TRADE OFFS AND SOLUTIONS:
Investigating Survival Strategies and Decision-making to Mediate the Effects of Poverty in Whānau

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ABSTRACT

Aim: The aims of this project were to understand the experiences of whānau Māori living in poverty in New Zealand, and to evaluate the implications for health care practice in a primary care setting. Poverty has a major effect on the determinants of inequities in health outcomes for Māori. These negative outcomes can have detrimental ongoing inter-generational effects that are important to understand. Although there have been past studies that have given voice to the narratives of New Zealanders living in poverty, there are few, if any, that give voice specifically to young adult Māori and their whānau living in poverty. We aimed to expose the realities of poverty for this group, and identify the decisions and survival strategies they may use to mediate the effects of poverty. Additionally, we aimed to identify General Practitioners' perceptions of and knowledge about young Māori living in poverty.

Method: The project had two components: 1) an online survey of GPs, conducted through Qualtrics and analysed using SPSS and 2) interviews with young Māori and their whānau who identify as living in poverty. These interviews were transcribed and underwent thematic analysis.

Findings: We analysed responses from 114 GPs and 14 interviewees. Key themes that emerged in the interviews with young Māori and their whānau living in poverty and the perceptions of GPs were found to be the impacts of poverty, barriers to moving out of poverty, and the resilience strategies used to help mediate poverty's effects. Many of these inter-related and showed a realistic view of living in poverty. They were able to be formatted into a framework based on the Meihana Model of clinical assessment that summarises these as the determinants and mediators of poverty, and would allow a specific Māori measurement of poverty and possible intervention targets.

Conclusion: Our findings have added to the research on Māori living in poverty and the real issues they face. This research has highlighted the need for Māori specific measurement of and intervention to address poverty, to reduce inequity in New Zealand. Current efforts, policy and welfare strategies are not working to decrease inequity in New Zealand, despite a recognised need for this in accordance with the Treaty of Waitangi and the UN Declaration of Indigenous People. Our findings also warrant further research into Māori poverty, particularly compared to non-Māori, and can be used as a global case study into indigenous inequity in health and wellbeing.

<u>INTRODUCTION</u>

Evidence of Māori poverty in Aotearoa

New Zealand definitions of poverty assert that a family is living in poverty if their income after housing costs is less than 60% of the national median (1). Using this definition, one third of all Māori children were living in impoverished families in 2013 (1), more than double the proportion of Non-Māori children. Children growing up in poverty have two to three times worse health outcomes compared with children not in poverty, such as higher rates of infection and trauma (1). The difficult childhood that many Māori children experience sets up a vicious cycle of economic hardship that traverses generations with features of Māori poverty inclusive of: disproportionate representation in the most deprived areas of New Zealand (2) since 2006 (3); being more likely to live in overcrowded housing (1) and experience of associated poorer health outcomes; being more likely to be on working age benefit than non-Māori (4); being twice as likely to drop out of school before age 16 or leave school without an NCEA qualification (5); being overrepresented in poorly paid and insecure jobs (5) and tendency to be most affected by economic recession (1), and finally, Māori are over-represented among those dependent on food aid - For example, The Family 100 Project found that 40% of the regular users of Auckland City Mission Food-banks were Māori. Māori also experience health inequities at the primary care level, associated with lower rates of GP visits than non-Māori, poorer rapport with the doctor, shorter consultation times and less frequently referred to specialist services. These disparities have a role in the gap between the life expectancy of Māori and non-Māori (6, 7).

The New Zealand and other international definitions of poverty such as those provided by the WHO (8) and UN (9), tend to be focused on the economic hardship of the people in question and presumed material deprivation without assessing their actual quality of life or social inclusion. For Māori and many other indigenous peoples (10), these definitions fail to capture the social and cultural dimensions that they value as part of their personal wealth (9-11). For instance, many whānau Māori living in relative income poverty do not self identify as poor due to their cultural connections and whānau ngatanga (familial connections) (11).
Having established that Māori are more likely to suffer the burden of poverty in Aotearoa, we now consider the consequences that poverty has on whānau .

Impacts of poverty

Poverty has a wide range of impacts on people's lives. One of the major impacts of poverty is on the health of those affected; those with lower Socioeconomic Status (SES) generally have poorer health outcomes (12). Area deprivation is consistently associated with increased odds of reporting poor health, and more than 50% of Māori live in areas considered to be among the most deprived in the country (13). These poorer health outcomes encompass preventable physical health conditions, long term management of health conditions, self-medication and mental health (14). For those living in poverty, money to see a health professional is a luxury they often cannot afford. Cost is the most frequently reported reason for not taking children to the GP, and 76% of Māori stated it as a concern, compared with 45% of non-Māori (15). This leads to preventable health conditions going undiagnosed and untreated (12), for example asthma and eczema in children (16). It also means that those living with chronic conditions do not get the follow up care they might need

(14). There is also the issue of self-medication, and sharing of medications between people who cannot afford to go to the doctor or fill their prescriptions themselves (14).

There are higher rates of mental health conditions, including anxiety, social anxiety, and PTSD in those living in poverty (14). Stress and the psychological effects of living in deprived neighbourhoods are linked with feelings of decreased control over one's life (12). Psychological stress has been found to influence suicide, depression and dementia (12). It has also been found that interactions with services such as WINZ that require people to repeatedly tell their stories of despair, and 'prove' how poor and desperate they are, leaves people with a constant sense of feeling judged and humiliated, leading to feelings of low self-worth and disempowerment (16).

Another impact of poverty is poor housing conditions. Rates of house crowding are four times higher for Māori than non-Māori (17). Cold, damp, mouldy houses in disrepair are a reality for many NZ Māori, contributing to feelings of shame, low self-worth, stress and poorer health outcomes (16). Ideal homes were described as being warm, safe, secure and big enough for the family, yet for many people living in poverty this is not an achievable goal, leaving them without a place of sanctuary. Again this takes its toll in the form of worry, anxiety, shame and embarrassment (16).

Food scarcity is an evident impact of poverty (16). After having to strictly prioritise paying rent and other bills first, little money is left to cover the groceries (16). Participants in the 100 Families study described only eating one or two meals a day for themselves and feeding their children first. Many also admitted to sometimes keeping their children home from school because they had no proper food to send in their lunchboxes (16). Participants described feeling guilty, sad, depressed and ashamed due to their lack of food and inability to provide for their families (16).

Poverty has an impact on educational achievement - a large amount of educational achievement disparity can be explained by disparities in socioeconomic status during childhood. Māori are less likely to attend an early childhood education facility before entering primary school, are far less likely to leave school with upper-secondary-school qualifications, and are also less likely to possess formal or tertiary-level qualifications when compared to other New Zealanders. Education contributes greatly to improvement of income levels, standards of living and psychosocial outcomes (18) such as anxiety and depression.

It is clear that poverty impacts whānau in nearly every aspect of life, namely poor nutrition, poor quality and safety of housing, poor physical and mental health, and poor opportunities for education. These impacts have a cumulative effect which results in higher rates of chronic diseases, shorter life expectancies and profound limitation on future aspirations. To establish the types of support that whānau may need to exit poverty, we must consider what types of obstacles need to be addressed.

Barriers to mobilising out of poverty

Numerous barriers exist that impact Māori in their ability to mobilise out of poverty. The most prominent of these barriers are unemployment, social exclusion, growing up in a low income family which is associated with racism, discrimination, stigma and lack of education, young motherhood, structural violence in service agencies and high interest fringe lenders such as loan sharks.

Employment is a key tool in making this transition, and although many Māori recognise this and have a genuine desire to be engaged in paid work, the realities and struggles of their daily lives can mean that accessing employment is not feasible in the immediate future (19). The Family 100 Project (19) found that some of these obstacles included ageism, racism and lack of confidence due to appearance, specifically issues such as having no teeth or visible tattoos, difficulty accessing reliable transport or adequate childcare, persistent health issues, and prior criminal convictions. Some participants felt like they were already working, either because they were a full-time parent, or they were working in unpaid jobs such as looking after other children for family and friends, or volunteering in their communities. Some also lacked skills and education, never worked in formal paid employment, or had completed multiple courses that increased their debt but never led to paid work.

Social exclusion is also a reality many Māori in poverty face. According to *Boon et al* (20), the two main aspects which impede mobility out of poverty are the lack of whānau due to the fragmentation of traditional whānau structure, and the lack of social and cultural participation. The fragmentation of traditional whānau structure leads to decreased support networks. This is important especially in the context of childcare. Kaumātua no longer live nearby and therefore are unable to assist while the parents go to work, and involving neighbours or friends comes with the burden of reciprocity pressure. This makes it more difficult for parents to seek further education or employment sufficient to live comfortably and move out of poverty. Lack of social participation in useful social networks can also have negative impacts on Māori living in poverty. Using sports teams as an example, sporting communities provide opportunities for young people to develop confidence and engage in helpful social networks, as well as encourage maintenance of good physical health. However, young people may be excluded from such opportunities due to lack of financial resources or whānau responsibilities, such as having to look after younger siblings while their parents are at work.

A study on African Americans (21), another disadvantaged ethnic group, has also reported other barriers to mobility out of poverty. These included growing up in a low income family, where less resources are available, and racism and discrimination. Stigma was another important barrier where poor societal messages about poverty led to low self-esteem and low expectations for the future. Lack of education can be contributed to, by parents having less resources for schooling, having less flexible work schedules to support their children into schooling, and marginalisation of poor parents by teachers.

Young motherhood is another important barrier, with high rates of pregnancy in Māori women aged younger than 20 years (22). This can adversely affect educational attainment, often resulting in long-term benefit dependency and poverty. (22)

Although numerous service agencies, including WINZ and food banks, are available to provide support and aid in daily costs, they can also be a barrier to getting out of poverty. Some Māori feel these agencies have been intrusive and/or obstructive in the past. A lot of time and energy is spent complying with paperwork, gathering evidence, finding help, waiting to be served and travelling on public transport. Māori are also less likely to receive benefits such as the disability allowance, which helps with costs involved with doctors, hospital entitlements, medicines, extra clothing and special food or travel (22). It is estimated that Māori children miss out on at least $5.8 million of potential assistance per annum (22). The obstructive nature of these agencies and the copious amount of time and effort required

to get benefits and assistance from these agencies is a potential barrier to obtaining much needed support for moving out of poverty (19).

High interest, unregulated fringe lenders may be seen as an easier, friendlier, more hassle-free solution than dealing with government and non-profit agencies, to get money quickly (19) There has been rapid growth in the fringe lender market in New Zealand over the past two decades, which is in part due to unmet financial needs of low-income consumers (23). Consequences of borrowing from fringe lenders can be costly and can generate or prolong financial hardship for low-income consumers (23). However for Māori in poverty, the immediate need for money can seem to generally outweigh the disadvantages of high interest rates, fees and ever-growing debt (19). People may also resort to fringe lenders after being excluded from mainstream financial services (23).

There are numerous hurdles that prevent whānau from escaping poverty and the identified impacts, particularly various sources of discrimination and lack of support. To survive in poverty, whānau are forced to make compromises on their quality of life, and often face an upward battle everyday in attempt to meet their basic needs. Next we examine some of these compromises and strategies used by struggling whānau to cope with the pressures of poverty in Aotearoa.

Strategies used in coping with poverty: priority trade-offs

In The Family 100 Project, whānau in poverty were living day to day and the trade offs made to deal with immediate confronting problems, such as seeking basic needs, often accumulated and became even larger problems in the future. The most prominent of these problems were the impacts on health and accumulating debt.

Despite benefits and family tax credits, there are whānau who do not have sufficient income for food, housing, electricity bills, phone bills, and household necessities such as clothing and furniture (24). Many families who have approached WINZ for support have been frustrated and demeaned by the institutional framework, which subjects vulnerable people to time-consuming routines, power imbalance, and judgemental attitudes (25). Within these systems, there is common misconception that unemployed or struggling members of society who seek government support are undeserving and have a shameless, willing dependence on actively employed taxpayers (25). With limited access to official support, participants in the Family 100 study relied on food banks, neighbours, friends, churches and marae, which sometimes came with pressure to reciprocate (24). Some reported gardening, fishing, selling household items, borrowing from others, and even prostitution and theft as means to get by (24). Struggling families often became desperate, and took out loans from high interest lenders, who were seen as a fast, easy and friendly way to get on top of things (24) so that they could feed their children and stop their power from getting disconnected. The immediate pressure to make ends meet and fulfil basic needs outweighed the disadvantages of high interest and mountains of debt in the future. Many participants in the study were faced with court action due to such loans (24).

When there was not enough money for food, families in the Family 100 Project were dependent on food banks. Some foraged for free food, took expired food from behind supermarkets in the middle of the night, or went hungry (24). Some reported that they smoked cigarettes or went to bed early to cope with the hunger (24). Others would grow their own food, fish, or borrow food from others (24). These strategies could pose a health

risk because the food obtained may be unsafe, for example expired food may have unacceptable levels of bacteria. Furthermore, it is degrading to resort to sneaking food from dumpsters behind supermarkets or having to ask others to borrow food. Because people in poverty have insecure food sources and are going hungry, they will have lower energy levels to access support services, health, education, and employment.

With scarce income, choices for housing are poor. Poor quality housing is inefficient to heat, has inadequate ventilation and is prone to dampness and mould. These factors increase the risk of airborne infectious diseases, asthma and allergies (26). Families in poor housing struggle to stay warm, as they simply cannot afford massive electricity bills to run a heating appliance. Some strategies that participants in the Family 100 Project employed in an attempt to keep their whānau warm included crowding the entire family into one room for sleeping, putting blankets over windows to stop draughts, and going to bed early to stay warm (24). The pressures of keeping power bills down drove families to take cold showers and sit in the dark rather than turn the lights on (24). Some families reported using household bleach to remove mould from the house, wiping down walls and windows every morning to remove condensation, and buying or borrowing cats to control vermin (24).

While whānau are hungry and cold, it is impossible to expect job seeking, study, or future planning to be of high priority, as the most pressing issues is getting from one day to the next. This prevents people from mobilising out of poverty. In the context of Māori youth facing poverty, it is imperative to examine not only the barriers and priority trade offs made, but also the processes of historical trauma that have entrapped these people in cycles of intergenerational poverty, and some strategies for resilience that support and empower young Māori in moving out of poverty.

Strategies for resilience: tools for shifting away from poverty

The concept of historical trauma experienced by Māori in Aotearoa encompasses the downstream effect of loss of lives and land during the colonial land wars, as well as the psychosocial domination through legislative assimilation of Māori language (Native Schools Act 1867) and restrictions on traditional Māori healing practices (Tohunga Suppression Act 1907), adoption of colonial cultural concepts and Christianity, and the fragmentation of Māori social structures (27). These processes have had massive detrimental impact over many generations of Māori, manifesting as depression, self-destructive behaviour, suicidal thoughts, anxiety, low self-esteem, anger and difficulties with recognising and expressing emotion (27). These manifestations of historical trauma could contribute to the higher incidence of young Māori struggling with poverty in today's context.

It has been recognised that tools for upward social mobility from lower to middle class include academic achievement, attainment of education, employment, economic independence and home ownership (28). There has been suggestion that a strategy for upward social mobility is for ethnic groups to maintain their cultural identity for spiritual and social fulfilment, whilst embracing parts of western culture for economic opportunity. Therefore, in order to discover strategies to support Māori in moving out of poverty, specific and effective methods of healing for Māori must be identified so that they may be resilient in challenging the intergenerational impacts of colonisation, including historical trauma, with which they are burdened, and to overcome the associated impacts that present as barriers from exiting poverty.

A Māori-specific approach to healing could be viewed using Mason Durie's Te Whare Tapa Whā model, which focuses on the connections between whānau (social), Wairua (spiritual), Hinengaro (psychological), and Tinana (physical) realms that contribute to well-being as a whole (29). In this context, spiritual and social factors are important tools for healing, and are essential in the restoration of psychological and physical well-being, which have been identified earlier in this report, to suffer as a result of poverty.

The historical adoption of colonial social structures has led to fragmentation of whānau Māori structures. Re-establishment of traditional whānau methods, such as the nurturing intergenerational, extended family child-rearing environment will help to restore the collective social structure of whānau and support well being of individuals as outlined in Whare Tapa Whā. The Whenua project, which discusses the cultural well being of Kai Tahu whānau , revealed that the vast majority of participants considered connection with whānau (82.5%) and whenua (76.3%) as a source of well being that was separate from economic well-being (30). Such connections have potential to contribute to cultural identity and enhance sense of belonging, which empowers individuals to understand themselves and their values (30). This means that facilitating the re-establishment of traditional whānau structures is likely a key step for young Māori navigating away from poverty.

Spirituality, or Wairua is another realm within which Māori youth in poverty could seek healing and support. Māori spiritual healing methods include waiata, mōteatea (lament), haka, whakanoa, and whakawhānau ngatanga (27), which are all means of expression and connectivity. Waiata is an expression of emotion and a traditional part of the healing process for emotional distress in Māori (27).

The concepts of both whānau and wairua have strong links to whakapapa and Te Ao Māori. Kōrero whakapapa embraces Te Reo Māori in connection with whānau , whenua and atua, and is often communicated as traditional narratives (27), which have potential to support healing from aspects of historical trauma as they provide an accessible pathway for young Māori to connect with their whakapapa and culture. The narratives also reiterate Māori views such as the value of intimate partner relationships, children as the carriers of future, examples of how emotion should be managed and expressed, and how healthy relationships should be developed (27).

As discussed, Māori youth who connect with traditional knowledge and tikanga have more strength and support for healing, and consequently a more effective tool for breaking down barriers of poverty and building up protection from poverty. While Māori culture can be seen as a social and spiritual healing tool for Māori, and has potential to support the improvement of psychological and physical health in accordance with Te Whare Tapa Whā (29), we must also consider the ways in which our health system can support Māori into health and confront the current health inequalities. We approach this in the context of health practitioners in general practice.

Māori and health practitioners

Health practitioners' attitudes and approaches to Māori and those in poverty are an important aspect of this literature review. Crengle et al. (31) found that in general, Māori patients present to their GP at a lower rate than the general population. Māori are more likely to experience poverty than non-Māori, perhaps this could contribute to less primary care appointments. Disparities have also been identified in several other New Zealand

studies (32-36). Crengle et al. (31) also found that doctors reported lower levels of rapport, tended to refer less and spent less time with Māori compared to non-Māori patients. Literature has shown that communication skills of the provider has the greatest impact on patient satisfaction and effectiveness of primary health care (37). Jansen and Smith (38) suggested that, "Primary care providers, like other health professionals, may unwittingly provide less care to those with the greatest health needs because of a lack of cultural or social concordance". Jansen and Smith (38) suggested solutions to combat this problem would involve a variety of approaches including cost, communication skills and attitudes of GPs, health service funding and government policies.

There is copious evidence that there are inequalities in Māori health outcomes. Regarding the health system itself, institutional racism plays a part in this. Institutional racism or structural discrimination is "when an entire network of rules and practices disadvantages less empowered groups while serving at the same time to advantage the dominant group" (40). Structural discrimination can occur subconsciously and can include "normal" everyday practices that are simply "part of the system" (40). Such discrimination not only occurs in the health system but encloses a variety of systems including education, employment and housing which all in turn have effects on individual's health.

He Ritenga Whakaaro was a study that explored Māori experiences of health services (41). The study found that overall, Māori were reasonably satisfied in their encounters with health services. The report showed that 78-89% of respondents found their health practitioner had spent enough time listening to them. Respondents also reported that their service provider had, generally, given them enough privacy (73-98%) and had treated them with respect (82-93%). This study did not include non-Māori so it is difficult to make solid conclusions based on this data. A study by Jansen et al. has found that compared to non-Māori, Māori were more likely to be turned away for urgent appointments but found no difference in actual GP services (42). This led Jansen et al. to suggest that perhaps these differences could reflect office staff, rather than GPs, lowering access to primary care. Their suggested explanation for this was that Māori have a cultural tendency to "*noho whakaiti*" – not make a big deal over things and may not appear very worried or upset when asking for an urgent appointment (40). Buetow et al (43) found that some Māori and Pacific peoples avoid going to their GP due to fear of embarrassment, wasting GP time, causing offence, receiving offence and loss of privacy. Other reasons why Māori tend to present less or later with more serious conditions could be due to health care not being a priority due to other roles in the whānau or community.

Views and opinions of the health practitioners' themselves is an important perspective to help us see the "bigger picture". A study by Russel et al.(45) involved interviewing PHOs and other individuals in primary health care. The major point that was brought up was the funding of PHOs and aims to keep co-payments down. The study found that this was achieved depending on the core values of the practices; some aim to maximise profit while others try keep fees low. Māori-led PHOs were fairly consistent on their focus on reducing fees. Another finding was that many practices expressed that some were "running at a loss" to keep payments down. Other practices commented that subsidizing didn't appear to make much of a difference as economically disadvantaged whānau didn't pay for appointments anyway. Most PHOs said they worked with whānau and encouraged them to pay small, regular amounts for their appointment debt. No PHO refused whānau based on

increasing debt. Another recurring theme throughout the interviews was that poverty was cited as the main reason for whānau debt and whānau poorer health. A study by Crengle et al. found that many Māori health practitioners or Māori-centred health services collect information regarding Māori against a long list of indicators (44). However, information and conclusions gathered from such information is not fed back into these primary health care organisations to help in Māori health-care planning and decision making (44-46). This feedback from primary health care providers appears likely to be a useful tool to help evaluate ways to fight poverty and its effects on health, particularly in Māori.

It remains that despite the efforts and good intentions of many health practitioners and health organisations, the poverty-associated health inequities experienced by Māori prevail. In order to address this, it would be most effective to take a "top down" approach, beginning with Māori-focused government policies and initiatives, such as whānau Ora which is a Māori-focused programme implemented by the Ministry of Health and the Ministry of Social Development, rather than at the level of individual providers, and this should pertain to the commitment to Māori well-being as outlined in the Treaty of Waitangi.

Treaty of Waitangi - Te Tiriti o Waitangi

Although the Treaty of Waitangi was signed in 1840, it is still significant and relevant to the inequities that exist between Māori and non-Māori today. Both the Māori and English versions of the Treaty consist of three articles, however due to translation issues they differ significantly in their meaning, interpretation, and therefore application (47). Both versions of the Treaty are legitimate as both were signed, and so both versions may be considered as New Zealand's founding document. However, despite the protection offered by the Treaty, it was ignored and disregarded for many years, and many rights guaranteed to Māori were violated (47).

The preamble of the Treaty of Waitangi states that the purpose of the treaty is to secure "peace and good order" among the indigenous peoples of New Zealand with the large numbers of immigrants from Europe and Australia. The Māori text emphasises negotiation with the various chiefs and the Queen's concern for the chiefs to retain their power, while the English text states that the Queen wishes to exert her sovereign authority over "the whole or any part of those islands", superseding the authority of the chiefs (48).

The first article refers to sovereignty in the English version, or kawanatanga (governance) in the Māori version (47). The English version implied a complete transference of power from the Māori to the British Crown (47). By contrast the Māori version implies the sharing of power: that they would cede governance of their lands to the Crown but are still entitled to manage their own affairs (47, 48). The assertion of sovereignty by the Crown, over Māori, created a fiduciary duty to protect and "avert the evil consequences" arising from the absence of law. However, the rising tensions between Pākehā and Māori over land ownership eventually lead to the Land Wars (49) which resulted in alienation and marginalisation of the Māori people along with confiscation of much of their land. This is only one example of how good governance was not upheld, resulting in dramatic and ongoing impact.

The second article refers to Tino rangatiratanga (chieftainship) (47). In the English version this mainly relates to the rights of Māori to maintain control over their lands, forests, fisheries and other taonga (treasures) (47). However the Māori version promised much

broader rights and implied the possession and protection of cultural and social items such as languages and villages (47). Māori ultimately believed that although the Queen would hold power of governorship, Māori would maintain their sovereignty as chiefs, and control over tribal matters would remain unchallenged (47). However, only the English version was enforced. As such, over the years Māori have struggled to maintain their autonomy and self-determination, on account of governmental policies and restrictions, which has lead to disempowerment, poorer outcomes for Māori communities, and is in breach of the Treaty agreement between Māori and the Crown. Some established Māori initiatives that attempt to restore self determination in New Zealand include whānau Ora, which uses Māori social structure models to implement future planning and coordination of services that address the needs of whānau with aim to improve education, health and economic well being of Māori. However, much is yet to be done to restore Tino rangatiratanga and honour the agreements made in the Treaty of Waitangi.

The third article of the Treaty of Waitangi promises Māori the same rights and treatment (tikanga) as all British subjects (47). This article stresses individual rights and guarantees equity between Māori and non-Māori. This article is considered the most fairly translated of the three and there is little disparity in the meaning of the English and Māori versions (50). However, it is evident that these promises have not yet been fulfilled considering the persisting socioeconomic and health disparities between Māori and non-Māori. The reason why these disparities not only remain but are growing, is asserted as attributable to the New Zealand Government, who often refuse to acknowledge and honour the treaty as a contemporary agreement (51), and the attitudes of the voting public, who are influenced by media framing of any treaty-related plans to address disparities as unfair Māori privilege or as erosion of non-Māori rights (51). These attitudes propagate institutional and interpersonal racism toward Māori in Aotearoa and add to the tendency of Government systems to disregard the agreements within the Treaty. This portrays to Māori that their needs are not important and thus generates internalised racism and marginalisation of Māori in education and health care systems, resulting in poorer health outcomes, lower rates of economic success for Māori, and exclusion from successful participation in society in general. The accumulation of these effects ultimately navigates away from equality in Aotearoa, and is in breach of the Treaty.

Because much of the confusion and doubt around whether the treaty is relevant in contemporary New Zealand is based around the translational differences between the English and Māori versions, the articles have been translated into three interrelated principles that make the treaty agreements more transferrable to modern policy making. The principles are Partnership, Participation, and Protection. The principle of Partnership refers to the collaboration of Māori iwi leaders and the New Zealand Government in the design of, and decision-making in, legislation, policies, and strategies. The Participation principle is most relevant to Māori self-determination, or Tino rangatiratanga, and ensuring that Māori are involved in the planning and delivery of services directed towards Māori people, which could include control of fund allocation to Māori health initiatives. Protection is the final principle, and it is applied to ensure equity between Māori and non-Māori, as well as to protect Māori culture, values and practices. There has been inconsistent contemporary application of the three Treaty articles and the three principles in the history of New Zealand, with the first item of legislation to include reference to the Treaty of Waitangi being the the Public Health and Disability Act 2000 (51).

Despite extensive discussion around the agreements made in the Treaty of Waitangi and the conversion of the treaty articles into principles in an attempt to encourage contemporary application of these agreements, Māori are still denied fair opportunity to have say or control in Māori affairs and are still subjected to inequities, and excluded from the state of health enjoyed by non-Māori in New Zealand. This is blatant breach of not only the treaty agreements, but also basic human rights as defined by the United Nations (UN), which has declared that *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control"* (UN: Universal Declaration of Human Rights. Article 25:1) (52).

Further, the unfair treatment of Indigenous populations around the world, and disregard of treaty agreement has been recognised and addressed specifically by the UN through the Declaration on the Rights of Indigenous Peoples (UNDRIP), which supports the protection of participation and self-determination of indigenous peoples (53). However, even though the UNDRIP states that *"native peoples have the right to recognition, observance and enforcement of treaties"* it is actually described by the UN as a non-binding text (54), and therefore acts more as an aspirational document than a binding contract (54). With New Zealand being one of the four countries to initially vote against this declaration, which was overwhelmingly accepted by other countries with an initial voting result of 143-4, and the government resistance to incorporation of the treaty into standard policy making, along with the media framing of strategies for equity as Māori privilege and discard of non-Māori rights, it is little wonder that Māori are still suffering in this country. There is institutional racism that prevents changes at the government level, and until there is observation of the local and international agreements made between the crown and Māori, it is likely that our Māori youth will remain in poverty.

Literature review conclusions and research rationale

This review of existing literature relevant to young Māori in poverty has four dominating themes. Firstly, Māori are over-represented in groups facing economic hardship and this predisposes them to disparities that often pose as direct or indirect obstacles to mobilizing out of poverty. Secondly, it was clear that people in poverty were forced to strategize and compromise their prioritization of needs in order to survive; however, it was more difficult to determine what tools and strategies whānau had or needed in order to cope with life in poverty. Cultural reconnection is likely to be one important mechanism. Thirdly, Māori in poverty are less likely to present to primary practice due to lower financial prioritization of health care, structural discrimination and inadequate cultural competence of some health practitioners. Fourth and finally, the clear lack of equity between Māori and non-Māori in New Zealand undermines the conditions outlined not only in the Treaty of Waitangi, but is also in breach of the UN Declaration of Human Rights and the UN Declaration on the Rights of Indigenous Peoples.

The aims of this project were to further understand the experiences of young whānau Māori living in poverty in Aotearoa, and to evaluate the implications for health care practice in a primary care setting. Though there have been previous studies that have given voice to

New Zealanders living in poverty, namely the Family 100 study, this project qualifies the experiences of young whānau Māori specifically. This project also explored the views of general practitioners in primary healthcare to obtain insight into their perceptions and knowledge about young whānau Māori living in poverty. In keeping with the themes that emerged in the review of the current literature, this project places emphasis on the impacts and consequences of poverty, barriers that entrap people in poverty, and strategies that are used to cope with poverty. In the discussion of our findings, we consider how these relate to the Treaty of Waitangi and Government policies, as well as some potential solutions to support young whānau Māori mobilising out of poverty.

Ethics

A number of ethical issues were raised by our project. During the research into census statistics around Māori and poverty, we noted that there is a significant number of non-Māori in poverty (60% of all those in poverty are non-Māori) (5) which surprised a few of the members of our group considering most of our teaching is on the plight of whānau in poverty. Some may argue that there is a problem of injustice in this project due to the fact that we are focusing on a smaller subset of those in poverty and excluding others based on ethnicity. Several concepts of public health ethics were highlighted including equity, utilitarianism, power/powerlessness, human rights, and communitarianism.

The concept of equity was highlighted by our project as there is a clear lack of equity between Māori and non-Māori in New Zealand, as seen by the persisting socioeconomic and health disparities. This not only undermines the conditions outlined in the Treaty of Waitangi, but is also in breach of the UN Declaration of Human Rights and the UN Declaration on the Rights of Indigenous Peoples. The third article of the Treaty promises Māori the same rights and treatment as all British subjects.(47) It stresses individual rights and guarantees equity between Māori and non-Māori. As the Treaty is considered to be New Zealand's founding document, and both the Māori and English versions were signed, it can be argued that the government has a moral responsibility to uphold the promises and rights guaranteed to Māori. However, there has been government resistance to incorporation of the Treaty into standard policy making. This also brings up the concept of equity versus equality. Both are strategies which can be implemented to produce fairness. Equity involves giving everyone what they need to be successful and equality involves treating everyone the same. However, equality can only work if everyone starts from the same place and needs the same help. Some of the media in New Zealand has framed strategies for equity as Māori privilege. However, the opposing prioritarianism argument, is that more priority should be given to Māori as they have been historically disadvantaged.

The concept of utilitarianism was also highlighted. Māori make up 15% of the New Zealand population and 40% of the families who live in poverty (5). From a purely utilitarian point of view, it could be argued that a population wide initiative would benefit a greater number of people than a Māori focused initiative. However, there is always the concept of equity and ethnic equality (along with the Treaty of Waitangi) (47) to consider before taking a utilitarian approach.

The concept of power/powerlessness is also relevant. Since Māori are significantly overrepresented in quintile 5 and other such measures of economic disadvantage (2), it can

be inferred that they have less resources to be able to correct inequities in the system and influence policy change.

In regards to human rights, it can be argued that it is a human right to have access to what many would consider basic resources such as good housing, educational opportunities, adequate nutrition, and access to healthcare. Using this argument, those living in poverty in New Zealand (the majority of which are Māori) do not have basic human rights. This brings into question what resources qualify as a human right and whether these rights are intrinsic or socially constructed.

Finally, the concept of communitarianism is raised. For Māori whānau, it is important to empower the group and the surrounding community in order to improve their livelihoods. Policies reaching out to Māori should be tailored towards whānau (such as the Whānau Ora project) rather than towards individuals.

Definition of poverty

This project is about understanding poverty from the point of view of those affected by it. Therefore, by providing a definition for "poverty" before carrying out the research, we would be undermining one of our primary aims and our research process. Thus self-identification was used as the primary measure of poverty throughout this project.

Our literature review found, however, that there is in any event a lack of consensus in New Zealand regarding the definition of poverty. As this research was primarily focused on poverty, specifically young Māori in poverty, we originally considered an objective definition extremely important. However, it became clear that the lack of objective definition was an important aspect to the project, as it focused on the subjective experiences of young whānau Māori living in poverty. It also became clear when conducting and analysing the interviews that objective measures, such as those used by WINZ and the government in relation to education (tertiary and early childhood), mental health and other health service funding, were feeding into the current state of inequity between Māori and non-Māori. Some whānau Māori living in relative income poverty may not self-identify as poor, having an alternate perception of what "poverty" encompasses due to their wealth of cultural connections and whānau ngatanga. whānau Māori may therefore be more likely to forgo seeking the assistance of government funded and other social service agencies, perpetuating the current state of inequity in New Zealand. It is perhaps possible that using a system of self-identification when identifying Māori in poverty may mediate this inequity.

Our key informants all agreed that while a definition for poverty is important, a way to measure poverty is more valuable as it allows for targets for poverty reduction to be set. It is very important that any such measure is designed with partnership and participation from Māori, and promotes equity. We hope this project gives voice to Māori youth in poverty, and in doing so can help design a measure for poverty that is inclusive of Māori elements. Given we are focusing primarily on subjective experiences of living in poverty, the use of self-identification is entirely appropriate and no objective measure is required in the context of our project.

METHODS

There were two parts to the project:
1. Survey of General Practitioners
2. Interviews with young Māori and their whānau
3. Interviews with key informants

Survey of general practitioners

An online questionnaire was created aiming to investigate GPs' perceptions of the impact of poverty on whānau Māori, and to gather information on suggested solutions to the issue. Survey questions were developed by medical students to explore GPs' experiences and attitudes towards Māori patients living in poverty, to identify what could be done to better aid those living in poverty at primary health and government levels, and find out whether funding was adequate for GPs who served a high needs population.

Dr Hera Cook and Anaru Waa from the Department of Public Health assisted with the design of the survey. In addition, general practitioners Dr Ben Gray, Dr David Wilson, and Dr Jonathan Kennedy were consulted for their expert opinions and to pre-test the survey questions.

The online survey application, Qualtrics, was used to create a shareable link which was sent out via email to general practitioners. The communication and member manager of the NZ Rural GP Network (NZRGPN) aided in the distribution of the survey to 195 practices/ GPs nationwide. Responses were anonymous. The survey link was activated on September 28 2016, and closed on October 10 2016. An invitation email including the shareable link (see Appendix 2) was distributed to the following groups:

- General practitioners associated with the University of Otago Wellington Medical School (50 emails sent out)
- General practitioners associated with the University of Otago Dunedin Medical School (280 emails sent out)
- General practitioners associated with the University of Otago Christchurch Medical School (90 emails sent out)
- New Zealand Rural General Practice Network (195 emails sent out)

Quantitative data collected via Qualtrics was analysed using SPSS (Statistical Package for the Social Sciences) with the help of University of Otago statistician Dalice Sim. 114 responses from a total of 120 submitted surveys were analysed, 6 responses being removed from analysis as they were incomplete. Qualitative data was analysed by three medical students, who identified the main themes from questions 13, 14, and 15.

Interviews with young Māori

Participants were recruited through community networks known to the researchers and on the advice of the project supervisor Dr Keri Lawson-Te Aho. The poverty status of the participants was determined through self-identification of currently living in poverty, with this self-identification based on their perception of what poverty meant to them. This measure was decided upon due to the current lack of consensus surrounding guidelines for measuring poverty. Whilst not ideal, this project has highlighted the need for a definitive set of criteria to be identified to be considered. The purpose of the study was explained to the participants and their agreement to participate was achieved by verbal agreement (for non face-to-face interviews), or with the informed consent statement and signed informed consent for the face-to-face interviews.

Nine interviews were conducted by medical students with fourteen Māori between the ages of 18 and 35. These interviews ranged from single interviewees to a whānau group of five members. The content of the questions was informed by the literature review. The dialogue focussed on the experiences of young adult Māori and their whānau as they face poverty, the trade-offs they make to mediate their limited means, barriers preventing their moving out of poverty, and support strategies or resilience factors they employ in the face of poverty. The interviews were conducted either in the participants' homes via phone or Zoom (a video conferencing programme), for participants living long distance, either in Auckland or Dunedin, or face-to-face at the University of Otago Wellington campus, and were overseen by Dr Keri Lawson-Te Aho. They were recorded on mobile devices, and subsequently stored on password-protected computers. A koha, in the form of a supermarket voucher, was given to each participant following their participation.

Thematic analysis was undertaken by seven medical students to identify key themes across the interviews. Each interview was initially analysed by one researcher, who listened to the recording, identified themes, and transcribed pertinent quotes or passages relating to these. Every recording was then independently analysed by a second researcher who followed the same analytical process. The themes from all the interviews were then analysed together for patterns, commonalities and differences, and categorised into a framework of superordinate and subordinate themes.

Category B ethical approval for this project was granted by the University of Otago Human Ethics Committee.

RESULTS

SURVEY OF GENERAL PRACTIONERS

A total of 120 GPs submitted responses to the survey, of which 114 were used in analysis using SPSS software (Statistical Programme for the Social Sciences). 6 responses were excluded from analysis as they were incomplete.

Demographics of the general practitioners

Data was collected regarding the gender, age, and ethnicity of the GP. Of responses recorded in regards to gender 49.1% were male, 50% were female and 0.09% did not respond. The majority of GPs who responded to the survey were of NZ European ethnicity (62.3%), with lower numbers of NZ Māori (7 responses, i.e. 6.1%). 83.3% of the GPs surveyed were between 36 - 65 years of age.

Information about patient population and GP practice location

Responses were relatively well distributed between GPs working in rural practices and GPs working in suburban/inner city practices. 44.7% of responses were from rural GPs, compared to 55.3% from suburban/inner city GPs. Regarding patient population, GPs were asked to estimate the proportion of patients they see who identify as NZ Māori, and the proportion of patients they see who would be in quintile 5 (the most deprived group). 64% of GPs estimated that 0-15% of their patients are of Māori ethnicity. 20.2% estimated that 15-30% of their patients are of Māori ethnicity, and 15.8% estimated that over 30% of their patients are of Māori ethnicity. Regarding the proportion of patients in quintile 5 there were 13 missing responses. Most GPs (63.1%) estimated that 0-25% of their patients would be in quintile 5, 14.9% estimated that 25-50% of their patients would be in quintile 5, 10.5% estimated that more than 50% would be in quintile 5, and 11.4% did not respond to the question.

Funding and waiving fees

111 GPs responded to the question 'Do you ever waive your fees for patients in financial hardship?' 51.8% of GPs reported that they often waive fees for patients living in financial hardship (see Figure 1). 27.2% reported that their GP practice received the 'Very Low Cost Access Scheme' funding (VLCA) (see Figure 2). Of the GPs who reported that their practice received the VLCA funding, 58.1% reported that they often waive fees for patients living in financial hardship (see Figure 3).

Figure 1: Do you ever waive your fees for patients in financial hardship?
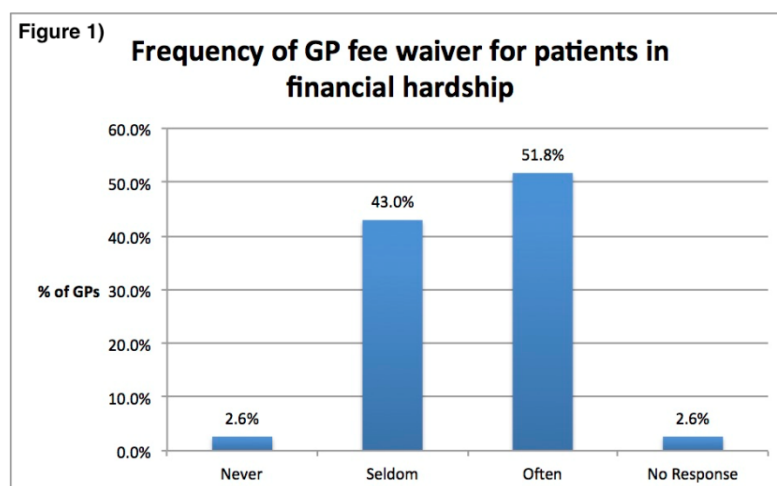
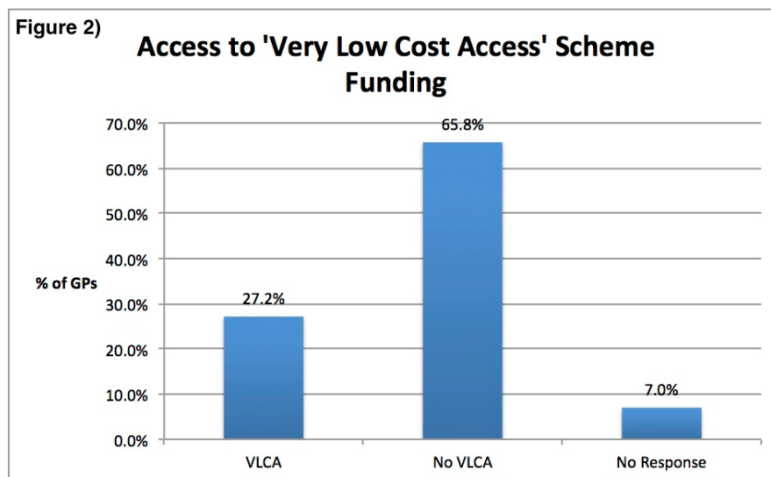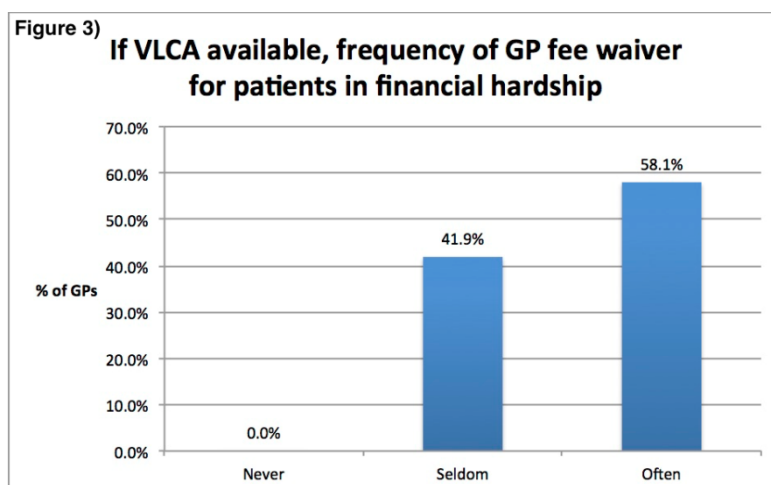Figure 2*: Does your GP practice receive the 'Very Low Cost Access Scheme' funding?*

Figure 3: *Proportion of GPs receiving VLCA funding who often waiver fees*

Cultural competency and GP training

The majority of GPs (59.7%) agreed or strongly agreed with the statement 'I believe I have adequate knowledge and understanding of Māori culture' (see Figure 4). 29.8% neither agreed nor disagreed with this statement, and 10.5% disagreed or strongly disagreed. Regarding the statement 'My GP training/experience has equipped me to help Māori patients' 54.3% of GPs either agreed or strongly agreed, 28.9% neither agreed nor disagreed, and 16.7% either disagreed or strongly disagreed. The statement

'My GP training/experience has equipped me to help patients living in poverty' showed a similar pattern of responses, with 49.1% either agreeing or strongly agreeing, 25.4% neither agreeing nor disagreeing, and 25.5% either disagreeing or strongly disagreeing.

Figure 4: *Please indicate how much you agree with each of the following statements listed below*
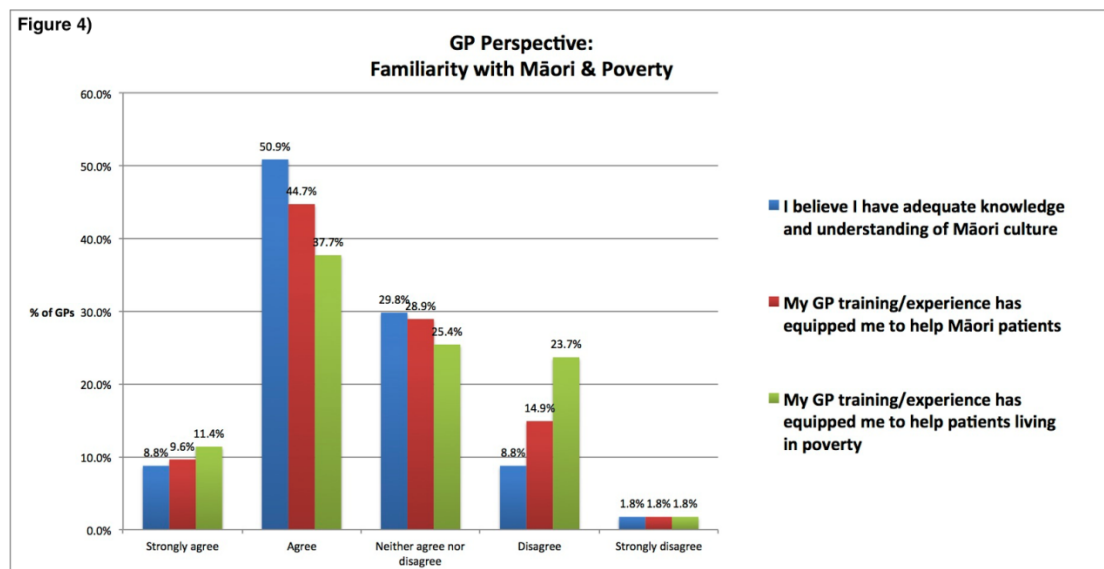
GP Perspective on what Is important for Māori living in poverty

GPs were asked to rate on a scale of 1 (least important) to 5 (most important) which factors they believe are most important for whānau Māori living in poverty (see Figure 5). Food, wellbeing of children, and happiness and hope were perceived to be most important, with 91.2% of GPs rating food at 4 or 5, 78.9% of GPs rating wellbeing of children at 4 or 5, and 74.6% of GPs rating happiness and hope at 4 or 5. Health, safety, and quality of housing were given less importance, with 56.1% of GPs rating health at 2 or 3, 39.5% of GPs rating safety at 2 or 3, and 46.5% of GPs rating quality of housing at 2 or 3.

Figure 5: *From your perspective, on a scale of 1 to 5, rate the following according to importance for whānau Māori living in poverty.*

Figure 5)

GP Perspective:
Factors that are important for Māori whānau living in poverty
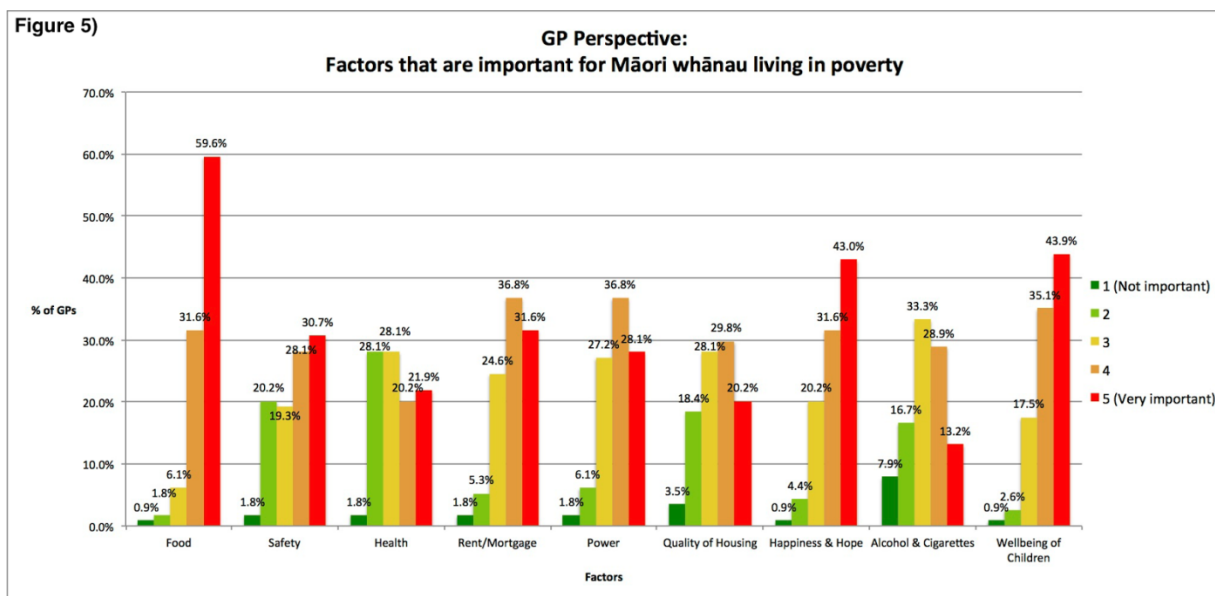
GP Perspectives

GPs were asked to indicate how much they agree with a number of statements in relation to the impact poverty has on patients, WINZ accessibility, the GPs role, and whether Māori living in poverty have worse health outcomes than Pākeha (see Figures 6 and 7). The overwhelming majority agreed with the statements "People who live in poverty present with more severe health conditions' (92.1% agreed or strongly agreed), and 'Māori patients living in poverty have worse health outcomes than Pākehā living in poverty' (70.1% agreed or strongly agreed). There was a range of responses to the statement 'WINZ benefits are easily accessible to the people who need it most', with 31.6% agreeing or strongly agreeing, 38.6% disagreeing or strongly disagreeing, and 29.8% neither agreeing nor disagreeing. The statement 'Motivation and hard work allow individuals to overcome poverty' also generated a variety of responses, 28.1% agreeing or strongly agreeing, 38.6% disagreeing or strongly disagreeing, and 33.3% neither agreeing nor disagreeing. 87.7% of GPs agreed or strongly agreed with the statement 'In my experience, poor mental health is associated with poverty.'

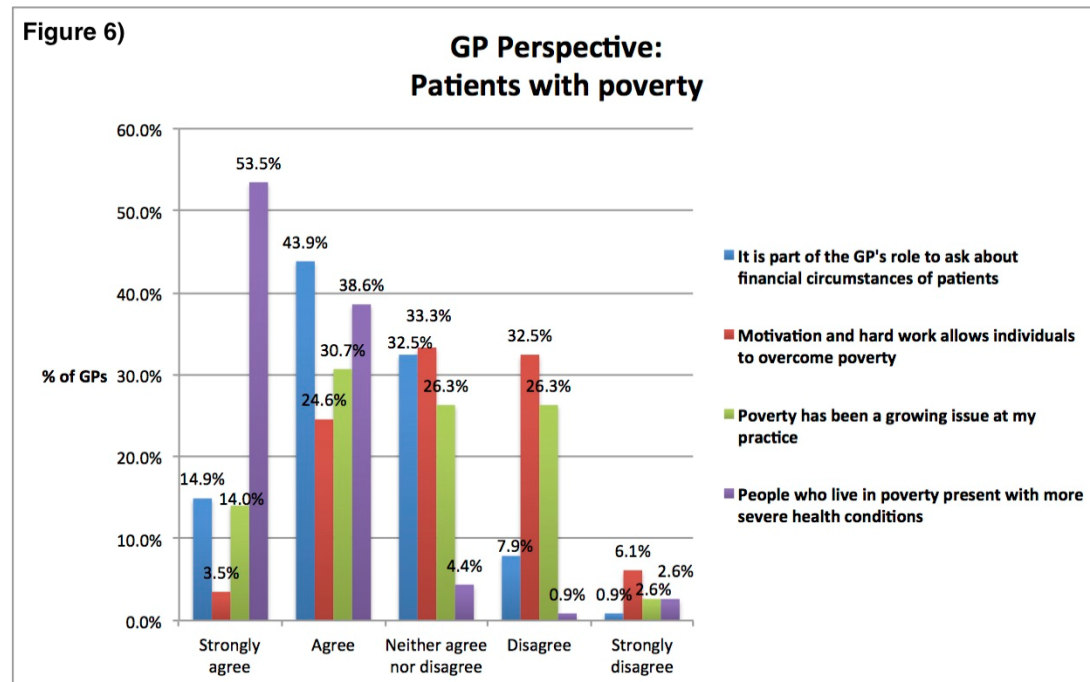Figure 6*: Please indicate how much you agree with each of the statements listed below*
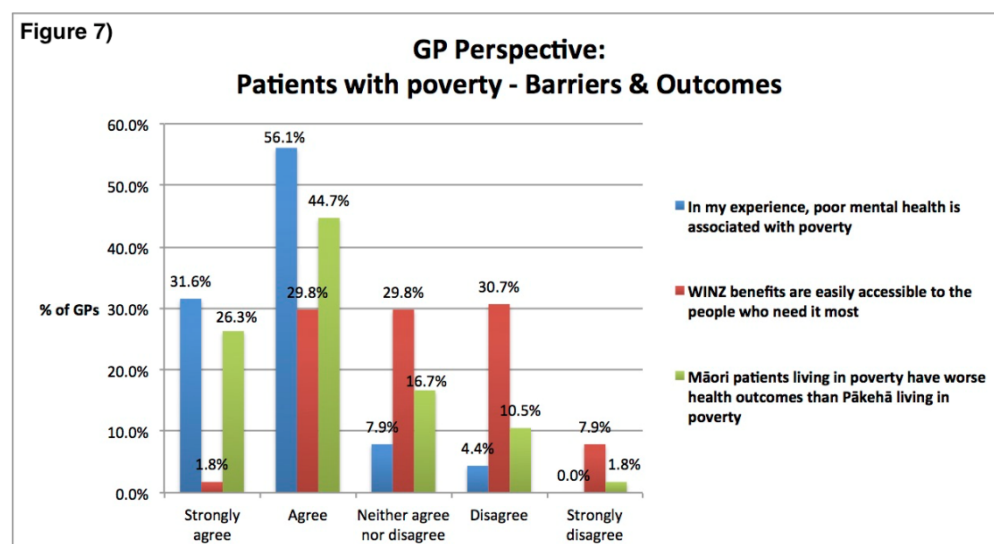
Figure 6)

GP Perspective: Patients with poverty

Figure 7: *Please indicate how much you agree with each of the statements listed below*

Figure 7)

GP Perspective: Patients with poverty - Barriers & Outcomes

Comparison Groups - Statistically Significant Findings

Urban vs Rural GPs

The number of responses from urban/suburban vs rural GPs was relatively well distributed, with 44.7% of responses being from rural GPs and 55.3% of responses being from inner city/suburban GPs. The comparison of responses from these two groups generated one statistically significant result.

- Inner city/suburban GPs considered safety to be a more important factor for whānau Māori living in poverty, than rural GPs (Mean 3.89 vs 3.37; 5 being very important) p=0.018

High proportion of quintile 5 vs low proportion of quintile 5

29 GPs with high proportion (>25%) of quintile 5 patients were compared to 72 GPs with low proportion (<25%) of quintile 5 patients. This comparison generated 6 statistically significant results however there were 13 missing responses which needs to be taken into account.

- GPs with a high proportion of quintile 5 patients more strongly agreed with the statement 'I believe I have adequate knowledge and understanding of Māori culture' than GPs with a low proportion of quintile 5 patients (Mean 2.1 vs 2.67; 5 being strongly disagree) p=0.002.
- GPs with a high proportion of quintile 5 patients more strongly agreed with the statement 'My general practice training/experience has equipped me to help Māori patients' than those with a low proportion of quintile 5 patients (Mean 2.48 vs 2.81; 5 being strongly disagree) p=0.013.
- GPs with a high proportion of quintile 5 patients considered safety to be a more important factor for whānau Māori living in poverty, than GPs with a low proportion of quintile 5 patients (Mean 4.1 vs 3.47; 5 being very important) p=0.011.
- GPs with a high proportion of quintile 5 patients considered quality of housing to be a more important factor for whānau Māori living in poverty, than GPs in with a low proportion of quintile 5 patients (Mean 3.83 vs 3.26; 5 being very important) p=0.009.
- GPs with a high proportion of quintile 5 patients strongly agreed more often with the statement 'It is part of the GP's role to ask about financial circumstances of patients' than those with a low proportion of quintile 5 patients (Mean 2.1 vs 2.5; 5 being strongly disagree) p=0.035.
- GPs with a high proportion of quintile 5 patients more strongly agreed with the statement 'Poverty has been a growing issue at my practice' than those GPs with a low proportion of quintile 5 patients (Mean 2.34 vs 2.94; 5 being strongly disagree) p=0.01.

Māori vs Non-Māori GPs

The responses of 7 Māori GPs were compared to 107 non-Māori GPs. This generated three statistically significant results, which should be interpreted with caution due to the low number of Māori GPs.

- Māori GPs considered quality of housing to be a more important factor for whānau Māori living in poverty, than Non-Māori GPs (Mean 4.43 vs 3.38; 5 being very important) p=0.015.
- Māori GPs more strongly agreed with the statement 'Poverty has been a growing issue at my practice' than Non-Māori GPs (Mean 1.86 vs 2.79; 5 being strongly disagree) p=0.027.
- Māori GPs more strongly disagreed with the statement 'WINZ benefits are easily accessible to the people who need it most' than Non-Māori GPs (Mean 3.86 vs 3.08; 5 being strongly disagree) p=0.045.

Comments Section Results - Thematic Analysis

Question 13 – "What can primary care do to mitigate the effects of poverty?"

113 comments were analyzed and the main ideas were identified. Access, funding, reducing costs, advocating and empowering patients were the main themes identified by the general practitioners regarding the roles GPs can play in mitigating the effects of poverty in New Zealand. Some GPs did not think there was anything that GPs could do to lessen the impact of poverty due to lack of resources. A number of GPs also identified interventions which could specifically target the Māori population living in poverty.

Access

Many GPs described increasing accessibility being an important role primary care can play in mitigating the impacts of poverty. The word access was used in different contexts, either referring to easy accessibility to the general practitioners themselves, or enabling better access to services that may be available to the patient. In regards to access to the general practitioner, many GPs talked about being flexible with appointment times. The main services mentioned by the GPs were WINZ, social work, community organisations, and budgeting services.

> *"Being flexible - e.g. fitting patients into day or doing home visits to try and improve access"*

> *"I am seeing a lot of families not able to get to the doctor because they are working in two jobs. Primary care hours could extend and allow more people access."*

> *"Also be well informed about and help people access support they are entitled to eg. WINZ benefits and ACC allowances"*

> *"Refer to help, like WINZ, Budget Advice, Social work."*

Funding/Reducing Cost

Many GPs emphasized the need for more funding to practices serving largely quintile 5 populations. The main themes that came up regarding funding were that current GP funding is inadequate which prevents doctors from helping patients living in poverty, and the funding is not targeted to the practices and patients that need it most. Reducing cost of appointments and treatment for patients living in poverty was another common theme

described by GPs when asked about the role of primary care in mitigating the impacts of poverty.

> *"Funding must follow patient needs NOT type of practice"*

> *"Targeted funding"*

> *"Many families cannot access because of the cost/or are whakama about the bill they owe. Primary care should be free"*

> *"Prescribe thoughtfully for max benefit and minimum cost*

> *"Reduced costs of consults and scripts"*

Advocating for and Empowering Patients

Advocating for and empowering patients living in poverty were important themes apparent in the GP responses. The need to advocate for these vulnerable patients in order to provide quality health care through referrals, communication with other services and lobbying to the government for change were discussed. Respondents described the role GPs play in empowering the patient through education, and motivating them to give up behaviours such as smoking and alcohol consumption which have a negative impact on both health and financial situation.

> *"GPs are not accountants, financial advisors or lawyers but advocacy involves all of these issues."*

> *"Empower people to take ownership of health issues. Largely through education."*

> *"Trying to get people off cigarettes/other addictions which cost."*

Primary Care Does Not Have the Tools/Resources to Help

Poverty is a recognised determinant of health and it was noted that some GPs feel it is the government's responsibility to tackle this barrier. Some thought this issue was not the responsibility of the GP, and that dealing with poverty is not in their area of expertise. Some GPs thought they did not have the tools or resources to help these patients, or that this population was hard to provide healthcare for as they do not present to the GP until seriously ill.

> *"Little, chiefly an economic issue."*

> *"Feel too many issues are being put back on the GP, and practices to solve multiple issues. GP's are highly skilled people who should be dealing with what they are trained in."*

> *"We can help those who present, but a number don't until very ill, so difficult to influence"*

Interventions Targeted to the Māori Population

Some GPs recognised that there is a need for more interventions and support targeted specifically at the Māori population living in poverty. Recommendations included engaging with the Māori community, empowering Māori patients through public health initiatives, and improving cultural competency of the healthcare workforce.

> *"Big pātai that. Access, advocacy, health promotion and disease prevention starting from antenatal period through to Kaumātuatanga, facilitating connection to Māoritanga and whānau , supporting principles of positive youth development, doing more for our whānau Māori to ensure equitable health outcomes: without health it is hard to overcome poverty, ensuring our staff are either Māori or working to the top of scope with cultural competence. God I could go on for ages but have patients to see"*

> *"Engage with the Māori community to ask them what would help"*

Question 14 – "How can the government more effectively support GP practices dealing with Māori living in poverty?"

110 comments were analyzed and the main themes were identified. The major themes included access to services, funding and reducing cost, and targeted interventions to the Māori quintile 5 population. Other common themes included health promotion and education, housing, employment and living wage, and mental health. Some GPs also reported wanting equality of healthcare across all ethnicities, i.e. they believe that all people in poverty should be helped equally.

Funding/Reducing Cost

Most GPs talked about the need for targeted funding of GP practices to high needs patients in order to improve care of their Māori patients living in poverty. It is clear that most GPs who responded to the survey believe the current model of funding is not targeted adequately at the practices and patients who need the most financial support. Many mentioned issues with the 'Very Low Cost Access' funding (VLCA funding), in particular, the fact that patients who are not in quintile 5 of the deprivation index are eligible for low cost GP appointments if their GP practice receives the VLCA funding.

> *"Stop underfunding high needs practices. SIA funding gone. Funding received by VLCA practices doesn't cover financial difference between them and more affluent practices. Unequal let alone inequitable service being provided. Shameful."*

> *"Targeted further funding and specific programmes - the problem with low cost access practices is that they have some proportion of patients who can pay a full fee but everyone just pays the reduced fee - then these practices can struggle."*

Access To Services

Social work and WINZ were identified by some GPs as key services needed to improve health outcomes of patients living in poverty. In regards to social work, GPs described needing more social workers who would be able to work with whānau Māori living in poverty. In regards to WINZ, some GPs described making WINZ more 'user-friendly', while others described needing to change how people access benefits.

"I think more designated social workers who can work across education, health and employment sectors may make a difference to navigating paths out of poverty"

"Make WINZ less bureaucratic and more user-friendly"

Interventions Targeted to the Māori Population

GPs recognised the need for specific interventions in order to improve the health outcomes of patients of Māori ethnicity living in poverty. Recommendations included providing Marae based community services and training healthcare professionals of Māori ethnicity who are able to provide high quality care.

"I would love to be able to afford to send a nurse/Māori health worker into the community to see these patients in their own environment and to help provide Māori with a health care system that provides for Māori to be healthy as Māori , not just a healthy Māori in a NZ European system"

"Fund development of Māori -centric health organisations to co-ordinate, communicate and liaise with Māori, and assist them in accessing health care."

"Māori nurses in community."

Health Promotion, Education and Regulation

Health promotion and education were identified by some GPs as potential areas where the government could intervene. More specifically, they described making healthy choices easy choices through public health policies, health promotion campaigns directed at Māori communities, and improving health literacy of this population via education.

"Education, education and education only way forward not money"

"Making healthy food choices affordable (and unhealthy ones less available/affordable), continuing to tackle drivers of smoking"

Housing

Housing was identified by many GPs as an area where the government should intervene. Affordability, improved quality, and better heating/insulation were the main points suggested by the general practitioners in regards to housing interventions. Housing is an important determinant of health which could be targeted by the government to improve health outcomes of this vulnerable population.

"Affordable well maintained housing"

"Fix the substandard freezing cold state housing"

"Provide well insulated, clean, well built houses at affordable cost"

Living Wage and Employment

Lack of employment opportunities was an issue identified by GPs which adversely affects Māori patients living in poverty. In addition, some GPs described a need for change to a

living wage instead of a minimum wage. The effect of unemployment can have a negative impact on health outcomes especially if patients are unable to attend follow up appointments or pay for the prescription fee.

> "Employment opportunities and raising the minimum wake to a living wage"

> "Recognise that all the most important determinants of health lie outside the health sector, and have good policies for dealing with these eg. a living wage rather than a minimum wage, unemployment…"

Mental Health

Mental health was identified by some GPs as an important area in which the government could intervene to improve health outcomes of Māori living in poverty. Anxiety and depression are more prevalent in this population, adversely affecting quality of life and physical health, and can be a barrier to getting out of poverty.

> "I would like to see free follow up appointments for newly diagnosed depression....just a small part of a big problem but something that has been on my mind."

> "Easier access to services eg mental health counselling"

Equality of Healthcare Across Ethnicities

Some GPs thought that all patients living in poverty should be helped equally, regardless of ethnicity. They did not agree that funding and services should specifically target people of Māori ethnicity who are living in poverty, and thought that instead, action needs to be taken to help all people in NZ living in poverty.

> "We have far more non-Māori living in poverty in South Taranaki so funding should follow need not race - racial profiling is no more acceptable in health as it is in law enforcement."

> "Stop positive discrimination."

Analysis of the 'Any Final Comments' Section

There was a total of 45 comments in this section. Many respondents were reiterating their main points, sharing what they thought were the main barriers faced by those in poverty and by those trying to help them. The complexity of the issue was also reiterated with solutions evading many GPs.

> "Complex area with no easy solutions."

> "It is the overlap between poverty, mental health, addiction, poor health literacy and ethnicity that makes some Māori families so very vulnerable. Coping with one of those determinants of poor health outcomes is bad enough, but when several coalesce, it can be very difficult for a GP practice to have the knowledge, skill and resources into making a difference."

The issue of funding was prominent in this section of the survey, with many GPs reinforcing the message that the current model of funding for primary care does not adequately target

high needs populations, and that more resources are required to help whānau living in poverty.

> *"Some system of increased funding for all deprived patients is actually needed across the country."*

> *"Māori in centres where they represent a greater % population probably get more targeted care. In areas where the numbers are small, they don't get the same range of services."*

> *"The funding model for primary care needs revision."*

The need for intervention at a political level was noted by some GPs in this section. Health is only one aspect of poverty, and other issues such as housing and employment need to be addressed to improve the lives of those living in poverty.

> *"Healthcare is the ambulance at the bottom of the cliff. We need affordable, high quality housing, accessible benefits, higher minimum wage, and free quality childcare from an earlier age."*

> *"The issues of housing costs [and quality], [difficulty in accessing] WINZ and violence in the community are broader issues that need broad societal responses."*

> *"Child poverty is a pressing issue which is neglected and obfuscated by the current government."*

There were a few comments questioning the focus on patients of Māori ethnicity, implying that everyone in poverty should be helped equally, rather than targeting resources at specific groups.

> *"Caucasian poor people are no better off than Māori but have even less benefits"*

> *"Everyone living in poverty should be helped equally!"*

> *"Poverty affects the health of people of all races and cultures and has an adverse effect on healthcare outcomes."*

> *"Increased funding for all deprived patients is actually needed across the country."*

There were also a few outliers who presented alternative hypotheses for why poverty occurs. A specific example was that poverty was caused by a breakdown in the family.

> *"Increased sex ed and contraception leads to increased teen pregnancy, increased abortion, and increased STIs which all lead to depression and anxiety. Māori and the poor are targeted to contracept by supplying free clinics in the poorest schools and communities."*

INTERVIEWS WITH MĀORI

We interviewed nine whānau groups with a total of fourteen members. All members within each whānau group self identified as Māori, except those of one group, in which there was a mixture of Māori, Asian and Pākehā ethnic identification.

Common findings from our interviews related to three overarching themes: the impacts of poverty, barriers to mobilising out of poverty, and resilience strategies to help cope with living in poverty. Sub-themes were classified under each of the three main topics.

Despite this categorisation, it should be noted that there is considerable overlap, in that some sub-themes can be rationalised into more than one of the three principle themes, and there is interplay between various topics due to the complex nature of poverty.

Impacts of Poverty

The impacts of poverty are many and far reaching. Poverty both directly and indirectly affects health outcomes, housing, transport, education and employment opportunities. The impacts of poverty are also often barriers to climbing out it.

Discrimination:

Some participants found that they were directly being persecuted and treated differently for being poor. They felt blamed for their circumstances, and felt others believed that the cause of their situation was due to their poor budgeting. One participant was charged more to obtain forms for WINZ than a normal consultation at their GP.

> *"If you're poor, you're not really human; and if you're poor, you don't deserve the same level of treatment as someone who can afford to self-sustainably live"*

Sacrifices:

Many participants made sacrifices to survive, and prioritised necessities. The impacts of poverty on the participants affected their housing, food, transport and health. Each whānau would rearrange their priorities and as such one or more of these factors were sacrificed to bolster higher priority needs. Luxuries were considered by many participants to be groceries, others having a gym membership. Participants described not having enough money for food, phone bills or child care. One participant would sell furniture if money ran out.

> *"We don't drink water, we don't heat properly, we don't do anything or go anywhere particularly because petrol costs money. We don't buy meds that we need desperately"*

Housing:

Housing was often stated as the top priority, along with power. Despite this, the residences of our participants tended to be in low cost areas where housing was dilapidated, damp, mouldy and cold, and often without insulation. Many did not heat their homes; to combat this some participants would sleep in the same room or put on more clothes to compensate. Some participants described their poor housing conditions as affecting their health. One participant had moved to a new flat and had consequently seen an improvement in their health. However, with rent projected to increase they were unsure if they could remain a tenant. Overcrowding was described by one participant, with 10 individuals living in a two bedroom house.

> *"You're living in these flats that are just damp … the condensation is coming down the walls, it's freezing cold, you're breathing out condensation, you can't get warm, you're constantly getting sick with infections"*

> *"Our house had no insulation and I'd heat the lounge with just the oven on, and would sleep, all of us, me and my three kids in one room and put every blanket on all of us"*

Food:

Food was commonly toward the bottom of the priority list for most participants. Mince, rice, frozen vegetables and other basics were staples when they could be afforded, however food was often the first necessity to be sacrificed in order to pay weekly bills or when money was scarce. Many participants described buying cheap food with poor nutritional value. Some participants did not have cheap produce or supermarkets nearby and being constrained by travel costs could not access these more affordable goods. Skipping meals was common among a few participants, with some not eating lunch if they went to university for the day. One participant would skip meals to ensure her kids had a sufficient amount to eat. Another participant described young siblings going to school without food.

> *"Some weeks I just wouldn't eat, because I had to feed these kids and if I ate then that would be taking away from them"*

> *"You can't afford nutritious food, so you just eat like real crap, like two minute noodles, and crappy bread"*

Transport:

Transport was sacrificed or preserved depending on participants' needs. Public transport was the most common method of transport, with few owning vehicles. Vehicles that participants owned were in disrepair and subject to breaking down; in one participant's experiences this caused them to lose their job as they were unable to pay for repairs. Lack of transport or cost prevented some participants from accessing cheaper supermarkets across town or only using transport when absolutely necessary. Others would be truant from university if their budget did not allow travel costs. Some participants stated that travel costs contributed to them not accessing health care. Others would travel long distances to for GP appointments, as GPs in their area were too expensive. One participant spent a large amount of their budget on transport as their medical conditions made walking large distances unfeasible, and another accrued high transport costs taking their son to appointments.

> *"I had a car for about two months and at that point I had a job, but then in the same week my car broke down and my phone broke so I lost my job at that time"*

> *"I can't get to Pak'n'Save cause it's on the other side of town and the bus fares would be so expensive"*

Physical and Mental Health:

Both physical and mental health impacts of poverty were mentioned frequently by our participants. Health was often affected by poor housing, travel costs preventing health care access and poor nutrition as mentioned above. Cold, damp housing was mentioned by some participants as the cause of constantly getting sick. Participants also remarked on poor

nutrition affecting their health. One participant postponed access to health care due to cost and ended up visiting ED once the situation escalated. Others did not continue treatment, or failed to fill prescriptions due to cost. One family did not wash often as personal hygiene products were too expensive. The added stress of living in poverty and the negative effect this had on their mental health was mentioned by some participants.

> *"Social deprivation and medical deprivation, it causes more anxiety which then goes towards creating a worse mental health situation for myself and for others around me"*

> *"Yeah so I used to live in a student flat, I did, I have for the last couple of years but I got really sick of being sick all the time, so I found a new house which the rent isn't too bad and um yeah, I haven't actually been sick since moving here"*

> *"Basically when you live in poverty, it doesn't help any aspect of your life, so if you've got mental illness, it just kind of becomes a spiral downwards"*

Altered 'Hierarchy of Needs'

Some participants regarded items generally viewed less necessary (e.g. having a working cell phone) as more of a priority than physiological needs (e.g. food and warmth), the latter of which are classically regarded as being fundamental for survival. Also when asked specifically what is prioritised in their budgets rent, power and internet came before food and food was sacrificed before all other materials when weeks were harder. Having an internet connection and a reliable cell phone were important for maintaining communication with WINZ and with each other, and the internet was also an important resource for the management of mental health issues.

> *"Internet is like $100 a month which barely suffices for what we do. Because we're all students ... or use the internet a lot to cope with depression."*

> *"My phone just broke and I need [it] for WINZ to be able to contact me."*

One participant, despite regarding it as a luxury, regularly uses the gym as they find it essential in the management of their depression.

> *"[The gym is] $10 a week... I make it a priority because if I don't do that, If I don't keep on top of all those things, I go down into depression."*

Use of Health Services:

Participants in general did not access health services due to cost or stopped accessing treatment due to repeated costs. Some could not afford to fill prescriptions, others shared their medications with whānau . In order to access health care some participants would accumulate medical bills and have to pay these off incrementally. As stated above, one participant ended up in ED as a consequence of postponing access to health care. One participant remarked that in order for them to have a productive experience they had to visit their regular GP which cost more but they knew their complicated medical history. Two participants mentioned that they needed to go the dentist but were unable to due to cost.

> *"I don't go to the doctor anyway because we just can't afford it, it's not realistic"*

"So as much as possible, we avoid [the doctors], if I have to, then I do [visit them], but I have to pay it off, and it's not a high priority but I'll pay it off as quickly as I can"

Education and Employment:

Education and employment were areas of impact for many. For some, their education was affected due not being able to attend university if they did not have enough money for travel. One parent observed that having a low income forces their family to live in certain areas where the cost of rent is low, and in these areas, because of school zoning, they are not able to access some schools with what they deem have better educational opportunities. For others job security was of concern. As mentioned above one participant lost their job after their car broke down and they were unable to repair it. Another participant mentioned they were fearful of losing their job should they take a day off work. Prostitution was used a method of employment by one of the participants as a means to provide food for the whānau .

"I'm a sex worker, and it's that money which buys most of the groceries for the house"

"I'm generalising, most Māori, their socioeconomic status forces them to live in specific areas, this means that they're only allowed to go to specific schools, which in turn allows a different type of education, opportunities and chances"

Barriers To Getting Out of Poverty

Another prominent overarching theme were the barriers that obstructed participants living in poverty from mobilising out of it towards better economic and holistic prosperity. These affected many aspects of the participants' lives, and thus both directly and more indirectly affected their potential to begin this process. Many of the barriers that arose were systemic in that they were external factors being imposed on participants.

Interactions with health services

Many participants described negative experiences with health services, in that they felt these exchanges were ineffective in fostering physical and mental wellbeing. These negative views however were not experienced by all participants. Participants described how they felt their living and financial situations were not adequately understood, with some commenting that health professionals had given advice that was not compatible with their circumstances:

"My doctor just doesn't believe that I'm too poor to go to the doctors. She says "you can talk to WINZ and you can get more money to pay for this". She does not understand that between food and travel and other things, while also saving a little bit of money for small luxuries which make life actually liveable, that I just don't have the money to see a doctor"

"You just have to budget better." And [as] if that helps anything and as if that's like humanly possible when you have no money"

Repeated experiences of this lack of understanding led some participants to not return, feeling that they would receive similar inadequate care should they do so. Some participants

also said that they felt persecuted by health professionals for being poor, and blamed and accused.

> *"Stop making excuses. You're lying. You have enough money, you're just not bothering to come in"*

> *"It's your fault and you must be spending your money badly"*

Many participants remarked that the health services they were able to receive were not as effective as they could be due to the Pākehā or Western approach the services used. Participants felt that this approach was neither culturally compatible nor effective.

> *"I've noticed with the psychiatric services … they don't focus so much on whānau "*

> *"The mental health system, it [is] very Pākehā dominated, and it's a different way of looking at medical stuff, cause [with] Māori there's a whole spiritual element, there's a whole tikanga, and a way of looking at the world that is completely different, and so when we get treated in a Pākehā system … there's a lot of things that get overlooked"*

Interactions with Work and Income New Zealand (WINZ)

Many participants described much difficulty in negotiating with WINZ to receive welfare and benefits. This was particularly expressed in regard to fulfilling obligations to receive a benefit. Participants found it especially difficult to provide regular medical information, describing the effort that it took to regularly have to make and complete separate appointments with general practitioners in order to receive medical certificates, followed by appointments with WINZ. This process was further complicated when transport costs were accounted for and were significant due to an already small budget, and also when participant's physical and/or mental health made them homebound.

> *"I was getting letters from them every two weeks, saying you have to come to this seminar or else you will lose your benefit, while I was unable to leave the house [due to health reasons]"*

> *"[My doctor] charges $15 for an actual consult and $25 for a WINZ certificate"*

> *"The WINZ people called me up on my phone and they said "look we understand that you just tried to kill yourself but when do you think you'll be able to find work next?"*

> *"I had to travel 20 minutes by bus which costs $5 each way just to go to a WINZ appointment that essentially lead to nothing. Nothing was changed. Nothing changed, nothing changed in my file, they just want to see me every month"*

Participants also described how they perceived that WINZ services were inadequate. Particular problems were: receiving poor advice, not qualifying for adequate financial assistance, being penalised for receiving extra income when on a benefit, and not being able to receive their benefit when applications were being processed, which was a regular occurrence. Some participants also described how dealing with WINZ was particularly distressing psychologically, with one person describing having to disclose a history of parental abuse to prove disassociation with their parents in order to receive financial support.

> *"I had to disclose a whole heap of abuse and stuff… that was about six weeks of constant phone calls at any time of day… asking really invasive questions completely out of the blue"*

Mental Health

Mental health was highly prevalent in the interviews, and when not optimally managed or treated became a disabling barrier to accessing services and/or getting to employment and education obligations.

> *"My sister helped me out with that [nervous breakdown]. Maybe she dragged me to WINZ a couple of times but I was pretty out of it."*

> *"In my twenties it was very bad, I was catatonically [depressed] a lot, … just really really sick ... [that was when it was] the worst dealing with WINZ - because when you're really really sick it's really hard to deal with, and you just can't do anything, you end up not being able to you know, trying to get all your doctor's forms in on time, and you're really sick, and you can't get out of bed, it can be quite difficult, and they don't really allow for that"*

> *"There was no way I could've done this degree if I was still untreated with mental health problems, and drinking. It's just no way, I would've basically drunk myself to death"*

Discrimination

Many participants felt discriminated against when accessing various services. The grounds for this discrimination were reported to be various and multiple, congruent with the idea of 'intersectionality', a term which describes belonging to, and being affected by being a member more than one social category. As mentioned above, participants felt they were directly discriminated against for being poor, but this was complicated further by other stigmatised identities, such as Māori, takatāpui/LGBT/queer, or a 'teen mum', having a mental health condition, or a criminal conviction. On being a person living in poverty:

> *"We're seen as just very inherently violent and undeserving of help and humanity… If you're poor, you're not really human and if you're poor, you don't deserve the same level of treatment as someone who can afford to self-sustainably live"*

One whānau group self-identified as being primarily takaāpui/LGBT/queer, and described the subsequent discrimination received due to being visibly different on multiple accounts:

> *"When cops see, like oh this visibly queer, visibly brown person, they're immediately gonna pick you up on the street and they're immediately gonna start hassling you"*

Many participants had a history of mental health conditions, and they described discrimination stemming from this:

> *"People think of mentally ill people, or they see someone who is like on the street that's mental, they're like 'they're not gonna contribute anything to society', but the*

thing is is that when we're well, we can do really good things, it's just that we have an illness that's not managed"

One participant struggled with her identity as a 'teen mum', to the point where they avoided seeking assistance from services:

"One of the barriers is probably that I'm a stereotype, so I was a teen mum. I had three kids by the time I was 19, and didn't finish school, was on a benefit and even though iI was studying ... I think it's all people usually see me for. So they would take me as that before even looking any further than that [stereotype] so I never even wanted to ask for help because it seemed more stereotypical for me to ask for help."

Transport

Transport itself was an important barrier largely due to the significant costs involved. The majority of participants relied on public transport methods such as trains and buses. Costs prevented many participants from using various services, such as healthcare appointments or university classes, as well as not being able to access cheaper supermarkets.

"Transport to uni costs at least $5 a day, and takes two hours so if we can't afford it we just won't go"

"It costs $5 and two hours to commute into the doctor. And to get a decent doctor at student health [it] is usually booked out months in advance"

Intergenerational Poverty

We recognised that many of the participants had been raised in what they would have defined as a household in poverty. Participants commented that living in poverty was the norm for them:

"I was raised in a family which was pretty poor…. so I've known this life for a long time".

"The kids, dad and their family, they are a gang family, their dad doesn't have a job, he has his fourth child on the way. He's never really got an education at all, and they live in poverty. They don't see any further out than that because they were raised in it"

Geographical Location

Some participants described how living in a low SES residential area acted as barrier by limiting access to local goods and services. Some remarked that there were no cheap supermarkets close by, another participant spoke of how their children were not able to attend high decile schools, which they felt were of better quality.

"Most Māori, their socioeconomic status forces them to live in specific areas … [this] means that they're only allowed to go to specific schools, which in turn allows a different type of education, and opportunities, and chances"

"In essence what [school zoning] is doing is it's creating that gap, and that void, and making it even larger, knocking out the bridges, and just putting little boats there that you gotta paddle on"

Resilience Strategies in Poverty

Despite the negativity reiterated throughout the previous two themes in regards the impacts of poverty and difficulties overcoming it, many participants also described various methods of resilience to aid them through times of hardship.

Support

The importance of having support systems in place was frequently mentioned by many participants. The various forms of support mentioned included whānau , kaupapa whānau , friends, GPs and community support systems. Having a good relationship with the health service, particularly GPs, helped greatly, especially with taking cost into consideration.

> *"I've been with my family doctor since I was a child. And anything I can cram into a 15-minute consult, it's all the same price."*

> *"It's nice to have a doctor that gets it."*

> *"The Dunedin activist community is really, really good as a support network in terms of rides [to] places, or food from the cupboard when you don't have any… [I] technically have student health, I have student support both at Uni and Polytech, I've got GP, I've got a counsellor, I've got my tutors, which is cool. And I've got the students associations."*

Participants were also supported financially and emotionally by whānau members and friends.

> "*Some of our friends with full time/semi full time jobs chuck us $25 a week into a private account [for us]."*

> *"[My mother] paid all my son's school fees, and paid for his uniform… I really don't know how I would have done it if it wasn't for her…"*

> *"Working as a team and unit; we're quite tight knit, we support each other when we have to."*

One participant reported, when she had a nervous breakdown:

> *"Family members came over and just talked to me and [that] helps me out … and a lot of my strength comes from my family."*

Māori identity as a source of resilience

Some participants viewed embracing and reclaiming their identity as a Māori as one important resilience strategy, whether it be in terms of tikanga Māori in modern medicine e.g. Te Whare Marie (a Māori mental health system), or the practice of rongoā Māori (the traditional healing system).

> *"… really important for Māori to represent their own issues because a lot of times, in the mental health system, it will be very Pākehā dominated, and it's a different way of looking at medical stuff, cause [with] Māori, there's a whole spiritual element, tikanga, and a way of looking at the whole world completely different…"*

> *"My clinical psychologist [from Te Whare Marie]… came to my house for therapy…and would sit on my bed and we'd do therapy and we'd go for walks… it was really different."*

> *"When I was there, their dad started trying Māori traditional medicine. He was interested in it so he did rongoā. So he would try and test out different creams and oils."*

For some, the pure act of returning to and learning more about their Māori identity brought clarity and a sense of belonging to their lives, and allowed them to develop personal strength.

> *"For me, [learning my whakapapa] was like reclaiming my identity. Because things started to fall into place a lot more once I realized I wasn't just white."*

> *"I think a strong sense of identity and belonging is really important for people to become more resilient."*

Resourcefulness

With planning ahead, intricate budgeting of finances, and gathering their own food, some participants were able to work with the skills they have and from past experiences to mediate their hardship.

> *"My partner… is a hunter-gatherer, so a lot of the time, he'll go fishing, eeling, pick watercress and puha, and that will balance out the food that we wouldn't be able to afford."*

> *"[I] just cook really cheap meals…I learnt a lot about nutrition, so I know how to make really cheap nutritious meals now"*

One participant, with thorough researching, discovered what all their entitlements were and were thus able to claim more financial help.

> *"[Navigating WINZ] is a skill. I clicked onto that very f***ing fast. Before they changed the WINZ website, they actually had on their site map all the policies and I learnt literally everything I was entitled to just to get assistance."*

Motivation

Some participants reported they maintained a forward-looking, positive focus on their goals for the future even in times of hardship. These kept them going and even motivated them to persevere to overcome poverty.

> *"Not worrying about being homeless, about having to get some food. So I can go out… see people and connect because that's another human need which I'm deprived of because of poverty"*

"It took a lot of perseverance [to get out of extreme poverty] … the constant struggling drives you to not to want to constantly struggle. So you're constantly wanting to get out of it."

"I want to be able to provide for [my kids]… My goal is to be able to educate them myself."

Maintaining relationships

The idea of spending some money on family time in order to maintain a healthy whānau or spousal relationship was mentioned by some participants.

"Setting aside a small amount to be able to treat ourselves [is important]… [we] spend a couple of hours at the pub or go to the movies so we don't feel so pressured and the strain and stress of it isn't as bad"

"I realised that we needed to be putting a small amount aside for, just things we wanted to do, not what we needed to do… it may be unwise with money but it's wise for the family"

"It's hard to explain to [WINZ] that that's important, when you're struggling… [it] isn't all about money… without a family money's useless, it doesn't matter whether you've got heaps of it or not.

DISCUSSION

Throughout our project, common themes have emerged from the literature review, results of the General Practitioner survey, and from the interviews. Some themes were present in the existing literature, the GP survey and the whanau interviews, while others were stronger to specific components of the research.

Sacrifices made by those in poverty take an immense toll upon all aspects of their lives and therefore health as well. The literature review showed that many Māori in poverty felt that the cost of seeing a health professional was a luxury they could not afford and the cost was a common reason that a parent might choose not to take their child to the GP. This resulted in sharing of and self-medication – a strategy that the interviewees reported as well. Many families in poverty prioritized paying rent over other expenses, most often food (16). Most of the GPS surveyed rated food four or five (out of five) in terms of importance for their Māori patients in poverty, whereas health was on average rated two or three.

Food scarcity was a theme in both the existing literature and interviews but this was not a concern voiced by the GP cohort. The literature reports Māori in poverty prioritising paying rent and power bills and thus having little money left for groceries (16). Sacrifices were being made – some would only eat two meals per day, while others would feed their children before themselves.. Our interviewees reported similar decision-making and behaviour; food was at the bottom of the priority list. Basic staples (such as bread, rice and noodles) were consumed at the expense of our interviewees' health as these more affordable items were of poorer nutritional value. A lack of cheap supermarkets in the vicinity of our participants and transport expenses added to the cost of food. The high

proportion of GPs reporting that they felt food was a high spending priority for their patients may reflect a lack of knowledge about the choices their patients have to make on the part of health practitioners. Across all realms of our research, it is evident that whanau living in poverty are unable to make food is a high priority.

The lack of a nutritious diet impacts greatly on their ability to function day to day, and has downstream negative impacts on health.

We found poor quality housing is a reality for Māori in poverty throughout our research. This appears to have an overwhelming negative effect upon their lives. In the literature review it was found that rates of overcrowding are four times higher in the Māori population compared to non-Māori (17). One interviewee spoke of having lived with a whānau of ten in a two-bedroom house. The literature, the GPs and the interviewees resoundingly agreed upon the dilapidated state of housing – cold, damp, mouldy, uninsulated and therefore very uneconomical to heat. The existing literature suggested that this left those in poverty feeling without sanctuary; they could not afford to live somewhere warm, safe, secure and big enough for their families. Their houses were not 'homes'. A sad irony found during the interviews was that while housing and rent were *the* top priority the interviewees were still residing in almost uninhabitable properties due to financial hardship. Attempts were made to combat these conditions: whole families sleeping in the same room, people wearing multiple layers of clothing inside and going to bed much earlier than the norm as it was the only warm place to be. There are major harmful impacts on the well-being of those exposed to such conditions. GPs' estimates of the importance of good quality housing were mixed, in stark contrast to the great importance of quality housing for the interview participants. This is concerning as GPs have a role to play in advocating for their patients in Housing New Zealand applications and influencing public policy, and it is therefore imperative that they have an accurate perception of the detrimental effect poor quality housing can have on their patients' lives.

An unexpected theme to emerge during the interviews was the skewed hierarchy of priorities (by traditional standards) held by many of the interview participants. According to Maslow's Hierarchy of Needs (1943) humans build on the fundamental physiological needs towards higher more self-enlightening levels. (55) The qualitative interviews suggested that the participants' hierarchy of needs and motivation did not conform to Maslow's theory. When asked what would be the first thing to be sacrificed from the budget if a week was particularly financially difficult, the answer was always 'food' or 'proper food'. Paying bills such as rent, power and phone came before the need for sufficient amounts of food which is a fundamental physiological need according to Maslow. These individuals also placed the need for relationships and the presence of family before the need for adequate nutrition. Having whānau support was necessary for mental health. Whānau might also provide income that would help in gaining food and warmth.

Transport, or lack thereof, had vast impacts upon our interviewees and this finding might warrant further literature searches or more targeted questions for GPs around the lives of their patients in the future.

Poorer health outcomes, particularly mental health issues, appeared repeatedly throughout the research. There has been extensive investigation into the negative health impacts of living in poverty.. People of lower socioeconomic status have been found to have much poorer health outcomes , and 50% of Māori live in areas considered to be some of the most deprived in the country *** (12, 13). Struggles with GP costs led to poor follow-up and

preventable problems and long-term condition management, and as a result, many self-medicated and shared medications among whānau members. The rising cost of healthcare resulted in conditions going undiagnosed and untreated. Anxiety and post-traumatic stress disorder were found to be much more prevalent among those in poverty, which could be attributed to a lack of feeling of control (12, 14). This has led to alarmingly high rates of suicide and depression among this population. The GP survey found that 92.1% of GPs agree or strongly agree that poverty leads to more severe health conditions. It also found, as aforementioned, that they felt their patients rated their health at a two or three (out of five) in terms of importance. Our interview results were in definite agreement with the rest of our study, with our participants attributing their poor health to a myriad of reasons - the state of their housing, poor nutrition from budget restrictions and those same financial limitations causing decreased GP appointments and access to healthcare/health literacy due to travel costs. One interviewee spoke of avoiding the GP for something they considered minor as it was unaffordable and subsequently ending up in ED. This is concerning as a night in public hospital costs the taxpayer far more than a GP appointment. Furthermore, we found that many chose not to continue treatment as prescriptions were too expensive to fill. Finally, the sheer stress that accompanies living day to day life in poverty causes worse health and well-being, as found by all avenues of our investigation.

Poor mental health is known determinant of poverty, and therefore barriers to achieving mental wellness can be seen as barriers to ascending out of poverty. Māori have higher rates of mental health conditions than non-Māori (14), and thus are disproportionately affected by lack of funding and poor outcomes in the mental health sector. Given that both living in poverty and being Māori are both associated with poorer mental health outcomes, it is no wonder poor mental health was a prominent characteristic of our interview cohort. Many of our interviewees suffered from mental health conditions which were appropriately managed, and had a detrimental impact on their ability to utilise support strategies and cultivate resilience, as well as attend employment or education obligations. With regards to experiences in the traditional mental health system, the lack of consideration of Te Ao, or the Māori worldview, and the philosophy of focusing on the individual rather than a whānau focus emerged as a negative theme. This may show a lack of consideration for Te Tiriti and lack of engagement with the principles of partnership, participation and protection on the part of healthcare providers. Māori mental health services such as Te Whare Marie were spoken about very positively by interviewees; this is evidence of positive outcomes when the principles of the treaty are applied in practice.

The impact of poverty on education and employment attainment was also a recurring theme that emerged, being evident more so in the literature and interviews. Contemporary works on poverty in whānau have found a correlation between educational disparity and lower socioeconomic status in childhood. These individuals were less likely to have attended pre-school, more likely to have left secondary school at a younger age, and were far less likely to possess a formal or tertiary level qualification. There is also evidence supporting the notion that education levels have an impact on many of life's domains, namely one's standard of living, income level, and psychosocial well-being (18). The surveyed GPs called for a living wage, feeling that this would make a considerable difference to their patients in poverty. Our interview findings were synonymous with these conclusions. Participants mentioned their struggle in attending university or work due to transport. A parent talked of their concern regarding where they could afford to live geographically, and the impact this might have on their child's education, feeling that the school zoning system disadvantaged

them as the quality of schools in their zone was poor. There were mentions of worry about job security with some fearing taking a day off and choosing not to when they or their children were sick, in order to retain employment. It is clear that lack of education and stable employment is a barrier to ascending out of hardship, due to the material deprivation and financial hardship that results. This furthers the cyclical nature of what it is to be poor.

Another theme to emerge from our findings was a marked impairment of access to health services for impoverished whānau . The literature shows evidence of a decrease in visits to the GP as well as a feeling of less rapport and shorter consultation times being reported for this population. Māori patients were also far less likely to be referred to a specialist by their GPs (7). One significant barrier reported by the current evidence was money; many chose not to visit a healthcare professional due to its unaffordability, and this had a significant impact on their health. Many of the surveyed GPs speculated as to why this might be, and presented potential solutions to decrease the subsequent harm. Suggested causes for decreased access included issues with WINZ and budgeting, transport and a lack of flexibility on the GP's part for appointment times. Some voiced the opinion that primary care could not and should not have to deal with the issue of access; many believed this to be an issue of policy that the government needs to resolve, thus leaving GPs to their sole practice of medicine. A significant proportion reported waiving fees for those who could not afford to pay them. Numerous suggestions of targeted funding schemes followed, although some discrepancy arose as a few felt that this should not be directed exclusively at Māori in poverty, but rather all patients in poverty. This represents a lack of understanding of the differences between equity and equality.

Our interviews presented much the same picture: the high cost of healthcare caused many to avoid seeking medical help when it was warranted. Some spoke of the cost of prescriptions being a reason that they do not fill them, or decide to share their medications with whānau . The accumulation of medical bills left many feeling overwhelmed at the thought of repayment; some were embarrassed to visit again when they needed to, knowing that they could not remedy the debt within the foreseeable future. Frequent ED visits were common for those who could not afford primary care; this is not a cost-effective spend of the health budget and warrants this framework to be revisited. Finally, many felt that the dentist was definitely a luxury; living with toothache and poor oral health was thus a sad reality reported by many. Hence our research shows that a lack of access to necessary and basic health services further impairs this already vulnerable and disadvantaged population.

The attitudes of health practitioners toward their patients can have a profound impact on the likelihood of a second visit to the doctor, as noted by one of our key informants, Dr. John Malcolm. He was cognizant of the fact that: "*Practitioners can approach Māori patients with conscious or unconscious attitudes, racist or otherwise, or personalize an interaction with a patient and assume the person is a bit hoha, and fail to look beyond what else has happened in their day or their life.*" Perhaps it is a lack of awareness on the part of other doctors in terms of their unconscious or conscious attitudes towards their Māori patients that has led to some of the poor statistics on Māori interactions with health services.

Attitudes of some GPs may be seen as a barrier for whānau in poverty, particularly in relation to how these attitudes have an impact on whānau and individual interactions with health services. Some GPs commented that Pākeha and Māori living in poverty should receive an equal amount of support, and others questioned why our research focused specifically on the Māori population. Given the obligations of the crown in accordance with

Te Titiri, there are specific actions required to address the inequities in Māori health (and poverty at large), and therefore a broad generalized approach aimed at addressing the entire poverty stricken population in NZ is inadequate. The opinions against the equity arguments may indicate a need for increased cultural competence and an understanding of the Treaty of Waitangi and how the principles of the Treaty relate to healthcare delivery. The comments regarding equity of healthcare and resource provision were reinforced in question 12b of the survey which asked GPs to agree or disagree with the statement "Māori patients living in poverty have worse health outcomes than Pākehā living in poverty." 71% of respondents agreed or strongly agreed, 16.7% neither agreed nor disagreed, and 12.3% disagreed or strongly disagreed. The 29% who did not agree may think that Māori do not have a greater need for healthcare resources, or may have practice populations which cause them to disagree. For example, one GP commented that "We have far more non-Māori living in poverty in South Taranaki so funding should follow need not race." The issue of equity was raised by some of the interview participants, who had a strong awareness of the lack of healthcare equity between Māori and non-Māori. The principles of partnership, participation and protection were perhaps not being implemented in the health settings attended by a lot of the interviewees. The doctor-patient relationship should be a partnership, therefore patient factors too can impact upon the success of this relationship - lower levels of health literacy or previous trauma as a result of mistreatment by health professionals in this population can be detrimental to the development of this partnership.

All three avenues of investigation revealed poor interactions with WINZ to be a barrier to overcoming poverty. Interviewees reported increased difficulty with accessing WINZ services when their mental health was suffering, which may have perpetuated a vicious cycle - without the support of a benefit, treating their mental health conditions became even more difficult.

The literature review found that while there are agencies such as WINZ designed to help people mobilise out of poverty, oftentimes they can in fact act as a barrier themselves. The time, effort, and money involved in complying with the demands of the WINZ system can take its toll on an already stressed individual trying to mitigate the effects of poverty. The experiences and difficulties faced by the interviewees was congruent with the existing evidence - many reported difficulty in paying for medical appointments to get a doctor's certificate to say they qualified for a benefit, and furthermore the psychological impact of repeatedly having to "prove" the need for a benefit was harmful. The extra time and financial costs involved with organising a benefit had a counterproductive effect on interviewees' efforts to mediate the effects of or mobilise out of poverty. Others had found it traumatic to receive contact from WINZ hassling them about their job-seeking or aspects of their benefit while dealing with severe mental or physical health issues. Some interviewees felt punished by the system, stereotyped, denigrated, or dehumanized. This was reflected by the comment of one of our key informants, Dr John Malcolm who reported that negative experiences with WINZ can have a detrimental effect on self-esteem - *"it's self-esteem - "I don't wish to be denigrated in that manner again" [it stops them going back"* This is significant because it is a barrier to people accessing the benefits they are entitled to, which was further evidenced by Dr. Malcolm's next commen*t: "There are [WINZ] offices where I do my clinics in Opotiki where families decline to take up my offer to apply for benefits because there's the perception of how they'll be received."*

In terms of GPs' perspectives on WINZ, when asked to respond to the statement "WINZ benefits are easily accessible to the people who need it most" 31.6% agreed, 29.8% neither agreed nor disagreed, and 38.6% disagreed. This shows a wide range of beliefs held by the GPs who responded in regards to the accessibility of financial benefits in New Zealand. This spread of responses may be due to difference in services between WINZ offices, or the degree to which a GP has made a collegial connection with the WINZ office in their town or vicinity of their practice. One of our key informants stated that he had found it helpful to familiarize himself with the WINZ office that services his patient population - "*after all, we are all aiming for the same thing, it can help to know each other.*"

An important concept raised by the literature review and interviews was the effect of discrimination on Māori in poverty. Many of the interview participants had faced discrimination. The intersectionality phenomenon applied to many of them, as they had faced discrimination for being Māori, for being poor, for being takatāpui, for being mentally unwell, and so on. There was a relative lack of awareness on the part of the GPs as to the effect discrimination might have on their Māori patients. This is important as it suggests that the GPs perhaps did not consider discrimination a major concern for Māori in poverty.

Young motherhood was a controversial theme that emerged from our research – not only acting as both an impact and a barrier to mobilising out of poverty but because of what it is to be a mother and why choosing this path now predisposes one to poverty. A small section of our literature review spoke of there being higher rates of pregnancy in young Māori women (22) – this was said to adversely affect their educational attainment and created long term benefit dependency and poverty for those families. There were sparse comments regarding young motherhood throughout our GP survey however, one outlier highlighted the vast range of opinions that may be held by New Zealanders around this topic. One of our interviewees, who was a young mother herself, spoke of the negative reactions and treatment she felt might ensue from being a "stereotype". She was aiming to upskill and thus had enrolled at University, however, due to not being able to attain university entrance at high school, she had to spend her first year completing a foundation course. Childcare for her was difficult, especially as she, for the most part, was a single mum. The Kohanga were very supportive of her in this and helped her with payment schemes – an example of how self-determination leads to positive outcomes for Māori in the modern day.

Social exclusion experienced by Māori due to fragmentation of the traditional whānau structure and cultural assimilation is a barrier to exiting poverty (20). Many of our interviewees spoke of the effects migration had had on their whānau structure. Urbanization had forced them away from their families and childhood homes and into the city for employment and education. Furthermore, the inter-generational trauma as a result of colonisation can lead to cultural dissociation and social exclusion from Māori support networks. Importantly, social inclusion and cultural connectedness can be strong resiliency factors for Māori in mediating the effects of poverty, and this is worthy of further research.

A lack of resources (in terms of government funding and allied health workers such as social workers) was found to be a major barrier for those in poverty and it was raised especially by the surveyed GP cohort. The literature shows the inequitable amount of resources allocated for Māori by our health system and questions whether this is a product of institutional racism (40) – something that is now just "part of the system" but which completely undermines the principles of Te Tiriti. There were discrepancies among those

Primary Health Organizations which aimed to keep fees down (and subsequently ran at a loss themselves) compared to others whose aim was to maximise profit. Research into this shows the majority of PHOs supporting increased funding and targeted schemes which would keep co-payments down. The GP survey was rich in responses around resource and funding allocation and many called for a restructure of our current 'targeted' funding scheme. There were frequent mentions of the Very Low Cost Access Funding Scheme (VLCA) being impractical as some patients, who were part of a VLCA practice, were not actually quintile five and therefore did not need the low-cost health care that they were receiving. Calls for a more culturally competent and user-friendly WINZ and other support services were made by GPs who felt their Māori patients in poverty were not getting the support that they deserved and needed. As well as this, an increase in health promotion and education and easier access and referrals were other suggestions made by the GPs. The interviews did not delve into this theme although some participants felt their living and financial situations were not well understood – this would indeed reflect a system that was not allocating resources to those who need them the most.

Reference to intergenerational poverty was made time and time again throughout our investigation – being alluded to as an immense barrier for those aiming to mobilise out of poverty. Our literature review paralleled the happenings here in New Zealand to the poverty of African Americans (28). It found that growing up in a low income household with a severe lack of resources was a barrier and often kept those who grew up in poverty, in poverty. This resulted in increased amounts of stigma, racism and discrimination which lead to poor societal messages about those in poverty – impacting heavily upon their self-esteem and expectations. Education as a contributing factor to intergenerational poverty was prevalent in the literature as well. A lack of education of those in poverty was attributed to lack of familial resources – their schedules were less flexible to accommodate the demands of modern schooling, and marginalisation was felt by poor parents from teachers. The survey results called for more health promotion and encouraging of better health literacy specifically for Māori – "education, education, education is the only way forward". Our interviews were in agreement regarding intergenerational poverty and its detrimental effects on those who were subject to its daily reality. Some spoke of household poverty becoming the norm and that *"they don't see any further out than that 'cause they were raised in it"*. An important point for us as authors to raise is that we struggled in writing this discussion as we had originally planned to do so. We thematically analysed all of our results with impacts and barriers separately, however, something that we soon learnt was that impacts and barriers were almost one and the same: many of our sub-themes appeared in both categories but, more importantly, impacts often led to more barriers and barriers led to worse impacts. This reflects the cyclical nature of poverty and why it is so often termed 'inter-generational poverty' – those born into it struggle immensely to escape as they both have a poor start in life, and know no different. This is vital evidence as to why the principles of Te Tiriti o Waitangi and the rights to Māori self-determination and equal rights must be upheld – without doing so, we have an inequitable society whereby the Māori people, a vulnerable minority, are being subjected to institutional racism and have worse health outcomes and well-being because of this.

It has been suggested from the literature that strategies for moving out of poverty include maintaining cultural identity for spiritual and social fulfilment while adopting western economic opportunity. Others have recommended the re-institution of traditional whānau structure as a mechanism of nurturing well-being by contributing to cultural identity, and

enhancing a sense of belonging. Both of these recommendations centre around the idea of improving resilience and wellbeing rather than economic stability, in order for families to navigate out of poverty. The interviews elucidated that whānau and kaupapa whānau were key factors that enabled the maintenance and development of resilience. whānau provided emotional and at times financial support to our participants, fostering their resilience and alleviating the burdens of poverty. Participants also included their GP in their support network, mentioning cost consideration as being particularly helpful - 51.8% of GPs in our survey reported to waiving fees often. Identity also was a central theme as some felt that their identity as Māori and its development through whānau support was an important contributing factor to their resilience. Strategies employed by participants to nourish their sense of cultural identity included learning about whakapapa, practising Rongoā (traditional Māori medicine), and using Māori health services.

Key informant Dr. John Malcolm spoke at length of the strategies whānau employ to help them mediate the effects of poverty: *"I think it's constantly done, the self-reliance, that concept of tino rangatiratanga, people hunting, feeding, sharing, supporting others, even goes down to sharing a bottle of meds, sharing inhalers, all those values have outlasted what people have been through. And of course it's different in different families depending on events and trauma, and some of those fragile families have lost a lot of that. But people are at their best, the willingness to go to a family group conference when somebody is quite distantly related and yet there's a sense of whānau that goes through generations and things like that. There's massive goodwill."* This is heartening commentary, and can be drawn upon to encourage application of the principles of the treaty by health professionals.

A question raised by this project is the appropriateness of having a separate definition of poverty for Māori, which may help address some degree of inequity between Māori and non-Māori. Through discussion with key informants Jacinda Ardern (a Labour List MP), Dr John Malcolm (a paediatrician based in Whakatane), Dr. Sean Hanna (a GP in Wellington), Child Poverty Action, and the Children's Commission, we found that definitions of poverty favoured in New Zealand currently by the government and support agencies tend to focus on objective economic hardship. International organisations such as the World Health Organisation and the United Nations Committee for the Rights of the Child likewise use economic and/or income based measures to define poverty. This does not allow for assessment of the more intangible, but no doubt impactful, aspects of poverty. These aspects may have particular impact on Māori, given that social and cultural dimensions may make up a significant part of what they consider their personal wealth (9-11). As a method of addressing inequity, it may be necessary to consider a separate definition of poverty for Māori which encapsulates these important aspects.

The office of the Children's Commission, when approached as a key informant, stated that *"There has been much discussion on how to ensure measures adequately include Māori, bicultural and multicultural elements. We have reviewed considerable information on other measures that capture the range of experiences for children in NZ. We acknowledge that by definition that 'poverty measures' are deficit indicators. Elements that better reflect a range of experiences and resilience (i.e. wider family/whānau connectedness) better sit within wellbeing frameworks and indicators. There is currently work on this underway by Māori researchers and agencies"*

While it is encouraging to hear that there is work being done to find measures that may reflect the experiences of Māori in poverty, it is imperative that the New Zealand

government and public understand the vital need for an equitable measure. Upon raising the topic of an appropriate definition for poverty in New Zealand, all of our key informants agreed a definition of poverty is important, however more importantly having a system of measuring poverty is more important to be able to set targets for poverty reduction.

A key informant interview with Labour MP Jacinda Ardern revealed that in the most current ideas on tackling poverty, the submission of the Poverty Eradication and Reduction Bill, the definition of poverty does not take into account Te Ao Māori. The bill uses an income-based measure and a material measure of deprivation, but no definition to encapsulate aspects of deprivation and poverty specific to Māori, for example cultural connectedness or social exclusion. She did promote the need to support Māori specific services that make a change for Māori.

*"We want to also reduce those who are experiencing poor health outcomes, educational outcomes, enhance social inclusion, ensure people are growing up with adequate housing and cohesive communities. We have also put in that we want more cost effective coordinated services support so that's models like whānau Ora, and enabling community responsivenes*s.*"*

Ms Ardern agreed it is necessary to consider the principles of Te Tiriti, and saw the need to reduce inequity. However the focus appeared to be, for differentiation between Māori and non-Māori needs, at an intervention level, rather than distinguishing a Māori specific need in measuring, not just mediating poverty. This has been seen to be a reoccurring issue in New Zealand policy where equity is identified as important however is not defined at higher levels of policy change, and yet still expected in the intervention. Key informant Dr Sean Hanna spoke of his frustration at the current attitudes at a government level: "Many of the health conditions that I treat have underlying social and economic determinants, and although the gap between Māori and non-Māori health outcomes is closing, it has not closed. It is upsetting that the word equity is not heard as often as it should be in policy and in Government."

Our key informants all agreed that while a definition for poverty is important, a way to measure poverty is more valuable as it allows for targets for poverty reduction to be set. It is very important that any such measure is designed with partnership and participation from Māori, and promotes equity. We hope this project gives voice to Māori youth in poverty, and in doing so can help design a measure for poverty that is inclusive of Māori elements. Given we are focusing primarily on subjective experiences of living in poverty, the use of self-identification is entirely appropriate and no objective measure is required in the context of our project.

STRENGTHS AND LIMITATIONS

Survey Strengths:

An online survey application, Qualtrics, was used to create the survey. This was used as the survey link generated is easy to access, and therefore more likely to get response from busy GPs compared to faxed or mailed surveys. The survey application generated anonymous responses, making it more likely that participants gave their honest opinion on

the complex topic. While the survey was anonymous, Qualtrics was able to estimate the location of the respondents allowing identification of any geographical patterns. The survey was distributed to the GPs via a number of sources, thus respondents were a mixture of rural, suburban and inner city GPs, increasing the generalisability of the results.

Input from various GPs and public health specialists during the design phase meant that the questions generated were of good quality and relevant to the research topic. The survey itself was a mixture of qualitative and quantitative questions, producing a wide range of data to analyse. Many GPs gave very thoughtful and passionate responses to the qualitative questions which provided strong data to use to make recommendations regarding changes that can be made at both primary care and government levels to tackle poverty amongst Māori in New Zealand. The survey was easy to follow, and for most respondents, quick to complete, with the majority of GPs completing the survey within eight minutes, making it more likely for busy GPs to submit a response.

Survey Limitations:

The short time frame of the project meant that there was time pressure to create suitable survey questions and distribute it to the GPs in order to allow for time to analyse the findings. Therefore, there were several limitations, some unavoidable and identified during the design phase of the survey, and some which were potentially avoidable had more time been available to develop the questions and send the survey out to a wider network of GPs.

A significant limitation of the survey was the way in which it was distributed to the GPs. Emails were sent to GPs associated with the Otago Medical School in Wellington, Dunedin, and Christchurch, and also to rural general practitioners via the NZRGP network. This selection of GPs may have biased the results, and may not be representative of the views of GPs nationwide. The low response rate, while expected, may also impact the validity of the findings, as there may be differences between those who answered the survey and those who chose not to. Unfortunately, there were only 7 responses from GPs who identified as NZ Māori. More responses from Māori GPs may have given valuable data as to whether these GPs had different views or insight into a complex issue. In addition, it is difficult to determine what the true response rate was, as some emails were sent to GP practices and some to individual GPs.

The survey application Qualtrics generated a shareable link which was distributed to the GPs. This link was not individualised to single participants, therefore anyone who had the survey link would be able to submit a response. This means it is possible that people took the survey more than once, or that people who are not GPs submitted a response. However, it is unlikely that this actually occurred as the survey was emailed out via reliable sources directly to either the GP or GP practice.

In regards to limitations of the survey itself, questions 5 and 6 asked respondents to estimate the number of Māori patients and number of patients in decile 5 that they see. There may be discrepancies between the estimated value and the true value. Some participants found the wording of questions confusing, or thought that some questions were taken out of context. In particular, the question asking participants to rate the importance of various things to whānau Māori living in poverty was difficult for GPs to interpret, which was taken into account when analysing the findings of the survey. In addition, it was not

compulsory for participants to answer all questions before submitting the survey. Some surveys were submitted incomplete, and it is not known whether this was because participants refused to answer certain questions, or accidentally skipped a question.

Interview Strengths:

The interview process was the main qualitative arm of our research, and with that comes the advantages of obtaining qualitative data. Qualitative research allows researchers to uncover the thoughts, feelings, and subjective experiences people have at a level of depth that quantitative research can not.

Despite being loosely guided by a list of focus questions, those conducting the interview kept the dialogue conversational and free flowing. This can be seen as a strength as it allows for a participant to express their view uninterrupted and without feeling interrogated. Furthermore, it broadened the scope of the interviews beyond the topics of our focus questions. This in turn made for rich, diverse and more contextualised data for our qualitative analysis.

Prior to the interviews, interviewers were given training and guidance from our supervisor, Dr Keri Lawson Te-Aho regarding cultural competence which helped make sure that all the interviews were conducted in an appropriate manner. Dr. Lawson Te-Aho also oversaw the interviews. She knew the interview participants personally, and was able to introduce the interviewers as well as be a familiar face. This highlights an important aspect of qualitative research - especially in context of Kaupapa Māori or other cultural investigations - where a rapport with the participants is important to establish, and best achieved through somebody with personal and cultural connections to the participants. We believe that Dr. Lawson Te-Aho's presence in the interviews allowed the participants to be more at ease with being interviewed by strangers about potentially sensitive topics.

A small sample size in quantitative research might invalidate the results. But this is not necessarily true for qualitative research. Instead "thematic consistency" is used as a gauge of whether it is necessary to conduct more interviews. For instance, the more interviews you conduct, the more you begin to uncover what ideas are common and what are outliers. There comes a saturation point where you have conducted enough interviews that you can comfortably predict the themes which may arise in the next interview, based on the consistency of themes in past interviews. But because our data analysis occurred after we conducted all the interviews, we had no way of knowing at the time whether we had arranged an adequate number of interviews. In retrospect, having analysed the data there was thematic consistency which is a strength in our research. Furthermore, our selection of participants included a diverse demographic of impoverished teenagers, in terms of geographical location, gender, sexuality, education, age, and parental status. The fact that we were able to elicit thematic consistency despite the diverse group of participants further strengthens our results.

Interview Limitations:

The interview method had several limitations. Given there is currently no consensus or international guidelines for measuring poverty, we had difficulty creating selection criteria for our interview subjects. Instead our participants were self-identified as being in poverty.

This could be seen as problematic as we did not retrieve any information which could help to gauge their level of impoverishment. But it should be noted that any measure of objective poverty would overlook the aspects of poverty which are culturally or subjectively bound, and the aim of our qualitative study was to investigate subjective experiences of poverty.

The researchers had five weeks to complete the study. As the time frame was limited, the number of interviews that could be undertaken was also limited. More interviews and a greater sample size may have further reinforced the thematic consistency. A small sample size could also affect the generalisability and transferability of the research results.

Several limitations arise from our sampling method. Since we were using non-probability sampling, it is unreliable to generalise our results to the general population. Also, the participants in our study were mostly recruited through convenience sampling. They all were connected to our research supervisor and hence there is an element of selection bias. It is unknown to us whether our interview participants' connection to an academic could have skewed or confounded our results.

The thematic analysis was undertaken after the interviews had finished. Given time constraints we could not apply an adaptive interview technique to strengthen our qualitative research. Neither were we able to go back after analysis to ask more about themes that emerged which may have benefited from more attention.

As for the interview process itself, the interviews were mostly conducted by medical students with limited training, and under supervision by our supervisor. The interviewers were different for each interview, and there was little attempt to keep the questions consistent between interviews. Furthermore, there was no control on how a question was posed; and some interviewers were likely to have phrased questions in more leading ways than others. It is difficult to know what effect this had on how the interview participants responded, and the subsequent effect on our data.

MEIHANA MODEL: A FRAMEWORK FOR ASSESSMENT AND INTERVENTION

The Meihana Model was developed as an adaptation and addition to Sir Mason Durie's Te Whare Tapa Whā, which was largely used in Māori health policy and integrated into health and disability providers service. The Meihana model was used to guide clinical practice, assessment and intervention with Māori clients/whānau, particularly in the mental health setting. It not only considers whānau as an aspect of an individual's hauora, but focuses on it, centering it alongside the patient with equal importance. An important reason the Meihana model was derived was the Te Whare Tapa Whā model was found to, with integration into non-Māori setting, become viewed as just 'best practice'. This 'de-Māorified' the focus of the tool and so didn't allow the Māori values, beliefs and experiences to be considered separately from non-Māori. Another important factor of the development is a need to avoid measuring whānau on a level of 'Māori-ness,' and instead self-identification determined somebody or a whānau as Māori. (56) This is particularly important in the context of our study, as we've found protective resilience in identity.

The Meihana model includes six dimensions, the development of which can facilitate better services for Māori at both a clinical and systemic level. (56) We propose that it can also be used as a summarising framework for tackling the inequity within poverty statistics in New Zealand. A version of the Meihana model can be used to evaluate the findings from our

interviews with whānau Māori, survey of general practitioners, and literature review. It also provides a diagrammatic framework that can be used to measure poverty's impacts, assess barriers and their effects, and understand resilience strategies, or lack thereof, for further support, and overall identify appropriate intervention targets for Māori.

The whānau or waka consists of 5 dimensions: Wairua, Tinana, Hinengaro, Taiao and Iwi Katoa. The impacts of poverty that we have identified extend beyond the traditional elements of poverty that are so often used in its definition and measurement: material and income deprivation. Key informant Dr Sean Hanna, who works with primarily Māori communities and NZDep 9-10 in Wellington, expressed that poverty is more than a state of material and income deprivation:

> *"Poverty is also the loss of hope and aspiration, the acceptance of living on the breadline. Bright kids not dreaming nor given opportunities to achieve. Generations of benefit dependenc*y." – Sean Hanna

What we propose is that social and cultural deprivation are strong elements of poverty in Māori and could be targeted for intervention and developing culturally appropriate measures of poverty. Measuring the impact of poverty could include understanding each of the aku (cross beams) strengths and weaknesses. These dimensions are not unique aspects to Māori - but with understanding they give a uniquely Māori experience. The most important factor is measuring impacts of poverty on individuals and whānau as one, this could be biological or kaupapa whānau.

These dimensions give a holistic view of our whānau. Many of the impacts found affect multiple aku. These impacts can have consequences on physical health, mental and spiritual wellbeing as well as the other two dimensions Iwi Katoa and Taiao, the services and systems that provide support for whānau and their physical environments, which is where Te Whare Tapa Whā has gaps. These services include WINZ, budgeting services and all levels of health care including community services and involves their need for these services and their experiences good and bad.

We propose these impacts on poverty on the dimensions of the model can be assessed by GPs and in primary care. GPs can give us an inside look into the total effect of poverty on both individual whānau and whole areas or populations if they use this model in practice and consider poverty or the effect of hardship on these aku. This information could be used to create severity scales of the impacts of poverty which could give other services such as WINZ a more detailed and Māori-specific insight into whānau well-being in poverty. Information could also be accumulated to indicate needs of local areas to guide funding, and also be used to track progress at personal and population levels.

The determinants of poverty for Māori are explained by Nga Hau e Wha, (colonisation, marginalisation, migration and racism). We can link these to our findings on the barriers to mobilising out of poverty. Some barriers were identified as specifically affecting Māori, under racism. There are three types of racism that influence Māori: interpersonal, internalised and institutional racism. Examples of these are discrimination as a barrier to employment, lack of self-confidence and overall well being or ability to thrive in society. Other barriers identified would likely be issues for all in poverty, Māori and non-Māori, however Māori overrepresentation in poverty would be accounted for by colonisation, marginalisation, and migration processes. Key informant Dr Sean Hanna, who works with

Māori populations in poverty, spoke of what he sees as the determinants of poverty in the Māori population:

> *"Much of the reason for poverty in Māori is due to our shared history and the adverse effects of colonisation. Take someone's economic base away from them and keep it away then see how their great grandkids fare.*" – Sean Hanna

These barriers included geographical location and the marginalisation of low SES groups into less desirable areas with often restricting factors such as low decile schools, poor supermarket and resource access, higher levels of crime and less security.

Another barrier identified is the idea of intersectionality, or living with multiple discriminatory factors. In practice, each of the four winds are inter-related. (57) This could be identifying as Takatāpui, living with mental health and/or having a criminal record. These factors heavily compound the weight of pressure obstructing mobilisation, as oppression and privilege undermine inequities. (57) While these obviously would affect all those in hardship, for Māori these are compounded with racial prejudices, historical assimilation, and trauma at a systemic and individual level. These underpin the cause of Māori overrepresentation in poverty.

The final concept of the Meihana model is Nga Roma Moana, or the ocean currents. These are used to 'navigate' a smooth course towards overall wellbeing. The Meihana model describes harnessing the currents aided in time efficiency and energy required to undertake the voyage which relates to our findings of improving resilience and wellbeing rather than only economic stability, in order for whānau to navigate out of poverty. The two important findings of resilience fit very well into three of Nga Roma Moana; these were whānau support and cultural identity and practices which relate to whānau, Ahua and Tikanga. The only one not found from our research was resilience around whenua but this could be found incorporating the concept of tūrangawaewae into research as it was not specifically asked in interviews or the survey. The strength of these currents will vary from whānau to whānau and their incorporation in Te Ao Māori. The flexibility of the model allows diverse Māori to not be measured on their 'Māori-ness' but all be included and equally valued.

Figure 8. *The Meihana Model, repurposed to conceptualise the determinants and effects of poverty for Māori*
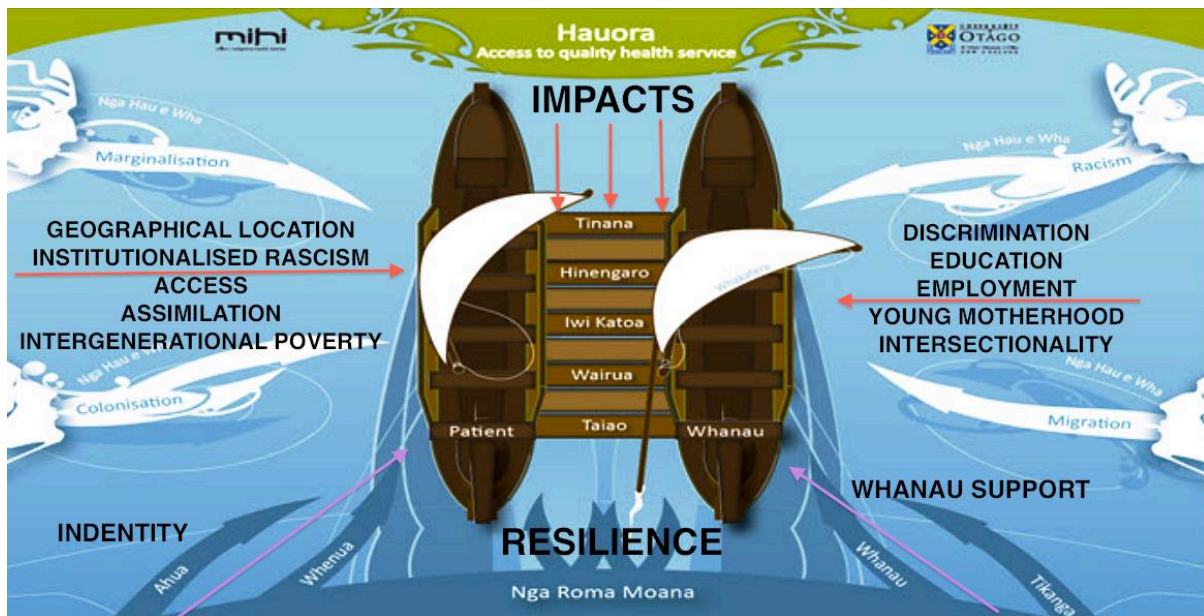
Poverty is clearly a complex issue, and interventions to date have largely been targeted at providing financial support to those in need. This financial support allows struggling families and individuals to survive, but does not give them the tools to thrive in New Zealand society. The Meihana model helps us conceptualise the determinants of poverty for Māori and could be used to measure poverty, alongside traditional measures of material and income deprivation. This measure could be used at an individual or system level for severity comparison and to expose possible targets for intervention or support.

RECOMMENDATIONS

Interventions for improving equity must make use of and incorporate the Treaty of Waitangi. The three major principles Participation, Partnership and Protection relate to the three articles and give them relevance to modern policy. These describe the fiduciary duty of the government, Māori rights to self determination, and equity of Māori and non-Māori. The Treaty set up a partnership, and the partners have a duty to act reasonably and in good faith. Furthermore, the UN Declaration on the Rights of Indigenous Peoples emphasizes the protection of culture, language and interests of indigenous populations. This includes self leadership and involvement in all that which involves them. In summary, the following interventions which can be drawn from our results and framework are necessary, and our government has a responsibility to remedy past breaches, and put Māori interests into all policy and plans for development to mediate the effects of historical trauma. Also in reference to the UN Declaration this study's results and ideas can be seen as a case study for a nation with inequity between the indigenous and non-indigenous populations. Our process and analytical lens used could be implemented into other indigenous populations and allow them to find the determinants specific to those people.

As found from our research, poverty in whānau Māori is a multifaceted, intricate issue, and thus warrants interventions at multiple societal levels and across various domains. The issue of inequity between Māori and non-Māori in the poverty statistics and

the flow on effect of poorer health outcomes necessitates the development of solutions to mitigate this issue, not solely because an equitable society is seen by most as important in an ethical regard, but also because, as stated above, the Treaty of Waitangi dictates it, particularly article three. We have therefore developed a number of recommendations for potential interventions, which fall under either the health care system level, or wider governmental level, in order to target some of the multiple determinants and impacts of poverty.

Possible interventions at the health-care system level include both better-targeted funding and an overall increase in funding for patients who require financial assistance the most. It has clearly been elucidated from our findings that budget constraints prevent Māori from accessing primary care level services. The current funding in place to improve access to primary care by those in poverty is the government's Very Low Cost Access (VLCA) scheme, a payment made to primary care services (i.e. PHOs and general practices) whose populations are composed of at minimum 50% high needs patients (Māori, Pasifika, or New Zealand Deprivation Index quintile 5). This payment allows practices to charge $12 maximum for those aged 13-17 years, and $18 maximum for adults 18 years and over. However, it is evident from the GP survey responses that this current funding model does not adequately target the patients and practices that need it most. Patients not in quintile 5 still pay the subsidised fee if the practice they belong to receives the VLCA funding. Conversely, patients in quintile 5 who do not belong to a VLCA-funded practice have to pay their fee in full. We propose, in alignment with a significant number of our GPs, that the funding model be reconfigured to follow the patient, not the practice. This could be implemented through the use of a form of identification such as a Community Services card, and could be measured through our framework above, that enables patients identified as eligible for increased financial assistance (for example beneficiaries) to receive this funding that is currently tied up in the VLCA scheme.

The survey results also show that even in VLCA-supported practices, it is still a frequent occurrence for GPs to waive their fees for their Māori patients who cannot afford the reduced consultation price. Evidently cost is still a barrier for many whānau, therefore another recommendation we put forward is for increased funds in general to be funnelled into further subsidising those in need in terms of lowering consultation fees further. These solutions can be viewed as equitable for not only Māori who are overrepresented in our poverty statistics, but also for all those facing poverty in Aotearoa, ethnicity aside. Considerable research would be required to determine the feasibility of such a recommendation as we are aware of the limited capacity of the government's budget and resources. It would be interesting to determine whether the redesigning of the VLCA scheme to target individuals would be cheaper or more expensive to implement, as it would depend on the number of eligible individuals versus the amount of patients currently signed up to VLCA practices who have the financial means to pay a full fee. Another limitation to this proposal for targeted funding is that it may be labour-intensive to continually monitor the eligibility of patients to receive this funding as people are often fluid in their financial status. Nevertheless, funding for those in poverty is a clear avenue in principle for implementing interventions to mitigate poverty and its effects.

With Māori disproportionately represented in quintile 5, interventions also need to be targeted directly at this group in order to reduce this inequity. As commented by one GP, we need a "health care system that provides for Māori to be healthy as Māori, not just a healthy

Māori in an NZ European system". Key informant Dr Sean Hanna commented on the current focus at government level in New Zealand at the moment: "Health dialogue is now about targets (measuring things that are easy to measure rather than things that are important and evidence based for reducing disparities) and about maximising information technology. Neither of these policy directions has had an equity lens applied to them."

An equitable approach requires a 'by Māori, for Māori' approach to health care services, which aligns with article two of the Treaty describing the concept of Tino Rangatiratanga, or self-determination. This could manifest as increased numbers of Māori nurses and doctors working in the community, which would increase the proportion of health professionals with intrinsic cultural proficiency. Improving cultural competency of all health care workers in New Zealand is also crucial in order to provide high quality care to Māori patients and tackle inequities on an individual basis, which are partly due to manifestations of institutional and personally-mediated racism. More community services specifically targeted at the Māori population may also improve health outcomes and reduce inequities, such as marae health clinics, whānau Ora services, and Māori mental health services.

Before describing our specific recommendations pertaining to political solutions to poverty, our research has led us to firstly call into question the current definition and measures of poverty. We feel this could be improved to better embrace aspects of deprivation which go beyond economic and material deprivation currently used as poverty measures. We propose a revised definition of poverty be created to encompass both a social and cultural aspect of deprivation. This arises from our conclusion from the literature and interviews that the poverty experience of whānau Māori is often precipitated, intensified or mediated by social and/or cultural issues including, for example, consequences from historical trauma, the various forms of racism, or other aspects of Nga Hau e Wha as experienced by some individuals. The Meihana Model as discussed previously is a useful framework which could be used to aid the development of a revised definition which takes into account the intangible impacts poverty can have on whānau. Having such a definition which includes a means of measuring these cultural aspects would help to more accurately identify the at need population, enable targets to be set, and thus provide a means of better monitoring of any improvements made to reduce these inequities. Additionally, it provides scope for the measuring of other vulnerable populations in poverty, as specific cultural measures could be created to individualise the definition of poverty for different cultural groups. A limitation to this recommendation is that defining these social and cultural impacts and placing them into a standardized definition and measures may be logistically difficult due to their inherent intangibility.

While health is an important issue for Māori living in poverty, it is only one of many which need to be addressed in order to make a significant difference in their lives. A lot of the changes that need to be made are outside the realms of healthcare, and largely need to be tackled at a governmental/political level. As commented by one GP in the survey, "Healthcare is the ambulance at the bottom of the cliff. We need affordable, high quality housing, accessible benefits, higher minimum wage, and free quality childcare from an earlier age." We propose that there need to be major changes at a political level in order to improve the lives of all New Zealanders in poverty, while ensuring that the inequity between Māori and Pākehā is also addressed. The changes we are suggesting are significant system changes, but we believe they are achievable and can be carried out with a combined effort at a political level, with the aim of abolishing poverty in Aotearoa. Policies to promote

healthy living may help improve the health of this vulnerable population, for example by taxing sugar and making healthy food more affordable by removing GST from products like fruit and vegetables. Funding to improve the quality of state housing, in particular through adequate heating and insulation, is needed, as is a warrant of fitness for all rental properties. Employment is another major area in which interventions could reduce the impact of poverty on whānau. Abolishing zero hour contracts was a step in the right direction, allowing more stable income for many New Zealanders. The next step could involve changing the minimum wage to a living wage, which would give struggling families more disposable income, improving the lives of those who do their utmost to make ends meet each week. Finally, as an addition to increased education on cultural competence for healthcare workers as previously suggested, we feel it is important to instigate personnel training for this across all social services which frequently interact with Māori clients, such as WINZ, in order to better the understanding on how to manage issues and to improve the experiences of Māori who utilise these.

Finally, we recommend further research into different aspects pertaining to poverty in whānau Māori. In particular, more research into the experiences of non-Māori New Zealanders facing poverty would be valuable as it would allow for comparisons to be made between the experiences of the two groups, and therefore better inform Māori-specific interventions to close the current inequity gap.

CONCLUSION

Our findings have added to the research on Māori living in poverty and the real issues they face. It has highlighted the need for Māori-specific measurement and intervention of poverty to reduce inequity in New Zealand as in accordance with the Treaty of Waitangi and the UN Declaration on the Rights of Indigenous Peoples, and that current efforts, policy and welfare strategies do not support this. It has also added a possible framework for measurement of poverty in Māori, and suggested this as an answer to the controversy around definitions of poverty for Māori and targets that could be supported for intervention. Primary care was identified as an important source of both measuring and aiding the effects of poverty and GP cultural competence is important to begin steps toward equity. This also warrants further research into Māori poverty particularly compared to non-Māori, and can also be used as a global case study into indigenous inequity in health and wellbeing.

APPENDICES

APPENDIX 1 - Search Method for Literature Review

A literature review was performed to identify existing literature and provide insight into our topic using the following databases: PubMed, Scorpus, Ovid, Index NZ and Google Scholar. We initially searched using criteria "whānau OR Māori" AND "Poverty or Socioeconomic or deprivation or disadvantage" AND "Youth or young or adolescence*". Following this search, we added on criteria such as OR barriers* OR strategies* OR impacts* OR resilience* OR trauma*". We also extensively used the Family 100 study which was provided by our supervisor. Regarding the health practitioner's views of those in poverty we initially searched using criteria "Health practitioners OR doctors OR general practitioner" AND "views OR opinions OR perspectives OR comments" AND "poverty". Many subsequent articles were found from those referenced in the key articles found in the original search. Articles and reports that were appropriate and relevant to our topic were included in the literature review. Articles were limited to the English language only. Relevant statistics were included in the papers found in the initial search strategy and additional statistics were accessed through New Zealand government websites such as MSD and MOH. A major limitation of our literature review was the lack of current research relevant to our search; We did not put a limitation on publication year as a result of this.

APPENDIX 2 - Invitation Email for GP Survey

Tenā koe,

We are a group of University of Otago 4ᵗʰ year Medical Students currently conducting a study about whānau Māori living in poverty, as part of our public health module.

We would really appreciate it if you could take 5 minutes to complete a short online survey (closing on Monday 10ᵗʰ of October).

This survey looks to establish GP's perceptions of Māori living in poverty. Our research also involves interviewing whānau Māori in the community about their experiences with poverty.

We thank you in advance for your support and for taking the time to complete this survey using the URL provided below.

Ngā mihi nui,

University of Otago Wellington 4ᵗʰ Year Medical Students

Project Supervisor: Dr Keri Lawson-Te Aho

(keri.lawson-teaho@otago.ac.nz)

If you agree to participate in this study any information you provide will be anonymous, that is no one will be able to identify you in any reports that are based on information from this survey. Please click on this link to the survey if you agree to participate. If not thank you for your time.

LINK TO SURVEY:
https://otago.au1.qualtrics.com/SE/?SID=SV_1BbuDejK7fciAfP

APPENDIX 3 - GP Survey

This survey aims to explore GPs perception of whānau Māori living in poverty. This research is being undertaken by 4th year University of Otago Medical Students as part of our public health module. Thank you very much for your participation.

Q1 What is your age?
❍ 25-35
❍ 36-45
❍ 46-55
❍ 56-65
❍ 66+

Q2 What is your gender?
❍ Male
❍ Female
❍ Other

Q3 What ethnic group do you belong to? Select all that apply.

❏ NZ Māori
❏ NZ European
❏ Samoan
❏ Cook Island Māori
❏ Tongan
❏ Niuean
❏ Chinese
❏ Indian
❏ Other (please specify) _____

Q4 Which best describes your GP practice?
❍ Inner city
❍ Suburban
❍ Rural

Q5 Approximately what proportion of all patients you see identify as NZ Māori?
❍ 0-5%
❍ 5-15%
❍ 15-30%
❍ 30-50%
❍ Over 50%
❍ Don't know

Q6 Approximately what proportion of all patients you see would be in quintile 5 (i.e. most deprived)?
❍ Under 10%
❍ 10-25%
❍ 25-50%
❍ 50-75%
❍ Over 75%
❍ Don't know

Q7 Does your GP practice receive the 'Very Low Cost Access Scheme' funding?
❍ Yes
❍ No
❍ Don't know

Q8 Do you ever waive your fees for patients in financial hardship?
❍ Never
❍ Seldom
❍ Often

Q9 Please indicate how much you agree with each of the following statements listed below.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I believe I have adequate knowledge and understanding of Māori culture	❍	❍	❍	❍	❍
My general practice training/experience has equipped me to help Māori patients	❍	❍	❍	❍	❍
My general practice training/experience has equipped me to help patients living in poverty	❍	❍	❍	❍	❍

Q10 From your perspective, on a scale of 1 to 5, rate the following according to importance for whānau Māori living in poverty.

	1 (not important)	2	3	4	5 (very important)
Food	❍	❍	❍	❍	❍
Safety	❍	❍	❍	❍	❍
Health	❍	❍	❍	❍	❍
Rent/mortgage	❍	❍	❍	❍	❍
Power	❍	❍	❍	❍	❍
Quality of housing	❍	❍	❍	❍	❍
Happiness and hope	❍	❍	❍	❍	❍
Alcohol and cigarettes	❍	❍	❍	❍	❍
Wellbeing of children	❍	❍	❍	❍	❍

Q11 Please indicate how much you agree with each of the following statements listed below.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
It is part of the GPs role to ask about financial circumstances of patients	❍	❍	❍	❍	❍
Motivation and hard work allows individuals to overcome poverty	❍	❍	❍	❍	❍
Poverty has been a growing issue at my practice	❍	❍	❍	❍	❍
People who live in poverty present with more severe health conditions	❍	❍	❍	❍	❍

Q12 Please indicate how much you agree with each of the following statements listed below.

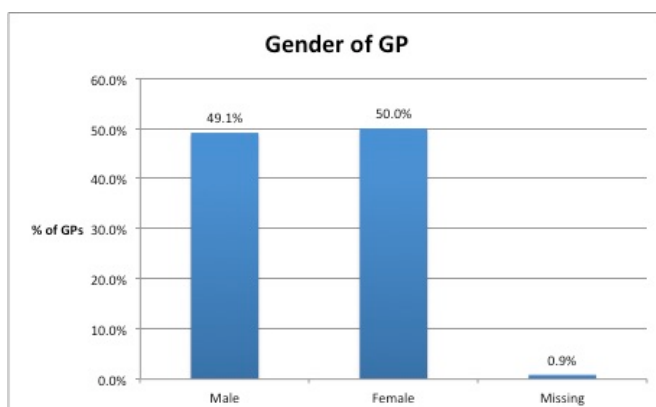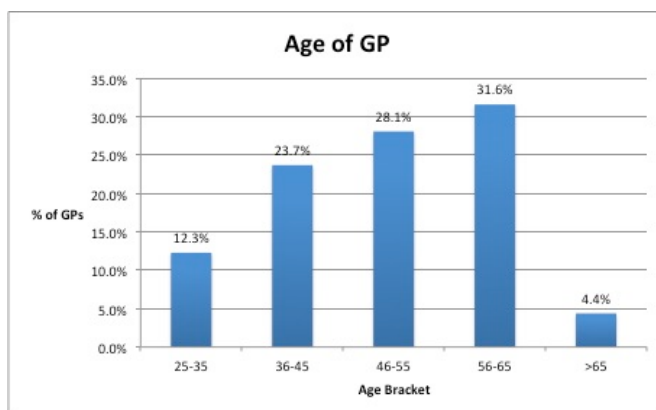|	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
In my experience, poor mental health is associated with poverty	❍	❍	❍	❍	❍
WINZ benefits are easily accessible to the people who need it most	❍	❍	❍	❍	❍
Māori patients living in poverty have worse health outcomes than Pākehā living in poverty	❍	❍	❍	❍	❍

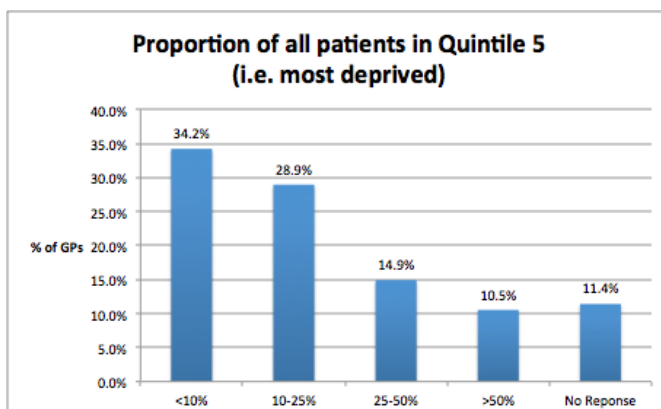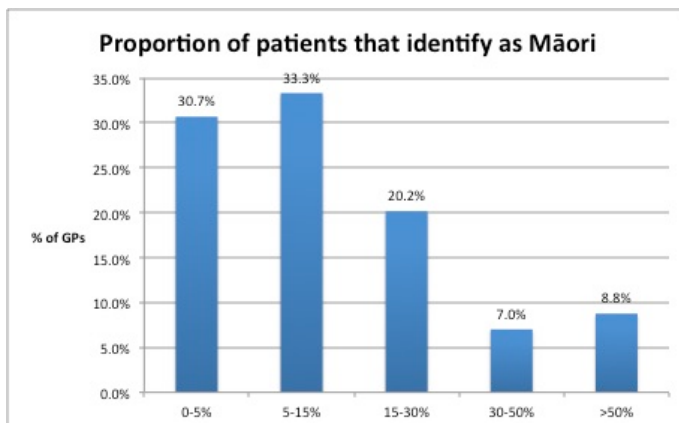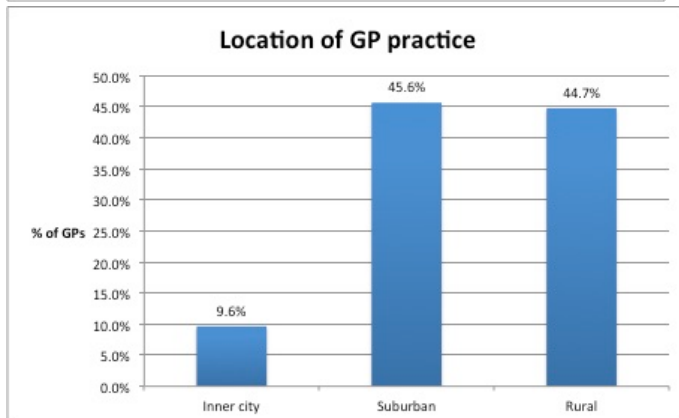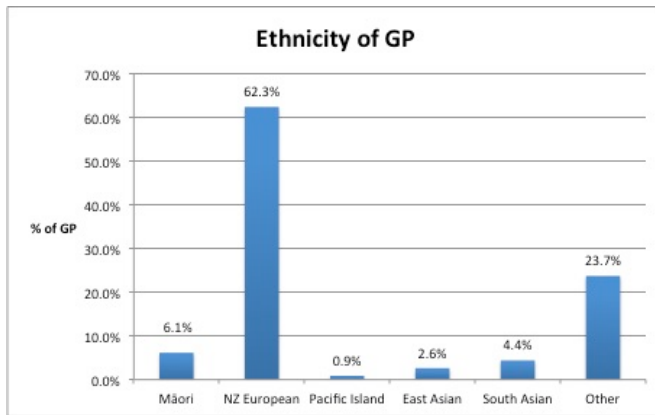Q13 What can primary care do to mitigate the impacts of poverty?

Q14 How can the government more effectively support GP practices dealing with Māori living in poverty?

Q15 Any final comments?

APPENDIX 4 – Demographic Data of GPs answering Survey
All data are represented as n=114

Ethnicity of GP

Ethnicity	% of GP
Māori	6.1%
NZ European	62.3%
Pacific Island	0.9%
East Asian	2.6%
South Asian	4.4%
Other	23.7%

Location of GP practice

Location	% of GPs
Inner city	9.6%
Suburban	45.6%
Rural	44.7%

Proportion of patients that identify as Māori

Proportion	% of GPs
0-5%	30.7%
5-15%	33.3%
15-30%	20.2%
30-50%	7.0%
>50%	8.8%

Proportion of all patients in Quintile 5 (i.e. most deprived)

Proportion	% of GPs
<10%	34.2%
10-25%	28.9%
25-50%	14.9%
>50%	10.5%
No Reponse	11.4%

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