IMPACT OF MIGRATION AND SOCIAL DISADVANTAGE ON MAORI AND PACIFIC ISLANDER HEALTH IN AUSTRALIA

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ABSTRACT
This research represents an examination of the role of class and culture in understanding obesity-related disease and the experience of related illness prevalent in this growing population group. With Polynesian communities in Australia there are often indicators of social disadvantage in relation to health care information and access, as well as issues such as over-crowding and poor primary health care common to low income families. This paper will also examine the role played by cultural practices surrounding food in helping to maintain identity in a ‘new’ country.

In Australia this area of study has been extremely limited in scope and reference. Many Maori and Pacific Island migrants from the Cook Islands, Samoa, Niue and Tonga come to Australia as ‘New Zealanders’, therefore it is very difficult to separate the health statistics and lifestyle issues specific to this experience. For this reason I have also examined data from New Zealand with its much larger Polynesian population, and which in many ways, is light years ahead of Australia in terms of this area of health research.

1 INTRODUCTION
As more Maori and Pacific Islanders are migrating and making their home in Australia, the health problems which have been identified in New Zealand are becoming increasingly evident across the Tasman. Preventable debilitating diseases, commonly associated with long term social disadvantage are highly represented - in particular heart disease and diabetes. This has led me to focus my academic work on this issue and hopefully make some small contribution to raising awareness in this area, both in the community and with health care professionals in Australia who have little experience or knowledge of Polynesian cultural practices. As with any enquiry into indigenous or migrant health, this project involves the delicacy of ‘Insider/Outsider’ issues relating to the gathering of information. Because I considered it essential to cite this research within localized, cultural understandings of health and illness I chose to use the methodology of Kaupapa Maori, pioneered in New Zealand (Smith:1999). This methodology embodies the ethics of ‘Cultural Safety’, allowing participants to be part of research planning, to use their language of choice and contribute to the direction of outcomes (Eckermann:1995). My on-going involvement with many Maori and Pacific Islanders outside my academic work, has enabled me to interview family groups, individual respondents and key informants who are Polynesian nurses and health workers trained and practicing in Australia.

Further to the choice of methodology, was the decision to research these population groups collectively. There were several reasons for this. Firstly the numbers from each represented group in Australia are quite small, although growing. Secondly each of these groups share marked similarity of health profiles – post colonial dislocation, current social
disadvantage such as household overcrowding, and similar childbearing statistics. There are also significant common or related cultural practices in relationship to food. Finally, because of the rate of intermarriage between members of these different population groups, it became impractical segregate one target community and respondents themselves suggested the grouping.

2 DISCUSSION

Newly released Australian Census figures confirm that Polynesians are arriving in Australia in increasing numbers, with Maori immigration increasing by almost one third since the last census to 92,911 (Australian Bureau Statistics:2006). The escalating number of Pacific Islanders - combined figures for Samoans, Tongans, Niueans and Cook Islanders in Australia have now reached 72,082 (ABS:2006) - appears to reflect the ‘beaten path effect’, whereby prior immigration of extended family members and established community ties, are regarded as significant factors in explaining current immigration patterns.

2.1 MIGRATION, IDENTITY AND HEALTH

In New Zealand, considerable work has been done to expose the relationship between land and language loss, security in identity, social disadvantage and health. When compounded by migration to a country such as Australia, where Polynesians make up a small minority within a larger population group, these issues are further magnified. For many children of Maori and Pacific Islanders born in Australia, they face the challenge of creating an identity informed by their parents – yet different.

‘There’s nothing wrong with growing up being an Australian, an Aussie, but you are not from here, your blood is Pacific Island, something they must never forget’
Teata Ruapuna, Cook Island migrant to Australia (Rodriguez:2003)

Being born in a country, once or even twice removed from your ‘country of origin’ adds to the complexities of defining a modern identity when exposed to a myriad of other often competing influences. This is not easy in contemporary Australia where indigenous communal concepts are misunderstood, ignored or invalidated, as evidenced by the current Federal Government’s intervention in Aboriginal communities. Perhaps we should not be surprised at such dramatic action as sending in the army to allegedly tackle the sexual abuse of children. Australia was declared by the first white ‘explorers’ to be terra nullius (unowned land) which continued to be the legal position until 1992 (Banner:2005). 2007 is the 40th anniversary of the Australian Federal referendum whereby anglo Australians voted ‘Yes’ to Aboriginal people being included for the first time in the national census, that is, to be counted as people. The White Australia Policy was in force until 1973.

Australia, after ten years of conservative government under John Howard, has defined itself as ‘the sheriff of the South Pacific’. At a government level, there remains a complete lack of awareness of cultural distinctions and a reluctance to understand or engage with the region. Despite our geographic proximity, Australia largely is unfamiliar with the languages, culture and customs of the South Pacific region. This is evident even in relation to the arts. ‘I’m actually quite amazed that a lot of people don’t recognize our imagery or can’t even relate to it … in New York or London people would be a lot more receptive to it … more positiveness and real interest.’ (Dyck:2000)

In regard to education, with the exception of sport where Polynesians are not only recognized but sought out by talent scouts, it is difficult for children to find any resonance in a school structure whereby primary and secondary teachers are not required to undergo any cultural awareness training. Professor Konai Thaman, Head of the School of Humanities at the University of the South Pacific, articulates what is often a
fundamental dilemma for Pacific Island students facing a highly competitive and individualistic education system that does not in any way reflect their collective experience and shared cultural identity.

‘... we know that Pacific Island (nationals) are generally more collective than individualistic ... perhaps there is something in this discrepancy that explains why some students seem to be having difficulties staying at school, an alien place which pushes out students who do not conform and where in order to be successful, students will need to hang their cultural identities at the school gates and perhaps for the first time be a person with no connections to anyone or anything’. (Thaman: 2002).

For many Polynesian migrants in Australia, their experience is that of the ‘Outsider’ to the dominant white, nuclear ‘Mainstream’. Migration, as well as widespread access to television and the internet has meant we are living in a global whirlpool of transmutable identities. With the high mobility of all sorts of population groups, there are more people of mixed race and ethnicity who attempt to bridge the worlds of two or more cultures. In many instances, it is food – the choice of food, how it is prepared, how it is shared – that is the bond for extended family members and communities. The elevated place of food at signature events such as weddings, twenty first birthdays and christenings plays a key role in the preservation of cultural practice.

2.2 SOCIAL DISADVANTAGE

In New Zealand, government policies such as ‘Closing the Gaps’ which aimed to reduce the disparities in equity between Maori and non-Maori, attracted the criticism that it is not a level playing field: deculturation has been associated with poor health while acculturation has been linked to good health. Therefore a goal of health promotion should be to promote security of identity (Durie:2003)

In the case of Maori, Durie (2003) identifies several shifts in diet and lifestyle that follow the colonial patterns of many dispossessed people. For example in the 1930’s, medical officers were concerned that bread and potatoes had became the mainstay for many families and this often led to severe malnutrition, whereas with subsequent urbanisation the problem became one of over-eating. A large study of Maori households conducted by Massey University, has confirmed that access to customary sources of food is severely limited and there is almost exclusive reliance on foods purchased from supermarkets and fast-food outlets (Te Hoe Nuku Roa:1999). This report details the implication of deculturisation and poverty in relation to Maori health.

The obesity-related figures are alarming and predictors of a growing health crisis. Polynesians, who regard eating as a central part of family life and cultural practice, are now presenting with major health issues related to the type of food and quantities eaten. This is essentially a collision between two major issues: firstly that food has a central role in family and community life, and secondly, but no less important, is social disadvantage – feeding large families cheaply increases reliance on the consumption of commercially produced, poor quality food which in turn translates into a litany of preventable health issues including asthma, gout and complications of pregnancy. This of course is a substantial part of the overall picture in increasing ill health in these communities. However it is heart disease and diabetes that are of the most immediate concern. Not only do Maori and Pacific Islanders have one of the world’s highest incidence of diabetes, the morbidity rate for this disease is manifestly higher than for non-Polynesians. Also, the estimated number of those who remain undiagnosed could be as high as a third or a half again, so actual prevalence rates are thought be significantly higher (Ministry of Maori Development, 2000). Given that Type 2 diabetes and most forms of heart disease are largely preventable, there is considerable evidence that multiple factors are at work to influence these figures, including social disadvantage, and equity of health access.
Although the rate of employment may be steady in Australia, and many Maori do have well paid jobs, for a significant number of Polynesian migrants to Australia, the lack of formal education, skill qualification and inconsistent employment often means that work choices are limited and income can be suddenly and drastically reduced because of redundancy or industrial injury. (Hakaoro:2003) These issues are becoming more pressing as the number of Polynesians permanently resident in Australia is likely to rise steadily due not only to increased migration, but also the high birth rate of this population. The Polynesian migrant community is young and the birthrate much higher than that of their anglo counterparts. Approximately two-thirds of the Polynesian population are under 30 years old and contained roughly twice the proportion of children under 15 years than white New Zealand households. (New Zealand Government Statistics:2000)

Because of this spiral of low income leading to poor health and inadequate access to primary community-based medical support, Polynesians are being represented in greater numbers in Australian hospitals. In Australia, the known correlations between social disadvantage, obesity and the incidence of diabetes and heart disease have been evaluated as costing approximately $2 billion in hospital admissions alone (Pirani:2007). Chronic diseases were responsible for almost two-thirds of avoidable admissions. More than 25% were related to diabetes and an additional 34% linked to circulatory and respiratory conditions including congestive heart failure, angina and asthma (Page:2007).

Carson et al (2007) demonstrate the complex interplay between class, social disadvantage and culture as social determinants of health. Economic disadvantage for Polynesians reflects many of the patterns outlined in their work, in that these communities embrace a fundamentally different attitude to money and family responsibilities than anglo New Zealanders or Australians. Not only do the income providers support more people in the household, as census statistics reveal, there is also a high compliance rate for the cultural expectation (especially for Pacific Island Nationals), that stipends be sent to relations in the home islands. Money sent back to the islands from relations abroad, largely from Australia and New Zealand, comprises an estimated third of Gross Domestic Product for Samoa, Tonga and the Cook Islands (Singh:2005).

2.3 WAHINE TOA
Central to my research is how Maori and Pacific Island women see themselves – in relation to their families, their bodies, their identity and their health. It is apparent that it is the women who are often compromising their own health by working to balance the household budget and carry the stress of responsibility for the family. This ‘double shift’ of work and home responsibilities, especially when there is a great deal of travel involved to reach work, or anti-social hours of work required, is taking a toll on the health of Polynesian women in Australia.

New Zealand evidence confirms worrying statistics on Maori women’s health cited below. There is nothing to indicate these would be any better in Australia and may indeed be worse because of being in another country where access to health care may be difficult and a place where culturally targeted health promotions are non-existent.

- Almost half of adult Maori women smoke
- Maori women are more than twice as likely as non-Maori women to develop cervical cancer – yet less likely to be hospitalised than Europeans
- Maori women undergo half the rate of coronary artery surgery than non-Maori, yet their death rate from heart disease is more than twice that of non-Maori.
- Almost 10% of Maori women have diabetes – the non-Maori rate is 2.5%

(See ‘Maori Women: Mapping Inequalities and Pointing Ways Forward’ 2001)
3 CONCLUSION

As combined Pacific Island migration to Australia is steadily increasing, this issue will be of growing significance as it impacts on Australia’s health services. Significant numbers of Maori and Pacific Islanders in Australia are exhibiting signs of obesity-related illness and associated morbidity. It is also evident that the correlation between diet and illness is not well understood. We are likely to see programmes and campaigns designed to address these issues. However Polynesian communities, with their cultural associations of being generous with food and regard of obesity as normal, even powerful, are unlikely to respond to health directives that simply say ‘eat less’. There is a need for specially targeted programmes and as has been demonstrated repeatedly in New Zealand, the solution needs to be whanau or family-based. There would appear to be an urgent need for more research into this area as the Australian government has been criticized for its lack of support and concern for non-Anglo communities in regard to preventable health issues: ‘Currently in Australia there is no national body of information or formalized mechanisms for sharing information regarding diabetes in culturally and linguistically diverse community (CALD) groups’ (Australian Centre for Diabetes Strategies:2005).

3.1 RECOMMENDATIONS

Essentially these are not individual problems, so the solutions are also not individual. There is a need to structure family based solutions. It is clear that women are commonly the gatekeepers of how and what their family eat and how they regard food. If we are to be effective in tackling obesity and associated illness, it is the women who have to be included at every stage of this process. Having said this, it would also clearly benefit the communities by having men ‘on board’ who understand these issues and are committed to a solution. Men taking the time to exercise with their children has been cited by respondents as a good way to bring the family together and improve health outcomes at the same time. Research monies need to be made available, perhaps from both New Zealand and Australia, to assess the effectiveness of culturally targeted health policies and interventions being undertaken in New Zealand. This research should also include which policies and interventions have proved ineffective in order to minimize duplication and eliminate ineffective programmes.

‘Even though they have been born here and grew up here, I tell my children they must maintain their identity and culture. Because if you’ve lost that you’ve lost everything’
Teata Ruapuna (Rodriguez:2003)

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5 REFERENCES


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