need for care relates to the level of experienced illness underpinning the most immediate cause of health service use: perceived need reflects an individual’s perceived health status, symptoms of illness, and disability; and evaluated need represents the professional assessment of the urgency of the presenting condition, diagnosis and surgery (Aday & Andersen 1974, p. 217). Thus, need may be perceived or evaluated differently by the individual and the healthcare professional (Aday & Andersen 1974, p. 213). In New Zealand the unmet healthcare needs of Māori are well-documented and evident in the disproportionate rates of avoidable mortalities and avoidable hospitalisations (Ajwani et al. 2003; Sporle et al. 2002). Harris et al. (2012b) findings that self-reported experiences of self-reported racism, healthcare settings, was positively associated with Māori under utilisation of recommended preventive care corresponds with some international research on the impact of discrimination on healthcare. (Burgess, Ding, Hargreaves, van Ryn & Phelan 2008).148

Actual (or realised) utilisation

In New Zealand, potential access is measured by affiliation with primary care provider; while affiliation with a provider is motivated by significantly decreased patient co-payments and does not indicate actual utilisation of primary care services, it nonetheless increases the likelihood that services will be used (Jatrana & Crampton 2009a, pp. 276-278). High levels of provider affiliation amongst Māori support the hypothesis that current health policies are ensuring high needs patients have high levels of provider affiliation (Jatrana & Crampton 2009a). However, in another study measuring access barriers, Jatrana and Crampton (2009b, p. 8) found that after adjusting for other factors, participants

148 In a review of the international literature, Cormack (2012) identified empirical evidence of consistent and significant associations with racial discrimination and delayed access to care and unmet need. Self-reported discrimination was associated with delaying or doing without healthcare (Keller, Silberberg, Hartmann & Michener 2010; Lee, Ayers & Kronenfeld 2009) in females but not males (Blanchard & Lurie 2004); delayed access to treatment and not filling prescriptions (Van Houtven et al. 2005); and delays in seeking and/or adhering to medical care (Casagrande, Gary, LaVeist, Gaskin & Cooper 2007; Keller et al. 2010). Comparable findings were identified among the socioeconomically disadvantaged in Sweden (Wamala, Merlo, Bostrom & Hogstedt 2007).
affiliated with a primary care provider were "consistently more likely to defer a visit to a doctor or buying a prescription."

**Exposure to and utilisation of primary care**

As annual exposure to primary medical care constitutes a direct measure of utilisation of primary medical care and an indicator of access, it also monitors equity of service provision across different populations (Crampton, Jatrana, Lay-Yee & Davis 2007). Thus, the relatively limited exposure of Māori to primary medical care, despite high need, indicates differential utilisation and access compared to non-Māori (Crampton et al. 2007; Crengle 2000; Davis et al. 2006; McLeod et al. 2006; Ministry of Health 2002a; Pomare et al. 1995; Scott, Marwick & Crampton 2003; Westbrooke et al. 2001). As Crampton and colleagues (2007, p. 8) state: "it appears that the experience of Māori ... [reveals a] distinctive (negative) features of primary medical care exposure data." People's experiences and/or perceptions of healthcare are instrumental in determining whether perceived need translates into utilisation, which in turn reflects the effectiveness of the healthcare system (Kelley & Hurst 2006). Of concern is that increased Māori primary care visits, apparently consistent with increased need amongst socioeconomically deprived populations, when adjusted for deprivation, were found to be similar to, or lower than, European rates of utilisation (McLeod et al. 2006). This finding provides but one example that the "equality standard" of universal provision does not guarantee "access to necessary, high-quality healthcare" (Rathore & Krumholz 2004, p. 635).

**Preventative care and screening**

Differences in the use of screening and preventative services contribute to health disparities between Māori and non-Māori. Barriers that underpin differential utilisation include the absence of culturally appropriate services, such as smoking cessation programmes (S. E. Hill, Blakely, Fawcett & Howden-Chapman 2005) and screening provisions (Crengle 2000), Cervical screening is reportedly "Hit and Miss" according to the *New Zealand Family Doctor* (16 November 2011). Harris and colleagues (2012b) found a positive association between lower rates of Māori women's participation in
cervical and breast screening\textsuperscript{149}, and racial discrimination by a health professional. However, findings from international studies are mixed.\textsuperscript{150} In New Zealand, prostrate cancer screening was not perceived as culturally appropriate by both asymptomatic and symptomatic Māori males (P. N. Williams et al. 2003), potentially contributing to late presentations and higher rates of Māori mortality (Lamb et al. 2008, p. 3891).

**Following medical advice**

Patient adherence to prescribed medical treatments is a longstanding issue, with empirical evidence indicating up to 50% non-adherence amongst the general population (Donovan & Blake 1992, p. 507). Notwithstanding that reviews of relevant literature emphasise the importance of patient acceptance and adoption of the advice and treatment regimes prescribed by health professionals (Leventhal, Riegel, Carlson & De Geest 2005; Vermeire, Hearshaw, Van Royen & Denekens 2001), the fact remains that patients’ cultural backgrounds and beliefs affect adherence (Horne et al. 2004) and the subsequent success or failure of medical interventions (Donovan & Blake 1992). Nevertheless, health professionals exploit minority patients’ cultural backgrounds to rationalise different outcomes (Trostle 1988). In New Zealand, for example, Penny and colleagues (2011, p. 73) found that clinicians described Māori as a non-compliant group with explanations ranging from ”Māori ignorance and poverty” to ”wilfulness and self-destructiveness;” in contrast, Māori patient discourses suggested ”engaged, proactive and mindful health-seeking behaviours.” Deficit and problematic characterisations of Māori are also challenged by Jansen et al.’s (2009, p. 63) findings that 92% of study participants reported filling prescriptions, despite only 87% reporting that prescribing doctors had provided clear

\textsuperscript{149} Breast and cervical screening in New Zealand focused on patient-level factors (such as transportation, accommodation) but ignored the structural causes of disparities (Cormack et al 2005) and has failed to achieve equitable coverage of Māori women (Cormack et al 2007).

\textsuperscript{150} A significant association was found between discrimination and mammography and colonoscopy utilisation (Hausmann et al. 2010); and screening for breast cancer and colorectal cancer for women, but not colorectal cancer screening in men (Crawley, Ahn & Winkleby 2008). Conversely, other studies found no significant association with cervical screening (Mouton et al. 2010; Shariff-Marco et al. 2010); breast cancer screening (Shariff-Marco et al. 2010), or mammogram utilisation (Dailey, Kasl, Holford & Jones 2007). Although perceived racial discrimination in healthcare does not independently predict utilisation of mammogram, pap tests or bowel cancer screening (Hausmann, Jeong, Bost & Ibrahim 2008), it may result in poor utilisation (Mouton et al. 2010). British research found ethnic barriers to cervical and breast screening included ”lack of knowledge, cultural beliefs, language and unhelpful attitudes of health professionals” (V. N. Thomas, Saleem & Abraham 2005, p. 562). However, the predisposition to seek care, tested using the discovery of a breast lump or chest pain, found that disadvantaged and ethnic minority populations did indeed self-refer (Adamson, Ben-Shlomo, Chaturvedi & Donovan 2003, p. 895).
explanations as to why treatment was necessary; more disturbingly, only half reported that potential side-effects of treatments had been explained.

Accordingly, professional allegations of patient culpability are not only indicative of abdicating responsibility for successfully engaging in cross-cultural clinical encounters (Bissell, May & Noyce 2004; McCreanor & Nairn 2002a), but are counterproductive to ensuring equitable allocation of the advantages of modern pharmaceutical treatments (Vermeire et al. 2001). Empirical evidence emphasises a shift from the paradigm of blaming patients for non-adherence to one of shared doctor-patient responsibility (Leventhal et al. 2005; Vermeire et al. 2001). This change is endorsed by the World Health Organisation's (2002) directive that patient non-adherence be regarded as a system failure in health service delivery that necessitates investment and support in improving the cultural competencies of clinicians. While New Zealand research found that adherence improved by approximately one-third amongst the general population when the doctor-patient rapport facilitated consensual decision-making (Kerse et al. 2004), and interethnic differences in prescription filling have been attributed to cost (Jatana, Crampton & Norris 2011), other recent research usefully provides a more in-depth analysis of Māori access to and use of medications.

Hodgetts et al. (2011, p. 152) identified an "emergent practice of Māori women presenting to ... GPs with proxy symptoms to obtain medications for their male partners." While this practice may be interpreted as a "pragmatic and innovative response," with benefits that, for example, reduce the exposure of Māori men to a potentially stressful healthcare environment and having to take time off work, it potentially exposes them to increased risk of adverse reactions (Hodgetts et al. 2011, p. 156).\footnote{Moreover, although this practice suggests that "whanau care" is in fact "primary care" that requires reconsideration of Western interpretations of adherence to medical regimes, Hodgetts et al. (2011, p. 156) stress that: "obtaining medications by proxy does not always require deception. Parents often obtain medications for children via proxy. Caregivers for older relatives with debilitating acute and chronic conditions often seek advice from physicians on behalf of their charges as a matter of course, particularly when ongoing relationships of care exist between a physician and whanau. Such acts rely on trust between doctors and family representatives. Deception in the interaction between doctors and whanau may prove problematic in that it can undermine trust and is associated with issues of safety. Rather than laying blame solely at the feet of whanau, we would argue that family members believing they need to use deception to procure medication is an indictment on a health care system that struggles to be responsive to the needs of Māori."} Interestingly, Clarke and Goosen (2005) found that diabetes patients who strongly identified with their Māori culture were as compliant as European patients, who in turn were more complaint than Māori whose identified only weakly with Māori culture. Nonetheless, in a study of four Māori
households, Nikora and colleagues (2011, p. 96) found that "once in the hands of whānau [medication] can enter into a network of social exchange, gifting and care" with lay prescribing and sharing of medications; and that access to and the storage and use of medications "are determined by a series of processes associated with culture, and the cost, time commitment and perceived necessity of medical consultations."

In a study of African Americans with diabetes, Peek et al. (2008, p. 457) found that non-compliance is perceived as an appropriate non-confrontational method for disempowered patients to exercise control and actively participate in treatment decisions, and that such decision-making frequently occurred at home, or in other circumstances outside of the clinical encounter, without the physicians' knowledge. Recent American research suggests that although minority racial/ethnic status represents a significant predictor of non-adherence (Casagrande et al. 2007; R. C. Kaplan, Bhalodkar, Brown Jr, White & Brown 2004), adherence improved when, for example, the side-effects of lipid-lowering medication are closely monitored (Thompson, Clarkson & Karas 2003) and low-income HIV-positive African American patients held positive stereotypes about their non-racially-concordant doctors (Bogart, Thorburn Bird, Walt, Delahanty & Figler 2004).152

**Respect/disrespect**

American research also found that minorities patients were more likely to report disrespect (Blanchard & Lurie 2004; Johnson, Saha, et al. 2004). While the concept of respect recognises each individual's inherent value and is perhaps "the cornerstone of all human interactions" (Cooper et al. 2006, p. S23), it has significant ramifications in non-concordant doctor-patient relationships. Saha and colleagues (1999, pp. 1000-1002) suggest that the higher satisfaction ratings reported by African American patients in race-concordant relationships may be explained by the ability of many African American doctors to establish "more harmonious interpersonal relationships" with their "black" patients because of "cultural and experiential similarities that promote mutual

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152 Further, as adherence to antiretroviral treatment is vital to disease suppression, patient responses to "race"-based discrimination are particularly informative. Greater experienced racial discrimination was significantly associated with lower than the average 60% rate of adherence amongst HIV-positive black males over a six month period (Bogart, Wagner, Galvan & Klein 2010). A consistent association was also found between the 71% of male and female HIV-patients (who reported infrequent experiences of racial discrimination) with mental and physical health and satisfaction with, and adherence to, treatment regimes (Bird, Bogart & Delahanty 2004). Significantly, while racial discrimination was a significant predictor of lower adherence, sexual orientation and HIV-related discrimination was not (Boarts, Bogart, Tabak, Armelie & Delahanty 2008).
understanding and trust" or, alternatively, cultural competency skills acquired through practising with primarily race-concordant patients, rather than factors attributable to racial concordance per se. Street et al. (2008, p. 198) noted that although greater patient satisfaction in racially-discordant contexts improved when patients perceived themselves as similar to their doctors, and "perceived personal similarity" was positively associated with intended adherence and greater levels of trust, the process was dependent on doctors' patient-centred communication skills.

**Patient trust/distrust**

The concept of trust in a healthcare setting includes both interpersonal and system trust, reflecting the "ability of medical professionals and institutions to meet patients' expectations" (Mechanic 1986; Mechanic 1998). In America, patterns of trust in the various components of the healthcare system differ by "race;" "whites" are more trusting of health professionals, hospitals and the healthcare system than racial or ethnic minorities (Boulware et al. 2003; Cooper-Patrick et al. 1999; Corbie-Smith, Thomas & St. George 2002; Doescher, Saver, Franks & Fiscella 2000; Johnson, Roter, et al. 2004; Johnson, Saha, et al. 2004; LaVeist & Nuru-Jeter 2002; Peek et al. 2010; Tucker et al. 2003).

Doctor-patient trust is a "complex set of overlapping domains of competence, fiduciary responsibility, disclosure and control;" from the patients' perspective, trust involves a choice, made from a position of vulnerability, especially if the patient is seriously or chronically ill (Corbie-Smith et al. 2002, p. 2460). However, distrust is not the opposite of trust, but rather a functional alternative (Luhmann 1989 cit. Mechanic 1996, pp. 174-175). Accordingly, patient distrust is not a racial attribute but arises from perceptions and/or experiences of racially prejudicial treatment during medical encounters (Adegbenbo et al. 2006), exacerbated by negative patient attitudes and internalised racism (Peek et al. 2010). Minorities trust doctors less than "whites" (Doescher et al. 2000) and are less satisfied with

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153 According to Boulware et al. (2003, p. 363), interpersonal trust is: "likely to arise from direct personal experiences with other individuals (for example, one's personal physician), while institutional trust is likely to incorporate general impressions of professional institutions formed not only on the basis of personal experiences but also through second hand experiences and social cues (e.g., conversation with others, media portrayals, and legal or regulatory protective measures designed to prevent racial discrimination)." Moreover, interpersonal trust (a fundamental component of all relationships) is determined by the extent to which individuals perceive "one another as competent, responsible, caring, tactful and ethical" (Mechanic 1996). The significant dimensions of trust in the contemporary medical environment are, according to Mechanic (1998, pp. 663-664): "(1) expectations about physicians' competence, (2) the extent to which doctors are concerned with their patients' welfare, (3) physician control over decision-making, (4) physicians' management of confidential information, and (5) physicians' openness in providing and receiving information."
hospital care than non-Hispanic "whites" (Woods, Bivins, Oteng & Engel 2005). "Blacks," Hispanics and Asians all reported higher levels of being treated with disrespect than "white" patients (Blanchard & Lurie 2004).

Studies found that racial discrimination significantly reduced trust amongst African American men and women (Adegbe, Tomar & Logan 2006; Benkert, Peters, Clark & Keves-Foster 2006), and older "black" males (Hammond 2010), and reduced utilization of services such as mammograms and prostate cancer screening (Musa, Schulz, Harris, Silverman & Thomas 2009). A study by Doescher et al. (2000, p. 1156) found lower African-American perceptions of trust compared to "whites" on two conceptually distinct measures: first, "trust in the doctor (patients' perception that the doctor would place the patients' needs above other considerations, would refer when necessary, was not influenced by monetary considerations, would not perform unnecessary tests)" and second, communication skills, for example, "listening skills, explanations, thoroughness." Older African Americans identified honesty, patience and kindness as facilitators of trust, but disruptions in continuity and doctors appearing hurried and deprived of time as barriers; minorities without continuity of care were found to perceive their doctors even less positively (Torke et al. 2004).

In a study of Māori experiences of the healthcare system, Jansen et al. (2009) found high levels of trust and confidence in GPs (92%), such that 93% of respondents were willing to consult the same doctor again, with 87% reporting that the doctors asked sufficient questions and gave clear explanations. However, Jansen et al. (2009, p. 58) identified attitudinal barriers to accessing medical care, including "a more resigned approach to illness, a greater concern for privacy, a reluctance to put one's own needs ahead of others, and a mistrust of the overwhelmingly non-Māori healthcare system." Additionally, Jansen and colleagues (2009, p. 58) noted that many respondents repeatedly stated that some Māori "have a culturally based reluctance to ask for information, to question a doctor's diagnosis or treatment." These attitudes may reflect psychological resilience to adverse social circumstances, often underpinned by knowledge of negative Māori experiences and dissatisfaction with Pakeha health professionals across generations (Cram et al. 2003; Walker et al. 2008) that correspond with low levels of satisfaction reported by impoverished American Indians/Alaska Natives (Haviland, Morales, Dial & Pincus 2005).
Patient satisfaction

International research found experiences of racial discrimination are positively associated with lower levels of patient satisfaction (Auslander, Thompson, Dreitzer & Santiago 1997; Benkert et al. 2006; Bird et al. 2004; Keller et al. 2010; LaVeist, Nickerson & Bowie 2000; Mandelblatt et al. 2003; Sheppard et al. 2008). Hausmann and colleagues' (2010) findings that perceived racial discrimination resulted in a greater likelihood of reporting unsatisfactory care, highlights the need for satisfaction measures to include an explanatory variable in racially discordant relationships, as external factors can significantly affect patient perceptions of clinical encounters (Barr 2004).

Patient satisfaction has long been, and remains, a controversial measurement of the quality of care that patients actually receive. Patient satisfaction is a complex, multidimensional concept determined by a variety of ideas that lacks a clear and precise definition (Crow et al. 2002; L. Gill & White 2009; Haggerty 2010; van Teijlingen 2010).\textsuperscript{154} Jansen and colleagues (2011) note that Māori satisfaction-based measurements are compromised by a reluctance to be critical and extremely low expectations of care, and thus require reported experiences to be objectively compared with best practice. Notwithstanding the identification of methodological issues such as high levels of acquiescent response bias

\textsuperscript{154} The authors of the Health Technology Assessment for the British National Health System concluded that the subjective affective component perhaps rendered the measurement of patient satisfaction "a hopeless quest" (Crow et al. 2002, p. 76) because of the "multiple possible sources of measurement and interpretation errors." The 37 studies investigating methodological issues and 138 studies investigating the determinants of satisfaction, reviewed by Crow et al. (2002), revealed a lack of consensus on a definitive conceptualisation of satisfaction. Gill and White (2009, p. 10) contend that understanding the rationale for patient satisfaction and/or dissatisfaction remains unresolved, as the concept "provides a cognitive evaluation of service that is emotionally affected, and it is therefore an individual subjective perception." Similarly, Salisbury, Wallace and Montgomery (2010, p. 1) found that patient surveys purporting to assess the performance of GPs in fact reflect differences between patients and random errors rather than differences between doctors. Judgements about whether expectations are met are influenced by different standards and expectations, patient disposition and previous experiences. False positives occur when negative experiences are positively rated, unless poor care is directly related to the doctor under evaluation rather than organisational factors; conversely, negative ratings better reflect true negativity, and are indicative of problems (e.g. perceived disrespect or medical errors). The rating "less than totally satisfied" is more informative than "average satisfaction" as high ratings indicate adequate, not superior, quality (Haggerty 2010, p. 791). The value of patient satisfaction surveys in detecting real and important problems is conditional upon maximising precision and minimising bias (Haggerty 2010, p. 791). Moreover, current evidence demonstrates that patient satisfaction is an unpredictable construct for the measurement of service outcome and service quality (L. Gill & White 2009), and as such should not be used as a basis for the allocation of resources (van Teijlingen 2010).
(34%) (Ware, Snyder, Wright & Davies 1983), satisfaction questionnaires have played an important part in quality measurements for thirty years (L. Gill & White 2009). 

Limitations notwithstanding, Crow et al. (2002) identified a stronger association of patient satisfaction at the healthcare process-level with provider attitudes and communications skills, rather than with the convenience of provisions. Aspects of the doctor-patient relationships that predicted satisfaction included affective behaviours indicative of friendliness, trust, courtesy, empathy, supportiveness, sensitivity and understanding, as well as clear explanations and information sharing. Conversely, dissatisfaction was occasioned by the doctor dominating the discussion and/or using highly technical language (Crow et al. 2002, p. 64). However, differences in communication patterns do not consistently explain higher patient ratings of care in race-concordant relations (Powe & Cooper 2004). For example, Cooper et al. (2003) found that despite higher patient satisfaction ratings, audiotapes showed no increase in patient-centred communication compared to non-concordant visits.

**Ethnicity-race concordance**

The term "concordance," which indicates shared doctor-patient identities (Cooper et al. 2006, p. S23) is especially relevant in the context where the treatment of Māori is predominantly provided by non-Māori healthcare professionals. Study findings that concordance of patient-provider beliefs and understandings improved access and adherence to medical advice (Baxter 2002; Cormack et al. 2005; Cram et al. 2003; Crengle 1999; Crengle 2000; Crengle 2007; Jansen et al. 2009; Jansen & Smith 2006) are reinforced by empirical evidence (Cross et al. 1989; Fiscella, Franks, Gold & Clancy 2000; B. D. Smedley et al. 2002). However, notwithstanding that ethnic-discordant doctor-patient relations may influence Māori expectations of receiving fair and equitable treatment within the health system (Jansen et al. 2009), empirical evidence vis-à-vis the effect of cultural, ethnic and/or racial provider-patient concordance on treatment acceptability and success, and patient satisfaction, is mixed.

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155 In a large Australian review, Hawthorne et al. (2006) found that, despite the availability of thousands of measures and research articles (38,000 Medline Pub Med articles plus an additional 10,000 from internet searches), none were satisfactory; few reported instrument or psychometric properties, and most were based on a single item. Moreover, the quality of healthcare has been primarily studied from a clinical rather than a patient perception of quality (L. Gill & White 2009).
In America, where racism within the health system is commonly perceived amongst minority patients, some studies have found that race-concordant relationships are positively associated with the quality and use of healthcare (Cooper-Patrick et al. 1999; S. H. Kaplan et al. 1996; LaVeist, Nuru-Jeter & Jones 2003); perceived discrimination is associated with receipt of poor quality care, particularly by African Americans and Hispanics (Saha et al. 1999; Sorkin, Ngo-Metzger & De Alba 2010). Although Saha et al. (2003) found that race-concordance did not influence perceptions of quality of care, other studies support this relationship (Cooper-Patrick et al. 1999; Saha et al. 1999). Moreover, while race-concordant relationships facilitated having problems explained, listening, and being accessible (Saha et al. 1999; Tucker et al. 2003), and greater patient participation in decision-making (Cooper-Patrick et al. 1999; Cooper et al. 2003), Kaplan et al. (1995) found that non-minority physicians may actually be more actively involved in treatment decisions than when the physician's "race" is the same as the patient's "race".

Studies found consultations with race-concordant physicians were longer (Cooper et al. 2003) and that minority patient were more satisfied with care provided (Chen et al. 2005; Cooper et al. 2003; LaVeist & Carroll 2002; LaVeist & Nuru-Jeter 2002; Saha et al. 2003; Saha et al. 1999) for reasons that include trust, comfort, and previous negative experiences (LaVeist & Nuru-Jeter 2002). However, race-concordance is valued differently by various minority groups (Tucker et al. 2003), and although "white" and African American patients value same-"race" providers, findings are less clear for Asians and Hispanics (LaVeist & Carroll 2002). For example, as Hispanics are more likely to report being treated with disrespect in racially concordant relationships than "white" or Asian patients, cultural and language concordance may more consequential than racial/ethnic concordance (Blanchard, Nayar & Lurie 2007). This finding may also reflect differences in the qualifications of doctors who treat Hispanic patients, as these factors were found to reduce the quality of care provided to African American patients (Bach et al. 2004). Other research found that perceived differences in doctor-patient relationships may reflect minority patients' fears of encountering interpersonal racism (Boulware et al. 2003; Chen et al. 2005; Cooper-Patrick et al. 1999; LaVeist & Nuru-Jeter 2002). Anticipated and/or experienced racial discrimination was found to be significantly associated with the patient preference for race-concordance (Malat & Hamilton 2006; Malat & van Ryn 2005).

156 American research has identified that doctors who treat predominantly minority patients commonly have less clinical training and less access to vital clinical resources than doctors attending to "white" patients (Bach, Pham, Schrag, Tate & Hargraves 2004).
However, Malat and Hamilton (2006) found that perceived discrimination by African Americans influenced the preference for racially concordant doctors in complex ways and that perceptions of societal discrimination are distinct from concerns about personally being treated unfairly. Reduced preference for same-"race" providers was associated with the belief that discrimination occurred irrespective of the physician's "race," and amongst patients relatively unconcerned about personal exposure to unfair treatment despite awareness of the frequency of discrimination. Malat and van Ryn (2005) found that personally experienced discrimination in healthcare, rather than knowledge of historical mistreatment or perceptions of current racial inequities in medical treatment, was associated with preference for racial-concordance. Significantly, patients who anticipated provider prejudice have psychological and cardiovascular stress responses (Sawyer, Major, Casad, Townsend & Mendes 2012). In their review of the literature, Ferguson and Candiby (2002, p. 359) found studies identified the need for greater ethnic diversity in the healthcare workforce "since minority patients are more likely to choose minority physicians...and to feel more connected and involved in decision-making with racially concordant physicians." Further, Tucker et al. (2003) identified the need for office and ancillary staff to undergo cross-cultural awareness training, and the characteristics of the physical environment to be culturally-sensitivity

**Chapter Summary**

This chapter has reviewed literature pertaining to barriers and facilitators for patient access to primary healthcare at the levels of the health system, the healthcare process, and the patient and/or population. Chapter Five outlines the methodological approach and research methods adopted in this research.
CHAPTER FIVE: METHODS AND METHODOLOGY

All I thought of [when asked to participate in the Hauora Manawa Study] was ... do I dare say it, "pakeha are going to pick that data up", you know, and it was the same old concept and perception that I've always had ... [but the outcome] was very unexpected [laughs] (Study Participant, Amanda).

Introduction

This chapter contextualises the positioning of Māori health and social disparities within an analytical framework and explicates the methods of selection, collection, and analysis of primary data from a Maori sub-group of the Christchurch cohort of the Hauora Manawa Study. The first section outlines the principal concepts derived from the integration of Bourdieu's theory of practice and Shim's cultural health capital into a context-specific framework apropos to the analysis of the dichotomous relationship between patient agency and the structure of primary healthcare. The synchronicity between Bourdieusian and Kaupapa Māori philosophy, the positionality of the researcher and processes of reflexivity associated with this study are also discussed. Section Two describes the specific approaches and techniques employed in relation to the selection, collection and analysis of primary data.

Principal analytical concepts

The theory of practice posits that practice is the outcome of the relationship between the concepts encapsulated in Bourdieu's (1984, p. 101) equation:

\[ \text{habitus + field = practice} \]

In the following discussion these, and other, key analytical concepts used in this study are defined in order to explicate how, by bridging the dualism of objectivism and subjectivism, Bourdieu's theory of practice facilitates a "more comprehensive reading of practice and experience of that practice beyond it immediate subjective evaluation" (Ozbilgin & Tatli 2005, p. 857); and furthermore, to convey why Bourdieu's "structuralist constructivism or
constructivist structuralism" (Bourdieu & Wacquant 1992, p. 11) is considered to "offer an epistemological and methodological third way" (Grenfell & James 1998, pp. 1-2).

Habitus

Formally, Bourdieu (1990, p. 53) defines habitus as a property of social agents (whether individuals, groups or institutions) that comprises:

systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organise practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them.

Thus, habitus is "structured" by an individual's past and present circumstances (including family upbringing and educational experience); "structuring" in that it shapes an individual's present and future practice; and "structured" in that it is systematically ordered rather than random or unpatterned (Maton 2008, p. 51). This "structure" encompasses a system of dispositions:

a template which generates strong, normative propensities of actual social practices that are considered normal, acceptable conduct within a given field; thereby functioning as a 'generative principle' that makes possible, but also sets limits to, the 'free production of all the thoughts, perceptions, and actions inherent in the particular conditions of its production' (Bourdieu 1990, p. 53).

Constant subjectivity to experiences means that habitus, while producing and reproducing regularities, also produces diversity. This conceptualisation is central to helping transcend the structure/agency binary as the "outer' social, and 'inner,' self, mutually shape each other" (Ball 2012; Maton 2008, p. 50). Thus, habitus is generative, not deterministic, "durable but not eternal" (Bourdieu & Wacquant 1992, p. 133), and must therefore be considered relationally by emphasising "relations between" rather than "either/or" with respect to the concepts of capital(s), fields and practice (Maton 2008, p. 55).
More recently, Bourdieu (2002, pp. 27-28) defined habitus as "a system of dispositions, that is of permanent manners of being, seeing, acting and thinking, or a system of long-lasting (rather than permanent) schemes or structures of perception, conception and action." The "mental structures" and dispositions from which choices derive are generated within the habitus as a "conditioned and conditional freedom;" the habitus generates "things to do or not to do, things to say or not to say, in relation to a probable 'upcoming future'" (Bourdieu 1990, p. 53). Structure is "embodied and working in" and "through" an individual's dispositions and actions, rather than "on them;" this is a world of common sense and self-evidence - "intelligible, foreseeable and hence taken for granted" - that generates a sense of what is and is not for us (Bourdieu 1990, p. 64).

Dispositions

Dispositions thus generate practices that are "regular" without being consciously coordinated or governed by conscious rules (Bourdieu 1977, p. 72); the two essential components - structure and propensity - are the result of:

organising action, with a meaning close to that of words such as structure; it also designates a way of being, a habitual state (especially of the body) and, in particular, a predisposition, tendency, propensity or inclination (Bourdieu 1977, p. 214).

While the internalisation of the earlier socialisation imposes structural limits on what particular groups perceive as possible or likely, dispositions also produce perceptions, aspirations and practices associated with the structuring properties of that earlier socialisation (Swartz 1997, p. 103). This reinforces the crucial distinction that while dispositions shape and orient human action they do not determine it (Swartz 2002, p. 63S). Thus, although the "fuzzy" (rather than formal) logic produced by habitus does not rule out strategic choice and conscious deliberation of possible action, habitus nevertheless remains the dominant principle of these choices; during times of crisis, the course of action suggested by habitus may encompass strategic cost/benefit calculations, and thus "rational choice" may triumph amongst those with the capacity to be rational (Bourdieu & Wacquant 1992, pp. 22, 131). Individuals choose from one of the multiple possibilities of their habitus where the doxa of the field - "the sense of limits ... the sense of reality" -
make it appear self-evident that only single, not multiple possibilities exist (Bourdieu 1977, p. 164).

**Doxa**

For Bourdieu, doxa implies a commitment to the tacit presuppositions that delimit the "relationship of immediate adherence that is established in practice between habitus and the field to which is attuned ... the pre-verbal taking-for-granted of the world that flows from practical sense" (1990, pp. 66, 68). The truth of doxa is therefore "only ever fully revealed when negatively constituted by the construction of a field of opinion, the locus of the confrontation of competing discourse" (Bourdieu 1977, p. 168). While "crisis is a necessary condition for a questioning of doxa ... it is not in itself a sufficient condition for the production of critical discourse" (Bourdieu 1977, p. 169). The power of doxa lies in concealing the fact that what is claimed to be "reality" represents a "reified abstraction" of one, and only one, possible "truth" about the nature of existence (Bourdieu 1989, p. 37).

The conceptual triad of habitus, field, and capital must be considered relationally. Practice results from the relations between an individual's habitus and current circumstances, which Bourdieu (2000, pp. 150-151) describes as "the meeting of two evolving logics or histories;" the physical and social spaces that individuals occupy (like the habitus) are structured, and it is the relationship between the these two structures that produces practice (Maton 2008, p. 52). This "obscure relation" is further complicated by being one of "ontological complicity" because the field, as part of the ongoing contexts in which individuals live, structures the habitus, while simultaneously habitus conditions individuals' understanding of their lives, including that which relates to a field (Bourdieu 1982 p. 47 cit. Maton 2008, p. 52):

On one side of the relation of conditioning: the field structures the habitus....
On the other side, it is a relation of knowledge or cognitive construction. Habitus contributes to constituting the field as a meaningful world (Bourdieu & Wacquant 1992, p. 127).
Fields

In fields of social action, Bourdieu (1977) frequently used the analogy of a game to convey a practical understanding of what motivated human action. In challenging the basic premise of Rational Action Theory, Bourdieu (1990, p. 67) argued that social agents "do not continuously calculate according to explicit rational and economic criteria, but rather operate according to their 'feel for the game', practical sense - sens pratique." It is, with caution, possible, Bourdieu states, to:

compare a field to a game (jeu) although ... a field is not the product of a deliberate act of creation, and it follows rules or better, regularities, that are not explicit and codified. Thus we have stakes (enjeux) which are for the most part the product of competition between players. We have an investment in the game, illusio...: players are taken in by the game ... only to the extent that they concur in their belief (doxa) in the game and its stakes.... Players agree, by ... playing, and not by way of a "contract," that the game is worth playing .... (Bourdieu & Wacquant 1992, p. 98).

Bourdieu defined fields as a network, structure or set of relationships and, positions within a field are:

objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation (situs) in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to others that agents unconsciously understand (Bourdieu 1985, p. 724; 1990; 1992).

By dividing the modern world into social spaces or fields, Bourdieu allowed for the analysis of society as an "ensemble of relatively autonomous spheres" that individuals encounter with varying rules, values, and structures (Bourdieu & Wacquant 1992, p. 18). Dynamic intra-field forces create continual power struggles directed towards transformation that manifest in endless change (Bourdieu & Wacquant 1992, pp. 103, 109). Practice results from "an obscured and double relation" (Bourdieu & Wacquant 1992, p. 126) between a habitus and a field, and from relations between an individual's dispositions.
(habitus) and position in a field (capital), within the current state of play of that social arena (field) (Maton 2008, p. 51). Practice is conditioned by the relationship between the evolving habituses within the contextual fields where agents are located, and changes in fields which are also evolving according to their own logic (Bourdieu 1990, pp. 52-65; Maton 2008, p. 53). Although each field is a dynamic field of force with its own internal logic governing how the game is played and the internal potentialities that exist, the relative autonomy of each field is nonetheless constrained by the political field - the locus of conflict and competition for all capital(s) (Mahar, Harker & Wilkes 1990, pp. 16-17). This hierarchy facilitates indirect dominant class control of access to societal resources across all fields (Mahar et al. 1990, pp. 16, 17). Moreover, the hierarchical structuring of fields accords with context-specific underlying nomos, or governing laws (Bourdieu 1977), meaning that fields are designated arenas of symbolic power in modern differentiated societies, where "specific forms of capitals are produced, invested, exchanged and accumulated" as discrete, though mutually convertible forms of power, with distinctive modes of accumulation and operation (Swartz 1996, p. 78).

Capital(s)

Bourdieu's (1986) theory of capital conceptualises capital(s) (economic, cultural, social and symbolic) as valued resources which function as a "social relation of power" (Bourdieu 1989 p. 375 cit. Swartz 1996, p. 75). While Bourdieu, like Marx, emphasised the primacy of conflict and class (or ethnicity) based social inequality (Swartz 1996, p. 73), he challenged the primacy of "economism' as a form of 'ethnocentrism' that recognised only the interests of capitalism, or quoting Marx, as 'callous cash payment'" (1990, p. 113). Positing that the exchange of capital was the locus of domination, Bourdieu (1977, p. 178) expanded the economic metaphor to encompass "all the goods, material and symbolic, without distinction, that present themselves as rare and worthy of being sought after." The inextricably, intertwined relationship between capital(s) (Bourdieu 1990, pp. 118-119) produced an unconscious acceptance of social differences and hierarchies - a sense of one's place (and the place of others) in society and concomitant behaviours of self-exclusion (1984, p. 471).
Economic capital

Equitable distribution and/or accrual of economic capital, material wealth, assets and concomitant power are antithetical to the colonial enterprise, which is by its very nature founded on the transfer and redistribution of all assets and resources from the indigenous to the colonised. Symbolic violence plays an integral role in the dehumanisation of the indigenous (Churchill 1994), and evolving justifications of the righteousness, morality, integrity and inevitability of the colonial process. In The Forms of Capital, Bourdieu (1986, p. 2) stated that depending "on the field in which it functions ... and at the cost of the more or less expensive transformations [economic capital] ... is immediately and directly convertible into money;" and, that the "different types of capital can be derived from economic capital" may be transformed "to produce the type of power effective in the field in question. For example, there are some goods and services to which economic capital gives immediate access, without secondary costs; others can be obtained only by virtue of a social capital of relationships (or social obligations)..." (p. 11). Accordingly, economic capital "is at the root of all the other types of capital and that ...transformed, disguised forms of economic capital ... [are] in the last analysis – at the root of their effects" (Bourdieu 1986, pp. 11-12).

Cultural capital

Cultural capital,\textsuperscript{157} as an irreducible form of power, interchangeable with economic power (Swartz 1996, p. 75), exists in three forms: objectified in cultural and material goods, institutionalised in status, honour and prestige, and embodied through processes of socialisation (Bourdieu 1986). Acquired "without deliberate inculcation," cultural capital is nonetheless permanently marked by the class, social (and ethnic) origins of its acquisition, which in a highly differentiated, racialised, neo-colonial society represents a formidable source of power, embedded in the reproduction of inequalities and hierarchies (Bourdieu 1984, pp. 47-49). Bourdieu's interpretation of culture usefully transcends the characteristics of ethnicity and "race" to encompass the values, beliefs, perceptions and attitudes of all social groups (Weininger 2005, p. 165).

\textsuperscript{157} Later Bourdieu used the term "informational capital to give the notion its full generality" (Bourdieu & Wacquant 1992, p. 119)
Cultural health capital

In the field of health, where culture is the "battleground" of human interaction (Navarro & Shi 2001), cultural health capital (CHC):

... clearly gestures towards its nature as a resource and to its holders as actors with a means of exchange, and therefore some measure of agency. But, as with cultural capital theory, holders of CHC are not individual free agents who can simply acquire and deploy resources at will ... [as] there are systematic inequalities in the ability to both accrue cultural capital and convert it into advantage... [and] aspects of patient-provider encounters can be linked to and understood as manifestations of broad inequalities permeating social structures, institutional arrangements and social life (Shim 2010, p. 4).

Cultural health capital has explanatory power in relation to the interactional dynamics between patients and clinicians; the effects can be direct and indirect, instrumental as well as symbolic forms of capital affecting the systematic yet variable relationship between social and ethnic status and the provision of unequal treatment (Shim 2010, p. 1).

Social capital

Social capital refers to "social connections, honourability and respectability" (Bourdieu 1984, p. 122), which represents the "sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu & Wacquant 1992, p. 119). Accordingly, resources, power and cultural capital derived from socialisation within informal social networks constitute a potential source for the production and reproduction of inequities (Malat 2006, p. 310).

Symbolic capital and symbol violence

For Bourdieu, symbolic capital is a disguised form of physical economic capital that produces its proper effect by concealing its material origins (Bourdieu 1977, p. 183). Symbolic capital incorporates "the form that the various species of capital assume when they are perceived and recognised as legitimate" (Bourdieu 1989, p. 17). Notwithstanding
the "links and potential conversions between the various forms of capital and their relationship to power" (Hillier & Rooksby 2002, p. 8), symbolic capital is commonly not perceived as power per se and may manifest as symbolic power or as expressions of symbolic violence that transform into "legitimate demands for recognition, deference, obedience, or the services of others" (Swartz 1997, p. 90). However, dominated actors are not "passive bodies to whom power is applied, but rather people who believe in both the legitimacy of the power and the legitimacy of those who wield it"; thus, for Bourdieu (1987, pp. 13-14) symbolic power was a "worldmaking power" due to its capacity to impose a legitimised vision of the social world" (Hillier & Rooksby 2002, pp. 8, 9).

Collectively, Bourdieu's concepts that speak to "relations between culture, stratification, and power," are not "tidy, well-delimited theoretical arguments but orienting themes that overlap and interpenetrate" (Swartz 1996, p. 72) that usefully contribute to the analysis of the complex relationship between contemporary Māori health practices and neo-colonial relations. Within the context of the modern nation state, symbolic power ensured that ownership of "the territorial landscape [and] ... imaginative landscapes" changed hands; inherited elements are evident in the durable ways in which in neo-colonial societies "retains much of the colonialist habitus" (Hillier & Rooksby 2002, pp. 9, 22). The social classification of indigeneity, on the basis of distance from the legitimatised dominant culture (Bourdieu 1990, p. 139), represents a "formidable, but highly elusive type of power, one that effects a 'mysterious alchemy'" (Bourdieu 1991, p. 233) by concealing its material interests (Bourdieu 1977, p. 183).

The concentration of symbolic power among the dominant group perpetuates colonial relations of the power to name, to represent commonsense, and create the official version of social reality (Mahar et al. 1990, p. 13). Political domination remains constant across all social fields, while the protean nature of dominant cultural ideologies, and attendant deficit theories, transmogrify as various group factions struggle for symbolic capital (Harker, Mahar & Wilkes 1990, p. 206); variants of deficit theory re-emerge once the scientific or ideological basis of a variant has been discredited (Valencia & Solorzano 1997). Thus, the construction of social relativity vis-à-vis the dominant and the dominated masks three interrelated factors (Bourdieu 1989, p. 18): first, classification as "other" imposes structural constraints; second, these structuring structures, cognitive structures, are themselves socially structured because they have a social genesis; and, third, the construction of social
reality is both an individual and collective enterprise, involving classification by self and others and concomitant processes of inclusion and exclusion.

Moreover, symbolic power explains "an important relational dimension between culture, social structure and action, showing how individual actions are produced within social structures and how, in turn, they creatively respond to and alter those structures" (Hillier & Rooksby 2002, p. 377). Within the context of this research, manifestations of symbolic violence include the power of the state, its institutions and representatives with socially recognised status or credentials (Bourdieu 1989, p. 21), as well as the power to determine the "status and legitimacy, distinction and deservedness" of Māori healthcare (Shim 2010) across time and space. Thus, symbolic power has explanatory power in understanding how expressions of symbolic violence contribute to the production and reproduction of interethnic inequities within the context of primary care.

Symbolic power is, however, as Bourdieu contends, exercised in collaboration with the dominated: social agents "are knowing agents who, even when they are subjected to determinism, contribute to producing the efficacy of that which determines them insofar as they structure what determines them" (Bourdieu & Wacquant 1992, pp. 167-168). Moreover, Bourdieu states that of "all the forms of hidden persuasion,' the most implacable is the one exerted, quite simply, by the order of things;" the dispositions that predispose agents towards complicity, in fact, represent the embodiment of that domination (Bourdieu & Wacquant 1992, pp. 24, 168). Symbolic violence is enacted through "cognition and misrecognition that lies beyond - or beneath - the controls of consciousness and will" (Bourdieu & Wacquant 1992, pp. 171-172). According to Wacquant (1995, p. v), the symbolic violence exercised by the state:

...bears upon us all, in a myriad minute invisible ways we perceive and construct the social world through categories instilled in us via our education. The state is not only out there, in the form of bureaucracies, authorities, and ceremonies. It is also in here, ineffaceably engraved within us, lodged in the intimacy of our being in the shared manner in which we feel, think and judge. Not the army, the asylum, the hospital and the jail, but the school is the state's most potent conduit and servant.
Bourdieu argues that "the exercise of all power requires legitimation, and that the logic of self-interest underlying all practices - particularly in the cultural domain - goes 'mis-recognised' as a logic of 'disinterest'" (Swartz 1996, pp. 76-77). In transcending the interpretation of culture beyond ethnicity and "race" to the values, beliefs, perceptions and attitudes of all social groups (Weininger 2005, p. 165), cultural resources, processes and institutions can be conceptualised as competition between individuals and groups in self-perpetuating hierarchies of domination (Hillier & Rooksby 2002, p. 378). Significantly, Bourdieu perceived that human behaviour was firstly, fundamentally cultural, which prevents reducing human action to "stimulus-response sequence in operant conditioning;" secondly, human behaviour is essentially "practical," performed with a tacit, informal, taken-for-granted measure of awareness and not governed by purposive goal oriented, rational calculation; and thirdly, human action is not based primarily on conformity, as while it is adaptive it is at the same time strategic, "constitutive of cultural standards as well as adaptive to them" (Swartz 2002, p. 62S).

Social class and symbolic violence

Bourdieu's theory of social class differs from contemporary class analysis underpinned by rational action theory (RAT) in two fundamental ways: first, as habitus orients "thoughts, perceptions, expressions, and actions," rationality is socially-bound (1990, pp. 55, 63-64); and second, symbolic systems are formative in establishing boundaries between social classes; accordingly for Bourdieu, class analysis requires simultaneous consideration of economic and symbolic relations (Weininger 2005, pp. 121-122). In Distinction, Bourdieu argued that differences in status (or lifestyle) represent manifestations of social class differences: first, because of the causal connection between class location and habitus, and second, a relation of "expression between habitus and a variety of practices (situated in different domains of consumption) cohere symbolically to form a whole "style of life." These practices function to establish social collectivities or "status groups" by instituting symbolic boundaries between individuals occupying different locations in the class structure through a process of "classificatory struggle" (Weininger 2005, pp. 124-125).

For Bourdieu (1984, p. 114), the occupational division of labour formed a system of theoretically significant factors which are derived from the distribution of capital(s): "the set of actually usable resources and powers." While economic capital relates to assets and material wealth, cultural capital represents is a culturally-specific "competence," albeit an
efficacious one in specific social setting (Weininger 2005, p. 126). In highly differentiated societies where cultural capital is primarily inculcated through the family and the school, transferability is limited as embodiment requires an investment of time (Bourdieu 1986, pp. 244-246). Accordingly, Bourdieu's theory of class structure positions individuals the occupation system in relation to their economic and cultural capital, the volume of their capital endowments, and the change or stability experienced over time in the volume and composition of capital (Weininger 2005, pp. 126-128). The habitus is differentially formed relative to each individual's location in social space and corresponds to a particular set of formative life conditions (especially, the experience of material necessity) imprints a set of dispositions upon the individual (Weininger 2005, pp. 131-132).

The third concept in Bourdieu's arsenal - the field - represents a battlefield or playing field, where individuals confront each other in conflict or competition from more or less advantageous positions (Bourdieu & Wacquant 1992, pp. 16-18). The formation of social collectivities results through constant, reciprocal acts of social classification which symbolically delimit "regions" of social space, the "separative power .... drawing discrete units out of indivisible continuities, difference out of the undifferentiated" (Bourdieu 1984, p. 479) through combined symbolic acts of self-classification and classification by others. The process of categorization and classification is not, however, evenly spread across this space, "as the symbolic force of practices that fulfil a classificatory function are derived from their proximity to or distance from the legitimate culture" (Weininger 2005, p. 142). Thus, for Bourdieu (1987, pp. 8-9) all social collectivities are "historical artifacts" as the social world encountered is "always already" riven by innumerable symbolic cleavages. Incorporated into the habitus, these "principles of vision and division" increase the likelihood of people being classified in a determinate manner, which in turn inclines habitus towards inertia and the reproduction in its own practice of classificatory structures encountered in early experience (Bourdieu & Wacquant 1992, p. 133). Classificatory structures may be modified by economic transformations which may alter the distribution of capital(s), and second, within the context of a highly differentiated social space, the existence of multiple systems of classification compete with one another in perpetuity (Weininger 2005, p. 152).

Most importantly, however, Bourdieu's theory of class recognises "the complex combination of domination generated by the intersection of different classificatory
principles" beyond that of class structure (Weininger 2005, pp. 157-159); and, the paradox of doxa of the everyday practical orthodoxy of symbolic violence that operates to natural the social order through desocialised and dehistorised discourses (Bourdieu 1998b). In the following excerpt from *Masculine Domination*, Bourdieu emphasises the relationship between gender and class as well as classificatory struggles vis-à-vis ethnicity:

Whatever their position in social space, women have in common the fact that are separated from men by a negative symbolic coefficient which, like skin color for blacks, or any other sign of membership in a stigmatized group, negatively affects everything that they are and do, and which is the source of a systematic set of homologous differences: despite the vast distance between them, there is something in common between a woman managing director ...and the woman production line worker.... (2001, p. 93).

**Analytical and conceptual frameworks**

**The Theory of Practice and Cultural Health Capital**

The integration of Bourdieu's *Theory of Practice* (1977) with Shim's (2010) concept of *Cultural Health Capital* allows for analysis of the complex relationship between the Māori study population, their position in the field of health and interrelated fields, and the subjective consequences of these objective structural arrangements (Swartz 1997, p. 97) that operate at meta, mesa and macro levels of New Zealand society. Within the context of this framework, habitus, as the property of individuals, groups, and institutions, is analysed in relation to past and present social circumstances that determine the systematic (rather than random) accrual of capital(s) that influence current practice (Maton 2008). Practice, in turn, is analysed in relation to a hierarchy of fields of forces, underpinned by the evolving logics and histories of these relatively autonomous but interrelated fields across time and space.

At the process-level, Bourdieu's generative structuralism frames the dialectic analysis of individual agency and the structure of primary healthcare; the concept of cultural health capital frames the analysis of the dynamics of "the often non-purposeful, habitual nature of culturally-mediated interactional styles" (Shim 2010, p. 1) of ethnically-discordant clinical engagements, where the Māori patient habitus is unlikely to encounter a taken-for-granted
social world of which it is a product (Bourdieu & Wacquant 1992, p. 127). This framework accords with mounting international recognition that "culturally embedded norms of social identity ... [are] expressed, distinguished, and experienced" (Sweet 2011, p. 19) as health status, medical treatment and interethnic disparities in the accrual of dominant group cultural capital (Malat 2006, p. 310). Moreover, this framework accommodates analysis of the broader context and the potential of the habitus of the social actors to have internalised objective colonial relations that ordered society; their practices are informed by the active presence of past experiences in perceptions, thoughts and actions which tend to ensure "the 'correctness' of practices and their constancy over time, more reliably than all formal rules and explicit norms" (Bourdieu 1990, p. 54).

At the patient-level, the Māori habitus, (and accrual of cultural health capital) as the product of a socially constituted sense of the game of the game (Bourdieu & Wacquant 1992, p. 7), can be analysed across space and time, gender and class-location and social status, and social classification as Māori. Gender differentiation reflects the integration into dominant group social and employment conditions; time reflects the history, context, and tempo and the social disruption precipitated by urbanisation, and the potential for the manifestation of a cleft, tormented habitus, marked by the contradictory conditions of its formation. Adult initiation of engagement and encounters with Western medical practices, which mandate acceptance of a new set of rules or doxa, may prove a protracted and/or stressful occurrence constitutive of a type of "second birth" (Bourdieu 1990, p. 68). The tendency exists for a collective habitus to be preserved over relatively long timeframes (Friedmann 2002, p. 301). Changes in medical culture, from continuous access to paternalistic, whānau-oriented family medicine, to the more technical and less personal delivery of contemporary primary care, may produce a hysteresis effect - a mismatch, a time lag when the patient habitus and the field structures no longer correspond (Deer 2008, p. 132). As Bourdieu (1990, p. 62) states:

The presence of the past in this kind of false anticipation of the future performed by habitus, is paradoxically, most clearly seen when the sense of a probable future is belief and, when dispositions ill-adjusted to the objective chances because of a hysteresis effect ... are negatively sanctioned because
the environment they encounter is too different from the one [to] which they are objectively adjusted.

Finally, social-ascription and/or classification as Māori reflects the construction of social reality and/or experiences that may inform propensities towards self-exclusion or limited engagement with mainstream provisions.

At the mesa-level, the effect of institutional changes within the field of healthcare over time can be analysed by exploring concomitant changes as the patient habitus adapts to new structures and practices that differ from the accepted norms at the time of entry, potentially three or four decades ago (Friedmann 2002, p. 301), and adjusts to modern primary care where doctor-patient engagement is advantaged by "socially-transmitted and differentially distributed skills and resources" (Shim 2010, pp. 1, 3). Additionally, the modern healthcare landscape reflects dominant group power to shape and define institutional arrangements, activities, resources and behaviours of value (Shim 2010, p. 4). Although power is experienced differently in and between all fields, healthcare is characterised by extreme differentials of power and objectified capital(s), and the success of patient interactions is conditional upon the possession and/or the development of cultural health capital and dispositions that reflect and/or encourage patient initiative, "self-knowledge, self-surveillance, and self-management" (Gaventa 2003, p. 3; Shim 2010).

At the meta-level of analysis, the field of politics conditions the social space, within which all transactions, interactions, and events are co-constructed in inter-dependent relations between habitus, capital, and fields. In a neo-colonial society, the political force field, by virtue of its constitution, ensures the ordering of fields in relation to proximity/distance from the dominant group culture. Thus, while fields are shaped according to their own rules, regularities, histories and distinctive logics of practice, social classification as Māori has the potential to encourage differential responses from social agents that impact on healthcare. This analysis extends to the embodiment of social relations within the habitus of social actors across the relatively autonomous, but "tightly coupled" fields (Swartz 1997, p. 124), where the habitus generates strong, normative propensities of dominant group practices considered to be normal, acceptable conduct (Friedmann 2002, p. 300). Moreover, in the relationship between colonial relations and contemporary interethnic health disparities, as Bourdieu states:
there is a probability, inscribed in the social destiny associated with definite social conditions, that experiences will confirm habitus, because most people are statistically bound to encounter circumstances that tend to agree with those that originally fashioned their habitus (Bourdieu & Wacquant 1992, p. 133).

Social trajectories reflect the "historical specificities of the different bases of social domination" (Weininger 2005, p. 156), and accordingly Māori engagement with primary healthcare can also be analysed in relation to both individual and collective trajectories, as the positions occupied within and across fields have been conditioned over time by their endowment (volume and structure) of capital (Bourdieu & Wacquant 1992, p. 109). Analysis of Māori "modal trajectory" in relationship to capital(s) informs an understanding the struggle for symbolic capital within all fields of economic, cultural, and social relationships (Mahar et al. 1990, p. 20) and the relationship between state policies that precipitated the downward trajectories of Māori health. Moreover, within the prevailing context of healthism, where conscious and intentional choices are posited as the fundamental principles of lifestyles, health-damaging behaviours and lifestyle factors can be analysed in relationship to the specific location in the social space (in combination with the social position and types of capital) that generates the systematic production of a specific habitus (Bourdieu 1984, p. 172; Hodgetts et al. 2005, p. 124; Korp 2010, p. 806).

Choosing Bourdieu

Bourdieu's understanding of power contrasts with Michel Foucault's; while the latter considered that power was ubiquitous, beyond agency or structure, for Bourdieu power was culturally and symbolically created, and constantly re-legitimised through an interaction between agency and structure.\textsuperscript{158} The reconciling of structure and agency (together with an array of theoretical, philosophical and sociological disciplines) traditionally considered to be discordant or incompatible, bears testimony to Bourdieu's "distinctive intellectual project and style," in that social action, structure and knowledge are "resolutely monist or anti-dualistic" (Wacquant 2006, p. 4):

\textsuperscript{158} Both theorists conceptualise the notion of power differently. Bourdieu focuses on answering the question, "Who has power and how they get it and use it?"; Bourdieu's definition of "symbolic power is a power of constructing reality" an "indivisible power which can be exercised only with the complicity of those who do not want to know that they are subject to it or even that they themselves exercise it" (1994 p. 164 cit. Geciene 2002, p. 117). In contrast, Foucault, who perceives that "state is a superstructural in relation to a whole series of power networks..." focuses on the question of "How does power function in society?" (1986 p. 64 cit. Geciene 2002, pp. 117, 119).
Objectivism holds that social reality consists of sets of relations and forces that impose themselves upon agents, 'irrespective of their consciousness and will' (to invoke Marx's well-known formula). From this standpoint, sociology must follow the Durkheimian precept and 'treat social facts as things' so as to uncover the objective system of relations that determine the conduct and representations of individuals. Subjectivism, on the contrary, takes these individual representations as its basis ... [asserting] that social reality is but the sum total of the innumerable acts of interpretation whereby people jointly construct meaningful lines of (inter)action.

Bourdieu's key conceptual concepts were influenced by a wide variety of intellectual theorists, including the forefathers of sociology. While opposed to the objectivist view that social reality was comprised of relations and forces, Bourdieu nevertheless expanded and integrated Marx's theory of capital into social practice, and Durkheim's social classification of rules and norms into the concept of social structures (Wacquant 2006, p. 6). Similarly, Bourdieu's concept of field was influenced by Max Weber's concept of relatively autonomous spaces and Goffman's frame and rules of irrelevance (Mahar et al. 1990, p. 8); Weber's life-changes through early socialisation (in conjunction with Merleau-Ponty and Husserl's phenomenology) influenced the concept of dispositions (Harker 1990, p. 109). The concept of habitus evolved from several different theoretical perspectives: ethnographical analyses of the Kabyle society society in Algeria and marriage strategies in Bearne, France; an emphasis on Lévi-Strauss's structuralist anthropology to encompass the external determinants of individual action; and, finally, Bourdieu's strong opposition to Sartre's existentialism which restricted action to human subjectivity independent of social influences (Swartz 2002). "The point was not simply to choose", as Calhoun (2002, p. 3) notes:

... Weber over Marx, or Lévi-Strauss over Satre, but to escape from false dualities and imposed categories. 'Objective analysis' [Bourdieu] wrote in *Homo Academicus* (1984), 'obliges us to realise that the two approaches, structuralist and constructivist... are two complementary stages of the same procedure.'

Notwithstanding that a Bourdieuan approach assumes primacy as the analytical framework within the context of this research, aspects of Kaupapa Māori epistemological
and methodological philosophies that correspond with the practices adopted in the broader *Hauora Manawa* study are recognised and loosely integrated within this study.

**Kaupapa Māori**

In essence, Kaupapa Māori refers to the philosophy and practice of being Māori: "It assumes taken-for-granted social, political, historical, intellectual and cultural legitimacy of Māori people, in that it is a position where Māori language, culture, knowledge and values are accepted in their own right" (Smith, 1992 p. 1 cit. Bishop 1996, p. 12). Meanings attributed to Kaupapa Māori, as Eketone (2008, p. 1) notes, often differ: from a community perspective, the concept commonly refers to a group or organisation that employs Māori cultural values and practices, whereas in academic circles, it usually refers to "a Māori philosophical approach to a field of practice or theory that focuses on challenging well-established Western ideas about knowledge;" this divergence reflective of the different and sometimes competing theoretical underpinnings of social constructivism and Critical Theory (Eketone 2008).

The emancipatory influence of Critical Theory was clearly influential in early manifestations of Kaupapa Māori responses to challenging persistent cultural deficit explanations that equated the position of Māori in New Zealand society, to "their inherent inferiority to their colonial counterparts" (Mahuika 2008, p. 1). In the late 1980s, early proponents, such as Graham Smith, developed Kaupapa Māori as a theory of social change, aligning the three fundamental components of Critical Theory with Kaupapa Māori praxis: conscientisation, resistance, and "praxis" or "reflective change" (Eketone 2008, p. 3). Similarly, Linda Smith (1999, p. 186), emphasised this relationship through "the notions of critique, resistance, struggle and emancipation." By way of contrast, "By Māori, for Māori" health initiatives providing culturally appropriate and relevant services reflect the influence of constructivism: "where knowledge is validated through a social construction of the world" and is therefore "located and specific" (Eketone 2008, pp. 1, 9).

In the contemporary milieu, while Kaupapa Māori remains highly critical of the external constraints imposed by Crown-Māori relations, it increasingly adopts a proactive stance on issues of relevance and concern for Māori (Mahuika 2008, p. 11). For example, the objectives of broader *Hauora Manawa Study* are not about critiquing power relations or resisting Western hegemony but improving Māori health within a Māori-centered context.
(Eketone 2008, p. 7) by employing a cultural framework that is not only meaningful to Māori but conducive to overcoming entrenched scepticism that many Māori have towards engaging in mainstream research (Mahuika 2008). As Mahuika (2008, p. 12) notes:

despite the need for more rigorous internal evaluation if [Kaupapa Māori] is to meet the lofty goals of empower and emancipation for Māori .... a monumental task as we are a heterogeneous and diverse group.... for many it is perceived to be a huge improvement on the options that previously existed that has the potential to deal with matters of importance for Māori beyond colonisation.

**Bourdieu and Kaupapa Māori**

This research is "not only Māori-led" (Mane 2009, p. 1) but foregrounds a Māori worldview that explicitly recognises the validity and legitimacy of cultural aspirations of being Māori, and the fundamental right to exercise autonomy over health and well-being (Cram et al. 2003). Kaupapa Māori and Bourdieusian philosophies of practice marry well. The need to incorporate Kaupapa Māori principles in active relationship with practice (Smith G, 1997 cit. Mane 2009, p. 2) corresponds with Bourdieu's *scientific sociology*, which requires the integration of theory and method as interdependent and totally reflective processes that guide the research process. The need to locate Kaupapa Māori research beyond the sole domain of academia (Mane 2009, p. 2) accords with Bourdieu's conceptualisation that the *theory of practice* is a method not a theory; Bourdieu's criticism of "intellectualist bias" is underpinned by researchers being insufficiently critical of the "presuppositions inscribed in the act of thinking about the world" (Bourdieu & Wacquant 1992) and their failure to grasp "the logic of practice" which arises. Indeed, Bourdieu endeavoured to destabilise and reinvent the sociological habitus, "a system of dispositions necessary to the constitution of the craft of the sociologist in its universality" (Bourdieu 1993, p. 271). According to Bourdieu:

> every act of research is simultaneously empirical (it confronts the world of observable phenomena) and theoretical (it necessarily engages hypotheses about the underlying structure of relations that observations are designed to capture) (Bourdieu & Wacquant 1992, p. 35).
Wacquant (2006, p. 5) adds that the "cause of social phenomena is to be found, not in the consciousness of individuals, but in the system of subjective relations in which they are enmeshed."

A similar correspondence can be found between Kaupapa Māori and Bourdieu's "obsession" with epistemic reflexivity\(^{159}\) of research practice (Bourdieu & Wacquant 1992, p. 36; Swartz 2002). The emphasis that Kaupapa Māori places on the collective and shared vision/philosophy of being Māori rather than the individual (G. Smith 2003) coincides with the Bourdieu's attentiveness to the personal motivations and affiliations of the researcher, the questioning of habitus, dispositions and practice that act as potential sources of bias (Bourdieu & Wacquant 1992). Although reflexivity has become a constituent, almost universally approved part of the lexicon of social science, enactment of the concept within research practice is less well defined (Maton 2003). Within the context of this research, reflexivity was perceived as an explicit self-conscious need on the part of the researcher to reflect on how personal biographical characteristics (such as values, motives, political views, life experience, employment and personal status) in conjunction with the social divisions of age, gender, sexuality, ethnicity and ability, may have influenced the design, execution and interpretation of the theory, data and conclusions (Greenbank 2003).

However, for Bourdieu, reflexivity, as Ozbilgin and Tatli (2005, p. 859) state: "does not simply refer to endless 'autobiographical referentiality,' or to the unconscious dispositions of the individual researcher, but to an examination of the 'epistemological unconscious' and the 'social organization' of the discipline" but a systematic exploration of the "unthought categories of thought which delimit the thinkable and predetermine the thought" (Bourdieu & Wacquant 1992, p. 40). Consistent with Bourdieu's scientific sociology, attempts have been made to give "equal epistemic attention" to, and recognise that an organic relationship exists between, all operations including the sampling method, participant selection processes, and the collection and analysis of data (Wacquant 2006, p. 5).

**Methods**

The Kaupapa Māori approach to data collection and interpretation of data employed in this thesis is consistent with the principles that guide the broader Hauora Manawa Study:

\(^{159}\) Maton (2003) argues that the actualisation of this concept requires the further development, particularly the addition of "epistemic capital" in order to realise the full potential of Bourdieu's enterprise.
The aims and objectives of this research reflect Māori values, beliefs and experiences, and are beneficial to Māori;

Cultural protocols are adhered to in all contexts involving human contact, thereby ensuring a safe environment for participants;

Ownership of data is jointly negotiated between the researcher and participants from the Hauora Manawa Study;

The analytic framework employed minimises mainstream cultural biases, stereotypical representations and contextualises the social reality of Māori participants in the Christchurch community.

Additional Kaupapa Māori principles reflected include: first, the principle of challenge exercised by questioning the status quo, emphasising the cumulative and deleterious impact of colonisation on Māori health, by explicitly acknowledging participants' perceptions and/or experiences of the "power relations that work towards the continued oppression of Māori" (Mane 2009, p. 7). Second, the validity and legitimacy of Māori culture is manifest in right of participants to express their needs and aspirations (and those of whānau) regarding perceptions of culturally sensitive and culturally competent primary healthcare. Third, the connection between participants and this researcher is fundamental to the sharing and generation of new knowledge across generations, and iwi affiliations consistent with the value Māori attribute to collective knowledge as a medium of survival and well-being (Jahnke & Taiapa 2001). Fourth, the principle of change is fundamental to the overarching emancipatory aim of this research vis-à-vis contributing towards transformative changes in the delivery of primary care for Māori individuals and/or the collective (Cram et al. 2003). Finally, notwithstanding that control of the method employed remains with Māori (Cunningham 1998), credibility is established by adhering to academic protocols, supervision and rigour (E. Curtis 2002).

**Purposive sampling**

This research adopted a purposive sampling strategy to "ensure the inclusion of relevant constituencies that can illuminate and inform that understanding" (Ritchie & Lewis 2003, p. 82). In the first instance, a sub-sample of Hauora Manawa Study participants who typified a circumstance or held a characteristic of relevance to the research were strategically and purposively invited to participate in semi-structured interviews (Ritchie & Lewis 2003, p. 82). Purposive sampling is a leading non-probability sampling strategy used in qualitative
research, where the logic and power resides in the selection of information rich cases which "yields insights and in-depth understanding rather than empirical generalizations" (Patton 2002, p. 230). This selection technique ensured diversity and symbolic representation (Ritchie, Lewis & Elam 2003) reflective of the heterogeneous reality of Maori society. The purposive sampling of "information rich" cases with the capacity to highlight subtle but potentially important differences in perceptions and experiences (Barbour 2001; Devers & Frankel 2000; Miles & Huberman 1984) produced rich, subjective descriptive narratives conducive to gaining maximum insights into and in-depth understanding of the research question.

The administration records of the Hauora Manawa Study provided a comprehensive source of data on the Maori cohort in Christchurch (n=244) randomly selected from the electoral roll on the basis of being enrolled as Maori between the ages of 20 and 64 years and domiciled in Christchurch in 2008-2009. Participation in the broader study involved attending a screening clinic, undergoing a personal interview, and receiving facilitated medical care on an as-required basis. Using an existing sampling frame was both expedient and pragmatic, as the response rate of the original Christchurch cohort was greater than 70% minimising the effect of under-coverage and response bias (Devers & Frankel 2000).

This study was based on the purposive selection of a relatively small sample to generate large amounts of rich information (S. Curtis, Gesler, Smith & Washburn 2000, p. 1002) rather than measure incident or prevalence of sufficient numbers to prove statistically significant relationships (Ritchie & Lewis 2003, p. 83). The size of the sample was based on the need to adequately capture and reflect an authentic representation of others consistent with the principle of achieving data saturation (Ritchie & Lewis 2003). While the small sample size precluded generalisation or statistical representativeness, the purpose of this study is to describe perceptions and/or experiences relating to specific aspects of primary healthcare over and above satisfaction or perceptions relating to the adequacy of care (Arah et al. 2006) rather than attempt to make generalisations (Ritchie & Lewis 2003).

A significant strength of the purposive sampling strategy was the flexibility to change and/or refine the sampling criteria as the research progressed as the sample size and design was not absolutely fixed from the outset. Sequential sampling facilitated drawing on additional and supplementary samples if important constituencies were found to be under-
represented or where the diversity of a subgroup warranted further cases (Ritchie & Lewis 2003, pp. 82-85). This flexibility was important as the researcher was not personally acquainted with any of the participants, despite having conducted many of the Hauora Manawa screening interviews. Purposive sampling involved a three-stage, non-random, sequential process:

**Stage One**

First, the sampling frame was divided into four strata - Groups A, B, C and D - according to participants' responses to questions asked during the broader Hauora Manawa Study screening. The rate of attrition from the Māori cohort in Christchurch (n=244) proved minimal. One participant was deceased, some could not be located at addresses recorded in the administration records and/or were no longer domiciled in Christchurch; others were excluded from consideration on the advice of the principal investigator of the broader study, particularly where individuals or their whānau were burdened with physical or mental illness. The testimonies of several participants were not used in the final analysis of this thesis because of ethical and practical considerations, including impaired capacity to provide sufficient and factual data of the nature required (S. Curtis et al. 2000). Those used were assigned pseudonyms where the first letter indicated group responses to questions relating to discrimination and/or unfair treatment (for example, AMBER, BRENT, CARL and DAN).

**GROUP A:** Invitation letters were sent to all Hauora Manawa Study participants (n=20) who had responded in the affirmative to the following questions:

3.13. Do any of these things stop you from getting health care?

3.13.7 I have had a bad experience(s) and do not wish to go back.

3.15.2 Have you ever been treated unfairly (e.g. treated differently, kept waiting) by a health professional...because of your ethnicity in NZ?

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160 These questions were sourced from a series of questions on individuals' experience of racial discrimination that were included in the 2002/2003 New Zealand Health Survey (Harris et al. 2006a), which has been adapted from questions included in the United Kingdom Fourth National survey of Ethnic Minorities, and items proposed for the United States 2002 Behavioural Risk Factor Surveillance System (Centre for Disease Control and Prevention 2002 (Harris et al. 2006a)).
within 12 months
longer than 12 months

A total of fifteen participants were located at the addresses provided, one declined to participate in this study due to research fatigue. Of the fourteen interviews conducted, one was not transcribed and one was transcribed but not used in the final analysis, leaving a net total of thirteen participants:

AMBER; ADELE; ANNETTE; ALBERT; AMANDA; ALICE; ALISTER; AILEEN; ANGELA; ALLAMAIN; AGATHA; ALRIC.

In the three remaining group categories, as participants often responded in the affirmative to various questions that spanned group categories, selection was based consideration for inclusion in one group category only.

GROUP B: Of the participants (n=61) who had responded in the affirmative to the Question 3.15.5 below and were eligible for consideration, the testimonies of the following eleven individuals were used in this study:

BRENT; BOBBY; BECKY; BETTINA; BIANCA; BROCK; BERNICE; BERT; BETTY; BELLAMY; BEVERLEY.

3.15.5 Do you think that people living in New Zealand are generally treated differently by health professionals (for example, Drs, nurses, dentists) because of their ethnicity?

within 12 months
longer than 12 months

GROUP C: Hauora Manawa administration records indicated that (n=106) had responded negatively to questions 3.15.2 and 3.15.5 above. Ten participants were interviewed, one transcript was accidentally deleted, and the following nine testimonies are used in this study:

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161 As this was the only individual who declined to participate in the qualitative study because of research fatigue (Wilmot 2005) the rate of attrition from this cause was considered negligible.
GROUP D: Of those participants (n=55) who had replied "don't know" to questions 3.15.2 and 3.15.5 above, eight were interviewed, one transcript was omitted from analysis and another ultimately not used in the final analysis. A further two participants who were available to be interviewed in 2010 were not required as data saturation was thought to have been achieved:

   DYLAN, DELIA; DAN; DAPHNE; DIANA; DORA.

In summary, interviews were conducted with 45 participants: (Groups A= 5; B=12; C=10; D=8) of which the testimonies of 39 participants were used in this thesis (A=13; B=11; C=9; D=6). Refer to Appendix 1 for further information on participants.

Stage Two

Case diversification was further increased in accordance with Hauora Manawa Study's triaging status:

   Healthy – no medical attention required;
   Referred to general practitioner for managed care;
   Referred to cardiologist;
   Referred to cardiologist and general practitioner.

Stage Three

Further intra-group diversity involved selection according to:

   Demographic characteristics, age range, gender and marital status;
   Socioeconomic, education and employment status;
   Psychosocial stressors and or supports;
   Lifestyle factors including cardiovascular disease risk behaviours, (such as cigarette smoking and hazardous levels of alcohol consumption).
**Interview schedule and process**

A semi-structured interview guide (see Appendix 2 Interview Schedule) was developed and tested on fifteen Māori health professionals in Christchurch and several refinements were made. The overall scope of the interview guide was structured to provide insights into experiences and perceptions relating to:

- Accessibility and utilisation of, engagement and relationship with, local health services;
- Life circumstances, stressors and psychosocial factors that may affect health;
- Current health status and need (individual and whānau);
- Evaluation of Hauora Manawa experience;
- Experiences of, and beliefs about, discriminatory health care practices.

**Data collection**

Primary data was collected from participants \((n=45)\) who received Information Sheets, and signed Consent Forms (in addition to those associated with the *Hauora Manawa Study*) prior to engaging in the interview process (see Appendix 3 Information Sheet). Interviews averaged forty minutes and primarily took place at the office of the Maori and Indigenous Health Institute in Christchurch, although some were conducted at a venue more convenient to participants. Participants were given a koha of $40 in appreciation of their time. The researcher audio-taped and transcribed all interviews verbatim which were then entered into the *Nvivo* software programme. The primary data presented in this study is unedited, except in instances where the researcher deleted "irrelevancies" to improve coherence and save space (Reilly, Doyle, Bretherton & Rowley 2008).

**Data analysis**

Thematic analysis was employed in this research to systematically organise, process and analyse qualitative data gathered from participants (Boyatzis 1998; Braun & Clarke 2006). Because of its inherent flexibility, thematic analysis is widely-used method for identifying and analysing patterns (themes) within data in qualitative research and has application across a range of epistemological approaches that have the "potential to provide a rich and detailed yet complex account of data" (Braun & Clarke 2006, p. 77). In this study, analysis entailed a multistage process of identifying themes (or patterns) in participants' narratives that responded to the broad research question relating to barriers and facilitator to
accessing and engaging with primary healthcare. The researcher acknowledges that analysis was an active process and that the themes identified and selected corresponded with the broader arguments that underpinned this research (Braun & Clarke 2006); these encompassed both commonalities and divergences of experiences or perceptions, including information that was directly observable at a manifest level, or apparent at the latent level underlying the phenomenon (Boyatzis 1998, p. 4). While analysis was primarily inductive and data-driven (Patton, 1990), some themes and sub-themes were generated deductively from the broader Hauora Manawa Study, including:

- exposure to discrimination (experienced personally and/or vicariously and/or perceived);
- dispositions towards following up on recommended GP and/or cardiologist referrals;
- health status and health-risk behaviours.

Data analysis involved the following six-phase process that corresponds with that outlined by Braun and Clarke (2006): The first phase entailed an interactive and interpretative engagement with data during both the interview and transcription processes as well as reiterative readings of the transcripts. During the second phase initial codes comprised of the most basic segments or elements of the raw data were assessed (Boyatzis 1998, p. 63). Codes identified encompassed tensions and inconsistencies vis-à-vis barriers to and facilitators of healthcare access across the corpus of data. The third phase focused on broader-level themes that captured information that related to the research question and constituted some degree of patterned response or meaning within the data set; relevant data extracts were collated within overarching themes and sub-themes outlined below (Braun & Clarke 2006, p. 83):

- Continuity of care: doctor-patient rapport - consultations with locums non/regular doctors (time constraints, value for money)
- Explanatory models of sickness
- Time (and cause) of entry into health system: impact of changes in medical culture, significance of shared decision-making (pharmaceuticals)
- Culturally competent and/or unfair treatment - personal and/or transgenerational
- Interpretations of patient-centred care (Maori-centredness)
- Lifestyle and individual/family risk factors
- Discrimination across different institutions: education, police, media
Social class backgrounds: parental ethnicity (Pakeha mothers), work habitus.

This evolving thematic map formed the basis of the preliminary findings reported to the Ministry of Health in December 2010 as a condition of funding for this project.

Stages Four, Five and Six sequentially involved refining the thematic map and positioning themes within a Bourdieusian theoretical framework (Braun & Clarke 2006). The subsequent analysis of data within the context-specific Bourdieusian framework identified a complex and multi-dimensional relationship between first, the spatial and/or class-specific location of the primary habitus, the volume and composition of capital(s) accrued, and childhood access to primary healthcare in the post-World War Two period; and childhood experiences and adult dispositions towards current access to and engagement with modernised primary care services. Second, gender- and age-specific conditioning of habitus, and adult dispositions towards contemporary care; third, skin colour and/or social-ascription as Maori and/or non-Maori as a determinant of clinical encounters with predominantly non-Maori healthcare providers; and finally, the overarching impact of colonial relations on the accrual and deployment of Western cultural health capital. Analysis of practice forms the basis of the discussion in Chapter Nine.

Ethics

Ethics approval for this research is covered by approval granted to the Hauora Manawa Community Heart Study from the Multi-region Ethnics Committee which reviews National and Multiregional studies and is funded by the Health Research Council of New Zealand (Ethnic Reference MEC/06/03/026).

Chapter Summary

This chapter has positioned Māori health and social disparities within at theoretical framework and outlined the methods employed in the selection, interpretation and analysis of quantitative data collected from a Māori sub-sample of the Christchurch cohort of the Hauora Manawa Study. The following three chapters present the results of the analysis and interpretation of primary data as outlined above.
CHAPTER SIX: FINDINGS SPATIAL SOCIAL CLASS
LOCATION

Up on the Coast we had doctors who did a stint there for two to four years or whatever ...I remember there was a whole bus load of us who were going down to [X] for TB checks, I was a kid at that stage .... We grew up with a public health nurse, she was the district nurse, Nurse [X], she had a grey uniform and a hat like the Salvation Army women wore and she was fantastic. She'd come to school and go through and inspect for kūi'ti in the hair [laughs] and she'd say "you need to get your head cleaned." Her favourite cure was castor oil (Study participant, Charles).

Introduction

The purpose of this research is to explore the complex relationship between the interplay of patient-level, institutional-level, and process-level factors that condition current access to quality primary healthcare. Primary data is based on self-reported perceptions and/or experiences of a purposively sampled Māori sub-group (n=45) of the Christchurch cohort of the Hauora Manawa Study. The data presented is accompanied by analysis primarily guided by the integration of Bourdieu's (1984) Theory of Practice and Shim's (2010) concept of cultural health capital. Analysis of primary data entailed a process of cyclic reflexivity by the researcher that enables repeated immersion in the data to determine and reflect on how the lifecourse narratives of participants could be interpreted within the theoretical framework (Mathias 2009). The health status of participants, recorded by the Hauora Manawa Study, indicated the level of need (both met and unmet) at the time of screening. In addition, demographic information is included to support the themes identified. Although, recruitment in the Māori cohort of broader Hauora Manawa Study was based on self-identification of Māori ethnicity, in-text references throughout this thesis vis-à-vis social-ascription as Māori/non-Māori reflects participants' references to the presence and/or absence of commonsense markers of Māori heritage. The first initial of the pseudonym (A, B, C or D) denotes responses to questions relating to experiences and/or perceptions of unfair treatment by health professionals because of ethnicity (see Chapter Five). The principal conceptual tools used in the analysis of data are those encapsulated
within Bourdieu's (1984, p. 101) equation: \[ \text{(habitus) (capital)} + \text{field} = \text{practice} \], together with cultural health capital which, within the context of a racialised, neo-colonial society, emphasises that there are systematic inequalities in the ability to both accrue cultural capital and convert it into advantage.... [the] use of cultural capital emphasises its embeddedness with durable social processes that produce inequality ... [and] patient-provider encounters can be linked to and understood as manifestations of broad inequalities permeating social structures, institutional arrangements and social life (Shim 2010, p. 4).

Outline of Results Chapters

The findings of this research are presented in three chapters to illustrate the vicissitudes of Māori access to primary healthcare across time and space. Time reflects history, context and tempo (Bourdieu 1977); space reflects the social disruption caused by the rural-urban demographic transformation and the attenuation of the spatial segregation of Māori and Pakeha populations. Notwithstanding the ideology of equal opportunities, the Hunn Report (1960) substantiated a comprehensive level of ethnic inequities across all social fields (see Chapters Two and Three); health statistics compelled institutional recognition and belated redress of substantial interethnic disparities in mortality and morbidity (Durie 1998c, p. 127). While causation was variously attributed to Māori "genes, behaviour, circumstances and engagement with the system" (Reid et al. 2000, p. 44), current policy reflects the urgency and extent of interethnic disparities in health status and outcomes. While primary healthcare is one of the mechanisms through which the government intends to redress the interethnic disparities (Ministry of Health 2001b; Ministry of Health 2009) as Shim (2010, p. 6) notes, within the context of the modern healthcare landscape:

Patients now need a host of distinctively cultural skills and competencies to be ..."savvy organisational players." Patients who possess or acquire and display an enterprising and proactive disposition, a fluency in biomedical concepts and language, bureaucratic know-how, and an interactional agility with authoritative experts are more able to successfully navigate such organisational complexity. The cultural expectations and responsibilities of contemporary patienthood—in terms of self-knowledge, self-surveillance, health promotion, disease management, and the like—have also escalated.
Accordingly, optimal Māori engagement is theoretically determined by the possession of Western cultural health capital accrued through repeated engagement with primary healthcare (Shim 2010). This chapter outlines the relationship between the spatial and/or class-specific location of the primary habitus, the nature of capital(s) accrued, and childhood access to primary healthcare in the post-World War Two period; concomitantly it considers the relationship between childhood experiences and adult dispositions (habitus) towards current utilisation of modernised primary care services. Moreover, this chapter emphasises variations in the overall volume and the composition of capital(s), accrued over time (Wacquant 2006, p. 7). Chapter Seven explores a similar relationship but focuses on gender- and age-specific conditioning of habitus, and adult dispositions towards contemporary care. Chapter Eight focuses attention on the implications of social classification as Māori and/or non-Māori as a determinant of access to and engagement with predominantly non-Māori healthcare providers, and the impact of colonial relations on the accrual and deployment of Western cultural health capital. However, as these relationships are complex and interrelated, primary data is presented in vignette format detailing an individual life story as well as excerpts from narratives, themes may also be introduced when integral to a life trajectory.

**Chapter Outline**

"All agents within a particular society have an objective position in social space by virtue of their economic and cultural capital" (Crossley 2008, p. 88). What Bourdieu terms as "classes on paper" have emerged from historical forces: the mobilisation of political struggles have an enduring effect as they become embedded in the form of ethos, habitus and doxa (Crossley 2008, p. 88). In any social space, an individual's experience, life chances and habitus produce a tacit *sense of one's place* (Bourdieu 1984, p. 466); their positions and corresponding dispositions are reflective of categories of social and/or class identities. In highly differentiated, racialised societies, power and inequality not only derive from possession of economic capital but equally from symbolic forms of cultural and social capitals (Crossley 2008, p. 88). Symbolic capital manifests as noneconomic and therefore disinterested forms of capital, which ensure the transubstantiation of immaterial forms of cultural capital or social capital that convert into an advantage (Bourdieu 1986). In New Zealand society, where dominant group cultural capital is ascribed value, social
stratification is not only dependent on the volume of composition of capital, but possession of dominant group cultural capital (Crossley 2008, p. 88).

The relationship between cultural health capital, and access to and engagement with primary care, is structured in three sections to explore the domestic habitus, capital(s) and variations in access to primary healthcare across time and space, as well as the relationship between the primary habitus, accrued cultural health capital "through repeated enactment of health practices" (Shim 2010, p. 3), and adult dispositions towards healthcare. Findings reflect corresponding differences in first, spatial and/or class location and lifecourse access; second, childhood access to healthcare precipitated by illness or medical emergencies; and third, belated adult access initiated in an urban environment.

**Lifecourse access - urban and semi-rural**

The testimony of a 55-59 year old woman exemplifies how happenstance was a formative determinant of childhood access to primary healthcare (i), and the volume and composition of capital(s) accrued over time that facilitated attainment of her present social position (Wacquant 2006, p. 7). DIANA's narrative illustrates how the selection of one whānau member from the collective determined generational variations in intra-whānau life trajectories vis-à-vis socialisation in a middle-class, bicultural domestic habitus, conducive to the accrual of capital(s) appropriate to the dominant culture (ii):

(i) DIANA: [The doctor] was a friend of the family's...you could go and see him anytime.

(ii) DIANA: We were one of only two part-Māori families in [X] so my experience would not be the same as some of my cousins.... My father married a Pakeha woman and then he was a professional, they travelled overseas...[he] was an educated person...the youngest of 13 siblings and my grandparents decided...he was going to come down to [X] get an education. They worked really hard for that and so that lifted him out of what might have been a typical family situation.

This participant's "well-constituted habitus" (defined by the possession of symbolic forms of capital and high levels of cultural capital) (Moore 2008, p. 100) is demonstrated by the
possession of economic capital (annual income $100,000+; private medical insurance); dominant group cultural capital embodied in the middle-class lifestyle, including lifelong engagement in sport-related activities and objectified in academic qualifications; and social capital illustrated by social relationships with doctors (Bourdieu 1986). With respect to social classification as Māori, DIANA's dialogue is, however, contradictory; although acknowledging a sense of individual distinction from others in the whānau (ii), and privileged access to specialist care (iii), in the absence of taken-for-granted phenotypes used to assign Māori ethnicity, she appears to misrecognise any potential personal advantage accrued (iv):

(iii) DIANA: My GP...who I've known for ages and ages...she's great, love her a lot...I can pop in a get a prescription or she'll squeeze me in there.... [My] gynaecologist...is a mate...we went to university together...I've never had any problem with access at all.... [When I needed a] skeletal specialist [for] a sports injury, I just got straight through to [X because of Y]...so I'm probably not typical.

(iv) DIANA: How would [my doctor] know? Would she know [of my Māori heritage]?...Surely it would be difficult...if [Māori] were being discriminated against in any service like the health service and I just don't know whether that happens...I hope it doesn't.

Notwithstanding that dominant group cultural capital was acquired "without deliberate inculcation," it nevertheless denotes the social-class and ethnic origins of acquisition, which within the field of health represent a source of power, embedded in the reproduction of inequalities and hierarchies (Bourdieu 1984, pp. 47-49). DIANA's testimony emphasises how lifecourse accrual of Western cultural health capital translates into unimpeded access to, and positive engagement with, primary (and secondary) care providers, and "the ability to communicate social privilege and resources that can act as a cue of favourable social and economic status and consumer savvy" (Shim 2010, p. 3). Even though these skills and attributes are "intrinsically social and relational in their origin, [they] are perceived to be individual in their accumulation and expression" (Shim 2010, p. 5).
However, DAPHNE, a 45-49 year old blue-collar worker illustrates that notwithstanding working-class location and *a sense of one's place* (Bourdieu 1984, p. 466), conditioned by social-ascription as Māori, lifecourse access to primary healthcare in the urban milieu appears to represent a formative determinant in her pre-reflexive doxic acceptance of, and positive disposition towards, Western medical practice. Her disposition reflects a co-constructed relationship between a long-standing association with an Asian solo practitioner and the lifecourse accrual of cultural health capital. Relational continuity and patient-centred care appears conducive to increased patient self-confidence and understanding of medical knowledge (i), and overcoming internalised barriers vis-à-vis class and power differentials (ii) (Shim 2010):

(i) DAPHNE: He's been our family doctor for about twenty-five years...even though we hardly see him he's still asking after the kids by their first name or still probably remembers something you told him a year ago, so he's really good...and he really breaks it down so you understand, so we never have had to worry about going out and thinking, "God, what did that mean?"

(ii) DAPHNE: …maybe a lot of [Māori] feel that doctors...are just up there and maybe they feel dumb.... I used to think "doctors were Gods" and it's not that I don't any more, it's just that they're people that have learnt a hell of a lot and it's OK to ask them stuff. Years ago he could have said I was "blue with dots" and I would have believed him, because he's the doctor.

In addition to reinforcing the benefits that accrue when practitioners take an interest in whānau members and utilise understandable language (Cram et al. 2003) (ii), this narrative illustrates *a feel for the game* (Bourdieu 1990, p. 66), an inherent understanding that the proximity of, and longitudinal association with, primary care providers is protective against exposure to discriminatory care (iii):

(iii) DAPHNE: I bet [discriminatory care] happens...in fact I'm sure, [laughs]...but for me, no...when we were little we had the old shopping blocks and the doctors in there...and the one we've got now is just around the corner, maybe if they weren't so close and...they didn't know you from day dot; maybe it would have been different.
Cultural health capital is socially transmitted and embodied in the habitus. Although the offspring of a migrant are not predisposed to the "cleft habitus" of the parent because they learn the habitus appropriate to their social circumstances (Friedmann 2002, p. 302), confusion may nonetheless result from the disjuncture between parental disassociation from Māori culture and exposure to symbolic violence on the basis of phenotypical markers of that culture. Moreover, dominant group cultural capital is embodied "within the corporality of the person as principles of consciousness in predispositions and propensities in physical features such as body language, stances, intonations and lifestyle choice" (Moore 2008, p. 105). The following testimony illustrates first, the incorporation of social-class status in corporal as well as in cognitive dispositions (Swartz 1997, p. S63); second, that within the context of a social hierarchy, exemplified by exposure to symbolic violence in the primary socialising institution of education, the habitus has responded, over time, to objective social conditions; protective practices are directed towards the inhibiting intuitively perceived stereotyped behaviours in subsequent generations (iv):

(iv) DAPHNE: I used to think I had to try and be better all the time to make up for [being Māori] because you were never quite good enough. Bear in mind we were brought up in Christchurch and [Māori] mum left her family, so we don't know any of our culture...but the skin colour made it difficult for us....Even when my children were little I had this fear of people thinking they were snotty nosed Māori kids. I used to just about wipe their nose off...sometimes I feel, not ashamed, just like, I don't know the words, sometimes, "Oh God, they're going to look at me and think I'm, I don't know how to say it...I don't know if stressful is the word.... [When picked on by a teacher] you felt horrible, like you weren't good enough, you're never good enough, it's just, "them and us" type of thing...I can cope with it, well I think it doesn't bother me as much now, cause you just get on and you're kind of busy just living in life...but having said that, if we're out anywhere...my kids they're prone to swear a bit and I cringe.... I say: "Don't do that," and they go: "But other people do." "Just don't, because it looks bad." So even now I guess there's still a part of me that thinks (but they shouldn't swear anyway)..."it's worse if you say it," so I don't know if I've found the way to deal with it or not.
The foregoing dialogue emphasises the generational transmission of cultural capital(s), directed towards facilitating access to and engaging in all social fields, including healthcare. A 60-64 year old woman, AGATHA, is an outlier amongst this age-group of the study population vis-à-vis dual-Māori parentage and unimpeded access to primary care in a semi-rural location. In addition to substantiating benefits associated with longitudinal therapeutic relationships (i) reported above, her dialogue reinforces that the concept of trust is indicative of patient expectations being met (Mechanic 1986; Mechanic 1998). Furthermore, AGATHA's testimony illustrates the advantages that accrue when doctors foster the development of cultural health capital in their patients in terms of longitudinal self-efficacy in preventative healthcare (Shim 2010) (ii):

(i) AGATHA: I really trust [my doctor]. I'm on the board of [X], so I make sure our people are getting good healthcare, but there are a lot of issues [to address].

(ii) AGATHA: Doctor [X] delivered me...then he delivered my daughter...he always...spoke to me about looking after the weight and heart...I've been taking aspirin for a very long time.... I worry about my sons...so I've got them both on aspirin...because their dad died of...a massive heart attack at 45 years old and it runs in his family.

Collectively, the testimonies of DIANA, DAPHNE and AGATHA imply a relationship between lifecourse access, accrued Western cultural health capital, longitudinal doctor-patient relations, and positive engagement with modern primary care provisions, irrespective of spatial location, social-class and/or the presence of commonsense markers of Māori heritage.

**Childhood access - urban and rural**

However, for the majority of participants in this age-group, childhood access was precipitated by illness and/or medical emergencies, the former indicative of concurrent institutional redress of interethnic disparities in infectious disease and illness, especially in geographically remote Māori communities. This section explores the relationship between socialisation within an impoverished primary habitus, childhood access to Western healthcare, accrued cultural health capital and adult utilisation of health services.
The narrative of a 55-59 year old male with multiple co-morbidities suggests a relationship between a positive disposition towards health services, and longstanding therapeutic relationships with regular practitioners, moderating the saliency of accrued cultural health capital in clinical interactions. BELLAMY’s evidence potentially suggests a historical relationship between contracting rheumatic fever as an infant (in an impoverished domestic habitus) in a remote Māori community (i) and premature departure from the workforce following adult onset of cardiovascular disease and diabetes. This finding serves to emphasise the interconnection between colonial relations and contemporary Māori health status, between childhood circumstances and the ability to accrue capital(s) that condition the quality of clinical interactions. Notwithstanding childhood hospitalisation and positive adult engagement with health providers, the inability to accrue economic capital, regulations restricting eligibility for sickness benefits, and healthcare-related costs impose additional financial stress, all of which have health implications for the quality of domestic life (ii). BELLAMY’s dialogue has parallels with Hodgetts et al.’s (2011, p. 156) findings that factors, including cost, cause Māori to seek mediations on behalf of others where trusting doctor-patient relationships had been established:

(i) BELLAMY: When I was 9 months old, I spent a whole year in hospital...my father abused me a lot...because we never had that bonding.... The old lady used to send me away with the older sister to live.

(ii) BELLAMY: I'm actually a bit bummed out with [my doctor] at the moment...I'll be running him down if I tell you what I think...30-40 bucks to write you a prescription..... Actually, I shouldn't have said what I said really...he's been OK, it's just last week I went to see him...I said: "I want some sleeping pills for the wife." [But] when the wife [collected the script]...there were no sleeping pills, so she had...to pay another $30-40.... We paid $80 [in all].... We're struggling [financially]...I don't get a razoo...because she's earning more money than a sickness benefit.... You can do it when two of you are working, but when one of you can't work, you've...got to sell up and go to live in a tin shed.

Moreover, despite the possible association between rheumatic fever and cardiovascular disease, the following dialogue illustrates the internalisation of personal responsibility,
consistent with the prevailing ideology of healthism, where causation is primarily attributed to the lack of self-discipline in reducing health-damaging behaviours (iii). This association represents a barrier to timely engagement with healthcare amongst other study participants:

(iii) BELLAMY: [I've been going my GP] since I was sick, 10 years, but I had to give up work 5-6 years ago when they found the problem. [Initially]...electric shock [treatment] worked...but I didn't look after myself...carried on...drinking [and] smoking, then boom 5 years later [my heart] went out again, this time they couldn't get it back.

The testimony of a 50-54 year old male on a sickness benefit similarly suggests that the significance of a patient's cultural health capital is moderated by chronic illness, and further reinforces the compensatory benefits accumulated through longstanding therapeutic relations and expectations of competent future care (Guthrie et al. 2008). Despite childhood socialisation in a working-class, bicultural domestic habitus in the urban milieu, potentially conducive to the reported contraction of rheumatic fever (i), CRAIG's dialogue illustrates learned self-efficacy through childhood engagement with healthcare providers (ii), and perceived optimal and compassionate care from his regular physician, notwithstanding limited economic capital (iii):

(i) CRAIG: We all lived in the same room...4 girls, they were older, but 5 boys used to have to sleep in the same room ...we were 5 under 5, so she had 5 children under 5 all at once, twins and us 3 elders all within a 5 year period [laughs] that's an alcoholic father for you.

(ii) CRAIG: When I used to go to [X hospital], my mum used to shove me on the bus and I'd go and make my own way as a little kid... [she] didn't care because she'd had heart problems so it's a hereditary thing.... They didn't really pick up why I was falling asleep in class until...the first year of secondary school...I used to get the strap in primary school for going to sleep in class, but I didn't go to sleep, I'd just go "clonk" and I was gone, just like that! [Heart disease is from mother's Māori side]...we had a brother that died at two and a half with a hole in his heart.
(iii) CRAIG: [My doctor]...is one of the best doctors I've ever had. I [met him] when my first child was going to be born... [at] ante-natal classes...I'd only just come out of hospital an hour before...and he says: "Come and see me tomorrow, you look like you need to see me."...The next morning I went to him and we've been doctor-patient ever since.

CYNTHIA, a white-collar worker (60-64 years), who also has cardiovascular disease, describes suspected rheumatic fever and early exposure to Western medicine occasioned by sporadic campaigns to eradicate tuberculosis (the last in 1964) which, in contrast to the Pakeha population, remained uncontrolled among Māori until 1975 (Durie 1998c, p. 61) (i):

(i) CYNTHIA: I don't think I ever saw a doctor when I was little...I went to a specialist for my eyes when I was a baby...when my granddad was diagnosed with TB we all had to have TB shots.... As a child I had [suspected] rheumatic fever and I never found that out until I was about 17 [when]...I went back to my eye specialist...of course mum never really said anything so I was quite surprised.

The data on CYNTHIA suggests the subsequent accrual of Western cultural health capital, demonstrated by her proactive and instrumental approach to accessing care from GP of choice, with whom continuity of care is maintained (ii). Furthermore, CYNTHIA's dialogue illustrates overt recognition that not being socially classified as Māori is protective against discrimination in all fields (iii), and reinforces the internalisation of the causal association between premature Māori mortality and health-damaging behaviours (iv):

(ii) CYNTHIA: I've been with the [X] Medical Centre for over 10 years. Normally [I see] one [doctor], if she's not there then any of the others...she's very good. I had another one there that I didn't like...there was just something in the makeup that just didn't gel...so I changed.

(iii) CYNTHIA: I'm not likely to have any problems, probably because I don't fit the standard mould of a Māori.... I'm treated more like a "white"...because nobody believes that I have got Māori [ancestry]...myself and three
siblings]...we're more European...whereas [one brother], he's got the dark features.

(iv) CYNTHIA: My [Māori] mother was 65 when she died...my father was 87...lifestyle had a lot to do with it...smoking...I think that's what caused mum's death early, because her sister's 87 and she's never smoked.

The testimony of a 60-64 year old female, AILEEN, who describes longstanding problematic engagement with the health system, demonstrates how negative childhood healthcare experiences are embodied and transform into corresponding adult expectations. Access to medical care was precipitated by a head injury, and her testimony suggests that the internalisation of childhood experiences, relating to extended and recurring periods of hospitalisation and familial socialisation, has generated a negative dispositional response towards the ability to achieve quality medical treatment (Bourdieu 1990, p. 54). Factors that encompass the restriction of access to medical care for emergency use, parental attitudes/practices towards healthcare (i), the potential consequences of subjection to a prepubescent internal examination (ii), and medical error (iii), appear to have manifested in perceptions, thoughts and actions that guarantee the constancy of negative associations and encounters with doctors over time (Bourdieu 1990, p. 54):

(i) AILEEN: I was in a coma...after [that]...if anyone hit me on the head I ended up in the hospital...they thought I was going to be brain damaged...it took me a long, long time to get better.... So I've had my fair share of hospitals. Dad...hated doctors, Mum was Pakeha but hardly ever went to the doctor either...we'd always go to A&E if there was something wrong.

(ii) AILEEN: When you're [12]...and have an internal examination and he was very rough and naah so I don't like doctors...and especially I hate doctors in hospitals. I always used to sign myself out [laughs].... When I was pregnant...with my first [child]... [I] only went to the doctor's once and that was to find out that I was pregnant. My foster parents had to come and take my clothes off me [so I could ] have my baby. No doctor was going to touch me!

(iii) AILEEN: I had a shoulder operation...I'm allergic to morphine...and the nurse [gave]...me morphine. (Husband: we discussed it with the anaesthetist
before [hand]...but after I'd gone home they gave her some more morphine and it slowed her pulse down). When I went for my check-up the surgeon said:
"...it's lovely to see you walking around...we just about lost you."

Furthermore, AILEEN's testimony reinforces the significance of cultural health capital, access to and engagement with primary care, by illustrating the widely-held perception amongst study participants that barriers to quality care are caused by the dissonance between biomedical practice, characterised by technical knowledge and professional authority, and the desire for psychosocial medicine, individualised patient-centred care encompassing patients' unique circumstances and preferences, and involvement in decision-making processes (Erickson 2007). AILEEN's testimony suggests correspondence with findings that non-compliance with medical advice is considered an appropriate non-confrontational method amongst disempowered patients wishing to exercise control and actively participate in treatment decisions (Peek et al. 2008), particularly in ethnically-discordant clinical encounters where information-sharing by doctors has been found comparatively wanting (Torke et al. 2004). In contrast, race-concordant relations resulted in a greater likelihood of doctors fostering the development of patient cultural health capital, by explaining, listening and being accessible (Saha et al. 1999; Tucker et al. 2003)

(iv):

(iv) AILEEN: I've been getting headaches and chest pains for a long time and nothing really has been done about them...I find it hard to talk to [doctors], if I could get out of going to the doctor I would. I really don't think [my GP] cares...it's a personality [issue].... I've asked to have a lady doctor, somebody that would actually listen.... We need more Māori doctors and nurses...and the doctors that are Pakeha to listen...don't look down at [Māori].... I'd like to see them just listen...get them to understand.... Another packet of pills and: "You work too hard and you need a holiday."... I felt that I was "fobbed off.... He put me on...tablets for high BP and as of yesterday he said that I should come off them 'cause that could be part of the headaches...so I haven't taken any today...I probably won't end up going to another doctor until I'm sick.
However, despite a negative disposition towards personal engagement with health professionals, this participant adopts a proactive stance towards the healthcare of the extended whānau (v):

(v) AILEEN: I didn't get treated very well...[but] as far as I'm concerned it's not going to happen to my family or my children...anyone...who doesn't understand the bloody doctor, I'll take them.

The findings in this section highlight the complex relationship between spatial and class-location and childhood socialisation in the primary habitus, limited exposure to Western care primarily precipitated by illness and/or medical emergencies, and the impact of these varying experiences and accrual of Western cultural health capital on current dispositions/practices toward medical care. Despite differences in opportunities to accrue Western cultural health capital over the lifecourse, and attitudes towards and experience of medical professionals, the narratives of AILEEN, BELLAMY, CRAIG and CYNTHIA strongly suggest acceptance of the doxa of Western medical care. Notwithstanding positive longitudinal engagement with primary care physicians among this sub-group, the prevalence of tuberculosis and rheumatic fever in the modern milieu demonstrates that the ethnic and socio-economic inequities that induced the participants' need for care remain deeply entrenched in a modern neo-colonial society (M. G. Baker et al. 2012).

**Adult access - urban location**

This section explores the relationship between the Māori cultural health capital accrued during childhood socialisation, belated post-urbanisation adult access to primary healthcare, doxic and heterodoxical beliefs vis-à-vis the efficacy of Western medicine, and contemporary engagement with primary health care.

AMANDA, a 40-44 year old, describes the continued utilisation of Māori medicines in the 1970s, despite the alternative availability of primary care (i). Her dialogue illustrates an explanatory model of illness that contrasts with that of biomedical disease causation (ii):

(i) AMANDA: When I was a child, our doctor...used to go fishing with my father...I don't think I ever went to him for any medical help [laughs]...my
cousin had acute appendicitis...but apart from that our healthcare was really my nanny.

(ii) AMANDA: [Māori] are still young as far as timelines are concerned...even though we are ancient souls, our physical bodies are...a lot younger than Western societies and so we're still trying to catch up...we have babies and they're prone to...picking up a few more bugs...I just say: "Yes that's because we're just so pure and sterile" [laughs].

AMANDA's evidence reflects how traumatic hospital experiences, exacerbated by the lack of information-sharing, exert an enduring influence on patient dispositions towards future care. Significantly, her dialogue emphasises the reciprocal nature of cultural health capital and the capacity for providers to foster and develop cultural health capital in a Māori patient or, as in this case to precipitate patient distrust is consistent with physician control over decision-making and lack of information-sharing (iii):

(iii) AMANDA: I was a carrier [of hepatitis B] so I was quarantined, had to go into hospital and was so isolated, it scared me. I thought I was dying, everybody was gowned up to the max, my whānau couldn't come and see me, next minute my children were being whipped away from me and I'd been having all these injections and I'm thinking, "Oh my God, I'm killing my family," because nobody talked to me about....You rely on the doctors, you believe and place your whole life in their hands and you believe everything that they say is absolute...but as I had more babies I thought, you're still not telling me anything that you haven't told me before and that was very little, especially about hepatitis B.... I was told that Māori are different to Europeans...more prone to contracting hepatitis B.... They gave me a pamphlet and that's all...it had nothing to do with "race" or genes...I was so bewildered, I wasn't sure if this condition was real in fact [laughs]...it made me become very suspicious about what I was told at the doctors.

However, despite the dissonance in belief systems and biological understanding between Western and Māori models of illness, AMANDA's dialogue illustrates the significance of patient awareness and cognition of medical decisions and processes even in times of crisis;
further, it shows the facilitatory effect of increased familiarity with Western health professionals, and exposure to culturally-sensitive practice, in bridging the cultural divide between deeply-embedded cultural beliefs and biomedical medical practice, reflective of differences in the cultural constitution of health capital (iv):

(iv) AMANDA: [At 20 I had an appendectomy] there was no discussion...I didn't even know what an appendix was, except for when my cousin had hers out and even then she just had something taken out...for me as Māori they'd taken something from me and that's what was going through my head with my hysterectomy.... What's going to happen to my uterus where my babies have been born? This was their whare;¹⁶² you'd better not be...pulling down their whare. At my preadmission, I said: "I really need to talk to somebody because this is really affecting my decision."... [During the surgery] they had a Māori nurse come in...I saw the terrified faces [laughs], so that was a real turn about because I'm thinking, these damn Pakeha brutalised my tinana¹⁶³ .... The doctors and the anaesthetist were really good.... I actually took a while to agree to have the operation because of my experiences with hospitals.... I was lucky that I knew the doctor...because he sensed this fear...he was sensitive to our culture...it was really satisfying to know that I wasn't being ignored.... It's all about how you feel really and if you're feeling OK, you're going to get well and that there is somebody on that side of the street that actually will cross the road and come over here to hold your hand to cross and he was that to me.

Participation in the Hauora Manawa Study proved to be a transformative experience for some. The following dialogue illustrates the resistance to engaging with mainstream providers among some participants, and the accrual of Western cultural health capital in Māori-centred health contexts (v):

(v) AMANDA: All I thought of was...do I dare say it: "Pakeha are going to pick that data up," and it was the same old...perception that I've always had, but this was very unexpected [laughs].... I've become a part of the Autaki Māori Diabetes Roopu...[and] a board member of our local medical centre...it's

¹⁶² Māori term for house or dwelling place.
¹⁶³ Māori term for physical body.
opened my eyes...to the risks of being Māori...about getting really good advice, getting good information...and being around...doctors...so when I'm accessing health services it's through those people... Our Māori Provider [X] has been a real big inspiration...there's valuable information from all our providers that are conducive to Māori, because I know even myself I sort of tend to shy away from Pakeha driven providers, mainly because we've experienced them as part of that cultural medical set.

ALRIC, a 60-64 year-old retired male describes treatment of reported rheumatic fever, contracted during childhood, where causation was attributed to "spiritual, psychological and family issues" (R. Jones 2000c, pp. 107-108) (i). In addition to reinforcing the prevalence of infectious disease among Māori in the 1950s, this testimony provides insights into the objective conditions under which the rural domestic habitus was formed vis-à-vis interethnic inequities of access to medical and educational infrastructure in Māori communities (Refer Chapters Two, Three and Eight) (ii):

(i) ALRIC: We had Dr [X]...he had a hell of an area to cover, so we hardly saw the dude but mum did a lot of the taking care of people using her rongoa so the GP wasn't that common, but he was well loved because he listened to the locals and he sort of complemented the sort of understandings and beliefs they had.... He talked the reo...he would say [to my mother]: "Well, explain it to me" and so she would.... [About my illness] she said there's another part of this as well the spiritual part because I was the sort of kid that listened to everybody and they dumped all their rubbish on me, put it that way, so she got all the whānau together and told them all off and said: "don't you do that anymore."

(ii) ALRIC: Of my 24 [siblings] I only knew of 19...I wasn't around when the others got the TB and died early from a few months to over the age of 2...mum was 13 when they started having children...dad was 15...I was bought up under the teachings of heia Matua koru and when I learnt to read at 26 years old it was like an explosion.
Once again, ALRIC's dialogue emphasises the propensity of habitus in times of crisis to generate dispositions that integrate the doxa of Western medicine into practice (iii). It also highlights that recognition of cultural capital, objectified in social status by social actors in a field, translates into preferential care, irrespective of ethnicity (iv). Although not following the recommendation of the Hauora Manawa Study with respect to consulting with a cardiologist, ALRIC nonetheless demonstrates an instrumental attitude, consistent with accrued Western cultural health capital, by deliberately selecting a practitioner who incorporates alternative and conventional medicine and accommodates co-constructed doctor-patient management of cardiovascular disease (v):

(iii) ALRIC: I got interested in health because my own health hasn't been that good.... I've kept up the interest in health especially since having the heart...blockage and I actually went anti-medicine anti-doctors, but when I realised that without drugs I wouldn't be alive I formed a new appreciation for the medical profession [laughs].

(iv) ALRIC: [Because I was known I got] special treatment, they rushed me up the list, I even ended up being put ahead and I knew this. The young doctors...in the emergency ward...said: "First things first, are you X...?" The nurses knew me because I used to visit the hospital...to see sick kids.

(v) ALRIC: [My GP is accommodating] because I didn't want to take any more tablets, which I don't, after...my [operation I suffered from] cramps, headaches...vomiting and nausea, so I stopped taking them altogether.... He actually listens to me and follows me rather than tells me.

Furthermore, ALRIC's testimony illustrates the contemporary relationship between spatial location and the accrual of Western cultural health and economic capitals as determinants of timely engagement with, and dispositions towards, primary care providers (vi):

(vi) ALRIC: My whānau are up in the North Island, they find cost...[and] the costs involved in travelling [factors], but also they tend to feel inferior in the company of medical practitioners and being kept waiting. They don't like that, they feel like [when] there's nobody in the doctor's office and yet they're kept waiting...and the language used tends to be demeaning...so visiting a doctor
isn't something they want to do, so they kind of do it when it's almost too late [laughs] because they have to.

DORA, a 60-64 year old female highlights how access to medical care amongst this gender/age group was commonly occasioned by childbirth, consistent with the state policies directed towards reducing Māori disparities in maternal and infant mortalities which, in 1968-9, were almost 3 times higher than non-Māori amongst babies from 1 to 12 months (NZMJ cit. Dow 1995, p. 197). For DORA, a positive birthing experience (despite unmarried status reflective of heterodoxical Māori attitudes concerning children being born out of wedlock) and intermittent access have encouraged a doxic acceptance of Western medical practice (i):

(i) DORA: [As children] we never went to the doctor, our grandmother looked after us...the only time was when I got pneumonia... After 1960 I came down South...then I had to have a doctor... [because]...I’d get asthma... I’d just go to hospital when having babies.... I was an unmarried mother and I can’t fault the hospitals ... they looked after me very well.... It was the booze that worried our family; we felt babies were precious.... The way I was brought up... I didn't see not being married in the European sense as being wrong...as long as we were in a stable relationship it didn't matter. It was our feeling, not other people's...lots of [whom were judgmental of unmarried mothers].

However, DORA’s testimony below reflects widely-held dissatisfaction amongst this peer group vis-à-vis accessing healthcare, commensurate with the quality of care formerly received from family practitioners. This finding suggests a relationship between the dissonance between the cultural constitution of health capital accrued over time, and current access to, and engagement with, primary care. First, the hysteresis effect, the time lag of habitus in adjusting to changes (Hardy 2008) in medical culture; from an era of medical paternalism, characterised by authoritarian doctors and passive patients, appears detrimental to constant lifecourse adaptation to changes in the field of primary care.

Second, transitional complications, underpinned by exposure to, and/or reliance on, Māori models of health practice during childhood appear to have been superseded by adult acceptance of the Western biomedical model of practice. The longitudinal doctor-patient
relationship, characteristic of the later part of the twentieth-century, accorded with the traditional significance Māori attach to establishing rapport (Cram et al. 2003; T. Walker et al. 2008) and concomitant perceptions and/or experiences of collaborative healthcare (Cram et al. 2003, p. 4). Finally, this dialogue illustrates an association between the doctor's ethnicity/race, *affinity of habitus* (Bourdieu 1989, p. 17) and culturally-sensitive care (ii). Third, DORA's dialogue reflects the relationship between loss of financial/economic capital and potential loss of access (iii):

(ii) DORA: When we moved to Christchurch in 1985...he was the closest doctor...I don't think he's a fabulous doctor as doctors go because you always seemed to have to tell him what's wrong with you, rather than him helping you.... He was very good when I had cancer.... It's not really a relationship; it's just a doctor...that can prescribe you whatever you need.... I had a Chinese doctor in Dunedin... It was different...he used to ask how you felt...was it culturally OK to do certain things.... I understood where he was coming from because they're of the same ilk, if you know what I mean.

(iii) DORA: I've been treated pretty professionally each time but again in saying that it was because I paid...[but] because we lost all our money in the Hanover collapse...we don't have health insurance anymore.... We're getting older...we're needing more care, the only time I can't afford it...[insurance company] had money from us for years when we didn't need it, now we need it we can't afford it.

The narrative of 55-59 year old ANGELA reflects how longitudinal post-urbanisation engagement with a general practice, since the 1970s, has played a formative role in encouraging a proactive disposition towards primary care and redressing the negative consequences of what is reported as a difficult rural Māori community; in response, the patient's habitus generated innovative practice directed towards self-improvement (i, ii):

(i) ANGELA: [I was] a single mum and had these children to different partners and [the GP said:] "You need to protect yourself from getting pregnant." That's what I liked about him...nobody told me that ever before.
(ii) ANGELA: [When X took over the practice, he said]: "I need to put you under a therapist with your anger management... because while you're dealing with your anger problem, the social welfare won't touch your children but if you don't do anything, they'll uplift your children." So that information I needed at that time.

Loyalty notwithstanding, the following dialogue illustrates sufficient mastery of the game to question why diabetes was diagnosed during the Hauora Manawa Study rather than by her primary care provider (iii), which serves to reinforce arguments vis-à-vis discontinuity of care (J. M. Gill & Mainous III 1998; Gulliford et al. 2007; Infante et al. 2004; Liaw, Litt & Radford 1992; Tandeter & Vinson 1998; Wachter 2001). ANGELA's narrative also reinforces how restricted childhood access to Western medical care has been internalised as a virtue was made of necessity (Bourdieu 1990, p. 54) (iv). Despite cognition of familial circumstances (v), embedded heterodoxical beliefs vis-à-vis the efficacy of Western medical care require that a doxic doctor-patient understanding is realised, rather than professional taken-for-granted patient adherence to prescribed treatment regimes; this reinforces empirical evidence that social-class is not a useful predictor of desired level of patient involvement in their own care (Elwyn et al. 1999; Frosch & Kaplan 1999; McKinstry 2000) (vi):

(iii) ANGELA: [The GP said:] that it was good that I was selected and..."I'll just have to keep an eye on you...now that you're ageing." The study picked up that I had diabetes [and a heart murmur] not the doctor...I hold nothing against him, I was just thinking..."Am I not asking the right things...is it more that I'm the one not doing the asking?" But if you don't know what to ask and that's probably on my part, I don't always think to ask.

(iv) ANGELA: We rarely visited [the doctor]...I guess we had a pride...where we didn't need anybody. We were all right as we were, we'd been like that for years and we were not going to change, so yeah I'm sure that would have been the attitude [laughs].

(v) ANGELA: I'd been to the doctor with headaches one or two times...I think mum took me to the doctor [because]...the Education Department was
wondering why I wasn't at school and of course her reasons were that I had headaches but it was really that I was...minding the other children..... There's eight of us and then she married a second time and there's three more...two babies died...I was fostered for two years [by] my uncle...then nine going on ten I went back to my mum. So going to the doctor's...[was because of]...the Education Department...but the other children, I don't remember them going to the doctor's.

(vi) ANGELA: I don't like popping pills because...we were brought up rough and ready and tough as, and mum had often said to us: "Look if your body can't heal itself there's something wrong with it".... We didn't have a lot of Māori medicine back in that day either but she used it if she had to...but children didn't need it...I grew up with that mentality.

The habitus is, however, always "oriented to practical functions" and upon encountering new situations, strategic calculations result that have the potential to become unconscious over time (Bourdieu 1990) (vii). ANGELA's narrative also reinforces that the accrual of Western cultural health capital vis-à-vis diabetes management from a Māori provider is potentially facilitated by the habitus encountering "a social world of which it is a product" (Wacquant 1989, p. 43) (viii):

(vii) ANGELA: Doctor [X] knows I don't like taking tablets but he said: "Now you must...begin to accept the magic."... So now I do, with regrets.... I want to get off that medication, so I've been going for walks.

(viii) ANGELA: I went to the Māori Diabetic Clinic and [X] was awesome, really simplistic with ... how I got diabetes and...what I must do...I said: "I am so thankful that you have explained this so that I could understand." I left there with a good understanding about diabetes.

**Chapter Summary**

Findings suggest a relationship between the spatial and/or class-specific location of the primary habitus, capital(s), and access to primary healthcare in the post-World War Two period, and the adult accrual of cultural health capital, access to and engagement with
modern primary care. The first section suggests a relationship between lifecourse access to primary healthcare and positive adult engagement, irrespective of spatial and/or class location of the primary habitus and/or the presence of commonsense markers of Māori heritage. Testimonial reports of doctor-patient continuities across this study also reflect proactive participant attitudes and dispositions and practitioner encouragement of biomedical understandings. Longitudinal doctor-patient relationships are associated with increased familiarity and use of biomedical concepts and language. The narratives of socially-ascribed Māori suggest that maintaining relational continuity may be considered as protective against exposure to discriminatory care. Doctor-patient relationships are powerful and the subjective element of this dialectic relationship - mastery of the game - is influenced by individual competencies and capital(s) (Bourdieu & Wacquant 1992, p. 117). Although generational inequalities in accrued capital(s) manifest as embodied symbolic capital (Moore 2008, pp. 109-110), unimpeded lifecourse access to Western medical care appears to facilitate increased mastery of the game - sensible practices - a subjective orientation, an illusio or sense of investment, which translates into a commitment to the doxa of the game (Bourdieu 1984, p. 466), the coincidence between dispositions and a positive sense of the game of accessing healthcare (Bourdieu 1990, p. 66).

In the second section, childhood access to health services was precipitated by illness or emergencies, and concomitant adult engagement appears to be interrelated to the quality of doctor-patient interactions, irrespective of spatial and/or social-class location. Positive experiences manifest in a doxic acceptance of Western medical care; the maintenance of relational continuity with regular GPs appeared to be associated with positive attitudes, behaviours, and self-knowledge among chronically ill patients. Conversely, negative experiences are interrelated to correspondingly negative dispositional attitudes and behaviours towards adult engagement with primary care. Such responses are potentially exacerbated by the generational transmission of negativity towards health professionals. Findings suggest a relationship between the objective conditions of the domestic habitus, characterised by functional adaptation to the exigencies of survival (Crossley 2008, p. 93), exposure to diseases of poverty and adult health status.

Section Three identified that complex and multi-dimensional factors affected the relationship between post-urbanisation adult access to primary care, the accrual of Western cultural health capital and contemporary engagement with healthcare. First, complications
are interconnected with the primary domestic habitus and exposure to, and/or reliance on Māori medicine, and the dissonance between Māor and Western cultural health capitals. Second, notwithstanding dissonance between heterodoxical and doxic beliefs in the efficacy of Western medical care, in times of health crisis, habitus responds with innovative dispositions directed towards self-interest, reflecting how habitus is the principle of both social continuity and discontinuity:

continuity because it stores social forces into the individual organism and transports them across time and space; discontinuity because it can be modified through the acquisition of new dispositions and because it can trigger innovation whenever it encounters a social setting discrepant with the setting from which it issues (Wacquant 2006, p. 7):

The provision of culturally-competent and culturally-sensitive and/or integrated alternative and conventional care appears formative in overcoming negative experiences and bridging cross-cultural dissonance, leading to positive adult engagement with primary care. This phenomenon illustrates that although social discontinuity of habitus across time and space does not rule out strategic choice and conscious deliberation of future action, the influence of childhood socialisation remains the dominant principle of these choices (Wacquant 1989, pp. 22, 131). Third, testimonial reports across this chapter strongly suggest that positive benefits accrue to patients when doctors foster the development of dominant group cultural health capital in their patients. Finally, changes in medical culture engendered by the transition from individualised care from a single practitioner to modern encounters characterised by less-personalised, often episodic encounters with locums and non-regular GPs, appear to create discordance between the patient’s habitus and dispositions and the contemporary delivery of primary care.

Findings relating to the relationship between age and gender, accrued capital(s), and adult dispositions towards engaging with modern primary care are presented in the following chapter.
CHAPTER SEVEN: FINDINGS, AGE AND GENDER

I never, I never thought I'd notice the barriers too much, but I certainly did after I had my children ...I remember going in and being left in the room by myself, I remember the door being wide open my legs wide open and people walking up and down, yeah. I screamed all the time and told them to close that door and, and I picked up those real insensitivities. So yeah not a very good experience for me ...I wasn't the only one in that boat at the time when I look back at it. The other thing was being bound so we couldn't breast feed ... I remember a lot of my relations and friends not being able to breast feed, lucky for me mum came down saw what was happening and pulled [the bindings] off. They put [the baby] in the Prem. Room so we never got access to the baby for at least 3 or 4 days which meant by then the milk was on it's way out. I never knew those things then, I know them now ... I'm quite prickly about what that meant (Study Participant, Allamain).

Introduction

This chapter concentrates on the relationship between the age- and gender-specific conditioning of habitus, accrued capital(s), and adult dispositions towards engagement with modernised primary care services. Testimonies reflect differences between first, social discontinuity of habitus across time and space of rural migrants versus the social continuity of habitus of the generation of urban-born Māori, and the concomitant effect of belated or lifecourse access; and, second, gendered differences in engagement with healthcare. The concept of gendered habitus broadly refers to the:

social construction of masculinity and femininity that shapes the body, defines how the body is perceived, forms the body's habits and possibilities for expression, and thus determines the individual's identity - via the body - as masculine or feminine (Krais 2006, p. 121).

Findings are presented in two sections to emphasise the gender-specificity of habitus that occasioned access to healthcare and the relationship between cultural health capital, and utilisation of primary care across time and space.
Females

For older women who migrated from remote Maori communities in the 1960s, the availability of healthcare coincided with the increasing medicalisation of Māori childbirth and adaptation to the *cult of domesticity* within the context of the nuclear family, and concomitant responsibilities of attending to the health needs of their children. The testimony of ALLAMAIN, a 60-64 year woman, is in many representative of this age-gender group in that the process of rapid assimilation in the urban milieu, and engaging with healthcare, appears to have resulted in the cleft habitus characteristic of first generation migrants (Friedmann 2002, p. 302). However, in contrast to many of her peers whose experiences of childbirth were unremarkable, ALLAMAIN’s testimony illustrates the enduring effect of exposure to professional expressions of symbolic violence on the patient habitus (Bourdieu & Wacquant 1992, p. 97) (i):

(i) ALLAMAIN: [My first access to Western medical care was] when I had children....not a good experience...I never thought I'd notice [the barriers]...but I certainly did after [that]...I remember going in [to the hospital] and being left in the room by myself...my legs wide open and people walking up and down. I screamed all the time and told them to "close that door." I picked up on those real insensitivities.... [Also] being bound so we couldn't breast feed.... Luckily for me, mum came down...saw what was happening and pulled [the bindings] off; [but the staff] put the baby in the Prem. Room, so we never got access to the baby for at least 3 or 4 days which meant by then the milk was on its way out.

Symbolic violence is evident first, in medical doxa regarding breastfeeding, "the taken-for-granted assumptions (orthodoxies of an epoch which lie beyond ideologies...)" that generate oppositional practices (Deer 2008, p. 120), and second, in extreme professional insensitivity and financial exploitation (ii). Collectively such exposure has created residual dispositional distrust of healthcare providers:

(ii) ALLAMAIN: Having a wonderful doctor [or so] I thought at that time but...[his patients] would have to go to a private hospital to have their babies.... So one of my children was actually born in that private hospital.... We weren't aware of that because, he was a doctor...someone I trusted...it was like I was
not given a choice.... It cost us an arm and a leg to...have that baby there and I look at her today and say: "You know how much you cost me?" [Laughs].

The habitus, having internalised objective conditions, generates anticipatory dispositions based on those experiences and assigns disproportional weight to earlier experiences. Childhood reliance on traditional health practices instills heterodoxical beliefs regarding the efficacy of traditional care, thus making a virtue of necessity (Bourdieu 1990, p. 54), (iii):

(iii) ALLAMAIN: My parents, my grandparents...used rongoa 164...I can only remember...going to a doctor...because I cut [a vein and]...having it stitched but prior to having that done, they just got the cobweb165 [laughs]...we were just never brought up with that and it does amaze me how our parents [were] able to bring us up...[laughs] 13 of us, there's 11 of us still alive and we're all over 60...running off to the doctors is all very good...but how did our parents...grandparents do it?

The habitus is, however, generative and not determinative; longitudinal engagement with a solo family practitioner moderated negative dispositions towards primary care. This excerpt reinforces the significance that Māori attach to establishing doctor-whānau rapport (Cram 2006; T. Walker et al. 2008), which aligns with the cultural emphasis placed on the collective (rather than the individual), and a doctor-patient relationship conducive to fostering the development of dominant group cultural health capital (iv):

(iv) ALLAMAIN: My [previous] doctor I'd had for...probably about 20 years...he was just absolutely wonderful. He knew who we were, we knew who each other were...we were with him until my husband died 12 years ago, then I shifted...so lost contact.

However, structural changes in the delivery of primary care are very different from practices that prevailed some three or four decades ago (Friedmann 2002, p. 301).

164 The term Maori used to define traditional medicines made from native plants.
165 The efficacy of spider webs as a blood clotting agent (because of high vitamin K content) is widely recognised around the world (Damir 2012).
Impediments to establishing a rapport commensurate with that of her former family doctor underlie dissatisfaction with current provisions (v):

(v) ALLAMAIN: Well, he's not really my doctor as such it's...whoever is available...and that doesn't sit well with me. I like to know that I'm going to be able to have a rapport with a doctor that I think I can trust, that I want to be with, that is going to find out who I am and what my needs are and listen to me.

Again, Bourdieu's concept of hysteresis which indicates the "disruption in the relationship between habitus and the field structures" when they no longer correspond appears relevant (Hardy 2008, p. 134). ALLAMAIN's testimony suggests that modern medical culture has occasioned a disjuncture of habitus, a time lag in adjusting from medical paternalism (characterised by authoritarian doctors and passive patients) during the 1960s and 1970s, to less personalised and psychosocially-orientated care. ALLAMAIN's desire for affinity of habitus, ethnic-concordance, although preferable, is tempered by the quest for culturally-sensitive care regardless of the doctor's ethnicity (vi). This excerpt is illustrative of experienced that have precipitated her desire for culturally-sensitive and/or culturally-competent care (vii):

(vi) ALLAMAIN: If...there was a Māori doctor close by, or it doesn't really have to be a Māori doctor, but someone who is sensitive to things Māori...I could probably get on with any doctor.

(vii) ALLAMAIN: I don't mind him saying that I'm a bit on the obese side...I probably stop short of being told that Māori are "different" and I'll say: "I'm an individual...yes, I'm of the Māori "race" but I don't really want to know about the rest of my "race" [laughs]...I already know what the statistics are...I don't need that shoved down my throat. I want to know what you can do for me." So we did have a few words about that...but I've got used to my doctor and so I don't let him get away with too much. He quite often says: "Obesity, it's a Māori thing"... I will often say to him: "Well I don't believe that...there's a lot of [large] people around me that are not of Māori ethnicity but I do agree that I am on the obese side.... But he tends to do that.
ALLAMAIN's journey through the Hauora Manawa experience and struggle to navigate ongoing follow-up care in mainstream general practice may be understood within Bourdieu's (1977) metaphoric notion of the game: Testimonial evidence suggests a desire to play the game, the illusio tacitly recognising what is at stake, and the action suggested by habitus (a cost/benefit analysis) precipitated rational choice. Notwithstanding a problematic engagement with health providers, having a feel for the game means "a capacity for practical anticipation of the 'upcoming' future, contained in the present, [so that] everything that takes place in it seems sensible: full of sense and objectively directed in a judicious direction" (Bourdieu 1990, p. 66) (viii):

(viii) ALLAMAIN: First thing a lot of my whānau...and friends said [was:] "Why, is there something wrong with you?" I thought [this]...might just be what I need.... I had been caught out once and went on the ambulance...unless you actually land up in hospital, and even then, I'm not too sure what you're actually...entitled to. But that [Study]...it was an eye opener for me in terms of what could be done for me if something did happen.

The following dialogue illustrates how the Study Doctor engendered medial rationality by fostering health capital (Shim 2010) to overcome heterodoxical beliefs manifest in her resistance to pharmacological treatment. The deployment of the culturally-concordant practice of whakawhānaungatanga, effective practitioner communication and partnership culminated in a mutual agreement to implement a therapeutic regime (ix):

(ix) ALLAMAIN: ...just introducing himself...where he's come from and where he lives, I know his family or I know of them.... The way he...really [told] me what I need to be doing, that I need to take those tablets and why...rather than...saying: "This will fix you up" [and] me saying: "I don't take pills, is there an alternative or what else is available to me before I take those pills?"... He was able to speak to me.... "You need to do this...[and] these are the reasons why you should do it."

While encouragement from her regular doctor initially stimulated a proactive dispositional response and preparedness to play the game, this impetus was lost during two subsequent

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166 The affirmation of bonds.
consultations. The following excerpts from ALLAMAIN's testimony illustrate professional practices antithetical to encouraging patient rationality or understanding of health related knowledge (Shim 2010): first, the non-communicative exchange with a non-regular doctor regarding changes to the treatment regime (x) was exacerbated by a similar exchange with her regular doctor, that ultimately precipitated non-adherence to the treatment regime (xi):

(x) ALLAMAIN: I was put on tablets [by the Study Doctor]...I took those diligently...he let my doctor know what was happening.... The last time I went...a foreign doctor...put me on some [new] tablets...didn't even go and get them.... It was a different [prescription]...and she never explained to me whether they were stronger.... I did ask her: "Why?”.... I didn't push her hard enough.... I think it's not [having] enough knowledge about health issues in order to ask the right sorts of questions.... I don't think I was qualified enough to have the right questions to ask.... I'm not a person who takes a lot of pills of any sort... so for me it was really important to know why I have to take those.

(xi) ALLAMAIN: I did go back to my own doctor...he says: "Well, if that's what they've given you, that's what they've given you." So I decided I'm not going to take any of them.... I was quite happy on the ones that [the Study Doctor prescribed], or well I thought I was, but at that time too I was doing a lot of walking so I felt really good in myself. I understand that I have to go back and do something, I'll start in the next week or two.

While habitus has not ruled out strategic choice or conscious deliberation regarding the need for ongoing care and the management of cardiovascular risk, dispositional responses are conditioned by a practical sense of what can be reasonably be expected for the likes of us (Bourdieu 1990) based on previous experience (xii):

(xii) ALLAMAIN: Something usually has to happen before I'll even go the doctor [laughs].... I'm not keeping up with my [medication], probably need to be on some sort of medication but I'm not. I haven't been probably for the last three, four, five months.... Probably [because] I'm going to be given the same as I've always been given [laughs]...it always seems to be just going to the doctor's, just to pick up a pill, whereas...[it] might be nice sometimes just to
talk about how I'm feeling, and why I'm feeling like that....I don't think it's pride ... it's just pure stubbornness, it's like, "I can beat the odds" that's stupid, yes.... I suppose it's going back and getting the same information I had the last time I went ... so maybe I need to change my doctor.

While the foregoing dialogue can be interpreted as a lack of patient self-efficacy vis-à-vis management of personal health, within the context of asymmetric doctor-patient power relations, repeated expressions of symbolic power, unethical, discriminatory and authoritarian practices, are diametrically opposed to the culturally-competent and/or culturally-sensitive practice essential to providing equitable care (New Zealand Medical Association 2011).

AMBER, a 25-29 year-old offspring of a Hunn Apprentice Trade Training Scheme father and a Pakeha mother reflect changes in the Māori demographic vis-à-vis bicultural family composition and normalisation of lifecourse access to primary care. Her testimony illustrates how, in the urban milieu, maintenance of a longitudinal family relationship with a sole practitioner, and receipt of affordable (i), competent, compassionate, and responsible care (ii) has fostered the accrual of dominant group cultural health capital:

(i) AMBER: I've been with him [since I was 6].... It's only $10...whereas it's normally $25...and if [I] have to go back regarding the same ailment then he won't charge.

(ii) AMBER: I saw 2 doctors...at the hospital and they had no idea what was wrong...[and] gave me an appointment with a neurologist...6 months down the track. I went to [my doctor] that evening and he straight away diagnosed it and looked on Google to show me what...what the symptoms of [x] were...he can always squeeze you in if it's an emergency.... When my father passed [he]

167 The Hunn Report's (1960) recommendations for the integration of Māori included Apprentice Trade Training Schemes. The mobilisation of Māori youth into the cities that began during World War Two became highly orchestrated in the post war period. "From a full employment perspective, the state viewed Māori youth as a 'resource of industrial labour' who should be transferred from 'uneconomic' areas to cities and towns. At the time, there were over 20,000 job vacancies. An official relocation scheme from 1960 until 1967, when costs were cut, provided support for families prepared to shift centres. Young Māori women were attracted to hotel and hospital work by cheap board and good pay, and into teaching and nursing, all viewed as suitable training for future wives and mothers. Young men, largely from the East Coast of the North Island, migrated to Christchurch for trade training. Of nearly 2700 young people relocated between 1961 and 1967, 52 per cent moved to Christchurch as apprentices" (Mein Smith 2005, pp. 186-187).
said...if I needed to talk to someone like a father, he'd be there for me; he's a lovely man.

This longitudinal doctor-patient relationship exemplifies a corresponding expectation of a certain standard of individualised care (iii), contrasting with negative aspects of discontinuity of care frequently and widely identified amongst the study population, and reinforces how socially-ascribed participants consider continuity of care with a known GP protective against potential exposure to symbolic violence (iv):

(iii) AMBER: My sister...had something wrong with her [x]...and her doctor wouldn't even talk to her on the phone, the nurse would ring with the results.... So she's actually came back to see [our family doctor].... Whenever she would go to see the doctor [at the medical centre], it would be a different doctor, there was a chain of 3...so she didn't really get very good healthcare.

(iv) AMBER: I don't think I've had prejudice really...solely because I've had my own family doctor since I was young.

AMBER's testimony further endorses that although lifetime access to Western medical care tends to produce pre-reflexive acceptance of the doxa of Western medical practice, commonly-held beliefs that are discordant with conventional "medical rationality" can co-exist (Mechanic 1986, p. 154), and highlights the need for professional recognition that spiritual and metaphysical attributions of illness causation remain entrenched even in industrialised societies (Kleinman et al. 1978) (v):

(v) AMBER: I just would always have bad feelings about the [hospital rooms]...one room I couldn't go into I think someone had died in there and I just told [the staff] I was going to have to go home...because...of bad spirits, it was just a horrible feeling and I was scared to take [my son] in there in case that happened to him...but they were obliging they put us in another room.

CARMAN, a 44-45 year old participant of sole Māori heritage, demonstrates how embedded enculturation, and social discontinuity of habitus present challenges to engagement with primary healthcare. Her dialogue illustrates the objective conditions habitus has internalised: a transgenerational aversion to doctors (underpinned by culturally
dissonant conceptualisations of the body); the attribution of illness to the adoption of Western lifestyles; the salubrious effect of maintaining spatial separation from the urban environment; and a concomitant preference for ethnic-concordant practitioners (i):

(i) CARMAN: I think I inherited [my aversion to Western health care from] my grandparents, they never went to see a doctor no matter how sick they were, but it was more a tapu\textsuperscript{168} thing, where they didn't like a European looking at their body...but if I know there was a Māori doctor, I probably would go there first. It wasn't until we moved to [X in 1976] that we started getting asthma...all my brothers [and] sisters get it, my father died of it. I've got 3 uncles left [in tribal area] and they're in their 90s and their skin, it's just so fine and yet my mother's people from [X iwi] they've all died off from diabetes, heart problems...I see a difference in their health...is it because they] live in a town?

CARMAN's testimony further reinforces the generative nature of the individual habitus in overcoming beliefs instilled during primary socialisation, and illustrates the gender-specific propensity of women who, although deeply embedded in traditional Māori culture, to engage more readily with Western medical care (ii):

(ii) CARMAN: [My siblings]...won't go to the doctor unless they're really, really sick...the women are more into their health whereas my brothers...are very whakama\textsuperscript{169}, very shy of their bodies.... My brother was getting chest pains and ... he said: "Oh well, if I die, I die."... Unfortunately most of my brothers say that too...they have seen a lot of the aunties and uncles die at a young age, so they think that's part of the cycle...whereas just recently I've adopted the idea that I want to live as long as I can.... When we were children if we did get sick our grandparents knew what to do...so I guess you go through life thinking that you don't need a doctor.

While reinforcing exposure to symbolic violence because of skin colour, this dialogue provides an interesting insight into how dispositional responses to medical care have

\textsuperscript{168} Sacred or prohibited.
\textsuperscript{169} The Māori term for embarrassment, indignity, shame or shyness.
resulted in a primary affiliation being afforded to gender rather than culture on the basis of need (iii):

(iii) CARMAN: The first thing [the dentist's receptionist] pointed out was: "Well do you realise that it's a $40 consultation?" I thought "...maybe it's because I was Māori, maybe it looked like I didn't have the money."... I get better treatment due to my gender...because I'm more confident in that area so I push for what I need...my gender is stronger than my Māori side because it's been a survival thing.

Notwithstanding that engaging in a Māori-centred health initiative provided the impetus to take a more instrumental approach to personal health, critically, CARMAN's dialogue demonstrates how co-constructed doctor-patient changes have precipitated an extraordinary dispositional reaction to primary care (iv). Accordingly, CARMAN's experiences serve to reemphasise the potential of culturally-competent and culturally-sensitive care to produce exponential gains in patient cultural health capital (iv):

(iv) CARMAN: Recently I've had a really good relationship with my doctor and I've been with her for about 8 years...but since my [Hauora Manawa] screening I've become interested in my health...we can talk about anything now.... She's European, but she was asking me things about my iwi [etc]...I think that's where the barrier broke.... I actually understood what she was saying, whereas over the years I've just gone straight in every 6 months, picked up my hormones and I couldn't wait to get out of there.... It was because she opened up to me...really showed an interest [in my culture that] she's a very good doctor whereas before she was just a doctor, if that makes sense.

For ANNETTE, a 35-40 year old offspring of two Māori migrant parents, access to improved material conditions of the urban infrastructure facilitated the accrual of economic capital (family income $100,000+), middle-class cultural capital, and concomitant lifecourse access to primary care. Her dialogue illustrates a relationship between the employment conditions of a graduate of the Hunn Apprentice Trade Training Scheme and health (i), and reinforces how for many participants, dispositions towards trusting health
professionals are conditioned by the internalisation of negative care experiences of previous generations (Cram 2006) (ii):

(i) ANNETTE: Unfortunately my dad...used to work at [X factory] there was the issue with asbestos ...he has respiratory problems...I don't know if he's been getting any sort of compensation but he lives a very quiet, very quiet, life.

(ii) ANNETTE: I've always been quite negative [about doctors] it had pretty much started when my mother...had a hysterectomy...she was suffering from lower abdominal pain...when they decided to go in and take a look, they went in on the wrong side and she was suffering from one problem after another and then they prescribed her anti-depressants...she flushed that stuff down the drain and...decided "I'm going to take care of myself." She actually did...with a syringe and some detergent...she said she got this incredible heat in the area where she had the problem and she passed out this...gooky, bloody sort of thing and she said she hadn't looked back since.

Moreover, ANNETTE's dialogue exemplifies two persistent and salient findings reported by study participants: first, that delivery of modern primary care and concomitant episodic interactions with locums or non-regular doctors constitute barriers to receipt of quality care; and second, that social-ascription as Māori is widely associated with potential and/or experiential receipt of suboptimal care (iii):

(iii) ANNETTE: After I had my baby...I got pneumonia and then my [other] daughter got swine flu...[for 2 months]...I really struggled to find the right responses...[no provider] said: "We want to take a spittle sample...so we can give you the right antibiotics."...I ended up taking 4 different antibiotics [plus] different pills...my milk almost dried up.... There were 2 doctors that eventually stood out.... Instead of using whichever doctor was available at the medical centre, I specifically asked for [Doctor X]...and we started to get my health turning around.... [I] probably had at least 14 visits.... I do think [being Māori] had played a part because my midwife wasn't Māori and she...immediately got great care and results.
Reported incidents of discriminatory care encompass policies and practices associated with the sexualisation of Māori women. ANNETTE's account suggests attempts to reduce "unwanted" pregnancies, reflective of societal attitudes and stereotypes about illegitimacy and/or a desire to limit childbearing amongst Māori (i) that correspond with the treatment of minorities in America (Downing, LaVeist & Bullock 2007); ALICE's experience suggests professional stereotyping on the basis of expectation (ii) (van Ryn et al. 2011; van Ryn & Burke 2000); and finally, CARL, in describing potential professional stereotyping of his sister that translated into suboptimal and negligent care, reflects male cognisance and sensitivity of discriminatory assumptions about Māori women (iii):

(i) ANNETTE: One particular doctor I had [was] stereotyping me as a...young Māori teenager because of high [rates of Māori teenage] pregnancies...he was saying to me that I was at the prime age...where I could start having children [laughs]. I thought "What's that got to do with anything that I'm here for?"

(ii) ALICE: When I had the children they thought that I was too young...They just assumed that, in actual fact I had my first child at 24 so they probably just looked and thought...my [Māori] name sort of came up and I felt that I was being picked on [laughs].

(iii) CARL: my sister[s]...appendix burst...that was really bad actually to be honest.... The [local doctor] misdiagnosed her...he thought that maybe she was pregnant...she would have been 16-17...still at school...that's why my parents were pretty angry about it, instead of him just checking, that was his first presumption...maybe he prejudged her being Māori and [X] it's not a very rich area.

Males

Testimonies reflect the co-relation between the impact of Post-World War Two colonial relations on male migrant workforce integration during the Economic Boom (1950-1966), and the segregation of Māori into occupations and/or institutions that became the genesis of the contemporary Two-Nation Cleavage in employment status (Jessop 1989). Furthermore, testimonial evidence suggests a relationship between accessing health services, and employment in institutions commissioned to maintain social control and/or
protect national security. Employment in such institutions appears to have instilled into the male habitus an understanding of, and compliance with, the law inherent in that particular field; the effect of state power upon the mentalities of employees results in a "tactic, pre-reflexive agreement over the meaning of the world which itself lies at the basis of the experience the world as a 'commonsense world'" (Bourdieu 1994, p. 13).

The testimony of a 35-39 year old male reflects the complex interplay of generational perceptions of masculinity and accessing medical care, inculcated institutional culture and delayed access, rationalised by resistance to capitalist exploitation. Engagement in the Hauora Manawa Study, motivated by a family history of cardiovascular disease (resulting in GP and cardiologist follow-up), precipitated a future orientated, attitudinal and instrumental transformation of lifestyles (Shim 2010), culminating in weight loss and aligning compliance with the prevailing ideology of healthism. Despite lifecourse access to primary care, ALBERT's dialogue reflects how the habitus, although structured by past influences that informed avoidance rationalisations (i, ii) has, post-Study, generated new dispositional attitudes (iii, iv):

(i) ALBERT: I don't feel comfortable [in a Dr's office]...it makes me feel weak...my sinuses...it gets to the point where I can't see and I just have continual headaches, noise...or anything irritates me pretty much, its painful, I've been bleeding a lot...my eyes continually weep, so I take stuff for it, but it gets to the point where it's just not enough so I try and get some antibiotics and sort it out. [But] paying for [medications], I work at [x], I see how much these things come across the border for and I see how much I pay for them at the chemist...the taxes and having to pay to make myself well again is just, doesn't seem right to me so I avoid trying to pay money to businesses.

(ii) ALBERT: [Before the study] I'd have to be pretty much at the end of my tether to go to my own GP.... I feel a bit vulnerable...not so much as a Māori man but as a man you think that you're head of your family and you don't want to appear to the kids that you're going through a bit of a patch where you've let your guard down.... Dad didn't go to the doctors often.... It wasn't until he got into his forties and he started going quite a bit.... Seeing crims going to the medical block after scratching themselves and taking medication for the sake
of taking medication...it put me off going...it appeared to me to be a weak man's choice.

(iii) ALBERT: ...Dad had heart problems and [was only 54 when he died]...I didn't want my kids to suffer the same way that myself and my brother and sister did and not doing anything about it.

(iv) ALBERT: I've learnt [from the Study] that working behind a desk for Māori is not good.... I went back to [my father's marae]...you see all the photos on the wall of my ancestors...all these lean...hard-working people.

A primary motivation for a 45-49 year old male's participation in the Hauora Manawa Study exemplifies how life service in institutions that demand logical and moral conformism embody corporeal and mental discipline that encourages a taken-for-granted acceptance of the social order (Bourdieu 1994, p. 13) (i):

(i) COLLIN: 80% of [prison inmates] are Māori or Polynesian.... The health of inmates is very bad, a lot...expect [the institution] to...fix up all their ailments...that could have been done on the outside .... It's a point of contention for me.... [So] all I want to see come out of this [study] is to tell Māori: "It's not the system that's letting you down, it's yourselves...you need to...be proactive and take good care of yourselves really and look after yourself and your families."

COLLIN's dialogue illustrates how the distinct logic of practice informed by the doxa of the field potentiates misrecognition of the practice at work, so that even when confronted with the apparent social (re)productive purpose of the institution (Thomson 2008, p. 70) (exemplified by cognition of interethnic disproportionality of incarcerates), the social agent nonetheless draws on deficit ideology to rationalise interethnic health disparities (ii):

(ii) COLLIN: The family up north could do with a little bit more healthcare...[most of my] Māori family (outside of my sister, younger brother and a couple of my cousins)...live life to the hardest...once something happens to them, then they turn.... " We Māori[s], why can't we have this?" I always say
to them: "Well that's because [the Pakeha] have worked hard...so they're able to afford the good healthcare," and I think that that's the only difference.

His decision not to follow *Hauora Manawa Study* recommendations appears to reflect a dispositional response to corporeal and mental discipline (Bourdieu 1994, p. 13) embodied in the habitus and confusion stemming from a divergence of medical advice and limited cultural health capital (iii):

(iii) COLLIN: When I got the letter...stating what I have to do, certain exercises...I was already doing them, even this morning like I got up go for a 5K run on my day off.... [The Study Doctor] said my blood pressure was...reasonably high...that's never really bothered me...I did 20 years in the [x]...they said: "That [my blood pressure] was normal" [laughs]. So, I don't know what's right, so I'll forget about that.... *Have you had any treatment for your cholesterol?* None, it's never really bothered me [except]...when I go for a medical. [The institution] always sent me overseas with it...but every time I get a physical...they'd tell me: "Your cholesterol's very, very high, you'd better be more careful because you're getting older." I think, oh fine! I haven't changed anything...I still eat the same and I'm never going to change.

However, the following dialogue reinforces that habitus is always orientated towards practical function (Bourdieu 1990) vis-à-vis a self-imposed exercise regime to compensate for allergic reactions to oral medications and a family history of diabetes (iv). Significantly, however, it also suggests latent potential for adherence to a treatment regime conditional upon clinical practice that first, explores the underlying cause of resistance to oral medication; second, monitors potential side-effects of prescribed pharmaceuticals (v); and third, communicates medical information, including that relating to the asymptomatic nature of elevated cholesterol (vi):

(iv) COLLIN: Dad was diabetic, my older brother just found out he's diabetic.... I believe for people like myself and my younger brother...the facilities are there for us to go walking or running, it doesn't have to cost the earth.

(v) COLLIN: *Would you take a pill to bring your cholesterol down to within the normal range?* No, me and pills don't go together...even in the [X ] half the
time I was chucking them back out...I can take an injection but never take a pill.... Maybe they have cholesterol pills now that won't affect your migraines. They probably have...if someone said: "Take this pill every day," I wouldn't take them every day, I'd take them once a week.

(vi) COLLIN: I've been going to [my GP since 2000].... [When I last saw him] for work was 3 years ago, it wasn't him either.... [That doctor asked about medication for] high cholesterol and I said: "if you have a look at my [x] records, you'll see that it's quite [normal]...I've never taken medication for it...don't really want to either." Why? Because I don't feel sick...I don't see it as a problem.

The family habitus appears to have made a virtue of necessity by affording primacy to child healthcare needs and restricting adult access on the basis of the cost (family income $70-100,000) (vii). COLLIN, who has remained with his GP despite his family transferring to a medical centre, expresses uncertainty about the quality of care delivered further emphasising commonly-held perceptions and/or experiences amongst the study population that structural changes to the delivery of primary care constitute access barriers to ongoing receipt of personalised, quality care (viii):

(vii) COLLIN: These days [it costs] big time, big time and that's why...I just get the basics right...those who pay the money...to get them the better health...I haven't got that [money] so...both me and my wife just keep it really simple...if you're really crook, hopefully not too crook, then you go to see a doctor, but outside of that yeah, when the kids get sick for any little reason we take them straight in, but us, that's a little different [Laughs].

(viii) COLLIN: My doctor explains...at what stage in my children's lives I have to start paying ... because of their [x problems].... He's always keeping me informed about what I can do...I don't know what it's like with this new lot [at the medical centre].... I couldn't get into the [x] until I got my [x] done...so that's why I say...my good health comes from the [X, laughs] because they always look after their own quite well and you don't have to worry.
The narrative of 60-64 year-old CALVIN describes restricted childhood access to primary care. His participation in the Hauora Manawa Study, motivated by the untimely death of his father, resulted in the diagnosis of diabetes and referral for GP and cardiologist follow-up (i). His dialogue illustrates professional transfer of health-related knowledge was instrumental in encouraging patient self-efficacy in reduction of risk factors (ii), and significantly, this narrative suggests exposure to practice that fails to comply with recommended guidelines for the monitoring of cardiovascular risk amongst Māori (Riddell, Jackson, Wells, Broad & Bannink 2007; Riddell et al. 2010) (iii):

(i) CALVIN: We had Doctor [X]...Māori up there loved him...[we would] go if it was serious, fell out of a tree and broke an arm.... Dad died of [X] at 39, I was about 13 or 14...I became the father figure in the household being the oldest boy.

(ii) CALVIN: The [Study] Doctor told me what I had to do, basically my diet and exercise, so I now bike 22 kilometres a day...I just take them [the tablets] if they give them to me.... My [Pakeha] wife said she wants me living as long as I can for my grandchild...we lost a daughter about two years ago...and we share [custody of her son] with the father...I'm not scared of dying...but it's just nice to know if...[there is anything to help] me to prolong my life.

(iii) CALVIN: Sometimes I wonder...if they've got the right [diagnosis].... The Study Doctor...is the only one that's actually spoken to me about Māori issues...no [other doctor] has asked about my family history in relation to sickness.

Notwithstanding that engagement with the health system occasioned by the death and illness of his children, CALVIN's dialogue illustrates both a desire for, and a need (demonstrated by reducing medical insurance coverage) to accrue greater medical knowledge in order to orient future calculation and action (Shim 2010) (iv):

(iv) CALVIN: I've gone off the comprehensive [insurance coverage]...because I don't get sick very often...it's a lot cheaper just to pay the doctor's bill rather than medical insurance all year. My eldest daughter...has a great big medical history and so we've got her on comprehensive medical insurance.... Since
being diagnosed with diabetes I've gone [4 times]...the most I've ever been to a
doctor.

CALVIN's narrative suggests that management of diabetes, dependent upon informational
continuity of care (through patient-records) (Freeman et al. 2007) is not conducive to
fostering the development of patient cultural health capital. Moreover, the inability to
establish a rapport with a single practitioner is again identified as a negative characteristic
of modern primary care, with a detrimental impact on patients less able or willing to adapt
a proactive stance with frontline staff (Tarrant, Windridge, Boulton, Baker & Freeman
2003; Windridge et al. 2004) (v):

(v) CALVIN: I changed over to [X Medical Centre] two years ago after [my
old doctor retired]...he was a lovely guy, and every time you'd make an
appointment I...saw him but now [at the new medical centre]...every time I've
gone there it's been a different doctor. I'm not complaining... but it would be
nice to have a relationship with like a regular person. But if you look at my
prescriptions [they've] been given out by one doctor and they've got to find on
the chart who actually put that prescription out so I can get another one....
Luckily I can afford it now...a lot of Māori people can't afford $15 just...for a
dr to write out another prescription for two months.... I suppose I'm one of the
lucky ones.

Despite denying exposure to discrimination, during the Hauora Manawa screening
interview (see Chapter Eight), CALVIN's dialogue illustrates cognition of differential
treatment by frontline staff and Māori exposure to symbolic violence in broader contexts
(vi). Furthermore, although acknowledging encounters of interpersonal racism as a Hunn
Training Scheme apprentice, this dialogue illustrates the internalisation of the mythical
racial harmony discourse characteristic of the social conformity of many older Māori
(Ballara 1986; Belich 1996) (vii):

(vi) CALVIN: A receptionist-cum-nurse [was racist], you feel it.... People say:
"Well, how do you feel it?" and I say: "You [as a "white" person] walk into a
surgery where [they're] all "black" and you come back and tell me you didn't
feel anything." [Laughs].... They're polite enough but it's just overtones. Mind
you, there's a lot of bloody cops that haven't got it either and they try to pride themselves on it.... I just can't find the right word for it.... There is racism out there...it's amazing how many people say that they're not racist and deep down they are.... I haven't seen that [at] the hospital, the staff...were extremely courteous to everyone...it didn't matter what "race", creed or colour you were.

(vii) CALVIN: I was brought up where you weren't Māori or Pakeha; you were just a New Zealander.... When I came down to Christchurch...[in] the early 60s...the only people that you knew were the ones that were living at the [Hansell's Lane Hostel]\(^ {170} \) with you and there might be 3 or 4 or 6 of us going out on a Friday night...we got slandered as "gangs," but we didn't even know what a gang was!

DYLAN, a 35-39 year-old offspring of dual-Māori parentage, supports that lifecourse access to primary care conditions acceptance of orthodox Western medical care and demonstrates future orientated practice consistent with accrued cultural health capital (i). Nevertheless, this dialogue illustrates that habitus as a socialising agent disposes the inculcation of cultural attributes of the older generation and that affinity of habitus, vis-à-vis the provision of Māori-centred services, reduces the sense of alienation in medical institutions. This excerpt is also indicative of higher incidence of hospitalisation for car accidents among Māori (Robson & Harris 2007, p. 40) (ii):

(i) DYLAN: We'd jump on the bus...we all used to go together...five of us...it took the nervousness out of going to see the doctor...[who] had the privilege of delivering all my family.... As soon as there was a cough in the house [our mum would] rush us up to the doctor...she was just real cautious with our health.... [I participated in the study] mainly because a lot of my family have been affected by heart disease...I'd like it to stop in this generation.

(ii) DYLAN: I was in a bit of an accident and had my skull on my left hand side fractured...and I had a mental plate inserted...after the surgery the doctor said that I was very lucky to still to be alive.... I was in hospital for...two-and-a-half weeks. I just felt alone...my family and friends used to come in regularly,

\(^ {170} \) A hostel in Christchurch where Māori Trade Scheme apprentices were accommodated.
but...I don't like hospitals 'cause...when your family and your friends aren't there ... I hate that alone feeling.... But now I see that they have Māori Liaison People...it's awesome...when I took my dad up to hospital for an operation, she was always there and dad [and her]...they'd be laughing away.

DYLAN further highlights that, irrespective of age and/or gender, there were perceived and/or experiential differences in the current quality of primary care, particularly with respect to the propensity of longstanding family doctors to foster the ongoing development of cultural health capital in their patients (iii):

(iii) DYLAN: Sometimes...I don't get to see [my GP].... It never used to be like that.... When my doctor sits down and explains to me what's the cause of whatever sickness I may have or the steps I can take to help myself to eliminate the progress of it...and I'm like: "Oh, can you explain that?" And he does...to a level where I can understand it...the other doctors they probably just tell me what symptoms I have and the...medication that they want to give me...whereas my doctor will go more fully in detail of the symptoms, how it's caused.

While lifecourse access to a family doctor has reportedly afforded protection against exposure to discrimination in health contexts, this participant acknowledges the impact of state violence, expressed by the implementation of neo-liberal policies in the late 1980s-1990, on his family and friends (iv):

(iv) DYLAN: [Dad] came down with a group of his friends from the East Coast.... [While] a lot of his friends went through the hostel system with Rehua171...he just started off with odd jobs [then in] 1969 he started working in the freezing works172...[where he remained] until the late 80s.... [When he was] made redundant... [but] he knew how to save and he's still got a lot of money.... I've got friends and family members...that have struck it hard and

171 The Christchurch marae that coordinated the accommodation needs of Māori Trade Scheme apprentices.
172 The statistical blackout of Māori at higher levels of education resulted in Māori working in low-skilled occupations. Colonial "race" relations motivated the voluntary segregation of Māori into preferred industries, including the freezing works. Over-representation in low skilled occupations exacerbated exposure to the neo-liberal restructuring of the economy in the 1980-1990s (Consedine 2007). Extended periods of dependency on state payments and associated benefit related poverty are associated with a decline in health and life expectancy (Ajwani et al. 2003).
mainly within the work...a lot of them...blame the government for their situation...I understand why they think that way...I can see that the government doesn't do enough [for Māori but].... I haven't seen that happening to me.

In contrast, the testimony of CARL, a freezing worker (aged 30-34 years) with a family history of diabetes, reflects a less proactive disposition towards the maintenance of personal health. Despite receipt of satisfactory surgery following an industrial accident, and overcoming initial resistance to participating in the *Hauora Manawa Study* (i), at the time of the interview he had not attended the recommended GP follow-up consultation for markers of elevated cholesterol (ii):

(i) CARL: A lady [from the Study]...knocked on the door otherwise I wouldn't have bothered to be honest...once I came, it was about Māori health...I'm glad I came just for the check up.

(ii) CARL: You know what they're going to say: "Give up smoking, exercise more..." so you just dodge it. It's not that you don't know any better; it's that you don't want to, you get stubborn and lazy or you just try and avoid it...my wife is on at me about it.

CARL's dialogue suggests an association with healthism where "individual agency is accepted as the primary source of health and the prevention of illness is associated with personal choice and willpower" (Hodgetts et al. 2005, p. 124) and concomitant avoidance of clinical interactions with health providers (ii). Moreover, recent research by Harris et al. (2012a) reconfirms the relational association between experiences of racial discrimination and smoking (and hazardous alcohol consumption) (Harris et al. 2006a; Harris et al. 2006b; Robson 2004).

The case of BOBBY, a 35-39 year old factory-worker whose access to primary (and secondary) care was precipitated by a head injury and subsequent back injuries provide additional insights into a male disposition towards healthcare. His dialogue reinforces the connection between participating in a Māori-centred health initiative (albeit instigated by the psychosocial resources of whānau) and the effectiveness of affinity of habitus in overcoming resistance to accessing primary care (i):
(i) BOBBY: [At the Study] I was more welcomed and looked after...most Māori, especially me, are too stubborn to go into their doctor to get something like this done. That's why my daughter told me to come...I'd had a few chest pains so since she heard it was a heart thing for Māori[s], she encouraged me...it would be good if Māori[s] can come to places like this, where there are other Māori[s] as well...being Māori, seeing Māori people, it's a Māori thing for Māori[s].

The context of a difficult domestic habitus and reliance, albeit limited, on Māori medicines, has resulted in heterodoxical beliefs vis-à-vis the efficacy of Western medicine (ii):

(ii) BOBBY: I was a bit of a troubled kid...left home at fourteen, survived on my own since then.... [My grandmother] was into [rongoa]...that's why none of us really went to doctors...[and] even though I've got a bit of Pakeha in me, I'm not really into this Pakeha medicine, I call it: "The white man's medicine"...and I'm straight up with my doctor and tell him: "I'm not really into your pills."

Social-ascription and physical appearance are perceived to impose constraints on normal societal engagement vis-à-vis hyper-surveillance in Christchurch (iii), and BOBBY’s dialogue illustrates sensitivity to the game, and responses showing that experience of the game have resulted in the habitus internalising general sensibilities to discriminatory care in health contexts (iv):

(iii) BOBBY: It doesn't matter where I go, people look at me and straight away they think I'm cruel or a gangster. In my younger days I might have got into naughty stuff but then you learn as you get older, and I don't do any of that kind of stuff and I pass that onto my kids...don't want them doing what I did when I was at their age...In Christchurch I think it's just too bloody Pakeha-fied, and I've been in a lot of shops and have had evil looks from the Pakehas and had them watching me...looking at me as if I'm going to pinch something.
(iv) BOBBY: [The] orthopaedic [specialist], he made me feel as if I was kaka\(^{173}\) with my injury...it seemed like he couldn't wait for me to get out...maybe he's racist.... If I do go into places and at the reception there's a Pakeha lady and she hasn't got respect, then I feel as though, "Oh, she must be racist." [That makes me feel] low yeah, low, not wanted in there.... I wouldn't say stressed or angry, maybe a bit upset but that's just my thoughts and I mean, maybe they're not [racist].

The foregoing excerpt emphasised that the perception of not being respected in a non-ethnic-concordant doctor-patient relationship deters engagement with health services and further reinforces the sensitivity of socially-ascribed Maori vis-à-vis detecting discrimination (iv). However, the following excerpt potentially illustrates professional understanding of the relationship between Maori smoking and social inequality (Barnett, Moon & Kearns 2004), and once again highlights the perception that consultations with a locums or non-regular doctors compromise the quality of clinical encounters. Significantly, in this instance, the positive attributes of care identified relate to the fostering of cultural health capital (Shim 2010) and managing the side effects of drugs. Furthermore, this testimony reinforces the perceived shortcomings, acknowledged in international research, associated with informational continuity via electronic patient records (Freeman et al. 2007) (v):

(v) BOBBY: Every time I...make an appointment, it's a different doctor...I get on well with one...he knows I smoke cigarettes and he's been trying to push me to stop and always said to me: "Just come and let me know when you're ready to stop and I'll help you out and give you the old patch and all that," but I don't get that from the other doctors...they don't say things that can help me...but the main doctor...I'm comfortable with him...he's more understandable...more caring towards his patients, he's good and he's Pakeha.... If you're seeing one doctor, then another ... and they're all looking at your files, they don't really know you.... [Voltaren makes me] sick in the guts...[the doctors] always say: "Have a meal."... I could have a good meal but then the next day I'll wake up

\(^{173}\) While the origins of "kaka" are Yiddish and the word has been adopted via American English, in this particular context it denotes the Māori term for excrement.
sore then I'm in the toilet...my doctor says: "Just don't take them if it upsets your tummy...just carry on with the other ones."

This participant exemplifies the corollary of disproportional Māori exposure to work-related injuries (Cram 2007). The consequences of head trauma and preceding back injury bode ill for the sustained employability of a semi-skilled male under 40 years old (vi). BOBBY's dialogue illustrates how, following extended off-work periods, the depletion of sick pay and delayed ACC payments have had a deleterious affect on his ability to finance basic necessities (vii):

(vi) BOBBY: [After the head injury] I was recovering fast but...I get dizzy spells...[and] a lot of headaches.... I feel as if someone's pushed a needle in my brain and I forget things...my wick's got shorter, so when someone makes me angry I can just fire up [clicks fingers]...before I wasn't like that, I used to think about it first and then sort it out.

(vii) BOBBY: I was off work [for three to four months] on ACC... I started [back] on low hours but I wasn't coping...so put me on [light duties] which I felt better off doing.... [The back injury] happened a few years ago.... bumped into the corner of a machine...it's an ongoing thing [when] my back plays up.... I do my stretches and if it gets worse...I'll go to a physio...[and] my doctor...I had Nurofen-Plus and Voltaren but [after] the third week...the boss said to take...annual leave.... I've been on ACC [for six weeks]...just started back [at work] last week.... I still haven't been paid [by] ACC yet... they said were going to pay me, but I don't know if they're going to pay me the whole lot or not but they said that I won't get it for a few weeks...I moved out of my flat cause I couldn't pay rent.

**Chapter Summary**

Findings illustrate a complex, multidimensional relationship between age- and gender-related habitus, cultural health capital, and access to and engagement with modern primary care. Age differences reflect that younger participants are more likely to be urban-born, better integrated and/or accepted into Christchurch society, and have had lifecourse access to mainstream societal infrastructure. In this sample, the gendered nature of habitus
occasioned greater female exposure to healthcare, whereas male access was commonly precipitated by industrial and/or car accidents and increasing age-related need; the "masculine attributes of habitus" appear to contribute to resisting engagement, exacerbated by institutionalisation of the work habitus.

The relationship between lifecourse and/or longitudinal access to primary healthcare and positive engagement, irrespective of age and/or gender-specific habitus is identified in Chapter Six. Continuity of care facilitates confident clinical engagement, thereby bridging power-relations vis-à-vis disparities in objectified cultural capital, and is considered protective against exposure to discriminatory care. Support notwithstanding, findings suggest that first, this relationship is conditioned by transgenerational negativity towards, and/or resistance to engaging with, doctors; this is reflective of discriminatory treatment and/or cultural dissonance between biomedical and alternative models of illness, irrespective of the volume and composition of cultural health capital possessed. Second, exposure to practitioner stereotyping of obesity and sexual behaviour described by several female participants serves to highlight that culturally-inappropriate care remains a characteristic of primary care. Nevertheless, for this sample longstanding doctor-patient relationships (particularly with a single practitioner) appear to be associated with increased medical rationality and biomedical understanding, proactive attitudes, and dispositions towards self-management (Shim 2010).

Similarly, findings support the complex and multi-dimensional array of factors that affect the relationship between access to primary care, the accrual of Western cultural health capital and contemporary engagement identified in Chapter Six. First, age-related complications are interconnected with the primary habitus and exposure to, and/or reliance on Māori medicine, and the dissonance between Māori and Western cultural health capital(s). Second, notwithstanding the dissonance between heterodoxical and doxic beliefs in the efficacy of Western medical care, the onset of chronic disease and/or industrial accidents stimulate innovative dispositions directed towards accessing optimal care. Strategies include choosing GPs who integrate both alternative and convention medical understandings within their practice and exhibit an understanding of the relationship between Māori smoking and societal stressors associated with inequality.
Findings suggest gender-related differences in motivations for participating in the Hauora Manawa Study. The majority of women, consistent with more frequent engagement with primary care, were, in the main, interested in accessing a free health check. For women who were deeply imbued in Māori culture and/or had been subjected to traumatic experiences in mainstream contexts, the opportunity to access a Māori-centred initiative was considered as, and proved to be, a means of accessing culturally-competent and culturally-sensitive Western medical care. In contrast, male engagement was, for the most part, motivated by awareness of family histories of cardiovascular disease and/or diabetes. Responsiveness to the Hauora Manawa Study reinforces the effectiveness of ethnically-concordant doctor-patient relations and/or Māori-centred provision in stimulating patient self-efficacy in the management of health needs. The correspondence between Māori cultural health capital and affinity of habitus illustrates how: "When habitus encounters a social world of which it is a product, it finds itself 'as a fish in water,' it does not feel the weight of the water and takes the world about itself for granted" (Wacquant 1989, p. 43). Further, findings underscore the salience of culturally-competent and culturally-sensitive care by non-Māori providers in bridging cross-cultural dissonance and engendering positive engagement with primary care, thus emphasising the generative and dynamic quality of habitus in offsetting childhood socialisation.

Notwithstanding hysteresis of habitus amongst the older cohort, indicative of the transitional difficulties vis-à-vis paternalistic, whānau-oriented family medicine and the more technical and less personal delivery of contemporary primary care, discontinuity of provider care is considered problematic irrespective of gender, age, and/or levels of cultural health capital accrued. Episodic care from locums and/or non-regular doctors is associated with deficit characteristics of the practitioner's habitus that encompass "the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles," which, when not practised, result in inferior healthcare relations (Shim 2010, p. 1). Empirical evidence acknowledges that provider discontinuity disproportionately affects vulnerable and minority patients (R. Baker et al. 2007; M. Boulton et al. 2006; Freeman et al. 2007; Lakhani 2007; Windridge et al. 2004).

In the contemporary primary care landscape, structural constraints on the capacity to strategically access a doctor of choice precipitate a practical sense of "reasonable" expectation. For socially-ascribed Māori, clinical interactions with non-Māori health
professionals are conditioned by the subjective understanding of the objective probabilities of exposure to symbolic violence (Bourdieu 1990, p. 54). A sense of the game conditions intuitive understandings that optimal primary care access requires constant vigilance and responsiveness to oppositional play within the field (Bourdieu & Wacquant 1992, pp. 128-129).

The decision not to follow medical advice pursuant to traumatic engagement and/or suboptimal care vis-à-vis the lack of monitoring of allergic reactions to pharmaceuticals (also identified in Chapter Six) can be understood, as Bourdieu (1990, p. 54) states, not to be deviant behaviour:

...the dispositions durably inculcated by the possibilities and impossibilities, freedoms and necessities, opportunities and prohibitions inscribed in the objective conditions ... generate dispositions objectively compatible with these conditions and in a sense pre-adapted to their demands. The most improbable practices are therefore excluded, as unthinkable, by a kind of immediate submission to order that inclines agents to make a virtue of necessity, that is, to refuse what is anyway denied and to will the inevitable.

Dispositions, Bourdieu (1989, p. 18) states: "tend to be adjusted to position[s], agents, even the most disadvantaged ones, tend to perceive the world as natural and accept it much more readily than one might imagine - especially when you look at the situation of the dominated through the social eyes of a dominant." The relationship between the symbolic association of social-ascription and/or classification as Māori is further examined in Chapter Eight.
CHAPTER EIGHT: FINDINGS SOCIAL-ASCRPTION AND SKIN COLOUR

I feel like I am getting quality care when the doctor is looking me in the eye, not typing away; he's already read my notes and he's acknowledged me, and he's really listening to what's going on with me ...then he will give his assessment, then he will investigate the pain, then he will say: 'Well how about if you just ... go to the physio, do a bit of exercise and I'll give you a pain killer. I won't give you antibiotics, things like that, at the moment and then we'll see you back in another three days' (Study Participant, Amanda).

Introduction

The findings presented in this chapter focus on the relationship between social-ascription as Māori and/or skin colour, cultural health capital, and engagement in and access to the field of healthcare; the findings also discuss the relationship between colonial relations, the habitus of social actors and agents of institutions, across the interrelated social fields and social spaces. The four sections are structured first, to explore the association of social-ascription and/or skin colour at the process-level of the healthcare system; second, the effect of social classification and/or Māori commonsense assumptions of Māori phenotypes across the interrelated fields of criminal justice, politics, education and the media; third, the strategic deployment of dominant group cultural capital to, and/or the effect of "whiteness" on, doctor-patient interactions; and finally, the relationship between skin colour and spatial location in Christchurch.\textsuperscript{174}

Section One - Process-level Factors

The dialogue of a Māori health worker who is on the board of a Community Health Centre explained having to "address a lot of issues" to ensure Māori access to quality healthcare as "our people ... they felt it was racist." AGATHA describes how one patient was unable to access a doctor, despite need (i). In contrast, DELIA, a self-

\textsuperscript{174} In the 2006 Census, 25,725 Māori usually live in Christchurch City, an increase of 3,192 people, or 14.2 percent, since the 2001 Census; 4.6 percent of New Zealand's Māori population usually live in Christchurch City (Statistics New Zealand 2012a).
defined "white Māori" (individual income $50-70,000) suggests the symbolic efficacy of skin-colour and cultural capital in overcoming gate-keeping practices (ii) (Shim 2010, p. 6):

(i) AGATHA: ...one patient...was [repeatedly told to:] "Go home and take some panadol." The third or fourth time he went down [after] he was sent away...collapsed in the gutter just up the road...the bus driver...picked him up and rang the ambulance.... When they got him in hospital and found out that he was [diabetic]...they rang us and...said this patient should have been here last week...that's how bad he was.... The doctor [at the medical centre] didn't even see him...he was [triaged by] the nurse all the time...he's moved from [X]...and I didn't stop him.

(ii) DELIA: I have a really good [5 year] relationship with my GP and so do my family...I can be quite casual with him.... [The Medical Centre has] got a Māori name but there doesn't seem to be any Māori there.

AGATHA further reports that exposure to suboptimal care extends to hospital settings and implies that the quality of care is differentiated on the basis of social-ascription, social distinction, and the volume and composition of capital(s) possessed; her testimony reveals how accrued capital and social status facilitates misrecognition of systematic differences that maintain disparities in care provisions (iii):

(iii) AGATHA: I went to see...an old man [who] was told to go home...he was up in CT unit...he couldn't even walk...I said: "This man...should be here" and they said: "No, no, no, he's all right, he can go."... The doctor assured me, so...who am I to argue. They were sending him home on a bus.... I took him home...about 4 or 5 o'clock...at 10.30 he was back in hospital. I had to call an ambulance; he couldn't breathe.... I brought this issue up with [a tribal leader].... I said: "They're bloody racist...our health system does not take good care of our people."... He said:"my mother went in and they treated her just like royalty." I said: "That's because you're a pretty little "white" boy...and your mother is "white" and you're...very powerful...but if she was a big
"black" lady and had a big "black" son...[who] was in Mongrel Mob, you wouldn't get the same treatment."

Another participant also employed in the health sector demonstrates effective application of accrued cultural health capital by selecting a physician who accommodates her beliefs in orthodox and alternative treatment perspectives (iv). Further, BERNICE's dialogue highlights the salience of skin tone, and how the embodiment of objective structures manifests in subjective dispositions (deportment, physical mannerisms and style) that have implications for Māori when engaging with health professionals (v):

(iv) BERNICE: [My doctor] knows of my background in nursing...we talk...about herbal medicine, like Māori herbs...[she asks if there is] anything I know that she should be doing with her Māori patients.

(v) BERNICE: [It's partly]...to do with your own self esteem...if you feel a wee bit [disempowered]...and your body language portrays that, people tend to treat you that way, particularly when anyone goes up against a medical professional, they automatically have not got the same power.... I know there are some bolshie nurses and doctors out there who like that power.... I think there are very good reasons [for patients] to feel that way but I don't know if it's solely because of being Māori, because [medical] people will do it to anyone who's got a wee bit of a posture problem.... It's never to my knowledge really happened to me because probably I look fairer than most. Racism is still here. My son and my daughter are very dark...and Māori tend to be very humble...they hold their heads a wee bit down if they feel a bit nervous, my son does that a bit...whereas my daughter doesn't, she's a bit more like me...I can tell it's a posture thing. I say [to him] "Don't do that, stand up like them...if they stand up, you stand up taller."

In hospital settings, Māori patient dispositions suggestive of the active presence of internalised colonial relations include learned responses of stoicism that differ from the conventional responses and coping strategies associated with the traditional Western "sick role" (Parsons 1951); BERNICE perceived that vulnerability and powerlessness occasioned elevated levels of discomfort amongst Māori patients (vi):
(vi) BERNICE: Māori patients tend to want to be good...even the young ones...they don't moan as much in general...they're staunch, they try and "keep it in."... They're a bit more private with their inner feelings, so they won't share immediately.... [In hospital]...you have to leave your dignity...your control, your power at the door.... Māori don't like that [laughter] no one does but Māori tend not to feel very comfortable with that.

BELLAMY, an older socially-ascribed Māori, describes interethnic differences in the dispositional responses of patients upon encountering professional practices perceived as improbable, unthinkable or inaccessible for the likes of us or not for us, that is inconsistent with the established neo-colonial norm (Bourdieu 1990, p. 54), and further, how receipt of perceived preferential treatment is rationalised as a counter-hegemonic strategy directed towards ameliorating social unrest (vii):

(vii) BELLAMY: I was in a [hospital] room with 6 people and [this nurse]...said: "I'm going to give you your own room."... Later she comes and says: "We're getting this new gear, we're experimenting on...you're going to be the first"...and these Pakehas...say: "How come you get that?" "Because I'm a king." [Laughs]... But she looked after me for some reason, I don't know why; maybe that's when all the Māoris were playing up [laughs].

In contrast, CRAIG, a self-defined "White Māori" denies ethnic based differences in medical treatment. His dialogue exemplifies misrecognition of the arbitrary construction of dominant group discourses vis-à-vis the attribution of interethnic disparities to health-related behaviours and Māori demands for privilege (viii):

(viii) CRAIG: I don't feel there's any difference in treatment, I had Māori[s] attending the heart unit when I was a kid and there were the same things for them as there was for me.... I've had a lot Māori friends...that say they're treated differently...I don't know [why], is it because they think they are [treated differently], or is there a racial overtone?... Personally, I think...that they [think that they] should be getting everything. It costs to go to the doctor...but a lot of Māori[s] don't want to pay that cost and that's generally why.... I have friends that...go to the pub every night...[but] do you need to go every night?
CRAIG's assertion is, however, counteracted by BETTINA's description of witnessing different professional responses to Māori victims of domestic violence which translate into practices reflective of stereotypical expectations (van Ryn and Burke 2000; van Ryn and Fu 2003). Moreover, her dialogue reinforces heterodoxical beliefs vis-à-vis interethnic equity of care, and perceptions of heightened exposure to discrimination in Christchurch (ix):

(ix) BETTINA: I think a lot in the medical profession look at Māori differently...they don't offer them as good a healthcare, they think they can sort of cut corners and [Māori] will be happy with what they're given...I've witnessed it often...they are given substandard care...you can tell when...they're taken into hospital...people's body language towards them, it's very apparent..... One lady...had been assaulted...[the staff] look at it like that's the norm and she'll be back and it will happen again and that's how she lives...they sort of patch her up and send her on her way.... I don't know if like Christchurch is...worse for it...because it's quite "white"...[and] wealthy.

BEVERLY, a Māori support worker, lends credence to increased exposure to symbolic violence in hospital contexts on the basis of social-ascription as Māori. The persistent nature of reported differential care potentially illustrates the instrumentality of media bias in inculcating perceptions of domestic abuse as an inherent Māori cultural attribute rather than a societal aberration that transcends ethnic, cultural and class boundaries (x), particularly as her dialogue reflects the personal embodied demonisation of Māori males (xi):

(x) BEVERLY: The nurse [at the hospital] phoned the medical centre to verify the mother's story...[in turn, their nurse] rang our office and voiced her concerns.... It happens a lot with our mothers in the hospital because...[the staff] suspect things and make assumptions.... [Māori mothers and children are taken] to the Scan Group.... [Although] they're all professionals, they make the wrong diagnoses...this happens all the time with Māori babies.

(xi) BEVERLY: Our Māori men have got a lot to answer for, because...there's this beautiful wedding photo on the wall and I looked at this person and I
thought: "it can't be the same person" but it was the same person and she looked so haggled and drawn...that's where our Māori men are doing it to these women...they bash the woman up.

Similarly, the correlation between an abusive domestic habitus and the movie *Once Were Warriors*175 reflect the symbolic efficacy of popular culture on the Māori habitus. (xii). In contrast, CALVIN’s dialogue reflects recognition of the arbitrary nature of media bias in the promulgation of family violence as an inherent characteristic of Māori society (xiii):

(xii) ANGELA: that movie "Once Were Warriors"...I said to [my husband]: "I've been brought up like that"...that's where I'm from, that's my background.

(xiii) CALVIN: The majority of news items, they come across where a brown face has done this [and that].... I'm thinking of when we went through that spate of abuse of children, and you go: "Please, please, please no!"

Engagement with health providers, irrespective of accrued Western cultural health capital, is conditioned by social relations. The following excerpts illustrate that, within the context of healthism, social-ascription as Māori provokes persistent subjection to professional manifestations of symbolic violence. Clinical encounters characterised by professional "expectations rather than actual experience" (van Ryn et al. 2011) precipitate concomitant patient stressors associated with exposure to stereotypical beliefs (xiv, xv):

(xiv) ADELE: Health professionals always think I'm lying when I say that I don't smoke and I've never smoked...I see them look at my hands and my teeth...and it's every time and sometimes I don't even think that they know that they're doing it...some Māori don't smoke!

175 Based on the novel by Alan Duff published in 1990.
(xv) AMANDA: I had my moko\textsuperscript{176} in hospital and she's very fair...she's a bit asthmatic...[the nurse]...says to me: "Are you mum?" There was no introduction...I said: "No, actually I'm her grandmother." So [the nurse] says: "Oh, so I guess you smoke."... They don't say it directly: "Oh, because you're Māori so you must smoke." I said: "Well actually, no I don't [laughs]...but does that really matter? This is my daughter's daughter, she doesn't smoke, neither does her [Pakeha] father but her great grandfather was asthmatic and he was English." [Laughs] But it makes you feel you have to defend yourself.... It's that indirect, that underlying [insinuation] and yes, I was angry...I felt really stink after that because I didn't have to stoop down there...and I'm thinking, oh well you've just played into that.\textsuperscript{177}

ALISTER, a blue-collar worker, (family income $30-40,000) highlights exposure to discriminatory care and illustrates how a sense of the game of the game, following lifecourse exposure to symbolic violence on the basis of skin colour, translates in intuitive perceptions (xvi):

(xvi) ALISTER: The type of work that I do requires crawling under houses...and every now and then...I'd break out in really horrible sores.... [I saw a locum], she didn't even get up out of her chair... just looked across and said: "Oh, that's just shaver's rash".... \textit{Did you think that was in any way because you're Māori?} I wondered about that and I did, you know how you get those sorts of intuitions and that was the first thing...even before she made the pronouncement, I just got this feeling.... You can't write it down in words but when you've been brought up, when your whole life has been around that stuff, you get to sort of figure it out.

Furthermore, ALISTER's testimony illustrates disruption to the domestic habitus following urban migration and the tortured habitus of adult migrants occasioned by rapid social change. He also reinforces the post-migration onset of asthma and how, notwithstanding the availability of primary care, access was nonetheless restricted because of limited economic capital (xvii). Although engagement with primary care is mandated by

\textsuperscript{176} The Māori term for grandchild.

\textsuperscript{177} Research suggests that "taking actions in response to discrimination experience(s) appears to proliferate stress but reduce adjustment reactions..." (D. R. Williams & Jackson 2005, p. 26).
conditions of employment and compliance with ACC regulations, this participant's disposition towards the efficacy of Western medical care is evident in non-orthodox practice (xviii):

(xvii) ALISTER: Mum and dad moved down to [X]...it was a huge adjustment...particularly for my father who suffered from alcoholism.... He died [when I was 10-11]...so mother was there trying to keep down a part-time job and raise four children on a benefit...so things like health...go on the back burner.

(xviii) ALISTER: All my brothers and sisters are asthmatics and I developed asthma very late (at 25).... An aryuvedic doctor in India ... made up some medicines for me...and since I started taking all these...haven't had an attack of asthma...and all my sisters and brothers are still on their squirters...so I don't have a lot of faith in the health system.... My son had weeping eczema when he was less than a year old and the doctors wanted to...put him on steroids. A kinesiology [practitioner] cured him within 3 months.

Section Two - Other social fields

Testimonial accounts accentuate that access to and engagement with health services is detrimentally affected by stereotypical representations and their embodiment within the habitus of social actors across multiple fields; moreover, the ability to accrue cultural health capital is correlated to systematic inequalities that transcend all social fields and institutional arrangements (Shim 2010).

Social Justice, the Media and the Education System

In the field of criminal justice, doxa represents a form of misrecognised unconditional allegiance to the rules of the game, the unquestioned orthodoxy of the maintenance of social control (Deer 2008, p. 123). This narrative illustrates a commonly perceived relationship between classification as Māori and exposure to symbolic power, and that differential access to societal resources is not restricted to the field of health but encompasses exclusion of the protective resources of institutional justice (i):
(i) BETTINA: [With the Police] it feels like [Māori] are lower class…. Māori still tend to keep it to themselves and don't ask for the help because perhaps in the past they have tried and...the assistance hasn't been there and they haven't been...valued.

A 45-49 year old male who describes himself as only "one thirty-second Māori" has a "well-constituted habitus" (Moore 2008, p. 100), (individual income $100,000+), and perceived that he accesses quality primary healthcare. His dialogue illustrates police-targeting on the basis of social-ascription, and cognisance of the symbolic efficacy of media bias maintaining public misrecognition of institutional injustice (ii):

(ii) DIONE: The media...has blown it out of proportion...people don't realise that...[the media] give you all the information like [the high proportion of Māori]...prison inmates...[but] I've seen [the police target Māori]...a good mate of mine who's clearly identifiably Māori was sitting at a table chatting to an older couple...[when someone] broke the window...the police...went straight for him.... We actually ended up having this big argument with these police[men].... Luckily...a police[man] we knew...sorted it out.... The funny thing was the guy who broke the window was a policeman!

DAN reinforces the importance that socially-ascribed Māori attach to maintaining relational continuity with a single practitioner as both protective against receipt of discriminatory care and conducive to the accrual of health-related knowledge and cultural health capital (iii). His dialogue describes vicarious exposure to symbolic violence expressed by educators that suggests the embodiment of the Māori propensity for crime (iv). Additionally, DAN's dialogue reflects how abuse of state power by social agents is manifest in a dehumanising cycle of abuse and harm that encompasses the "mind, heart, spirit and soul" (Moana Jackson cit. Quince 2007, p. 12) of Māori youth, and further reinforces the protection afforded by lighter skin tone (v):

(iii) DAN: I've been treated well and I think that's greatly due to the GP we have.... I've had [prejudicial treatment but] not in health.... We like her because we know her...because both myself and my wife are Māori ...she said:
"You have to watch this because genetically... [the] Māori population have a higher risk of heart disease and diabetes."

(iv) DAN: [My brother's]...teacher said: "My bag is missing...so you stole it."... Then [another] teacher...hits me up...."Your brother, what has he done with this wallet?"... When you're twelve, it's quite a fearful thing...[but the way] that we were brought up, I just knew that he hadn't done that.... It was a Pakeha teacher, she was in tears...[when] she found it...there was no apology.

(v) DAN: [My brother] was in town to go to a dentist's...a couple of cops...said: "Oh, are you wagging school?"... The cop walked [up to] him and punched him in the guts [laughs]...my sister saw him double over...and since then my brother, he just hates cops, I mean he hates cops [laughs].... But probably because I'm quite fair, well compared to my brothers and sisters...there's a difference...[in the way I'm treated].

Exposure to symbolic violence, both direct and indirect, requires constant vigilance, and the anticipatory stress of future occurrences has negative implications for health (D. R. Williams & Mohammed 2009; D. R. Williams & Sternthal 2010). The following testimonies provide additional insights into how differential medical treatment of Māori potentially results from provider's misrecognition of symbolic violence associated with the cumulative and intergenerational trauma of surviving colonisation (Archibald 2006; Quince 2007, p. 3) (vi); BELLAMY highlights how the democratic process facilitates contemporary extinguishment of indigenous rights, and the potential of the youth habitus, in embodying state violence to contribute to the efficacious reproduction of symbolic force (Deer 2008, p. 121) (vii):

(vi) ALISTER: My grandfather...uncle were in the Māori Battalion and my grandfather's younger brother [and] grandfather-in-law who died from shrapnel wounds...for our village the war had a huge impact...I have heard figures bandied about more than 60% never came back...it means that there were no men to guide the younger boys into adulthood.
(vii) BELLAMY: I think the European thinks everyone else is [down] here and they're [up] there...You see how they took the foreshore\textsuperscript{178} off us, they think they can come along and just change the law, bang! I mean the way it was, [the foreshore] was there for everybody anyway. Now the government...took it...they had to cheat to do that.... The majority rules, but...we're a group of people that don't like to be pushed around, not today, we got suppressed by them and promised this and promised that and they were all lies but today...these young fellas, they've got no respect for the law...they don't care. Bang, jail, because...it's in their blood...that's why we're in trouble.

Another male participant also highlights the relationship between political and media misrepresentations and commonsense public misunderstanding of the state expressions of symbolic force (viii). Moreover, his testimony serves to further reinforce the pervasive dissatisfaction with quality of care received from non-regular doctors, and illustrates an instrumental approach to the exchange and understanding of medical information, characteristic of cultural health capital (ix):

(viii) BROCK: [Pakeha] say things like... "Tariana's\textsuperscript{179} just raping the country."... I also think...a lot of Pakeha just aren't aware.... I took something [about the foreshore to a work colleague]...and said: "Read that mate and tell me what you think"...and [then] he's like: "Oh, that's not what I thought it was." So a lot of it is just naivety...mind you when you try and tell...some people they just don't want to listen anyway.

(ix) BROCK: Sometimes you get a doctor fill-in...and they just want to get you in and out of the door like you weren't there: "What's wrong?" "I've got a cough:" "See you later." It's no time spent...I suppose too, my doctor...believes [in] less pills more exercise...which I think is pretty cool.... I usually give as much information as I can, as they say: "You know yourself best and the more information you give [doctors] the easier it is for them to

\textsuperscript{178} The Foreshore and Seabed Act (2004) extinguished Māori rights to ownership of the foreshore and seabed, which critics argue "amounts to an outright extinguishment of customary rights in the coastal marine areas in a manner fundamentally at odds with the principles of the Treaty of Waitangi" (Anderson et al. 2006, p. 1782). Although the Act was repealed and replaced by the Marine and Coastal Area (Takutai Moana) Act 2011, the issue remains a source of political contention because the new Act places encumbrances specifically on Māori.

\textsuperscript{179} Tariana Turia is the incumbent co-leader of the Māori Party.
help you."... Sometimes they don’t explain why I need to take something or what’s that big word mean [laughs]... so I’ll go home and look it up on the computer and check it out.

The narratives of two non-socially-ascribed Māori highlight how, regardless of social-ascription, the heterogeneity of the study population generates diverse explanations and understandings of political capital and dominant group interests vis-à-vis Treaty of Waitangi settlements. The first exemplifies the symbolic efficacy of public ignorance in constraining state redress of historical injustices (x). The second recognises that public discourse is what is taken-for-granted and goes unchallenged; its legitimacy, through misrecognition of arbitrariness, goes unrecognised, and reality lies beyond any notion of enquiry (Schiff 2009) (xi):

(x) CYNTHIA: I think in some cases that [Māori] bring [discrimination] upon themselves... I don’t agree with... all this hoha\(^{180}\) we’ve had... [over] the Māori lands has [made it] worse for them... all this money’s being paid out... should never have been, because as far as I’m concerned, we’re all one person, we’re one country, we’re all struggling and we all should be working together, not some thinking that they should get more than. Do you think that the Waitangi Tribunal settlements have been divisive? I think so, cause a lot of my friends, they don’t like it either and some [are] Māori.

(xi) CALVIN: Also because people don’t understand about the Waitangi Tribunal process\(^{181}\), they think Māori are getting so much more, when in fact they’re not.

The ability to accrue cultural health capital derives from past experiences that are tied to social stratification, "in that schemes of thought, perceptions, and actions originate out of class- or status-specific conditions of existence" (Shim 2010, p. 5). Notwithstanding that the formation of habitus and the concomitant accrual of cultural capital initially occur within the family or domestic habitus, for Bourdieu (1977, 1990) the authority to objectify

\(^{180}\) For Māori, the word "Hoha" is commonly understood to mean bored or annoyed, similar to the English 'hoo-ha' meaning fuss.

\(^{181}\) The Waitangi Tribunal was established under the 1975 Treaty of Waitangi Act as a commission of inquiry to investigate Crown breaches of Treaty of Waitangi and make recommendations to the Crown regarding compensation.
cultural capital meant that education was the most influential primary socialising agent. However, the field of education, ostensibly responsible for creating social inclusion, has since the time of colonisation been formative in consolidating social separation (Simon & Smith 2001); policies and practices continue to determine interethnic disparities in the accrual of cultural health capital.

The aims of the primary socialising agents of the domestic habitus and the school, which both function to conserve and inculcate cultural heritage (Swartz 1997, p. 190), are antithetical within the context of a neo-colonial society. The dialogue of a 60-64 year old native speaker illustrates the relationship between perceived deficit linguist facility and health-related knowledge (Shim 2010, p. 3) (i), the ameliorative effect of maternal empowerment in countering colonial constructs of social classification of Māori (ii), and how exposure to symbolic violence in educational contexts remains indelibly embodied within the habitus (Maton 2008, p. 105) (iii):

(i) ALLAMAIN: I think it's not [having] enough knowledge about health issues in order to ask the right sorts of questions...I don't think I was qualified enough to have the right questions to ask.

(ii) ALLAMAIN: ...self-worth [is a problem for a lot of Māori not] brought up in their own culture...we were ... always put down..."you're never going to come to anything"...but we had a mother...who always said "you can be anything you want to, if you want to put your mind to it"...but not everyone thought like her...so we'd hear both sides...most of it was probably more the negative.

(iii) ALLAMAIN: I was brought up in the time when...we had to bow to the headmaster and...curtsey to the headmistress...we were never ever stopped from speaking the language in school...we spoke broken Māori, broken English...mum and dad and grandparents only spoke Māori at home.... Basically [teachers have] done a lot of shit with us...while I might think: "oh well I've moved on a bit in life," those things still sit there...I think a lot of it's to do with the way we didn't have what they did. We were we almost made to look up to them.
The complex relationship between the overall volume of capital accrued and the relative weight of economic and cultural capitals in the total volume of assets (Bourdieu 1989, p. 17) is illustrated by AILEEN (55-59 years old). Notwithstanding the successful accrual of economic capital (family income $100,000+), discrepancies in accrued dominant group cultural capital have resulted in the habitus embodying structures of a racialised and male dominated society, and generating patterns of thoughts conducive to the maintenance of the established social order (iv):

(iv) AILEEN: It's hard to explain but you just know...[people] have looked at me in such a way that I know that it's one, because of my colour and two, because I'm a woman.... You don't feel you're good enough, so many times I haven't felt as if I'm good enough...I'm not educated but I'm also a Māori, so I'm on the back foot anyway...I went back to an Adult Education Centre to learn to read and write.

The need for adult remediation of illiteracy in this instance, and the disproportional rates of functional illiteracy among Māori (Ministry of Health 2010a) more generally, highlight the relationship between symbolic violence in the field of education and engagement with health professionals, and the direct and indirect ways in which interethnic health disparities are (re)produced (Shim 2010, p. 7).

The testimonies of two participants in their thirties highlight that despite the commonality of second generation understanding of the trauma of symbolic violence perpetuated by institutional policies of language and cultural genocide, different responses tend to correspond with levels of dominant group cultural capital accrued. The first, from a male semi-skilled worker, implies the generational reproduction of educational and social-class location and concomitant hierarchical social systems (v); whereas, the second, that of a middle-class woman, illustrates firstly, that exposure to symbolic violence has provoked resistant manifestations of Māori cultural pride and endeavours to offset language and genocide, and secondly, reinforces Bourdieu's (2000, p. 166) premise that social practice is always interested and begins in childhood as an "investment in the domestic social space"

(v) CARL: My father...has started opening up about how...they used to get beaten up for speaking in Māori...he didn't learn to speak English until he went
to school and so he found it really hard...they'd give you a Pakeha name because they couldn't pronounce your name.... So he didn't like school at all and he left as soon...as he was old enough, left the area and never went back pretty much until just recently.... [Mum]...didn't stay at school very long either...but she didn't really talk about school or her upbringing.

(vi) ANNETTE: [My parents] they're both three-quarters Māori and when they were in school...they'd get strapped if...heard speaking Māori...so my daughters [will be] taught te reo and any other avenues that I can access to get them educated that they're Māori. But lots of negative experiences and when you're young and very impressionable and...there is so much negative information projected down upon you...makes people react very poorly, if they can't handle it, or if they don't have a supportive whānau.

Section Three - Patient Responses

Symbolic power operates partly by controlling an individual's beliefs (Bourdieu 1990, p. 69). The dialogue of a non-socially-ascribed Māori is illustrative of the efficacy of symbolic power in creating ethnic inequities in access to societal infrastructure and misrecognition that disparities in accrued dominant group cultural health capital, while "individual in their accumulation and expression," are "social and relational in origin" (Shim 2010, p. 5) (i):

(i) DELIA: ...everyone is a racist to a certain degree, even small ethnic "races" and I think it can work both ways really. Possibly [Māori] are treated differently because the majority of them, they come across as less aware of medical procedures, they don't know the jargon of medical procedures.

The narrative of a 60-64 year old male illustrates the relationship between longitudinal exposure to symbolic violence on the basis of social classification as Māori and health and wellbeing; BELLAMY's narrative also shows the efficacy of counselling, and religious beliefs, in ameliorating the debilitating effects of psychological stressors underpinned by colonial relations (ii):
(ii) BELLAMY: [When I get angry it] really puts me on a downer...I have to try and stay positive all the time but...we're always going to be in that position because [Pakeha] think they're [up] here and we're [down] there...they don't want us up there...half of my sickness is what I'm carrying [in my head], medication can only heal you so much but if your road is negative, you can't heal yourself...so I'm doing counselling and that's helping me heaps.... I'm not going to say it'll fix my heart...make my heart better...help my diabetes...but now the medication...is working hard to keep me alive. I'm not scared to die...if I have to go, I have to go, but...it's better to sit here happy than negative....I've actually crapped out [of going to church] but the daughter is going to take me...I feel better and I know it's from [church], because I come out of there on a high all the time. But [when] I'm in [church]...my mind is elsewhere, and I...think: "Oh man, he won't like that, sitting in here and your mind is out the window."

Within the context of a colour-conscious society, where classification as non-Māori represents a capital that converts into an advantage, symbolic power motivates "the intergenerational diffusion of Māori ethnic identity" (Kukutai 2007, p. 1151). The testimonies of two bicultural males of 25-29 and 45-49 years respectively, illustrate first, the impact of social disorientation as a determinant of self-classification (iii), and second, the relationship between colonial relations, the domestic habitus and adult disorientation in Māori cultural contexts (iv):

(iii) CHAD: [My parents] separated when I was seven...the way I was raised with dad being Māori and mum not and dad's family had the Māori stuff beaten out of them in school, like my grandfather never spoke Māori, whereas mum being European was trying to get me...to embrace my culture.... It was just confusing, so I just thought buggar it! I'm not European, I'm not Māori, I'm a New Zealander and that's what I put on my census forms.... I don't think [my GP is] even quite aware of it, I don't look terribly Māori I get called Arab more than anything else.

(iv) BERT: I don't look Māori I don't think, I'm fairly, fairly light skinned but apart from my surname you probably wouldn't even know that I was... we've
[grown up] more pakeha than Māori.... Dad never taught us anything...never mentioned anything about it...which leaves us in a bit of a lurch at tangi...[when you are] not too sure what the protocol is and...that feels very embarrassing actually.

In healthcare contexts, the symbolic power of social classification as Māori appears to stimulate the strategic and deliberate (rather than non-purposeful) deployment of cultural health capital to enhance social acceptability by displaying "verbal and nonverbal cues, vocabulary, styles of dress, mannerisms" in clinical interactions (Shim 2010, pp. 9-10). BIANCA, a 45-49 year old participant exemplifies how objectified history instilled in the habitus orients future practice (Bourdieu 1990, p. 66). Her *feel for the game of the game* has resulted in strategic improvisations, pursuant to witnessing the fatality of a young Māori (allegedly from medical misadventure) and concomitant distrust\(^{182}\) of doctors, manifest in the practice of maintaining discontinuity of care at a long-frequented medical centre (v):

(v) BIANCA: I attended the sudden death at [X]...where a young [Māori] lass, 16 died...because her 2 doctors...had written her off...she had a hole in her heart...she went to see them with severe migraine. They diagnosed her as having the flu and sent her home with panadol. [Her] mum and dad saw her in so much pain that they sent her to the Emergency Clinic where she had a major heart attack...she lived in the poorer side of town.... [Her parents] were so distraught, they blamed themselves because...they hadn't taken her to the hospital earlier.... I've been very distrustful of doctors ever since. So I'm quite happy to have a whole pile of different doctors, within my medical centre.

BIANCA's dialogue demonstrates *mastery of the game*, with an intuitive understanding of what social-ascription as Māori entails; accrued economic (family income $100,000+; medical insurance) and cultural capital(s); have rationalised the strategy of demonstrating social privilege via meticulous attention to presentation of self and linguistic ability to maximise the quality of care received (Shim 2010, p. 3) (vi). Practical experience and internalised sensibilities apropos the ubiquity of societal stereotyping have stimulated an

\(^{182}\) Patient distrust is not a racial attribute per se but arises from perceptions and/or experiences of racially prejudicial treatment during medical encounters (Adegbembo et al. 2006).
"elitist" dispositional response, underpinned by the perception that access to optimal quality healthcare is correlated to accrued economic capital (vii):

(vi) BIANCA: The way I present myself and...speak, absolutely, it has an effect on the way I'm treated...but I would also be treated differently if I walked into the doctor's surgery with a hoodie and jeans on and I know that...[doctors are] no different...we're all people and we're absolutely subject to stereotype.... My daughter's at [private girls' school]...call me an elitist but I think you are who you associate with, I've seen it.

(vii) BIANCA: I must be getting quality health care if it costs a fortune...we've always had insurance.... My [13 year old] daughter...is suffering from headaches...so she's...seeing a specialist...I will spend the money if I need to.... The doctor said..."If she was older...we might start trying some...medication but...for peace of mind...an MRI would sort that out just like that."

A 30-34 year old socially-ascribed Māori illustrates a contrasting, albeit uncommon, dispositional attitude amongst the study population towards the significance of maintaining relational continuity with a GP. This testimony is reflective of the age-cohort effect of young middle-class males where access is conditional upon convenience (viii), and positive engagement with health professionals is facilitated as objectified educational qualifications are embodied within individual's corporality "as principles of consciousness in predispositions and propensities in physical features" (Moore 2008, p. 105) (ix):

(viii) BRENT: I've always gone [to the doctor for]...injuries from playing sport.... I don't really have a relationship with her... [its] convenience...I don't go because I think she's a good doctor or anything I just go because she's close [laughs], I suppose I trust her.... [in] seven years and maybe I've been five times.

(ix) BRENT: I don't get [treated differently] as much...but I can see if you were slightly obese...[or] a bit nervous or a bit apprehensive...people would be quick to judge...you don't need to be a rocket scientist to know that someone doesn't appreciate you or has little respect for you.... I have not found that but...my last name and my appearance, there's a world of difference.
Significantly, this dialogue exemplifies the efficacy of symbolic power in controlling an individual's beliefs (Bourdieu 1990, p. 69). His *practical sense of how the game is played* in a colour conscious society has translated into strategic attempts to camouflage evidence of his Māori ancestry in response to experiencing symbolic violence associated with dominant group discourses (x):

(x) BREN'T: Personally I...find it more stressful [being Māori]... in mainstream I think it is...harder, not harder, just...I haven't found it easy and when I was young, basically, Jeeze I wished I wasn't Māori...didn't have that label, which is not good really, you should be proud of where you come from.... In [X] we really suffered quite a lot of racism...I went to a "white" middle-class New Zealand school.... When I got to university: "Oh you're only going to go somewhere because you're Māori."... So I've eradicated all that off my CV and everything...[laughs] it really upset me big time when I was about 21... I don't want anyone ever...saying: "You got there because you're so many [parts] Māori." I just can't deal with that.

The testimonies of two participants in their forties illustrate intuitive understandings that Pakeha maternity, irrespective of social-class location, was instrumental in accessing non-discriminatory and/or optimal care during childhood (xi, xii):

(xi) BROCK: [Where] I grew up...[it] was pretty tough over that side of town because...[of] the White Power.... I'm in the panel and paint industry...they don't like Māoris too much...especially when [Māori] are better than [Pakeha] are.... [With health professionals] I don't know if that racism or stubbornness, more stubbornness I guess or they're stuck in their own ways.... My sister, she's spinal bifida so, she's spent most of her life in a hospital...I remember mum...'cause like dad's Māori, mum's pakeha so...I suppose...they just thought they could go and do what they wanted and mum would just stick her foot down and say: "no bloody way."

(xii) BIANCA: I was very, very, very ill when I was about 18 months. They weren't sure whether it was meningitis or polio.... My mother...had nothing but
praise for the way they looked after me...but she's the "white" one though [laughs].

However, cultural capital represents qualitative differences in forms of consciousness within different social groups; while the habitus acts as a specialisation of "cultivation" of consciousness and recognised mastery of the game, social membership in a dominant group does not automatically translate into a habitus that confers symbolic capital in a uniform way, as varying degrees of cultural capital are attached to the class habitus (Moore 2008, p. 103). The following testimonies suggest a relationship between maternal ethnicity and the accrual and deployment of cultural health capital, highlighting the significance of the domestic habitus in determining social trajectories by constraining what individuals regard as likely to be accessible for the likes of us or not for us (Bourdieu 1990). Notwithstanding exposure to intra-family symbolic violence, Pakeha maternity for BIANCA, a socially-ascribed Māori, is causally associated with resilience and the accrual of dominant group cultural capital (xiii). Conversely, for BECKY (a non-socially-ascribed Māori) her testimony suggests the adult accrual of Māori cultural capital and confusion underpinned by parental dissonance (xiv):

(xiii) BIANCA: My parents were poor, but my [Pakeha] mother was very bright and intelligent and read. I obviously picked that up from mother and so was able to learn more and then develop life skills to...improve myself because...from my background, I could have gone either way. I have seen some Māori people [discriminated against] in my career...I have heard the derogatory...stereotypical comments...so I can absolutely understand, [but] for me it has not ever been that way.... [There were] racists comments always...my "white" Pakeha side of the family [said] "don't you dare end up in the factory...like your Māori cousins."...I could have said: "Oh poor me, I'm just a Māori and I'm going to get treated really badly, or up yours, you will treat me with respect," and yes, I was beaten up when I was at school.... I was the only brown kid there.

(xiv) BECKY: I think there's still, there still is a perception of Māori being useless...dad's mother was Scottish...and to her Māori people were just..."useless, dole bludging bastards"... and that was the perception that we
grew up with.... I've sort of stayed away but...when I started [learning Māori] Dad was like: "oh what a useless subject, what you want to learn that for?" Mum would say: "because its her culture" and they're still married and they're arguing over it.... Mum often said to us: "you remember that your grandmother's not right." ... There was definitely something in that generation that...follows through...dad still had that perception, not on a nasty level like grandma but he still has issues...which I didn't realise until I did start learning Māori... and I'd say to mum: "but he married someone with that in their ancestry, what's he talking about?"

Moreover, BECKY reinforces the generational transmission of negativity towards health professionals and the implications for adult engagement (xv), and identifies the issue of compromised confidentiality occasioned within the modern primary care context (xvi):

(xv) BECKY: You'd be so sick before [Māori] mother would take us to the doctors, chronic before she'd actually got off her butt.... The doctor that she went to...has been accused of child molestation... [Mum has] not admitted to it, but I suspect that was part of her fear of going to the doctor and she's pushed that on to us as well because when I go to the doctor I'm not comfortable with it.

(xvi) BECKY: I think there are four doctors at [X] and it depends on who's available on the day...I moved from [X Medical Centre] for the same reason [and] because they're all locums.... I try to [see the same doctor]...because with [my son's disabilities] the doctor has to know his history and often you...go to another one or a locum and you've got to explain it all again.... You're constantly having to bring up the past about what has happened to him....[which my son] shouldn't really know about which ... changes his feelings towards his father...if I had just the one doctor who knew me well then it wouldn't be so bad.

Section Four - Regional Context

Testimonial evidence reflects widely-held perceptions that skin colour discrimination is intensified in Christchurch. This may relate to local specificities, including demographic
under-representation of Māori; their spatial polarisation in the most deprived areas; the reputation of the local iwi, Ngai Tahu, as a "white tribe" following a long-history of mixed-descent (Wanxalla 2009, p. 107); and the relative homogeneity of the resident Pakeha population until the influx of North Island Māori in the 1960s. The dialogue of a first generation migrant to Christchurch illustrates exposure to employment discrimination on the basis of skin colour (i), while that of a younger male in his thirties describes cultural isolation after migrating from a region predominantly populated by Māori and from which migration since the 1960s has been encouraged (ii):

(i) BEVERLY: I was always refused [work]...because of the colour of my skin, it was obvious...It made me angry, yeah... it felt awful.

(ii) CARL: I guess it was a bit different because where...we grew up, it was more like 50/50 so you just took it for granted that everyone that you knew was Māori and most of them were...as opposed to living in Christchurch.... You just feel like you get distance from everyone...because my wife is pakeha...if she heard me talking to my brothers on the phone she'd like hassle me saying: "you're pretty Māori, you're talking like a bro."... I guess people call it trying to be staunch...but it's not being staunch up there it's just the regular way you talk to each other and you know how to react to...but you come down here and you talk to people like that, straight away they don't like it...like in social settings...if you walk in to a bar or whatever here with your head and shoulders back and you get a look like that, and straight away they don't like you...that was kind of a culture shock.

Two participants provide contrasting insights into regional responses towards Māori. The first illustrates that experience of the game has resulted in the strategic deployment of skin colour to facilitate access and/or reduce exposure to discriminatory treatment (iii); the second reinforces that any discernible association with Māori heritage may precipitate subjection to manifestations of discrimination, which in this instance is symptomatic of dominant group stereotyping of the propensity towards criminality (iv):

(iii) ANGELA: When I see that happen and I can pick it...the insecurity is theirs not ours...if they've got a problem with the "race", then I say: "Deal with
your own insecurities." I'm secure...I happen to love the colour of my skin, there's nothing I can do about it, but I love me.... [When I encounter discrimination] I'll say to my Pakeha daughter: "You go in." If I've had difficulties...I'll send her... and that's when I want to go and say: "Now why was I treated differently?"... I've seen that with my eldest daughter too, who's very dark, she's had that situation...in Christchurch.... She's in [X] doing very well; she's in amongst the Māori[s]. Now she's coming back to Christchurch. I said: "There's prejudice here in Christchurch ... and you must notice it," and she said: "Yes."

(iv) ALICE: I quite often get.... "You don't look like a Māori," and I think, what does a Māori look like? .... I don't think Māori[s] are well received here in Christchurch...possibly because the ones down here aren't doing that good.... There's not that many of them and...they certainly stand out.... [During a job interview because of] my name...they asked me if I had any criminal convictions, and I said, "Where did that come from?" They said: "Well, you're Māori are you?"

For ALICE, vicarious experiences of symbolic violence occasioned by social-ascription and/or an absence of accrued dominant group cultural health capital underscores that a greater Māori representation among health professionals, and more Māori-centred provisions similar to initiatives established in regions with high densities of Māori populations, facilitates access to non-judgemental, culturally-competent and non-discriminatory care. Her perception that ethnically-concordant provisions encourage the joint construction of the development of Western cultural health capital amongst patients accords with the view of many of the study population (v):

(v) ALICE: If there were more Māori doctors it might make it easier for...[my whānau] say it's easy for me because I'm skinny.... [Māori] are treated differently because...if I take [my cousin] into a doctor...[the frontline staff] talk to me but...she's the patient supposedly and they'll treat her like [pause] and...then she wants to leave.... Where I come from [on the East Coast]...you can go to the marae and there'll be a doctor there and honestly people...feel comfortable...no one's judged, they're all equals, you are not really...here? It's
a dreadful thing to say...I can feel it...my family, they're all huge and a lot of them don't have a lot of money and...don't work and they certainly are looked down on.

**Chapter Summary**

Findings suggest a complex relationship between skin colour and/or social-ascription as Māori, cultural health capital and access to and engagement with health services. Within the local healthcare contexts, commonsense phenotypical markers of Māori heritage are frequently associated with potential and/or realised discriminatory care. Of particular concern are reported incidents of the inability of ancillary staff to respond to Māori patients with high health needs; persistent stereotyping of health risk-behaviours on the basis of commonsense Māori phenotypes; differential treatment of vulnerable patients with deficit levels of cultural health capital; and/or expressions of symbolic violence towards mothers of young children and victims of domestic violence in hospital settings.

Testimonies support findings presented in earlier chapters that embodied dominant group cultural capital (Bourdieu 1986) and/or social classification as non-Māori functioning as a form of capital that converts into an advantage when interacting with non-Māori health professionals. This finding indicates the "arbitrary and instrumental" nature of symbolic capital as a disinterested form of cultural and social capital that ensures transubstantiation of assets associated with cultural advantage or disadvantage (Moore 2008, p. 104). The significance of maintaining relational continuity, including patient confidentially, while reinforced, is also conditioned by the age-cohort effect of young males possessing Western cultural health capital. Socially-ascribed participant responses include the strategic deployment of cultural and economic capitals to communicate social-class location, social privilege and resources (Shim 2010, p. 3). Moreover, the concept of cultural health capital has utility in understanding that, within the context of a racialised, colour-conscious, neo-colonial society, the potential for the provision of differential care is underpinned by a complex relationship between historical forces, regional contexts, and ongoing maintenance of dominant group power.

Māori exposure to expressions of symbolic violence across interrelated social fields demonstrates that although institutions are "distinct and distant from the economic field with their own personnel, principles and logics" (Moore 2008, p. 104), their function is
nevertheless directed towards the reproduction of structured inequalities and colonial power relations. Findings illustrate how the concentration of symbolic power among the dominant group perpetuates colonial relations vis-à-vis the power to name, to represent commonsense, and create the official version of social reality (Mahar et al. 1990, p. 13). Several participants emphasise the symbolic efficacy of the police, the media and popular culture in promulgating family violence, alcoholism and substance abuse as characteristic of the contemporary disenfranchised urban Māori (Quince 2007, p. 1); the testimonies also accentuate the instrumentality of politicians and the media in correlating the extremely modest state reparations for historical Treaty of Waitangi breaches (D. V. Williams 2004) with spurious accusations of Māori privilege (Nairn, Pega, McCleanor, Rankine & Barnes 2006). Within the context of a neo-colonial society, testimonial evidence highlights how symbolic capital has become symbolically efficient as both patients and healthcare providers respond to "socially constituted expectations or beliefs" that facilitate the translation into action of symbolic force without the need for physical violence (Bourdieu 1997 pp. 171-72 cit. Garcés 2010, p. 4).

Narrative evidence highlights the relationship between inequitable access to educational infrastructure, and systematic inequalities in the ability to accrue cultural health capital, and patient encounters that contribute to the reproduction of inequalities in the health sector (Shim 2010, p. 6). For Bourdieu, education was the most important socialising agent vis-à-vis the objectification of cultural health capital; socially (re)productive policies and practices in education (Grenfell 2008, p. 159) that were directed towards Māori assimilation into dominant group culture, albeit in a non-competitive manner (Simon & Smith 2001), have had a detrimental impact on engagement with health professionals (Shim 2010). Further, dimensions of power (symbolic, social, cultural, political and economic capitals) are manifest in the under-representation of Māori health professionals that inhibit Māori engagement in ethnic-concordant doctor-patient relations. Testimonies suggest that within the context of a racialised, colour conscious society, social classification as Māori shapes health trajectories and constrains what individuals regard as probable and accessible for us or not for us (Bourdieu 1990, p. 54).

Findings reinforce that dominant group cultural capital represents an irreducible form of power, interchangeable with economic power (Swartz 1996, p. 75), that is objectified in cultural and material goods, institutionalised in status, honour and prestige, and embodied
through processes of socialisation (Bourdieu 1986). Clinical interactions are reciprocally influenced by both the habituses of providers and patients. The habitus, in shaping individuals through socialisation, embodies dominant group and class-related cultural capital that translates into the continuity of colonial relations in practice. As Swartz (2002, p. S63) states: "social practices are engendered and regulated by incorporated, generalised, transposable dispositions, rather than by cultural roles, rules or by conscious intent or calculation." Thus, dominant group cultural capital is marked by the class, social (and ethnic) origins of its acquisition, which remain deeply embedded in the reproduction of inequalities and hierarchies (Bourdieu 1984, pp. 47-49).

A discussion of the complex and multidimensional relationship between habitus, cultural health capital, and engagement with and access to healthcare, and first, social-class and/or spatial location; second, age and gender; and third, social classification as Māori, manifest in practice, is presented in the following chapter.
CHAPTER NINE: DISCUSSION

... public health needs a theory of truth. The colonisation that Australia and New Zealand have endured has transformed the social order of both societies. And the consequences of that colonisation continue—in maintaining advantages for one community over another; in focusing on individual, not societal, responsibilities; in blaming victims; and in constraining the leadership of indigenous communities. ... Science has an important part to play in challenging this 'contemporary colonisation': by legitimising indigenous health as a subject for study, by demanding high-quality data to monitor progress in indigenous health, and by ensuring that research findings about indigenous populations are not cast to the margins of political debates about health.... Papaarangi Reid's final call to public health science was this: 'I dream of a time when it is safe to be born an indigenous child.' Her argument carries huge force for all disadvantaged peoples, and the responsibilities of medicine and public health to those communities (Population Health Congress, Adelaide, Australia, Part 2) (cit. Horton 2012 The Lancet Editorial).

Introduction

The purpose of this thesis was to explore the interplay of factors constitutive of the barriers and facilitators that condition access to and engagement with quality primary healthcare and its distribution amongst a Māori sub-sample of the Christchurch cohort of the Hauora Manawa Study. This qualitative component of the larger study purposively sampled a subgroup (n=45) of Māori from the Christchurch cohort to ensure maximum diversity of self-reported perceptions and/or experiences of primary healthcare characteristic of the heterogeneous composition of Māori. Kaupapa Māori principles, consistent with the Māori, for Māori and by Māori approach of the broader study, guided the method of data collection and interpretation.

Pierre Bourdieu's Theory of Practice (1977) and Shim's (2010) conceptualisation of cultural health capital were integrated into a context-specific framework for analysis of the relationship between subjective participant experiences and objective structural arrangements (Swartz 1997), in an attempt to reconcile the dichotomies of agency and
structure in primary healthcare. This study found a complex and multifaceted relationship between colonial relations; cultural health capital; skin colour and/or social-ascription as Māori; and age, gender, and, spatial- and class-location. Barriers and facilitators to access and engagement with healthcare for Māori reflected the cumulative legacy of state power to naturalise systems of classifications that are produced and reproduced "by securing the misrecognition, and the recognition, of the arbitrariness upon which they are based" (Bourdieu 1977, p. 164). The complex and multidimensional interplay of historical and contemporary factors suggest that state power has culminated in a dialectical relationship between agency and structure, between the subjective experiences of Māori, in the form of "structured dispositions" and the "objective structures" of system-level and process-level factors of the health system (Swartz 1997, p. 103).

This chapter begins by positioning barriers and facilitators to modern primary healthcare within the broader sociological context of colonial relations in order to contextualise the dynamic and cumulative factorial interplay over time and space that condition engagement with healthcare professionals and services. First, the relationship between the legacy of skin colour and/or social-ascription relative to social fields shows that although institutions have "their own personnel, principles and logics" (Moore 2008, p. 104), they have collectively functioned to produce and reproduce structured inequalities between Māori and non-Māori. Second, the relationship between age and gender reflects the distinctions in firstly, lifecourse and/or childhood access to Western medical, and secondly, healthcare precipitated by childbirth and childrearing responsibilities in the urban milieu. Third, the relationship between spatial location at birth and the objective conditions of the Māori domestic habitus, and the exposure to diseases of poverty, suggests that in some instances, adult health status may potentially reflect the lifecourse effect (Gee, Walsemann & Brondolo 2012). Social-class location demonstrates the separative power of the state to create "occupational taxonomies" (Weininger 2005, p. 149) that have conditioned Māori

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183 For Bourdieu (1994, p. 4) the state is the: "culmination of a process of concentration of different species of capital: capital of physical force or instruments of coercion (army, police), economic capital, cultural or (better) informational capital, and symbolic capital. It is this concentration as such which constitutes the state as the holder of a sort of meta-capital granting power over other species of capital and over their holders."
integration into an ethnically distinct section of the working class (Pearson 1991a, p. 206), reflected in the modern Two-Nation Employment Cleavage (Jessop 1989).184

Section Two contextualises the implications for Māori healthcare practices, during the 1980s and 1990s, when what Bourdieu terms as the "scourge of neo-liberalism" transformed the "allegedly flaccid and overgrown Keynesian welfare state" into an ostensibly "lean and nimble welfare state" (Wacquant 2010, p. 214). The subsequent process of "re-reforms" (Gauld 2009, p. 137), was implemented to moderate the abrupt widening of interethnic health inequities (Ajwani et al. 2003). Section Three explores the implications for Māori access to and engagement with primary healthcare pursuant to its restructuring under the Primary Health Care Strategy (2001). Section Four positions the findings of this research and the current health crisis within the broader socio-political context of neo-colonial relations. This chapter concludes with a discussion of the factorial interplay between colonial relations and cultural health capital, barriers and facilitators to primary healthcare for Maori, and possible implications for Māori healthcare.

Skin colour and/or social-ascription as Māori

Findings relating to skin colour and/or social-ascription as Māori emphasise the enduring colonial legacy of colourism and the protean nature of racism across social fields over time and space. Notwithstanding the contemporary New Zealand Medical Council's Best Practice Guidelines recognition of "potential judgements and prejudices based on skin colour and appearance..." (Adam 2011, p. 20), findings suggest that neo-colonial relations represent an ideological, pathological form of misrecognition that perpetuates naturalised taken-for-granted social and political arrangements (Schiff 2009, pp. 20-21). The perception that social classification as non-Māori constitutes an advantage, a type of cultural capital, amongst the study population is indicative of the power of colonial amnesia, the "forgetting" of history (Schiff 2009, pp. 20-21).

Following the military subjugation of Māori by the 1880s (Belich 1986), the full force of state power continues to manifest in "race relations" (Bourdieu 1994, pp. 12-13). The

184 Testimonial evidence supports the premise that pre-existing colonial relations encouraged the "voluntary segregation" of Māori into "preferred industries" and occupations [such as the freezing works] where "no questions [were] asked about their colour..." (Hon. Matiu Rata, 1963 cit. Ballara 1986, p. 101). Participants also participated in Hunn Vocational Trade Training Schemes; and joined the Armed Forces in growing numbers (Soutar 2012). The latter is reflected in that although Māori constituted approximately 6% of the total population, one in seven soldiers fighting in the Korean war was Māori (Soutar 2012).
salience of skin colour and/or social-ascriptive found in this study reflects the enduring legacy of state power to officially nominate and impose "primitive classifications" (Bourdieu & Wacquant 1992, pp. 12-15) on the basis of proximity to, and/or distance from the legitimised colonial culture (Weininger 2005, p. 142). The correlation between social classification as Māori and health is not a recent aberration but one that has had discrepant consequences since contact with Europeans. In the early nineteenth century monogenist missionaries attributed the pigmentation of Māori skin colour to a "Fall from Grace" and degeneration (A. Smedley 1993) and death from introduced diseases the "inevitable consequence of immorality or sin" (Durie 1994, p. 33). From the mid-1860s, Social Darwinists attributed the inevitable extinction of Māori to contact with a civilised "white race" (Durie 1994, p. 31), an unchangeable law "on which human progress depended" (Lange 1999, p. 57). By the end of the century, notwithstanding that the "dying race" was favourably classified as Semites not Hamites (Sorrenson 1979 cit. Ballara 1986, pp. 53-54), merely dark "white" with coloration attributed to "miscegenation with an inferior, darker species, the Melanesian Moriori" (Ballara 1986, p. 54), it was public fear "that the people be plagued" that ultimately provided the catalyst for the state to mount a public health campaign (Dow 1995, p. 42).

Study findings correspond with the contemporaneous observations of the visiting American psychologist, David Ausubel, in 1958. Ausubel's (1958, pp. 235-236) hypothesis that the "difference in skin colour has come to symbolise all of the social, economic and cultural differences at present separating two peoples;" and, that symbolic acts of self-classification and classification by others were indicative of "the prominence of colour consciousness in Pakeha's mental and emotional image of the Māori and in the Māori's mental and emotional image of himself" still has relevance. Within the context of increasing intermarriage, this study found that the presence and/or absence of commonsense markers of Māori heritage conditioned ethnic identification in multiple, nuanced and complex ways. Internalised racism manifested in varying degrees of embracing "whiteness", deprecating and concealing Māori heritage. According to Bourdieu, attempts to conceal Māori heritage are indicative of "bodily submission, unconscious submission," and "this smooth working of habitus" is the cause of "internalised contradictions" (1994b pp. 276-277 cit. Webb, Schirato & Danaher 2002, p. 185)

Paradies (2006a, p. 359) states: "whiteness may attract: 'racism, scorn and disbelief' from other Indigenous and non-Indigenous people alike, whose perennial interrogation of their identity leads to acute anxiety as well as 'ambivalence, and doubts about themselves as 'real' [Indigenous] people" (Boladeras, 2002: 147).
The study also suggested there may be some relationship to what Robinson (2001, pp. 174, 176) describes as "resocialisation and desocialisation processes" underpinned by confusion and guilt vis-à-vis the advantages of aligning with the ethnic background of one parent, and that the status of parents' ethnic background, acceptance within a particular culture, and physical appearance are factors that influence choices about seeing the intersection of one's many identities or choosing one parent's race as dominant."

Moreover, this study found some evidence of a relationship between Pakeha paternity and/or maternity, life trajectories, and the conversion of accrued dominant group cultural capital into practical resources and power over time. Within the context of a paucity of national research regarding the salience of maternal transmission of middle-class capital American research has relevance (Robinson 2001). The domestic habits of wives of African Americans (where class identity assumed primacy) translated into the generational transmission of "white" middle-class cultural capital; post-marital cognition of racial injustices motivated maternal transmission of dominant group capital to enhance societal acceptance of their offspring in the absence of the invisible passport of "white" privilege (O'Donoghue 2004, p. 75).\(^{186}\) Socially-ascribed Māori participants' denial of exposure to discrimination may reflect "conscious or unconscious efforts to minimise the pain of negative experiences ... a passive escape strategy linked to poor psychological function, or ... active distracting strategies that are adaptive and lead to lower levels of psychological distress" (D. R. Williams & Mohammed 2009, p. 32).

The paucity of local research vis-à-vis the impact of skin colour and/or social-ascription as Māori (Callister 2007)\(^{187}\) in the field of health and interrelated fields potentially warrants redress as international research has identified both contemporary significance and regional specificity of colourism. In America, where the "one drop rule" has perpetuated the legacy

\(^{186}\) Notwithstanding findings that the privilege of whiteness (Fine et al 1997) and social-class combined to inform the aspirations and attitudes of mixed heritage individuals, international research reinforces the need for caution when interpreting the psychological implications for children of bi-racial unions (Barn & Harman 2006; O'Donoghue 2004). As Meredith (1998, p. 3) states: over-simplified and essentialised identities fail to acknowledge the "multiple subject-positions, aspirations and contrasts" of 'hybrids' or capture their "... innate knowledge of 'transculturation' (Taylor, 1991), their ability to transverse both cultures and to translate, negotiate and mediate affinity and difference within a dynamic of exchange and inclusion."

\(^{187}\) Sociological research in the United States has demonstrated the association of skin colour with income, education and occupation, particularly for males (Klonoff & Landrine 1999) and those with darker skin (Borrell, Kief, Williams, Diez-Roux & Gordon-Larsen 2006). According to Hall (2005, p. 116), the salience of skin colour in America has been superseded by 'race', despite sociological research confirming that far from being "a relic of the past" (R. E. Hall 2005, p. 122), skin colour remains a formidable determinant of life for people of colour "in all matters of public affairs" (Loury, 2000 cit. R. E. Hall 2005, p. 120).
of colourism, Jones et al (2008) found that being classified as "white" by others was associated with sizable and statistically significant benefits in health status, irrespective of individual self-identification. While the health implications of skin colour (versus "race") using the American CARDIA data base were mixed and findings were potentially confounded by complex methodological issues,\textsuperscript{188} the different relationship between skin colour\textsuperscript{189} and health in the United States and Brazil, (and the minimal effect of skin tone in the latter) (Dressler, Balieiro & Santos 1999; 2005) reflect the national specificity of skin colour.\textsuperscript{190} Accordingly, conducting research into skin colour discrimination in New Zealand could ascertain "the extent to which multiple social statuses combine to affect both the levels of exposure to discrimination and the effects that discrimination can have on health" (D. R. Williams & Mohammed 2009, p. 39).

The interrelationship between skin colour health and other fields

Study findings relating to skin colour and/or social-ascription as Māori should not be considered in isolation, but rather within the context of a complex interrelationship between and across social fields. Barriers to engagement with primary healthcare are not only conditioned by inequities in the capacity to accrue dominant group cultural health capital but also from a collective sense of one's place and the place of others (Bourdieu 1984, p. 466) and concomitant behaviours of self-exclusion and/or expectations of what is probable and accessible for us or not for us (Bourdieu 1990, p. 54). Reported experiences

\textsuperscript{188} First, Krieger, Sidney and Coakley (1998) found that reported racial discrimination in multiple situations did not vary by skin colour. Second, Klonoff & Landrin (2000), using self-reported (instead of measured) skin colour to test the association of different exposure to discrimination, found that darker skin resulted in eleven times more exposure to frequent racial discrimination compared with those with light skin; these researchers contend that as Krieger et al's (1998) findings were based on an exposure (ever) measure (as opposed to frequency of discrimination), and as eighty to ninety-five percent of Blacks in health studies report experiencing some type of discrimination, little variance remains for association with skin color.

\textsuperscript{189} Third, Borrell et al (2006) found that skin colour was not a salient factor, despite racial discrimination being associated with worse self-reported physical and mental health. Fourth, Sweet and colleagues (2007, p. 2253) found that "the protective gradient on systolic blood pressure seen among African Americans with lighter skin is not observed to the same degree among those with darker skin. Psychosocial stressors, including racial discrimination, may play a role in this relationship."

\textsuperscript{190} The objective measurement of skin colour remains problematic: some projects train researchers to designate categories of gradient of skin tones on their complexions, however, sun exposure represents an important variable with measurable differences between the inner arm (natural skin colour) and the forearm, and self-identification may also differ from researchers' ascription (Borrell et al. 2006).

\textsuperscript{191} Dressler et al (2005, p. 242) examined the interaction between skin colour, socioeconomic status, and blood pressure with "cultural consonance" in the United States and Brazil. Using the "cultural consonance in lifestyle" measure, derived from a general cultural consensus on constituent parts of a good life (lifestyle of domestic comfort, not conspicuous consumption), these authors found that the ability to approximate this valued lifestyle resulted in lower blood pressure. Furthermore, in Brazil, there was an interaction effect between cultural consonance and skin color, such that the persons with darker skin color and higher cultural consonance had blood pressures lower than white Brazilians at any level of cultural consonance.
of racial discrimination in this study encompassed both overt and covert expressions; socially-ascribed Māori appeared attuned to detecting subtle, anti-Māori biases expressed by social agents who potentially self-define as liberal and egalitarian and supportive of interethic equality and social justice, that correspond with the characteristics of aversive racism (Hodson et al. 2004). Reported discriminatory treatment of Māori by the police, both experiential and vicarious, as private citizens and operating in official roles span time and space, from the period of Māori re-criminalisation occasioned by post-World War Two urbanisation (Pearson 1991a; Quince 2007, p. 2; Spoonley 1993; R. Walker 1990; Workman 2011) to the current socio-political climate of "popular punitiveness" (David Brown cit. Quince 2007, p. 23). 191 Contemporary manifestations of state violence and their relationship to healthcare should be positioned within the broader context of strategic state management of social control of deepening interethic marginality and the enforced "normalisation of post-neoliberal social insecurity" (Wacquant 2010, p. 204). 192

From a modern Bourdieusian perspective, the response of the government of "social insecurity" towards disproportionate levels of Māori unemployment, poverty and expanding socioeconomic disparities is reflective of the "martial reaffirmation" of the state's capacity to maintain social control (Wacquant 2010, p. 202), and further, how the "government of poverty .... offers relief not to the poor but from the poor...." (Wacquant 2010, p. 204). This is exemplified by the stigmatised danger of Māori gangs', and the putative Māori propensity for aggressive and criminal behaviour (McCreanor 2009) which contrasts markedly with the apparent public tolerance of Pakeha white-collar and corporate crime (Paterson 2009). 193 Some study participants also identified biased media reporting

191 Interethic disparities in levels of policing (Fergusson, Swain-Campbell & Horwood 2003a; Fergusson, Swain-Campbell & Horwood 2003b), disproportionately higher rates of Māori apprehensions, and custodial detention while awaiting trial, and receipt of custodial sentences rather than home detention or fiscal penalties compared with non-Māori (Quince 2007, p. 2) have been reported by some research.
192 "Small government" in the neo-liberal economic register begets "big government" spending on criminal justice, as the police, the courts, and prisons are core components of the right-hand of the bureaucratic field (Wacquant 2010, pp. 202, 214). 192 Juridical capital represents an objectified and codified form of symbolic capital which facilitates state monopolisation of "the official definition of identities, the promulgation of standards of conduct, and the administration of justice" (Bourdieu 1994 pp. 4, 9 cit. Wacquant 2010, p. 200).
193 As Wacquant (2010, p. 206) asserts: ... "penalisation is not an all-encompassing master logic that blindly traverses social order to bend and binds its various constituents. On the contrary: it is a skewed technique proceeding along sharp gradients of class, ethnicity, and place, and it operates to divide populations and to differentiate categories according to established conceptions of moral worth."
and/or correlating a dysfunctional domestic habitus with the movie *Once Were Warriors*\textsuperscript{194} illustrating misrecognition that family violence is an inherent Māori cultural attribute rather than a societal aberration that transcends ethnic, cultural and class boundaries.\textsuperscript{195}

As Bourdieu (1994, p. 2) noted, it is in "realm of symbolic production that the grip of the state is felt most powerfully;" study findings imply that the racialisation of social fields, such as the police, the criminal justice system,\textsuperscript{196} journalism, popular culture, and political capital accrued by condemning the minimal state reparations for historical Treaty of Waitangi breaches (D. V. Williams 2004) have discrepant consequences for accessing quality healthcare. For Māori, the racialisation of social space serves to reinforce potential exposure to differential treatment. Several participants provided evidence to support the Bourdieusian position that symbolic violence across social fields, translates into differential medical treatment of, for example, Māori victims of abuse.\textsuperscript{197}

**Age and gender, lifecourse effect**

This study found a multidimensional and complex relationship between age, spatial location at birth, childhood exposure to health risks (Belgrave 2008, p. 70), and contemporary health status. Some older participants provide evidence that their adult healthcare needs may be indicative of the life-course effect (Gee et al. 2012). The life

\textsuperscript{194} The movies *Once were Warriors* and *The Piano* epitomise the instrumentality of popular culture in the promulgation of racialised stereotypes. While both depict the violent oppression of women, the portrayal of European violence in *The Piano*, depicted against a "backdrop of breath-taking scenic beauty," facilitated its recontextualisation as "an erotic love story set in beautiful nineteenth century New Zealand" (Mikaere 2008, p. 14). In contrast, *Once were Warriors* presents family violence, alcoholism and substance abuse as characteristic of the contemporary disenfranchised urban Māori (Quince 2007, p. 1).

\textsuperscript{195} By way of example, although Pakeha committed 50% of child homicides, the media reported only one-third of approximately 9,000 incidents of physical child abuse in the 2000-2008 period, 21 of which involved Māori cases that became "household names" (Levy 2011).

\textsuperscript{196} Acts of symbolic violence against coloured and minority populations by the Criminal Justice System are widely-acknowledged manifestations of institutional racism (Brondolo, Love, Pencille, Schoenthaler & Ogedgebe 2011) and the direct health effects of Māori imprisonment on Māori are recognised (J. Carr 2007).

\textsuperscript{197} Notwithstanding that young Māori women represent the demographic most likely to be repeat victims of violence, conviction rates of Māori male assaults on females are 8 to 10 times higher than those of non-Māori. Hook (2009a; 2009b; 2009c) forcefully argues, the coincidence of an upsurge in Māori convictions (compared to Pakeha) under the Domestic Violence Act (1995) and the Sentencing Act (2002) during a period of decreasing Māori unemployment (1986-2006) reflects discriminatory interpretation of statutes within the Criminal Justice System rather than abrupt behavioural changes in Māori males; the sociocultural attribution of contemporary Māori domestic abuse (virtually absent in historical accounts) to the nuclear family structure, and the attendant elimination of traditional constraints imposed within communal contexts lacks explanatory power.
trajectories of the baby-boomer subgroup of the study population encompass the period circa 1951 when, despite the national standard of living ranked third highest in the world (Lang 1987, p. 145), Māori life expectancy remained 14 and 17 years (for males and females respectively) lower than that of Pakeha (Pool 1991). The habitus of the medical profession (both social agents and the institution) suggests that increased healthcare provisions for Māori reflects the "recurring motif" of Pakeha self-interest stimulated by closer interethnic proximity (Dow 1995, p. 31). Older participants in this study confirmed belated measures to treat tuberculosis, already eradicated amongst the Pakeha population (Dow 1999, p. 86), which remained uncontrolled amongst Māori until 1975 (Durie 1998c, p. 61). Similarly, for some participants, childhood hospitalisation precipitated by diseases of poverty, such as rheumatic fever, and reported incidents of sibling mortality are indicative of the objective conditions of the primary domestic habitus, inequitable Māori access to modern and potentially more efficacious medical treatment, and concomitant reliance on traditional medical practices.

Narratives from some participants suggest that notwithstanding the universal provision of fully subsidised, integrated hospital services (including specialist care) for Māori and Europeans under the 1938 Social Security Act, the spatial location of many Māori communities precluded equitable access to Western medical care. Findings relating to this age group of the study population reflect sporadic access precipitated by medical emergencies and/or illnesses. Racially segregated infant and maternity healthcare provisions (Bryder & Dow 2001, p. 7), which translated into gross interethnic disparities in mortality rates (Pool 1991) reflective of "standard[s] of antenatal services, obstetrics, nursing and post-natal care, personal hygiene, nutrition, environmental conditions and general living standards" (Department of Health 1969, cit. Lange 1999, p. 34), remained institutionalised until the 1960s in New Zealand. The study found that while most participant reports of natal and post-natal care experiences that constituted first-time encounters with Western medical care were generally unremarkable, some amongst this age group described traumatic incidents related to birthing and/or emergency treatment. The latter suggests that negative and/or traumatic introductory experiences of Western

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198 The baby-boomer generation, defined as the generation born between the years 1946-1966 is associated with the post-World War Two population increase that resulted in the New Zealand population reaching three million in 1973 (Statistics New Zealand 2005, p. 13).
medical care continue to condition, in indirect and direct ways, current access to and engagement with primary care, limiting timely utilisation of health provisions. 199

Spatial and class location

The study found a relationship between participants' spatial location at the time of birth, and/or class-location and lifecourse access to social goods, resources and services, including modern healthcare. Inter- and intra-social-class divisions, what Bourdieu terms as "classes on paper" (Crossley 2008, p. 88), reflect on the one hand, the of distribution economic or cultural capitals on three axes: the total volume of capital(s), the composition of capital(s); and life trajectories, as well as change and/or stability over time relative to the volume and composition of capital(s) (Weininger 2005, p. 89). On the other hand, divisions such as socio-spatial location, gender and social classification as Māori represent a system of causally interactive factors (Weininger 2002, pp. 68-71) underpinned by the historical specificities of different forms of social domination. Accordingly, the complex combination of intertwining factors generated by colonial relations can not just be "interpreted in predominantly class terms, as social class amounts only one facet of a complex classificatory prism... animating acts of symbolic violence" (Weininger 2005, p. 160).

Barriers and facilitators of primary healthcare utilisation occasioned by a lack of dominant group cultural health capital illustrate the cumulative effect of pre-existing colonial relations that precipitated the urbanisation of a landless, Māori proletariat (illustrative of racialised educational provisions) to meet the labour requirements of Post-World War Two Fordism (Poata-Smith 1997). A significant proportion of study participants provide evidence for Bourdieu's position that state institutions and their agents, particularly with respect to education, are responsible for the production of social inequality (Swartz 1997, p. 285). For many participants, experiences of state education are framed in negative ways.

With respect to reported perceptions of state attempts at the elimination of te reo Māori, Bourdieu's conceptualisation of language as the battlefield and the weapon in the struggle for symbolic power has relevance. First, as a "structuring structure" providing the means

199 Caution must be exercised with respect to the categorisation of cultural, historical and social contexts, as "exposure to most stressful experiences does not lead to illness. The overwhelming majority of persons exposed to even the most traumatic life experiences have transient symptoms in response to these problems" (D. R. Williams & Mohammed 2009, p. 32).
for understanding the world (Webb et al. 2002, p. 96) exemplified by the prohibition of te reo Māori in schools on the basis that "civilisation could only eventually be carried out by a means of a perfect language" (Carleton 1867 cit. Simon & Smith 2001, p. 169). Second, language is a "structured structure" through which understandings are communicated (Webb et al. 2002, p. 96); as the Senior Inspector of Native Schools asserted in 1945: "... if the result has been to make Māori lose his language, don't forget that in its place he has the finest language in the world ..." (Bird cit. D. V. Williams 2004, p. 6). Notwithstanding that the health implications appear to be under-researched, the colonial legacy of cultural and language genocide spontaneously emerged in this research as an apparent transgenerational catalyst of symbolic violence that served to reinforce the potential for differential treatment as Māori across all social fields.

It could be argued that the relationship between colonial relations, symbolic violence, the systematic under-education of Māori and the under-representation of Māori in the health workforce that impacts on Māori engagement (realised and potential) was evident in this study. Although the medical training of Māori was first proposed in 1819 by the missionary Samuel Marsden (Lange 1999, p. 37), prevailing "race-science" deemed Māori to be "inherently inferior in intellectual and cultural terms to civilised peoples" (Simon & Smith 2001, p. 249). In 1862, the School Inspector Henry Taylor opposed the higher education of Māori as incompatible with their future social position, as "they are better calculated by nature to get their living by manual than mental labour" (Simon 1992, pp. 8-9). Māori ambitions to enter the medical and other professions were, however, supported by some missionary educators, notably John Thornton, the incumbent principal of Te Aute College who facilitated the graduation of several prominent Māori leaders. Although Sir...
Peter Buck and Sir Maui Pomare were the only Māori of 119 graduates from Otago Medical School by 1910 (Ngata 2002), following the 1906 Royal Commission into teaching practices at Te Aute, pressure was exerted to limit teaching to the stipulated curriculum of manual and technical instruction in agriculture for Māori (Openshaw 1993). Thereafter, Māori access to higher education was severely impeded, as the prerequisite subjects for matriculation were not taught in native schools (Shields et al. 2005).

The status quo was maintained in the post-II urban milieu by practices including the low streaming of Māori pupils. The *Hunn Report's* (1960, p. 25) attribution of the "statistical blackout" in Māori educational achievement to "parental apathy," not to the "quality" of education, is distinctly dissimilar from the personal and whānau educational experiences described by many participants in this study. The fact that a century after the establishment of national universities (in 1868), a meagre 200 Māori had graduated (Phillips 2003), with only 41 Māori on the medical register by 1991 (Durie 1998c) is unsurprising, given the consistency of reported exposure to institutional, interpersonal and symbolic expressions of racism. Notwithstanding the value attributed to higher education, participation in tertiary education was rare; one testimonial account described a disturbing relationship between skin colour and accusation of Māori privilege at university. In the compulsory education sector, where Māori students are two and a half times more likely to leave without qualifications than non-Māori (Robson & Reid 2001), discrimination on the basis of skin colour was commonly reported. Accordingly, it could also be argued that the enduring transgenerational legacy of negative educational experiences reported in this study are related to the current crisis in Māori health literacy, which is increasingly recognised as a driver of interethnic inequities (Ministry of Health 2010a). In the contemporary healthcare environment, Shim (2010, p. 6) emphasises the need for health literacy: patients various distinctively cultural skills and competencies, and that the ability to "display an enterprising and proactive disposition, a fluency in biomedical concepts and language, bureaucratic know-how, and an interactional agility with authoritative experts" is advantageous in successfully navigating the complexities of the modern healthcare landscape.

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203 Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Shim 2010, p. 6). The Ministry of Health (2010a, p. iii) identified that regardless of "gender, age, level of education, labourforce status, household income, or rural/urban location" a total of 80% of Māori males and 75% of Māori females had poor health literacy skills."
This study provides some support for the relationship between inequitable access to educational infrastructure, and systematic inequalities in the ability to accrue dominant group cultural health capital, and patient encounters that contribute to the reproduction of inequalities in the health sector (Shim 2010, p. 6). However, in this research, the significance attached to the use of te reo Māori in clinical interactions and/or the desire for ethnically-concordant doctor-patient relations was mixed, complex, nuanced and commonly subsumed by the broader desire to access care that was both culturally and technically competent, and non-discriminatory as well as culturally sensitive. Many study participants who described close engagement with traditional cultural practices had developed positive, often longstanding clinical relationships with non-Māori practitioners; the exceptions generally involved those who had endured past trauma healthcare experiences and lost continuity of care. Moreover, some participants described Māori-centred health provisions as conducive to the self-management of health conditions, such as diabetes, which potentially reflects the absence of "stereotype threat" (van Ryn et al. 2011) when engaging with Māori health professionals.

The life trajectories of the younger urban-born subsample reflect changes in the broader social space that facilitated more equitable access to societal infrastructure and capitals, and increased interethnic marriage. Nevertheless, the symbolic force of the state remained despite the official adoption of biculturalism, as neo-colonial relations appeared to incorporate Māori into the dominant group culture in a non-competitive manner. Notwithstanding that current health practice reflects a relationship between lifecourse access to, pre-reflexive doxic acceptance of, relatively stable utilisation of, and satisfaction with primary care, this study found that the legacy of colourism was retained. The study also found that skin colour and/or social-ascription as Māori, and age were primary determinants of whether discriminatory care was experiential, perceived and/or vicariously witnessed, symptomatic of secular changes in "race relations" with the moderation of overt expressions of racism into more subtle and nuanced forms. This finding suggests the cohort effect of lifecourse exposure to racism and discrimination, and the variations in types of racism, and its frequency and intensity, impact on the determinants of health and inequity (Gee et al. 2012).
Neo-Liberal Reforms

Contemporary barriers to primary healthcare utilisation need to be considered within the context of neo-liberalism from the mid-1980s until the late 1990s, when Māori bore the brunt of economic restructuring (Ajwani et al. 2003; Poata-Smith 1997, p. 177), and interethnic disparities in mortality rates widened from the mid-1980s to the mid-1990s (Tobias et al. 2009). From a Bourdieusian perspective, the implementation of neo-liberalism in the mid-1980s constitutes a paradox of doxa. While the state is contingent upon misrecognition to ensure the stability and reproduction of sociopolitical order, misrecognition is also "the source of stability and instability, status and change"; protests by increasing numbers of Māori militantly demanding recognition of their political and economic rights under the Treaty of Waitangi during the 1970s and early 1980s challenged the doxa of taken-for-granted system of domination (Schiff 2009, pp. 19-22). The Fourth Labour government's (1984-1989) response to the crisis of constitutional legitimacy was premised on a "policy which sought to defuse and pacify Māori demands without disrupting the fundamental economic and political structures of the colonial-derived state" (Kelsey 1991, pp. 108-109).\(^{204}\) The reimagining of Māori-Crown relations was untenable. Implicit recognition of the causal association of the colonial legacy and interethnic differences in health and social indices notwithstanding, the Treaty of Waitangi discourse was transmogrified from being "needs-based" to a focus on special "race-based privileges;" this new discourse arguing that Māori were being unfairly favoured, contrary to the Pakeha egalitarian notion of equal opportunity (Barber 2008, p. 143; Humphage 2006, p. 229),\(^{205}\) illustrative of "the forgetting of history," and misrecognition of the extent to which Māori have been denied equal opportunity (Reti 2002).

Māori became the "shock absorbers" (Pomare et al. 1995, p. 149) of neo-liberal response to the crisis of capitalism that was based on liberal economics and ideology and a retraction

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\(^{204}\) Crisis is however, a necessary but insufficient condition; substantive changes in colonial relations are contingent upon the dominated having "the material and symbolic means of rejecting the definition of the real that is imposed on them" (Schiff 2009, p. 24). State manipulation of Māori nationalism was realised through institutionalised procedures that neutralised land claims, co-opted individuals as advisors (rather than decision makers) and maintained budgetary control (Sissons, 1989 cit. Spoonley 1994, p. 96).

\(^{205}\) "...Māori went from being framed as socio economically and politically excluded (and thus in need of special policy attention) to being increasingly characterised as a group whose inclusion within a Treaty framework actively excludes non-Māori New Zealanders from their rights and privileges as citizens" (Humphage 2006, p. 222).
from the Keynesian welfare state (Kelsey 1991, pp. 108-109). Notwithstanding that the Māori experience of neoliberalism was not homogeneous, for the overwhelming majority, the reality demonstrated that although "it embraces laissez-faire at the top, releasing restraints on capital and expanding the life chances of the holders of economic and cultural capital, it is anything but laissez-faire at the bottom" (Wacquant 2010, p. 214). The disproportional impact that the substitution of Cradle to Grave welfarism with the neoliberal philosophy of the "participating citizen" which emphasises "individual choice" (Belgrave 2008, p. 76) had on the Māori population reflects the paradox of doxa, how "the established order, with its relations of domination ... ultimately perpetuates itself so easily" (Bourdieu 2001, p. 1).

The New Right restructuring of the health system in the 1980s and 1990s meant that health initiatives to promote equivalent standards of health were superseded by public demands for equal treatment based on civil rights (Belgrave 2008, p. 76). The pernicious effect of privileging Pakeha self-interests in social policy and risks to health (Belgrave 2008, p. 70) resulted in the gap between Māori and non-Māori life expectancy abruptly widening during the 1980s and 1990s (Blakely et al. 2004; Blakely et al. 2005; Ministry of Health 1999b; Ministry of Health 2002a; Ministry of Health & University of Otago 2006b; Robson & Harris 2007; Robson & Purdie 2007; Robson, Purdie & Cormack 2006). Notwithstanding subsequent improvements at the turn of the century, when the reduction of interethnic health inequities became the key policy objective (Tobias et al. 2009), initiatives designed to ameliorate interethnic disparities, such as the Free Child Health Scheme, in the late 1990s benefitted the middle-classes (Belgrave 2008, p. 79; Dovey et al. 1999).

**Restructured Primary Care**

From 1999, health sector reforms explicitly moved away from the competitive neoliberal model (Gauld 2003) to a more population focused health approach (Tobias et al. 2009)
with primary care identified as one of the primary mechanisms to reduce inequalities. However, this study identified among participants the compromised ability to maintain continuity of care with a preferred GP, as a corollary of The Primary Health Care Strategy (2001) that requires mandatory patient enrolment with a Primary Health Organisation and/or General Practitioner, represents a primary organisational barrier to accessing quality primary care. The disjuncture between the policy objective of reducing and eliminating interethnic barriers to primary care and the patient habitus suggests institutional misrecognition of the cumulative and transgenerational effect of colonial relations responsible for interethnic differences in the accrual of cultural health capital (Shim 2010, p. 1), and of the direct and indirect relationship between social-class and spatial-location and social classification as Māori and access to optimal and/or non-discriminatory care.

The Primary Health Care Advisory Council (2009), following Starfield and colleagues (2005, p. 488), acknowledged the benefits associated with "continuing interpersonal relationships between particular practitioners and patients" deserve further exploration, and supports earlier recognition by The Royal New Zealand College of General Practitioners that relational continuity "tends to be undervalued" (1997, p. 2). However, the statement from the current College President, Dr Harry Pert, that "if you have continuity within a practice team, particularly within the micro-team of the nurse and doctor, then you have continuity of service" (Cameron 2011, p. 1), contrasts with recognition of the collateral effects of fragmentary care occasioned by structural and organisational changes both nationally (Ross & Kenrick 2011) and internationally, where competitive forces in the medical market place have demanded change for economic and clinical reasons (Nutting, Goodwin, Flocke, Zyzanski & Stange 2003; Saultz 2003).

**Comparative changes in New Zealand and Britain**

Within the context of a paucity of national research into the impact of the reconfiguration of primary care (Penney et al. 2006; Ross & Kenrick 2011), empirical evidence vis-à-vis the impact of changes implemented in the British National Health Service provides a useful basis of comparison of the impact of structural changes. In Britain, the solo practitioner has been largely superseded by "group patient practices which provide modern, well equipped premises and staff by large multidisciplinary teams;" general practice has evolved in a service that provides a wide range of "reactive, anticipatory, and preventive
services" that require greater staffing numbers and more complex patterns of organisation (R. Baker 1997, p. 831). The current study found evidence to support some of the assertions from British research that although patient registration with a practice purportedly affords patients the choice of consulting with any doctor within the practice, partnership arrangements and clinical schedules have comprised the ability of vulnerable patients, particularly ethnic minorities (Lakhani 2007), to establish and/or maintain interpersonal therapeutic relationships with a preferred GP (Freeman et al. 2003; Freeman et al. 2007).

Moreover British researchers recognised the need to qualify the term continuity of care (Freeman et al. 2007, p. 9) and identified three main types in the National Health Service report Continuity of Care 2006: What have we Learned since 2000 and What are Policy Imperatives Now?:

Management continuity - the communication of both facts and judgements across team, institutional and professional boundaries, and between professionals and patients;
Informational continuity - timely availability of relevant information;
Relationship continuity - a therapeutic relationship of the patient with one or more health professionals over time (Freeman et al. 2007, p. 9).

The findings of this study tends to support international findings that the current policy emphasis on "management and informational continuity through guidelines, care pathways, and electronic health records" (Guthrie et al. 2008, p. 548) has eroded a vitally protective characteristic of general practice: personalised care by an individual GP that is continuous over time (R. Baker 1997; Haggerty et al. 2003). Furthermore, this study provides evidence that the choice of a GP is both personal and important particularly within the context of predominantly non-Māori doctor-Māori patient relations. Some narratives suggest that the ability to maintain relational continuity with a trusted GP may be necessary to ensure receipt of non-discriminatory, empathic, and quality primary care.208 The significance

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208 The positive effects of provider empathy on patients are well documented and include "increased patient satisfaction, adherence, self-efficacy, perceptions of control, less emotional distress, and better outcomes" (Burgess et al. 2007, p. 884).
209 The synthesis of quantitative and qualitative mixed-method studies in Britain substantiates that practice reconfigurations have reduced the ability of minority and vulnerable populations to maintain relational continuity (R. Baker et al. 2007; M. Boulton et al. 2006; Freeman et al. 2007; Lakhani 2007; Windridge et al. 2004). This is the case in the United States even when minorities have equivalent insurance status to whites (Lillie-Blanton, Martinez & Salganicoff 2001), particularly where relationships bridge cultural gaps patient (LaVeist et al. 2000).
that many socially-ascribed Māori participants attached to developing and maintaining doctor-patient relationships supports other research (Cram et al. 2003; T. Walker et al. 2008), and appeared to be rationalised by an innate understanding that some GPs are unable to establish equivalent levels of rapport with Māori and Pakeha patients (Crengle 2007; McCleanor & Nairn 2002b). Moreover, evidence also suggests support for Starfield's (1998) premise that between two to five years is necessary to perceive that care received is personally focused.

Comparative research findings

Differences between the findings of this study and those of other recent research is potentially illustrative of the lack of conceptual consensus of the definition of continuity of care, and persistent and complex methodological challenges (Saultz & Albedaiwi 2004) 210 to conclusively establishing the value of continuity of care for vulnerable populations (Raymont 2008, p. 64). 211 First, this study's findings contrast with those of Jatana, Crampton & Richardson (2011, p. 16), who found that continuity of care, which these authors define as "seeing the same health care provider over time..." was high amongst vulnerable patients with low income or chronic conditions. However, Jatana and colleagues (2011, p. 23) acknowledge that high levels of enrolment/registration with a Primary Health Organisation and/or General Practice were incentivised by eligibility for lower consultation fees, and limitations of the Primary Care Assessment Tool in accounting for "observed variation" in continuity of care. Second, Jatana & Crampton (2009a) concluded that high levels of provider affiliation 212 ensured that the health needs of vulnerable and chronically-ill patients were being addressed, whereas this study's findings are mixed, and conditional upon the maintenance of relational continuity with GPs and specialists. Third, notwithstanding support of Jatana and Crampton's (2009b) conclusion that financial and economic circumstance constitute determinants of inequitable access to societal resources (including healthcare), access barriers reported by study

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210 For example, Saultz and Albedaiwi (2004, pp. 445-446) found that, despite identifying a consistent and significant positive relationship between interpersonal continuity of care and patient satisfaction, they were unable to establish "whether the same [was] true for all patients or only for those who seek ongoing relationships with physicians in primary care."

211 Report Reviewing Literature for District Health Boards Improving access to primary health services for vulnerable populations.

212 Provider affiliation "refers to having a usual source of care (doctor, nurse or medical centre) or primary care provider ... one could go to if need arises" (Jatana & Crampton 2009a, p. 287); whereas, personal affiliation is the "degree to which a person feels a shared identity with another person" (Cooper et al. 2006, p. S23).
participants (regardless of provider affiliation and economic capital), reinforce the causal association of disparities in accrued dominant group cultural capital and social classification as Māori.

Further, while Jatrina, Crampton and Norris (2011) found that economic capital represents an impediment to adherence to prescribed pharmacological regimes, participants in this study also described a complex interrelationship between doctor-patient practices. Participants talked about the relationship between following the doctor’s recommendations and professional exploration of their rationalisations for disliking pharmaceutical medications, which encompassed former adverse reactions to, and/or heterodoxic beliefs related to the efficacy of Western medication. The generally high levels of adherence to medical advice and treatment regimes amongst the study population challenge the stigmatisation of Māori as a singularly non-compliant group (Penney et al. 2011, p. 125), supported by evidence of up to 50% non-adherence amongst the American population (Donovan & Blake 1992, p. 507). The professional attribution of non-adherence to "Māori ignorance and poverty ... wilfulness and self-destructiveness" (Penney et al. 2011, p. 73) contrasts with reported professional practices deficient in consensual decision-making vis-à-vis the rationale for and/or changes to treatment regimes, and/or a lack of monitoring of side-effects. Within the context of limited dominant group cultural health capital, evidence in this study appears to suggest a relationship between professional practice and recourse on the part of some participants to self-imposed compensatory measures, such as an exercise regime, thus precluding access to the advantages of modern pharmaceutical treatments (Vermeire et al. 2001). Although minority racial/ethnic status represents a significant predictor of non-adherence in America (R. C. Kaplan et al. 2004), adherence is improved when low-income African American patients hold positive stereotypes about their non-racially concordant doctors (Bogart et al. 2004) and, for example, when the side-effects of lipid-lowering medication are closely monitored (Thompson et al. 2003).

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213 Kerse et al (2004) found that adherence in New Zealand improved by approximately one-third when the doctor-patient rapport facilitated consensual decision-making.
214 The 2006/07 Health Survey (2008) found that Māori adults were significantly more likely than adults in the general population to report not having collected a prescription or accessed needed GP services because of cost (p. 277). Māori males and females were significantly more likely to report an unmet need for GP services in previous 12 months compared to their peers in the total population (p. 269). Since 2002/03 reported unmet need for GP services reduced almost 50% in the general population (p. 272) (primary reasons reported by women were not being unable to see a GP soon enough or at a suitable time and men wanting to make a fuss or could not be bothered (p. 275); the reduction was less for Māori (43% for men and 35% for women) (p. 272) with cost reported as the primary barrier to accessed needed primary care (p. 277).
Finally, variations in findings between this study and those of Jatrana and Crampton (2011) may also reflect differences in qualitative and quantitative methods as well as methodological issues associated with the collection of Māori data. This author found that first, the socially-ascribed subsample (with one exception) who initially reported no experience or did not know to questions asked about discrimination during initial Haurora Manawa screening interviews, recalled disconfirming information during in-depth interviews. Incidents encompassed personal, whānau, and intergenerational experiences of discrimination by health professionals (and other social actors); these changes contrast with the consistency of data from their non-socially-ascribed counterparts. Second, face-to-face contact, a culturally appropriate qualitative research method, was a necessary but insufficient condition. Establishing a level of interviewee-interviewer rapport proved essential; this was not automatic or immediate, but required a process of whakawhānaungatanga\textsuperscript{215} - the process of becoming acquainted by establishing some tribal affiliation or connection with the extended Māori community. Third, patient satisfaction measures although commonly used, with standardised measurement techniques, are generally considered problematic (Crow et al. 2002). Māori satisfaction-based measurements may be compromised by a reluctance to be critical and extremely low expectations of care, and thus require reported experiences to be objectively compared with best practice (Jansen et al. 2011). The inherent complexities of gathering Māori data highlight the need for caution when interpreting results relating to doctor-patient interactions.

Evidence in this study also suggests that age, social-class, and spatial location at the time of birth, have significant implications for contemporary adult healthcare engagement and that the ability to maintain relational continuity with a trusted practitioner is of primary importance. Limited childhood and/or belated access to Western healthcare appears to require co-constructive doctor-patient encounters, conducive to addressing heterodoxical beliefs vis-à-vis the efficacy of Western medical care, particularly regarding pharmacological treatments; this need appeared to translate into a propensity for some participants to strategically select practitioners who integrated conventional and holistic treatments into their practices. Evidence also suggests a concomitant relationship between professional practices, previous patient experiences and current adult practices. Initial

\textsuperscript{215} McNatty (2001, p. 1) argues that "whanaungatanga has taken on a new meaning in the modern milieu. It is sometimes seen as a process of getting to know each other (whakawhanaungatanga)."
experiences of Western healthcare, underpinned by professional fostering of the patient accrual of cultural health capital appears to translate into relative acceptance of the doxa of Western treatment (particularly among chronically-ill participants); conversely, negative experiences correspondingly beget negative adult healthcare practice, irrespective of current health need.

Moreover, age and socially-prescribed gendered roles that determined levels of exposure to Western healthcare appear to have implications for current healthcare practice. Limited male access to healthcare (restricted to medical emergencies and/or employment-related requirements) appears to be associated with a propensity for resistant engagement; evidence suggests that masculine dispositions embodied in the work habitus, particularly in relation to "... social categories such as manual workers or occupations such as those [in the] army, which owe much, if not all of their value, even in their own eyes, to their image of manliness" (Bourdieu 2001, p. 96) complicates contemporary access vis-à-vis current age-related need. In contrast, it seemed that within the context of the prevailing cult of domesticity, female access, initiated by pregnancy and childbirth (illustrative of the normalisation of Māori hospital births by the 1960s (Harte 2001, p. 89)) tended to remained constant because of childcare responsibilities. Moreover, evidence found in this study appears to suggest that the health practices (particularly of females) may be complicated by the Bourdieusian concept of hysteresis, occasioned by the dissonance between the contemporary culture of medicine compared with the more paternalistic care likely to have been experienced three or four decades earlier (Hardy 2008, p. 134). The contemporaneous practice of older participants is suggestive of clinical interaction conditioned by medical authoritarianism and psychosocially-orientated care, with patient responsibilities limited to complying with medical advice (Charles, Gafni & Whelan 1999), which seem to contrast with less-personalised, modern clinical encounters where the levels of dominant group cultural health capital possessed are of greater importance.216

Age-related findings suggest that the functional adaptation to the exigencies of survival (Crossley 2008, p. 93), characteristic of the primary domestic habitus have embodied stoic practices towards sickness that manifest in responses and coping strategies discordant with

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216 Older clinicians were more acculturated to deferential patients compared to their younger colleagues, trained to engage with relatively proactive patients (Shim 2010, p. 11).
"medical rationality" (Mechanic 1986, p. 154)\textsuperscript{217} and/or the Western "sick role" (Parsons 1951).\textsuperscript{218} While some health professionals may define delayed Māori responses to sickness as "abnormal illness behaviour," the narratives of several participants in this study suggest that responses were frequently dependent on the capacity to undertake normal activities and roles and that seeking formal care was delayed until normal functioning was disrupted; the potential for some Māori to access healthcare at a different stage of the illness trajectory than many non-Māori corresponds with international research (Mechanic 1995, p. 1208).\textsuperscript{219}

This research reinforces the proposition that dominant group cultural capital represents an irreducible form of power, interchangeable with economic power (Swartz 1996, p. 75), that is objectified in cultural and material goods, institutionalised in status, honour and prestige, and embodied through processes of socialisation (Bourdieu 1986). Evidence suggests that clinical interactions were reciprocally influenced by the habituses of both providers and patients. The habitus, in shaping individuals through socialisation, embodies dominant group and class-related cultural capital that may translate into the continuity of colonial relations in practice. As Swartz (2002, p. 663) states: "social practices are engendered and regulated by incorporated, generalised, transposable dispositions, rather than by cultural roles, rules or by conscious intent or calculation." Thus, dominant group cultural capital is marked by the class, social (and ethnic) origins of its acquisition, which remain deeply embedded in the reproduction of inequalities and hierarchies (Bourdieu 1984, pp. 47-49).

It could also be argued that this study's findings reinforce the mobilisation of middle-class cultural capital to enhance receptivity, and moderate sociodemographic difference and

\textsuperscript{217} Explanatory models of sickness (Kleinman et al. 1978) explain the variation between doctors' biomedical model of disease and patient beliefs that encompass psychological, social, cultural, and physiological contexts. The universal need for all individuals, including those in industrialised societies, to understand their sickness experience within the context of their personal lives has long been recognised (Kleinman and Sung 1979 p. 303 cit. E. Lynch & Medin 2006, p. 287).

\textsuperscript{218} Parson's (1902-1979) concept of the "sick role" encompassed four characteristics. First, "the sick person is freed or exempt from carrying out normal social roles.... Second, people in the sick role are not directly responsible for their plight. Third, the sick person needs to try and get well. The sick role is regarded as a temporary stage of deviance that should not be prolonged if at all possible. Finally, in the sick role the sick person or patient must seek competent help and cooperate with medical care to get well. This conceptual scheme implies many reciprocal relations between the sick person (the patient), and the healer (the physician). Thus the function of the physician is one of social control" (McQueen 2002, p. 1).

\textsuperscript{219} Findings suggest support for research that older Māori, compared to their non-Māori peers (despite greater levels of physical symptoms, chronic medical problems and worse self-rated health) nonetheless reported a corresponding lack of difficulty with chronic limitations in daily functioning, undertaking basic activities, cognitive activity, or household activities; and that lower utilisation of primary care was compensated for by higher level of Accident and Emergency Service usage (Hirini et al. 1999).
class prejudices held by physicians (Malat 2006). Notwithstanding lifecourse accrual of dominant cultural health capital, some participant narratives suggested that the presence of visible markers of Māori heritage at times influence the manner in which resources were deployed. Non-socially-ascribed Māori described responding "in largely habitual ways that are rooted in their experiences," reflecting an innate understanding of the privilege of "whiteness" (Shim 2010, p. 5); in contrast, socially-ascribed Māori reported that they very purposefully and deliberately employed "impression management" strategies (Goffman 1959) to convey social privilege (Shim 2010, p. 3), and moderate potential stereotyping by non-Māori practitioners. Thus, the dynamics of unequal treatment reinforce Shim's (2010, p. 8) premise that "the compounding of advantageous cultural resources is less (or not only) a matter of bias or provider beliefs [but] the result of complex interactional processes during the clinical encounter."

Evidence from this study lends support to an association with the poverty of the domestic habitus; transitional stressors relating to urbanisation (John Lynch & Smith 2005); racialised employment and job related stressors (Mills 2010), and low socioeconomic status may have intersected with other social stressors to exert long-term effects on health and well-being (New Zealand Medical Association 2011; Robson 2004; D. R. Williams & Mohammed 2009). Findings also suggest some support for the concept of "linked lives:" the interdependent relationship between the lives of individuals and their whānau, and the secondary effects of institutional racism in exacerbating financial stress (Gee et al. 2012, p. 969).

Current study findings provide support for misrecognition of the underlying agendas of "power interests," the coincident introduction of the New Right's health reforms, and the phenomenon of healthism in the 1990s (Hodgetts et al. 2005, p. 124). Notwithstanding the complex factorial interplay, health-risk behaviours "are not autonomous individual factors but variables that have been shaped by larger societal forces;" tobacco (and alcohol) consumption partially reflect macro-level forces, "the cooperative efforts of a broad range

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220 The concept of 'linked lives' is related to, but distinct from, social networks and social support. Whereas networks refer to the structural characteristics of social relationships (e.g., density, reciprocity) and support refers to the resources that flow from those relationships (e.g., emotional and financial assistance), the concept of linked lives considers that events that affect one person also affect other persons in their networks" (Gee et al. 2012, p. 969). While this study supports that the social network of working-class participants was restricted to friends and kin relationships (Shim 2010, p. 4), the social function of whanau amongst enculturated Māori plays a significant role in decisions to access formal care as well as the provision of informal healthcare (Hirini et al. 1999).
of governmental and commercial interests to initiate and maintain substance use" (D. R. Williams 1997a, p. 330). Some participant narratives serve to reinforce first, the symbolic efficacy of the moral probity of the individual in the attribution of interethnic disparities in life expectancy to individual responsibility for health-risk behaviours (Hodgetts et al. 2005, p. 124) and second, that some professionals assume that social-ascription as Māori equates to tobacco use (Harris et al. 2012b). Moreover, a relationship between experienced racial discrimination and smoking was suggested (Harris et al. 2006b; Robson 2004).

The doxa of the Socio-Economic Behavioral Model\textsuperscript{221} is increasingly recognised as lacking explanatory power vis-à-vis the causal association of health damaging behaviours and adverse circumstances endured by marginalised peoples (Dressler et al. 2005; J. W. Lynch & Kaplan 2000, p. 25). Practitioner misrecognition that engaging in health-risk behaviours (such as smoking) is the underlying cause of Māori health outcomes (McCreanor & Nairn 2002a; McCreanor & Nairn 2002b) not only abjures professional responsibility for interethnic health disparities (E. Curtis et al. 2010), but ignores empirical evidence of the independent effect of social inequality and Māori rates of smoking (Barnett et al. 2004), and that socioeconomic status contributes more to Māori mortality than smoking (Blakely T, Fawcett J, Hunt D & N. 2006).\textsuperscript{222} Recent recognition of the relationship between psychosocial pathways (including racial discrimination), socioeconomic deprivation, psychological states and lifestyle behaviours, and health, accord with study findings of the harsh and complex reality of life in a highly differentiated and racialised society (Harris et al. 2012a; Hodgetts et al. 2005; National Health Committee 2007).

Participant narratives relating to skin colour discrimination suggest that clinical interactions between Māori patients - non-Māori practitioners may be conditioned by health professional stereotypical expectations of physical appearance as Māori and engaging in health-risk behaviours (such as tobacco consumption); for example, the reported communication of prejudicial attitudes of an associated connection between early sexual activity and obesity and Māori heritage. The internalisation of the lifestyle

\textsuperscript{221} Dressler et al. (2005, p. 234) states: the Socioeconomic Status Model posits that health disparities can be explained by "the over-representation of some racial and ethnic groups within lower socioeconomic statuses \ldots and differences \ldots in the distribution of individuals behaviors related to health, such as diet, exercise and tobacco use."

\textsuperscript{222} Similarly, in the United States, where rates of smoking between African Americans and whites are almost equivalent, the causal association of tobacco consumption and racial health disparities lacks explanatory power (Dressler et al. 2005, p. 237).
perspective in the habitus of health professionals potentially manifests in "implicit racial biases and explicit racial stereotypes" (van Ryn et al. 2011), in this context vis-à-vis obesity (G. D. Foster et al. 2003) and the sexualisation of Māori women. There is international evidence that experienced and/or anticipated racial discrimination occasions heightened vigilance for cues of aversive racism conveyed by mixed messages of providers (Dovidio & Fiske 2012, p. 948) and social rejection (Mays, Cochran & Barnes 2007, p. 214), the cumulative effects of which are potentially more detrimental to health than those of other stressors (D. R. Williams & Mohammed 2009, p. 31).

Moreover, testimonies in the current study suggested that hurried, unproductive and perfunctory clinical encounters with unknown GPs discouraged the utilisation and perceived value of primary care. Notwithstanding that judgements about healthcare primarily related to interpersonal rather than technical aspects of care (Jansen et al. 2009), findings nonetheless corresponds with the Primary Care Medical Survey's (2000-2005) findings of interethnic differences in consultation times, investigations and referrals (Crengle 2007). Reported dissatisfaction with management and informational continuity related to the lack of accumulated professional knowledge and confidentiality issues. As Freeman, Olesen and Hjortdahl (2003, p. 625) contend, although electronic patient records may facilitate faster and cheaper information-sharing, recorded information cannot substitute for personal knowledge and therapeutic relations; the practicality of transmitting historical information within consultation time-frames commonly prevents adequate and

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223 The narratives of some participants in this study suggest that despite the lack of traditional stigma attached to premarital sex or illegitimacy, stereotypical but erroneous professional assumptions of early sexual activity and pregnancy were interpreted as discriminatory care. The provider bias reported by some participants may reflect the racialisation of Māori sexuality, informed by colonial ideologies of Māori women as wanton and amoral (Johnston & Pihana 1994), and reinforced by societal discrimination exemplified by, for example, venereal disease being designated as "a Māori problem" in the 1940s by the public, government officials and the medical fraternity alike (Kampf 2007, p. 446). Accordingly, attempts to limit unwanted pregnancies may reflect societal attitudes and stereotypes about illegitimacy and/or a desire to limit Māori childbearing (Downing et al. 2007, p. 1806). While cultural differences have been implicated as the cause of higher current rates of teenage pregnancies and lower rates of terminations in Māori in comparison with non-Māori (Dickson, Sporle, Rimene & C. 2000; Marie, Fergusson & Boden 2011), other factors, including financial and regional access barriers, also have explanatory power (Silva, Aston & McNeill 2011; Silva & McNeill 2008). National rates of early terminations are poorer than those in the United Kingdom, Australia and the America (Silva et al. 2011), and 3 of the 5 regions without local pregnancy termination services have higher than average proportion of Māori population (Silva & McNeill 2008).

224 The persistent belief that care provided by a known doctor across successive episodes is superior to that of a similarly qualified locum and/or non-regular doctor supports empirical evidence vis-à-vis the complexity and uncertainty that surround many presentations, episodic encounters are treated symptomatically, often in the absence of context and without the ability to monitor the problem over time (D. P. Gray et al. 2003, p. 160; Mechanic 1995, p. 1209).
succinct summarising and/or reading of data, some of which may be inappropriate to convey in a medical record (Freeman et al. 2003, p. 625).

Evidence in this study appears to reinforce empirical evidence that rapid access to any doctor is generally acceptable when consulting with minor, acute problems (Christakis 2003; Guthrie et al. 2008; Mainous, Baker, Love, Gray & Gill 2001; Nutting et al. 2003), particularly for young, healthy participants with issues such as sports injuries. For a minority of the study population, continuity of care appeared to provide no advantages and/or constitutes a potential disadvantage (D. P. Gray et al. 2003), as Hauora Manawa’s screening diagnosed diabetes among patients with both transient and longstanding doctor-patient relationships and also detected cardiovascular risk factors among some young Māori males who utilised primary care. While stoicism and employment-related expectations have been reported as deterrents of healthcare utilisation (Jansen et al. 2009; P. N. Williams et al. 2003, p. 74), amongst this cohort, undiagnosed risk factors may also reflect professional complacency (Infante et al. 2004) vis-à-vis appropriate screening of Māori patients for risk factors and application of best practice and cardiovascular disease guidelines (PHO Performance Programme 2011). Nevertheless, evidence in this study appear to suggest that for socially-ascribed Māori any protective advantages of discontinuity (Mainous et al. 2001) are superseded by experiential reasoning regarding the reduced likelihood of receiving non-biased and/or optimal care from an unfamiliar GP.

Furthermore, testimonial evidence in the current study suggesting that health status is a salient predictor of valuing relational continuity appears to support substantial empirical evidence (Christakis 2003; Guthrie et al. 2008; Pandhi & Saultz 2006), particularly for patients with complex health problems (Tarrant et al. 2003), worse self-reported health status (Nutting et al. 2003), facing hospitalisation or significant life events (Schers, van de

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225 It is unclear, however, whether this is a “cohort effect and not a life-cycle effect” (Guthrie 2002 cit. Erickson 2007, p. 5).
226 Proponents of discontinuity argue that diagnosis of slow progressive illnesses, such as diabetes, may benefit from a “second look” (J. M. Gill & Mainous III 1998; Liaw et al. 1992; Wachter 2001), as “familiarity can sometimes breed neglect” (Broom 2003 cit. Gulliford et al. 2007, p. 248) or complacency (Infante et al. 2004). Thus, transient discontinuity may allow other doctors to see “what we have missed” (Tandeter & Vinson 1998, p. 423), thereby safeguarding against patient satisfaction with sub-optimal care.
227 Van Ryn and colleagues (2011, p. 201) state that: “Bias includes generally negative feelings and evaluations of individuals because of their group membership (prejudice), overgeneralised beliefs about the characteristics of group members (stereotypes), and inequitable treatment (discrimination). These biases may be conscious and intentional (explicit) or unconscious and automatically activated (implicit).” Further, the social distance between socially-ascribed Māori healthcare seekers, and receptionists and ancillary healthcare personnel, represents an important variable in accessing equitable medical care (Malat 2006).
Ven, van den Hoogen, Grol & van den Bosch 2004), (Schers et al. 2002), or chronic disease (Erickson 2007).228

Participants in this study indicated that responses to the ethnicity of doctors are highly complex, and despite the preponderance of positive cross-cultural doctor-patient relationships, the increasing inability to maintain relational continuity of care with a doctor of choice since the restructuring of primary healthcare represents a significant barrier to accessing quality medical care, as encounters with unfamiliar doctors potentiate exposure to discriminatory healthcare. The objective of the Māori Health Workforce Development Plan, Rananga Tupuake (2006a), to increase the percentage of Māori in the health and disability workforce (Ministry of Health 2006a; Workforce Taskforce 2007) accords with increasing recognition of the role of the doctor-patient racial/ethnic concordance in redressing current health inequities (Cooper & Powe 2004).229

As previously discussed in the earlier section on Māori education, colonial relations may be inculcated in the habitus of New Zealand-born and trained doctors through a "durably installed generative principle... an immanent law laid down in each agent by his [or her] earlier upbringing" (Bourdieu 1977, p. 82); this potentiates the "forgetting of history which history itself produced by incorporating the objective structures it produced in the second nature of the habitus" (Bourdieu 1977, pp. 78-79). However, habitus "must not be considered in isolation .... it must be used in relation to the notion of field" (Bourdieu 2002, p. 31) that provides a cultural context within which practitioners must act; foreign trained

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228 For example, more than 50% of participants in an American study, especially those with chronic conditions, indicated a willingness to pay a nominal monthly fee to maintain interpersonal continuity (Pereira & Pearson 2003).

229 Notwithstanding the substantial progress made over the past 15 years (Ratima et al. 2007), with Māori student enrolments Otago Medical School's domestic intake increasing from 4.2% in 2006 to 10.6% in 2011 (McMillan 2011a), an extra 150 Māori medical students will need to be recruited annually over the next 10 years in order to meet the increasing population and health needs of Māori (Wall 2010). In the report Shifting Māori Health Needs, Cram (2010) notes that predicted demands on the Māori medical workforce reflect changing demographic trends, with expanding numbers of Māori over the age of 65 years. By 2026 the Māori population is predicted to increase from 620,000 (2006 Census) to 820,000, which represents a faster rate (30%) than the non-Māori population (16%). In 2004, there were 234 Māori doctors (132 male and 102 females), up from 198 in 2000 but still only 2.6 percent of the medical practitioner workforce; by 2008 the number of Māori doctors had increased to 328 (178 males and 150 females), representing 3.1 percent of the workforce. However, approximately one third of Māori doctors are no longer certified to practice, and a structural maldistribution exists in the private/public mix as well as a deficit in specialties. The projected 31% increase in Māori population to 810,730 in 2026 equates to 1,784 Māori doctors or 1,544 more doctors than existed in 2006. The qualification of an additional 1,500 doctors would require an intake of approximately 150 Māori students into medical school every year for the next decade. Fulfilment of this aspiration requires the collaboration of various government agencies to meet the requisite basic requirements (Cram 2010).
and/or born doctors may, in the process of internalising the externality of colonial relations in New Zealand, reinforce existing cultural baggage.\textsuperscript{230} Despite its durability, the habitus "may be changed by history, that is by new experiences, education or training (which implies that aspects of what remains unconscious in habitus be made at least partially conscious or explicit)" (Bourdieu 2002, p. 29).

**The health of a racialised society**

This study reinforces the New Zealand Medical Association's (2011) claim that ameliorating the current Māori health crisis necessitates a whole government approach to redress the determinants of inequity. The concentration of symbolic power among the dominant group and concomitant power to name, to represent commonsense, and create the official version of social reality (Mahar et al. 1990, p. 13) appears antithetical to achieving this end. The divergence of responses identified in this study to overt expressions of racism, such as spurious accusations of Māori privilege (Nairn et al. 2006) in the *Nationhood Speech* (Brash 2004)\textsuperscript{231} and the incumbent Prime Minister's accusation that Māori resistance to confiscation of the Foreshore and Seabed in 2004 emanated from a few radical Māori "stirrers" (McCreanor 2009, p. 8),\textsuperscript{232} were generally differentiated by skin colour, class-location and levels of accrued dominant group cultural capital. The deployment of scientific racism, exemplified by the "warrior gene" debacle, to turn

\textsuperscript{230} The New Zealand medical workforce is comprised of the "the highest ratios of foreign-born and foreign-trained doctors in OECD countries (respectively 52% and 36% in 2005-06)...and the third highest ... expatriation rates for doctors ... (28.5%)" (Pascal & Dumont 2008, p. 8).

\textsuperscript{231} Brash's deployment of racism is characteristic of political manoeuvres to regain political legitimacy following the reduction of economic and social protection granted by the Keynesian-Welfare state (Wacquant 2010, p. 208).

\textsuperscript{232} Furthermore, condemnation of Turia's reference to Post-Colonial Traumatic Stress Disorder by the public, the incumbent Prime Minister, Helen Clarke, and government officials reflective of misrecognition of the doxa of the spurious accusations of Māori privilege (Nairn et al. 2006).
"history into nature" such that history is denied (Bourdieu 1977, pp. 78-79) has utility in preserving misrecognition of Māori as "uncivilised 'others'" (Watt 1995, pp. 65-66 cit. Chant 2009, p. 1), and ensures the continuance of two centuries of colonial relations (Hook 2009d, p. 7). Lea and Chambers (2007, p. 3) claim that "reverence for the 'warrior' tradition" in the Māori cultural structure, that ensured Māori survival against and initial defeat of the British military (Belich 1986), is portrayed as barbarism and savagery, whereas British violence committed against Māori is presented in the name of civilisation and Christianity. Misrecognition is a more palatable alternative to recognition of the cumulative and intergenerational trauma that colonial relations have wrought (Archibald 2006; Quince 2007, p. 3), thus reinforcing that "socially constituted expectations or beliefs" represent a symbolic force that obviates the need for physical violence (Bourdieu 1997 pp. 171-72 cit. Garcés 2010, p. 4).

The New Zealand Medical Association's (2011, p. 1) use of the term equity rather than equality implies recognition of the need to question taken-for-granted socio-political factors that have resulted in the culmination of interethnic inequities across all social fields (Schiff 2009, pp. 4-5). The Medical Association, in advocating that the redress of health inequities not only constitutes a human rights issue, but that concomitant benefits accrue in terms of economic growth, reflects the emergence of "competing possibilities [and] alternative social and political discourses" (Schiff 2009, p. 25). Conditional Prime Ministerial acknowledgement in response to the Baker Report (2012), "that some social

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233 While acceptance of the "warrior gene" discourse is symptomatic of naïve acceptance of scientific and medical research as value-free, devoid of political agendas or cultural racism (D. R. Williams & Sterntthal 2010), it further implies dereliction of duty on the part of the media to disseminate scientific condemnation of Lea and Chambers' (2007) findings (Chant 2009). Despite Merriman and Cameron (2007, p. 1) reporting the lack of evidential support for the hypothesis that "the MAO-A gene confers 'warrior' qualities on Māori males, either modern or ancestral ... [and that] generalising from a sample of 17 individuals is not representative of general Māori population ...", the concept of the Māori "warrior gene" has gone global (in Michael Crichton's new novel Next). Further, Crampton and Parkin (2007, p. 2) state that: "In Caucasian (but not non-white Americans) the gene is associated with antisocial behaviour in males only against a background of prior maltreatment. However no association is apparent when the gene is examined in isolation. Even if the data in Caucasian were to be replicated in Māori males, that does not make the gene the cause of the behaviour. Its presence might predispose towards such behaviour but only in the context of a disadvantageous environment. To make the causal claim on the evidence of association alone is naïve. In this case, the naivety is masked by the positive public stereotype of the cutting edge scientist reporting a breakthrough."

234 Hook (2009d, p. 7) claims that a more plausible explanation for the asymmetric rates of convictions of Māori (and indigenous minorities in Canada and Australia) is his victimhood, underpinned by colonial expediency in stigmatising indigenous people as "excessively violent." As cogently reported in The Press, a closer approximation of the 'truth' vis-à-vis the 'warrior gene'... may be the result of too close an association with aggressive Caucasians" (Van Beynen 2006).

235 Equity implies "the absence of systematic disparities in health (or in the determinants of health) between different social groups who have different levels of underlying social advantage/disadvantage – that is, wealth, power, or prestige" (Braveman & Gruskin 2003, p. 254).
determinants may have contributed to adverse outcomes among [the] country's Indigenous peoples" (Lancet Editorial 2012, p. 1075) and the subsequent announcement of potential funding cuts to Māori Health Providers (Radio New Zealand 2012, 3 April) indicate tensions between the right- and left-hand sides of the bureaucratic field (Wacquant 2010, pp. 200-201). Notwithstanding the assumption of greater responsibilities for redressing Māori health needs, The Controller and Auditor-General: Health Sector Report (2012) identified institutional inertia vis-à-vis the statutory reporting of district-specific Māori health disparities and initiatives implemented to improve reporting requirements. Institutional inertia reflects the "homogeneity of habitus" of agents possessing schemes of thought that translate into practices that take-for-granted existing power relations (Bourdieu 1977, p. 80).

Limitations

This study has several limitations. First and foremost, primary data was collected from the administration records of the Hauora Manawa Study, which potentially restricts the findings of this research to a Māori sub-population prepared to participate in health research. As a result, the research has potentially excluded "hard to reach" and/or mobile Māori who comprise the group who are potentially most affected by barriers that preclude access to and engagement with primary healthcare. Second, findings are also restricted to one geographic region where Māori are underrepresented as a percentage of the population compared to the national distribution (Christchurch City Council 2005). Third, in addition to potential memory decay or recall bias, data derived from self-reported discrimination is inherently subjective because of differences in the way people interpret and respond to objective experiences (Harris et al. 2006a; Krieger 2000; D. R. Williams et al. 2003), especially the personal/group discrepancy, and the tendency of individuals to perceive their groups rather than themselves as targets of discrimination (D. M. Taylor, Wright, Moghaddam & Lalonde 1990). Individuals may also provide socially acceptable responses and/or exaggerate or minimise their experiences (Davidson & Tolich 2001; Karlsen &

236 Allegations of "[b]latant bloody racism" by the Mana Party Leader, Hone Harawira (McMillan 2012, 25 April), highlight tensions between the Ministerial review of the cost-effectiveness of Māori health providers vis-à-vis the "contractual requirements of District Health Boards and expectations of meeting the health needs of Māori communities" (A. F. Boulton et al. 2009).
237 The authors of this report state that the provision of Māori Health Plans, if not connected to performance reports, fail to provide the information necessary to hold District Health Boards accountable for reducing Māori health disparities; however, performance indicators introduced in the Ministry's Māori Health Plan template (2011/12) are expected to provide greater transparency and accountability (Controller and Auditor-General Health Sector 2012).
Nazroo 2002). Finally, the purposive sampling technique employed in this study was intended to achieve a wide diversity of healthcare perspectives and experiences by selecting a small number of participants and gathering in-depth information. Collectively, these factors preclude statistical generalisability or representativeness of study findings (Barbour 2001).

The aforementioned limitations are however, compensated for by the strengths of this study which include identification and exploration of contradictions between participants’ responses to initial questions asked during Hauora Manawa screening and disconfirming evidence provided in subsequent face-to-face interviews as previously discussed. Moreover, the theoretical/methodological perspective and the sociological framework employed enabled identification of complex socio-environmental influences on health seeking behaviours that transcend time, generational boundaries, physical localities and political movements, all of which combines to provide a new set of date and broader understanding to public health research.

**Conclusion**

This study found the barriers and facilitators to accessing and engaging with primary healthcare, and their distribution amongst the study population, are conditioned by a complex and multifaceted relationship between neo-colonial relations, and cultural health capital, skin colour and/or social-ascription as Māori, age, gender, and spatial and class-location. The process of colonisation has determined systematic inequalities in the ability of Māori to accrue dominant group cultural health capital: the "cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles ... that, when deployed, may result in more optional healthcare..." (Shim 2010, p. 1). Interethic inequities in health status and outcomes can therefore be "understood as manifestations of broad inequalities permeating social structures, institutions and social life" (Shim 2010, p. 4).

The cumulative, intergenerational and interconnected nature of these factors reflect the manner in which colonial and neo-colonial relations are embodied in institutional policies. These in turn translate into practices of social actors across various social fields in the form of "lasting dispositions, or trained capacities and structured propensities to think, feel, and act in determinate ways" (Wacquant 2005, p. 316). The significance attached to
maintaining relational continuity with known primary care practitioners reinforces perceptions and/or experiences of discriminatory healthcare; this warrants further attention as it appears to represent a significance barrier to the priority attached to reducing interethnic disparities through primary healthcare. The seemingly intractable nature of discriminatory practice in medicine has compelled the leading racism scholars, van Ryn and colleagues (2011, pp. 201-202), to re-emphasise the "moral responsibility and accountability" of medical practitioners to eliminate unjust practices; unequal treatment has been reframed from "the impact of patient race . . ." [to the] more accurate 'impact of racism . . .' on clinician cognitions, behavior, and clinical decision making."

The findings of this study support the assertion by New Zealand Medical Association (2011, p. 1) that achieving equitable interethnic health outcomes may necessitate vertical (rather than horizontal) equity - the unequal, or preferential treatment of unequals). Within the context of a highly differentiated, racialised, neo-colonial society, vertical equity may be conceptualised as a virtue made of necessity (Bourdieu 1990, p. 54), as emerging epigenetic understandings potentiate the Māori embodiment of colonial relations:

[P]ast experience influences not only our behaviour through learning, but both our biology and our behaviour through chemical changes in the way our genes are controlled. This leads to long-lived (effectively permanent, although putatively reversible) changes in the way both our brain and other aspects of our biological systems respond. It is this information that leads to the crucial understanding that events in any one part of the life course can have important influences on how subsequent parts of our life course play out .... that events before birth can have life-long consequences that manifest as a greater risk of heart disease or diabetes in adulthood (Gluckman, Low & Franko 2011, p. 6).

The vicissitudes of Māori health reflect the inevitable failure of the "golden cargo of British civilisation" - Western medical care - (Salesa 2001, p.21) to equitably provide for Māori. The humanitarian ideals of early Colonial Office officials, aspirants to indigenous protection following the triumphant abolition of slavery (McKenzie 2010), were superseded by the dispossessionary and dehumanising enterprise of colonisation. Michael King (2003, p. 257) quotes Archdeacon Walsh in the late nineteenth century as declaring: "The Māori [race] has lost heart and abandoned hope .... It is sick unto death ...." Yet the
colonial contribution to Māori morbidity, mortality, marginality, and misery is only part of a much wider context of attitudes, determined by sociopolitical ideologies from Vattel's concept of state sovereignty and Locke's concept of property rights, to the pseudoscientific Social Darwinist premise of European superiority, and most recently, the impact of neolibertarianism.

Insofar as consensus exists in modern differentiated societies, it is largely through "state forms of classification" (Bourdieu 1994, p. 13). Misrecognition functions to legitimise and make invisible the relationship between post-colonial power and equitable access to capital(s). Primary healthcare practitioners are uniquely positioned to improve equity (New Zealand Medical Association 2011) by fostering the development of cultural health capital in their Māori patients to remediate the dynamics of unequal treatment (Shim 2010). This study's findings demonstrate that improving the accrual of dominant group cultural health capital amongst Māori would require that the political and social capital associated with Māori privilege be reformulated. Such a dynamic shift mandates recognition of the often non-purposeful, habitual nature of culturally-mediated interactions; their growing significance amidst structural changes in the delivery of primary healthcare; the direct and indirect instrumental and symbolic forms of capital (Shim 2010, p.1); and the impact of colonial relations, social status and social classification on clinical interactions. Only then can the Māori right to health be seen not as a service, charity, commodity or privilege, but as an inalienable, fundamental human right (Reid 2011, p. 45), central to the medical ethic of distributive justice (Reti 2002).
REFERENCES


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APPENDIX 1:
GROUP A: Personally experienced different treatment by health professionals

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GROUP B: Maori generally treated differently by health professionals

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<th>3.3.17 Had a bad healthcare experience</th>
<th>Referred to GP for follow-up care</th>
<th>Referred to GP and/or cardiologist for follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>DYLAN</td>
<td>M</td>
<td>35-39</td>
<td>15 20</td>
<td>40 50</td>
<td>No</td>
<td>DK</td>
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<td>TRUE</td>
<td>FALSE</td>
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<tr>
<td>DELIA</td>
<td>F</td>
<td>35-39</td>
<td>25 30</td>
<td>70 100</td>
<td>No</td>
<td>DK</td>
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<tr>
<td>Discarded</td>
<td>M</td>
<td>40-44</td>
<td>25 30</td>
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<td>No</td>
<td>DK</td>
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<td>DAN</td>
<td>M</td>
<td>40-44</td>
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<td>DK</td>
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<tr>
<td>DAPHNE</td>
<td>F</td>
<td>45-49</td>
<td>30 40</td>
<td>70 100</td>
<td>No</td>
<td>DK</td>
<td>FALSE</td>
<td>TRUE</td>
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</tr>
<tr>
<td>N/A</td>
<td>M</td>
<td>45-49</td>
<td>100 001 +</td>
<td>100 001 +</td>
<td>No</td>
<td>DK</td>
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</tr>
<tr>
<td>DIANA</td>
<td>F</td>
<td>55-59</td>
<td>100 001 +</td>
<td>100 001 +</td>
<td>No</td>
<td>DK</td>
<td>FALSE</td>
<td>FALSE</td>
<td>FALSE</td>
</tr>
<tr>
<td>DORA</td>
<td>F</td>
<td>60-64</td>
<td>10 15</td>
<td>30 40</td>
<td>No</td>
<td>DK</td>
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<td>TRUE</td>
<td>TRUE</td>
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APPENDIX 2:
<table>
<thead>
<tr>
<th>PARTICIPANT INTERVIEW SCHEDULE</th>
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<tbody>
<tr>
<td><strong>INTRODUCE SELF</strong></td>
</tr>
<tr>
<td>Whakawhanaungatanga</td>
</tr>
<tr>
<td>Explain option of passing on questions if preferred; thank patient for agree to participate in interview; ask if any?</td>
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<tr>
<td>What encouraged you to participate in HM study?</td>
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<tr>
<td>What have you learnt as a result of participating in the study?</td>
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<td>How do you usually access health care?</td>
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<td>What other health services do you use on a regular basis?</td>
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<tr>
<td>% Maori participants reported that they had been treated differently by HP because they were Maori.</td>
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<tr>
<td>Can you share any experiences that you or whanau have when you felt that you were treated differently or unfairly?</td>
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<tr>
<td>What would you like to see happen as a result of the HM study?</td>
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<td></td>
</tr>
<tr>
<td>Participant thanked and given koha</td>
</tr>
</tbody>
</table>
APPENDIX 3:
Tena Koe

The Hauora Manawa Study will soon begin the follow-up study of all those who participated in the screening clinics. As part of this follow-up, we are inviting a small selection of Maori participants to undertake a further interview that will explore your experiences of accessing health care in Christchurch.

What will the interview involve?

I will phone you and if you agree to take part, we can arrange a time and place of your choice to conduct a face-to-face interview. The conversation will be audio-taped and you can choose whether you want to answer all of the questions. The interview will take about 40 minutes and to reimburse your time, you will be given a small koha ($40). As with the rest of the study all information that you provide is confidential and your name will not be attached to any reports.

What will happen to the information collected?

All information will be kept in a locked filing cabinet at the University of Otago – Christchurch. Interview transcripts will be retained for (20 years) before being destroyed. Information collected will be analyzed by the Hauora Manawa team. Once this part of the study has been completed, you will receive a summary of the results.

Why take part?

The Hauora Manawa Heart Study wants to more fully understand what Maori health consumers consider to be the strengths and barriers to accessing quality health care in Christchurch and through the Canterbury District Health Board. Your opinion and experiences will help us to make better informed recommendations to the Ministry of Health and Canterbury District Health Board regarding the provision of health care for those of us who live in Christchurch.

INFORMATION SHEET
This study has received ethical approval from the Multi-region Ethnics Committee which reviews National and Multiregional studies and is funded by the Health Research Council of NZ (Ethnic Reference MEC/06/03/026).

If you have any queries or concerns regarding your rights as a participant in this study, please contact a Health and Disability Services Consumer Advocate, telephone 0800 377766.

If you would like to ask any other questions or you have any queries about this project please ring Jennifer Reid on 364.3647 or the Hauora Manawa Team on 0800 HAUORA (0800 428672).

Heoi ano / Kind regards

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