Ethnic classification in the New Zealand health care system

In New Zealand a section of the Maori population experiences inter-generational low health status. Evidence from numerous studies, in that country as elsewhere, show that differential health status is strongly associated with socioeconomic status and inequalities in income, education, housing, diet, and conditions of work. However, since the 1980s there has been a shift to a belief that Maori low health status today is the result of an inequality between colonial oppressor and oppressed indigenous people. It is a way of understanding social experiences in terms of an ethnic or race group category which sees all individuals who are classified as Maori belonging to that category.

The race explanation is part of the ethnic politics of the post-1960s decades and can be seen in the multicultural policies developed by many countries with multi-ethnic populations. In New Zealand, ‘biculturalism’ distinguished between those identifying as Maori and those identifying as ‘Pakeha’ or settler-descendants. Within this new political landscape, a Maori elite emerged to drive the retribalisation of the increasing number of individuals identifying as Maori. Its strategy has been to claim that the 1840 Treaty of Waitangi established a ‘partnership’ between the reviving tribes and the government rather than establishing British sovereignty. This approach was highly effective in changing the policy environment to include ethnic categories.

Although ethnic categorisation supports retribalisation politics, it may reinforce stereotypes and perpetuate inequalities. It may also obfuscate the complex factors which cause low health status. Poor health does not accrue to individuals because they share a genetic ancestry. Ethnicity may play a part, but as a social factor not a biological one in that racial discrimination is more likely to be experienced by the section of the Maori population that has low socioeconomic status. Personal experiences of racism do affect an individual’s health negatively. The demography of New Zealand’s population adds to the complex picture of Maori health. The relative youth of the Maori population contributes to the high incidence of Maori mental health problems given that young people are more likely to engage in behaviours that put their health at risk.

There are conceptual problems with using ethnic categories to deliver health care. Explaining social life in terms of genetic ancestry or ‘race’ is unscientific. The idea of ‘colonial-imposed trauma’ which is transmitted from generation to generation is also unsound scientifically. Defining and measuring ethnicity or race creates major methodological problems. The concept of a Maori non-Maori binary does not fit the reality of life in New Zealand where there has been constant intermarriage between Maori and non-Maori for two centuries. Socioeconomic status is implicated in how individual identify as ‘sole-Maori’ or ‘Maori and other’ with those in the growing Maori managerial and professional class claiming more than one ethnic identity.

Ethnicity does play a role in Maori low health status but not in terms of a broad race or ethnic category. It is in the materiality of ethnic status, that is, how people who identify ethnicity live their daily lives and are treated by others that explain Maori health disadvantage. The health status of groups in New Zealand, as in other countries, is associated with socioeconomic advantage or

deprivation. Ethnically based health provision in New Zealand is justified by retribalisation politics, using a partnership strategy that depends upon a clear ethnic bifurcation of the population. However, the strategy obfuscates intra-group and individual differences and the myriad of social factors that cause disadvantage.

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Publication

Ethnic Classification in the New Zealand Health Care System.
Rata E, Zubaran C
J Med Philos. 2016 Apr