An Overview of the existing knowledge on the social determinants of Indigenous health and well being in Australia and New Zealand
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Preamble on the brief

We have been asked to assist in the creation of a paper for inclusion into an overview of existing global knowledge on the social determinants of Indigenous health. This overview will become a part of an international symposium sponsored by the World Health Organization’s Commission on Social Determinants of Health (CSDH). This symposium is to be held in Adelaide in April 2007.

This two-part overview contains a synthesis of current knowledge on some of the social determinants of Indigenous health in Australia and New Zealand. We have made little reference to those peoples outside of these two nations as we understand the broader regional and global perspectives will be addressed by the consultants (Clive Nettleton, Carolyn Stevens (Public and Environmental Health Research Unit, London School of Hygiene and Tropical Medicine (LSHTM))).

In this submission, we have examined the demographic, epidemiological and broader health profiles and the impact of the relatively recent arrival of colonisers on our respective shores, and make comment on our understanding of these and the broader social determinants on health.

We realise there is much that we have not included in this work. We hope these documents gives voice to some of the myriad of issues that underpin health in the Indigenous peoples of Australia and the Maori of Aotearoa/New Zealand.

This combined document was created by Lisa Jackson Pulver, Head of Unit, Muru Marri Indigenous Health Unit, School of Public Health and Community Medicine, UNSW, Elizabeth Harris, Director. Centre for Health Equity, Training Research and Evaluation, part of Centre for Primary Health Care and Equity, UNSW for the Australian component; and John Waldon, Research Officer and Doctoral Scholar, Te Pumanawa Hauora, Te Pūtahi-ā-Toi, Massey University for the New Zealand component. We all participated in the introductory and summary sections.

The corresponding author is Lisa Jackson Pulver.

To assist us in this work, and to ensure we were heading in the right direction, we invited a number of key Aboriginal and Māori academics and researchers to become
either co-authors or members of our reference group. The following individuals opted for membership to the reference group:

- Ian Anderson, Professor and Director, Centre for Health & Society and Onemda VicHealth Koori Health Unit, Melbourne University; Research Director CRC for Aboriginal Health.

- Yin Paradies, Postdoctoral Research Fellow, Menzies School of Health Research, Charles Darwin University.

- Jacinta Elstone, Associate Professor and Assistant Dean. Indigenous Health Unit, James Cook University.

- Chris Cunningham, Professor and Director. Research Centre for Māori Health and Development, Te Pumanawa Hauora, Te Pūtahi-ā-Toi, Massey University.

- Amohia Boulton, Post Doctoral Scholar, Research Centre for Maori Health Research and Development – Te Pumanawa Hauora, Te Putahi-a-Toi School of Maori Studies, Massey University

- Heather Gifford, Whakauae Research Services, Whanganui

- Bevan Clayton-Smith, Doctoral Scholar, Research Centre for Maori Health Research and Development – Te Pumanawa Hauora, Te Putahi-a-Toi School of Maori Studies, Massey University

We thank our reference group, and acknowledge that our expectations for short turn around of feedback were a stretch. Hopefully, the CSDH will find this document of use.
Introduction

The region

The Pacific Ocean covers approximately 28% of the planet and is larger than the total land area of the world. This great southern ocean extends between Asia, Australia and the America’s, and has tens of thousands of islands creating our regional cultural, linguistic and geographic seascape. It is upon this incredible seascape that we present our brief survey of the indigenous people of this region, and revise the context of recent history, the impact of colonisation and the effect of these factors in the broader role of social determinants and Indigenous health.

Colonisation of this region entangled the lives of people with the fortunes and luck of those in far away lands. Many European powers maintained their colonies during the 20th century, such as those of the French in French Polynesia and the US in Hawai’i and US Associated Micronesia. Britain, on the other hand, withdrew her dominion in New Zealand from 1852 and in Australia from 1901. And yet the shadow remains.

The people

Being indigenous is a label that has become associated with deprivation and marginalisation, however for many of the worlds indigenous people, their identity is self conferred by a long association with the lands they live and from which their ancestors derived their existence and identity, and a tradition of unity with the environment that is told in song, reflected in custom, evident in subsistence as well as approaches to healing and rituals associated with birth and death [1].

Accurate information about Indigenous peoples is generally very difficult to find, authenticate and assess for accuracy; census and health related information, for example, is often aggregated without distinction or reference to minority groups.

The multiplicity of languages spoken in Oceania is another important point of demarcation between indigenous groups. For the region of South East Asia, there are around 1,500 languages spoken today. About half of them are spoken in Indonesia, and about 271 of those are spoken in Papua, a relatively small nation. Timor Leste
has 22 different indigenous languages, and Australia has well over 350. Many Indigenous people speak more than one language.

The population of the region today is diverse, and is estimated in 2005 by WHO to be 34,452,156. The following tabulates the proportions of each nation’s Indigenous peoples, those less than 30%, those from 30 to 60% and those nations with over 60%.

<table>
<thead>
<tr>
<th>&lt;30% Indigenous People</th>
<th>30 to 60% Indigenous People</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australia</strong></td>
<td><strong>Fiji</strong></td>
</tr>
<tr>
<td>20,984,595</td>
<td>853,445</td>
</tr>
<tr>
<td><strong>New Zealand</strong></td>
<td><strong>New Caledonia (Fr)</strong></td>
</tr>
<tr>
<td>4,274,588</td>
<td>243,233</td>
</tr>
<tr>
<td>Northern Marianas Islands (USA)</td>
<td>84,228</td>
</tr>
<tr>
<td>Small Territorial of Chile, Norway, UK And US (4)</td>
<td>4,397</td>
</tr>
<tr>
<td>Antarctica</td>
<td>Nauru</td>
</tr>
<tr>
<td>1,446</td>
<td>10,065</td>
</tr>
<tr>
<td>Christmas Island (Au)</td>
<td>Norfolk Island (Au)</td>
</tr>
<tr>
<td>1,600</td>
<td>1,673</td>
</tr>
<tr>
<td>Terres Australes</td>
<td>Cocos (Keeling) Islands (Au)</td>
</tr>
<tr>
<td>310</td>
<td>618</td>
</tr>
<tr>
<td>Pitcairn Islands (UK)</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>&gt;60% Indigenous People</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Papua New Guinea</strong></td>
</tr>
<tr>
<td>6,157,888</td>
</tr>
<tr>
<td>Marshall Islands</td>
</tr>
<tr>
<td>60,422</td>
</tr>
<tr>
<td>Solomon Islands</td>
</tr>
<tr>
<td>492,170</td>
</tr>
<tr>
<td>American Samoa</td>
</tr>
<tr>
<td>57,291</td>
</tr>
<tr>
<td>French Polynesia</td>
</tr>
<tr>
<td>266,935</td>
</tr>
<tr>
<td>Palau</td>
</tr>
<tr>
<td>21,897</td>
</tr>
<tr>
<td>Vanuatu</td>
</tr>
<tr>
<td>222,606</td>
</tr>
<tr>
<td>Cook Islands</td>
</tr>
<tr>
<td>18,027</td>
</tr>
<tr>
<td>Samoa</td>
</tr>
<tr>
<td>184,633</td>
</tr>
<tr>
<td>Wallis And Futuna Islands (Fr)</td>
</tr>
<tr>
<td>15,352</td>
</tr>
<tr>
<td>Micronesia (Federated States)</td>
</tr>
<tr>
<td>114,100</td>
</tr>
<tr>
<td>Tuvalu</td>
</tr>
<tr>
<td>10,885</td>
</tr>
<tr>
<td>Tonga</td>
</tr>
<tr>
<td>104,057</td>
</tr>
<tr>
<td>Niue</td>
</tr>
<tr>
<td>1,722</td>
</tr>
<tr>
<td>Kiribati</td>
</tr>
<tr>
<td>92,533</td>
</tr>
<tr>
<td>Tokelau</td>
</tr>
<tr>
<td>1,515</td>
</tr>
</tbody>
</table>

*Table One: Total population, by Indigenous proportion. Source: available from estimates provided by WHO at [http://www.wpro.who.int/countries/Countries.htm](http://www.wpro.who.int/countries/Countries.htm)*
New Zealand and Australia

Knowing who we are is an important facet of our identity.[2, 3] We, amongst the many and diverse people of New Zealand [4] and Australia [5], remain distinctly different and identifiably Indigenous [6, 7]. The Indigenous peoples of Australia have continuously occupied this land for many more than the 40,000 years ascribed. The peoples of our two countries have been in contact with migrants for many years, but most change can be attributed to the arrival of European settlers in the late 18th century that tested our resilience.[8] It was contact with these people that affected and led to the decline to today’s levels of relative deprivation and health inequality, which seem to characterise the Indigenous people of our two countries. Contrary to predictions that we would die out more than a century ago[i][9], we continue to freely self identify as Indigenous people and work actively to protect and promote our cultures.

The experience of Australian and New Zealand Indigenous peoples has been different in some fundamental ways. We touch on some, including treaty, citizenship and population proportions, in the work that follows.

Despite these differences, Indigenous peoples in both countries systematically experience poorer health. Were evidence is available; it is denial of economic and health resources that explains most of these inequalities.[10] However, inequalities are social in nature and extend beyond routine indicators of health and economics.

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[i] See Durie (1998), page 30-31 for a fuller description
The Australian perspective.

“I have come to realise health is not dependent on the physical well-being of individuals. It is also dependent on key indicators such as education, financial status, adequate housing, sanitation, diet, and access to a range of goods and services. When considering health you need a model that has a focus on structural inequities, not just a focus on personal stories of misfortune. Also you need a model that acknowledges a history of oppression and dispossession, and a history of systematic racism.”

Lowitja O’Donoghue (2004).ii

In developing this chapter on Aboriginal peoples of Australia we are fortunate to have two major relevant sources to draw on. Firstly there is the work of the Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW) which provides detailed information on what is known from major routine data sets on the health and well-being of Aboriginal peoples of Australia.

Secondly a book on the Social Determinants of Indigenous Health has recently been published that draws together much of the current information and debates on the potential positive and negative role of the social determinants of the health of Aboriginal people in Australia.[11]
1. Demography

As detailed in the map of Australia, it is currently estimated that in 2007 there are 561,387 Indigenous people living in Australia[12] and account for about 2.4%[13] of the total Australian population. Of this total, 90% identify as Aboriginal, six percent as Torres Strait Islander, and four percent as both Aboriginal and Torres Strait Islander.[12]


New South Wales and Queensland have more than half of the Aboriginal population of Australia as residents. The Northern Territory has the highest proportion of Indigenous people (29% of all people in the NT) with only 12% of all Australia’s Indigenous people.[14]

Only 25% of Indigenous people live in rural and remote areas (see Table One) with the majority of Indigenous people living in urban settings. As the Indigenous
population of in the major cities represent only about one percent, Indigenous people remain invisible to most Australians.[15]

<table>
<thead>
<tr>
<th>ASGC Remoteness areas</th>
<th>State/Territory</th>
<th>Major cities(a)</th>
<th>Inner regional</th>
<th>Outer regional(a)</th>
<th>Remote very remote</th>
<th>Total</th>
<th>Proportion of total state population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>56,773</td>
<td>43,697</td>
<td>25,922</td>
<td>6,178</td>
<td>2,318</td>
<td>134,888</td>
<td>2.1</td>
</tr>
<tr>
<td>Victoria</td>
<td>13,655</td>
<td>9,711</td>
<td>4,410</td>
<td>70</td>
<td></td>
<td>27,846</td>
<td>0.6</td>
</tr>
<tr>
<td>Queensland</td>
<td>31,208</td>
<td>22,995</td>
<td>41,318</td>
<td>11,513</td>
<td>18,876</td>
<td>125,910</td>
<td>3.5</td>
</tr>
<tr>
<td>WA</td>
<td>21,168</td>
<td>5,295</td>
<td>9,717</td>
<td>10,670</td>
<td>19,081</td>
<td>65,931</td>
<td>3.5</td>
</tr>
<tr>
<td>SA</td>
<td>11,789</td>
<td>2,197</td>
<td>5,910</td>
<td>1,220</td>
<td>4,428</td>
<td>25,544</td>
<td>1.7</td>
</tr>
<tr>
<td>Tasmania</td>
<td>8,869</td>
<td>7,911</td>
<td>402</td>
<td>202</td>
<td></td>
<td>17,384</td>
<td>3.7</td>
</tr>
<tr>
<td>ACT</td>
<td>3,901</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td>3,909</td>
<td>1.2</td>
</tr>
<tr>
<td>Australia(b)</td>
<td>138,494</td>
<td>92,988</td>
<td>105,875</td>
<td>40,161</td>
<td>81,002</td>
<td>458,520</td>
<td>2.4</td>
</tr>
</tbody>
</table>

*Table Two: Aboriginal and Torres Strait Islander population, by remoteness area and state/territory*  
(Table 1.1 taken from AIHW Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001–02[16])

(a) Darwin is included as an outer regional area under ARIA

(b) Includes populations of Christmas Island and Cocos Islands.
2. Epidemiology

For those people who are identified in administrative data collections, Aboriginal people experience greater levels of ill health resulting in higher levels of disability and reduced quality of life. Aboriginal people have significantly shorter average life expectancies than many people in the developing world[17] and of those Indigenous peoples of Canada, and the United States of America, and of the Maori of New Zealand [18]. The overall life expectancy was 59.4 years and 64.8 years for Aboriginal males and females respectively, compared to 76.6 for all males and 82.0 for female populations in the period 1996-2001.[12] In some parts of New South Wales, the average age of death of Aboriginal males was just 33 years of age.[19]

Mortality

For the period 1996–2001, differentials for life expectancy at birth for Aboriginal infants were around 17 years for both males and females. There were 7,387 people identified as Indigenous in WA, SA, NT and Queensland who died, accounting for 3.2% of all deaths. Death rates among Aboriginal people were higher than those recorded for the all-Australian population for most causes of death in every age category, and were almost three times as many deaths for all causes as would be expected based on the rates of non-Indigenous Australians.[12]

Morbidity

Quasi national data (see footnote two) suggests that Aboriginal people are about three times more likely to be admitted to hospital than other Australians. Non-communicable, chronic and notifiable disease all contribute to the greater burden of ill-health experienced by Aboriginal Australians.[12]

Indigenous peoples average rate of hospital separation is twice that of non-Indigenous people, however a larger proportion of lower cost interventions such as renal dialysis are noted.[16]

iii Data from the Northern Territory, Western Australia, South Australia and most recently Queensland are used to collective create a quasi-national picture of Indigenous health statistics. These four jurisdictions alone are considered accurate enough to use in any ABS or AIHW statistical publications.
Mental health, social and emotional wellbeing in Aboriginal populations are still poor compared to other Australians, the impact of trauma, grief, racism and violations of human rights issues largely unrecognised.[20] Social and emotional well being issues are often misunderstood and considered to be a part of the larger realm of mental illness. There is increased recognition that individuals and communities with social and emotional wellbeing issues do not necessarily suffer mental illness.[21]

High rates of established behavioural health risk factors such as smoking, substance misuse, exposure to violence in the home and in the community, lack of exercise and have body mass indices of greater than 30 (technically obese) are well documented in Indigenous populations.[22] The resultant high rates of non-communicable diseases are “to a great extent preventable through interventions against the major risk factors and their environmental, economic, social and behavioural determinants in the population” (WHO 2000, cited in AIHW 2005[12]). It is generally recognised that this is not only a matter of individual responsibility but requires interventions at many levels by individuals, families, communities and the wider society to ensure that people are able to live healthy lifestyles through the provision of food, safe and supportive environments and access to supportive preventive services.
Beyond Morbidity.

Since the arrival of Europeans there has been very little formal recognition of the profound spiritual links of Aboriginal peoples to their Land. The common law principle of Terra Nullius -- a territory belonging to no one -- was applied unilaterally. The British "took possession" of the land because they considered it to be unoccupied. Moreover, unlike the experience of Maori in Aotearoa (New Zealand) or the indigenous peoples in both the United States and Canada, there has never been a formal treaty between the Aboriginal people and the newcomers to Australia. It has been argued that the absence of a treaty with Aboriginal peoples is causally associated with their poor health and social disadvantage.[23]

The loss of land and marginalisation of Aboriginal people accompanied by individual and institutional experiences of discrimination and racism have placed heavy burdens of stress, alienation and loss of sense of control on many individuals, families and communities. Little work has been done in specific areas such as those associated with the forced removal of Aboriginal children from their homes and communities,[24] the stripping of rights from returning Aboriginal servicemen[25] and relatively recent right to be counted in national census.[26]

The strong and complex interrelatedness of individual behaviour, material deprivation and the psychosocial stressors is poorly understood, especially as they play out across generations and within the Aboriginal conception of health which is holistic and strongly linked to community well-being as well as individual health status.[27]

Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life.[28]
3. **Information Gaps**

In this section we focus on two kinds of information gaps; those that are commonly seen in routine data collection systems, particularly health service data; and secondly, information that we need to answer some of the emerging questions to explain the continuing poor health of Aboriginal population of Australia.

**a) Those that are commonly seen in routine data collection systems, particularly health service data.**

Despite the identification issues, accurate differentials Aboriginal and majority population life expectancies are difficult to establish because of data quality issues with both the Indigenous data and the experimental nature of Indigenous population estimates.[29] A contributing factor is the under enumeration of Aboriginal people, especially the lack of identification of Aboriginal people in those states where there are large numbers of Aboriginal people but where they are a small, widely dispersed proportion of the population.

While there are these limitations, the available statistics can provide a sense of mortality, morbidity and health, in comparison with those of the remaining Australian population. Despite this, all available evidence informs a picture of Aboriginal people suffering a disproportionate burden of ill health, but provides little data with which to understand the social determinants of health in routine collections.

As current data systems mature and become more reliable we need to explore a wider set of issues including:

- is there is social gradient in Aboriginal health?
- is there a systematic difference in the health of urban, rural and remote Aboriginal people?
- where are health gains being made?
- what are the patterns in health service use, especially between acute and preventive services.
b) Information that we need to answer some of the emerging questions to explain the continuing poor health of the indigenous population of Australia.

Ian Anderson, in his chapter on understanding the process through which the social determinants of health, [30] highlights many of the additional information we may need to ask:

- What is the significance of work, family, social connectedness and the other social determinants of health in Aboriginal social life and do these operate in a different way than in mainstream Australian society. For example there is some evidence that the health of employed Aboriginal people is poorer than those who are unemployed? How can financial responsibilities that Aboriginal people have to their family group impact on comparative measures of financial resources?

- What is the relationship between access to different models of health care (as a social determinant of health) and health outcomes?

- What is the impact of shifting relationships between an individual and society over the lifespan?

- What are the social processes that lead to the reproduction of disadvantage over generations?

- What is the role of racism and discrimination in contributing to marginalisation and poor health of Aboriginal people.
4. The social determinants of health

Social and political context

The poor health experience of Aboriginal people in Australia should also be understood in the historical context which put in context the structural determinants of health that have systematically reduced the opportunities of the Australian Aboriginal population to be self-determining and to have access to the opportunities for health that many other Australians take for granted.[31]

The impact of the continuing dispossession and discrimination on cultural identity and community functioning was recognised by government in the second half of the last century. This led to the development of Land Rights movements and the establishment of Aboriginal community controlled organisations, health and legal services, along with the politicalisation of the rights process.[32]

The innovation of the Decade of Reconciliation drew to a close in December 2000. It would have been reasonable to expect that the resources developed over a decade, including a Declaration Towards Reconciliation, a Roadmap for Reconciliation, National Strategies for Reconciliation and various recommendations would be undertaken Australia-wide, following on from public consultations led by the Council for Aboriginal Reconciliation, a statutory authority.iv The Act set out, as a part of its preamble, reasons for the enactment of this extraordinary legislation. The preamble read (in part):[33]

(a) Australia was occupied by Aborigines and Torres Strait Islanders who had settled for thousands of years, before British settlement at Sydney Cove on 26 January 1788; and

(b) many Aborigines and Torres Strait Islanders suffered dispossession and dispersal from their traditional lands by the British Crown; and

(c) to date, there has been no formal process of reconciliation between Aborigines and Torres Strait Islanders and other Australians; and

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iv The establishment of the Council for Aboriginal Reconciliation as a statutory authority occurred on 2nd September 1991 when the Council for Aboriginal Reconciliation Act 1991 received Royal Assent. The first members to Council were appointed on 15th December 1991.
(d) by the year 2001, the centenary of Federation, it is most desirable that there be such a reconciliation; and

(e) as part of the reconciliation process, the Commonwealth will seek an ongoing national commitment from governments at all levels to cooperate and to coordinate with the Aboriginal and Torres Strait Islander Commission as appropriate to address progressively Aboriginal disadvantage and aspirations in relation to land, housing, law and justice, cultural heritage, education, employment, health, infrastructure, economic development and any other relevant matters in the decade leading to the centenary of Federation, 2001.

The Declaration and the Road Map, along with Councils ongoing recommendations, were presented publicly to the Prime Minister at the Corroboree 2000 meeting on 27 May 2000 in Melbourne. Many of these recommendations, as well as many of the policies related policies created during the previous decades were either substantially wound back or abolished altogether.

Prime Minister Howard refers to the recognition of past wrongs as the black arm band view of history for which he is unwilling to say sorry. He argues that he personally did not take Land, he did not kill anyone – it is a debated history that many people have trouble in accepting. His government favours “practical reconciliation” as an approach claiming this will lead to better outcomes. It is acknowledged by the government that Aboriginal Australians have poorer health, educational, employment and social outcomes, however the solutions that are to address these issues have little to do with the underlying causes.[34]

There is a fundamental struggle in recognising the causes of poor health between those who see the cause as an issue of only material deprivation (squalid housing, lack of basic health hardware such as running water, electricity) and those who see the causes as a combination of material deprivation and psycho-social stressors related to stress, alienation, discrimination and lack of control. Some commentators see this is a tension between material deprivation and symbolic reconciliation.[35] However, to see the acknowledgement of past wrongs as symbolic fails to acknowledge the profound psychological impacts that these past and current wrongs have on Aboriginal people sense of identity and our capacity to actively participate in Australian society.
Research on changes to the socioeconomic status of Aboriginal socioeconomic status between 1991-2001, a period that closely matches the decade of reconciliation, showed that in absolute terms it was difficult to differentiate statistically significant impacts of the varying government policies. However in relative terms the period 1991-1996 (symbolic reconciliation) clearly outperformed the period 1997-2001 (practical reconciliation), with only a slight improvement across core socioeconomic indicators such as unemployment rates, home ownership, or rates of post-school qualifications.[36] In part these gains appear small because of relatively larger gains by non-Indigenous Australians. Altman and Hunter observed that Indigenous socioeconomic problems do not seem to be amenable to solution, are deeply entrenched and are not abating in even during times of rapid economic growth.[34]

The rightful place of Aboriginal Australians as the original custodians of the Land is still to be routinely recognised and the past decade has seen increased funding but an unwinding of processes for self determination.

5. The structural determinants of health

A review of changes in socioeconomic status of Aboriginal Australians between 1971-2001 by the Centre for Aboriginal Economic Policy Research found that there have been slow improvements since 1971 but that Aboriginal Australians are still disadvantaged in comparison to other Australians. Slow improvement in disadvantage indicates that broad policy setting may be suiting most of Australia, but when the differentials close at a much slower rate, we cannot afford to be complacent while systematic differentials remain.

The table below clearly demonstrates that for most social indicators, Aboriginal Australians are less likely to have equivalent levels of income, employment, education, or level of home ownership.
Table Three: Ratio of Indigenous to non-Indigenous outcomes, 1971-2001 (Table 3 used from CAEPH Indigenous Socioeconomic Change 1971-2001: A Historical Perspective[34])

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment rate (% labour force)</td>
<td>5.44</td>
<td>4.22</td>
<td>2.7</td>
<td>2.79</td>
</tr>
<tr>
<td>Employment to population ratio (% adults)</td>
<td>0.73</td>
<td>0.61</td>
<td>0.66</td>
<td>0.71</td>
</tr>
<tr>
<td>Labour force participation rate (% adults)</td>
<td>0.78</td>
<td>0.77</td>
<td>0.84</td>
<td>0.82</td>
</tr>
<tr>
<td>Full-time employment (% adults)</td>
<td>0.88</td>
<td>0.44</td>
<td>0.56</td>
<td>0.57</td>
</tr>
<tr>
<td>Private-sector employment (% adults)</td>
<td>0.65</td>
<td>0.42</td>
<td>0.50</td>
<td>0.48</td>
</tr>
<tr>
<td>Median income in $2001 – Individual</td>
<td>n.a.</td>
<td>0.55</td>
<td>0.62</td>
<td>0.56</td>
</tr>
<tr>
<td>Median income in $2001 – Household</td>
<td>n.a.</td>
<td>0.72</td>
<td>0.77</td>
<td>0.78</td>
</tr>
<tr>
<td>Home owner or purchasing (% population)</td>
<td>0.37</td>
<td>0.27</td>
<td>0.27</td>
<td>0.37</td>
</tr>
<tr>
<td>Household size</td>
<td>1.33</td>
<td>1.32</td>
<td>1.38</td>
<td>1.31</td>
</tr>
<tr>
<td>Never attended school (% adults)</td>
<td>39.32</td>
<td>14.42</td>
<td>5.21</td>
<td>3.14</td>
</tr>
<tr>
<td>15–24 year olds attending educational institution (% of non-secondary students)</td>
<td>n.a.</td>
<td>0.38</td>
<td>0.35</td>
<td>0.43</td>
</tr>
<tr>
<td>Post-school qualification (% adults)</td>
<td>0.13</td>
<td>0.18</td>
<td>0.30</td>
<td>0.44</td>
</tr>
<tr>
<td>Population aged over 55 years (%)</td>
<td>0.43</td>
<td>0.34</td>
<td>0.31</td>
<td>0.31</td>
</tr>
</tbody>
</table>

Total spending on health services for Aboriginal Australians were estimated at 2.8% of national health expenditures, slightly higher than that spent on non-Indigenous people despite the greater burden of illness experienced by Aboriginal Australians. The average cost, per Aboriginal Australian, is estimated at $3,901 (cf $3,308 per non-Indigenous person). Aboriginal Australians use more publicly funded health services $3,614 per person compared with $2,225 per non-Indigenous person.

Services covered by Medicare (39% per person compared to non-Indigenous) and the Pharmaceutical Benefits Scheme (one third of the amount per non-Indigenous)[16].

There continues to be poor school retention rates for Aboriginal children in most parts of Australia. Recent research indicates that participation in mainstream education should be critically accepted as a pathway to improved health. The quality and cultural appropriateness of the education are important.

Baum has compared the current situation of Aboriginal people in relation to features of high social capital societies.[37] She identifies many gaps including institutional racism, few opportunities for interaction with other social groups (bridging social capital), high reliance on welfare payments making Aboriginal Australians different from other Australians. As well she notes signs of alienation in many Aboriginal
individuals groups and communities and higher rates of suicide, mental illness and alcohol and drug misuse.

There is a profound lack of trust between many Aboriginal people and the Police and judicial systems. In the recent past, there have been a number of inquiries that have highlighted the extent to which Aboriginal human rights have been compromised, and include the report into Aboriginal deaths in custody[38] and the Bringing Them Home Report.[39] In 2003, 23,555 people where classified as prisoners in Australia, with 20 per cent of all prisoners identified as Indigenous (n=4,818). Over this time, 26 per cent of all deaths (n=10) were of Indigenous prisoners, representing a rate of Indigenous deaths in prison custody of 2.1 per 1,000 Indigenous prisoners (cf 1.6 per 1,000). Approximately one third of all prisoners were unsentenced prisoners on remand .[40]

**Intermediate social determinants**

Child abuse and neglect, domestic violence and high levels of inter-personal violence have been reported in many Indigenous communities and are often accompanied by alcohol and drug abuse.[41] Aboriginal people are more likely to have contact with the justice system irrespective of income. In NSW 40% of Aboriginal people aged 20-24 have appeared in court charged with a criminal offence.[42].

There is growing debate about the extent to which Aboriginal people, individually and as communities, need to take responsibility for many of the risk behaviours that lead to death, disability and poor health such and drug and alcohol abuse, inter-personal violence and injury. There is increased interest in building the capacity of individuals and communities to take responsibility for creating safe and sustainable communities.

However this emphasis on self-determination needs to be married with serious, long term investments in providing opportunities for health For example the poor availability and expense of fresh food and vegetables in many remote communities, safety and security concerns and poorly maintained road and pathways are often beyond the resources of individual and communities without government and community support.
The living conditions for Aboriginal Australians in rural and remote areas remain a source of national shame with many communities living in extremely poor quality housing without access to basic infrastructure such as safe, running water, drainage, all weather roads and access to affordable, high quality food, particularly fruit and vegetables. As noted earlier, most Aboriginal Australians live in urban area but even in this setting their housing is more likely to be overcrowded and poorly maintained. There has been some recognition that housing for Aboriginal Australians needs to be differently designed to be compatible with family structures and lifestyle but progress in changing housing design has been slow.
The New Zealand perspective.

“The challenge facing public health, no matter how defined, is linked to navigating the relationship between peoples and their environments in order to achieve the best possible gains for health. [43]

Durie (1998) provided a contemporary approach to indigenous health framing good health for Maori as a rightful legacy of citizens of the world and the result of the advantage of accumulated knowledge, the lessons of history to guide them, and the capacity to anticipate and prepare for the unexpected. [9].

Health for Maori, the indigenous peoples of New Zealand, is an important feature of our culture; a feature that illustrates our unique view of the world we share with some of those around us. There is no doubt that by most measures of inequality Maori experience an unfair burden that stems from social, cultural and economic deprivation.

\[E \text{ kai te manu o te miro, nona te ngahere, } E \text{ kai te manu o te matauranga, nona te ao, ma te huruhuru ka rere te manu}\]
\[(A \text{ bird who thrives at home will venture close to home, a bird who thrives on knowledge will share the world, for a bird flys with feathers)}\]

We need others to live.

Map Two: Proportion of Maori Ethnic Population by Regions.
1. Demography

The 2006 census provides the most recent demographic information for New Zealand [44]. While the Maori population has grown along side that of the Asian and Pacific populations relative to the ‘European only population’, we have fallen as a proportion of the overall population by 0.5% in ten years [45, 46].

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>2,879,085</td>
<td>2,871,432</td>
<td>2,609,592</td>
</tr>
<tr>
<td>Māori</td>
<td>523,371</td>
<td>526,281</td>
<td>565,329</td>
</tr>
<tr>
<td>Pacific Peoples</td>
<td>202,233</td>
<td>231,801</td>
<td>265,974</td>
</tr>
<tr>
<td>Asian</td>
<td>173,502</td>
<td>238,176</td>
<td>354,552</td>
</tr>
<tr>
<td>MELAA(^v)</td>
<td>no data</td>
<td>no data</td>
<td>34,743</td>
</tr>
</tbody>
</table>

Other Ethnicity

<table>
<thead>
<tr>
<th>Ethnicty Group</th>
<th>1996</th>
<th>2001</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealander (new in 2006)</td>
<td>no data</td>
<td>no data</td>
<td>429,429</td>
</tr>
<tr>
<td>Other 'Other' Ethnicity</td>
<td>16,422</td>
<td>24,993</td>
<td>1,491</td>
</tr>
<tr>
<td>Total(^v)</td>
<td>16,422</td>
<td>24,993</td>
<td>430,881</td>
</tr>
</tbody>
</table>

Total People

<table>
<thead>
<tr>
<th>Total People</th>
<th>3,466,587</th>
<th>3,586,731</th>
<th>3,860,163</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maori percentage of population</td>
<td>15.1%</td>
<td>14.7%</td>
<td>14.6%</td>
</tr>
</tbody>
</table>

Table One\(^x\): Ethnic Group  
Source: Statistics New Zealand Census 2006

Compared with data from the 1996 and 2001 censuses, replacement of the population has slowed with numbers of Maori children in the 0-4 year age group falling 1.68%. Maori remain a relatively young population group contributing to 29% of the births in the last calendar year (see table below).

---

\(^v\) Includes all of the people who stated each ethnic group, whether as their only ethnic group or as one of several ethnic groups. Where a person reported more than one ethnic group, they have been counted in each applicable group.

\(v\) MELAA = Middle Eastern, Latin American and African. This is a new category introduced for the 2006 Census. Previously, 'MELAA' responses were counted to the 'Other ethnicity' category.

\(v\) In 1996 and 2001 'Total Other Ethnicity' included MELAA.

\(v\) All data has been randomly rounded to protect confidentiality. Individual figures may not add up to totals, and values for the same data may vary in different tables.
An Overview of the existing global knowledge on the social determinants of Indigenous health and well being in Australia and New Zealand

<table>
<thead>
<tr>
<th>TOTAL POPULATION 2006</th>
<th>BIRTHS Live births in the year ending September 2006.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of New Zealanders who identify themselves as a particular ethnic group.</td>
<td>Number of births 59,120</td>
</tr>
<tr>
<td>European</td>
<td>67.6%</td>
</tr>
<tr>
<td>Maori</td>
<td>14%</td>
</tr>
<tr>
<td>New Zealander</td>
<td>11.1%</td>
</tr>
<tr>
<td>Asian</td>
<td>8.8%</td>
</tr>
<tr>
<td>Pacific</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

*Table Two: Live births Source: Human Rights Commission (2007)*

Education and language acquisition are important activities for the young [47, 48]. The average age for Maori has increased slightly (21.9 to 22.7 years) [49], however our children’s access to the Maori language and education remains poor [50].

Educational attainment for Maori over the age of 15 years has improved since the last census with an 5.77% increase in the number of Maori gaining a school or higher certificate or qualification [46]. However, this improvement must be considered in the context of the relatively low baseline figures for Maori educational attainment. In 2004, 25% of Maori left school with no qualification at all [51].

English remains the predominant language spoken in New Zealand [49], followed in descending order were Maori, Samoan, French, Hindi, Yue [Cantonese]. For Maori living in New Zealand, 23.7% indicated we could hold a conversation in Maori about everyday things. Alongside the capacity to speak our own language, there is the opportunity to participate in Maori medium education. In 2006, 89% of those participating in Maori medium education were Maori students. The Maori language is also taught outside Maori medium education to 8.3% of Maori students. In total approximately 39,852 students are being taught Maori, representing 24.5% of all Maori students are being formally taught our language [52].

*Languages Spoken (total responses)*

**for the Maori Ethnic Group**

<table>
<thead>
<tr>
<th>Languages spoken</th>
<th>Census year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
</tr>
<tr>
<td>English</td>
<td>494,679</td>
</tr>
<tr>
<td>Māori</td>
<td>130,482</td>
</tr>
<tr>
<td>Samoan</td>
<td>4,074</td>
</tr>
<tr>
<td>NZ Sign Language</td>
<td>6,549</td>
</tr>
</tbody>
</table>

*ix* Includes all of the people who stated each language spoken, whether as their only language or as one of several languages. Where a person reported more than one language spoken, they have been counted in each applicable group.

*a* All figures are for the Māori ethnic group census usually resident population.
An Overview of the existing global knowledge on the social determinants of Indigenous health and well being in Australia and New Zealand

Other 9,063 9,264
None (eg too young to talk) xi 17,376 15,576
Total People Stated 518,730 554,355
Not Elsewhere Included xii 7,554 12,072
Total People 526,281 565,329
% speaking Maori 24.7% 23.3%

Note: This data has been randomly rounded to protect confidentiality. Individual figures may not add up to totals, and values for the same data may vary in different tables.

Table Three: Languages Spoken in New Zealand: 2001-06 Census Source: Statistics New Zealand Census 2006

2. Epidemiology

Compared with our non-Maori peers, Maori can expect shorter life expectancy (even when adjusted for low income) [10], fewer disability-free years, more preventable illness, a poorer prognosis for cancer when it is diagnosed and poorer access to health services. This situation has existed for some considerable time [53-55].

Mortality

Life expectancy for non-Maori, Maori and Pacific men in 2000/02 was 77.2, 69.0 and 71.5 years respectively. Life expectancy for women was 81.9, 73.2, and 76.7 years respectively. When considering the length of life a person could expect to live a healthy life for non-Maori and Maori women were 68.2 and 59 years respectively, and 65.2 and 58 years for men [56].

Morbidity

Although Maori experience high levels of morbidity in terms of hospital admission for preventable disease (ref) and injury in children [57], we do not always feature as those most at risk as indicated in Table 4.

We tend to carry the unfair burden of preventable ‘old world’ diseases, vaccine preventable disease and unintentional injuries. However looking at what is reported may not illustrate the whole picture. As we have already indicated Maori concepts of health and well being extend beyond the presence and absence of disease and include the mutual interaction of family-based relationship, spirituality and mental well being [58-62].

xi Includes people who were too young to talk or unable to speak a language.
xii Includes Don’t Know, Refused to Answer, Response Unidentifiable, Response Outside Scope and Not Stated.
**Interaction of Health Determinants.**

In the first of three reports on ethnic mortality trends in New Zealand, Ajwani, Blakely, Robson, Tobias, & Bonne [63] described the disparity in life expectancy that grew between Maori and non-Maori throughout the 1980s and early 1990s. The disparity became more apparent after correcting for under-recording of Maori ethnicity. In their second report [64] Tony Blakely and his team investigated trends in mortality by socioeconomic position. Focusing on income they found that although all groups experienced declines in mortality, the ratio of mortality rates in low- to high-income groups had increased. The second report used age and ethnicity standardisation to examine socioeconomic inequalities in mortality (removing confounding by ethnicity). Controlling for ethnicity precluded the analysis of interactions between ethnicity and socioeconomic position in shaping inequalities in mortality and whether they were mediated by socioeconomic inequalities. The third report in the series described the effect of ethnicity and socio-economic position on mortality [10]. They found that Maori were over represented in lower socioeconomic groups over many measures. This implied that Maori carried a disproportionate health burden as consequence of lower socioeconomic status [10]. Combining the effect of relatively high rates of premature morbidity in fertility a youthful population provides Maori with a high dependency load.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Maori (rate per 100,000, with standard error)</th>
<th>Pacific</th>
<th>Asian</th>
<th>European /Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Infectious disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious disease-related mortality, 2001–02, rate per 100,000</td>
<td>14.4 (13.3, 15.5)</td>
<td>12.0 (11.2, 12.7)</td>
<td>13.1 (12.4, 13.7)</td>
<td>22.8 (19.1, 26.9)</td>
</tr>
<tr>
<td>Tuberculosis notifications, 2002–03, rate per 100,000</td>
<td>11.3 (10.2, 12.4)</td>
<td>10.4 (9.4, 11.5)</td>
<td>10.8 (10.0, 11.6)</td>
<td>17.1 (14.3, 20.3)</td>
</tr>
<tr>
<td>Meningococcal disease notifications, 2002–03, rate per 100,000</td>
<td>18.4 (17.0, 20.0)</td>
<td>15.1 (13.8, 16.5)</td>
<td>16.8 (15.8, 17.8)</td>
<td>24.4 (21.8, 27.2)</td>
</tr>
<tr>
<td>Hepatitis B notifications, 2002–03, rate per 100,000</td>
<td>2.1 (1.7, 2.7)</td>
<td>1.4 (1.1, 1.9)</td>
<td>1.8 (1.5, 2.1)</td>
<td>3.7 (2.6, 5.1)</td>
</tr>
<tr>
<td>Rheumatic fever (initial attack) notifications, 2002–03, rate per 100,000</td>
<td>3.1 (2.6, 3.8)</td>
<td>2.3 (1.8, 2.8)</td>
<td>2.7 (2.3, 3.1)</td>
<td>7.1 (5.8, 8.7)</td>
</tr>
<tr>
<td>Campylobacteriosis notifications, 2002–03, rate per 100,000</td>
<td>404.3 (397.8, 411.0)</td>
<td>330.7 (324.9, 336.6)</td>
<td>367.0 (362.6, 371.4)</td>
<td>108.7 (102.4, 115.4)</td>
</tr>
<tr>
<td>Cryptosporidiosis notifications, 2002–03, rate per 100,000</td>
<td>27.7 (26.2, 29.6)</td>
<td>26.6 (24.8, 28.4)</td>
<td>27.2 (26.0, 28.5)</td>
<td>7.7 (6.3, 9.4)</td>
</tr>
<tr>
<td>Giardiasis notifications, 2002–03, rate per 100,000</td>
<td>46.8 (44.6, 49.1)</td>
<td>38.3 (36.4, 40.4)</td>
<td>42.6 (41.1, 44.1)</td>
<td>10.9 (9.1, 13.0)</td>
</tr>
<tr>
<td>Salmonellosis notifications, 2002–03, rate per 100,000</td>
<td>49.1 (46.8, 51.5)</td>
<td>42.8 (40.7, 45.0)</td>
<td>46.0 (44.4, 47.6)</td>
<td>25.4 (22.5, 28.6)</td>
</tr>
</tbody>
</table>

*Table Four: Selected health risk factor indicators, New Zealand Source: Ministry of Health and Public Health Intelligence [65]*
3. Structural Determinants of Health

Access to culture, land and economic resources are priority determinants for Maori as we continue to negotiate to improve the provision of a wide range of services critical to health and economic investment. In Parliament and local bodies, the ground over which the rules of deciding how society’s resources are distributed is constantly changing. Maori representation remains an admix of election to predominantly fixed positions complimented with nominations by Government to some District Health Boards (DHB) to ensure Maori representation. Maori are now more likely to be represented in the Parliament \textsuperscript{iii} and on DHBs \textsuperscript{iv} occupying 17.3\% and 24.8\% of the available seats respectively. Maori are however under represented in elections to many local bodies (including some DHB) \textsuperscript{[49]}

Education

Prior to 1847, Maori were taught in the Maori language at Mission Schools that brought about a very high degree of literacy in Maori when compared with their colonial peers. The Native Schools Act (1852) was passed which provided a subsidy for Maori schools that taught in English \textsuperscript{v}. In 1899, the first Maori to graduate in medicine Dr Maui Pomare attended the American Medical Missionary College, Chicago \textsuperscript{[67]}, became Minister of Health in 1923. The first Maori to graduate in medicine in New Zealand was Peter Buck (known as Te Rangi Hiroa to Maori) graduated from The University of New Zealand in 1904 \textsuperscript{[68]}. Both men were from the same area of New Zealand and both were knighted (op cit).

It took 120 years to establish teacher-training schemes for native Maori speakers and 120 years re-establish competent Maori language teachers before courses in Maori language were included in the curriculum of 5 Universities and 8 training school colleges. In 1981, the first Kohanga Reo (Maori language nest) pre-school Maori

\textsuperscript{iii} Designated Maori seats were established in 1867 and a year later the first Maori representatives were elected. Maori men who owned land were granted the franchise to vote in 1853 alongside all other male land owners; however few Maori men had title to their land, so could not register to vote until the franchise was extended to all Maori men over the age of 21 in 1867. The same right was not granted to all other non-land owning men over 21 years old until 1879. In 1892, New Zealand again led the world in the application of social justice when women won the right to vote 66. Elections New Zealand. \textit{History of the Vote}. 2005 3 April [cited 2007 28 March]; Available from: http://www.elections.org.nz/history.html.

\textsuperscript{iv} 11 of the 121 DHB members elected were Maori, the Minister of Health nominated a further 39 Maori of 78 people appointed to the District Health Boards.

\textsuperscript{v} Interrupted by the New Zealand Wars that forced the closing of schools in 1865 and the abandonment of the mission schools, the Native Schools Act was extended in 1867 with the offer to communities of a school teacher, building and resources if land was provided to site the school.
language immersion programme was established, led by Maori women. The aim was to make every Maori child bilingual by the age of 5 years old. By 1994 there were 809 Kohanga Reo Schools established.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
<th>Ethnic group</th>
</tr>
</thead>
</table>
| School completion (Sixth Form Certificate or higher), 15+ years, 2001, percent | 50.0 (49.7, 50.1) | 50.2 (49.9, 50.3) | 50.1 (49.7, 50.1) | Maori (30.5, 30.7)  
Asian (37.8, 37.5)  
European /Other (69.6, 70.0) |
| Unemployment, 15+ years, 2001, percent         | 5.5 (5.5, 5.5)  
5.4 (5.3, 5.4)  
5.5 (5.4, 5.5)  
10.1 (10.0, 10.2) | 6.7 (6.6, 6.9)  
9.2 (9.1, 9.4)  
4.2 (4.1, 4.2)  | 4.2 (4.1, 4.2)  
6.7 (6.6, 6.9)  
24.5 (4.1, 4.2) |
| Low income, 15+ years, 2001, percent           | 21.4 (21.2, 21.4) | 30.8 (30.6, 30.9) | 26.2 (26.1, 26.3) | Maori (29.3, 29.5)  
Pacific (30.6, 31.2)  
Asian (42.9, 43.6)  
European /Other (43.3, 24.4)   |
| No access to a telephone, 15+ years, 2001, percent | 7.3 (7.2, 7.3)  
6.7 (6.7, 6.8)  
7.0 (6.9, 7.0)  
12.2 (12.1, 12.3) | 15.6 (15.4, 15.9) | 4.4 (4.3, 4.5)  
5.8 (5.7, 5.8)  | 5.8 (5.7, 5.8)  
6.0 (4.3, 4.5)  
24.5 (5.7, 5.8) |
| No access to a motor vehicle, 15+ years, 2001, percent | 4.9 (4.9, 5.0)  
7.1 (7.1, 7.2)  
6.1 (6.1, 6.1)  
12.3 (12.1, 12.4) | 12.3 (12.1, 12.5) | 6.0 (5.9, 6.1)  
4.7 (4.7, 4.8)  | 4.7 (4.7, 4.8)  
6.0 (5.9, 6.1)  
24.5 (4.7, 4.8) |
| Not living in own home, 15+ years, 2001, percent | 47.0 (46.7, 47.1) | 48.9 (45.6, 46.0) | 46.4 (46.2, 46.5) | Maori (60.3, 60.6)  
Pacific (62.8, 63.7)  
Asian (54.1, 54.7)  
European /Other (43.1, 43.5) |
| Household crowding, all ages, 2001, percent     | 9.3 (9.3, 9.4)  
9.9 (9.8, 9.9)  
9.6 (9.6, 9.7)  
19.1 (19.0, 19.2) | 38.3 (38.0, 38.5) | 18.7 (18.5, 18.9)  
4.2 (4.2, 4.2)  | 4.2 (4.2, 4.2)  
18.7 (18.5, 18.9)  
24.5 (4.2, 4.2) |

Table Five: Socioeconomic indicators, New Zealand (age-standardised rates with standard error)

Source: Ministry of Health, Public Health Intelligence from 2001 Census [65]

Illustrative of the notion of structural and intermediate social determinants is the Government’s role in the reduction of access to our own language for more than 120 years. As early as 1852, the Government offered incentives to use the English language in the education system provided for all of New Zealand. After being found wanting by The Waitangi Tribunal in 1985, the Government, with constant prompting from Maori, had to redress the situation. Progress has been slow with 25% of Maori children learning our own language at school, there is considerable ground to make up for New Zealand’s official language, helped in no small part by the leverage Maori representatives in the Parliament have been able to apply. Proportional representation has seen an increase in the number of Maori representatives in Parliament. Maori have become an effective minority lobby in Government, effective beyond the proportion of the population the candidates identify with. The capacity to exercise the franchise to vote and have Maori in Government to pull on the levers of power has left Government with few excuses for their lack of efficacy. In short, Maori remain a minority that can simply be out voted when Parliamentary action was required.

Maori society is responsive to its environment; however as citizens, many people who identify as Maori continue to carry a disadvantage [63] that has strong elements of

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Indigenous language nests for pre-school children.

---
racism implicated in the genesis and maintenance of these inequalities and determinants of health [69]. Fewer Maori students leave school with a qualification (25%) or get a job [49], and those that go onto tertiary education are fewer in number and are less likely to graduate [51]. Maori remain under-educated, under-employed and under-paid. The Government has been unable to address to inequalities characterised by the limited quality and range of socioeconomic indicators available. When economic conditions led to higher unemployment in the 1990s, it was Maori who carried the excess burden of morbidity [10].

**Intermediate Social Determinants**

Many Maori conceive of health as being the balanced interaction of social, physical, spiritual and emotional aspects of our lives [59, 70] within a community with which we have reciprocal accountabilities and obligations between and across generations [2, 71, 72]. The rules and protocols that govern and regulate these processes have developed as times have changed for Maori society [73], sometimes to the disadvantage of some Maori, Maori have developed new resources to address our changing environment [74]—a determinants approach. A determinants approach to policy formulation was recently incorporated by Government into their policy [75] and monitoring reports [56, 76] for inter-departmental consistency [76].

Intermediate social determinants for Maori are characterised by inequalities that have a negative health dividend – poor housing and over crowding [77] with disease [78], or going to school hungry [79]. However we must also consider how interventions may be applied and therefore how cultural and linguist meaning can be accurately transmitted to improve health and well being. Therefore we must include our language because without our language we are no longer able to celebrate who we are in a manner that honours our cultures — our language cements our social capital. Integrating effective interventions into existing national strategies and goals is now an explicit part of health and social policy to improve the provision of resources to address inequalities [77].
Conclusion

Persistent differentials in health and socio-economic status for the Indigenous peoples of Australia and New Zealand has its antecedents in the social and political context that characterised early stages of colonisation when structural determinants of health and well-being were changed.

Government was established by arbitrary decree in Australia and with little effective Maori representation in New Zealand cementing in place new structural social determinants, diminishing the influence traditional strategies had on intermediate determinants brought about by land alienation and new, exclusive forms of education—traditional knowledge was no longer sufficient to meet the challenges to health in a cash economy.

As new challenges to health emerged with the intermingling of European and Indigenous people, the stress of rapid change, brought about conflict, left Indigenous populations susceptible to new infectious diseases that had been kept at bay by the distance and time it took to travel half way around the world, culminating epidemics that included the swathe of death carved by the 1918 Influenza Epidemic through out Oceania, devastating not only the Indigenous populations of Australian and New Zealand where there was contact with Europeans recently returned from Europe, but also devastating the islands where these ships stopped for respite.

There is evidence that over the past thirty years progress has been made to improve the social determinants of health of Australia’s and New Zealand’s Indigenous peoples. However, on many indicators, our health now remains unacceptably lower and at levels experienced nearly a century ago by our non-Indigenous peers.[80]

The influence that structural determinants have on inequities cannot be addressed without fundamental changes to the consequences of a history of colonisation. This is where our two countries diverge; New Zealand has begun a journey down a path of reconciliation, a journey the Government of Australia seems reluctant or unable to sustain. Inequalities experienced by the Indigenous peoples of Australia and New Zealand are significant and would be fundamental breaches of human rights if either Government was prepared to debate the notion of Indigenous rights; the same inequalities are a denial of autonomy – the right to self-determination, because they
deny disproportionately more Indigenous people the right to development free of the dictates of hand outs.[81]

As noted by Latmans, Biddle and Hunter:

Similar statistical outcomes can only result from similar resource endowments, histories, legacies, aspirations. Viewing Indigenous socioeconomic progress as a process that is seeking equality, in some simple statistical sense, within mainstream Australian norms is problematic and contestable[34].

We suggest an alternative approach by Government because of the repetition of patterns of disadvantage with the emergence of new diseases of the 20th and 21st century. Without changes we can surmise that we are going to die earlier and get help later. When will we know that the chronic inequalities have been resolved? Reducing existing inequalities without producing new ones will be the metric by which success will be judged. How will these inequalities be addressed?

Restoring access to the cultural and social facilities that maintain social capital for the Indigenous peoples of Australia and New Zealand will do much to maintain resilience that is a defining character of all Indigenous people. Providing Indigenous people with sufficient resources to complete this transition in our own terms will encourage autonomy and therefore the opportunity own and solve emerging problems along the way. This cannot be undertaken without the help and support of the rest of society and without the shared wisdom that arises from a problem shared and understood.

As two of the countries we like to call God’s Own, we will not travel far if we travel alone – separated by inequality.
References


