

# Disparities in health: common myths and uncommon truths

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## Abstract

A reappraisal of disparities by deprivation provides new and important information. NZDep96 is an area-based index of socioeconomic deprivation that uses nine variables measured in the 1996 census. The distribution of the Māori ethnic group is sharply skewed towards the most deprived deciles with only three percent in decile 1 and twenty-six percent residing in decile 10 meshblocks. More than half (56%) of Māori live in areas represented by the three most deprived deciles. This pattern is consistent within both sectors of the Māori ethnic group: sole Māori – those who give Māori as their only ethnicity and mixed Māori – those who give Māori as only one of their ethnicities. This is a 'distribution gap'. Within disparities analysis, there is also evidence of an 'outcome gap'. That is, the health outcomes of Māori are different from non-Māori, even after controlling for deprivation. For example, overseas data on life expectancy at birth have demonstrated social class gradients with lower life expectancy among manual workers and increasing life expectancy for tradespeople, through to managerial and professional workers. This gradient is also evident in Aotearoa with life expectancy

at birth decreasing as deprivation increases. A third dimension is evident in a review of disparities by deprivation, - a 'gradient gap'. This describes the relationship between ethnicity and increasing deprivation. It is as if the effect of increasing deprivation compounds risk for Māori whereas Pākehā do not seem subject to this effect. Analyses that foreground disparities have been portrayed as oppositional or secondary to Māori health development. In such frameworks where a disparity focus intersects with a development focus, the impression is given that the two are interconnected but move past each other in different directions. Our analysis promotes the disparities focus and the development focus as parallel reinforcing variables, each informing the other in the design and provision of services that have as their starting point, Māori needs. These services offer hope and opportunity for Māori but risk the vulnerability of special provision services (eg. cuts in government expenditure). Furthermore they may delay the imperative of addressing the societal drivers that perpetuate disparities. This tension to engage in remedial reform is an important dilemma in Māori health development.

## Introduction

Māori health status, of itself and in comparison to non-Māori New Zealanders, is of significant concern to Māori whānau and communities, health workers and advocates, policy makers and researchers. The Crown has acknowledged disparities in health between Māori and non-Māori and is committed to reducing these<sup>1-5</sup>.

A reappraisal of disparities by deprivation provides new and important information. NZDep96 is an area-based index of socioeconomic deprivation that uses nine variables measured in the 1996 census (no access to a telephone, receiving a means tested benefit, unemployed, low household income, no access to a car, single parent family, no education qualifications, not living in own home, overcrowded home).<sup>6</sup> The index provides a deprivation score for each meshblock (geographical units containing a median of 90 people) in Aotearoa. The NZDep96 scale of deprivation from 1 to 10 orders these meshblocks into tenths. A meshblock with a value of 10 is in the most deprived 10 percent of small areas in Aotearoa<sup>6</sup>.

This paper seeks to inform and extend understanding of health disparities between Māori and non-Māori citizens of Aotearoa. Using analyses with NZDep96<sup>6, 7</sup>, issues that

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Figure 1. Distribution of Māori and non-Māori populations by deprivation decile, 1996

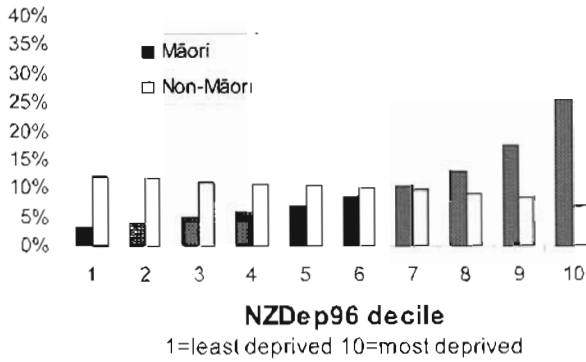
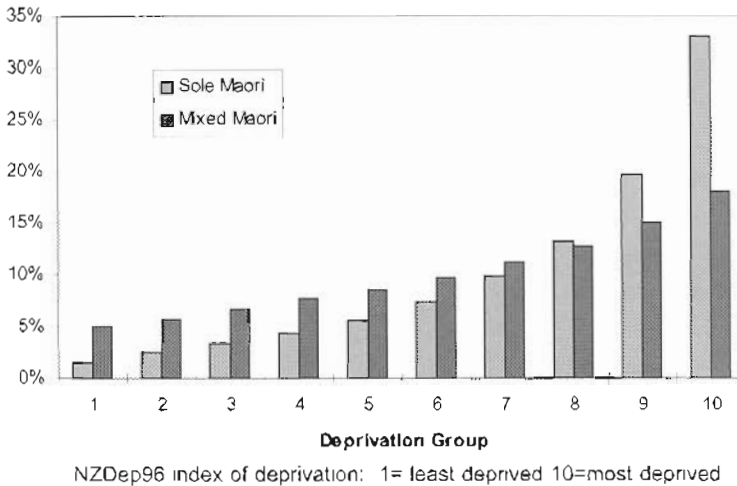


Figure 2. Distribution of sole Māori and mixed Māori populations by deprivation decile, 1996



underpin disparities will be examined and common myths about disparity analyses will be challenged. Our ability to understand and monitor disparities largely depends on our ability to re-view the frameworks within which the disparities are described. Without such a review, the design of interventions that are safe and effective for Māori is likely to be hindered.

### The distribution gap

In a society where privilege and deprivation are independent of ethnicity Māori and non-Māori would be equally distributed through the deciles. In this scenario, ten percent of both Māori and non-Māori populations would reside in meshblocks assigned to each decile. In reality, the distribution is very different.

Figure 1 shows that non-Māori are over-represented in decile 1 (12%) and become progressively under-represented with increasing deprivation until only seven percent reside in decile 10 (most deprived) meshblocks. In contrast, the distribution of the Māori ethnic group is sharply skewed towards the most deprived deciles with only three percent in decile 1 and twenty-six percent residing in decile 10

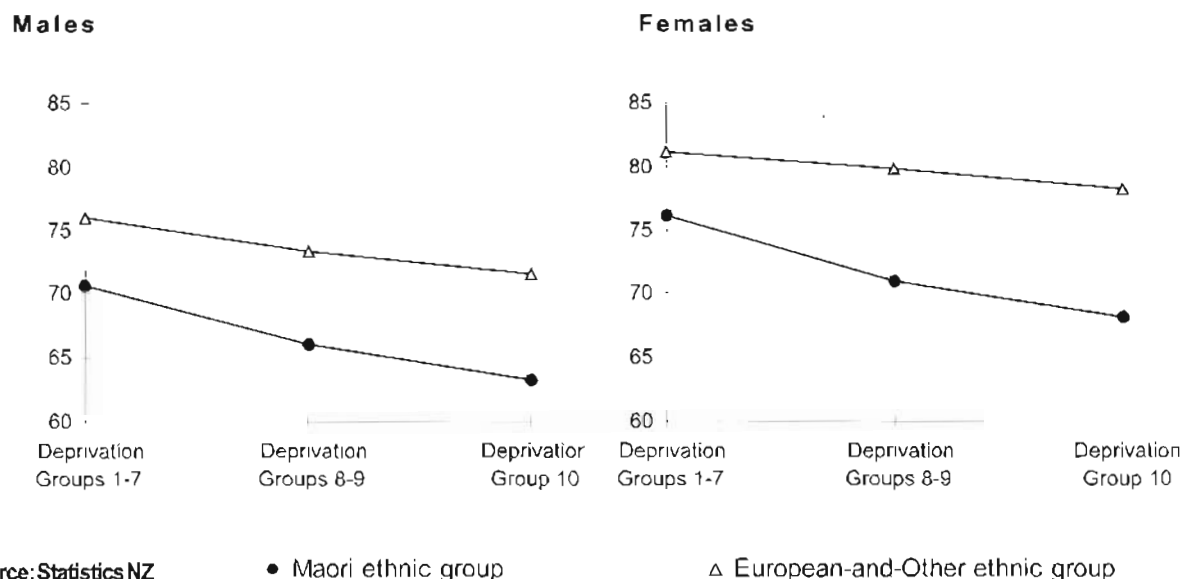
meshblocks. Indeed more than half (56%) of Māori live in areas represented by the three most deprived deciles. This pattern is consistent within the Māori ethnic group that has two population components:

- i) sole Māori – those who give Māori as their only ethnicity
- ii) mixed Māori – those who give Māori as only one of their ethnicities.

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The deprivation distribution of these two populations (see Figure 2) highlights two issues. Firstly, sole Māori are more likely to be distributed among the more deprived deciles than mixed Māori. This provides some support for the thesis of a gradient of stigma and marginalisation underpinning the maldistribution of deprivation among Māori. Secondly, the deprivation distribution of mixed Māori remains far more similar to sole Māori than to that of non-Māori (see figure 1). This relationship highlights that whatever causes this deprivation distribution, it drives both the sole Māori and mixed Māori populations to increased deprivation, although the effect is expressed more acutely among sole Māori.

Figure 3. Male and female life expectancy at birth, 1995-97, by deprivation



Source: Statistics NZ

● Maori ethnic group

△ European-and-Other ethnic group

## The outcome gap

Within disparities analysis, there is also evidence of an 'outcome gap'. That is, the health outcomes of Māori are different from non-Māori, even after controlling for deprivation.

Life expectancy at birth relates the current mortality experience of a population to its impact on longevity. Overseas data on life expectancy at birth data have demonstrated social class gradients with lower life expectancy among manual workers and increasing life expectancy for tradespeople, through to managerial and professional workers<sup>9</sup>. This gradient is also evident in Aotearoa with life expectancy at birth decreasing as deprivation increases. To examine this effect by ethnicity, data from deciles 1-7 were combined, because of the relatively small population of Māori in these deciles, as were deciles 8 and 9, and these were compared with decile 10.

Figure 3 shows that the average life expectancy at birth for Māori is consistently less than that of Pākehā at each of these deprivation points. This effect is present in both men and women.

This graph indicates that not only is the average life expectancy at birth for Pākehā residing in decile 10 higher than that of Māori in decile 10, it is also higher than the average for Māori in deciles 1-7.

In the face of this outcome inequality, one is curious about the level of health system response. Publicly funded hospitalisations have been reviewed by ethnicity and deprivation for different age groups.

Hospitalisation increases with increasing deprivation in New Zealand<sup>10</sup> and this is especially true for hospitalisations that may be "considered potentially avoidable through the provision of health promotion, disease prevention or other clinical services in ambulatory settings"<sup>3</sup>.

Among the young, at all levels of deprivation, Māori gain access to public hospital services at rates lower than Pākehā residing in areas with the same deprivation scores. This pattern is evident until the age of 25 years when service utilisation by deprivation becomes more equivalent.

Between the ages of 45 to 64 years, for both men and women, Māori hospitalisation by deprivation is higher than Pākehā but this is reversed among those aged over 65 years, especially men. Some have noted that the relationship in this age group may be confounded by the different age structure of the populations over the age of 65 years<sup>10</sup>.

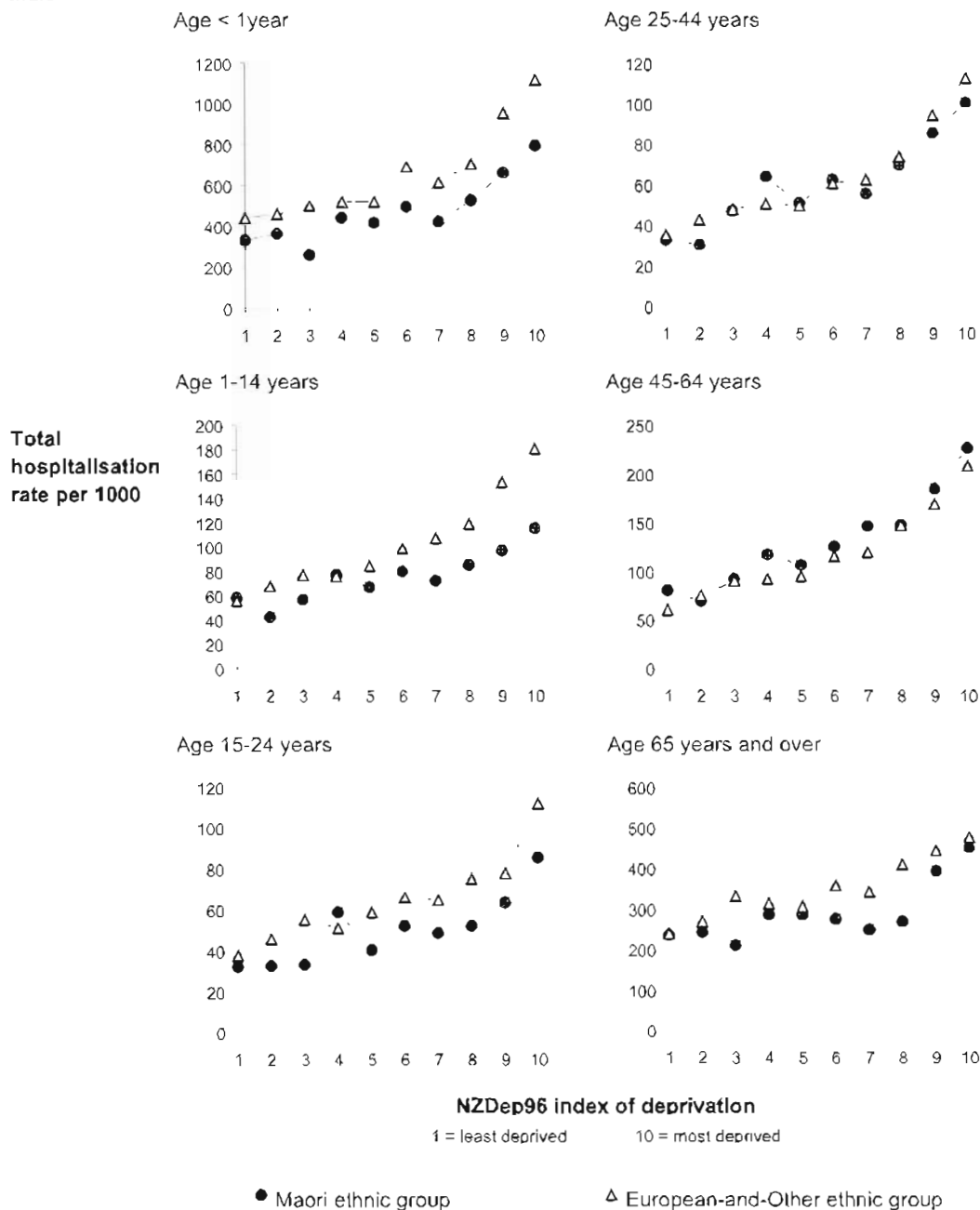
However, a study of public hospital service utilisation in ten-year age bands suggests Māori and Pākehā utilisation is similar for all deciles at ages 65 to 74 years. But in the age bands after age 75 years, rates of hospitalisation for Māori are reduced compared with Pākehā at all levels of deprivation (Baxter, unpublished).

Hospitalisation data is known to undercount Māori by as much as 25%<sup>11</sup>. However, if Māori mortality outcomes represent an indicator of health service need, this data supports suggestions that the health services have yet to respond adequately to meet Māori health need.

Hospital utilisation is not a measure of health or even an adequate measure of health service activity. Currently it is

Figure 4. Age-specific male and female public hospitalisations 1996-97, by deprivation and ethnicity

Male



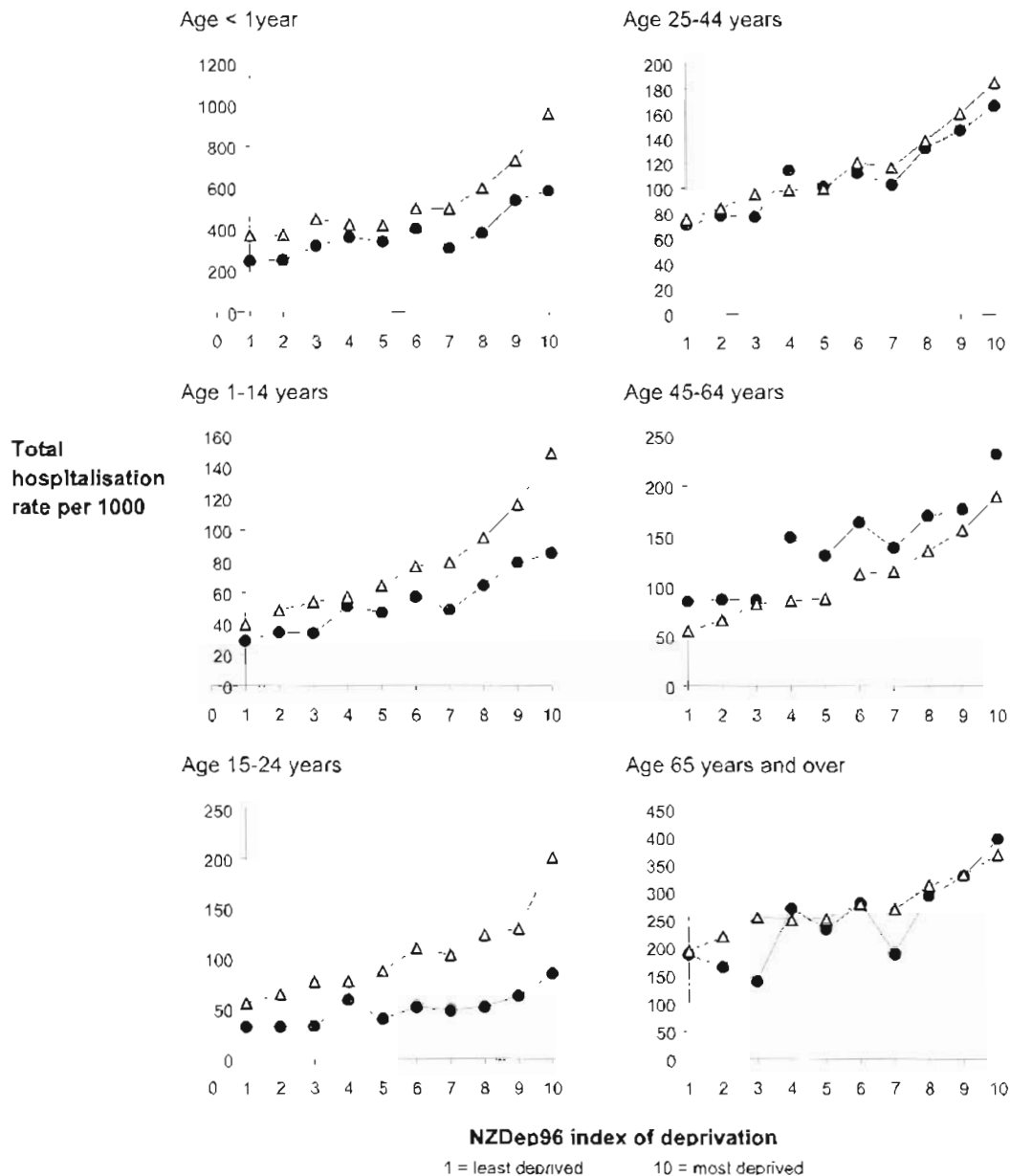
difficult to obtain primary health care data by ethnicity and deprivation, as most services do not yet routinely collect ethnicity information.

This second aspect of disparities, the outcome gap, demonstrates a number of important lessons. Firstly, in New Zealand there is both increasing mortality and increasing public hospital utilisation with increasing small area deprivation. Secondly, Māori with few exceptions have worse health outcomes than Pākehā counterparts when controlled for small area deprivation. Thirdly, even given issues with data quality, it seems likely that the service response is inadequate given the level of Māori health service need.

The gradient gap

A third dimension is evident in a review of disparities by deprivation, - a 'gradient gap'. This describes the relationship between ethnicity and increasing deprivation. In some cases, the impact of increasing deprivation is greater for Māori, so the resultant Māori profile is steeper than that of non-Māori. It is as if the effect of increasing deprivation compounds risk for Māori whereas Pākehā do not seem subject to this effect. This gradient gap is demonstrated in mortality data but is generally not evident in hospitalisation data (see Figure 5).

Female



Source: NZHIS<sup>10</sup>

● Maori ethnic group

△ European-and-Other ethnic group

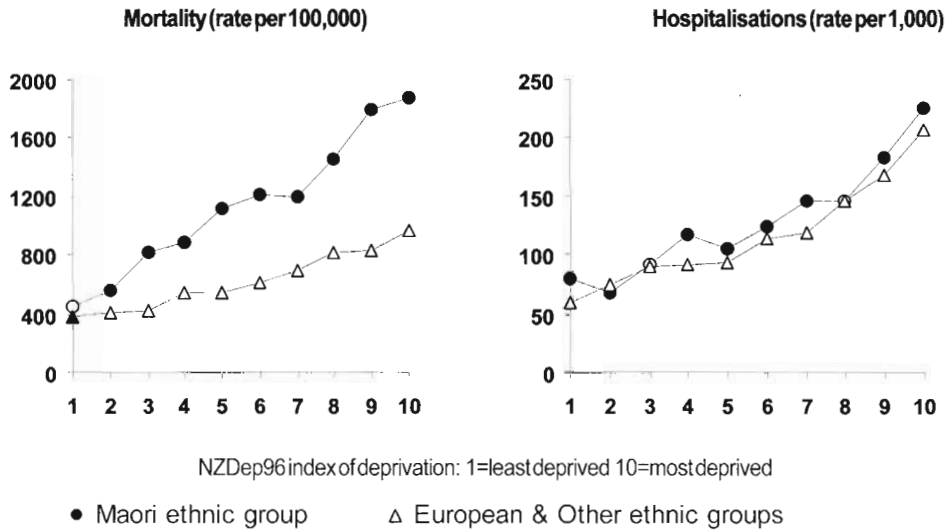
In some analyses, the effect of increasing deprivation is similar for both Māori and non-Māori and the two experiences are expressed as parallel lines. This is particularly obvious in tobacco use, (figure 6) where a strength of this data is that both numerator and denominator have been derived from self-reported information from one census.

In other data, this gradient effect may be shaped by bias in the classification of ethnicity by deprivation. In mortality and morbidity data, ethnicity is often not self-identified but rather identified by third parties such as funeral directors or hospital admission clerks. In this way value judgements may be made. A third party may be more comfortable identifying a

brown person from a deprived neighbourhood as Māori but less likely to identify the affluent 'olive skinned' person in front of them as Māori. If such a bias exists, Māori/non-Māori life expectancy, mortality and hospitalisation may in reality be more parallel. More work is needed to tease out the implications of these findings and their relevance to disparities.

Evidence for bias also exists in mortality data with respect to age and geographic area (figure 7).

Figure 5: Māori and non-Māori males aged 45-64 years, mortality and public hospitalisations, 1996-97



### Whose gaps are they anyway?

These NZDep analyses provide support for the hypothesis that above and beyond the health effects of increasing deprivation in New Zealand, there is an additional and significant health effect of ethnicity. That is, Māori health outcomes are worse than Pākehā at all levels of deprivation.

To many Māori these and other disparities are clear evidence of a breach of the Treaty of Waitangi that sought to protect Māori from marginalisation as a result of colonisation. Treaty authorities highlight issues of partnership, the active promise to protect Māori interests, and the full expression of citizenship as being central tenets of the Treaty of Waitangi<sup>12</sup>.

Te Puni Kōkiri has a statutory responsibility to monitor Māori outcomes using a Treaty of Waitangi framework. These outcomes are reported in their regular "Closing the Gaps" documents. Their second report notes:

"The new Government has included among its key goals a commitment to uphold the principles of the Treaty of Waitangi and to close the gaps between Māori and non-Māori achievements in education, labour force, housing and health. The 'Closing the Gaps' series is directly relevant to both these goals. The Treaty of Waitangi was signed to protect the interests of Māori and it is certainly not in the interests of Māori to be disadvantaged in any measure of social or economic wellbeing."<sup>2</sup>

However, the Crown has 'rebranded' its focus on disparities away from a Māori/non-Māori analytical framework that foregrounds the Treaty of Waitangi to a focus on all New Zealanders who are disadvantaged socio-economically, with an emphasis on minority groups including Māori. This move to a social justice framework, not only ignores evidence of serious Māori/non-Māori gaps within socio-economic groups, but also moves the debate out of a Treaty of Waitangi framework for action and intervention. This policy shift does not diminish Crown responsibility guaranteed by the Treaty

Figure 6. Regular smokers, aged 25-44 years, by sex and ethnicity, 1996 census

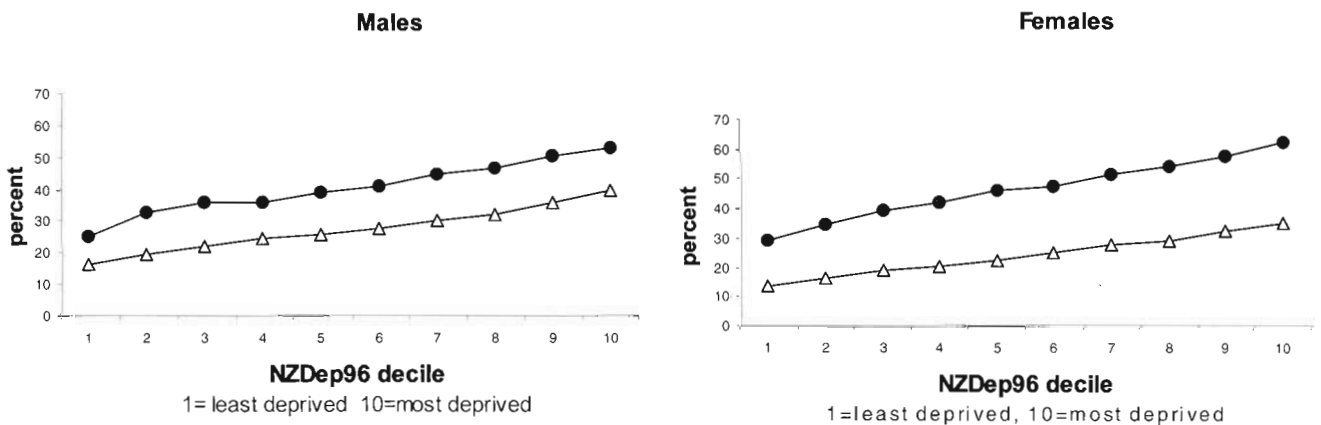
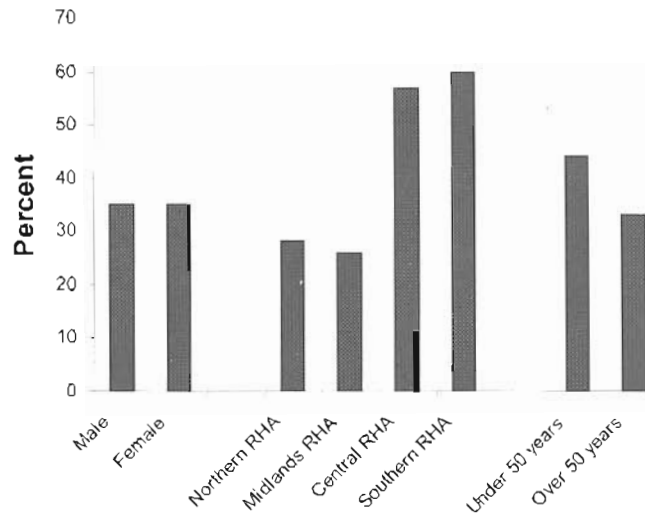


Figure 7: Proportion of Māori deaths on National Health Index classified as non-Māori in mortality data, 1992-95



Source NZHIS

but rather highlights Crown inaction in the face of need, opportunity and stated intention.

## Māori as the “other”

Ethnic disparities in health outcomes are often described in the New Zealand literature yet they remain poorly understood. Various models have been proposed that attempt to describe important determinants of health<sup>3,13</sup>. Furthermore they promote possible pathways to good health and a hierarchy of connections and interrelations between individuals, communities and environments. However, most of these models assume that society values its members equally and engages with equal responsiveness. In this way the various influences of sexism, racism, ageism, heterosexism and religious discrimination may be ignored.

While the Crown regularly reports on health, indeed it has the statutory responsibility to do so, the primary focus of Crown commentary is the health of the total New Zealand population and not specifically that of Māori. Māori health outcomes are therefore framed as “different” from “ordinary” New Zealanders. Māori are thus portrayed as “abnormal” or the “other”.

This framing of Māori as the “other” promotes narrow explanations of disparities that typically represents Māori behaviour, genes, culture, socioeconomic status and engagement with services as the “problem”. This representation has been referred to as “blaming the victim”<sup>14,15</sup> or “deficit thinking”<sup>16,17</sup>.

“[Blaming the victim is] a way of thinking about social problems that locates their origins in the purported deficits and failings of their victims rather than in the social institutions and practices that had brought about and sustained their victimisation.”<sup>14</sup> (Lykes et al, 1996, p7)

“With such an elegant formulation, the humanitarian can have it both ways. He can, all at the same time, concentrate his charitable interest on the defects of the victim, condemn the vague social and environmental stresses that produced the defect (some time ago), and ignore the continuing effect of victimising social forces (right now). It is a brilliant ideology for justifying a perverse form of social action designed to change, not society, as one might expect, but rather society’s victim.”<sup>15</sup> (Ryan, 1971, p7)

Of further concern, “deficit-model” analyses assume that New Zealand society and systems including the health system are neutral towards Māori despite compelling evidence to the contrary<sup>3</sup>. Interventions based on this framing seek that Māori behave more like Pākehā to achieve health gain and hence encourage assimilationist goals.

Deficit thinking is also demonstrated in discourse on intra-ethnic groups, where identity is linked to and judged by a “culture” yardstick.

“If you ‘carelessly’ lose your culture and identity, really all you can become in this discourse is an empty vessel, waiting to be refilled. Māoris [sic] are no longer seen as deficient in relation to Pākehās, they are seen as deficient as *Maoris*.”<sup>18</sup> (Nash, 1982, p.131)

## Debunking common myths

Disparities commentary has become controversial and opposing viewpoints are foregrounded in order to cloud the basic issues. A number of common myths are regularly trotted out in response to information about disparities and it is important that these are critically reviewed.

### Myth 1

"Interventions based on ethnicity are racist. What about poor Pākehā?"

The deprivation data described earlier in this paper highlights that ethnic disparities in health outcomes exist along the entire social gradient. It is the existence of these ethnic disparities that is racist, not the analysis nor any intervention to deal with them. Non-intervention in ethnic disparities, including silence, privileges and perpetuates these racist outcomes.

### Myth 2

"By focusing on disparities we promote Pākehā levels of health as the Māori goal. It means we want to be like Pākehā and promotes assimilation."

This is a very common myth and on the surface a seductive argument. A useful analogy is women's suffrage. When women sought the right to vote, it was not to become men, although that criticism was often levelled at women, usually by men. Rather, women sought suffrage for the full constitutional expression of citizenship. Likewise, Māori seek to remove ethnic disparities, not to become Pākehā, but as an expression of full citizenship in Aotearoa. The elimination of disparities is a necessary part of Māori health development. We would argue that the danger of assimilation exists through the adoption of deficit model thinking to frame policies and interventions, not through the addressing of fundamental disparities between Māori and non-Māori.

### Myth 3

"We know enough about disparities already. The Crown and other researchers' publish ample information."

While ethnic disparities are often described in the New Zealand literature, the analysis frequently fails to go beyond description. Disparities remain poorly understood and research rarely provides adequate Māori data to inform this understanding. Where it is provided, it is usually framed in deficit-model analyses.

Until recently, large (and expensive) studies have failed to recruit adequate numbers of Māori to ensure equal explanatory power by ethnicity<sup>19</sup>. In these projects, all that can be described is Māori "difference" from the non-Māori "norm", risking a deficit-model analysis. Despite some attempts to oversample Māori (eg. National Nutrition Survey, NZ Health Survey), Crown analyses continue to be hampered by these limitations. Furthermore, there is considerable political pressure for the government of the time to foreground policies that are popular with their particular constituency, and the temptation to present political 'spin'. A Māori analysis of disparities is important to critique the Crown treaty partner

and provide Māori advice that highlights Māori need and informs intervention planning from that reality.

### Myth 4

"Disparities analyses promote negative statistics – it's all bad news – it's paralysis by analysis."

There is a tension between the need to recognise and honour the scale, scope and down-stream effects of disparities and the need to implement interventions and accentuate the positive outcomes of Māori health development. But it is not a matter of either/or. Disparity analyses and informed interventions are complementary strategies. bell hooks notes, there is a need to stop speaking the language of victimhood, while at the same time addressing actual victimisation<sup>20</sup>.

### Myth 5

"The differences among Māori are more important than those between Māori and non-Māori"

Intra-population analyses will provide interesting information however there are two potential weaknesses. Firstly the debate will shift from within a Treaty framework into an arena where Māori become one of a number of competing minority groups. In this space Māori treaty rights are difficult to access and our tangata whenua status is neutralised. Measurement of and commentary on Māori and non-Māori disparities locates the discourse within a Treaty of Waitangi framework. It is within this location that Māori voice has constitutional depth and direct recourse with the Crown.

Secondly, intra-population analyses place the frame of enquiry around Māori and therefore fail to ask questions of society and systems. In this way major issues such as institutional racism may be overlooked and interventions will address superficial symptoms rather than underlying causes.

The previous analyses by deprivation demonstrate that the societal forces that drive the distribution gap affect the entire Māori ethnic group in a similar manner. Sole Māori and mixed Māori are affected by the distribution gap in a fashion more similar to each other than to non-Māori.

While these are just a few of the numerous myths blurring the disparity debate, they highlight the main tensions. Debunking these myths is central to locating disparities within Māori health development.

### Future issues

Analyses that foreground disparities have been portrayed as oppositional or secondary to Māori health development<sup>21</sup>. In such frameworks where a disparity focus intersects with a development focus, the impression is given that the two are



interconnected but move past each other in different directions.

Our analysis promotes the disparities focus and the development focus as parallel reinforcing variables, each informing the other. For example, in a health promotion model, health development is hindered by inequities. The same relationship exists between ethnic disparities and Māori health development. The elimination of disparities will not signal the end of Māori health development, it will not even signal the beginning of the end. However, it is likely to be an important signal of the end of the beginning of Māori health development.

The purpose of monitoring disparities is to intervene appropriately and eliminate inequity. This begs the question of how to intervene. New Zealand, as with many other countries, has an underlying "universal" approach to service provision (ie. directed to everybody irrespective of their income, wealth, socio-economic status or ethnicity). In addition there are 'targeted' or 'special provision' services<sup>22</sup>.

The proponents of universalism note that these policies are more politically sustainable than policies targeted on class or ethnic categories<sup>23</sup>. However, the assumption that the 'same service to all' irrespective of needs, means 'equal service to all' has been challenged. Atkin<sup>24</sup> argues that this ideology assumes everyone has equal access to services and ignores the obstacles faced by ethnic groups (such as Māori) in accessing services. The adoption of a universal approach to service provision both legitimates the non-recognition of ethnic disparities and privileges Pākehā. In doing so it provides evidence of institutional racism (differential access to the goods, services, and opportunities of society by race<sup>25</sup>).

Firstly it ignores structural barriers to service receipt. Secondly, the existence and importance of the culture and inherent values within systems such as health are disregarded. And thirdly, attempts to engage with ethnic groups are usually preoccupied with cultural needs that provide decorative rather than functional value. Services based on policies informed by a cultural deficit model are developed and when these services fail to change outcomes, the service blames the client group rather than the relevance of the service being provided. In this way ethnic group stereotypes and myths are perpetuated.

Special provision or 'targeted services' are usually the next level of system response<sup>26</sup>. Unfortunately this is often a euphemism for tenuous, inadequately funded provision that absolves other services of their responsibility to ensure service receipt by ethnic groups with health disparities.

The design and provision of services that have as their starting point, Māori needs and a Māori reality has begun. Often called "by Māori, for Māori", this label may misrepresent

these services as exclusive to Māori. However, if they have the capacity to be so, these services are inclusive and provide to all those seeking help. These services offer hope and opportunity for Māori but risk the vulnerability of special provision services (eg. cuts in government expenditure). Furthermore they may delay the imperative of addressing the societal drivers that perpetuate disparities. This tension to engage in remedial reform is an important dilemma in Māori health development.

The alternative, and necessary option is to address those societal factors, especially racism, that drive not only ethnic disparities but also non-Māori complacency and inaction in the face of these disparities. This silence validates the inhumanity represented by disparities. It is a form of extremism that discredits all New Zealanders in the eyes of future generations.

## Acknowledgements

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## HEKUPU HOU

he turi

*deaf*

he taringa maro

*glue ear*

he takirikiri

*neuralgia*