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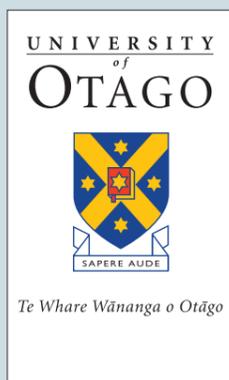
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SICK UNTO DEATH: Barriers and Facilitators to Māori Access to Primary Care in New Zealand

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Context

Primary healthcare is one of the mechanisms through which the New Zealand government intends to reduce and ultimately eliminate significant health disparities between the indigenous Māori minority and predominantly European majority population [1]. Māori life expectancy is more than 8 years shorter than non-Māori, disparities persist in most mortality and morbidity indicators (including most major chronic diseases, infectious disease and injuries, mental health and disability) [2].

Problem

This qualitative research examined self-reported barriers and facilitators that influenced Māori access to and engagement with predominantly non-Māori primary care physicians in a highly differentiated, racialised, neo-colonial society

Study Design

Face-to-face interviews were conducted with a purposively sampled subgroup (n=45) of the Māori cohort of the Hauora Manawa Study, aged between 25 and 64 years. Bourdieu's Theory of Practice [3] and Shim's conceptualisation of Cultural Health Capital [4] were integrated into a context-specific theoretical framework to enable analysis of the dichotomous relationship between subjective participant experiences and objective structures of primary healthcare [5].

Results

Encounters between Māori patients and non-Māori clinicians are conditioned by a highly-complex and multidimensional relationship between colonial and neo-colonial relations and access to capital(s) that transcend time, generational boundaries, physical localities and political ideologies:

- Age and gender differences reflects the history, context, and tempo of demographic change precipitated by rapid Māori urbanisation in the 1950-60s; gendered access denotes the concurrent medicalisation of Māori childbirth with male access commonly restricted to illness, medical emergencies and/or employment related requirements.
- Spatial location at birth determined the time of entry into the health system. Lifecourse access occasions greater pre-reflexive acceptance of Western medical care; conversely, belated access requires co-constructive doctor-patient encounters conducive to overcoming heterodoxical beliefs (particularly relating to pharmaceuticals) underpinned by childhood reliance on traditional Māori medicines.
- State policies that determined the collective working-class destination of Māori have impeded the transgenerational accrual of all capital(s) including Western cultural health capital.
- Engagement and timely utilisation of services is influenced by personal, extended family and transgenerational experiences and/or perceptions of Western health professionals.
- Commonsense phenotypical characteristics, such as skin colour or social ascription as Māori, generally represents a determinant of potential or realised exposure to discriminatory treatment and concomitant utilisation patterns.
- Mandatory patient enrolment with a general practice, under The Primary Health Care Strategy [6], constitutes a significant barrier to maintaining relational continuity with known and trusted physicians and access to quality, non-discriminatory care.
- Positive long-term benefits accrue in clinical encounters when physicians foster the development of Western cultural health capital to ameliorate the psychological pathways (including racial discrimination), socioeconomic deprivation, psychological states and lifestyles behaviours reflective of the complex and harsh reality of the lives of many of their Māori patients.

Discussion

Ethnic health disparities are not only conditioned by provider dispositions and bias but indirect (symbolic) and direct and material manifestations of colonial and neo-colonial policies and practices that have permeated social structures, institutional engagements, and social life across time and space [4]. In the modern healthcare landscape, dominant group cultural health capital: "cultural skills, verbal and non-verbal competencies, attitudes and behaviors and interactional styles" has the potential to maximise the quality of care received [4]. The implications of systematic inequities in Māori access to dominant group cultural health capital is implied in The New Zealand Medical Council's [7] proposal that reducing disparities in Māori health outcomes may require vertical equity - unequal or preferential treatment of unequals. Changing the status quo will, however, require the reformulation of the systematic deployment of political, symbolic and social capital associated with Māori privilege and recognition of the unpalatable reality that the colonial legacy has cumulative and pernicious consequences across time and space. Until such times, Māori will be denied the fundamental human right of equitable healthcare consistent with medical ethics and thus remain disproportionately "Sick unto Death."

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