Inequity and Māori Health

Multicultural Perspectives on Neuropsychological Assessment
NZ Special Interest Group in Neuropsychology

Waipapa Marae, University of Auckland
15 September 2014

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Health does not occur in a vacuum

- Health system and health service delivery is informed by Western biomedical approaches.
- Despite “equal access” with have notable disparities in health status and health outcomes.
- Determinants of health and environment count

Socioeconomic Determinants

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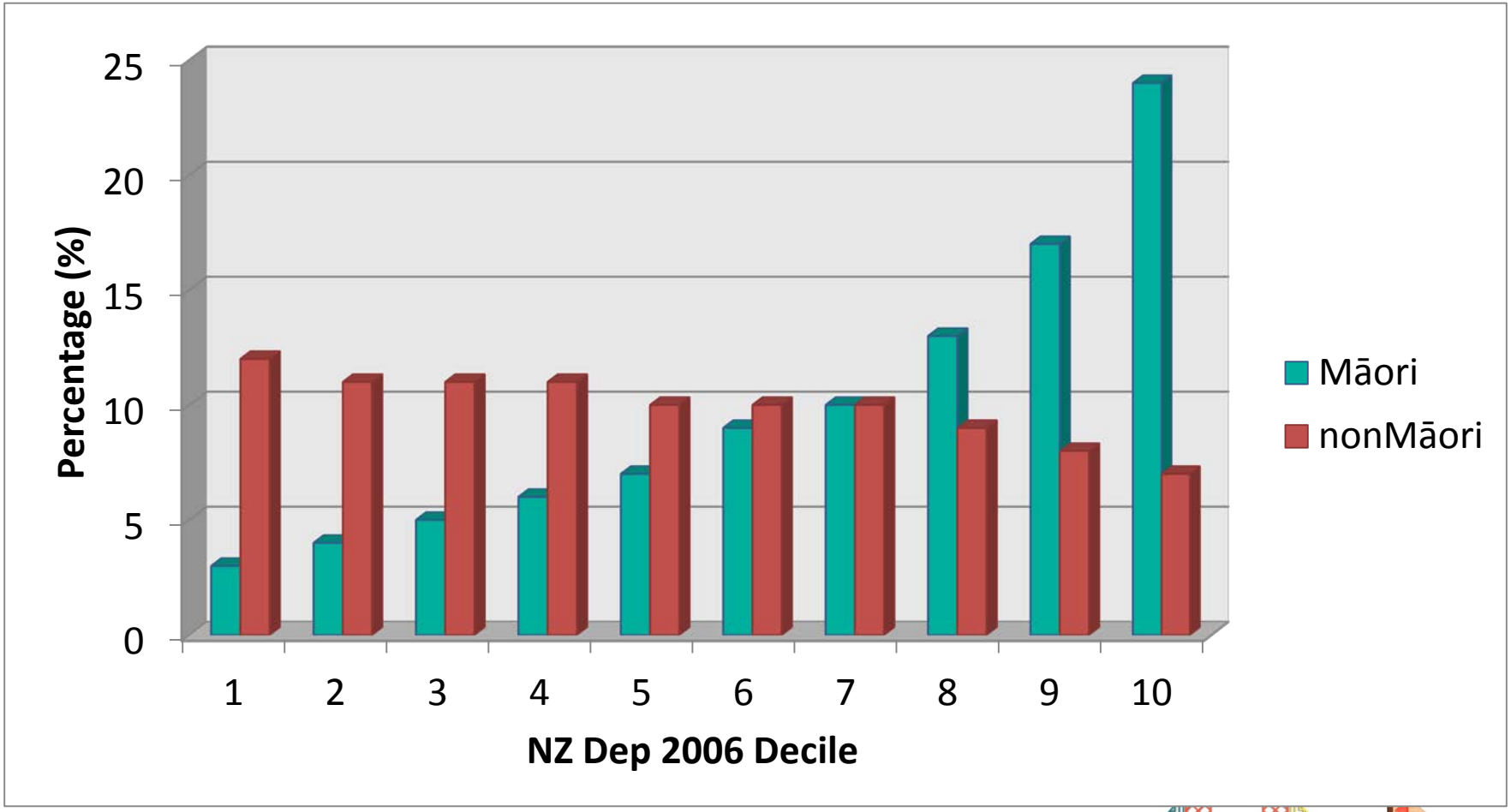
Neighbourhood Deprivation Distribution [NZ Dep 2006] (MOH, 2010)



Socioeconomic Determinants of Health

		Maori		Non-Maori		Difference in 2013 Census
Census		2006	2013	2006	2013	
Median age		22.7 years	**23.9 years**	35.9 years	**38.0 yrs**	**-14.1 years**
≤15 years		35.4%	**33.8%**	21.5%	**20.4%**	**+13.4 years**
> 65 years		4.1%	**5.4%**	12.3%	**14.3%**	**-8.9 %**
Life expectancy	Males	72.1 years –-	**72.8 years**	78.1 years	**80.2 years**	**-7.4 years**
	Females	75.1 years	**76.5 years**	82.2 years	**83.7 years**	**-7.2 years**

(Ministry of Health, 2010; Statistics NZ, 2014)

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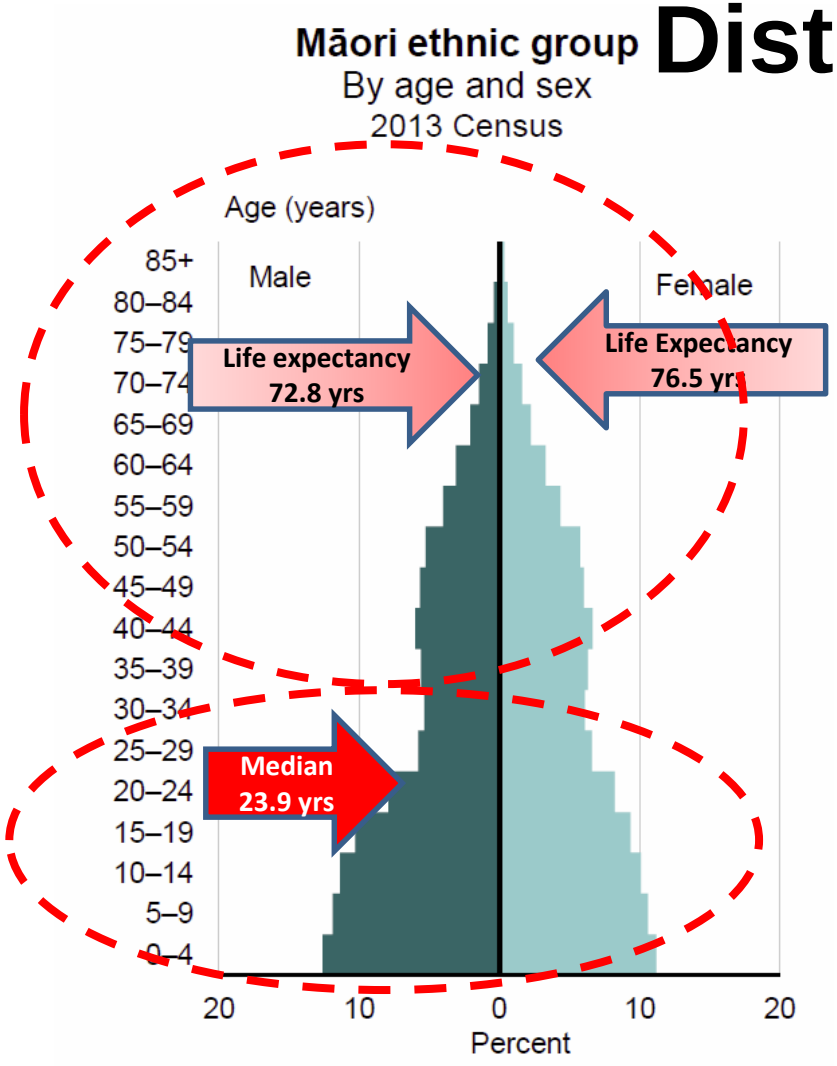
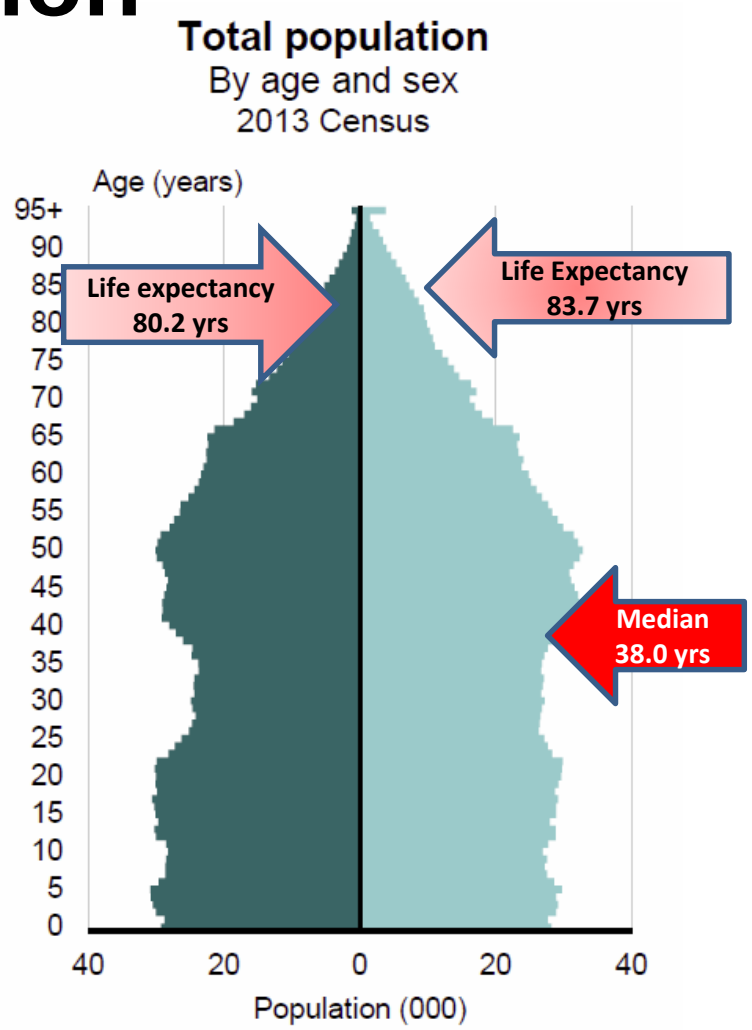
Māori /Total Population Age-Sex Distribution



Source: Statistics New Zealand



Source: Statistics New Zealand

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Socioeconomic Determinants of Health

		Māori	Non-Māori	Difference in 2013 Census
NZDep2006 Decile 10[a]		24%	7%	
NZDep2006 Decile 6-10[a]		73%	44%	
Median income[b]	Total	$22,500	$28,500	**-$6,000**
	Male	**$27,200**	**$36,500**	**-$9,300**
	Female	**$19,900**	**$23,100**	**-$3,200**
	Female diff	**-$7,300**	**$8,000**	-
Unemployment[b]		15.6%	7.5%	**+8.1%**
Household crowding[a]		23.3%	7.9%	+15.4%
Plus.... Telephone, transport, source of income, etc				

([a]Ministry of Health, 2010; [b]Statistics NZ, 2014)

Unhelpful but Persuasive Portrayals

Source: stuff.co.nz; radiolive.co.nz

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Affordability of Food

	Highest Income Quintile Food Baskets		Lowest Income Quintile Food Baskets	
	Typical	**Healthy**	**Typical**	**Healthy**
Affordability (Proportion of weekly household income)	6-8%	8-9%	33-44%	40-48%
Cost	$268.50	$313.40	$222.30	$288.70

(Barosh, Friel, Engelhardt, & Chan, 2014)

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Historical Trauma

- Historical Trauma – massive traumatic event(s) (such as colonisation) that impacts on group of people, which impacts on successive generations (Walters et al., 2011)

- Postcolonial Stress: ". . . Symptoms of sequelae of prolonged and complex trauma across time on psychological functioning. . ." (Stone, 2002, p. 99)

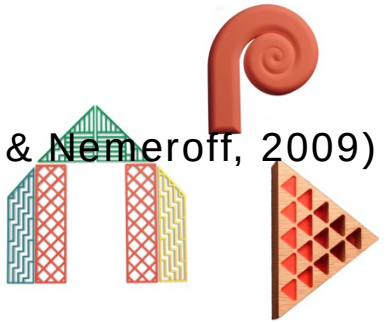
- Impacts on health and wellbeing, attachment, self-regulation, & infant mental health

Epigenetics

Nature vs Nurture

- Genetics vs Environment
- Influences individual's vulnerability OR resilience to disease
- Epigenetic changes result from exposure to stress not confined to individuals
  - Intergenerational transmission
  - Perpetuates adverse effects

(Neigh, Gillespie, & Nemeroff, 2009)



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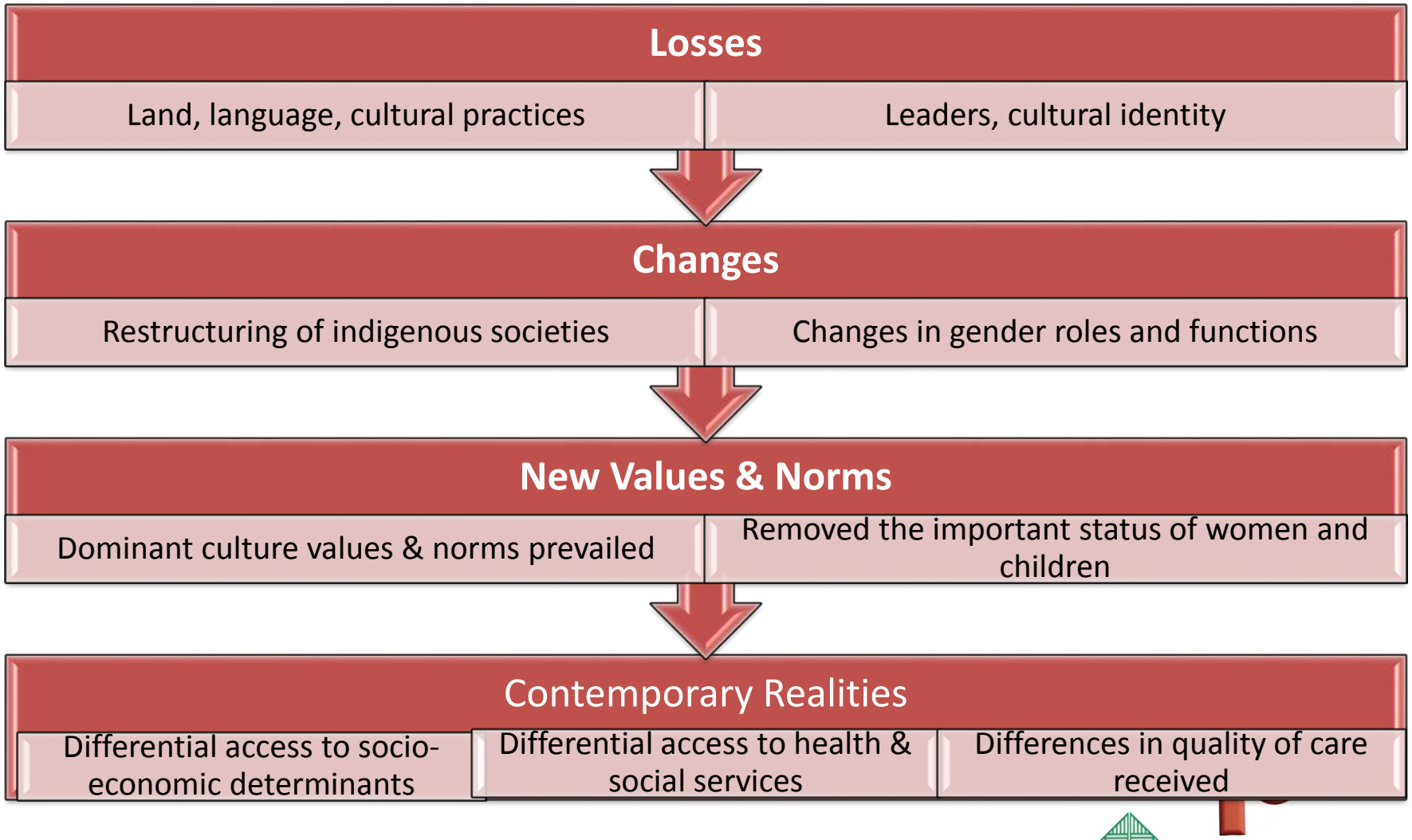

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Resilience

- “What doesn’t kill you makes you stronger”

- Caution – often romanticised that leads to overlooking the ongoing stress and adversity that people who “cope” live with on a daily basis.

Health Literacy defined

‘the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions’

(Kickbusch et al., 2005)

Health Literacy

Ma te whakatu, ka mohio
Ma te mohio, ka marama
Ma te marama, ka matau
Ma te matau, ka ora

Once you have been shown, you will know
Once you know, you will understand
Once you understand, you will have information
Once you have information, you will be knowledgeable.

Pa Henare Tate

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HEALTH SYSTEM EXPERIENCES

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Key Measures

Avoidable Hospitalisations

- **Hospitalisations** <75 years that are:
  - ***Preventable***
    - thru' population-based health promotion strategies
  - ***Ambulatory-sensitive***
    - diseases sensitive to prophylactic/therapeutic interventions delivered in the primary health care sector
  - ***Injury-preventable***

Avoidable Mortality

- **Deaths** in those <75 years potentially avoidable thu' population-based interventions or at an individual level thru' preventive & curative interventions.
  - ***Amenable mortality***
    - Deaths from conditions amenable to health care

(Ministry of Health (2010) [Tatau Kahukura])

Health System Indicators 0-74 years

Health System	Maori			non-Maori			Rate Ratio (RR)
	Male	Female	TOTAL	Male	Female	TOTAL	
Avoidable Mortality	213.7	143.0	330.4	84.4	52.6	68.1	**2.59**
Amenable mortality	73.2	63.3	132.1	32.1	29.4	30.8	**2.2**
Avoidable hospitalisation	6031.6	5867.8	5955.7	3643.8	3077.1	3357.6	**1.77**
Ambulatory-sensitive hospitalisation	4925.4	4853.6	4896.9	2914.8	2492.0	2701.5	**1.81**

(Ministry of Health (2010) [Tatau Kahukura])

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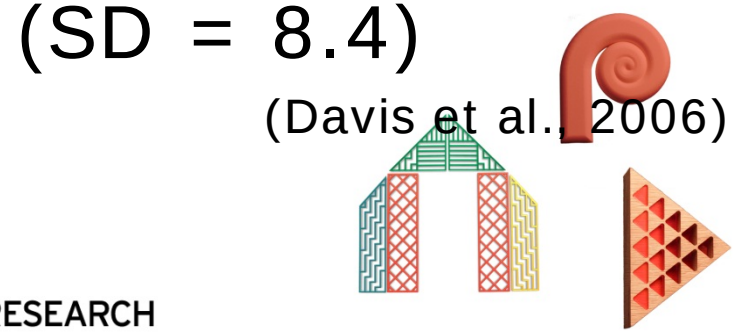
Hospitalisation Experience

- Adverse Events
  - Rate ratio = 1.47 (p=0.05) adverse events while in hospital (Davis et al., 2006)

- Mean Hospital Length of Stay
  - Maori : 4.3 days (SD = 7.6)
  - non-Maori : 5.3 days (SD = 8.4)

(Davis et al., 2006)



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Who gets treated?

"If a price reduces demand by discouraging those with minor conditions from accessing treatment, that's probably good. If it discourages people who need treatment but can't afford it, that isn't good, either for the patient, or for the system, if the condition will require more expensive treatment down the track" (Morgan & Simmonds, 2009, p. 148).

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Diagnostic Tests
Treatment
Positioned on the waiting list

Queue Jumping

YES

1. Do you have health insurance?

2. Can you afford to see the consultant privately?

NO

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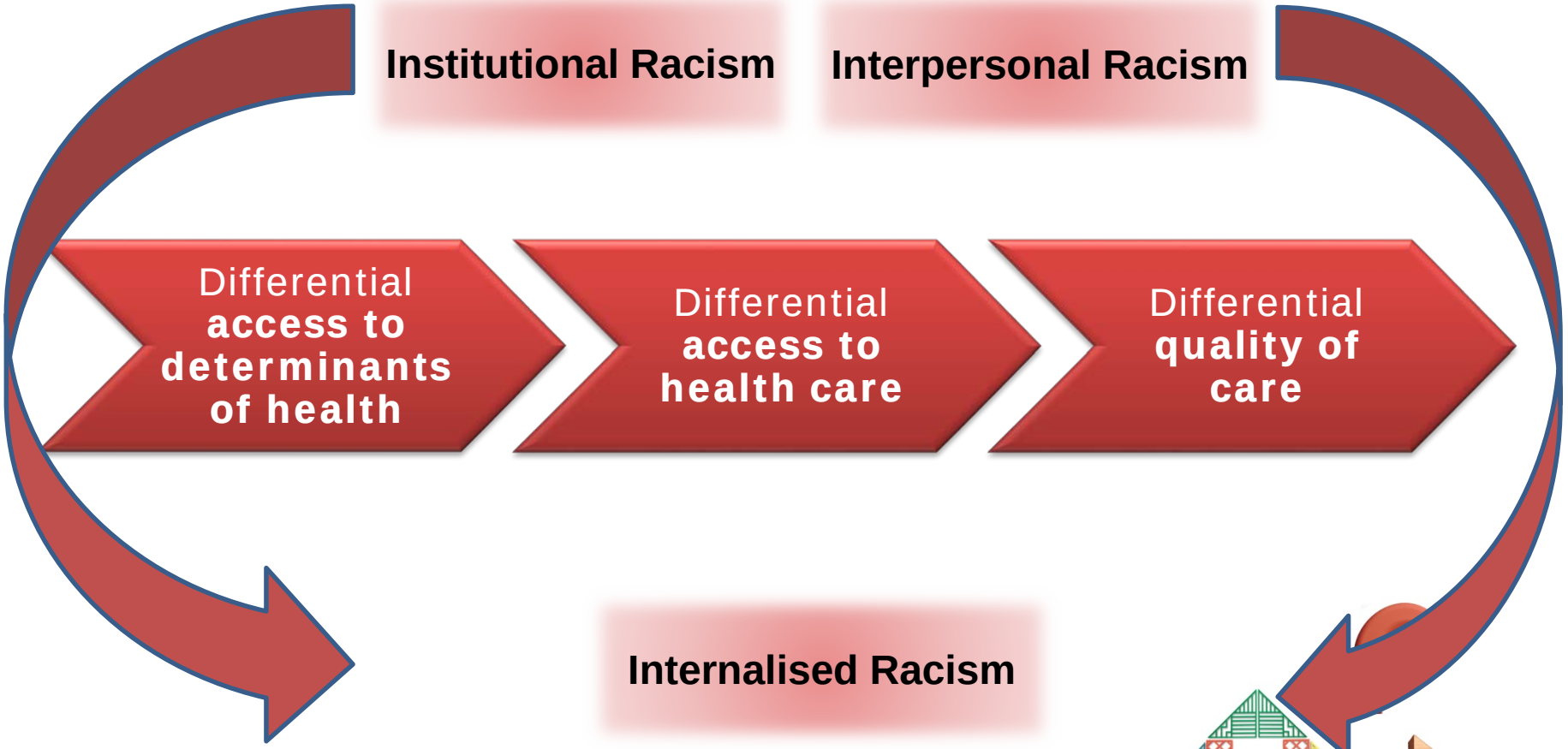
Impacts on Health Experiences

- Maintaining mana and cultural integrity of Māori and their whānau
  - Wairua and whānau are important
- Connecting and relating
- Discouraging environments
- Engaging with health services

Racism contributes to health inequities



(Jones, 2000; Reid, Robson & Jones, 2000)

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Equality – Equity - Disparities

- **Equality** – measurable standard
- **Equity** – normative, value based, ethical principle related to rights
- **Disparities** – strongly associated with unjust social structures
  - Disadvantaged groups are at increased risk of ill-health compounding the socioeconomic consequences of ill-health

(Braveman & Gruskin, 2006)

What Explains Socio-economic Inequalities in Health?

Structural Constraints

Personal Responsibility

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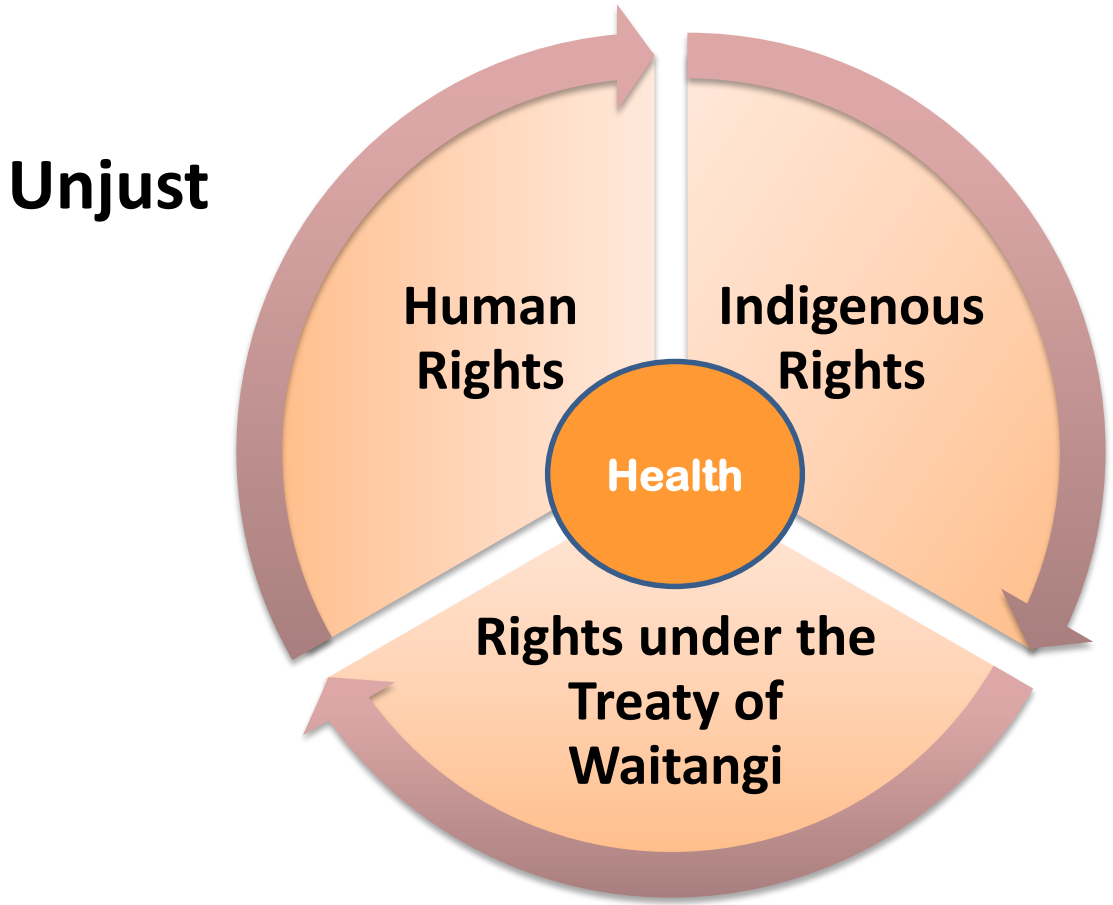
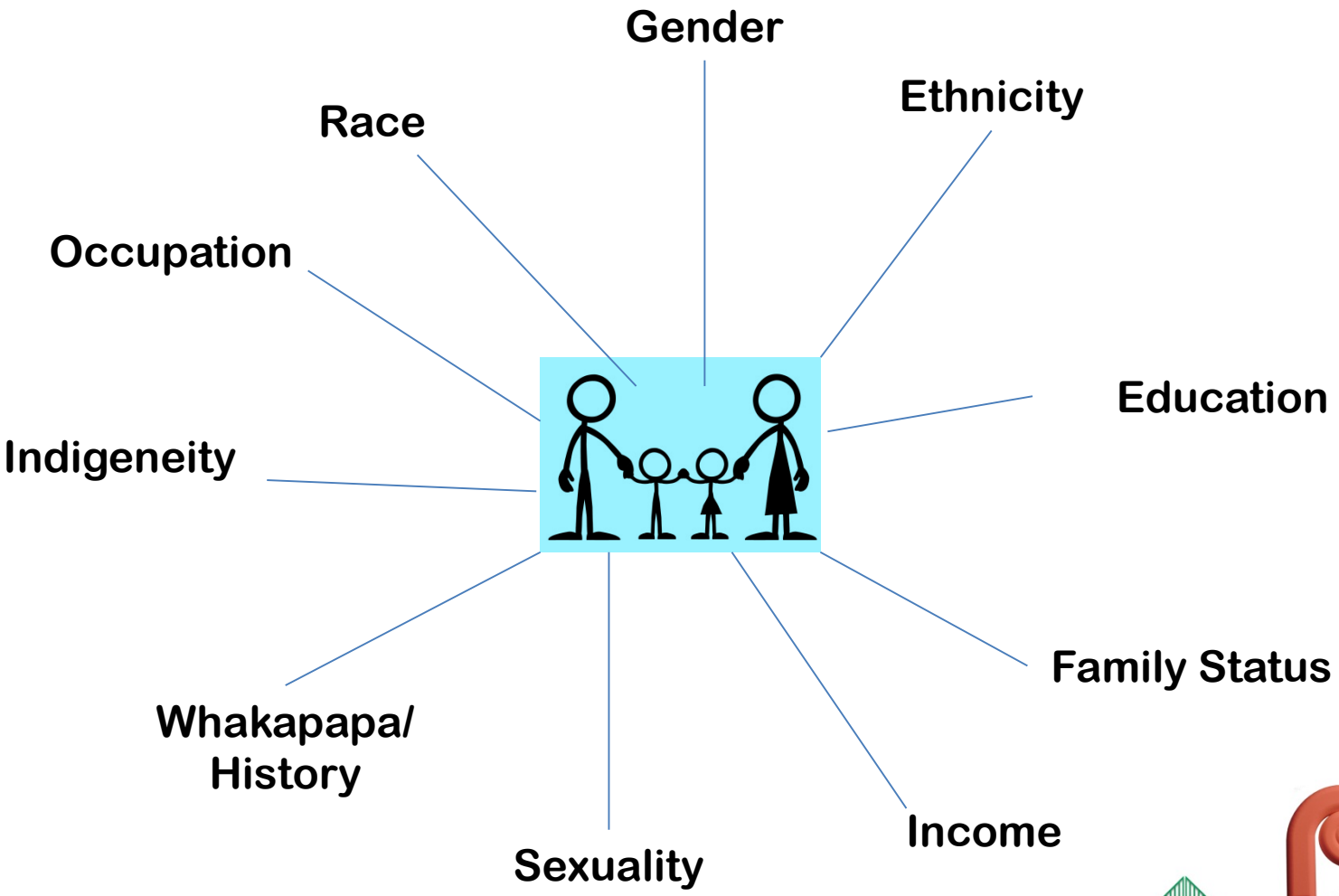
Normalisation of inequalities



Equitable interventions are generally met with resistance

(Reid & Robson, 2007)

Intersectionality



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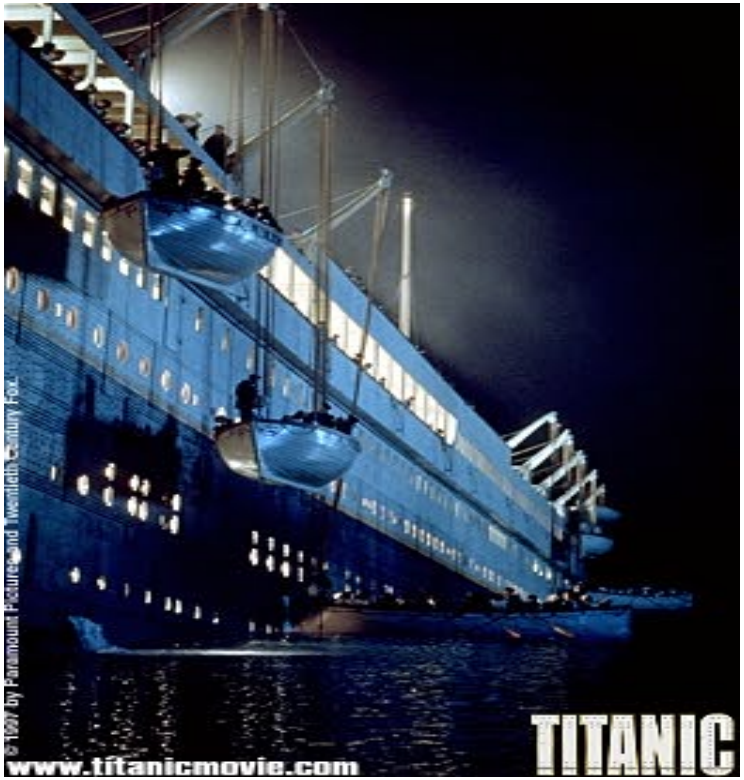
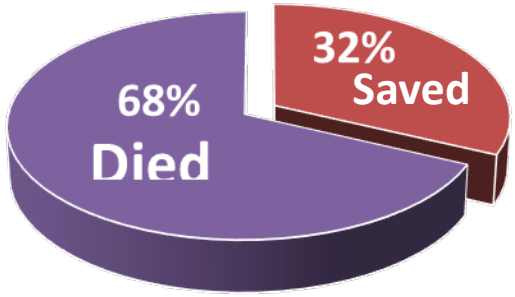
Inverse Law of Care

- Inverse Law of Care

  ". . . the availability of good medical care tends to vary inversely with the need for it in the population served" (Hart, 1971).

Titanic Casualties





Total on Board	**2,223**
Lifeboat Capacity	**1,178**
Total Deaths	**1,517**

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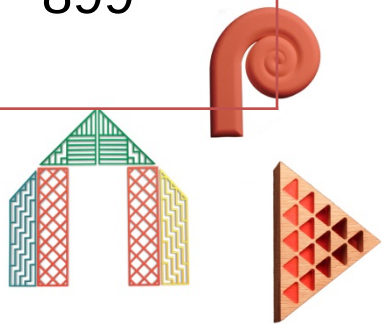
Who were the Titanic Casualties?

CLASS	% DIED	DEATHS	TOTAL
First	**39.5%**	130	329
Second	**58.3%**	166	285
Third	**75.5%**	536	710
Crew	**76.2%**	685	899



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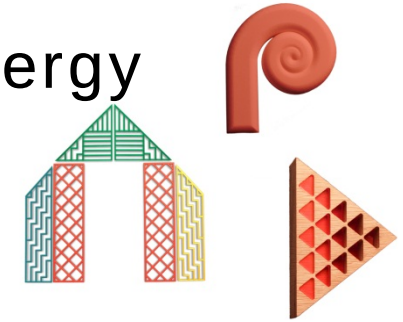
BIAS-FREE Framework

Premises

– Health policies, programmes and practises can impact human rights

– Violations or not fulfilling human rights negatively affects health

– Health and human rights act in synergy



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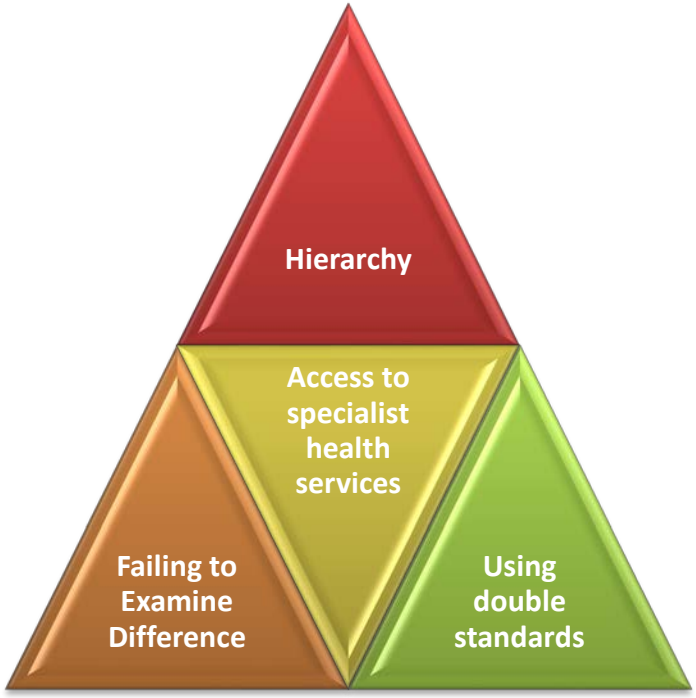
H. Hierarchy



H1: Objectification - But gratitude for 'small things'
H2: Victim-blaming - Held accountable; Without recognition of systemic, structural and interpersonal factors
H3: Appropriation - Cultural safety – originated from concerns
of Māori but "taken over" but lip-service paid/inadequate measures, etc.
H4: Denial of hierarchy - Ethnicity data not used or collected
H5: Maintenance of hierarchy - Dominant group practises are normalised; Focus on individual; Quality of information shared
H6: Dominant perspective - Dominant view of health – denial of importance of wairua and whānau

D. Using Double Standards

D1: Overt double standards - Treated differently, discrimination

D2: Under-representation/exclusion - Evident in inequalities in use of services and access to treatment

D3: Exceptional under-representation/exclusion - Health inequities; Did not attend; Māori representation on committees

D4: Denying agency - Lack of choice/information; Health literacy

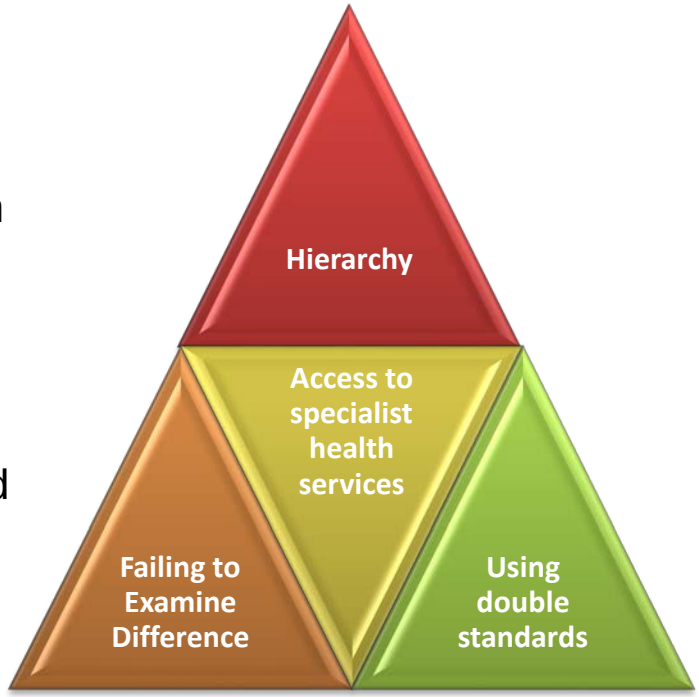
D5: Treating dominant opinions as fact - Stereotypes and commonly held beliefs; Portrayal in media

D6: Stereotyping - Frequently portrayed negatively – e.g. food

in schools cartoons

D7: Exaggerating differences - "Warrior genes" to explain violence

D8: Hidden double standards - "Equal access" to publicly funded health services



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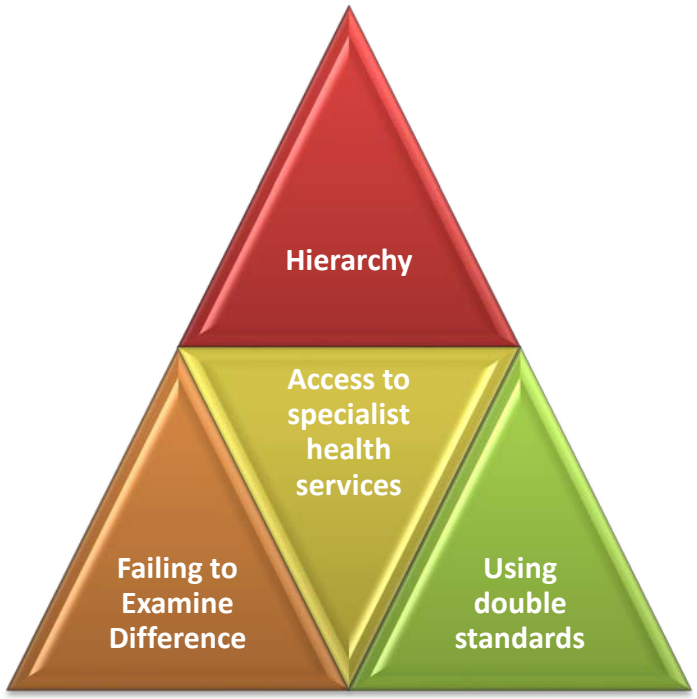
F. Failing to Examine Difference



F1: Insensitivity to difference

"All one people", "Treat everyone the same"

Recognise inequalities exists but avoid targeted services

F2: Decontextualisation

Reality ad social disadvantage not acknowledged/paid lip service

F3: Over-generalisation/Universalism

Accusations of being non-compliant, not caring about health

F4: Assumed homogeneity

"All one people" "Equal access"

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Conclusion

Dominant opinions = Fact

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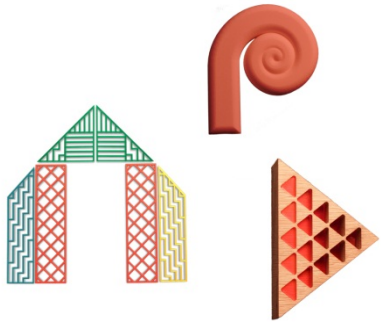
Actual experiences or reality



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