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Ethnicity, acculturation and health: who's to judge?

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If socioeconomic factors were the only driver of ethnic differences in mortality, Pacific people in New Zealand should have the highest mortality rates. However, Pacific people have intermediate mortality rates between Maori and non-Maori non-Pacific people[1] (although specific health problems such as infectious disease, stroke and diabetes are of pressing concern among Pacific people). Clearly, ethnic differences in health are due to more than just socioeconomic position. It is interesting to speculate whether and how Pacific *culture* has protected Pacific people from the full impact of lower socioeconomic position, and whether any such protection will be maintained into the future with their increasing acculturation. Unfortunately, culture is examined all too often in deficit terms in attempts to explain ethnic differences in health. Research and understanding of the beneficial effects of Pacific culture (and both Maori and the dominant Pakeha culture) on health is required in New Zealand, not just for its own intrinsic value but because it may identify positive policy options for reducing inequalities in health.

In the current issue of the NZMJ two papers address Pacific health issues and cultural contexts.[2,3] Neither paper defines culture, but both imply a definition of culture as a way in which 'human groups create and share explanatory systems about the world in which they live and the ways in which they act according to their shared understandings'.[4] Culture is dynamic, perhaps particularly so when confronted with different explanatory systems. The change in one culture in response to another has been termed 'acculturation', or in some situations 'assimilation'. These papers raise the issue of assimilation and its possible health benefits. Assimilation into a dominant culture has the potential to increase one's 'cultural capital', a term that relates to forms of knowledge and language that are privileged. Cultural capital is a resource that provides a return, for example, in educational success.[5] As such, cultural capital is linked to socioeconomic position and life chances.

Barnes et al focus on Type 2 diabetes (clearly a major health problem for Pacific people), and compare health beliefs and healthcare adherence among Tongan and European patients.[2] In this instance, the authors identify beliefs commonly held by Tongan people with diabetes that (from a largely Western paradigm) are unlikely to be conducive to successful treatment and control of their diabetes: beliefs that God's will and other external factors are aetiologically important for their diabetes, and that their disease is acute and cyclical rather than chronic. However, further interrogation of the data (Table 3) supports the hypothesis that such beliefs are associated with poorer adherence to diet and medication. The implicit message to healthcare practitioners is that asking about Pacific people's beliefs regarding their disease, not just their knowledge or understanding of their disease, is important. However, Barnes et al take a rather individualising model of health beliefs, where the solution is largely to alter incorrect beliefs. We could take the questioning of culture further, and ask what social roles these beliefs play. Why do some members of the Tongan community adhere to diet and medication and others not? If health beliefs sustain other important

social structures and interactions (such as the place that food may have in social interaction), altering the beliefs of individual patients alone is unlikely to result in substantive benefit.

Sixty per cent of pregnant Pacific mothers in the study by Paterson et al had an unplanned pregnancy.[3] If one accepts the (normative) standpoint that unplanned pregnancies are disadvantageous, and there is much empirical evidence that the social outcomes for the mother, child and family are likely to be worse than for planned pregnancies, this study suggests that more needs to be done to provide contraceptive advice and services to Pacific women. Here, too, culture and acculturation are important. Higher education, being born in New Zealand, and living longer in New Zealand (indicators of increasing cultural capital) are all predictive of a planned over an unplanned pregnancy. Contraceptive choices and behaviour are about more than just culture, though – for example, and most obviously, gender is also a major factor. Park et al, in their research on sexuality and reproduction, found that in the Samoan community children were seen as God's gifts and a blessing.[6] For the younger men contraception was a part of God's way of teaching them to plan, but for the older men the suggestion that they could not provide for a large family would insult their masculinity. An important point to take from this finding is that the notion of God's blessing can be assimilated into quite different behaviours.

Two other papers in this issue consider Maori health from an epidemiological perspective.[7,8] Ellison-Loschmann et al add to the evidence base on Maori/non-Maori differences in asthma by reporting that asthma hospitalisation rates among Maori are higher than among non-Maori,[7] despite most other studies finding a similar prevalence of asthma by ethnicity. At a further level of detail, the elevated rates of asthma among Maori were most pronounced in rural areas. (However, one has to be cautious at this level of analysis – undercounting of Maori deaths (although not hospitalisations) has been shown to be less common in rural areas compared with urban areas.[9]) Assuming the pattern is real, the results again point to the importance of accessibility to health services. However, it is not clear which aspect of health services is important. Is it the access to primary care, quality of primary care delivered, preferences of the caregivers/whanau, or even simply the patient's distance from secondary health services? Given that rural Maori communities are often long distances from hospitals, a lower threshold for overnight hospitalisation may be a desirable and prudent measure in case symptoms flare up again overnight.

The final paper on Maori road crash injuries (fatal and non-fatal) by Sargent et al provides a descriptive account of demographic, crash and clinical characteristics of nearly 10 000 Maori injured in or by motor vehicles from 1980 to 1994.[8] Whilst not an analytical study (ie, there is no comparison group), the absence of ethnicity data on police crash reports means that this linked police–health data set provides hitherto unknown information. As the authors state, meaningful comparisons of risk characteristics over time were not possible due to varying data quality over time. This inability to make comparisons over time is most unfortunate, as it prevents a deeper understanding of why and how Maori road-traffic-crash fatality rates remained the same (or even moderately increased) during the 1980s, then decreased during the 1990s.[1]

The explanations for ethnic differences in health are many and multi-layered. A range of research from a variety of perspectives will assist in finding significant intervention

points in terms of both aetiology and policy. Growing cadres of Maori and Pacific researchers are critical to this journey of understanding. In raising the debate about the role of culture it could be easy to fall back on the colonialist and imperialist project of assimilation. More considered approaches would explore the ways in which culture acts as a resource, and the ways in which cultural capital can be built without the negative aspects of assimilation. Ellison-Loschmann et al offer a way forward here, when they point to findings that asthma self-management programmes have been successful when planned, established and maintained through active Maori involvement.[7] An ownership model may offer a way of building cultural capital, maintaining shared understandings and resisting deficit models of culture.

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