HEALTH (IN)JUSTICE: EXAMINING STRUCTURAL DYSFUNCTION IN HEALTH SYSTEM LAW

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This article explores the ways in which the use of regulation, through the use of law, ethics, policies and standards, raises complex and deeply important questions about the ways in which our systems enable health (in)justice. My research journey started when I sat in a specialist's office as a 19-year-old student at Te Herenga Waka—Victoria University of Wellington, and heard words no one wants to hear. As I sat there with the noises of the world drowned out by those words echoing over and over in my head, I thought about power, privilege and their impact on peoples' access to, and experience of, the health system. Reflecting on vignettes of my experiences as a patient, I discuss the implications of these moments for the law, policy and ethics of health systems. If our health system is an expression of our values, what are they, and how can we and should we use the law to better express and enable them?

I INTRODUCTION

As a 19-year-old student at Te Herenga Waka—Victoria University of Wellington, I developed a range of alarming symptoms. Mauri Ora, as it is now known, acted swiftly and organised a referral to a specialist. On the Thursday before the Easter break, I sat in the neurologist's office and heard words that no one wants to hear. A brain tumour. Multiple sclerosis. I sat there with the noises of the world drowned out by those words echoing over and over in my head. The world fragmented and then reformed. A scan to confirm or exclude the diagnoses was organised for immediately after Easter. Spoiler alert: I had neither, but it was the beginning of a six-year journey through the health system.

As soon as the consultation was over, I immediately went to the public library to research what

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these words might mean for me. As I read, the scream in my head of "why *me*?" transmuted into "*why* me?". I read accounts of how long the process could be at that time in New Zealand to get an appointment, diagnostic testing and a diagnosis. I sat in the neurologist's office and was able to get a scan so swiftly because my parents had private health insurance and maintained my coverage after I became an adult. I had the socio-economic privilege that I could move around the queue for publicly funded services.

But was that fair? In my studies we had been discussing the Woodhouse Report[1] that was the impetus for the development of New Zealand's no-fault accident insurance scheme that replaced suing for compensatory damages for personal injuries in New Zealand in the 1970s. Part of the rationale for the sweeping recommendations in the report were concerns for equality and a perception that the community should be responsible for the protection of all its members who faced physical injury due to an accident. Shouldn't timely access to healthcare be determined by need and not economic privilege? If health is considered a public good and is considered a human right, why should one sector of society have privileged access to health services over another?[2] This raised questions of justice for me. Yet, in my naivety, and because of the situation I was in (otherwise known as self-interest), I was soothed by the logic of capitalism. If economically privileged people were able to access the private system, this would take some of the burden from the public system and enable less economically advantaged people to get access to services sooner. Later research I undertook with a health economist colleague when I lived in Australia confirmed that this was a likely furphy.[3]

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1 Owen Woodhouse, Herbert Bockett and Geoffrey Parsons *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (Government Printer, Wellington, December 1967).

2 A public good is something that benefits the population as a whole, such that government should fund and or provide it universally: Randall G Holcombe "Public Goods Theory and Public Policy" in Jan Narveson and Susan Dimock (eds) *Liberalism* (Springer, Dordrecht, 2000) 125. On health as a human right, see International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976), art 12; International Convention on the Elimination of All Forms of Racial Discrimination 660 UNTS 195 (opened for signature 21 December 1965, entered into force 14 January 1969), art 5(e)(iv); Convention on the Elimination of All Forms of Discrimination against Women 1249 UNTS 13 (opened for signature 1 March 1980, entered into force 3 September 1981), arts 11(1) 11(f), 12 and 14(2)(b); Convention on the Rights of the Child 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990), art 24; International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families 2220 UNTS 3 (opened for signature 18 December 1990, entered into force 1 July 2003), arts 28, 43(e) and 45(c); Convention on the Rights of Persons with Disabilities 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008), art 25; *United Nations Declaration on the Rights of Indigenous Peoples* GA Res 61/295 (2007) art 24.

3 Fiona McDonald and Stephen Duckett "Embracing Private Finance and Private Provision: The Australian System" in Colleen M Flood and Bryan Thomas (eds) *Is Two-Tier Health Care the Future?* (University of Ottawa Press, Ottawa, 2020) 267; and Fiona McDonald and Stephen Duckett "Regulation, Private Health Insurance, and the Australian Health System" (2017) 11(1) MJLH S31. For judicial consideration of this see *Cambie Surgeries Corp v British Columbia (Attorney General)* [2020] BCSC 1310; and *Cambie Surgeries Corp v British Columbia (Attorney General)* (2022) 473 DLR (4th) 1 (BCCA).

The other thing that struck me as I sat in that room, and the many other subsequent rooms in this and other journeys through the health system, was its architecture. Not in terms of actual architecture but in terms of the architecture of power. We had discussed in class how the structure of courtrooms was intentionally designed to reinforce the power of the state, the sense that the individual needed to cower before its majesty or at least be properly deferential to it.[4] The way the judge was elevated above everyone on a dais. The iconography of the state adorning its walls. The room designed so that individuals were supplicants. The use of rituals to reinforce power: standing when the judge enters and leaves; the defendant or applicant remaining silent unless asked by the judge or the lawyers to speak; and the rote words spoken by the judges and the parties. The use of artifacts like, at one time, robes, wigs and gavels. All of these elements were purposefully designed to reinforce power dynamics.

In the spaces in the health system where I frequented, the architecture of power was more subtle, more muted, towards a different end but just as real.[5] The rooms with certificates framed proudly on the wall. The reference books. The informational models and posters. The desk behind which the health professional sits in specialists' offices, often separating themselves from the patient. The apparatus of expertise: the stethoscope, the blood pressure cuff and so on. The long confusing corridors and the inherent stress in navigating your way through unfamiliar surroundings. The waiting room where you approach reception as a supplicant and fidget as you wait for your name to be called before you are ushered into the "presence". The visually depressing environments in most adult-focused health spaces.[6] The sometimes evident hierarchies between doctors, nurses and other health professionals, and within professional groups.[7] And the language and concepts, which can be highly technical if the professional forgets or chooses not to translate. Of course, even if they do, these concepts require a degree of health literacy to navigate. Large numbers of people who are not immersed in that world (and some that are) are not health literate. And some are just too sick or shocked to comprehend.

All of these factors support a profession's claim to power, based on "expertise".[8] But who determines who is expert or has expertise? How and why do we reinforce this?[9] To what end? What

4 Linda Mulcahy *Legal Architecture: Justice, Due Process and the Place of Law* (Routledge, Oxford, 2011).

5 Daryl Martin and others "Architecture and health care: a place for sociology" (2015) 37 Sociology of Health & Illness 1007.

6 At 1007.

7 At 1012.

8 At 1014.

9 Fiona McDonald "Regulation of Health Professionals and Health Workers" in Ben White and others (eds) *Health Law in Australia* (4th ed, Thomson Reuters, Sydney, 2024) 687.

is determined to be the "legitimate" basis for expertise?[10] How can people, professions or organisations challenge or contest expertise?[11]

When the system was first designed, doctors and other health professionals often had paternalistic relationships with patients.[12] However, increasingly, the rhetoric is that we, as a society, are (or should be) moving into a partnership model between patient and health professionals and communities and hospitals.[13] Partnership is considered important as it aims to shift power to a more equal footing and enable patient autonomy[14]—a rationale that supports justice. It is also argued to be structurally important from a population health perspective, as true partnerships can be empowering for groups who have traditionally been stereotyped, discriminated against and/or abused.[15] But what does this purported shift mean for claims to power based on expertise? What or whose expertise should now be legitimated? In what form?

Sometime later in this patient journey I sat in yet another specialist's office. The tone was patronising. I left the consultation feeling that I had been told that my illness was my fault and my responsibility. That I had, as it was implied that many women do, thought myself into being ill. That I was magnifying what I was experiencing for attention. That I should get over myself and my illness. I am sure that many women relate to this type of experience where gender stereotyping, such as the old medical theory that women are prone to hysteria, is used as a way to diminish a woman's concerns about her health and to address uncertainty experienced by health professionals.[16] The term we use today is "gaslighting". It made me second-guess myself for many years. Indeed, today, I still second-guess myself and whether I am imagining something is wrong with my health. This was not just the result of this one encounter but has been reinforced by other interactions I have had with health systems in three different countries.

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10 Fiona McDonald and others "How Do Postgenomic Innovations Emerge? Building Legitimacy by Proteomics Standards and Informing the Next Generation Technology Policy" (2019) 23 OMICS: A Journal of Integrative Biology 406; and Fiona McDonald "The Legal System and the Legitimacy of Clinical Guidelines" (2017) 24 JLM 821.

11 Janice E Graham and others (eds) *The Social Life of Standards: Ethnographic Methods for Local Engagement* (University of British Columbia Press, Vancouver, 2021).

12 See for example Angela Coulter "Paternalism or partnership? Patients have grown up –and there's no going back" (1999) 319(7212) BMJ 719.

13 Coulter, above n 12.

14 Coulter, above n 12.

15 Anna Matheson, Philippa Howden-Chapman and Kevin Dew "Engaging Communities to Reduce Health Inequalities: Why Partnership?" (2005) 26 Social Policy Journal of New Zealand 1.

16 See for example Gabrielle Jackson *Pain and Prejudice: A Call to Arms for Women and their Bodies* (Allen & Unwin, Sydney, 2020); and Anushay Hossain *The Pain Gap: How Sexism and Racism in Healthcare Kill Women* (Simon & Schuster, New York, 2022).

I experienced this treatment because of gender, but everyday Maōri and Pasifika peoples, homeless people, people experiencing disability, people who live in rural areas and many other groups experience gaslighting, its close cousin discrimination, or, at its worst, out and out racism, misogyny or abuse.[17] It is not a revelation that this conduct is destructive of trust and explains why some people are reluctant to access the health system or refuse to do so.[18] It also might, at least somewhat, explain the contestation of medical expertise and knowledge that is increasing at this moment around things like free-birthing or vaccinations.

At the time I was sitting in that particular office, we had anti-discrimination legislation[19] and we were about to introduce individual patient rights after a highly publicised Committee of Inquiry.[20] So was more regulation needed to change the existing system to deal with this? Or did we need to fundamentally reform the way in which health services are delivered to address structural discrimination and misuse of power to ensure justice?

Another thing that occurred to me during journeys through the New Zealand, Canadian and Australian health systems was the impact of public management norms.[21] When the focus turns to efficiency, transparency, productivity and fiscal accountability, it can create perverse incentives to focus on these factors, rather than cultivating relationships of care with patients and/or the safety and quality of care. I felt that what I experienced in these systems was generally transactional. In the moments of intense vulnerability that come with great uncertainty, pain and fear, patients deserve more. We (patients) are not line items on a budget, but are real people, with real hopes and dreams and lives that are complex, multifaceted and relational. We are embedded in our whānau, our friendships and our social networks. We are not impediments to the function of the system but should be its focus. The system and the people who work within it should be set up in a way that acknowledges the complex lives we lead, the choices we make or the choices we are unable to make, because that power or choice has been taken from us or was not afforded to us in the first place.

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17 Ricci Harris and others "The impact of racism on subsequent healthcare use and experiences for adult New Zealanders: a prospective cohort study" (2024) 24 BMC Public Health 136; Sarah Hamed and others "Racism in healthcare: a scoping review" (2022) 22 BMC Public Health 988; and Christy Simpson and Fiona McDonald *Rethinking Rural Health Ethics* (Springer International, Basel, 2017).

18 Harris and others, above n 18; Hamed and others, above n 17; and Sarah Hamed and others "Racism in Healthcare: A Scoping Review" (2022) 22(988) BMC Public Health.

19 New Zealand Bill of Rights Act 1990, s 19; and Human Rights Act 1993.

20 Silvia Cartwright *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (Government Printing Office, Auckland, July 1988); Health and Disability Commissioner Act 1994; and Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

21 Jonathan Boston and others *Public Management: The New Zealand Model* (Oxford University Press, Oxford, 1996).

I recall sitting on a bed in the accident and emergency (A&E) department in Australia with breathing issues and hearing myself discussed as a problem for their statistics. In Australia there were, at that time, targets for how long patients should be in A&E and I was "taking too long … we need to do something about her".[22] I am not sure whether they thought I was struggling too much to hear this or they just did not care. It was an incredibly hard thing to hear that their care was not for me, the patient, who was struggling to breathe despite all the interventions they had used, but that their overwhelming concern was meeting the targets they would be audited against. They then moved me to what was formerly a storeroom with some other patients, as that space did not count as A&E and they could keep their stats up. The feeling of being an inconvenience to a system is very real and it also is something that creates, at best, hesitation and, at worst, refusal to return.

The focus on public management also raises questions about what we perceive that we value the most: economic management or health as a public good. They do not have to be mutually exclusive, but they often appear to be. A decision to close down services in a rural community may be justified on the grounds of economic efficiency, safety or quality (with limited and poor-quality evidence about the latter two), but this ignores the will and choices of those who live in those communities.[23] It may raise greater barriers to their ability to access the right services, in the right place, at the right time and in the right manner, with associated implications for health justice.[24]

By the way, the Australian hospital I just discussed was the same hospital that, on a previous visit to A&E with breathing issues, had asked me if I had private health insurance. They explained that if I had private health insurance, they would admit me, but if I did not (and I did not), then they would discharge me home, in the same condition that I had presented to them, due to ramping of ambulances and a full waiting room. Which brings us in a full circle to privilege, or lack thereof, and how it influences your journey through the system. Is this consistent with our views about justice in accessing a public good?

Many years later it struck me that no one I had dealt with during my illness as a student had asked about any causal factors that may have influenced my illness. When I got ill, I was living in Adams Terrace in Aro Valley. Those of you who have spent time in Wellington will know what this means: no sun, damp, dreary and built into a hillside. I lived in a house built many years ago with no

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22 See Tim Tenbensel and others "Gaming New Zealand's Emergency Department Target: How and Why Did It Vary Over Time and Between Organisations?" (2020) 9 IJHPM 152; and Katie Walker and others "Review Article: Have emergency department time-based targets influenced patient care? A systematic review of qualitative literature" (2021) 33 Emergency Medicine Australasia 202.

23 Simpson and McDonald, above n 17; F McDonald and others "Reconsidering Governance Models to Strengthen Rural Healthcare" (2025) 23(2) Journal of Bioethical Inquiry 377; and Fiona McDonald and Christina Malatzky "Responding to *Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales*" (2023) 20 Journal of Bioethical Inquiry 191.

24 McDonald and others "Reconsidering Governance Models to Strengthen Rural Healthcare", above n 23.

insulation, condensation problems and warped windows that let the wind whistle in. We could not afford to heat it, other than short bursts here and there, and there was a real cost to doing this. I could almost swear that while lying in bed at night I would shift in my always damp sheets and on my mildewed mattress protector and look up from my book to see the black mould spreading across the ceiling and walls to further colonise the space. DampRid did not even put a dent in it. In 2014, Truebridge wryly noted: "Anyone who goes a year living in Aro Valley without getting sick deserves a knighthood, or investigation by medical science at least".[25]

The Healthy Homes initiative was built on the insight that living in a home that was not healthy caused or exacerbated disease.[26] Many of the adverse determinants of health, such as poor housing, low income and food insecurity are disproportionately felt by those who experience socio-economic disadvantage, a status which is again highly correlated with Indigenous peoples and other groups that are considered at-risk.[27] This brings us back to power and lack of privilege.

The determinants of health are critical when we think about justice in the health context. We need to be concerned as much about health outcomes as we are about access to health services, and recognise their interconnectedness. But it seems that the focus of attention in health is often on reacting to problems rather than on seeing whether we can stop issues becoming problems that require health system intervention, whether from primary, secondary or tertiary care services. This is possibly because these issues, poor housing and so on, are often in a separate governance silo from health. They may also be more vulnerable to the pressures of capitalism and ideology. One reason why healthy homes initiatives are so recent in Australasia is resistance based on concerns about property values for investors and the costs of these requirements leading to an exodus of commercial operators and a decrease in rental stock.[28]

Power, privilege and public management are the prominent themes I have explored in my research, and all emerged from my patient experience. My research focuses on the regulation of health and health systems. I think about the regulation of health in a broad way. It is not just what the government does in terms of the law it makes. It includes the other regulatory tools that the government, and other actors like regulators and professions, use to govern the health system, its workforce and the equipment it uses, as well as to promote population health. These tools include law, policy, standards, guidelines, codes of ethics and so on. In other words, I am interested in the

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25 Nick Truebridge "Let's live in… Aro Valley" (2 December 2014) Stuff <www.stuff.co.nz>.

26 Residential Tenancies (Healthy Homes Standards) Regulations 2019; and Ministry of Business, Innovation and Employment *Healthy Homes Standards Discussion Document* (Wellington, 2018) at 8.

27 Ministry of Business, Innovation and Employment, above n 26.

28 Labour Minister describing the National Party's arguments during the 3rd reading of the Healthy Homes Guarantee Bill (No 2). Hon Phil Twyford (30 November 2017) 725 NZPD 622.

constitutive functions of law,[29] or as prominent 20th century legal scholar Karl Llewellyn termed it: "the net organization of the group or society *as a whole* so as to provide direction and incentive".[30] But I am also interested in the impact of regulation on individuals and communities and their relationships with each other and with the world around them: the impact of regulation on society.

I am a multi-disciplinary researcher. I work across disciplines undertaking legal, policy and ethical analysis. But I have also been incredibly privileged to work with many scholars and practitioners from other disciplines and professions. The way injustice presents itself when we design the structures that we use to enable health and provide health services needs attention from researchers and practitioners with varying disciplinary perspectives and different ways of gathering and analysing data.

I have also researched the law, policy, ethics and practices of the health systems of a number of countries: Aotearoa New Zealand, Australia, Canada, England, Indonesia, Nepal and Vietnam. There are more similarities than differences when thinking about health outcomes, health systems and services, and justice. The problems and challenges for health justice are truly both global and universal as well as local.

As academic researchers we build on the work and thinking of others, but we also research what is and imagine what could or should be. In the rest of this article, I will reflect on the limitations of "what is" from a health justice perspective. To do that, we need to go backward so that we can go forward. But before I do this, I want to be clear that I am drawing on my thinking about health systems generally—not just the system in Aotearoa New Zealand but in all the countries where I have undertaken research. While they are disparate in economic capacity, language, culture and in many other ways, they were all, except England (at least not since 1066), colonised by European powers. The impact of international human rights instruments,[31] the World Health Organization,[32] the World Bank[33] and other international (some argue neo-colonial) actors[34] have also influenced, and to some extent standardised, the shape of health systems and their regulation globally.

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29 KN Llewellyn "The Normative, the Legal, and the Law-Jobs: The Problem of Juristic Method" (1940) 49(8) Yale LJ 1355.

30 At 1373.

31 For example, the right to health: see above n 2.

32 The World Health Organization has undertaken extensive work over the years supporting member nations in the areas of developing universal health systems, health system governance, health system performance, and resilience. It has also facilitated international declarations about health services/systems delivery. See World Health Organization "World Health Organization" <www.who.int>.

33 The World Bank "Health" <www.worldbank.org>.

34 Nicole A Szlezák and others "The Global Health System: Actors, Norms, and Expectations in Transition" (2010) 7(1) PLoS Med e1000183.

Health services have been regulated for many thousands of years. The oldest surviving written legal code dates from 1795–1750 BCE. The Code of Hammurabi states:[35]

> If a physician make[s] a large incision with the operating knife, and kill[s] him, or open[s] a tumor with the operating knife, and cut[s] out the eye, his hands shall be cut off.

However, this type of law regulates an individual patient–doctor interaction and reflects the lack of complexity in how health services were provided at that time.

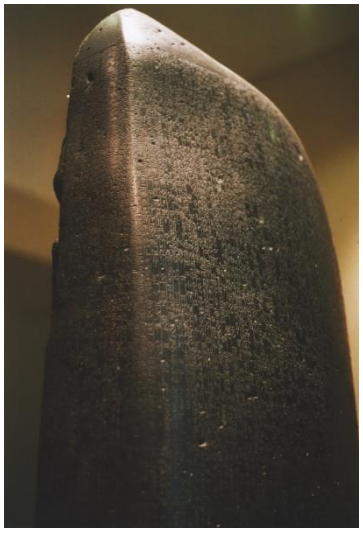


Image of Code of Hammurabi: photograph by Rama, used under CC Attribution-ShareAlike 3.0 France licence without changes.

The starting point for health system law or regulation, as we understand it today, is generally agreed to date from about 200 years ago.[36] English public health law was formulated in the 19th century when intensive industrialisation and urbanisation saw visible population-level health impacts.[37] This necessitated a focus on population-level interventions, which generally tried to

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35 Yale Law School "The Code of Hammurabi" (LW King (translator)) (2008) The Avalon Project <www.avalon.law.yale.edu>.

36 Sam Roach and Fiona McDonald "Public Health: One Health's Influence on Reimagining Public Health Law for the Twenty-First Century and Beyond" in KatieWoolaston and Jane Kotzmann (eds) *The Cambridge Handbook of One Health and the Law: Existing Frameworks, Intersections and Future Pathways* (Cambridge University Press, Cambridge, 2025) 259.

37 Dorothy Porter *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (Routledge, London, 1999).

minimise the spread of infectious diseases and manage the immediate health impacts of occupational and industrial activity.[38]

In work I have undertaken with Sam Roach from Queensland University of Technology, we argue that the shape of public health and public health law, as we conceptualise it today, has its roots in the period that is referred to as the Enlightenment in European history.[39] Enlightenment thinking influenced the structure of modern public health law, as developed in England and other European nations and was transferred to their colonies. It was a movement away from religious dogmas (the truth as decreed by God(s), prophets or the church) as a basis for thinking, to "rationality". Rationality (and by that they meant the use of the scientific method of inquiry and logic) is seen as the basis for developing new knowledge and values intending to drive human progress.[40] In other words: science, not faith. Disease was an impediment to human progress and economic development, and impacted on *human* flourishing, and therefore needed to be managed scientifically. The greatest good of the greatest number of people (a utilitarian approach) was part of this calculation.[41] In many accounts, the gains made through public health interventions such as sanitation, vaccination, industrial hygiene and clean water were framed as an achievement of the rationality associated with the Enlightenment.[42] But "progress" was defined in Eurocentric terms.

Rationalism and capitalism were deeply intertwined. While the free market was seen as important for capitalism to work, it was argued that the state had a role to correct for market failure when capitalism created externalities leading to many people not flourishing.[43] This was complemented by a concern, emerging from philanthropy, about the welfare of the poor and the need for charity (the rich being benevolent towards the "deserving" poor).[44] These factors led to a recognition by the state that it should use law to control certain structural factors that impact human morbidity and mortality at the population level.

Enlightenment thinkers also made a conceptual distinction between humans and nature, departing from past beliefs derived from ancient Greece (especially Aristotle) that there was an integral connection between people and nature.[45] Nature was viewed as both an object of study and an object

38 Roach and McDonald, above n 36, at 259.

39 Roach and McDonald, above n 36.

40 At 260.

41 At 261.

42 Porter, above n 37.

43 Roach and McDonald, above n 36, at 261.

44 At 261.

45 John A Powell and Stephen M Menendian "Remaking Law: Moving Beyond Enlightenment Jurisprudence" (2010) 54 St Louis U LJ 1035 at 1050.

of control.[46] For example, Descartes wrote of making men "masters and possessors of nature",[47] positioning humans as outside of and separate from nature.[48]

Although the Enlightenment was an intellectual movement and a conscious departure from religious thinking, the idea of the dominion of man over nature was also broadly consistent with some versions of religious thought.[49] Capitalism also supported the exploitation of nature to maximise human interests (and especially those of the "civilised peoples", ie Europeans).[50] As Roach and I noted:[51]

> The legal norms emerging from the Enlightenment were therefore inherently anthropomorphic, albeit as many critics justly conclude, in a way that was structured to ignore the interests of those humans and civilisations who were not considered by the colonising powers to meet euro-centric norms (including those living in harmony with nature), who were women, or who were othered for some reason.

The concerns of public health, and health more generally, may arise, and are increasingly arising, from the interactions between people, animals and places.[52] But this line of thinking from the Enlightenment separates these concerns into different governance and legal silos. Even today, this differentiation affects the scope of law-making and regulation more generally.

Part of Enlightenment thinking was an emphasis on the development of "civilisation". Whether peoples were "civilised" was measured against "superior" European norms. Colonisation, with its framing of non-Europeans, and particularly Indigenous peoples, as in need of "civilising", was integral to the thinking of the Enlightenment. Colonisation was framed as an act of beneficence by the civilised to the "inferior" "other". In nations that were colonised, the "uncivilised" were subjected, through the use of law, to processes of forced assimilation[53] and the suppression of health practices that were

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46 At 1050.

47 René Descartes *Discourse on the Method* (Donald A Cress (translator), 3rd ed, Hackett Publishing, Indianapolis, 1998) at 35.

48 Roach and McDonald, above n 36, at 261.

49 See a critique of this view in Peter Harrison "Subduing the Earth: Genesis 1, Early Modern Science, and the Exploitation of Nature" (1999) 1 J Religion 86.

50 Carmen G Gonzalez "Bridging the North–South Divide: International Environmental Law in the Anthropocene" (2015) 32 Pace Environ L Rev 407.

51 Roach and McDonald, above n 36, at 261–262.

52 At 263.

53 See for example Terri Libesman "Dispossession and Colonisation" in Larissa Behrendt and others (eds) *Aboriginal and Torres Strait Islander Legal Relations* (2nd ed, Oxford University Press, Oxford, 2018) 3.

deemed by the colonisers as "uncivilised". An example in the New Zealand context was the Tohunga Suppression Act 1907.[54]

Whether a group was "civilised" or not also drew on the popular understanding of Darwinism and "survival of the fittest".[55] Thus, there was thought by some to be a biological-based hierarchy between civilised peoples and others (race-based),[56] and indeed between men and women (the "weaker" sex).[57] Biological determinism on the basis of race led to a strong eugenics movement in the 19th and early 20th centuries.[58] Eugenics-informed thinking also influenced, in some jurisdictions, the direction of public health and the way in which services were, or were not, provided to groups of the population.[59]

Biological determinism about women also influenced the design and delivery of health services. Interestingly (at least I think so), although women were the "weaker" sex (ie biologically different), they were routinely excluded from medical research until relatively recently for a plethora of reasons, including to protect women and that women's hormones made it all too difficult.[60] Results from studies involving only men were assumed to represent the population as a whole, with adverse effects for women.[61] But I digress. Enlightenment thinking was embedded in what Mercier has described as the "deep institutions of colonisation"[62] (European legal and governance systems and frameworks).

The next major step by governments in the regulation of health systems came with the introduction of universal public health care or universal health coverage. This focused on creating a system where all (or almost all) had access to at least some important health services provided or funded by the state.[63] For some of the countries I have studied this occurred early in the 20th century and others somewhat later. The justification for universal public health systems, and the way in which law was

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54 Repealed in 1962.

55 Diane B Paul "Darwin, social Darwinism and eugenics" in Jonathan Hodge and Gregory Radick (eds) *The Cambridge Companion to Darwin* (Cambridge University Press, Cambridge, 2003) 219 at 236.

56 At 224.

57 Michelle Chilcoat "The Legacy of Enlightenment Brain Sex" (2000) 41 The Eighteenth Century 3.

58 Alison Bashford and Philippa Levine (eds) *The Oxford Handbook of the History of Eugenics* (Oxford University Press, Oxford, 2012).

59 Bashford and Levine, above n 58.

60 See for example Judith H LaRosa and Vivian W Pinn "Gender Bias in Biomedical Research" (1993) 48 J American Medical Women's Assoc 146; and Jonathan M Eisenberg "NIH Promulgates New Guidelines for the Inclusion of Women and Minorities in Medical Research" (1995) 10 Berkeley Women's LJ 183.

61 See for example Eisenberg, above n 60.

62 Ocean Ripeka Mercier "What is decolonisation?" in Bianca Elkington and others (eds) *Imagining Decolonisation* (Bridget Williams Books, Wellington, 2020) 40 at 64.

63 World Health Organization "Human rights" (1 December 2023) <www.who.int>.

used to constitute the system, was deeply entwined with strands of Enlightenment thinking (to varying levels depending on the nation). An example is the need to ensure a healthy population to maximise the opportunities for economic development and ensure states had, and maintained, healthy populations to support power disputes (otherwise known as war and aggression).[64] It was also underpinned by a framing of the state as being paternalistic and beneficent towards the population by creating a system to provide them access to health services.[65] These systems were founded on a concern about formal equality: everyone has equal access, at least notionally.[66] However, formal equality continues to privilege those who already have power, as equality is not equity.[67] Just because the system is universal, it does not mean that people can and will be able to access it, as barriers to their ability to do this remain.[68]

It was also a system that, in concert with prevailing medical practices at the time, justified and reinforced the undermining of the autonomy of persons and peoples, especially those who were othered because of race, disability, gender and so on.[69] It also continued to exclude other "non-rational" understandings, knowledges or ways of doing, especially those that emerged from non-European traditions, about health, what it means and how it can be assured.[70] It reinforced hierarchies of expertise (doctors and scientific knowledge), while also continuing to legitimise professions that in and of themselves were, and are, hierarchical, gendered and paternalist.[71] It continued the focus on human health but also continued the separation of the preventative focus of public health and the delivery of health services: a separation that continues today.

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64 David E Bloom and others "The promise and peril of universal health care" (2018) 361 Science 9644.

65 Norman Daniels "Is There a Right to Health Care and, If So, What Does It Encompass?" in Helga Kuhse and Peter Singer (eds) *A Companion to Bioethics* (2nd ed, Wiley-Blackwell, Chichester, 2009) 362.

66 World Health Organization, above n 63.

67 P Braveman and S Gruskin "Defining Equity in Health" (2003) 57 J Epi & Com Health 254; and Yukiko Asada and others "Unexplained health inequality – is it unfair?" (2015) 14(1) Int J Equity Health 11.

68 See for example Commonwealth Fund "The Cost of Not Getting Care: Income Disparities in the Affordability of Health Services Across High-Income Countries" (16 November 2023) <www.commonwealthfund.org>.

69 Madison K Kilbride and Steven Joffe "The New Age of Patient Autonomy: Implications for the Patient–Physician Relationship" (2018) 320(19) JAMA 1973.

70 Evan Willis *Medical Dominance* (2nd ed, Routledge, London, 2020).

71 See for example Mary Frank Fox "Gender, Hierarchy, and Science" in Janet Saltzman Chafetz (ed) *Handbook of the Sociology of Gender* (Springer, New York City, 1999) 441; Dianna Kenny and Barbara Adamson "Medicine and the Health Professions: Issues of Dominance, Autonomy and Authority" (1992) 15 Australian Health Rev 319; and Eliot Friedson "The Characteristics of a Profession" in Sarah Earle and Gail Letherby (eds) *The Sociology of Healthcare: A Reader for Health Professionals* (Palgrave MacMillan, Basingstoke, 2008) 247.

While a concern about moving from formal equality towards greater equity of access and outcomes was gestured towards in the years following, the next major shift in health systems law, in my opinion, was the introduction of new public management in the late 20th century. The thinking about healthcare was now through an economic management lens. Patients became self-interested consumers.[72] Private management norms were said to promote needed efficiencies within the system.[73] Private delivery, or at least contestable delivery, was argued as being better for the economic bottom-line.[74] Institutions needed to budget-hold, find savings and break even.[75] Funding models in healthcare had often promoted a sense that health services were transactions, but this was exacerbated by the expectations from the new public management. Many aspects of the health system became increasingly impersonal and pro forma. To mangle Immanuel Kant: people felt that they were being treated as a means to an end, rather than being an end in and of themselves.[76] While health was still considered a public good in most circles in these countries, this was to a greater or lesser extent overshadowed by concerns about sound economic management by governments and their promotion of economic growth: the business of healthcare, rather than aroha and whanaungatanga.

It is also important to note the significant impact of the new public management and neo-liberalism on other aspects of governmental operations that impact on health. Hence, we see rising inequities at the population level in relation to income, housing, access to food, education and health outcomes, amongst other indicators.[77] Some countries have seen a leap backward in life expectancy.[78]

The past twenty or thirty years have also seen an increasing scepticism about healthcare as people push back against a perceived lack of care because of competing or conflicting interests, commercialisation and corporatisation, ongoing inequities, time and personal pressures on the professionals who work in the system and the flow-on impact on and for patients.[79] Also of concern

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72 Ruth E Malone "Policy as Product: Morality and Metaphor in Health Policy Discourse" (1999) 29(3) Hastings Cent Rep 16.

73 Boston and others, above n 21.

74 Boston and others, above n 21.

75 Boston and others, above n 21.

76 Immanuel Kant "Groundwork of the metaphysics of morals (1785)" in Mary J Gregor (translator and ed) *Immanuel Kant: Practical Philosophy* (Cambridge University Press, Cambridge, 1996) 37.

77 OECD *Society at a Glance 2024: OECD Social Indicators* (20 June 2024).

78 At 98.

79 See for example Caitjan Gainty, Agnes Arnold-Forster and Paul Addae "Healthy scepticism" (17 January 2024) Wellcome Collection <www.wellcomecollection.org>; and Adnan Kisa and Sezer Kisa "Health conspiracy theories: a scoping review of drivers, impacts, and countermeasures" (2025) 24(93) Int J Equity Health.

is the lack of holistic focus: the need for a care for, and concern about, the person's way of living and values, their joys and fears, and their important relationships with people, animals and place.

Bringing these epochs together, we can continue to tinker with the system to promote justice as equity, rather than equality, but these measures are often ad hoc or undermined by economic rationalism or ideology. Or we can reimagine what a just system would look like: a system that is both relational and integrated. Some might say that this would cost too much, but the costs of continuing with a broken system may be much higher.

Turning to Aotearoa New Zealand, while some might see the door closing on a fundamental revision of law and policy after the current government's decision to end the Māori Health Authority as quickly as it began,[80] I continue to hope for the future. I continue to advocate for a fundamental reimagining and redesign of health systems law and policy, as well as the legal and policy structures traditionally siloed away from health, despite their real, often negative, impact on health outcomes.[81]

If health and equitable access to health services are human rights, as I believe they are, then this analysis indicates the ways in which we currently use and employ law and policy across the board are failing us in seeking to realise this vision. We need to move away from being confined by concepts from the past that still define our norms and move into a future underpinned with values that reflect who we are and who we want to be: a more just system. For me, my patient experiences confirmed that this is a pressing need, and my experiences inform my research journey every step of the way.

80 Ministry of Health "Cabinet and briefing material: Disestablishment of the Māori Health Authority – Next Steps on Māori health" (12 August 2024) <www.health.govt.nz>.

81 See Phil Bagshaw and others "Is health a basic human right or a commodity? Travelling the difficult road toward equity of outcomes" (2026) 139(1632) The New Zealand Medical Journal 92; Phil Bagshaw and others "Cross-sector group outlines blueprint for major health reform" (13 July 2026) New Zealand Doctor Rata Aotearoa <www.nzdoctor.co.nz>; and John Potter and others "Funding the rebuild: Why Aotearoa can afford universal healthcare" (24 August 2026) New Zealand Doctor Rata Aotearoa <www.nzdoctor.co.nz>.