

1 UNDERSTANDING HEALTH INEQUITIES¹

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Māori have the right to monitor the Crown and to evaluate Crown action and inaction.

This right is derived from different sources. Firstly, from our indigenous rights embodied in the United Nations Declaration on the Rights of Indigenous Peoples (United Nations 2007) and reinforced by the Treaty of Waitangi (CERD 2007). The primary right of indigenous peoples is to self-determination, which includes to name ourselves as tangata whenua and be recognised as such. As tangata whenua, our duty includes ensuring the wellbeing of all people in our territories, Māori and tauīwi. This necessitates Māori monitoring health, including any disparities in health outcomes between Māori and non-Māori.

Secondly, our right to monitor the Crown is derived from the consistent, comprehensive and compelling disparities in health outcomes, exposure to the determinants of ill-health, the lack of health system responsiveness and the under-representation of Māori in the health workforce. Despite the strength of these long-standing health inequalities, they do not create dismay, disbelief or horror. They have become an expected and accepted feature of Māori health. This acceptance and 'normalisation' of inequalities provides an excuse for government inaction.

Internationally this pattern of ethnic inequalities in health is repeated over and over. Research, both here and overseas, shows a complex, layered spectrum of factors associated with these inequalities that need to be addressed in order to eliminate inequalities and prevent their re-creation. National and international human rights conventions recognise the injustice of these inequalities as well as how they, in turn, generate further injustices. These human rights charters acknowledge that inequities are unjust and assert that where systematic inequalities exist governments have a duty to provide interventions such as affirmative action programmes and legislative protection (Bill of Rights Act 1990, NZ; Human Rights Act 1993, NZ; United Nations 1965, 1980, 2001). Despite this legal obligation to intervene, efforts to reduce and prevent ongoing inequalities in health between Māori and non-Māori continue to be met with powerful resistance by non-Māori, who benefit from them and by those Māori recruited to support this resistance.

What are health inequalities?

Disparities in health status between different groups within a population are found worldwide. These include disparities by age, gender, socioeconomic position, ethnicity, impairment and geographical region. In Aotearoa, ethnic inequalities between Māori and non-Māori are the most consistent and compelling inequities in health (Ajwani et al 2003; Ministry of Health and University of Otago 2006).

¹ This chapter is adapted from Reid P, Robson B. 2006. The state of Māori health. In: M Mulholland (ed) *State of the Māori Nation: Twenty-First Century Issues in Aotearoa*. Auckland: Reed.

Health inequalities, or more correctly health inequities, are defined as “differences which are unnecessary and avoidable, but in addition are considered unfair and unjust” (Whitehead 1992, p. 431). The word ‘inequities’ is preferred as not all inequalities are unexpected or unfair. For example, men get prostate cancer but women cannot and women get cervical cancer and men cannot. These are inequalities (differences) but not inequities (unfair). Equity, like fairness, is an ethical concept based in a model of justice where distribution of resources ensures everyone has at least their minimum requirements. It does not necessarily mean that resources are equally shared; rather, it acknowledges that sometimes different resourcing is needed in order that different groups enjoy equitable health outcomes.

Health equity is defined as ‘the absence of systematic disparities in health (or in the determinants of health) between different social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy’ (Braveman and Gruskin 2003, p. 254). This concept of health equity focuses attention away from the individual and her/his health. Instead it monitors how resources, including health services, are distributed to the community. This includes evaluating the processes that determine how resources are shared and the underlying values of society.

The word ‘inequalities’ in this country is widely used to mean inequities, as are the terms disparities and gaps. In this volume of *Hauora*, we have also chosen to use these terms interchangeably.

Colonisation and health inequalities

It is impossible to understand Māori health status or intervene to improve it without understanding our colonial history. Central to colonisation is creating a ‘new history’. In this ‘new history’ indigenous knowledge and beliefs are relabelled as myths, legends and superstition. The land gets ‘discovered’ by colonisers and the landscape is renamed. Unless we recognise colonisation as a deliberate and continuous process it is easy to assume that colonising events are accidental, inevitable and over. We must never assume that colonisation is something confined to our past. The confiscation of Māori rights to the foreshore and seabed confirms colonisation as our constant contemporary.

Ward Churchill (1996) notes that colonisation is based on dehumanising indigenous peoples. Dehumanisation occurs on a spectrum from genocide to neglect, from paternalism to romanticism. This dehumanisation depends on colonisers having a central belief in their own superiority and that they therefore have superior rights to the territory and resources of indigenous peoples.

This colonial belief in white superiority is born from a racist ideology. The concept of ‘race’ is derived from the simplistic presumption that there is a hierarchy of peoples from black to white, where white is proposed to be more advanced genetically, biologically, intellectually, socially, culturally and spiritually. This idea of a hierarchy of different ‘races’, has long been discredited, yet the term ‘race’ still has popular useage even today, with expressions like ‘race-based funding’. This return to discredited terminology suggests that the foundations of white superiority are still alive and well in our country today.

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In essence, colonisation permits the (mis)appropriation and transfer of power and resources from indigenous peoples to the newcomers. This process of transfer is enabled by layer upon layer of new systems established to determine how resources will be obtained and how they are to be redistributed and to whom. These systems, therefore, construct who will benefit and be privileged.

These new systems are built on new values: they promote new ideas about who is normal (and therefore who is not); who is knowing and who is ignorant; who is civilised and who is barbaric; who is deserving and who is undeserving; and who is good and who is bad. Through this process Māori move from being normal to being 'different' from Pākehā, non-Māori, non-indigenous norms. Māori rights as tangata whenua are appropriated as we become marginalised, reclassified and scrutinised as 'outsiders'.

The new society promotes that their new systems provide equal opportunity for all participants. When unequal Māori outcomes are apparent, the problem is said to lie with Māori through any mix of inferior genes, intellect, education, aptitude, ability, effort or luck. This type of colonial thinking, where the 'problem' or 'deficit' lies with Māori, is called 'deficit theory' or 'victim blame' analysis (Ryan 1976; Valencia 1997). Reports using this analysis seek to brainwash both Māori and non-Māori into believing that the problem is located with us and only us. It ignores system and structural bias. The focus on Māori as 'the problem' ensures that the outcomes of non-Māori are never closely examined and Pākehā privilege never exposed (Fine et al 1997). Evidence repeatedly suggests that Māori are receiving lower levels of health services and poorer quality of service. If Māori are getting less, non-Māori are getting more. Any discussion on equity and rights must be informed by acknowledging this preferential benefit accrued by Pākehā from the systems they introduced and built, and continue to refine and control.

Unequal Māori health outcomes are often represented in terms of increased Māori health needs. Jackson (2002) proposes that it is more appropriate for us to frame Māori health needs as arising as a consequence of our indigenous rights being breached. Recently, both here and internationally, there has been increasing focus on health as an important indicator of human rights, with a growing number of documents discussing the parameters of our right to health (see United Nations 2007).

Understanding causes of ethnic inequalities in health

Some commentators interpret persisting ethnic inequalities in health as evidence of significant genetic or cultural differences between ethnic groups. They hold that what ethnicity measures are factors inherent within the group. However, others disagree and suggest that the health disadvantage measured by ethnicity is external to the group. It stems from the ways in which ethnicity is perceived by and acted on by others (Nazroo 1999).

The view of ethnicity as a *natural* division between social groups allows the *description* of ethnic variations in health to become their *explanation*. So, explanations are based on cultural stereotypes or suppositions about genetic differences rather than attempting to assess directly the nature and importance of such factors. (Nazroo 1999, p.219)

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Krieger (2001) supports the notion that different understandings of ethnic disparities are polarised around two different theoretical positions. First, “the racialised expressions of biology” (Krieger 2001, p. 696), where the different health experienced by ethnic groups is thought to be derived from the groups’ different biology or genetic mix. Second, where ethnic inequalities in health result from processes related to “the biological expressions of racism” (Krieger 2001, p. 696), as our social environment and our place in the social hierarchy shape our bodies.

The term ‘racism’ makes many people uncomfortable. To clarify the term, Jones (2000) differentiates between three types of racism:

1. *Institutionalised racism* is defined as “differential access to the goods, services, and opportunities of society by race²” (Jones 2000, p. 1212). It is illustrated by the different distributions of Māori and non-Māori across deprivation deciles, income brackets and occupational classes (Howden-Chapman and Tobias 2000). These differences will mean that these two population groups have different capacities to participate in various activities, make a full range of choices, to be represented and to be heard.
2. *Interpersonal racism* is defined as “prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives and intentions of others according to their race and discrimination means differential actions towards others according to their race” (Jones 2000, pp.1212–1213). We have seen recent examples in the differential treatment of Māori seeking employment or rental housing (Harris et al 2006a, Harris et al 2006b). Jones notes that this personal aspect of racism is what most people think of when they hear the word ‘racism’.
3. *Internalised racism* is defined as “acceptance by members of the stigmatised races of negative messages about their own abilities and intrinsic worth” (Jones 2000 p.1213). It is manifest when Māori are anti-Māori.

To accept that environmental factors such as racism can influence our physical health we have to visualise a pathway that enables this. Krieger and colleagues (1993) argue that our social environment affects our bodies just as our physical environment does. It shapes what we know, how we understand the world and relate to it, the level of access we have to societal resources and opportunities, as well as our ability to navigate our way through social systems. A critical measure in this model is power and control. It is demonstrated by whether we feel our opinions are heard and respected and whether we believe that we have any choices in, or control over our lives (Krieger 2001). Societies that foster or permit racism, sexism, homophobia and stigma against disabled people have underlying beliefs about the value of peoples they consider different or inferior. These values impact on health and shape inequalities between groups.

Jones (2001) further suggests there are three main pathways that contribute to ethnic inequalities in health:

² ‘Race’ is not used as a biological construct reflecting innate differences but a social construct that captures the impacts of racism.

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1. *Differential access to the determinants of health or exposures leading to differences in disease incidence.* New Zealand evidence includes the very different profile of Māori to non-Māori with respect to the determinants of health such as education, employment, income, housing, income support, dealings with the criminal justice system, health literacy, deprivation, etc (Ministry of Social Development 2006). These factors also pattern exposures to other risks like tobacco use, poor nutrition, overcrowded and substandard housing, unsafe workplaces, problem gambling, and 'binge' patterns of alcohol use (Howden-Chapman and Tobias 2000; Jarvis and Wardle 1999; Shaw et al 1999).
2. *Differential access to health care.* Examples include: Māori experiencing longer and slower pathways through health care (Sadler et al 2004); hospitalisation rates that are disproportionately low in disease categories where Māori have high death rates and a health service configuration where people without access to transport or resources have more difficulty attending health services for both treatment and prevention (Ministry of Health 2006a).
3. *Differences in the quality of care received.* Evidence of Māori being less likely to receive appropriate levels of care is seen in screening for and treatment of ischaemic heart disease (Bramley et al 2004), pain relief during labour and childbirth (Ministry of Health 2006b), the diagnosis and treatment of depression (Arroll et al 2002), diabetes screening and management (Ministry of Health 2005), and higher levels of adverse events in hospital (Davis et al 2006).

In New Zealand, we have direct evidence linking the personal experience of racial discrimination to poorer health outcomes (Harris et al 2006a). In this national survey Māori reported the highest prevalence of 'ever' experiencing racial discrimination (34%) and were also more likely to report experiencing multiple types of discrimination than other ethnic groups. Therefore, any adverse health outcomes as a result of racism will disproportionately impact on Māori. Socioeconomic inequalities (as a marker of institutional racism) and experience of interpersonal racial discrimination appeared to account for much of the inequality between Māori and Pākehā (Harris et al 2006b).

That anyone should experience racial discrimination is an unacceptable breach of human rights. The findings of this work support the growing body of evidence that racism is a major determinant of health and fundamental driver of ethnic inequalities that must be addressed in order to improve Māori health outcomes and reduce inequalities.

The health status of every population is patterned by a great many influences in complex and layered ways that must be understood in order that health interventions be successful. Māori health status in the current context is likely more complex because of the overlay of indigeneity. Commentators who propose simplistic descriptions of our health, or those based on shallow analyses, seek to deny us the right to this complexity and the right to fully resourced and informed solutions.

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Conclusion

There are different views on how to describe Māori health status. These various views debate which measures of health are appropriate, valid and meaningful; what are the current and evolving health challenges facing Māori; what are the likely underlying causes; where (and how) should we intervene; what resources (human, financial and knowledge) are needed to improve Māori health outcomes and eliminate inequalities; and how should progress be monitored. Recognising the diversity of views and opinions in Māori health, in this section we have highlighted various reference points that assist us to understand Māori health within the context of indigenous rights. These issues, in turn, promote approaches to monitoring and intervening for Māori health development.

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