RACISM AND MĀORI HEALTH:
What do we know and what can we do?

Te Tiriti o Waitangi Symposium, Whangarei
Ngā mihi

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- For studies using NZHS data, the Crown is the owner of the copyright of the data and the Ministry of Health is the funder of the data collection for the New Zealand Health Survey.
- Socially-assigned ethnicity, adult experiences of racism and multiple discrimination work was supported by funding from the Health Research Council of New Zealand.
- The views expressed in this presentation are my own.
Overview of presentation

Background
- What is racism?
- How does racism impact on health?
- What do we know about racism and its health impacts?

Racism and Māori health
- How does racism impact Māori health?
- What is the role of racial/ethnic bias among health providers?

Intervening and responding to racism
- What can the health sector do to address racism?
- What can be done at the broader societal level?
Racism is a complex system rooted in unequal power relations by race/ethnicity that involves ... shared social cognition (prejudice), as well as social practices (discrimination), at both the macro level of social structures and the micro level of specific interaction and communicative events” (van Dijk 1993)

Racism manifests as privilege for some, and disadvantage for others
Racism is increasingly recognised as a fundamental determinant of health and driver of disparities

“The purpose of studying health effects of discrimination is not to prove that oppression is “bad” because it harms health … [but] to enable full accounting of what drives population patterns of health, disease, and well-being so as to produce knowledge useful for guiding policies and actions to reduce social inequalities in health and promote social well-being” (Krieger 2000: 39)
Racism and human rights

Convention on the Elimination of all forms of Racial Discrimination
In this Convention, the term "racial discrimination" shall mean any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life”.

UN Declaration on the Rights of Indigenous Peoples

*Affirming further* that all doctrines, policies and practices based on or advocating superiority of peoples or individuals on the basis of national origin or racial, religious, ethnic or cultural differences are racist, scientifically false, legally invalid, morally condemnable and socially unjust,

*Reaffirming* that indigenous peoples, in the exercise of their rights, should be free from discrimination of any kind,
Institutionalised racism

- Differential access to the goods, services, and opportunities of society by ‘race’ or ethnicity, expressed in material conditions and in access to power. It can manifest as inaction in the face of need (Jones 2001)

- “...when an entire network of rules and practices disadvantages less empowered groups while serving at the same time to advantage the dominant groups” (Human Rights Commission 2012: 3)
Personally-mediated racism

- Defined as prejudice and discrimination (Jones 2001)
- Expression of societal racism through interactions between individuals
- Assumptions and stereotypes about groups
- Explicit racially-motivated violence, crime and harassment and subtle, ambiguous actions
- This is often the ‘common sense’ understanding of racism
Prevalence of racism ‘ever’ (11/12 NZHS)

<table>
<thead>
<tr>
<th></th>
<th>Any racial discrimination</th>
<th>Any personal attack</th>
<th>Any unfair treatment</th>
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<tbody>
<tr>
<td>Māori</td>
<td>27.5</td>
<td>22.2</td>
<td>12.4</td>
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<tr>
<td>non-Māori</td>
<td>14.7</td>
<td>12.6</td>
<td>4.2</td>
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Source: Ministry of Health 2015
Pathways from racism to health

1. Structuring of societal resources and health determinants by race/ethnicity

2. Direct physical and psychological effects from racially motivated violence and racial harassment

3. Racism as a psychosocial stressor, impacting negatively on health through chronic exposure to racial discrimination e.g. physiological, psychological and behavioural effects

4. Health care (access and quality)

Evidence of health impacts of racism

- There is now a large body of evidence on self-reported experience of racism and health
- Racism has been shown to be linked to multiple health measures, including mental health, physical health, biological/physiological markers, and health risk factors
- Most of the focus has been on stress pathways
- Less focus has been on impacts on health care
- Limited focus on impacts for indigenous peoples and children

(References: Bastos et al 2010; Paradies 2006; Paradies et al 2008; Paradies et al 2015; Pascoe & Richman 2009; Williams & Mohammed 2009; van Ryn et al 2011)
Health impacts of racism for Māori

- Mental health (e.g. psychological distress, chronic mental health conditions) (Harris et al, 2012a)
- Physical health (CVD, physical health scores) (e.g. Harris et al, 2012a)
- Smoking and hazardous alcohol consumption (Harris et al, 2012a)
- Sleep problems (difficulty falling asleep, frequent nocturnal awakenings, early morning awakenings) (Paine et al, 2016a)
- Maternal and child health, including cortisol in pregnancy (Thayer & Kuzawa 2015), maternal stress and depression (Bécares et al, 2016), and infectious disease hospitalisations (Hobbs et al 2016)
- Racism by a health professional associated with lower likelihood of having cervical screening and mammography (Harris et al, 2012b)
- Negative patient experiences (Harris et al, 2012b)
The need to question and critique

- Shifting the gaze from ‘race’ or ethnicity to an examination of the processes

- ‘Race’/ethnicity $\rightarrow$ racialisation $\rightarrow$ racism

“Racialisation occurs through the marking of bodies. Some bodies are racialised as superior, others as inferior”

(Grosfoguel et al 2015)
Race:— European ½ Polynesian (or more) □

Other (specify)
Racism and Māori health

How does socially-assigned ethnicity (who other people think you are) relate to experience of racism and health in Aotearoa/New Zealand?

- Māori who were socially assigned as European-only had a significant health advantage compared to other Māori after adjusting for age and gender (Harris et al, 2013)

- This appeared to be due to lower exposure to racial discrimination and better socioeconomic position and was irrespective of self-identified ethnicity combinations (Harris et al, 2013)

- We need to shift to examining “… the process by which it [‘race’/ethnicity] becomes meaningful in a particular context” (Garner 2010: 9)
The need to reflect and challenge

- ‘Shifting the gaze from Māori individuals and communities to an examination of the health systems, structures and providers

- Racism → societal discourses and structures → health systems

- Reflecting on whose norms, values, histories, narratives and ways of knowing and being are centred in our health systems? And whose are marginalised?
The need to reflect and challenge

- Colonisation disrupted existing health systems and imposed new structures
- Hospitals established to meet settler population priorities
- Land used to provide facilities to service intended population

“From the outset, hospitals were located in settler towns. As a result, it was the pattern of Pakeha settlement and urbansation that determined the geography of hospital locations. A number of rural hospitals did serve nearby Maori communities. But the majority of rural Maori did not live close to the rural hospitals in Pakeha districts, and even further from the large town hospitals” (Waitangi Tribunal 2001: 131)
Societal racism interacts with clinicians’ perception of patient race and common social-cognitive processes to influence clinicians’ implicit and explicit beliefs about, feelings towards, and expectations of patients independent of other patient and clinician characteristics” (van Ryn 2011: 204).

Racial/ethnic biases may impact on both the healthcare encounter (through influencing both provider and patient behaviour or feelings) and decisions about care (by both the provider and the patient) (van Ryn & Fu 2003)
Implicit racial bias and health inequities

Figure 1. Model of paths through which provider implicit bias may contribute to health disparities.

Source: Zestcott et al, 2016
Health provider racial/ethnic bias

- Studies with health providers have shown racial/ethnic bias among a range of health providers.

- Some associations have been found with clinical decision-making, but not consistently.

- Associations with measures of the health care encounter, e.g. communication, outcomes of interactions, are more consistent.

- We know that health providers have stereotypes and generalisations about Māori patients.
Bias and decision-making in medicine

Study aimed to:

- To investigate ethnic bias in relation to Māori and NZ European people among NZ medical students
- To determine whether any such bias is related to clinical decision making

Study was an anonymous web-based study with final year medical students, and included:

- Measures of implicit bias
- Measures of explicit bias
- Clinical vignettes
Bias and decision-making in medicine

- All final year medical students in 2014 and 2015 invited to participate (n=888, across two medical schools)

- Cross-sectional anonymous online study to measure multiple dimensions of ethnic bias (beliefs, feelings, and discrimination) in relation to Māori and NZ European

- 302 students participated (34% response rate)

- Development of study published elsewhere Harris et al 2016
Bias and decision-making in medicine

- In the depression vignette, some differences in the order of how recommended treatment options were ranked by patient ethnicity.

- In analysis of association between implicit/explicit bias measures and vignette questions, explicit preference for NZ Europeans was associated with response to question about likelihood of benefitting from treatment (slope difference 0.34, 95% CI 0.08, 0.60; \( p = 0.011 \)).

- Ethnic bias demonstrated among medical students.
- Inconsistent associations between ethnic bias and clinical decision-making in our study (Harris et al, 2018).
What can we do in the health sector?

Name racism (Camara Jones)
- As a health determinant and a global public health issue

Ask “How is racism operating here?” (Camara Jones)
- In our policies, processes, practices and structures
- In our organisations and interactions

Interrogate health systems and structures
- Monitor and audit health services for racism
- Make healthcare environments conducive to anti-racist practice
What can we do in the health sector?

Promote reflexivity and empathy
- Reflect on assumptions and stereotypes
- Understand the contexts within which you work

Think critically about ‘ethnicity’ and Māori health
- Challenge discourses that position ethnicity as the risk factor
- Shift our gaze onto the environments that create health risk for Māori
- Focus on the processes that make being Māori significant in relation to a particular health outcome (Garner 2010)
What can be done more broadly?

Reduce the health effects of racism: improving socioeconomic opportunities (Williams & Mohammed 2013)
- Improving environments and social conditions in neighbourhoods, housing, income, employment, and education
- Reducing violence and incarceration

Reducing the health effects of racism: reducing cultural racism (Williams & Mohammed 2013)
- Reducing stereotypes, racial prejudice, and discrimination in the general public and within societal institutions (e.g. media, social institutions, policy, person-level)
- Campaigns such as #givenothingtoracism

Promote and advocate for the right to be free from racism and all forms of discrimination
We need to imagine a future that is different and better for our tamariki and mokopuna
Acknowledgements

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References


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