Māori health – moving to equity?

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Tena koutou (Greetings)

• **Eru Pomare Māori Health Research Centre** set up in 1992 to do research by and for Maori and to train Maori in a variety of research methods. University of Otago Wellington

• Ngati Raukawa

• Kikopiri Marae
A youthful population

Māori Population 2006

Non-Māori Population 2006

Source: Hauora IV
What is heath and wellbeing to Maori?

- Rangatiratanga - self-determination, self-actualisation as a people
- ‘Succeeding as Māori’ – language, culture, environment
- Right to health protected, respected, fulfilled,
  - conditions for health
  - excellent health care, including allopathic and traditional healing systems.
- Economic independence
- Politically strong, participating in decision-making
- Healthy in body, mind, spirit, family, land
Shock absorbers

“At Hui Taumata in 1984 Māori were warned to resist policies which make Māori the ‘shock absorbers in the economy’ through hitting those at the bottom of the economic ladder hardest during poor times, while rewarding those at the top of the economic ladder during good times.”

Pōmare et al 1995 Hauora: Māori Standards of Health III. Page 149
Trends in unemployment rates

Unemployment rate, by ethnic group, 1987–2009

Source: Statistics New Zealand, Household Labour Force Survey
Note: Other includes Asian

From The Social Report 2007. MSD.
Life expectancy at birth

![Graph showing life expectancy at birth for different groups over time.]](image)

- Non-Māori (SNZ) Male
- Non-Māori (SNZ) Female
- Māori (SNZ) Male
- Māori (SNZ) Female
- Māori (NZMCS) Male
- Māori (NZMCS) Female
- Māori (MoH latest) Male
- Māori (MoH latest) Female

Courtesy of Tony Blakely HIRP & Martin Tobias PHI
Decades of Disparity III

1 Maori disproportionately in lower socioeconomic strata.

2 Maori : non-Maori inequalities in mortality persist within socioeconomic strata.

3 The different socioeconomic resources of Maori and non-Maori non-Pacific account for about:
   - half of the ethnic disparities in mortality for working-age adults
   - one-third of the ethnic disparities in mortality for older adults.

4 Widening inequalities in socioeconomic resources during the 1980s and 1990s explained about one-third to one-half of the widening mortality gap, at least for people of working age when Place in Labour Market included.

Whakatu and Tomoana Meatworks closure studies

• 1986 closure of Whakatu
• 1994 closure of Tomoana
• Half workers were Māori
• Deaths, hosps, cancers
• Increased suicide risk among redundant workers compared to controls (significant for mid-90s closure)
Unemployment 2004-2009

Unemployment rates, 2004-2009

- Māori Unemployment Rate (%)
- Total Unemployment Rate (%)

Percent

Dec-04 Jun-05 Dec-05 Jun-06 Dec-06 Jun-07 Dec-07 Jun-08 Dec-08 Jun-09 Dec-09
15-24 year olds Not in Education, Employment or Training (NEET)

NEET rates, 2005-2009
Why talk the right to health?

• Equity inherent – includes non-discrimination
• Moves away from ‘deserving/undeserving’ (or ‘vulnerable’?)
• “We have to challenge definitions that are not our own – especially those that confine us to a subordinate place” – Moana Jackson
• States obligated to
  – respect (not to interfere)
  – protect (ensure others don’t infringe)
  – fulfil the right (take positive steps)
  – monitor it in disaggregated form.  
  UN Human Rights Fact Sheets
• Progressive realisation and resource constraint cannot be used to discriminate
Ethnic disparities in health

• Result of the unequal distribution of the economic, social, environmental, and political determinants of health (including access to effective, high quality health and disability services)
Gaps

- Two types of gap to address alongside flattening the gradient
  - **Distribution gap**
    - the unequal distribution of socioeconomic resources or circumstances between ethnic groups.
  - **Outcome gap**
    - differential outcomes for Māori and non-Māori within each socioeconomic category (health outcome or intermediary outcome such as wages per occupational class)
Distribution gap
Māori and non-Māori distribution by small area deprivation, 2001

(1=least deprived) NZDeprivation Index (10=most deprived)

non-Māori
Māori
Outcome gap

Cancer deaths 2002-2006
rates age-sex-standardised to 2001 Māori population
Societal determinants of inequity

• What forces are driving the inequitable distribution of the social determinants of health between ethnic groups?
• Historical and contemporary racism and colonisation (interlocked with other forces)
  – Racism accepted as threat to public health by Ministry of Health – built into the NZ Health Monitoring programme
Self-reported experience of discrimination and socioeconomic deprivation accounted for most of the gap between Māori and non-Māori in

• Self-reported cardiovascular disease
• Poor/fair self-rated health
• Poor physical functioning

Dose response evident

Discrimination

- Systemic or institutional, interpersonal, internalised racism
- Intentional, explicit discrimination
- Subtle, unconscious discrimination
- Aversive – favouring in-group
- Intrinsic – ideological, not rational (regulate)
- Extrinsic – may respond to evidence (educate)
- Cumulative and dynamic
“racism is causally prior to SES and exerts its most profound impact by transforming SES such that an equivalent value on a traditional SES measure represents important differences in social and economic circumstances for persons belonging to different racial groups.”

David Williams 1996
“What if we took the position that racial inequities were not primarily attributable to individual acts of discrimination targeted against persons of color, but increasingly to acts of cumulative privileging quietly loaded up on whites?”

Cancer 2002-2006

Incidence 19% higher, Mortality 78% higher

Rates age-sex-standardised to 2001 Maori population, Registrations adjusted for undercount of Maori

Source: Unequal Impact II (in press)
Colon cancer survival

Figure 16.4: Māori and non-Māori colon cancer survival, 1996–2001 (unadjusted)

Colon cancer survival disparities

• Deprivation (access to health care)
• Comorbidities (affecting treatment options – although not necessary)
• Treatment disparities – similar rates of surgical resection but less likely to receive adjuvant chemotherapy (among stage III)
• Longer waiting times
• No ethnic differences in treatment refusal

Hill S, et al, J Epi Com Health 2010 64;117-123
Colon Cancer Survival, Treatment Disparities

Oncology referral, review, offer and receipt of chemotherapy in Māori and non-Māori patients with stage III colon cancer, 1996-2003

Hill S, et al, J Epi Com Health 2010 64;117-123
Cervical Cancer Deaths 1996-2006
(rates age-standardised to 2001 Māori population)

Where gaps are closing

• Cervical cancer (incidence, survival, mortality)
  – Community development approach by Māori providers
  – Clinical leadership
    • More consistent centralised treatment regimes
    • Supporting diagnosed women to stop smoking
    • Small workforce to upskill

• Breast cancer
  – screening gaps closing in certain areas
  – among screened population Māori women receiving similar treatment (although waiting longer for surgery)
  – But still being diagnosed with larger tumours

• Lung cancer deaths – males
Male Lung Cancer Deaths 1996-2006
(rates age-standardised to 2001 Māori population)

Monitoring developments

• Ethnicity data
  – resources and training for public, collectors, processing, analysing, reporting, interpreting

• Developing survey methods and content
  – equal explanatory power for Māori
  – new content (eg. discrimination questions, cultural content)

• Health sector performance indicators
  – to report to Ministry, Māori governance groups
  – training for Māori governance members
Circulatory disease deaths, by DHB, 2000-2005
(age-sex-standardised rates)
Mana Whakamaarama
Equal Explanatory Power

• Right to evidence that will benefit Māori health

• Good governance – evidence based practice and policy that is at least as valid and effective for Māori as for non-Maori

• Resists marginalisation of Māori population in evidence based health care/development of interventions

• Increases study power to answer questions for Māori

• Increases Māori determining power within research
Health Research

• Building Māori research capacity and control
  – 1990 Key leaders HRC Māori health committee
  – Māori research capacity building fund ongoing
  – Māori assessing committees and funding pool
  – Stronger focus now on building community capacity
    • small grants for developing partnerships, seeding funds, strategic grants, requests for proposals

• Requirement for all to consider relevance to Māori health (and others), provide evidence of consultation with Māori

• Constant vigilance required
Equity initiatives in health policy

Legislation and Strategy (improving health and reducing inequalities) – necessary

Equity tools and training

– HIT Training - collaboration of Māori and non-Māori academics and policymakers
– Health Equity Assessment Tool (HEAT).
– HIA and Whanau Ora Impact assessment training
– “Equity is everybody’s business every day.”

Māori equity advisory groups – accountability
Building Māori health workforce

• Education programmes
  – Te Kotahitanga – changing teachers behaviour to lift Māori student outcomes
  – Starpath – education pipeline through to PHD, working with schools, students, families
  – Tertiary student support programmes, scholarships, mentoring, accommodation support in 1st year
  – Research student programmes – Nga Pae aiming for 500 Māori PhDs
  – Māori nursing programmes – polytech, wananga

• Māori health professional organisations
• “Kia ora hauora” – recruit 1000 Māori into health career in 2 years
Whanau Ora

- Whanau (extended family) -centred initiatives
- Ministry of Māori Development lead agency, with Ministries of Health, Social Development
- Integrated service contracts
- Supporting whanau to support themselves.
- Outcomes focused
Current positives

• Post-settlement Iwi increasing economic power
• Political representation (central govt)
• Māori media
• Education – kaupapa Māori, Te Kotahitanga
• Māori service provision development
• Declaration of the Rights of Indigenous Peoples
• Tobacco endgame on the agenda – iwi on board
• Māori health workforce initiatives
• Māori research and policy developments
Current threats to equity

- Increasingly regressive taxation system
- Recession – unemployment gaps
- Child poverty remains high – likely to increase with new punitive benefit regime
- Environmental degradation (dairy, mining)
- Public health devalued by current Cabinet
- October terror raids – police surveillance of activists and ongoing erosion of civil liberties
- Auckland Supercity merger omitting Māori representation
- Adult education cuts
Transformation

- Changing the inherent character of Aotearoa society to achieve equity in health and the conditions for health
- Māori development – self-determination, strong contribution to decision-making nationally, locally, internationally, economic independence, cultural vigour, environmental recovery, service provision
- non-Māori development – capability building
- Institutional transformation, dismantling ‘whiteness’ and other ‘isms’ to fulfil the right to health for all
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Kia ora!