This historical study sets the context for understanding the current health situation of Pacific peoples in New Zealand. Our title is an attempt to invoke Polynesian understandings of health and to convey the aspirations of Pacific peoples who have made New Zealand their home. The monograph discusses transnationalism and the demographic history of Pacific peoples in New Zealand, the changing patterns of health and health research, and the development of specific Pacific health services and Pacific led health care and health promotion. A chapter on tuberculosis and Pacific people in New Zealand weaves together the key themes of this story. Apparent throughout is the mixed progress towards better health for Pacific people in New Zealand, the way in which the same health problems are rediscovered each decade, and the growing recognition that ‘Pacific Islanders’ are here to stay in New Zealand but in the context of extended transnational families.
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Better Lives
The Struggle for Health of Transnational Pacific Peoples in New Zealand, 1950-2000

The Authors

The authors are members of the interdisciplinary ‘Transnational Pacific Health through the lens of TB’ research group based in the Department of Anthropology at the University of Auckland, led by Associate Professors Judith Littleton and Julie Park. Deborah Dunsford led the historical analysis which forms the basis of this monograph.
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Research in Anthropology and Linguistics Monographs

Better Lives

The Struggle for Health of Transnational Pacific Peoples in New Zealand, 1950-2000

Deborah Dunsford, Julie Park, Judith Littleton, Ward Friesen, Phyllis Herda, Pat Neuwelt, Jennifer Hand, Philippa Blackmore, Sagaa Malua, Jessica Grant, Robin Kearns, Linda Bryder, Yvonne Underhill-Sem

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2011
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‘Pacific people came to New Zealand to have better lives’

This is the Pacific dream—a story repeated from generation to generation by migrants and their descendants who have chosen New Zealand as their home. Better health and access to health care, improved education and employment opportunities are often quoted as powerful forces for migration. Migration has created new opportunities and Pacific peoples have excelled in the arts, music and professional sports in New Zealand. Pacific individuals have excelled in many areas of endeavour. There are bright spots such as the decline in infant mortality and growth of Pacific community-owned health services. The health sector in general has attracted many of the Pacific’s best young talent and there is good reason to be optimistic.

However, better health has not occurred for the majority and, in some cases, the reverse has occurred. Pacific peoples in New Zealand have some of the worst health and social statistics and the trends are of concern. Chronic non-communicable diseases such as heart disease and diabetes are the leading causes of death and disability among Pacific peoples. While these conditions are now prevalent among Pacific peoples, infectious diseases such as rheumatic fever and tuberculosis remain high among this group also. Incidence rates of acute rheumatic fever and rheumatic heart disease among Pacific children are worse than those reported in the islands. Rheumatic fever and tuberculosis have long been regarded as reliable barometers of the living conditions of affected people. Children are most susceptible to the effects of poverty on their health and development potential. Variable quality of health care services provided to Pacific peoples is an additional barrier.

This study provides a comprehensive account of the growth of the Pacific population in New Zealand, a description of their health status, changes to health research funding and delivery, and the evolution of ‘for Pacific by Pacific’ health services during the period 1950 – 2000. It provides a valuable record of the major changes to the Pacific population and factors which shaped their health over the years. Tuberculosis was used to describe the ‘window on the struggle for health’ by Pacific migrants in the early years of settlement in New Zealand. Study findings showed the difficulties of new migrants coping with a condition associated with stigma and a ‘one size fits all’ health system prevailing at the time.

The study also shows the integral links and unbreakable bonds between Pacific families who live in New Zealand and those who remain in the islands. Continuing strong bonds between families have important social and economic consequences, including for health. It is generally well known that family members who need health care frequently travel to New Zealand for care, both as formal referrals and referrals arranged by families. The phenomenon is not well documented but it is common. The impact on families in New Zealand is significant.

The study is an important historical account of the evolution of health care services for Pacific people in New Zealand and the factors that drove the change. It is a powerful story of communities taking action in response to dissatisfaction with the status quo. While the health statistics of Pacific peoples remain a cause for concern for New Zealand as a whole, the emergence of community-owned health services alongside mainstream services is reason for optimism. The signals are encouraging that Pacific peoples may finally be able to realise their dream of a better life for all.

Colin Tukuitonga
April 2011
A note on the Research Group

This monograph has been written by members of the ‘Transnational Pacific Health through the lens of TB” research group, a project funded by the Health Research Council of New Zealand and The University of Auckland and led by Associate Professors Judith Littleton and Julie Park of the Department of Anthropology. The core research is concerned with the relationship between transnational experiences and health of Pacific peoples focusing in particular upon the experience of Tuvaluans and Cook Islanders both in the islands and in New Zealand. This volume comprises the third of a series of historical studies setting the context for understanding the current health of Pacific Islanders. The cross-disciplinary group consists of nine members drawn from three University of Auckland Faculties: in Science, Professor Robin Kearns and Dr Ward Friesen (Environment), in Arts, Professor Linda Bryder (History), Dr Yvonne Underhill-Sem (Development Studies), Dr Phyllis Herda (Anthropology), in Medical and Health Sciences, Dr Jennifer Hand and Dr Patricia Neuwelt (Population Health). Two members are from the University of Southern Oregon (Professor Anne Chambers, Dr Keith Chambers (Emeritus)) who have a very long history of scholarly engagement with Tuvalu. A crucial part of the project are the six research students (three of Cook Islands background (Ms Debbie Futter-Puati, Ms Evelyn Marsters, Ms Rochelle Newport) and three of Tuvaluan background (Ms Setapu Resture, Mr Tufoua Panapa, Ms Sagaa Malua). Two research officers/research assistants (Ms Philippa Blackmore, Ms Sagaa Malua), several summer scholars (Laura McLauchlan, Kaea Matenga, Lara Penman, Rosanna Keam, Ally Palmer, Siobhan Patia) and a visiting researcher from Canada, Ms Jessica Grant, are also involved. Independent historian Dr Deborah Dunsford joined the group for this historical project. In all, eight members of the group have island Pacific ancestry while other members hail from Canada, Australia, England and New Zealand. The research and writing group for this book was drawn from those members whose research has a New Zealand focus, but the whole team for 2010/2011 had critical input into it.

Acknowledgements

We are particularly grateful to the wonderful men and women who have been movers and shakers in Pacific communities, often for many decades, who contributed interviews to this report and in some cases generously shared their personal archives with us. We are grateful for the permission received to view historical files of the Ministry of Health and Auckland District Health Board held at Archives New Zealand in Wellington and Auckland and the preventive medicine dissertations held as a Special Collection at the University of Otago Medical and Dental Library, Dunedin. The assistance of Archives New Zealand staff and Richard German and library staff at the University of Otago is very much appreciated. Heartfelt thanks to the Health Research Council of New Zealand and to the Faculty of Arts Research Development Fund which have made all our undertakings in the project, including this one, possible. We also acknowledge the support and assistance of colleagues within the Anthropology Department.
Tuberculosis (TB) is no longer a major health problem today for the majority of New Zealand’s population: yet disproportionately high rates of TB among Pacific peoples in New Zealand are cause for concern (see Chapter 6). In this report we examine contexts for and selected aspects of the health of Pacific peoples in New Zealand between 1950 and 2000. This work is part of the historical component of our research project “Transnational Pacific Health through the lens of TB” and is being pursued within a theoretical framework informed by syndemic and transnational perspectives.

Our title, Better Lives, is an English language attempt to invoke Polynesian cultural understandings of ‘health’ and to convey the aspirations of those voyagers and their descendants who have made New Zealand their home. The words in Polynesian languages: ola, ora, ora ‘anga or malosi, and their cognates, which have become accepted as translations of ‘health’, or ‘wellness’ can be understood in terms of being alive, living (well) and being well (strong). In these concepts there is no distinction between mind and body, self and others. To live well, social, cultural, spiritual and ecological interconnectedness is taken for granted. Relationships need to be harmonious in accord with specific cultural understandings. Connectedness, balance, propriety and flow are required, as are those material and non-material resources necessary for a good life. Sickness, maki, ma’i, mate, is anticipated and occurs when relationships are disrupted (see Chapter 5 and Capstick et al. 2008).

There are obvious implications here for transnational lives. Many Pacific people who made the journey to New Zealand were in search of better lives for themselves and their children, and sometimes for the people back home too, whom they hoped to resource. Some people achieved what they were looking for; others had to settle for something less. The ironies entailed in the migrants’ assumption of better lives in New Zealand are not lost on them or their descendants (See Box 1.1).

After an introduction to TB, transnationalism, and syndemics, we examine in Chapter 2 the demographic history of Pacific peoples in New Zealand and sketch in relevant aspects of their lives including mobilities, housing, work and community life. Within a syndemic framework, the changing patterns of health during these five decades are analysed in Chapter 3. Knowledge of Pacific health is based, to a large extent, on published medical and health research and, in Chapter 4, we reflect on the research into Pacific health concerns funded by the main government funder in New Zealand, the Medical Research Council of New Zealand ((MRC) now Health Research Council (HRC)). We concentrate especially on the 1970s and 1980s, the period when Pacific health needs became visible and prioritised. Between the 1950s and the 1970s, little attention was given to Pacific health service needs. Chapter 5 charts the development of specific Pacific health services, from self-help efforts to raise the profile of Pacific health needs from the mid-1970s, to the development of Pacific-led health care organizations in the 1990s, and recognition of Pacific issues throughout the health services, including primary care and health promotion. TB is the focus of our final substantive chapter, Chapter 6, which describes and analyses Pacific peoples’ experiences with TB in New Zealand. The book concludes in Chapter 7 with a discussion of the key themes raised in this historical analysis. These themes include the belated recognition that Pacific ‘Islanders’ were in New Zealand to stay, and the propensity to imagine Pacific peoples as either ‘in New Zealand’ or ‘in the islands’ rather than as moving between or straddling both places. Further themes include the long time it took for a broad understanding that Pacific peoples (and others) might have different health needs requiring different solutions, the long invisibility of New Zealand’s Pacific peoples within the hospital and broader health system and in health research, and the ongoing efforts to expand the Pacific health workforce. The relationship of convergence between Pacific and Māori health status is discussed.

What this report shows is that, despite early recognition of particular disease nexuses (e.g., diabetes,
gout, hypertension, obesity and renal failure), acknowledgement of the disproportionate burden of a range of infectious diseases (e.g., hepatitis B and respiratory and skin diseases), and attempts to reduce these problems, these diseases still severely compromise the health of many Pacific peoples. A further major insight is the way in which that high burden of disease has been discovered and rediscovered over four decades, each time accompanied by recurrent expressions of surprise. In this context, TB is a lens through which we can understand the health, health services and history of Pacific peoples in New Zealand. As Colin Tuikuitonga wrote in 1997:

> It is clear that conventional thinking is inadequate and Pacific communities need innovative solutions together with great participation. A clear national direction for the health of Pacific people is required including adequate resources for its implementation (1997:5).

The genesis of this volume

From 2003 to 2006, several of the current research group and a group of students were engaged in social research into the political ecology of TB in Auckland (Littleton, Park, Herring and Farmer 2006). As in our current study, TB was used as a lens through which we could research social inequality and health. We worked with a wide range of groups: Māori Pakeha, Pacific, people from various parts of Asia and people from refugee backgrounds. In addition, Dunsford carried out a historical study of TB in New Zealand from World War II until the 1970s. It was through these and other epidemiological studies that we came to realise that Pacific groups were the main ethnic groups within which TB was being actively transmitted in New Zealand at that time. Further, in the post-war Pacific migrations to New Zealand, TB was identified as one of the issues defining Pacific people’s citizenship status in their new country. Our research also indicated that in order to understand the current situation of Pacific people’s health, we needed to frame a new study on both historical and transnational lines. This volume then consists of a series of co-written chapters which provide windows into diverse aspects of the history of Pacific health and community, health research and the development of health services by and for Pacific peoples in New Zealand. The historical case study of TB brings together the themes which run through the book, indicating, as Dr Tuikuitonga has said in his Preface, that the achievement of better lives is an ongoing struggle for Pacific peoples.

Who are Pacific Peoples in New Zealand?

The vast majority of Pacific people resident in New Zealand derive from the islands of Polynesia. At the last census (2006) they comprised nearly seven percent (265,974) of the New Zealand population of approximately 4.15 million (Statistics NZ 2006). Although nearly 20 distinct language and culture groups are represented, approximately half are Samoan. After a period of high migration from approximately 1950 to the early 1970s, most Pacific people in New Zealand are now New Zealand born and two-thirds live in the Auckland area (Cook et al. 2001).

Pacific identities are multiple and fluid. While the constructs ‘Pacific’ and ‘Pasifika’ are commonly employed, and may be an aspect of individual identity, Pacific peoples frequently identify strongly with their island nation, their island, their district, their village, their church, as well as their city or suburb in New Zealand,

Figure 1.1 Pasifika festival, Auckland 2010
and New Zealand itself. These identities intersect with a range of others, such as gender, generation, age, sexuality, and birthplace. In the contemporary setting, people travel a good deal between the various islands and New Zealand; and migration, especially from the islands to New Zealand and further afield, still continues, as does movement within New Zealand and within the islands (Macpherson 1997, 2004; Lee and Francis 2009).

The socioeconomic status of Pacific peoples in New Zealand is one of relative disadvantage. Pacific peoples tend to live in more impoverished urban areas, earn lower incomes, are less likely to be employed and generally have worse health status than the population as a whole (Ministry of Health 2009). Nonetheless, segments of the population show high achievement in education, the arts, sports, fashion and business and the professions. Pacific communities are vibrant and are a recognised social force in the wider community (Figure 1.1).

**Through the lens of tuberculosis**

Internationally, rates of tuberculosis in New Zealand are generally low at around 10 cases per 100,000 of population. However, this rate masks significant differences between ethnic groups and cohorts within the nation (see Chapter 6). In contrast to Pakeha and Māori, Pacific communities in NZ are not experiencing a decline in TB notification rates and the incidence within some cohorts is increasing (Das et al. 2006). In some cases, reported rates in New Zealand are higher than reported rates in the home islands (Ng Shiu et al. 2008). Rates of TB among elderly Pacific peoples in New Zealand are high at around 185-190 per 100 000 of population. Importantly, significant TB disease is found among Pacific children. This event is a sentinel marker of active transmission and of the disadvantaged living conditions and life situations of many Pacific children (Voss et al. 2006). Despite its preventability, there is broader evidence of active transmission of TB among some Pacific groups in New Zealand and analysis of TB strains shows clustering in Pacific communities (Sexton et al. 2008). High rates today of TBD (active tuberculosis disease) among Pacific elders is both a reflection of the historical pattern of tuberculosis in the Pacific, where TB rates were high until recent decades, and of current health challenges facing those who migrated to New Zealand from the 1950s onwards. For example, diabetes makes a person more liable to become infected if exposed to the bacillus, and, if infected, more likely to progress to active disease. The treatment of people with diabetes and TB is complex and TB also exacerbates diabetes making a chain of complex interactions (Littleton and Park 2009). Furthermore, difficulties in accessing health services by Pacific people have been noted in several studies (Wright and Hornblow 2008:27). Delay in accessing services leads to delay in diagnosis and treatment and creates greater opportunity for TB infection to spread to social contacts (see Hay 2010 for detailed accounts of these difficulties). This complex interaction between past and present and between disease entities and social conditions has led us to adopt a syndemic approach to tuberculosis and to argue more broadly for the relevance of an approach using syndemic and transnational frameworks to understand Pacific health.

**Syndemics and Transnationalism**

The term syndemic refers to:

- a set of interactive and mutually enhancing epidemics involving disease interactions at the biological level that develop and are sustained in a community or population because of harmful social conditions and injurious social connections (Singer and Clair 2003:429, see also Singer 2009).

We use a syndemic perspective because it requires consideration of the mutual causality between TB and other conditions. Conditions potentially implicated in a synergistic relationship with tuberculosis in New Zealand include:

- household crowding (Baker et al. 2008, Wanyeki et al. 2006),
- tobacco use (Bates et al. 2007, Chiang et al. 2007, Lin et al. 2007),
- diabetes (Restrepo et al. 2007, Dixon 2007, Jeon and Murray 2008),
- stigma and discrimination (Harris et al. 2006),
- poverty (Farmer 2000, Thomas and Ellis-Pegler 2006),
- helminths (intestinal worms) (Elías et al. 2007),
- poor nutrition (van Lettow et al. 2003), and
- Vitamin D deficiency (Ustianowski et al. 2005).

All these conditions are directly or indirectly related to social and economic inequalities, histories of colonialism and displacement, racism, and past and present political arrangements and ideologies.

**Transnationalism**

Intimately tied with this situation is the necessity to recognise Pacific peoples in New Zealand as members of transnational communities (Macpherson et al. 2001). By transnational we emphasise the “ongoing interconnection or flow of people, ideas, objects and capital across the borders of nation states, in contexts in which the state shapes but does not contain such linkages and movements” (Schiller 2007, see also Vertovec 1999). The seminal work of Ian Prior and the Tokelau Islands Migrant Study group (Wessen [ed] 1992) demonstrates the value of paying attention to both ‘here’ and ‘there’ in understanding health and social change. Their research
demonstrated that migration sets up a pattern of long term mobility among both ‘stay at homes’ and ‘migrants’.

Pacific peoples retain strong tangible, economic and emotional links with the home islands and New Zealand. Indeed, they are linked to many other countries as well, particularly Australia and the US. Trips back to country of personal or of family origin and visits to overseas kin are often frequent. As well as providing social, cultural and economic resources, such trips are opportunities for transmission of infection in both directions and for securing health services. Transnationalism creates particular dynamics in terms of the relationships of individuals with health services (Messias 2002, Gastaldo et al. 2005). As they move between New Zealand and the islands, people carry their life experiences of society and of health and health services, which are reshaped, exported and reshaped again. As Siem’s (1997) review indicated, this situation requires health services and professions to be able to orient themselves to different paradigms, and this is a key process in ensuring accessible and appropriate services for Pacific peoples.

Migration Histories

While this historical review is framed in terms of Pacific peoples, the migration histories and the health experiences of the national groups are diverse (Macpherson 1997, 2004). Different groups arrived in New Zealand at different times as Chapter 2 will show. The timing and extent of migration was partly a function of the colonial relationships of the emergent Pacific Island countries and territories. Those with prior colonial links with New Zealand (e.g., the Cook Islands) have a longer history of transnationalism with this country than does, for example, Tuvalu, which was part of the British Western Pacific High Commission until the 1970s (Futter-Puati 2010, Resture 2010). The early Pacific migrants arrived at a time when there were no specific health services for Pacific peoples within the New Zealand health system. In contrast, later arrivals have a greater set of health care choices. Patterns of disease have shifted substantially since 1950 and non-communicable, ‘lifestyle’ diseases are now regarded as the greatest health challenges of the day. For example, in the 1950s, TB was declining rapidly but was still a major problem both in New Zealand and the Pacific (Dumsford 2008, Futter-Puati 2010, Resture 2010). As already noted, the decline in tuberculosis and some other infectious disease rates for Pacific peoples in New Zealand has not been as substantial as the decline for pakeha. Successive generations of Pacific arrivals have therefore confronted the new challenges of non-communicable disease while still dealing with the stubborn persistence of some infectious diseases including TB and, more recently, HIV (Ministry of Health 2009).

The linkages between structural conditions, transnationalism and health operate across time, place and generations. Transgenerational transmission and patterns are one result as the following narrative model shows (Box 1.2).

Box 1.2  A common scenario for transgenerational TB

T… grew up in the Pacific in the 1950s when tuberculosis rates were still high. Indeed while still a child her father had a bout of tuberculosis. She did not develop tuberculosis at the time. At the age of 20 she and her husband migrated to New Zealand. He had work in a freezing works. She worked as a cleaner. They had difficulty finding rental housing—landlords were not eager to rent to ‘Pacific Islanders’ plus their wages were low which meant that the only solution to the housing problem was to share a small house with another family (from the same island). Under these stressful living conditions T… developed tuberculosis disease due to reactivation of her long standing latent tuberculosis infection. The disease was, however, successfully treated at the time and brought under control, but as later events showed, it was not completely eliminated: she had latent infection.

There are multiple versions of this story. Sometimes it is not activation of the old infection but a completely new infection from a new strain of tuberculosis. Sometimes the first bout of TB disease was not the result of tuberculosis in the family during childhood but the result of TB transmitted among adults in New Zealand (see for example, Voss et al. 2006, Ng Shiu 2006). Common to all stories, however, are the histories of migration and the marginalisation of Pacific migrants in terms of housing, wages, education and health care. A significant factor is also the existence among Pacific elders today of multiple health conditions that interact to create major challenges (including tuberculosis) and the further impact of that burden upon a much younger generation.

Thinking of this recurrent constellation of circumstances in syndemic and transnational terms compels us to focus on the relationships between political arrangements, migration policies and movements, the social and economic structures of the host society, the employment and education of those migrants, their subsequent living conditions and their health experiences within an environment of racism and discrimination that can operate at each stage. The element of transnationalism emphasises that this is not a unidirectional movement from island to New Zealand. Rather it is a circulation which can stretch across generations. This historical study of developments and patterns of Pacific peoples’ health and health services in New Zealand, with a special emphasis on tuberculosis, provides a layered understanding of the significance of these influential relationships at different times and stages of Pacific lives in New Zealand.
Chapter Two

Becoming Pacific in New Zealand: An overview

Migration from Polynesian nations to New Zealand began in earnest following World War II and led to the local establishment of transnational Pacific communities. For many Pacific Islands this migration mirrored colonial relations in the region. People from those islands under New Zealand administration, with the exception of Samoans, were allowed relatively straightforward access from the time of annexation: 1900/1901 for Niue, 1901 for the Cook Islands, 1914 for (Western) Samoa and 1916/1925 for Tokelau. Through the first half of the 20th century, there was a slow growth in the non-Māori Polynesian population of New Zealand from about 150 in 1916 to just under 1,000 in 1936 and over 2,000 by the end of World War II (Table 2.1). Over this period, most Pacific Island migrants originated from (Western) Samoa, the Cook Islands and Niue. Many of these were people of chiefly rank, had one European parent, or had married a European. World War II brought opportunities as well as devastation to the Pacific and many people considered life beyond the islands as a viable option.

In this chapter we chart the variable fortunes of Pacific peoples in New Zealand from 1950. Welcomed as workers in the 1950s through to the 1970s when the economy was booming, Pacific ‘islanders’ faced discrimination and an uncertain welcome as permanent residents and citizens. Many struggled to find suitable housing, with consequent overcrowding. Despite these hardships, Pacific people settled in New Zealand, many choosing spouses from different ethnic backgrounds. By the mid-1970s, with the economic downturn especially affecting those manufacturing industries in which Pacific people were primarily engaged, unemployment added extra burdens to already low income households. In addition, the dawn raids that forcibly repatriated Pacific people who did not have valid residence or work permits demonstrated crudely that now their labour was not a valued commodity, neither were they welcome. Yet throughout these 60 years, numbers of Pacific people grew, reaching over a quarter of a million by 2006 Census. The numbers of ‘Pacific’ people born in New Zealand equalled the numbers of migrants in 1991. Statistics also show how intensely mobile Pacific people are, underlining the multiple transnational links between New Zealand and its Pacific neighbours. By the end of the 20th century, some Pacific people in New Zealand had become household names through their success in sports, the arts, public life and community work. Huge festivals drew attention to Pacific creativity and Auckland claimed to be the biggest Polynesian city in the world. Pacific people were here to stay. Despite these successes, because of low wages, many Pacific households struggle to feed their families, keep them warm and housed, even when they are in work and especially when under- or un-employed. Throughout the period churches have been a major rallying point for community life. These features of Pacific communities in New Zealand have important implications for health and wellbeing, both positive and negative.

The 1950s and 1960s: Arrival and Consolidation

During the post-war economic boom when New Zealand’s economy was protected by tariffs, demand for labour resulted in at least two migrations which had significant impacts on the ethnic composition of New Zealand cities, especially Auckland. One was the urbanisation of Māori which was, in the post-war period, one of the fastest of any group in the world (Pool 1991:133). The other was the increased immigration from external Polynesian nations (Ongley 1991). Several factors contributed to Pacific Island migration to New Zealand at this time. Established New Zealand colonies in the South Pacific facilitated this movement in the 1950s. In addition, population growth rates in the Pacific increased dramatically during this time with no concomitant increase in employment in the islands. Several devastating cyclones also wreaked havoc in the region (Niue, 1959 and 1960; Western Samoa and Tokelau, 1966). These factors resulted in workers and their families from the Cook Islands, Tokelau, Niue and Western Samoa emigrating to New Zealand in search of employment, better educational opportunities for their children and a chance to better the extended family back home in the islands through cash remittances (Cowling 1990, Ahlburg 1991, Ravuvu 2002, Macpherson 2004b). Smaller, but still significant, numbers came from Tonga and Fiji (Tu’inukuafae 1990:209, Morton 2004:134). By 1956 there were over 8,000 Pacific-born people resident in New Zealand, with about 3,000 of these from Samoa, 2,000 from the Cook Islands and 750 from Niue. The only other significant source of Pacific migrants was from Tonga, with a similar number to Niue, but drawn from a much larger population base.

The 1960s was a time of decolonisation in the Pacific. Western Samoa elected for complete independence from New Zealand in 1962, while the Cook Islands (1965) and Niue (1974) chose to be in free association with New Zealand and Tokelau (1994) became a dependency. These choices resulted
in differing types of access for their citizens to New Zealand. People from the islands in free association (Cook Islands and Niue) as well as from Tokelau were deemed to be citizens of New Zealand. However, in the case of Western Samoa, although the New Zealand government recognised the former relationship with an annual immigration quota, its people were not automatically granted citizenship and had to apply for work or visitor visas in order to enter the country.

From 1964 the New Zealand government issued three month work permits, with annual immigrant quotas set from 1967. Labour shortages were a prime factor at this time. Migrants from the Cook Islands, Niue and Tokelau, as citizens of New Zealand, were exempt from the scheme, and most applicants for work permits came from Western Samoa and Tonga. Neglecting to renew visas and turning a blind eye to those working beyond their legal permits became commonplace (Liava’a 1998:1, Savelio 2005:31). By 1966, Pacific populations were about one percent of the New Zealand population, and this proportion has steadily increased so that in 2006 they comprised 6.9 percent (Table 2.1).

Table 2.1 Pacific Islands population in New Zealand 1916-2006. Source: Census reports 1916-2006

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of “Pacific Islanders” *</th>
<th>% of N.Z. population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1916</td>
<td>151</td>
<td>0.01</td>
</tr>
<tr>
<td>1921</td>
<td>334</td>
<td>0.03</td>
</tr>
<tr>
<td>1926</td>
<td>588</td>
<td>0.04</td>
</tr>
<tr>
<td>1936</td>
<td>988</td>
<td>0.06</td>
</tr>
<tr>
<td>1945</td>
<td>2,159</td>
<td>0.14</td>
</tr>
<tr>
<td>1951</td>
<td>3,624</td>
<td>0.19</td>
</tr>
<tr>
<td>1956</td>
<td>8,103</td>
<td>0.4</td>
</tr>
<tr>
<td>1961</td>
<td>14,340</td>
<td>0.6</td>
</tr>
<tr>
<td>1966</td>
<td>27,594</td>
<td>1.0</td>
</tr>
<tr>
<td>1971</td>
<td>47,434</td>
<td>1.7</td>
</tr>
<tr>
<td>1976</td>
<td>62,902</td>
<td>2.1</td>
</tr>
<tr>
<td>1981</td>
<td>93,941</td>
<td>3.0</td>
</tr>
<tr>
<td>1986</td>
<td>130,296</td>
<td>4.0</td>
</tr>
<tr>
<td>1991</td>
<td>167,073</td>
<td>5.0</td>
</tr>
<tr>
<td>1996</td>
<td>202,236</td>
<td>5.8</td>
</tr>
<tr>
<td>2001</td>
<td>231,801</td>
<td>6.4</td>
</tr>
<tr>
<td>2006</td>
<td>265,974</td>
<td>6.9</td>
</tr>
</tbody>
</table>

* From 1916 through the 1960s, these were ‘Polynesians, not including Māori’, in 1971 they included Fijian, and subsequently all groups of Pacific origin.

Throughout the second half of the 20th century, there have been considerable fluctuations in the movements between Pacific Island nations and New Zealand, partly in response to changing immigration policies (Lee 2009:10). Thus, while populations were increasing in New Zealand, there was also a great deal of circulation taking place, both short-term and long-term. For example, arrivals and departures of Cook Islanders during the 1950s and 1960s (Figure 2.1) demonstrate that, while net migration in a particular year might have been in the hundreds, total numbers of arrivals and departures were sometimes in the thousands. This regular and sustained movement of people was not initially understood, but has created transnational Pacific Island communities with sustained social, cultural, economic and health implications.

The greatest concentration of Pacific populations in the 1950s was in inner city Auckland, where one-third of all of those in New Zealand lived. The largest cluster was in Freemans Bay (619), making up about nine percent of that population. Further, when Māori (834) in this suburb are considered, ‘Polynesians’ made up over 20 percent of Freemans Bay’s population, which, with smaller numbers of Chinese and Indians also attracted to the inner city, made it the most ethnically diverse of any Auckland suburb at that time.

In the 1950s, Freemans Bay and Ponsonby (and some adjacent suburbs) were widely considered to be slums:

Ponsonby, because of the transient nature of its population, has been an attractive area for the underworld. Bookies, fences and slygrogs [various illegal activities] made their home in Ponsonby. Freemans Bay was even worse. It was described as a den of thieves’ and taxi drivers would charge extra to take passengers to hotspots there (University Environment Group 1982:39, see also Loomis 1984a).

Discrimination against Pacific people was widespread and overt. In an inventive survey of rental accommodation in inner Auckland in 1957, and as part of his research on Cook Islanders in Auckland for his University of Auckland Masters thesis in Anthropology, Hooper (1961) telephoned 83 establishments advertising accommodation in the two local daily newspapers, explaining that his Cook Island friend was arriving the next day and needed somewhere to stay. Two-thirds of the respondents said that they would not let accommodation to Cook Islanders.

In the post-war period and through the 1950s the middle classes retreated to the suburbs. This resulted in a large rental stock in the inner city, often comprising the subdivision of larger houses into multiple units (Loomis 1984b:113). According to a survey of Pacific peoples’ housing in Auckland (McCready 1965), approximately 58 percent of Auckland Cook Islanders,
Niueans and Tokelauans were living in inner Auckland. Houses were cheaper to buy although the 1964 survey also found that the associated mortgages had higher interest rates, and shorter repayment times than in outer Auckland (McCreary 1965:25). On the other hand, these households had an average income higher than those in outer Auckland, had fewer dependents per house and, more commonly, more than one wage earner compared to houses in outer Auckland. In contrast to buying a house, rents in inner Auckland were more expensive than outer Auckland (£7.68 compared to £3.44), where a much higher proportion of houses were handled by the State Advances Corporation (the precursor to Housing Corporation New Zealand). Affordability of renting or buying housing was only one of the incentives for living in the inner city. For example, Curson (1970:176) identified other significant incentives for residing in the inner city for Cook Islanders including the desire to live near others of their group and the proximity of employment and entertainment venues (See Box 2.1 over page).

In the 1950s and 1960s there was a great deal of employment available in the inner city. Many men were employed in unskilled or semi-skilled jobs on the wharves, the railway yards, industrial plants, and the waterfront fruit and vegetable markets, while others commuted to the freezing works (Westfield and Southdown) further south in Mount Wellington. Women were more likely to be working in rest-homes around the inner city or in the laundry of the Auckland Hospital Board. Both women and men worked in many of the factories in the area, most of which have subsequently been relocated further from the city centre.

By the 1960s, there were significant numbers of Pacific peoples beyond Central Auckland also. Within the Auckland region, the largest concentration was in Otara, where the stock of state housing had expanded rapidly since the 1950s. However, interviewers in the 1964 housing survey noted that, even in newer suburbs, Pacific peoples tended to live in the remaining pockets of older housing (McCreary 1965:26).

This same survey noted incipient problems with overcrowding with a larger average number of occupants per house for the number of rooms (bedrooms, living rooms, kitchens). While the national average was 0.73 persons per room, for Māori it was 1.29 and for Pacific people 1.32 per room. The authors concluded:

> the Islanders seem to be attempting to fit a larger number of people into houses than either the New Zealanders in general or the New Zealand Māori. Although the Islanders, then, are not occupying unduly small houses, the houses they are occupying are not large enough to house the number of people they wish to, with a density which is comparable to the national standards (McCreary 1965:28).

Using a measure of statutory overcrowding\(^4\) 4.5 percent of the houses in the survey were assessed as overcrowded yet, of the 14 overcrowded houses, only two were in the outer suburbs.
Beyond Auckland, the largest number of Cook Islanders had settled in the Wellington region, especially in Porirua (Curson 1970:175), but others were located where there were specific employment opportunities, such as in forestry in Tokoroa in the central North Island.

**The 1970s and early 1980s: Concentration, dispersion and dawn raids**

The acceleration of migration from the Pacific to New Zealand in the 1970s is shown in Figure 2.2. The importance of Samoa and the Cook Islands as source countries is obvious but movement from Tonga also increased in the 1970s and into the 1980s. Migrants from the Cook Islands, Niue and Tokelau continued to have free access via New Zealand citizenship. After the independence of (Western) Samoa in 1962, some Samoans entered as part of a quota system but, through the 1960s and 1970s, many entered New Zealand on short-term permits or as visitors. This was the main option for Tongans and migrants from other Pacific nations; many stayed beyond the term of their visas but these ‘ overstayers’ were often overlooked because their labour was in demand.

From the mid-1970s the New Zealand economy shrank, as did economies throughout the Western world. As a result, unemployment rose sharply and inflation increased. The New Zealand government responded by severely limiting the availability of new work permits, not renewing the visas of those already working here and deporting those guilty of overstaying working visas. The situation was inflamed by the 1975 National Party election campaign which targeted Polynesian overstayers and implied they were less than desirable migrants (Hopper 1957:30). Water was polluted, parks were degraded, some manufacturing caused smoke haze and fumes, and sewerage and waste disposal were inefficient. Poor living conditions were reflected in the poorer health of children in particular. Political advocacy for better housing began later in the decade, continued in the 1960s, and was well developed at the time of the formation in the early 1970s of the Polynesian Panther party, a political group of inner city Pacific and Māori youth who organized action and protest against racism and marginalization of Pacific peoples (Anae et al. 2006).

A wave of gentrification began in Ponsonby in the 1970s. As house prices rose dramatically, many Māori and Pacific Island peoples were forced out by higher rents or chose to leave for new houses in other suburbs. However, some retain strong connection to the area today despite ongoing economic and cultural pressures. This is illustrated in the following 1994 song by Tigi Ness, musician, father of Che Fu, and long-term resident of Ponsonby (Carlyon and Morrow 2008:361):

“Ponsonby where I live
Ponsonby where I stay
I never asked you to put
A café in my street
Looking at me like another refugee”

Hopper (1957) was invited into 60 homes of the 100 women who took part in her study investigating living conditions and health of Pacific people in Auckland. She particularly noted the bright, clean and tidy domestic interiors of the houses owned by Pacific people, the number of modern conveniences, the universality of radios, and several with musical instruments. These houses were painted inside and out indicative of maintenance. However, while this was a vibrant community, many Pacific Island people did live in old, cold and dilapidated Ponsonby residences and experienced both prejudice and some exploitation by landlords (Hopper 1957:30). Water was polluted, parks were degraded, some manufacturing caused smoke haze and fumes, and sewerage and waste disposal were inefficient. Poor living conditions were reflected in the poorer health of children in particular. Political advocacy for better housing began later in the decade, continued in the 1960s, and was well developed at the time of the formation in the early 1970s of the Polynesian Panther party, a political group of inner city Pacific and Māori youth who organized action and protest against racism and marginalization of Pacific peoples (Anae et al. 2006).

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other cities and towns, especially the timber processing areas such as Tokoroa.

The location of the Pacific population within Auckland was changing during the 1970s as the countervailing processes of general growth in Auckland’s Pacific population and accelerating gentrification in the inner city converged in the 1970s. In Freemans Bay, Ponsonby, and smaller adjacent suburbs, the total Pacific population peaked in 1976. An exception to this was Grey Lynn, where the Pacific population continued to grow for a further decade, and the large size of this suburb meant that the inner city Pacific population as a proportion of the total population peaked in 1986 (Figure 2.3, see also Friesen 2009).

The changing housing market also had an impact on access to rental property. Studies in that period documented discrimination against Pacific people attempting to rent a house (Macdonald 1986), and Loomis contends that this was a result of:

the re-valuation of the inner city by the various capitalist classes through both economic and political means, and the recent trend to locate State housing in peripheral suburbs (1984b:117).

As young professional residents moved in, older cottages, villas and bungalows were bought and there was a steady decline of housing available to rent through the 1970s and 1980s (Friesen 1994).5

---

**Figure 2.2** Pacific-born populations in New Zealand 1945-2006 by country of birth.

Data source: New Zealand Censuses 1945 to 2006.
The timing of concentration and dispersion varied between suburbs. Grey Lynn appeared to be resisting the trends seen in Freemans Bay and, during the 1970s, became a vibrant centre of Pacific, especially Samoan, culture (Hiyama 1991:95-101). Countering the generalisation that Pacific households usually lived in rented houses, an increasing number of those in Grey Lynn bought homes:

Several families and generations often lived together so money could be saved and one family at a time could be financed into their own home. Then, with nothing left for the luxuries of a fridge or telephone, men would take on a lot of overtime to cover necessities and the mortgage. As the banks would not lend on the small deposits saved people depended on lawyers in their churches and on a Pacific Island funding network (Hiyama 1991:97).

Similar experiences existed for Pacific Island migrants in the suburbs of Kingsland and Morningside. As had been the case for many migrant households renting from the 1940s onwards, home ownership also often involved multiple family units:

As South Auckland expanded, more Pacific people moved there with Otara forming a particular focus. In 1978 more than 20 percent of Otara residents were Pacific people (West and Harris 1978). While the amount of state housing in this area was significant, the South Auckland Health Needs Survey found that 75 percent of homes in South Auckland were owned by the householders (West and Harris 1978). This was much lower for Otara (44 percent). Yet in this suburb, 53 percent of Pacific people owned their own home, compared with 45 percent of Europeans and 37 percent of Māori.

Overcrowding, however, was an issue. The 1981 census found that, while Pacific peoples’ households comprised two percent of the total number of households in New Zealand, they were more frequently overcrowded, comprising 14 percent of crowded houses with crowding defined as more than one person per room including bedrooms, living rooms and kitchen only (Bathgate et al. 1994:77). Barnett (1977) and Kerr (1981) both drew attention to poor quality overcrowded housing and its contribution to health problems, particularly respiratory conditions.

The 1980s to the present: New Zealand becomes a Pacific nation (again)

The controversy and debate following the immigration crisis and dawn raids of the late 1970s continued into the early 1980s and was fuelled by a Privy Council decision of 1982 in Lesa vs. the Attorney General which declared that all citizens of Western Samoa born between 1923
and 1948 were also, by right, citizens of New Zealand (Savelio 2005:35). This provoked a perception of New Zealand being overrun with migrants from Polynesian nations. A 1982 cartoon, see Figure 2.4, which depicted stereotypical Polynesians flooding into a governmental office through the door, window and even the ceiling with the caption “Shut the door – they’re coming through the window” summed up the resulting political and social furore (New Zealand Herald, 20/7/82 in Savelio 2005:54).

This furore was further aggravated by the Immigration Bill of 1986 which deemed that visitors from Western Samoa, Tonga and Fiji could enter New Zealand for a three month period without a special visa, bringing the immigration policy for Pacific Islanders in line with that which applied to visitors from Europe, North America and Japan (Toft 1990:114-5). Once again there was much social and political fallout for Pacific Island communities as stereotypic images and racist fears fuelled a negative social environment for migrants. The automatic visitor visa for individuals from Western Samoa, Tonga and Fiji was rescinded in February 1987, with a return to a strict quota system for the allocation of visitor visas.

The Immigration Act of 1987 also changed the nature of the inflow of migrants to New Zealand. From 1991 the preferred country of origin approach was replaced by selection based on criteria of age, educational levels, skills and importation of capital, each of which was attributed points; a successful migrant had to achieve a certain score in order to be granted entry. This situation had little impact on those Pacific Island nations whose inhabitants also hold New Zealand citizenship (Cook Island, Niue and Tokelau), but it did affect other Pacific Island countries such as (Western) Samoa and Tonga. The quota of 1100 migrants from (Western) Samoa, established in 1970 (Lee 2009:10), remained. Some within-family reunification did occur but the overall effect was to increase the competition for places. This was especially true for migrants from Asia who had been largely excluded under the earlier system. Because Pacific Island migrants tended to have low levels of education and lacked investment capital, only a relatively small proportion received permanent residency through the ‘Skill’ or ‘Investment’ immigration categories.

Nevertheless, there were still significant numbers of new migrants from Pacific Island nations who came under the family reunification category and quota system, as well as on visitor or other temporary permits, such as student permits. From the 1990s relatively substantial numbers of Tuvaluans began settling in New Zealand, although the Pacific Access Scheme which allows permanent residence for 75 Tuvaluans and their families each year was not put in place until 2002 (Lee 2009:10). A high level of circulation in the wider transnational communities has continued between New Zealand and its Pacific Island neighbours including both countries with citizenship rights and those without. Table 2.2 shows all Permanent and Long Term (PLT) movements between selected Pacific Island countries and New Zealand in the 1980s and 1990s. Significantly, the net migration gain from the Cook Islands is shown to be only about one-sixth of the total number of Permanent and Long Term arrivals. For (Western) Samoa, Permanent and Long Term net movement was about one-third of all
arrivals, and for Tonga there was only a small net gain despite a considerable level of circulation.

The migration of Pacific Island people and communities to New Zealand cannot, however, be understood as a one-way chain migration. Pacific Island people clearly retain strong physical, economic and emotional links with home islands. A greater island diaspora exists especially with those located in Australia and the United States. As air travel became more frequent and affordable from the 1980s, migrants regularly travelled back to countries of family or personal origin as well as visiting family living overseas. This regular and sustained communication and contact has resulted in transnational communities with unique social, cultural, economic and health needs (Alexeyeff 2009). Even within specific island groups, patterns of national and transnational movement can be diverse (Francis 2009).

In addition to migration, the Pacific Island population of New Zealand increased with the growth of the New Zealand born Pacific Island population. Figures 2.5, 2.6 and 2.7 show the age/sex structure of Pacific Island populations in 1976 and 1996. When compared to the total population of New Zealand, the Pacific population was young, despite the fact that the post-World War II baby boom had only started to decline in the total population during the early 1970s. Figure 2.5 charts the growth between 1976 and 1996 in the Pacific population of New Zealand. Over this twenty year period, the cohort aged under five increased from approximately 10,000 to over 30,000, with the majority of these being New Zealand born. The decreasing impact of immigration on the total Pacific population of New Zealand and the increasing importance of locally born Pacific people is also shown in Figure 2.7. Birth rates have thus remained relatively high during this period whereas in the total New Zealand population they have declined, increasing the contrast in the proportions between Pacific Island and the total population in the younger age cohorts (See Box 2.3).

Through the 1980s, changing demographic and

<table>
<thead>
<tr>
<th>Selected Pacific countries</th>
<th>PLT Arrivals</th>
<th>PLT Departures</th>
<th>Net Migration Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook Islands</td>
<td>10,236</td>
<td>8,529</td>
<td>1,707</td>
</tr>
<tr>
<td>Fiji</td>
<td>23,576</td>
<td>8,732</td>
<td>14,844</td>
</tr>
<tr>
<td>Niue</td>
<td>2,601</td>
<td>1,701</td>
<td>900</td>
</tr>
<tr>
<td>Tokelau</td>
<td>804</td>
<td>671</td>
<td>133</td>
</tr>
<tr>
<td>Tonga</td>
<td>7,365</td>
<td>7,025</td>
<td>340</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>383</td>
<td>193</td>
<td>190</td>
</tr>
<tr>
<td>Samoa</td>
<td>25,318</td>
<td>16,425</td>
<td>8,893</td>
</tr>
</tbody>
</table>

Box 2.3 Youthful Otara

Contemporary Otara is an epicentre for Auckland’s Pacific Island identity with almost 80 percent of its population identifying as Pacific Islands ethnicity (Friesen and Kearns 2010). While the key annual festival celebrating Auckland’s Pacific Island identity, Pasifika, continues to be held at Western Springs – close to the early inner city concentrations of Pacific Island migrants – a lower profile, but no less significant and enduring event occurs weekly – the Otara Market (de Bruin and DuPuis 2000). The Market is a social as well as an economic event that draws Pacific people from across Auckland. Much of the material exchanges at this event reflect the economic status of Otara and other Pacific suburbs in the new century. Increasingly, Otara has a ‘2-P Identity’: Pacific and Poverty. Most of Otara’s inhabitants find themselves in the lowest decile according to the New Zealand deprivation index. Since Otara’s inception in the 1950s as an area of predominantly state housing, the community has been disproportionately susceptible to nationwide restructuring and changes in welfare policy (de Bruin and DuPuis 2000). In addition to this vulnerability, Otara has developed a degree of social stigma associated with its name. However, it is increasingly becoming distinguished for its commitment to community development and the high levels of voter turnout in local body elections.

The young age structure of Otara is an outcome of high levels of fertility that, to a large extent, mirror those in Pacific Island nations, but also of groups of lower socio-economic status worldwide. One of the outcomes of the youth age structure in Otara is the presence of a number of schools with high Pacific enrolments. In 2008 there were ten schools from primary to secondary level within the greater Otara area with total enrolments over 4,000 (Friesen and Kearns 2010). As a ‘youthful’ area there are challenges as well as opportunities in the locality. Music, especially hip hop and R and B, has thrived with arguably the best known group being the ironically named ‘Otara Millionaires Club’ (OMC) who had a 1997 international hit with ‘How Bizarre’.
Figure 2.5  Age-sex structure of Pacific population compared to total NZ population 1976. Data source: NZ Census 1976

Figure 2.6  Size and age-sex structure of Pacific population in New Zealand, 1976 and 1996. Data source: NZ Census 1976 & 1996

Figure 2.7  Age-sex structure of Pacific population compared to total NZ population 1996. Data source: NZ Census 1996
economic conditions challenged the continuation of the welfare state in many Western countries (Esping-Andersen 1996). New Zealand’s responses to these conditions centred on radical policies of economic deregulation and liberalisation. In addition to labour-market reforms, the New Zealand government restructured various social welfare programmes and changed the conditions of entry to publicly-owned housing (Sharp 1994). The net result was that state housing increasingly became an option of last resort and for those deemed in greatest need (Ferguson 1994). A primary aim of the reforms was to create a single, rental system that was fully responsive to market forces (Morrison 1995). In addition, the government sold off many state owned houses in gentrified, middle class neighbourhoods. Rising rents and reduced availability of state owned housing in the inner city saw the increased relocation of Pacific Island families to outer, southern and western, suburbs of the Auckland metropolitan area. By the 1990s, an increased proportion of state housing tenants were drawn from economic and socially marginalised groups, such as Pacific Islands peoples (Murphy and Kearns 1994).

The new regime had profound and rapid impacts on low-income Housing New Zealand tenants. As Murphy and Kearns (1994) recount, after Housing New Zealand adopted ‘market’ rates, their rents rose by 106 percent in the years 1992-99, compared with a 23 percent increase in the private rental sector. The pressure of these ‘market rents’ exacerbated deprivation in parts of Auckland that had become home to Pacific people (Cheer et al. 2002).

The higher rental costs inherent in the market rent policy increased the risk that Housing New Zealand tenants would be unable to maintain payments and, indeed, housing-related poverty became more widespread through the 1990s (Thorns 2000). Despite the then Minister of Housing’s assertion that no one would be forced to move, the occurrence of high-profile evictions of tenants increased (Cheer et al. 2002). Even in the absence of such extreme events, tenants who moved to cheaper options in response to housing-induced poverty incurred social costs including disruption to community networks and schooling for children. Those who stayed put often experienced overcrowding as families ‘doubled up’ to save costs (Howden-Chapman et al. 2000, see also Ministry of Social Development 2010).

Based on the New Zealand Health Survey (1996/7) of permanent (not rental) households, 7.8 percent of adults lived in houses where there was a shortage of bedrooms but 34.9 percent of Pacific households were short of bedrooms (Howden-Chapman and Wilson 2000). Tukuitonga and Finau (1987) argued that this phenomenon is more likely to be the result of economic hardship than of any cultural preference. In the 1990s Pacific Island families in Otara were found housed in garages, sheds and caravans. This accommodation was invariably damp and un-insulated, predisposing them to heightened risk of diseases such as tuberculosis and rheumatic fever. South Auckland, with the highest rate of meningococcal disease (particularly among Pacific children), had the highest proportion of crowded housing. Baker and colleagues (2000) found that the addition of two adolescents or adults to a household doubled the risk of meningococcal disease. The strong association between overcrowded and inadequate housing and meningococcal disease led to the development of the Healthy Housing Programme – a broad-based housing intervention co-sponsored by Housing New Zealand and District Health Boards to both improve housing stock and enhance health related opportunities for its occupants (Bullen et al. 2008). Krishnan et al. (1994:83) sum up the legacy of economic change since 1984 for Pacific Islands peoples in New Zealand by proposing that they were becoming an entrenched and ethnically visible underclass, along with Māori, “despite the different histories and status of the two groups”.

A return to income-based rents under the Labour-led Government from 1999, together with locality-based interventions such as Healthy Housing, arguably eased some of the health and housing burdens of Pacific Island families living in New Zealand. Indeed, it is now timely and increasingly possible to disaggregate the ‘Pacific people’s’ descriptor and consider, where appropriate, the experiences of individual constituent populations. For example, a survey of over 1,000 people of Pacific Island descent in Auckland revealed ethnic-specific socio-economic characteristics that comprise some key determinants of health. Niuean and Cook Island groups with a longer collective length of residence in New Zealand were found to have more favourable socio-economic profiles compared to Samoan and Tongan counterparts (Sundborn et al. 2006).

Better Jobs?: Pacific Peoples and Work

Pacific peoples have been overly represented in less skilled manual occupations since they came to New Zealand. The post-war decades were a time of high import tariffs that encouraged the development of manufacturing industries in New Zealand. Full employment meant Pacific peoples were welcomed by employers as factory assembly and process workers. Jobs were also easily found in the expanding urban service sector. Pacific women found work as officer cleaners and in hospitals as laundry, kitchen workers and nurse aids as well as in light industry. Similarly, Pacific men worked as hospital orderlies and as storemen, drivers and labourers.

Hooper (1961:162) notes that the Cook Islands people with whom he worked in the late 1950s:

have acquired a reputation among certain employers for being stable and capable workers, and generally willing to accept a lot of overtime and shift-work hours. Consequently, a number
of firms and institutions in the city have built up large groups of Cook Islander employees, and they appear to give them preference over others seeking employment.

Hooper (1961) explained that whole sections of factories were staffed by (in this case) men from the same island or district or men who were kin. In one case he described a foundry had had trouble maintaining its workforce. A Cook Islands employee suggested recruiting from his island. The company sent money for fares to the workers, selected by the employee’s father, who paid this off from wages. The foundry purchased a large house for the workers, set it up as a hostel, with the wife of one of the men as cook and housekeeper, and provided free transport to and from work. Other Cook Islands men also joined the foundry workforce. At work the Cook Islands workers tended to stick together and did not have a lot of social interaction with the other men. Hooper remarked that women sometimes had their fares paid by the families who were going to employ them as domestics. As time went on, similar patterns of island-specific employment clusters could be found in the cities and towns where Pacific peoples settled.

The labour force participation rates of those aged over 15 years are shown in Figures 2.8 and 2.9. For both men and women, the Pacific population had higher rates of participation than the total population from 1976 to 1986. This is because the Pacific population was younger so relatively few were in the retired category but also because, as a recent migrant population, a lower proportion were in non labour force activities such as studying and household duties. Pacific women showed a considerably higher rate of participation than other women. Young women were sometimes seen by their families in Samoa as more reliable family members, workers, and remitters and therefore a better choice than their brothers to fulfil the family’s transnational aspirations (Park and Morris 2004). In many New Zealand-based Pacific families, both parents worked outside the home to make ends meet and to get ahead, as with many migrant groups.

It should be noted that ‘labour force’ includes the unemployed who are actively seeking work and, while in 1976 the unemployment rates of 3.4 percent for Pacific men and 2.5 percent for Pacific women were more than twice the national average, these rates were relatively low compared to those experienced later. Figures 2.7 and 2.8 show that, by 1991, the participation in employment of Pacific men and women had fallen below the national rates but slowly caught up in subsequent years. Reasons for this include an ageing population and higher levels of participation in education, but especially the restructuring of the late 1980s and early 1990s which resulted in many job losses, particularly for Māori and Pacific workers. Although those actively seeking work would be included in the labour force statistics, many would have also moved into the ‘discouraged’ category and into non-labour force activities.

The concentration of Pacific workers in particular industries, such as manufacturing and the service sector, was sustained through the rest of the century, with some change over time. For both men and women, manufacturing remained the most important source of employment. In 1976, 61 percent of Pacific men and 49 percent of Pacific women who were active in the labour force worked in manufacturing, compared to 26 and 20 percent respectively of the total New Zealand population of male and female workers. Other significant sectors for Pacific men were transport and construction, and for Pacific women ‘community, social and personal services’. Twenty years later, the 1996 Census showed that manufacturing was still the most important sector of employment for both Pacific men and women, though much reduced, with 34 and 20 percent of the workforce respectively in these sectors. Other significant sectors of employment were retail trade, property and business services, health and community services, accommodation, cafes and restaurants, and wholesale trade. In terms of occupation, the most common for men was plant and machinery operators and assemblers, elementary occupations (labourers), and trades workers, while for women they were service and sales workers, clerks, and elementary occupations.

The social and economic restructuring of the 1980s and 1990s brought substantial change for New Zealand’s businesses and workforce. The country’s motor vehicle assembly industry embodied the depth of these changes. Many Pacific peoples had enjoyed stable well-paid employment in the country’s large vehicle assembly plants. The economic restructuring of the 1980s overturned the import tariff policies that had sustained not just the vehicle assembly industry but many other forms of manufacturing. As a group that derived high levels of employment from these now sunset industries, Pacific peoples were disproportionately affected by restructuring. The closing of factories meant a sharp increase in unemployment. As late as 1997, the Pacific unemployment rate was still at 16.9 percent, similar to the Māori rate of 16.2 percent but much higher than the European rate of five percent (Ministry of Health 1997).

Technological change also contributed to a decline in manual occupations as a proportion of all jobs and a corresponding increase in white-collar service and sales occupations (Statistics New Zealand 2002). This can be seen in the proportion of Pacific peoples employed in sales and the hotel and restaurant sector which increased from 15.1 percent in 1991 to 22.6 percent in 1996. Pacific women in particular have moved from occupations in the manufacturing sector into work for the service sector (Ministry of Pacific Island Affairs 1999).

There has been some occupational upward mobility among Pacific peoples (Ministry of Pacific Island Affairs 1999, Statistics New Zealand 2002).
The proportion of Pacific peoples working in the ‘legislators, administrators and managers’ category moved from 0.8 percent to 4.3 percent in the decade from 1986 to 1996. Nevertheless, Pacific men and women remain under-represented in the professional and legislator, administrator and manager occupations and over-represented in unskilled occupations and as plant and machine operators and assemblers (Statistics New Zealand 2002). These categories have the lowest socio-economic status and the lowest hourly payment rates (Ministry of Pacific Island Affairs 1999). When the occupations were analysed by age group, there was further evidence of some social mobility. All Pacific age groups tended to have fewer people in the higher skilled occupations compared to the general population but the disparities were less for the younger age groups than for the older (Statistics New Zealand 2002).

**Providing: Pacific Incomes in New Zealand**

As a result of their pattern of less skilled employment, Pacific income levels have been significantly lower than the national average. It is difficult to illustrate how this has changed over time, not simply because of the issues surrounding inflation adjustment, but also because of variable data availability between censuses. Therefore we have simply used two different comparative...
measures, one for the labour force in 1976 and another for 1996, in each case comparing Pacific groups to the total New Zealand population (“the national average”). Table 2.3 shows relative income levels for selected Pacific groups and the total labour force in 1976. It shows that the proportion of the Pacific males earning less than $5,000 a year was at least 50 percent higher than the national average, and in the highest income bracket above $7,000 less than one-third of the national average. A much higher proportion of female workers, both Pacific and total, were in the lowest income category. There were no major differences between Pacific and non-Pacific women in this category except for Tongan women who were more likely to have a low annual income. At the two highest income brackets there was a marked difference between Pacific women and the national total. The relatively lower incomes for Tongan workers may be explained by the fact that their migration to New Zealand was on the average more recent than the Cook Island, Niuean, Tokelauan and Samoan groups.

In 1996, marked differentials between male and female and between Pacific and national incomes were still evident, as shown in Table 2.4, although it is not possible to comment on relative changes over the 20 years since 1976 because of data differences. Overall, the median income of Pacific males was about two-thirds of the national average, while that of Pacific females was about four-fifths. As we have seen above, in the mid-1990s Pacific workers still tended to be working in industrial sectors such as manufacturing and services in which income levels are significantly lower than in most
other sectors. Many lost their jobs through restructuring in the late 1980s and early 1990s. Other employment opportunities did not fill the gaps, hence the almost 17 percent unemployment rate, and accompanying lower incomes, as the century drew to a close."

Growing Connections

Pacific people rarely migrated to New Zealand as isolated individuals. They were already part of family, village, island and/or church groups and often were links in a strategy of chain migration. People who travelled by themselves frequently joined other family members on arrival and in their turn would host others; some came as family groups, such as parents and children, or sets of siblings or cousins. A Cook Islands woman told Banwell (1986:10) that as a young woman, years before:

It was my father decided for me to come to New Zealand. It was my other sisters that really wanted me to come to New Zealand. Actually, I didn’t want to come. To be honest I didn’t want to leave, but it’s just the thing, you know, being told you have to go… As a matter of fact, my father wanted me to come to school in New Zealand.

The extended family, village, district or island associations, savings and credit organisations were (and are) important social groups, as were national organisations for sporting and cultural activities (Macpherson 1984:109, Macpherson and Macpherson 2009:73). For example, in a nation like the Cook Islands with 15 separate islands, most of the island groups and the districts of the larger islands had their own associations in New Zealand, along with some national-level organisations, such as for sports, cultural competitions or health. Touring tere parties – groups who performed oratory, song and dance and raised money for projects – were (and are) hosted by people from the relevant island now living in different parts of New Zealand.

In turn, parties from New Zealand would be hosted by their ‘home’ people (Loomis 1984c, Alexeyeff 2009). Twenty-first birthdays and other lifecycle events such as weddings, hair cuttings, funerals and unveilings knitted communities together through face-to-face contact and enjoyment, and shared work, expenses and emotions.

From the 1950s the PICC (Pacific Islands Congregational Church) and Pacific congregations of other Christian churches were important points of contact. McCreary’s (1965) survey shows that ministers, priests or island churches were second only to relatives as ports of call when people were in a range of difficulties. As time went on and numbers grew the congregations tended to differentiate themselves by nations and islands of origin and, as Pacific peoples moved to the suburbs, by their region of their newly adopted city. Churches were (and are) important centres for social as well as spiritual life; for language retention and for learning about the new society. New arrivals could learn a lot about how one could live in New Zealand, find work, find somewhere to live, make friends and find future spouses through involvement in the various groups associated with the churches (Hooper 1961). Indeed, Macpherson (2004:151) noted that church had taken on some of the social organisational roles of the Samoan village for the Samoan people he worked with. Once the specific needs of Pacific peoples were recognised in health promotion, churches became the communities of choice for the delivery of some these programmes, such as the Ola Fa’aautaua Project (Samoan Lifewise Project), a non-communicable diseases health promotion project (Swinburn et al. 1997 and see also Chapter 5). Pastors, ministers and especially their wives were key people in these communities.

However, as early as the 1970s, a trend away from the traditional churches and from church membership altogether was also apparent (Macpherson 1984) Macpherson signalled that Samoans in New Zealand were already differentiated in a range of ways and the assumption that almost the whole community could be assumed to attend the main Pacific churches was no longer the case. ‘Newer’ more evangelical churches which often had music that appealed more to young people attracted large numbers and ‘island’ congregations in these churches also developed. Church affiliation for Pacific people, however, was still at a very high level in the 1990s and compared with the New Zealand population as a whole. For example, in 2001, only 12 percent of Pacific people reported no religious affiliation compared to almost a third of the New Zealand population (Statistics New Zealand 2002).

Despite the importance of intragroup relationships, Pacific peoples in New Zealand were far from an isolated enclave. Marriage patterns provide a convenient and powerful indicator that young Pacific men and women were spending some of their social time mixing with young people from a range of ethnic groups even in the early periods of migration. Consequently, many children grew up with multiple allegiances. Hopper (1957) found that in the 66 Pacific Islands families in her survey (Samoan, Cook Islands and Niuean), 22 percent of the mothers were in ethnically mixed marriages. Hooper (1961:175), working with Cook Islands people, found that “over the four and a half year period ending June, 1957, there were more marriages between Cook Islanders and Pakehas than marriages between two Cook Islanders”. During this period, 44 Pakeha men married Cook Islands women and 10 Pakeha women married Cook Islands men. His comment (1961:176-7) “among Cook Islanders a certain amount of prestige is attached to marriage with a Pakeha, and both men and women actively seek Pakeha consorts, especially at public dances in the city”, provides a glimpse into the social life of Auckland at the time. Famous ball rooms like ‘The Orange’ in Newton, where many
Māori and Pacific performers established themselves in entertainment careers, along with church halls and community centres, attracted young people in search of a good time and a spouse.

Intermarriage had variable effects on community belonging, language transmission, church attendance and community involvement. Hooper (1961) observed that when Cook Islands women ‘married out’ they tended to be lost from the community whereas, when Pakeha women married in, the families had more involvement with the island community, although church attendance was often not part of this.

Approximately 10 years later, another study provides further insights (Christmas 1971). Christmas (1971) studied all infants born in the 12 months from 1 April 1966 of Māori and Polynesian Pacific Island parentage domiciled in Auckland Health District. The survey concerned social, biological and operational (personal health services) factors likely to affect health status and growth progress of infants of these migrant families undergoing the social processes of urbanisation. Māori were as much urban migrants at this time as people from the islands. Again, intermarriage was high in the study group: 30 percent for Māori, 21 percent for Polynesians. This rate is very comparable with McCreary’s study (1965) and similar to the Hopper survey.

This intermarriage rate seems to have been relatively constant over time. A Key Statistics report (Smeith and Dunstan 2004:11) explains that almost one quarter of Pacific births are contributed by non-Pacific women where the father identifies as Pacific. As intermarriage has continued, the term itself has become obsolete: how to describe the marriage between a person with Scandinavian, Niuean and Portuguese ancestry to another with Irish, Italian and Samoan forebears?

With many Pacific people in New Zealand being New Zealand born—the 50 percent point was reached in 1991—increasing intermarriage between diverse Pacific and non-Pacific people, and life experiences which were in many ways shared in official and other contexts, by the 1990s the label ‘Pacific Islander’ began to give way to ‘Pacific peoples’. Debates occurred about whether the new generations of New Zealand born Pacific peoples shared more in common with one another than with their island-born relatives, and whether a ‘Pacific’ identity was becoming an important aspect of these younger generations’ identity. At the same time, by the close of the 20th century, understandings of transnational Pacific identities stretching around the world became more commonplace, assisted by new communication technologies (see, for example, Macpherson et al. 2001, Spoonley et al. 2004, Lee and Francis 2009).

Conclusion
The increased presence of Pacific populations in New Zealand since World War II has resulted in many New Zealanders thinking of New Zealand as a Pacific nation, rather than an outpost of the British empire and of former migrants and their descendants from the Pacific as ‘Pacific peoples’ rather than ‘Pacific islanders’. The visibility of things Pacific has increased as the Pacific Island population of New Zealand increased. This presence is obvious in the participation of many Pacific Island people in politics, sporting events, and cultural activities. Pasifika, claimed to be the largest Pacific cultural event in the world, was founded in 1993 and has run every year since then, attracting hundreds of thousands of people to Western Springs in Auckland to listen to various Pacific music styles, eat Pacific food, and to celebrate the ‘Pacificness’ of Auckland and New Zealand. In other areas such as visual arts, theatre, film-making and fashion, the 1990s saw the increasing Pacific presence within mainstream New Zealand culture. Yet despite this vibrant presence, Pacific peoples have faced significant issues of discrimination, overcrowding, unemployment and lower incomes compared to the national population. The complex disease interactions that result are part of the syndemic health framework espoused in this study. In the next chapter we provide some of the richly detailed data and analysis on health and disease.
Chapter Three
The same again: Pacific peoples in health statistics

‘The same again’ documents the frustrating evidence that health problems that were recognised as needing urgent attention at a Pacific population health level decades ago are still or have become major health problems for Pacific people in New Zealand and for the health services. This chapter explores the evolution of ethnic classifications for Pacific peoples, their relative invisibility at national levels for several decades, the use of the construct ‘Polynesian’, and debates about the determinants of health and illness. A centrepiece of the chapter is the Tokelau Island Migrant Study by Prior and his team, established in 1966. The findings of this research into the Tokelau resettlement programme demonstrated the poorer health indicators of migrants, as measured by diabetes and obesity after some years in New Zealand, as compared with the stay-at-homes and with those who travelled back and forth. Community involvement appeared to be a protective factor. Early warnings about a developing cardio-vascular disease complex were prophetic for Pacific peoples in general as more recent studies examined in this chapter show. But interacting with this non-communicable disease complex is another of infectious diseases. Mortality rates from these have dropped but hospitalization and ongoing morbidity remain high, as the chapter documents. Debates about the causes of these patterns include suggestions that socio-economic conditions, environmental exposure, health service access and medical management may be variously implicated. On the positive side, the chapter documents some improvements: decreases in infant mortality and in smoking rates, and a small increase in life expectancy.

Pacific people were invisible for a long time in New Zealand health statistics (see Wright and Hornblow 2008). While during the 1950s-70s there was an awareness of the potential impact of ethnicity and place of birth on health (Arthur, Bush, Graham, et al. 1969, Elliot 1972, New Zealand Medical Journal 1973), health data were not routinely divided into ethnic groups beyond a Māori/non-Māori comparison (e.g., Hinds 1958, Robb 1960). Several factors contributed to this erasure: the small size of the Pacific Island population for much of that time meant that the calculations were subject to large error margins; the recording of ethnicity varied both over time and by agency; and ethnicity itself was not always seen as a significant variable.

More systematic data became available from the 1980s onwards. However, it is still subject to problems of reporting and classification. Health data are gathered from a range of sources including mortality, hospital discharge data, and cancer or other disease (e.g., tuberculosis) registration. Death registration up to 1994 was based on ancestry rather than self-identified ethnicity (Bathgate et al. 1994:132). Statistics New Zealand coded for Pacific Island ethnicity if a person was seen on the basis of the registration to have half or more Pacific Islands ancestry. Someone who was “half Pacific Islands and half Māori” was classified as Māori. Those classified as less than half Pacific Islands ancestry were classified as ‘other’. Given that death registrations were filled in by funeral directors there was room for a significant degree of mis-enumeration.

On hospital admission and discharge forms up to 1994 the ethnic classifications were Māori, Pacific Island and other. Only one ethnic classification was used so that any one of mixed ancestry might not be included as Pacific Island. These records are therefore subject to misclassification and underreporting (Bathgate et al. 1994:132). The problem of under-enumeration also affects the denominator data based on the censuses. These issues are addressed and adjusted for in the work by Ajwani et al. (2003) on ethnic-specific mortality differences from 1980 to 1999.

This review of health data among Pacific peoples until 2000 focuses upon published data, primarily from the New Zealand Medical Journal, and upon the particular sets of conditions or indicators that are either robust over time (e.g., mortality and life expectancy) or of particular relevance in relation to a syndemic approach to tuberculosis (e.g., other communicable diseases, diabetes, smoking). Through this analysis we trace both the continuities and changes in the health of Pacific peoples, their changing status in relation to the New Zealand health care system, and we attempt to identify sets of syndemic interactions.

Early indicators of the health of Pacific People within New Zealand

From an early stage the health of Pacific people, whether in the islands or in New Zealand, was entwined with that of Māori. Partly this was because of the forms of registration which did not adequately distinguish between New Zealand Māori and Pacific Islanders but it was also because of a strong focus on the category ‘Polynesian’ as a meaningful biological entity, representing a shared genetic composition, as well as a notion of a shared mode of life.

An early study by McCarthy and Marples (1954), for example, used Pacific Island health (in the islands) as a sentinel for Māori health. Reporting on the high
incidence of minor skin infections among Samoan children in Samoa, they note an apparent similarity in incidence to Māori children using this as a reason for undertaking a survey of Māori in the Hokianga. Their conclusions highlight the notion of Polynesian as a useful classification:

It seems evident that Polynesian children, whether they live in Samoa or in New Zealand suffer considerably from superficial skin infections. This is probably due to environmental conditions. Inadequate facilities for maintaining satisfactory standards of cleanliness may lead to infection of minor traumata and the transmission of pathogens from one individual to another can readily occur in the close contacts of life in the Samoan fale or the overcrowded Māori dwellings. (McCarthy and Marples 1954:236)

More common, however, was the identification of health problems among Māori as a sentinel for other Pacific populations. The conditions highlighted in a series of studies among Māori adults were tuberculosis, bronchiectasis (obstructive lung disease preventing the normal clearing of mucus) and other respiratory conditions, rheumatic fever, gout, cardiovascular disease, obesity, and diabetes (e.g., Hinds 1958, Robb 1960, Prior 1962). Among children, respiratory and skin infections as well as nutrition were identified as major issues (e.g., Akel et al. 1963, Naeve and Prior 1963, Tonkin 1970). Many of these papers focus exclusively upon Māori but Prior and Davidson (1966) compared diabetes rates between European, New Zealand Māori, and Cook Islander populations and noted that:

The pattern in the Cook Islanders will also be influenced adversely by increasing exposure to Western material resources and availability of food. The steady influx of Cook Islanders into New Zealand will give them the opportunity to develop the same health and disease pattern of the New Zealand Māoris and this, again, raises problems of preventive medicine (Prior and Davidson 1966:383).

It is striking that the diseases listed mirror concerns 50 years later in relation to Māori and Pacific people’s health.

During the 1960s, however, Pacific people in New Zealand did become increasingly visible in sub-national analyses of health. A series of reports identified disproportionately high rates of ill health among children although, generally, population-level statistics were not available. McKellar (1966), for example, reports on the frequency of moderate to severe anaemia among children less than four in Wellington Hospital (Table 3.1).

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% of children &lt; 4 admitted with moderate – severe iron deficiency (n=65)</th>
<th>% of population within Wellington Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>57 %</td>
<td>94 %</td>
</tr>
<tr>
<td>Māori</td>
<td>21 %</td>
<td>9 %</td>
</tr>
<tr>
<td>Non-Māori Polynesian</td>
<td>19 %</td>
<td>1 %</td>
</tr>
<tr>
<td>Indian</td>
<td>3 %</td>
<td>0.5 %</td>
</tr>
</tbody>
</table>

Similar overrepresentation was observed in studies of children with respiratory infections (Arthur et al. 1969), rickets (Arthur and Weston 1969), and malnutrition (Hardy 1972). Focus was also placed upon mothers, with Pacific Island mothers being identified in studies of maternal deaths (Wright 1967a, b) and teenage pregnancy (Mason 1965).

The risks associated with work were highlighted by a study of industrial hand injuries at Hutt Hospital in 1973 (Bossley and Duncan 1975). At this time many Pacific residents of the greater Wellington area were employed in the automotive industry, meat works and processing industries. Of 38 people with injuries, 17 were ‘New Zealanders’, 15 Pacific Islanders and six European. Given the size of the Pacific Island workforce at the time, this was a disproportionate number of the hand injuries and their injuries were more severe. The authors attributed this imbalance to a lack of training, unfamiliarity with machines, and carelessness. They cited the case of one man who had been in New Zealand for 10 days, and had worked three of those days on three different machines (Bossley and Duncan 1975:192). This illustrates the significant workplace challenges new immigrants faced that could impact on their well being. More broadly, this example represents the difficulties of language, unfamiliarity with New Zealand practices and systems, as well as a degree of indifference to these issues on the part of the host society that impacted on all aspects of Pacific peoples’ lives in New Zealand, and health in particular.

While at times it was speculated that health differences among both adults and children were the result of racial susceptibility (e.g., Arthur et al. 1969), most commonly the difference was attributed to living conditions and populations in transition as demonstrated by Elliot’s comment:

Lifestyles have changed for a great number of Polynesian families. The Tokelau immigration policy, and the centripetal population drift from the outer Cook Islands to Rarotonga has led to
depopulation and overpopulation respectively. Both events have led to as many Cook Islanders and Tokelauans being present in New Zealand as in their home countries. It is not surprising to find abrupt increases in child morbidity and mortality during these transitions from simple and familiar environments to complex and sometimes hostile new ones. (Elliot 1972:298 (See Box 3.1).

Much analysis was framed in terms of transition and assimilation.

**Box 3.1 An example of poor housing in South Auckland**

A report of such a case of an environment, hostile to the health of the eight Polynesian children in the family, is recorded: “An incredible dwelling that (I) took to be a farm shed but proved to be a market garden house in an extremely run-down state. The interior was furnished with sacks and primitive pieces of furniture. Beer bottles were stacked around the door...another old fellow...evidently sleeps in an old car (I) noticed at the side of the house with sacks draped over the missing doors. (Extracts from an Auckland Hospital Board social worker’s report, 1971).” Quoted in Elliot 1972:298

**The Tokelau Island Migrant Study (TIMS)**

The most significant study of Pacific Islanders’ health in New Zealand was undertaken by Prior and collaborators covering a period from 1966 to 1982. This study was prompted initially by work of the Wellington Hospital Medical Unit (later the Wellington Hospital Epidemiology Unit) assessing the difference between New Zealand Māori and European health and mortality data (Prior, Hooper, Huntsman, et al. 1977, Rose 1960). The disparity between the two New Zealand populations led to comparable surveys in the Cook Islands and Tokelau and that increasing body of work prompted a series of research questions which underlay the subsequent Tokelau Island Migrant study:

Would the very major shift in physical environment and dietary habits, social and living patterns produce changes in the direction of the New Zealand Māoris?

Would they occur to a sufficient extent and to a sufficient degree to be measured over a reasonable period of time?

Would the process of migration result in changes in coronary risk factors and blood pressure levels sufficient to allow specific hypotheses about morbidity to be tested? (Prior, Hooper, Huntsman, et al. 1977:166)

The study involved the collection of detailed health and social data about Tokelauans in Tokelau and those who emigrated to New Zealand, with repeat examinations every three years for those in New Zealand and every five years in Tokelau. The health coverage was broad including studies of blood pressure, weight, diabetes, growth and asthma in a multidisciplinary framework including social and cultural analyses (Prior 1986).

The increase in body mass index (BMI) of the adults, both males and females, was marked. A secular trend of increases was evident both in Tokelau and among New Zealand Tokelauans, but the BMI of the migrants was greater than their contemporaries at home in 1981/1982 whereas it had been less in the earlier phase (Table 3.2). Comparisons of non-migrant and migrant children also showed that Tokelauans resident in New Zealand were heavier than their Island contemporaries (Beaglehole, Eyles, Salmond, et al. 1978, Tonkin et al. 1979). This was true not just for older children; mean birth weights for Tokelauans born in New Zealand were significantly greater than those in the atolls. The increase in size over time was clearly identified as a source of potential future problems:

From the viewpoint of prevention, the contribution of increasing body mass index in the migrants stands out as the most important remediable factor contributing to systolic and diastolic pressures in both sexes (Salmond, C. et al. 1985:300).

Weight gains were correlated with increases in systolic and diastolic blood pressure. Blood pressures rose in both migrants and non-migrants over time in

**Table 3.2 Body Mass Index among males and females from Tokelau from 1968-82 over time, based on migration status (from Salmond, C. et al. 1989: Table 1)**

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-migrant</td>
<td>24.8 ± 3.0</td>
<td>26.1 ± 3.8</td>
</tr>
<tr>
<td>Migrant</td>
<td>24.1 ± 3.1</td>
<td>28.7 ± 4.2</td>
</tr>
</tbody>
</table>

23
both sexes, however, diastolic pressure was significantly higher in migrant men than those living in Tokelau (Salmond, Prior, and Wessen 1989). This increase was not fully accounted for by weight gain and was associated by the authors with the role of stress in men’s lives in New Zealand. The association of body mass index increases, blood pressure rises and an increase in gout (nine times higher among Tokelauans in New Zealand than in Tokelau) were interpreted by Prior as a sign of a worrying syndrome among the Tokelauan migrants (Prior, Welby, Ostbye, et al 1987). Diabetes rates among the Tokelauans in New Zealand were identified as significantly higher than among the non-migrants and a comparable indicator to weight and blood pressure. In both male and female migrants and non-migrants the rates increased over time (with the exception of the 1975-77 males), although there was no statistically significant linear trend except among non-migrant women. The disparity between migrants and non-migrants was credited to the higher calorie and higher protein diet, more alcohol, and greater weight of the migrants (Ǿstbye et al. 1989).

The initial data on diabetes rates on Tokelau (1968/71) were comparable with other Pacific Island groups (e.g., Niue, Rarotonga, and urban Samoa) although there was huge variation across the Pacific. But even in the 1970s the diabetes rates in New Zealand and Tokelau appeared higher than among non-Polynesians in New Zealand (Table 3.3), although there are problems with the definition of diabetes in comparable studies. As Ĭstbye et al. (1989:589) pointed out: “During their relatively short time in New Zealand, Tokelauans having come from a much lower risk status in Tokelau, have approached the New Zealand Māori in their risk of Type 2 diabetes”.

The Tokelua study was, at the time, a study of migration. The primary comparison was always between migrants and non-migrants, not migrants and other parts of the New Zealand population. In particular, the impact of migration in the early years on the health of children was identified as a major concern: Tokelauan children in New Zealand in 1972 experienced higher rates of ear infections, chest infections, asthma and skin problems than their contemporaries at home. By 1980-1982 the general health of all children in New Zealand had improved but the infections remained part of Pacific children’s burden of ill health for the next 20 years (Prior, Welby, Ostbye, et al 1987, Wright and Hornblow 2008).

The authors of the studies highlight the convergence of the rates of illness and other health measures among Tokelauans resident in New Zealand with those of New Zealand Māori. Effectively, the rates of illness among New Zealand Māori were used as a warning flag for what might happen to other Pacific peoples (particularly Polynesian) populations over time (Prior 1974). The disease complex of hypertension, coronary artery disease, obesity, diabetes, hyperuricaemia, gout, and renal failure, while still at a fairly low rate in the 1980s, was identified as a worrying syndrome (Ǿstbye et al. 1989). As the authors of that particular study stated:

The present study has shown increasing prevalence and incidence of diabetes in the Tokelauan migrants, highlighting the development of a serious health problem. The next step must be to work out ways and means of developing public health education programmes that involve the Tokelau community (Ǿstbye et al. 1989:589).

The work of the Tokelau Island Migrant study and their warnings seem prophetic given current health statistics. Importantly, the authors of the TIMS study were aware of the transnational nature of the people they were working with. Blood pressures were observed to be lower among those who maintained involvement with the Tokelauan community within the larger New Zealand society (Beaglehole, Salmond, Hooper, et al. 1977). Similarly, people who were frequent travellers to and from New Zealand to Tokelau had lower blood pressures than migrants who had made a single move from Tokelau to New Zealand (Prior 1989), while a small group who travelled back to Tokelau from New Zealand lost weight and had lower blood pressures (Salmond, Prior, and Wessen 1989). Health outcomes were viewed in the context of a group with multiple forms of mobility rather than a static ‘migrant’ population.

The huge output of the Tokelau study contributed to increasing recognition throughout the 1970s of the poor health and living conditions of Pacific migrant populations in New Zealand (New Zealand Medical Journal 1973). It also encouraged attempts to understand

---

**Table 3.3 Prevalence (age standardised) of diabetes* among Tokelauans by sex and migrant status (Ǿstbye et al. 1989: Table 2)**

<table>
<thead>
<tr>
<th>Type 2 Diabetes prevalence per 100</th>
<th>Migrant (NZ)</th>
<th>Non-migrant (Tokelau)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1972-74</td>
<td>7.5</td>
<td>3.0</td>
</tr>
<tr>
<td>1975-77</td>
<td>7.1</td>
<td>5.1</td>
</tr>
<tr>
<td>1980-81</td>
<td>10.8</td>
<td>7.0</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1972-74</td>
<td>11.7</td>
<td>8.7</td>
</tr>
<tr>
<td>1975-77</td>
<td>18.3</td>
<td>11.5</td>
</tr>
<tr>
<td>1980-81</td>
<td>19.9</td>
<td>14.3</td>
</tr>
</tbody>
</table>

* Diabetes diagnosed as one hour plasma glucose level of 13.9 mmol/l (250mg/100ml) or more.
the complex of factors surrounding migration, class and ethnicity that created these conditions (e.g., Hood 1974, Thomson 1974). Davis (1984), using Pearce et al.’s analysis of mortality (Pearce et al. 1984), demonstrated worse outcomes for Pacific peoples than for non-Māori/non-Pacific (Table 3.4). Death rates for each social class (I being highest, V lowest) were highest for Māori but Pacific peoples were intermediate between Māori and other (non-Māori/non-Pacific) for most classes and comparable to Māori in Class IV. Given that Māori and Pacific peoples were overrepresented in Classes IV and V compared to other ethnic groups, the disparity in the death rates was clear. The difference between Māori and Pacific peoples could not be explained by reference to a shared biological character, i.e. ‘being Polynesian’, while socioeconomic disadvantage as captured by class categories did not explain the additional burden experienced by Māori and Pacific peoples. As Davis stated:

there is something further about the cultural, social and economic circumstances of ethnic minorities over and above their social class position that must be called into account to explain their special health disadvantages. There is also evidence of some further variation between the Māori and Pacific Island groups. Hence it is something more than a simple racial difference between European and Polynesian (Davis 1984:923).

Pacific peoples as a group belonging to New Zealand and distinctly different to Māori were beginning to be recognised not as a migrant population but as a resident group with their own local circumstances, including problems accessing health care (Wright and Hornblow 2008).

Table 3.4 Age standardised male (15-64 years) mortality per 100,000 population by social class and ethnicity for 1974-78 (From Davis 1984: Table 9)

<table>
<thead>
<tr>
<th>Social class level</th>
<th>Māori</th>
<th>Polynesian</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-II Non-Manual</td>
<td>816</td>
<td>557</td>
<td>426</td>
</tr>
<tr>
<td>III Manual</td>
<td>687</td>
<td>466</td>
<td>493</td>
</tr>
<tr>
<td>IV</td>
<td>865</td>
<td>827</td>
<td>508</td>
</tr>
<tr>
<td>V</td>
<td>1304</td>
<td>972</td>
<td>845</td>
</tr>
</tbody>
</table>

Post 1980 health status

The growing visibility of New Zealand’s Pacific Island population, changes in the methods of recording ethnicity and the data provided by 1970s studies all contributed to more readily available health statistics on the Pacific population from 1980 onwards (Wright and Hornblow 2008). This means there have been major analyses of adult and infant mortality over time and these are discussed in the next sections. We then turn to the cluster of conditions Prior noted in the 1960s (i.e., cardiovascular disease, diabetes, and obesity), as well as those conditions that may cluster with tuberculosis or share underlying conditions, such as other infectious diseases, asthma, and smoking.

Life expectancy

In a series of publications Blakely and co-workers have calculated the differences in mortality by ethnicity over the period from 1980 to 1999 (Ajwani et al. 2003, Blakely, Tobias, Robson, et al. 2005) using a series of adjustments to account for numerator-denominator bias (Figures 3.1 and 3.2 over the page). These figures show that over time the difference between Māori and Pacific and non-Māori/non-Pacific life expectancy has only widened. For sole ethnicity coded males, the life expectancy gap has grown from 3.5 years in 1980-84 to eight years in 1996-99. The gap in female life expectancy has also widened from 2.4 to 6.9 years over the same time within the same ethnicity code. At the same time, Pacific life expectancies have moved marginally closer to those of Māori. The end result is that there were minimal improvements in Pacific life expectancies over that time period (less than 1.2 years improvement for Pacific prioritised males and no improvement for females): a convergence in disadvantage.

Mortality

The age-standardised mortality rates from Blakely, Tobias, Robson, et al. (2005) demonstrate that, for the youngest age group (1-14), there was significant lowering of the mortality rate for males and females over the period from 1980 to 1999 (Figures 3.3 and 3.4). As these authors emphasise, however, some caution needs to be applied to the earliest age group, given problems in estimating the population size.

The lack of improvement in life expectancy of Pacific peoples observed over this period was driven by a lack of change in mortality rates for adult age groups (as shown here by the 64-74 year age group) (Figures 3.5 and 3.6).

Infant mortality

The number of infant deaths in any one year is relatively small so annual figures need to be treated with care. The period from 1987 to 1999 (Figure 3.7) shows evidence of a downward trend and that trend is most marked in Māori and non-Māori/non-Pacific populations. In 1999 the Pacific rate (6.4 per 1000 live births) was 1.45 times the non-Māori/non-Pacific infant mortality rate (4.4 per thousand) but considerably less than the Māori rate (8.7 per 1000). The major cause of death for all ethnicities was congenital abnormalities while Sudden Infant Death Syndrome (SIDS) accounted for around 20 percent of deaths in 1999.
Figures 3.1 and 3.2  Changes in male and female life expectancy at birth by ethnicity from 1980-99 using both prioritised and sole ethnicity descriptors (adapted from Blakely, Tobias, Robson, et al. 2005: Table 4)

Figures 3.3 and 3.4  Age-standardised all-cause mortality rates (per 100,000) by ethnicity (priorities series) for males and females 1-14 years (from Blakely, Tobias, Robson, et al. 2005: Table 2)
Figures 3.5 and 3.6  Age standardised mortality rates for males and females aged 64-74 (prioritised ethnicity series) by ethnicity (from Blakely, Tobias, Robson, et al. 2005 Table 2)

Figure 3.7  Infant mortality rate per 1000 live births by ethnicity from 1987-99 (Ministry of Health 2003a: Table 20)

Figure 3.8  SIDS death rates by ethnicity per 1000 live births (Ministry of Health 2003a: Table 20)
SIDS deaths vary significantly by ethnicity and, in the 1970s, Pacific populations appeared to be least affected of the three ethnic groups (Tonkin 1986). From 1973 to 1984 the death rate from SIDS was lowest among Pacific infants, with non-Māori/non-Pacific populations experiencing 1.8 SIDS deaths per thousand live births and Māori substantially more (5/1000 live births). Tonkin attributed this difference to the very small number of low birthweight babies among the Pacific population although other factors including smoking and sleeping patterns were probably involved.

By 1996, while there had been marked declines in the SIDS death rates for both Māori and non-Māori/non-Pacific, Tukuitonga (1996) was concerned at the lack of an obvious decline in the Pacific rate (Figure 3.8). Evidence of a decline in 1999 was welcomed when Pacific Island SIDS death rates were 0.8 per 1000 live births, comparable to the non-Māori/non-Pacific rate of 0.5. The lack of improvement in Pacific mortality rates and life expectancy is matched post 1996 by very little change in Pacific infant mortality rates although the SIDS rate has remained low relative to Māori (Ministry of Health 2010).

Cardiovascular disease

Among adults the growing incidence of cardiovascular disease was tracked by the Tokelau Island Migrant Study and is visible in the mortality data from the 1980s and 1990s (Figures 3.9-3.10). Overall mortality rates due to cardiovascular disease have declined in all groups but more slowly for Pacific peoples and Māori. In 1980-84 Pacific people experienced mortality rates 1.5 times higher than non-Māori/non-Pacific (prioritised series) and a significantly lower rate (0.7 times) than Māori. However by 1996-99 the difference had increased to 2.6 times the rate of non-Māori/non-Pacific although there was little change in the difference to Māori (0.78 times).

Analysis using the Auckland Stroke Register supports those trends. While the number of strokes had decreased significantly among NZ Europeans, they had increased in all other groups but most obviously among Pacific peoples for whom stroke rates had increased 66 percent (Carter et al. 2006). Table 3.5 provides the percentage of stroke cases by ethnicity and the average age at which stroke occurred. Bullen and Beaglehole (1997) analysed factors associated with accessibility of care but found relatively few statistically significant differences between Pacific peoples and either Māori or European. However, Pacific people tended to have multiple risk factors in addition to hypertension such as high body mass index (Bullen et al. 1996).

However, as Schaaf et al. (2000) point out, there is a complexity of factors operating and these vary according to the island group. In a workforce survey, for example, they found that men from the Cook Islands had higher total cholesterol, blood pressure and urinary microalbumin than other Pacific Island groups, while Tongan men were more frequent smokers and had, on average, lower high density lipoprotein (HDL) levels. Their study points to the danger of assuming homogeneity among Pacific peoples when, as shown in Chapter 2, different groups have very different histories and life histories and consequently the potential for different syndemic interactions.
Table 3.5 Stroke incidents from the Auckland Register (1981-2003) (from Carter et al. 2006 Table 1)

<table>
<thead>
<tr>
<th>% of stroke cases</th>
<th>1981-2</th>
<th>1991-2</th>
<th>2002-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>91.8</td>
<td>87</td>
<td>73.8</td>
</tr>
<tr>
<td>Māori</td>
<td>4.4</td>
<td>4.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Pacific</td>
<td>2.4</td>
<td>6.3</td>
<td>10.2</td>
</tr>
<tr>
<td>Asian</td>
<td>1.5</td>
<td>2</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Table 3.5 Prevalence of stroke incidents from the Auckland Register (1981-2003) (from Carter et al. 2006 Table 1)

Table 3.6 Prevalence of known diabetes by ethnicity based on a series of surveys (from Joshy and Simmons 2006: Table 1)

<table>
<thead>
<tr>
<th>Year</th>
<th>Age</th>
<th>Eur.</th>
<th>Māori</th>
<th>Pacific</th>
<th>Asian</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>SADP household survey</td>
<td>1992-95</td>
<td>All</td>
<td>1.86</td>
<td>5.21</td>
<td>4.01</td>
<td>4.32 Age standardised</td>
</tr>
<tr>
<td>NZ Health Survey</td>
<td>1996-7</td>
<td>&gt;15</td>
<td>3.1</td>
<td>8.3</td>
<td>8.1</td>
<td>4 Age standardised; Asians include others</td>
</tr>
<tr>
<td>NZ Health Survey</td>
<td>2002/3</td>
<td>&gt;15</td>
<td>2.9</td>
<td>8</td>
<td>10.1</td>
<td>8.4 Age standardised; Europeans include others</td>
</tr>
<tr>
<td>Pacific Study</td>
<td>1996</td>
<td>&gt;20</td>
<td>2.6</td>
<td>12</td>
<td></td>
<td>Age standardised</td>
</tr>
</tbody>
</table>

Table 3.6 Prevalence of known diabetes by ethnicity based on a series of surveys (from Joshy and Simmons 2006: Table 1)

Diabetes

Although Prior and co-workers clearly identified rising diabetes rates as a matter for concern, there is surprisingly little population level data on diabetes rates during the 1980s. Joshy and Simmons (2006) compiled the results of studies from the 1990s (Table 3.6). Because of differences in sampling and age distribution, the rates cannot be easily read in terms of a temporal trend, although the 1996 and 2002/3 New Zealand Health surveys do suggest an increase over time in the prevalence of known diabetes among Pacific peoples. The 1992-95 survey by Simmons and co-workers also highlighted the significant heterogeneity between island groups (Simmons, Harry and Gatland 1999).

Overall, the data suggest that the scenario proposed by Prior and co-workers that Pacific people in New Zealand would come to resemble Māori in terms of their health problems has in fact occurred as far as diabetes is concerned. The various surveys since the 1980s tend
to show only limited difference between the Māori and Pacific populations. This is in contrast to the studies of the 1970s when Pacific Islanders frequently occupied a position halfway between Māori and Europeans. Instead of maintaining or improving relative to European rates, Pacific rates converged with Māori and produced a widening gap with Europeans.

More detailed analyses highlight the impact of barriers to adequate health care (Simmons, Peng, Cecil et al. 1999) and especially the significant costs associated with treatment. Broader surveys (including the workforce survey and the South Auckland Diabetes Prevalence survey) highlight the constellation of conditions, including obesity, that contribute to diabetes.

**Obesity**

Given the current interest in obesity as measured by Body Mass Index (BMI), as well as the warning signs of increasing obesity identified by Prior and colleagues, it is notable that little data are actually available on rates of obesity for Pacific peoples in New Zealand during the 1980s and early 1990s. This invisibility was partly due to ethnic classifications. For example, the most extensive anthropometric study of New Zealand adults was the LINZ survey held in 1989 which divided ethnicity by Māori and non-Māori (Wilson et al. 1991). There was also an ongoing debate about relevant standards and the impact of genetic differences in body proportions and body fat distribution, as seen in the Public Health Commission report *Our health, our future* (Public Health Commission 1993:100).

The TIMS study identified a considerable increase in weight among Tokelauans in New Zealand from 1963 to 1981–2, at which stage weights were beginning to approach those of New Zealand Māori surveyed in 1974 (Prior 1989). Table 3.7 is a compilation of various measures of obesity by ethnicity. The difference between ethnicities was apparent in the Multi-racial Workforce Study (1988-1990) of men and women aged over 40 years and employed in 46 worksites in Auckland and Tokoroa (Dryson et al. 1992). Among this group, Pacific and Māori men and women had higher BMIs by occupational class than European while Pacific women were, in the majority of occupation grades, the heaviest of all. More extensive analysis of these data shows some significant differences between Pacific peoples. The BMIs of Pacific men were not statistically significantly different. In contrast, Samoan women had significantly higher BMIs (35.0) compared to Cook Island (32.6), Tongan (31.9) and Niuean (32.3) women (Schaaf et al. 2000).

Over half of all adult New Zealanders were classed as overweight or obese in 1997 but these figures were highest among Pacific peoples (Table 3.7) and a smaller survey by Bell confirmed even higher rates of obesity among some Pacific groups (cited in Public Health Group 1997:23).

Children were more systematically tracked from the 1970s and this reflected the early concerns about the

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### Table 3.7  Measures of obesity by ethnicity based on a range of surveys

<table>
<thead>
<tr>
<th>Study and Source</th>
<th>Age/ Gender</th>
<th>Eur.</th>
<th>Māori</th>
<th>Pacific</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Average Body Mass Index</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female Adults</td>
<td>31.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiracial workforce without tertiary education 1988-90 (Dryson et al. 1992)</td>
<td>Adults 40-64 yrs</td>
<td>26.27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>30.51</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>31.84</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age and gender adjusted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seventh Day Adventist church study 1995 (McAnulty and Scragg 1996)</td>
<td>Adults</td>
<td>25.6</td>
<td></td>
<td></td>
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<td>32.8</td>
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<th>% Obese or overweight</th>
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<tr>
<td>Samoan Ola Fa/aotua Project 1997 (Bell cited in Public Health Group 1997)</td>
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<tr>
<td>1997 New Zealand Nutrition Survey (Ministry of Health 1999)</td>
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<td>2002/3 New Zealand Health Survey (Ministry of Health 2004)</td>
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health of Pacific children. It was also more common to present the data on children by island group. Anderson and co-workers (1977) surveyed Auckland children between 1973 and 1975 assessing height, weight and head circumference. While there were no significant differences in height by ethnicity among children aged 2-13, they identified significant over-nutrition with the weight distributions of these children occupying the upper end of the Harvard Growth Standards. While 11 percent of Māori and 12 percent of European children were above the 97th percentile for weight, 11 percent of Cook Island, 17 percent of Niuean, and 25 percent of Samoan children fell above the percentile. Their results highlighted the general vulnerability of Pacific Island children to obesity but also the heterogeneity in this group.

A 1993 survey of Tokelauan and Tongan children aged 11-12 years (Bell and Parnell 1996) was compared with non-Pacific children (Figure 3.11). The results showed that despite non-significant differences in height between the groups, the Pacific children were significantly heavier than non-Pacific, although there was no significant difference between the Tongan and Tokelauan children. The high rates of overweight and obesity among Pacific children relative to the remainder of the population were confirmed in the 2002 Children’s nutrition survey (Ministry of Health 2003b).

More detailed analysis of nutrient intake indicated that Pacific children had diets larger in total amount but lower in nutrient density and were subject to specific micronutrient deficiencies (Bell and Parnell 1996; Wilson, Grant and Wall 1999). A consequence of obesity in childhood is poorer health outcomes during childhood and adulthood. Obesity therefore forms a crucial part of the disease networks involved in both cardiovascular disease and diabetes.

Communicable diseases

Mortality rates from communicable disease have decreased for Pacific peoples since the mid-1980s (Ajwani et al. 2003:27). However, morbidity data in the form of hospitalisations indicate that infectious disease is a significant contributor to the high rate of annual hospitalisations among Pacific peoples. Since 1989-93 the percentage of hospitalisations due to infectious disease has increased for all ethnic groups but the starting point for Pacific (and Māori) peoples was significantly higher (Figure 3.12). Up until 2000, Pacific peoples experienced infectious disease hospitalisations at twice the rate of European/other populations but this rate difference has increased since that time. Both close contact (that is, infections which may be respiratory, skin or enteric, spread by person to person contact in the community) and non-close contact infectious disease hospitalisations have increased but the greatest increase has been in the close contact infectious diseases (Figure 3.13; Baker et al. 2010 Table 3).

The significance of infectious diseases among Pacific peoples in New Zealand is evident in the data from a series of epidemics and was suspected from early on (see Cullen and Walker cited in Wright and Hornblow 2008:24). From August 1971 to February 1972, Auckland experienced a measles epidemic. Of the 114 cases hospitalised, 15 percent were Pacific children (out of a total 46 percent non-European). These children were disproportionately affected by pneumonia (27 percent of all cases of pneumonia due to measles, Steele 1973). Over 10 years later, during a measles epidemic in Auckland from 1984-5 that resulted in 250 children admitted to the Princess Mary Hospital, Pacific Island and Māori were overrepresented and experienced more complications. Hardy et al. calculated the rates per 100,000 as 350.9 for Pacific, 321.2 for Māori and just 17.7 for European, a relative risk of more than 19
compared to Europeans but close to equal for Māori (Hardy et al. 1987).

An epidemic of group A meningococcal disease in Auckland in 1987 showed the same overrepresentation of Pacific and Māori children. Lennon et al. (1993) noted that 79 percent of cases in the outbreak were Māori or Pacific and that this was associated with socioeconomic disadvantage.

The long-running epidemic of group B meningococcal disease during the 1990s showed similar disparity. The age standardised rates of notification in 1994 were 10/100 000 for Māori, 12 for Pacific and 3.8 for European (Wilson et al. 1995), while analysis of deaths in Auckland showed similarly higher rates for Pacific and Māori children (John and Koehlmeyer 1999). The authors noted much higher rates for children under five and this was born out by Baker and co-workers (Baker et al. 2000:984) who cite a rate for Pacific children (less than five years of age) that is 13.7 times higher than the rate for European/other for 1997. Their work also showed the significant contribution of household crowding and deprivation to this elevated risk.

The epidemics are dramatic evidence of disparity but the same disproportionate representation of Pacific children (along with Māori) is evident in non-epidemic infectious diseases since the 1970s. Kerr (1978 and 1981)
tracked children, particularly infants, with recurrent respiratory disease at Wellington hospital, drawing a comparison with the rates of lower respiratory tract disease among young children in Rarotonga (Kerr 1981). He suggested that, given the similarity in rates and type of illness between Rarotongan children (in Rarotonga), and both Samoan and Māori children in New Zealand, there was a common aetiology to the syndrome. Fifteen years later (Grant 1999), Pacific children in Auckland were five times more likely than European/other children to be hospitalised with pneumonia and two times more likely than Māori children (14/1000 Pacific, 6.7/1000 Māori, 2.7/1000 European). They also had much less seasonal variation in admissions compared to the other ethnicities, suggesting a chronic set of circumstances: “the lack of variability implies there are some things that are there every year, that are part of life for Pacific children in Auckland all of the time, that predispose them to being hospitalised with pneumonia” (Grant 1999:345). Grant identified the contributing conditions as poor housing, difficulties with access to primary health care and micronutrient deficiencies.

Clearly pneumonia was not the only condition disproportionately present amongst Pacific children and the underlying causes for overrepresentation of Pacific children had been present for a long time. Lang (1977) analysed the records of children with bacterial non-tuberculous meningitis from 1971 to 1976 in Auckland and found that ‘Polynesian children’ (Pacific Island and Māori) were almost four times more likely than European children to contract bacterial meningitis and 12 times more likely to die of the condition.

The impact of infectious diseases goes beyond the initial infection. Two diseases of particular importance for Pacific communities are rheumatic fever and hepatitis B. Acute rheumatic fever affecting particularly the heart may follow an inadequately treated streptococcal infection and result in residual damage to the valves. As a consequence the person becomes more susceptible to infection and incurs subsequent damage to the heart. From 1980-84, the rate of acute rheumatic fever among children less than 15 years of age in Auckland was between nine to 10 times those in European children, with disadvantage concentrated in South Auckland (Lennon et al. 1988; Table 3.8). Rheumatic fever continues to be a significant preventable health threat with Pacific rates nearly 50 percent higher than non-Māori/non-Pacific (see also Chapter 4).

Hepatitis B infection similarly results in health problems for carriers resulting in higher rates of cirrhosis or cancer of the liver in later life. During the 1970s it became increasingly apparent that Hepatitis B was endemic in New Zealand particularly among Māori and Pacific peoples (Milne 1980, Faoagali and Gidall 1976). Notifications between 1976 and 1987 revealed a rate of 27.2/100 000 for Māori and 23 for Pacific Islanders (Bandaranayake and Carlson 1990).

<table>
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<tr>
<th>Ethnicity</th>
<th>Location</th>
<th>Acute rheumatic fever*</th>
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<tr>
<td>Pacific</td>
<td>All Auckland</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>South Auckland</td>
<td>75</td>
</tr>
<tr>
<td>Māori</td>
<td>All Auckland</td>
<td>79.4</td>
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<tr>
<td></td>
<td>South Auckland</td>
<td>85</td>
</tr>
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<td>Other</td>
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<td></td>
<td>South Auckland</td>
<td>7</td>
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<tr>
<td>All</td>
<td>All Auckland</td>
<td>22</td>
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<tr>
<td></td>
<td>South Auckland</td>
<td>32</td>
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* Definites and probables

Other non-European ethnicities had similarly high rates. The mean annual rate from 1988 to 1992 was lower: 17.1 for Māori and 12.2 for Pacific Islanders (Public Health Commission 1993) which may reflect the decline in notifications noted by Bandaranayake and Carlson (1990), but equally may indicate the success of programmes to prevent maternal transmission, transmission within health care settings, and the increasing use of immunisation (see Chapter 4 and Jowitt 2010). The 2001 rate was 2.7 per 100 000 for Māori and 4.0 per 100 000 for Pacific, with notifications particularly concentrated among young adults (Population and Environmental Health Group 2001).

Notification rates were, however, lower than the rates obtained by a range of surveys among both adults (Ramirez et al. 1987, Lane et al. 1987) and children (Milne 1980). Work among children suggested that significant horizontal transmission among Pacific children was made easier by sharing beds, utensils, toothbrushes and towels, all more likely to occur in conditions of household crowding (Milne and Moyes 1983, Martin et al. 1996). However, because infection rates were much higher after children began school, it was postulated that sores from skin infections, which were very prevalent among Māori and Pacific children, along with the cuts and scrapes of playground rough and tumble may have provided extra opportunities for transmission.

In summary, infectious diseases among Pacific peoples disproportionately affected both adults and children. The social conditions that promoted the high prevalence of these diseases were common to many of them, including socioeconomic disadvantage and its concomitants. The infections themselves do not operate as single entities. Disease clusters and interacts in particular groups, households and bodies with current and future consequences.
Asthma

Asthma was noted in the Tokelau Island Migrant Study as a condition that affected Tokelauan children when they moved to New Zealand. From 1985 to 1993 the rates of asthma or recent wheeze among Pacific children remained comparable or lower than rates for European children but they experienced higher rates of more severe symptoms (Pattermore et al. 1994, Mitchell 1991, Robson et al 1993; Figure 3.13). Most recently analysis of the International Study of Asthma and Allergies in Childhood (ISAAC) results indicated a national decrease in the prevalence and severity of asthma symptoms among New Zealand children from ISAAC Phase I (1992-3) to Phase III (2001-2003) (Asher et al 2008). However, analysis by ethnicity, while still showing lower rates of wheezing or asthma ever experienced by Pacific children and adolescents compared to European/Pakeha and Māori, indicated that the prevalence had increased and that Pacific children have significantly higher prevalence of severe asthma symptoms than European/Pakeha children (Ellison-Loschmann et al 2009).

Mitchell (Mitchell and Cutler 1984, Mitchell 1991) examined the number of hospital admissions for children by ethnicity from 1972-80 and 1979-86. These studies noted a higher rate of admissions for Pacific children than either Māori or European children (877 per 100,000 children compared to 652 and 364). Annual asthma mortality rates for Aucklanders 10-19 years of age (1981-1983) were highest for Pacific young people (11.8 per 100 000 compared to 2.0 for European and 8.0 for Māori (Sutherland et al 1984)), although nationally their mortality rates lay between Māori and European rates (Sears et al 1986).

A survey undertaken from 1991-93 of adults aged 20-44 years showed Pacific rates significantly higher than European/other and marginally lower than rates for Māori. Again the same disproportion is visible in terms of hospitalisation. Garrett et al. (1988) noted higher use of hospital accident and emergency departments and more frequent hospitalisations for Pacific people in Auckland. Despite a decline in overall hospitalisations due to asthma from 1987-97, hospitalisation rates were significantly higher for Māori and Pacific adults and particularly for Pacific adults over 65 years of age (Public Health Commission 1993:212).

This ongoing contrast between a lower overall prevalence but worse outcomes for those affected follows trends noted elsewhere that the experience of Pacific peoples tends towards more hospitalisations rather than effective primary care (see also Wright and Hornblow 2008). Analysis by Mitchell and Quested (1988) suggested the difference for children lies in the type of medical management received by Pacific children rather than socioeconomic or other explanations. In the latest Phase of the ISAAC study it was postulated that environmental exposures may account for some of the excess risks but differences in access to care and management may be salient (Ellison-Loschmann et al. 2009).

Smoking

While care must be taken because of the use of two different definitions of ethnicity (see note below table), the New Zealand census indicated that there was a significant decrease in the amount of smoking in all ethnicities (Table 3.9). Amongst males, Pacific men in both time periods smoked at a rate intermediate between
Māori and non-Māori/non-Pacific. Pacific females, however, maintained a relatively low rate of smoking at both periods.

A large survey of 14-15 year olds in 1995 showed that fewer Pacific people were current smokers (Ford et al. 1995) and in general a larger proportion of Pacific adolescents had never smoked than European or Māori adolescents. However, among those smoking, the percentage smoking daily was intermediate between European and Māori.

This trend reflects the inadequacy of single measures of prevalence which may underestimate the size of the problem or fail to demonstrate the concentration and greater severity of health conditions within a group. It also demonstrates, how, despite apparent convergences in some rates between ethnicities (e.g., cardiovascular mortality among Māori and Pacific), the causal networks may be different. In contrast with many of the other health issues canvassed in this chapter, smoking presents a positive picture of reducing rates, which is of benefit to the whole population, especially to children. However, the rate of reduction in Pacific men and women is slower than in either Māori or non-Māori/non-Pacific.

**Conclusion**

This analysis lays bare the continuities in health statistics over time. The forecasts from the Tokelau Island Migrant study of a rising tide of diabetes and associated problems have occurred. Furthermore, rather than approaching the general New Zealand population, the health profiles of Pacific peoples have come to approach those of Māori in terms of poor outcomes. While mortality from communicable diseases has declined overall, the possible gains in life expectancy during the 1970s were not sustained and, from 1980 to 2000, Pacific peoples’ health status and life expectancy stagnated.

The analysis also shows areas of harmful interconnections. Poor socioeconomic conditions, household crowding, and difficulties of access to health care are implicated in the high rates of some communicable diseases. The linked conditions of obesity, cardiovascular disease and diabetes are a major threat to adult health. However there is also the potential for crossover between these networks of communicable and non-communicable disease as both conditions become concentrated in the same individuals, the same households.

The changing position of Pacific people as part of New Zealand and as part of the health care system is also demonstrated through the differences in health data (see also Wright and Hornblow 2008). Until the 1970s Pacific people were seen less as permanent residents of New Zealand and more as a group defined by their migration status. Comparisons of relevance were with Māori (on the basis of shared biological and cultural heritage) and with their home islands. The growth of a New Zealand-born cohort of Pacific peoples and recognition by Pacific health workers and others of deleterious local conditions relative to other New Zealanders had multiple effects: Pacific people became visible in health statistics, their position in health research became more apparent (Chapter 4), and the development of specific services started to occur (Chapter 5).

While this is an inevitable move, there have been two consequences which are rarely addressed (although with some notable exceptions). One is that the comparison with the islands has often been dropped.
Pacific people in New Zealand are seen as part of this nation but not as the transnational residents that they also are. The work by Prior and colleagues recognised the frequent back and forth movement of people and its impact in terms of health outcomes but this has largely not been followed through in New Zealand, although it has in other parts of the Pacific diaspora (Baker et al. 1986, Dressler and Bindon 1997, Janes and Pawson 1986). Yet most New Zealanders, particularly Pacific New Zealanders, are impacted by transnationalism in multiple ways, for example, the movements away of young people and the returns of older individuals.

The second consequence is that the term Pacific has become the dimension of analysis yet it encompasses people with ties to multiple island groups, who have been born in diverse settings and who have lived in New Zealand and elsewhere for variable amounts of time. The interplay between island ethnicity and place of birth in health statistics was not a focus of interest. It is only from the late 1990s that the heterogeneity of the Pacific population, the multiplicity of Pacific identities, and their transnational lives are being acknowledged. The impact of these dimensions on health is yet to be fully explored.
Chapter Four
From ‘there’ to ‘here’: Change in Pacific health research

As the title suggests, this chapter documents some tensions in the focus of Medical Research Council (MRC) health research on the island Pacific, versus Pacific peoples in New Zealand. It also charts the growing realisation that Pacific peoples were in New Zealand to stay. The Tokelau Island Migrant Study which it funded was a major contributor here. By the late 1970s the MRC recognised that Pacific people’s health in New Zealand needed prioritised attention, but the pathway to action was not always clear. In the 1990s, after its transition into the Health Research Council, there was recognition that qualified Pacific peoples were well equipped to formulate Pacific health research policy and to lead research. As in chapter 3, there are warnings over the decades of the seriousness of certain diseases and disease complexes. The simultaneous threats of both communicable and non-communicable diseases to Pacific people’s health are clear from the studies reported on. Throughout the period the MRC continued liaison with Pacific Islands governments and health services in its efforts to be of service to Pacific neighbours.

We review how the main health research funder in New Zealand at the time, the Medical Research Council of New Zealand (MRC), facilitated research into Pacific health. The chapter focuses specifically on research conducted in the 1970s and 1980s, by which time Pacific Island peoples formed a significant presence within New Zealand. We ask what health issues were addressed, how they were addressed, where the silences were and how these features changed over time. Through this review we chart the sustained interest of researchers in the health, and particularly the diseases, of Pacific peoples in the islands, especially in Polynesia, and the MRC’s efforts to assist in research and in creating alliances that had the potential to make a difference to island Pacific health. Over this period we can see an, at first, sporadic and eventually a more widespread interest in the health of Pacific peoples in New Zealand. This focus on research highlights many of the same themes that appear in the other chapters, and on which we reflect in its conclusion. For example, as noted elsewhere in this report, early warning signs of what are now serious problems, such as diabetes and rheumatic fever, were of concern several decades ago. In some cases, researchers repeatedly drew attention to the urgency with which these threats to health should be dealt, along with their underlying ‘causes’, ‘risk factors’ or ‘social determinants’. Yet these same calls to action are repeated ‘urgently’ today.

The research into diseases of Pacific peoples in the islands had long been of concern to MRC and was part of its organisational structure in the form first of the Island Territories Research Committee (established in 1946) and then the South Pacific Medical Research Committee (established in 1968) (see Box 4.1). However, it was not until the beginning of the 1980s that Pacific people’s health in New Zealand became an acknowledged priority.

Box 4.1 Goals of the Island Territories Research Committee of the MRC. Research Review 1973:33

The goals of the Island Territories Research Committee were:

- the accumulation and recording of all information related to health and disease in the Pacific area;
- the determination of the specific health problems which exist within its own geographical sphere
- active research work leading to the solution of these problems, and
- the maintenance of liaison and co-operation with other organisations working in the Pacific.

The MRC and the SPMRC

The MRC came into being in 1937 as part of the Department of Health. In 1950 its own Act of Parliament was passed and consequently it became a statutory body in 1951, with representation from the Department of Health on its Council. From the inception of the Council it reported annually to Parliament and these reports are available in the Appendices to the Journal of the House of Representatives (AJHR), either as part of the Department of Health’s Report or, from 1953, as a separate Council Report. These reports contain brief research summaries only, but nonetheless provide valuable information. From 1973 the reports were published in more detail annually as Research Reviews, which continued until 1987. It is these Reviews that form the foundation for this chapter: hence the focus on these years. Thereafter, the MRC, shortly to be the Health Research Council (HRC), published an annual research directory and thematic bulletins in addition to its annual reports to Parliament. The MRC was funded by triennial
grants, endowments and donations, small grants from other government departments, and investments.

As noted above, one of the committees of the MRC was the South Pacific Medical Research Committee (SPMRC), formerly the Island Territories Research Committee. Its early work focused primarily on Western Samoa, Niue and the Cook Islands. This committee received funding initially from the Department of Māori and Island Affairs and from 1975 the Department of Foreign Affairs, and conducted its own reviews of research applications, usually meeting three times a year for this purpose. As the funding source might suggest, much of the research supported was in the Pacific Islands, although some migration and health studies were funded or part-funded from this committee. One of these was the groundbreaking Tokelau Island Migrant Study, a multi-disciplinary longitudinal study led by Dr Ian Prior from 1966 to its final report in 1986 (as the MRC report described it: ‘The social, cultural and health effects of migration from the isolated, traditional Tokelau society to the modern urban society of New Zealand’).

Both the SPMRC and the funds it distributed were small in size; hence grants-in-aid in conjunction with other funding were quite common. Grants were often around $1000, and a grant of $10,000 was large by the SPMRC’s standards during the 1970s (out of the MRC’s then total annual budget of $2.1m per annum). Attendance at Pacific health and health research conferences and meetings with heads of national health services were also funded from this source. Because some grants were grants-in-aid, and Pacific topics were sometimes just part of much larger grants, it is not possible to estimate the amount of dedicated ‘Pacific’ funding from the records.

A Social Medicine Assessing Committee of the MRC was set up in 1974 to cover fields of general epidemiology, biostatistics, health care delivery systems, primary medical care and medical aspects of behavioural sciences. This and its descendants also proved important for Pacific health research, particularly Pacific health in New Zealand.

Pacific Research and the MRC: the 1970s

The Pacific research that MRC funded in the 1970s was a mix of basic medical research, even zoological research, clinical research, epidemiology, socio-cultural studies, health services and prevention research, mostly in the islands, but with some attention to New Zealand (where Polynesians might include Māori, or Māori might tacitly include island Polynesians). At this time there was no systematic attention to the health of people of Pacific island descent living in New Zealand but some researchers were directing attention to health problems or concerns, such as rheumatic fever and infant health which were very relevant to Pacific peoples. During this decade two large birth cohort studies were funded, one each in Christchurch and Dunedin. Because of the small numbers of Pacific people in those cities at this time—1.1 percent in both cities in the 1981 Census (Department of Statistics 1982)—Pacific participation was de facto almost excluded from these major research programmes.

The SPMRC and Research in the Islands

The MRC funded several units (with established long-term funding protected from competitive rounds) and projects (short-term, competitive). Three of the funded Units were involved in Pacific Island research. One was the Virus Research Unit at the University of Otago. Headed by Professor of Microbiology John Miles who was also a member of the SPMRC, this had been set up by the MRC’s Committee for Research in Microbiology, established in 1947. The Unit’s research included infectious and serum hepatitis, especially hepatitis B, in several Pacific islands. Miles was funded by MRC to assist in the establishment of a research laboratory in Suva, a project also funded by the Wellcome Institute of London and the WHO. In 1976, when there was an outbreak of dengue fever in Rarotonga, the Virus Research Unit supported an investigation by J. U. Mataika from the Wellcome Virus Laboratory in Suva. In the late 1970s the Virus Research Unit expanded its research on dengue fever in Tokelau, Western Samoa, Niue, Fiji, Tonga, Cook, Gilbert and Ellis Islands, and Papua New Guinea.

The SPMRC also supported the Wellington Hospital Epidemiology Unit, home of the Tokelau Migration Study. Among its research projects this Unit conducted work on rheumatic fever and heart disease in Tonga, in collaboration with the WHO. Another funded Unit was the Dental Research Unit in Wellington, which, for example, researched periodontal disease in Western Samoa and Tonga in the 1970s.

In its research programme, the SPMRC worked in collaboration with the South Pacific Commission (SPC) which had been set up in 1947 by six countries that had colonial interests in the Pacific, including Australia and New Zealand. SPMRC also collaborated with the World Health Organization (WHO) through its Western Pacific Regional Office. Collaborative studies in the 1970s included studies of dental health in the Pacific; the SPC was carrying out a study of several Pacific nations, and the SPMRC funded a study of fluoride in dental enamel, involving 3,000 young Pacific people. In 1975 the MRC funded biochemical assistance to an SPC nutrition study in the New Hebrides. In 1976 Dr Robert Beaglehole, who was at that time an MRC Senior Fellow, represented the SPMRC at the SPC’s seventh conference on Health Services, held in Vila, New Hebrides.

Co-operation was important to the SPMRC, and, in an attempt to ascertain research priorities, it funded the attendance of its representatives at meetings of the Directors of the South Pacific Territorial Health Services. For instance, in 1973 the SPMRC funded Professor Miles to attend a meeting of Directors in Noumea, to
Box 4.2 MRC-funded Pacific projects in 1973

In 1973 the already-established ‘Pacific’ projects/programmes/units funded by MRC were:

1. “The surgical correction of filarial elephantiasis of the limbs” by Dr. W. J. Vermeulen, Western Samoa, Surgical Specialist at Apia General Hospital (to 1974)

2. “The biological control of filarial mosquitoes in Western Samoa” – Dr. J. S. Pillai, Microbiology Department, University of Otago Medical School (to 1978)

3. “A study of a dengue epidemic in Fiji” by Prof J. A. R. Miles of Microbiology Department, MRC Research Unit, University of Otago Medical School (to 1973)

4. “The social, cultural and health effects of migration from the isolated, traditional Tokelau society to the modern urban society of New Zealand” by Dr. I. A. M. Prior of the Epidemiology Unit, Wellington Hospital (CVD research funded from 1966).

5. “Human Genetics” programme, by A.M. O Veale, Department of Community Health, University of Auckland—some projects related to Pacific health.

6. “Study of preschool child health in Rarotonga”, by R.B Elliot, Department of Paediatrics, University of Auckland (1971-74).

7. “Māori infant health and fetal health” projects by D. Bonham, S. Tonkin, A. Liley, W Henshall, Department of Obstetrics and Gynaecology, University of Auckland (some attention to Pacific ethnicity, 1973)

8. Dental Research Unit, University of Otago (Long term projects in Pacific dental health).

New projects funded by SPMRC in 1973:

1. “Anthropology of the nutrition of pre-school children on Rarotonga” by Dr. Margaret Mackenzie of Anthropology Department, University of California, Berkeley (note: a follow-up of the work done by M. Mackenzie as a member of the team under Prof R. B. Elliott which surveyed health in pre-school children in Rarotonga in 1971) ($2,128)

2. “A survey of trichomonad [parasite] agent infections in Fiji” by Dr. C. B. Rathod of Colonial War Memorial Hospital, Suva, Fiji ($907 – for the year).

discuss medical research requirements of the South Pacific region. The following year Sir William Liley attended a meeting in Port Moresby. In 1975 the MRC Director himself, Dr Jim Hodge, attended, indicating the importance the MRC attached to such collaboration.

The chair of the SPMRC in the 1970s was Sir William Liley, world-famous for conducting the first antenatal blood transfusion for rhesus haemolytic disease at Auckland’s National Women’s Hospital in 1963. In the 1970s he was funded by the SPMRC to investigate antenatal blood levels among women in Fiji. In the late 1970s new SPMRC projects also included a haematological survey in Fiji to assess anaemia and iron deficiency among Fijian Indian women, conducted by Professor John Buchanan from the School of Medicine, the University of Auckland.

From 1975 funding of the SPMRC came from the Department of Foreign Affairs and the 1975 Research Review (p.24) commented “it is likely that the Committee will be able to encourage research in a much wider area geographically than in the past.” At that time research was mainly based in Western Samoa, Fiji and Tokelau. In 1976 the SPMRC funded a project on ‘Biological control of mosquitoes in Tonga’. The previous investigations of biological controls of mosquitoes in Samoa had proven successful and a release of the organism was being recommended to the Western Samoan government. Subsequent reviews, however, show the Tongan study was abandoned because of trouble with the authorities, pointing to the importance of building local co-operation and the differences between different island nations.

Another new SPMRC-funded project in 1976 was ‘The epidemiology of peptic ulceration in Western Samoa’. The researchers were interested in incidence and whether it was localised. The team investigated relationships between ulcer disease and economic status, food habits, smoking, alcohol intake and other social factors. A questionnaire was used for all adults in three defined geographic areas conducted by a Samoan survey team, and the study included radiological assessment of suspected cases. Although all of the island-based research would have depended on the assistance of local people in myriad ways, it was rare for this to be so explicit in these research reports.

Other progress and end-of-grant reports in 1977 included one by Professor Eru Pomare from the Department of Medicine, Wellington Clinical School, who had investigated different population groups in the South Pacific (including Māori, Europeans and Tongans in Tonga) to explore whether disorders of biliary lipid metabolism and colonic motility (gall stones were the focus) were related to the consumption of refined, fibre-depleted foods.
In accord with ideas of the time, the concept of Polynesians as a ‘racial group’ was referred to in some reports. For example, a 1974 report on cleft lip and palate in Māori was sparked by a report of a high prevalence of the same in Hawaiians. In fact, relative genetic frequencies rather than groups seem to have been the target. Speculating about the high prevalence of hepatitis B in Pacific peoples, Miles suggested that “[it] is now less common in many parts of the world, but in New Zealand there are still a large number of cases occurring particularly in Polynesian children”. In this instance, Polynesians may have included Māori.

It was common in the 1970s for Māori and Pacific Islanders to be grouped together for research purposes. An example was a study of ‘Māori Infant Health’ by Dr Dennis Bonham, Professor at the Post-graduate School of Obstetrics and Gynaecology, the University of Auckland, and Dr Shirley Tonkin. This had previously been supported by a grant from the Māori Purposes Fund Board and then by the Department of Health, and its stated aim was ‘to improve the health of Māori and Pacific island infants and pre-school children in New Zealand’ (Research Review, 1973:187, and reported on in subsequent years). It sought to do this through a study of neo-natal deaths. While the study included Māori and Pacific Islanders, it also differentiated between the two, showing, for instance, that perinatal mortality indicated that low birth weight was uncommon among Polynesians but high among Māori in New Zealand, a finding which supported an environmental rather than a racial or genetic rationale. Another research topic involving Māori and Pacific people was that by Dr Woodfield, based at the Auckland Blood Transfusion Centre, which investigated techniques for identifying B cell antibodies and antigens by screening sera from multiparous European and Polynesian women against lymphocytes from patients with chronic lymphocytic leukaemia.

By the late 1970s the MRC was directing its attention to public health, or “the social aspects of medicine”. In its 1977 report, it commented that, Projects showed a wide range of interests with a significantly greater emphasis on social aspects of medicine than was the case a few years ago. This change reflected partly an increasing awareness of old problems and partly more recent changes in the society.

The following year, the MRC worked on its research priorities. Number two on the list was:

Studies of the health status and use of health services by sub-populations including: - definition of “at risk” groups, disadvantaged by current services, for example, migrants, lower socio-economic groups, Polynesian populations, pre-school, primary and secondary school groups, etc. – use of health services by sub-populations, for example, general practitioner services, prescriptions (including prognosis, therapy and outcome), hospital admissions and services (immunisation, radiographic, laboratory) etc.

This was the first time that Polynesians in New Zealand were included in such a list. Perhaps as part of the response to (or cause of) this emphasis on health status and health services, a new Council Committee was formed this year: the Health Services Research Committee (HSRC). This committee was established in conjunction with the Department of Health and jointly funded. To an extent, it was a development from the Social Medicine Assessing Committee, established in 1974.

Project grants which had potential to contribute to Pacific health included medical sociologist Dr Peter Davis’s investigation of measures of class which could be used in analyses of mortality, including ethnic patterns of mortality. Several health surveys which were limited to one geographical area or to some specific health issues could also contain information on Pacific ethnicity, although this was not specified in the brief summaries. Rather striking are comments relating to a 1978 project report on medication compliance by Dr G. Kellaway and others (see Box 4.3), which appeared to contradict the statements made in the year the project began (1975) about the positive effects of education about drugs for compliance by Polynesians. The recourse to ‘cultural attitudes’ as a possible reason for ‘compliance’ failure, recognition of the need for specialised cultural knowledge (but obtainable from anthropologists), the pinpointing of socioeconomic factors, and the final comment about community-based care, make this a rich and important statement.

In its 1977 Report the SPMRC referred to “further consideration to its future activities next year, both in the Pacific and among Māori and Polynesian groups within New Zealand”. The following year it noted that, because its grant was from the Ministry of Foreign Affairs and specified as development aid for health services in the
Discussion of 1970s

Although by the end of the 1970s Polynesian populations in New Zealand were one of several populations in a general category that had been accorded high priority by the MRC, this research needed to be funded from the general funds of the MRC, while the SPMRC concentrated on a diverse range of (mainly) investigator initiated topics based in the island Pacific, and on supporting the research of regional organisations. Within the general MRC, the mechanisms for according priority to any topics were rather weak, and became a point of discussion and action in later years. However, the ‘social medicine’ assessing committee and its successors may have been helpful in promoting public health focused work.

At this time, the idea that one could consult community members, not just anthropologists, for specific cultural knowledge as well as for input into projects was not apparent in the texts we consulted. Yet there was obvious recognition by some researchers that cultural knowledge was desirable. We could not identify any Pacific people on Council committees, nor was there evidence that a need for a Pacific health research workforce had been identified. Yet, as noted above, the medical research undertaken in the island states and territories must have repeatedly drawn on local expertise, even if this was limited to assistance with language and logistics. Indeed this is mentioned in the instance of peptic ulcer research, in which Samoans administered the questionnaire. In a few cases the investigators were health professionals already resident in the Pacific islands, but only exceptionally were they Pacific people themselves as far as we can tell: J. Mataika from

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Box 4.3 Reflections on research with Polynesian children and their health service needs

With those exhibiting compliance failure, data are being accumulated on the basic patient reasons for default and the influence of counselling on them. Because of the poor medical compliance of Polynesians, this will largely involve Caucasian children—and it appears at this stage that socio-economic factors contribute substantially to compliance in these children also. It is felt that a greater understanding of the cultural attitudes of Polynesians to health care is required to understand compliance failure in Polynesian children. This will necessitate appropriate consultation with social anthropologists and will be outside the scope of this study. However, acknowledging the limitations of our knowledge, the study has suggested that Polynesian children would probably gain more benefit from a community-based health care system than one based at the Children’s Hospital. (Patient Drug Administration, Adverse Effects, Compliance, and Education in Paediatrics” Department of Pharmacology and Clinical Pharmacology, University of Auckland, Director G. S. M. Kellaway, PI: S. A. Brown, Research Review 1978, p. 152).

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Box 4.4 The 1976 phase of the Tokelau Islands Migrant Study

Tokelau Islands Migrant Study

A return visit was undertaken to re-examine the population on the three atolls during which some dietary and respiratory surveys, anthropometric measurement and medical examination were done. The results from the dietary surveys would be compared with data from Tokelau adults in New Zealand. Within New Zealand, survey work and medical examination continued and the sociological examinations commenced. The genetic aspects of the study which focussed on the effects of changing environment on a genetically homogeneous population would form part of a special programme looking at Precursors of Hypertension in Young People. Migration status and pattern, further migration and social interaction were examined in relation to medical variables such as blood pressure.
the Wellcome Virus Laboratory in Suva being such an exception. Pacific peoples and their diseases were mainly the objects of research.

Pacific research and the MRC: the 1980s

In the 1980s the SPMRC had broadened its membership which had been mainly senior medical and dental professionals. By 1983 it included a university-based sociologist, Dr Cluny Macpherson, an anthropologist based in the Health Services Research Unit, Dr Patricia Kinloch (now Laing) and its first Pacific Islands person, who was both medically trained and a Pacific community leader, Dr Leo Foliaki.

As part of its continuing review of research priorities and activities, in 1981 the SPMRC requested that the heads of health services in Niue, Tonga, the Cook Islands, Fiji, the Tokelau Islands, and Western Samoa comment and give advice on the functions of the committee. As a result it compiled a list of health topics of major importance in the South Pacific region. These included respiratory disease, rheumatic fever, diabetes mellitus, infantile gastroenteritis, peptic ulcer, liver disease, filariasis, leprosy, and hypertension. Specific reference to tuberculosis is notably absent, but it would be included in the general category of ‘respiratory disease’. This lack of specific mention may have been due to the success of anti-tuberculosis campaigns in bringing down the rates in several of the island groups, e.g., Cook Islands (Futter-Puati, 2010). Some success in external relations was also reported in 1981; WHO had organised a meeting in Manila with other Pacific research-supporting organisations in response to SPMRC prompting and, as a result, some other Pacific nations were establishing medical research councils.

Through the 1980s the SPMRC continued to emphasise the importance of maintaining close ties with the WHO, health authorities in Pacific nations and other relevant organisations, and it funded representatives to attend WHO and SPC meetings. These meetings often sparked discussion about the future directions of the committee. The SPMRC accepted responsibility to co-operate with neighbouring countries in the Pacific on research matters, by exchange of routine information and by ‘sympathetic consideration’ of other forms of support. In 1987 the SPMRC funded conference attendance for a New Zealand delegate to a workshop on diabetes control in Suva, and to a meeting on viral diseases in the Pacific held in Canberra. As part of the ongoing process of reviewing priorities, heads of a wide range of island national health services (from Papua New Guinea to Tahiti) were asked for comment on local research needs, a refinement to priority setting. As a result, specific health problems for some countries were identified in the late 1980s: respiratory disease, hypertension, gout, diabetes, dental caries, filariasis and health services delivery in Cook Islands; gastroenteritis, filariasis, respiratory diseases, diabetes, gout, hypertension and heart disease in Fiji; liver disease, especially hepatitis, in Niue; nutrition in the Solomon Islands; hepatitis, rheumatic fever, peptic ulcer, filariasis in Tonga; peptic ulcer and respiratory disease in Western Samoa.

In 1981 the SPMRC approved eight out of 23 research applications. Topics ranged from specific diseases (hepatitis, gastroenteritis, diabetes, and dental disease) to broader surveys on hospital mortality, viral diseases, women’s health needs and alcohol consumption. The territories concerned were Tonga, Western Samoa and Fiji. The funding source for the SPMRC changed again. The Ministry of Foreign Affairs gave a terminating grant of $25,000 for 1981. After 1981, the committee was to be supported by an itemised supplement to the Council’s triennial grant.

The Tokelau Island Migrant Study continued to be funded from general MRC resources and annual progress reports were presented until it was wound up in 1986. Part of the report for 1981 is summarised in Box 4.5 along with the names of the researchers. The line-up of staff included a Tongan doctor, Dr Sitaleki Finau, who undertook a three-year training fellowship in epidemiology at the Wellington Hospital Epidemiology Unit (Finau was subsequently appointed Medical Officer in Charge of Community Health Services in the Tongan Ministry of Health). Many publications had already appeared from this project, and several staff members went on to have distinguished careers in health and social sciences. In addition to the research noted in Box 4.5, work on Tokelauan genetics and diet continued.

Several other projects of Pacific health relevance continued to be funded through the Virus Research Unit at the University of Otago, especially on dengue fever, Ross River virus and scrub typhus. The Dental Research Unit was a WHO collaborating centre and worked on periodontal disease, adult and children’s dental health and fluoride studies in the Western Pacific region.

In 1981 the MRC funded the Alcohol Research Unit, Department of Community Health, at the University of Auckland, which had been established in 1980 under the leadership of Dr Sally Casswell. The Unit was invited to participate in a WHO study via a pilot study of alcohol policy and consumption in several Pacific nations (including Papua New Guinea, Vanuatu, Fiji, Tonga and Western Samoa).

Work supported by the SPMRC in the 1980s included not only Casswell’s alcohol research, but also a 1983 proposal from University of Canterbury Professor (later Sir) Don Beaven, a pioneer in diabetes studies, to do a preliminary review of a diabetes prevention programme for the Cook Islands. Other studies were on inherited anaemia in Polynesians, and a study by anthropologist Anne Chambers on fertility and birth patterns in Tuvalu. Dr R.J. Eason was based at the Helena Goldie Hospital, Munda, in the Solomon Islands, and his work on local diabetes and childhood nutrition was
supported by the Council. Studies of quality of life for
Indian women in Fiji and on dental health education
in the Cook Islands by Dr Robert (Bob) McKegg were
also supported. In 1983 Professor Miles was given a
grant to publish a book he was editing on public health
progress in the Pacific. In Fiji a study of atheroscle-
rosis and lipids among Fijian peoples, carried out by
Dr Ted Nye, Associate Professor of Medicine at Otago
Medical School, was complemented with work funded
by SPMRC about food and beverage intakes of rural
and urban Fijians undertaken from the Department of
Human Nutrition at Otago.

In 1984 new topics or new variations on older topics
appearing were: insulin and diabetes, asthma in children,
immunologic and genetic approaches to Polynesian
disease susceptibility, tropical myositis (muscle inflam-
ination) in the Solomon Islands, gestational diabetes in
Fiji and an evaluation of biological control of mosquitoes
in the Pacific (mosquito-eating fish).

Dr Eason’s end-of-grant report in 1984 on
childhood malnutrition in the Solomon Islands found
that stunting was occurring along with some wasting
and malnutrition, a continuing problem for which
an intervention had been designed and was being
implemented. The work on Streptococcus types showed
that the relative frequencies of particular types differed
between Fiji and New Zealand, but the types in Fiji
were shared with the rest of the world, indicating Fiji’s
integration into global networks.

In 1986 the SPMRC funded seven new projects,
some by grants-in-aid, and allocated four supplementary
grants. These included studies of anaemia in pregnancy
in Fiji, and asthma and bronchial hyper-reactivity
as part of the Tokelau study, primary prevention of
rheumatic fever in Samoa and haemochromatosis (a
genetic disease of uncontrolled iron absorption) in the
Solomon Islands, neonatal hepatitis B in Vanuatu and
dental enamel studies in Port Vila. 1986 progress reports
to the SPMRC indicated that no definite conclusions
had yet been reached on the relationship between what
Fijians ate and fat deposits; and that there was a good
deal of room for improvement regarding oral hygiene
in the Cook Islands. The Virus Research Unit had been
working on sequencing and cloning the DNA of dengue
and reported on an outbreak in Niue which had affected
21 percent of the population.

In 1987 the SPMRC complained that it had too few
applicants. Four grants were funded including Wellington
anthropologist Dr N.J. Pollock’s study of food habits
and obesity in Wallis and Futuna, a hepatitis study by
Dr G. Woodfield in the Cook Islands, a small grant for
the Tokelau Island Migrant Study, and the non-commu-
nicable disease (NCD) evaluation noted below.

The SPMRC received several end-of-grant reports
in 1987, including three from Eason, all of which he had
published in medical journals. McKegg included some
details of his work on dental hygiene education in the
Cook Islands, specifically in Aitutaki and Atiu. He noted
the importance of local support, local involvement and
management to the success of this health promotion
project. Also in the Cook Islands, R. Taylor, who worked
in conjunction with SPC, reported on his evaluation of
the effectiveness of prevention and control programmes
against NCDs over the previous six years. For his 1987
study, he had made biological measures of 1,277 adults
living in the same cluster of villages as had been sampled
in 1980, and also collected mortality and morbidity data
on the 1980 cohort. The study included eye screening
and a health knowledge survey. He concluded that there
was no evidence of overall improvement in obesity in
the population, and that diabetes had increased in the
period 1980 to 1987. Another report concerned camply-
lobacter/peptic ulcer work in Fiji where it was found
that a remarkable 93 percent of those attending a clinic
in Suva for gastroscopy were infected. Dr L.F. Garner’s
work on visual problems in Vanuatu also featured. In
the general awards section for 1987, Julian Crane, later
professor in the Wellington School of Medicine and
an international authority on asthma, was awarded a
half-time training fellowship at the Wellington School
of Medicine to work on asthma among Tokelau people,
as part of the Tokelau Islands Migrants Study. In 1985
the Council set up travel grants for medical, dental and
social science students to travel to any of the island
nations in the South and West Pacific for their ‘elective’
periods but these proved to be undersubscribed.

Research concerning Pacific peoples in
New Zealand in the 1980s
The work of the Health Services Research Committee
(HSRC) was important to Pacific health research in the
1980s. In 1986 this Committee was replaced by a new
Health Research and Development Committee (HRDC),
with increased funding from MRC and the Department
of Health. Its aim was to foster applied research in
public health.

The health status and use of health services by
Polynesian populations was one of the priorities of the
HSRC and subsequent HRDC. In this it coincided with
the MRC and Department of Health priority listings.
Giving effect to these priorities in terms of awarding
funding for research was no easy matter, given that
research merit was the key criterion and the topics were
investigator initiated. However, the priorities mattered
‘around the margins’. Sponsoring workshops and
seminars and supporting personal awards for scholars
interested in Pacific health in New Zealand were other
ways in which Pacific health research was fostered.

In 1980, the ‘Christchurch Child Development
Study’ mentioned analysis of Māori and Polynesian
populations for the first time in its reports, noting that:
“women with no formal educational qualifications and
Māori and Pacific Island women were over-represented
in the population of single parent families formed at the
birth of the child.” Māori, variously defined, accounted
for around 11 percent of the sample of initially over
1265 babies (Marie, Fergusson, Boden 2010). Over
the period of interest “the proportion of those assessed
with any Pacific ancestry ranged between 3.7%-2.8 %”
and those claiming Pacific ‘sole or primary ethnicity’
are in the range 1.8-1.5 percent (John Horwood, pers
comm.10/12/2010).1

In contrast, Dr Rae West from the Department of
Community Health at the University of Auckland,
developed a study which included a large proportion of
Māori and Pacific peoples and an analysis by ethnicity.
This emerged from an earlier survey (the 1978 ‘Health
Needs Survey’) in South Auckland which he undertook
with Dr B.J. Harris (West and Harris 1980). The new
study, ‘Response to Morbidity in South Auckland
Families’ aimed to look more closely at responses to ill
health. Diaries were kept by 209 families about upsetting
events, illnesses, “general opinions on the enjoyment of
each day”, and these were related to analyses of socio-
economic status and family background. With the high
numbers of Māori and Pacific people in South Auckland,
these studies were of great relevance to Pacific people.
The HSRC also acknowledged the importance of this
kind of study of community responses to ill health when
it drew up an overview and bibliography of known
research in the health services field (Health Services
Research Committee 1983).

Lower and higher rates of certain health conditions
among Pacific people were noted. For example, in 1981,
outlining an intention to create a national screening
programme for cystic fibrosis, Professor Arthur Veale,
New Zealand’s leading geneticist, remarked in his
research summary that the New Zealand rate was lower
than expected, and speculated that this may be because
of the number of Polynesian births, because rates were
known to be low in this population.2 In the same year,
Bonham’s Auckland perinatal research group reported
improvement in perinatal mortality rates, but expressed
concern about the high number of Pacific Island
stillbirths. Polynesian bronchiectasis and hepatitis B
continued to be studied with MRC funding. Both these
problems had a higher incidence among Pacific peoples
than among the general population of New Zealand.

In the MRC-funded hepatitis B prophylaxis study,
mothers at National Women’s Hospital who screened
positive as carriers were allocated to two groups and
the babies of one group of mothers were given hepatitis
B immunoglobulin. They were to be followed up to
assess its preventative effectiveness. Only Polynesian
and Asian women had been enrolled by this date, which
indicated the relative prevalence of this virus in these
communities. At the same time, Drs P.J. Kinloch and
C.D.F. Horne, based at the Management Services and
Research Unit, Ministry of Health, Wellington, carried
out a study of Western Samoan and Tongan healing
practices, including migrants to New Zealand. Their
study was intended to provide information to enhance
health services in New Zealand as well as in the two
island nations.

For the new funding triennium in 1982, the
MRC’s Forward Planning Committee worked on
research priorities, and produced a revised list of
topics, confirmed by the Council, to which priority
would be given ‘as opportunity arose’. Topics included
respiratory disorders, health services research, health
of Polynesian populations, paediatrics and child health,
mental disorders, accidents, the use and misuse of
therapeutic drugs, behavioural factors in health and
disease, geriatric medicine/care of the aged and health
education. In addition to being named as a priority
group, Pacific people suffered disproportionately from
several of the conditions identified as priorities, and, as a youthful population, would benefit from an emphasis on child health and from research on health services. Commenting on Professor Eru Pomare’s report on Māori Standards of Health in 1982, the MRC noted that to be effective in improving Māori health, initiatives needed to come from the community, not be imposed. The MRC was responding to the wider social and cultural challenges of decolonisation evident in New Zealand and internationally.

In relation to hepatitis B, the Council funded Alexander Milne’s Kawerau hepatitis B study (see Box 4.6) and in 1982 noted the need for more descriptive studies and studies of childhood and of ‘at risk’ groups. At this stage the vaccine for hepatitis B was very expensive, so the MRC supported effective targeting. The MRC also supported Milne’s trialing a low dose vaccine which had early promising results, but noted that a two-year follow up was required (for further information, see Jowitt 2010).

Other studies funded by MRC committees around this time included analyses of health effects for Pacific peoples. For example, the work of Dr Tord Kjellstrom from the Department of Community Health, the University of Auckland, on environmental health in New Zealand included a study of the health effects of mercury in fish for pregnant women. He noted that about half the mothers with high methylmercury exposure were in fish for pregnant women. He noted that about half the mothers with high methylmercury exposure were Pacific Island women and a quarter were Māori which reflected the frequency of fish-eating.

Dr Peter Davis’s work on social class and ethnic patterns in health care, as well as the need for services to be provided. The development of services by and for Pacific peoples is discussed in more detail in Chapter 5.

Other relevant studies funded included one by Trish Donnelly on the pregnancy and childbirth experiences of Samoan women living in Wellington. Dr Peter Davis’s work on social class and ethnic patterns in health care, based on data from Hamilton, showed that disadvantaged groups did not receive the levels of care that might be expected, given their relatively poor circumstances. This was work of general relevance and of specific significance for Pacific peoples who tended to be socio-economically disadvantaged. In 1985 Dr Innes Asher from the University of Auckland carried out research on diabetes associated with Polynesian populations there were no hospital outpatient services. This report noted, the prevalence of carriers in the elderly, perhaps from highly infectious grandchildren. Europeans older than the town had lower marker rates (suggesting infection was related to conditions in Kawerau).

DG Woodfield reported on ‘Vertical transmission of hepatitis B virus infection and its prophylaxis in the newborn’, a three-year study. Nearly all the HBsAG mothers were of Māori, Pacific or Asian extraction. 30 percent of the mothers were in the high infectivity ‘e’ group and in this group 90 percent of the infants became chronic carriers at one year, compared with only six percent in the non-e group. However, the injection of HB immunoglobulin greatly reduced transmission (to nine percent) in the ‘e’ group, and to zero percent in the non-‘e’ group, indicating it was very effective. There was evidence that some infants were also contracting hepatitis B from other household members. The authors suggested a programme to protect Māori, Pacific and Asian mothers (at least) would be highly desirable.
on childhood asthma and specifically mentioned the magnitude of this problem for Polynesians in terms of their high mortality and hospital admission rates. She pointed out that this was despite Pacific peoples having the lowest rates of childhood asthma prevalence and severity. These findings raised questions about the effectiveness of disease management and access to health care. In 1986 anthropologist Dr Julie Park reported on the inclusion of specific studies of Samoan and Cook Islands women in the ‘Place of alcohol in the lives of New Zealand women’ research, a small part of which was funded by MRC. Both studies had women from the relevant Pacific nation as co-researchers.

1985 was the start of the twelfth triennium since the Council achieved independent status as a statutory body. It was a no-growth budget and comments such as “cut-off levels remained unrealistically high” suggest that good projects were not being funded. The allocations were: units and services 12 percent, programmes 30 percent, projects 40 percent, fellowships and scholarships 12 percent, and administration and meetings six percent. Of a total budget of $8.783 m, the HSRC had $100,000 and the SPMRC had $80,000. In 1985, of 13 project applications, the SPMRC funded seven, provided two grants-in-aid and approved supplementary funding for two on-going projects.

In the 1985 progress report from the Tokelau Island Migrant Study it is clear that, as well as ‘migrants’ and ‘stay at homes’, a section of transnational ‘commuters’ had been identified. Social, biological and health studies of Tokelauans were all proceeding and being linked. For example, a hypothesis was tested that considered whether a mismatch between men’s status in the Tokelauan and general New Zealand communities and their core cultural values was related to high blood pressure.

A migration study by anthropologist Dr Judith C. Barker offered insights into the difficulties Pacific peoples faced in accessing effective health care in New Zealand. In her end-of-grant report to the SPMRC, Barker summarised her work on ‘Migration and children’s health: the Niuean case’ which had found treatment delay for children in New Zealand. She noted that language difficulties, income problems, fleeting relationships with health care providers, transport, different cultural values regarding children and illness and family disruption on migration were all contributing factors. Most of the issues that she identified have proved relatively intractable and have challenged each succeeding generation of health care providers and created barriers to access for Pacific peoples.

Dr A.R (Dick) Bellamy’s epidemiological study of infantile gastroenteritis in Western Samoa confirmed that transnational links were already a fundamental part of Pacific health in New Zealand and the island Pacific. He found that rotoviruses were mainly involved and the predominant serotype in Western Samoa was the same as the one circulating in Auckland. Bellamy worked in the Department of Cell Biology, University of Auckland, in collaboration with the Department of Pathology, Apia Hospital.

In 1986 the Christchurch longitudinal study, which had been studying nine-year olds that year, mentioned in their progress report that Māori and Pacific children did less well on IQ tests. Their evidence suggested that this was due to social disadvantage rather than genetic factors or cultural biases because these children did just as well as others on non-verbal tests. They noted that the lower home ownership of Polynesian families could not be explained by SES alone. This was only the second time that analysis using Pacific ethnicity was noted in the annual reports of either of the two South Island longitudinal studies.

The fiftieth Jubilee of the MRC’s founding was celebrated in 1987 with extra seminars, symposia and celebrations. The Director’s Report included a note of disappointment that an application to the Minister of Health for a supplementary grant for diabetes research had not been successful. He reported that the MRC was going to try to set aside some money for this increasingly important issue, focusing on clinical and health service aspects, not fundamental (understood as biomedical) research. There was no mention in the report of Pacific or Polynesian except in relation to SPMRC business. However, ethnic analyses including Pacific ethnicity may have been intended in some funded studies, for example, in large cardiovascular and diabetes studies.

**Transformation of MRC**

1987 was the final year of publication of the *Research Review*. It was a time of considerable discussion of the role of the MRC in relation to the support of public health research, and of the relationship between public health and biomedical research. At the time of the submission of the MRC for its triennial block grant early in 1988, the Government initiated a review of the Council, while maintaining its funding level for the next triennium. This review was one of several affecting science and technology organisation and funding, along with tertiary education in New Zealand. The implementation of these reviews led to considerable restructuring in all these sectors.

In this complex and changing context, the Review of the MRC reported in 1989. It recommended a Health Research Council of New Zealand be instituted on July 1 1990, with two standing committees: Biomedical and Public Health Research and Development. No longer were research groups or units to be directly employed by the Council (Stewart 1989). When the new HRC was constituted in 1990, the (South) Pacific Health Research Committee was part of its structure and, significantly, it was charged with responsibilities in New Zealand as well as the islands. In 1995 Dr Colin Tukuitonga was the first Pacific person appointed as Chair and Moera Douthett (now Grace) was Research Coordinator.
By the end of the 1990s, two Pacific Health Research Centres had been established with initial funding from the HRC: one at Whitireia Polytechnic, the other at the University of Auckland. They have since been joined by several others at other tertiary institutions and Pacific health research has grown in quantity and diversity.

The decades in review
At the beginning of this period, Pacific people in New Zealand were almost invisible in health research. But during the 1980s greater attention was paid to them in the context of more general recognition of the need for research on health services, access to those services, their appropriateness, and into the different cultural values and practices that might need to be considered. Although the SPMRC was largely concerned with research in the various Pacific Islands, it also funded or part funded some New Zealand-focused research, while other projects were funded from general MRC funds. One of the ongoing contributions of the Tokelau Island Migrant Study was the realisation that Tokelauans were not just ‘here’ and ‘there’ but that there was a continuing flow of people and resources between Tokelau and New Zealand in both directions. This circulation was not limited to Tokelauans or to people, as the Samoan-New Zealand rotovirus linkages demonstrated.

Principles of research practice began to be recognised and formulated. Involvement of Māori and Pacific peoples and nations in initiation of research, setting of priorities and management of research were all noted as important in Research Reviews during this period. However, in the brief reports these Reviews contain, the practice of the principles is seldom visible. During the period of the Tokelau studies, for example, no reports discuss how Tokelau people had a say in the focus of these studies, or how efforts were made to provide training in health research for Tokelauans. The huge resource put into two longitudinal birth cohort studies based in South Island cities, begun in the ‘70s and continuing through the ‘80s, ‘90s and beyond, showed how research design could effectively, if unintentionally, almost exclude whole populations.

The health of Polynesian peoples was repeatedly listed as one of several priorities, but there were no clear ways for this priority to be translated into research effort. However, the creation of working groups, task forces and workshops on particular topics, such as diabetes, had the potential to benefit those groups most affected, for example, Māori and Pacific peoples. Even when the MRC identified a very pressing need, such as to bring together expertise on diabetes and plan responses, the Ministry of Health did not always come to the party with funding.

From the research findings noted in these brief MRC Reviews, one can see that for Pacific peoples in New Zealand and in the island Pacific, non-communicable diseases such as diabetes, gout, and CVDs were significant at the same time that infectious diseases (or their effects), such as hepatitis, rheumatic fever, c. pylori /peptic ulcer, dengue, and deficiency diseases, such as malnutrition, were still important problems. Some studies, on asthma for example, showed that, even where a problem might not be so prevalent, outcomes were worse: a key indicator for unsatisfactory supply of or access to health services or lack of effective health promotion. Such inferences were supported by the work of Davis on the unequal distribution of health care. As the decade came to a close and major changes were underway in health research funding, the challenges of Pacific health were becoming ever more evident, calling for renewed efforts (see also Rankin 1997).

The HRC has clearly acknowledged, for example in its Guidelines on Pacific Health Research (2005), that the history of Pacific health research has been chequered. Among the issues have been objectification of research ‘subjects’, a focus on disease rather than prevention, neglect of health promotion and service development, a focus on disease with little recognition of Pacific concepts of ‘health’ and ‘wellbeing’ in which ‘disease’ is a foreign concept. During the 1990s and subsequently, the work on developing guidelines for Pacific research has transformed the scene. Foundational principles based on the understanding of research as a social relationship were established, the active leadership of Pacific people with the support of others was promoted, Pacific cultures and the contexts of Pacific lives were acknowledged, and the development of a Pacific health workforce has been emphasised. Nonetheless, the past is always with us, and health disparities for Pacific people in New Zealand are not decreasing, as headlines published as we were finalizing this report show (see Box 4.7).

Box 4.7 Rheumatic fever is still a health and a public concern. New Zealand Herald, Dec 2 & 4, 2010

“Heart checks show ‘alarming’ fever rate”

“Always check sore throat, mum warns”

These two headlines revealed that one percent of Northland children had heart damage, caused by previously undiagnosed rheumatic fever. The story reported that rheumatic fever occurs as an immune reaction to ‘strep’ throat. It is related to poverty, household crowding and untreated strep throat. The rate for Pacific Islands peoples is 49 percent higher than for non-Pacific non-Māori groups, and over twice as high as for Māori. The highest rates are in the South and Central Auckland areas (NZ Herald, 2 Dec 2010).

“Health experts say it reflects badly on New Zealand that it has one of the developed world’s highest rates of what is now considered a Third world disease” (NZ Herald 2010, 4 Dec 2010).
Chapter Five

Claiming space: The creation of Pacific health services

Introduction

Earlier chapters have shown how, before the 1980s, the specific needs of Pacific people in relation to health services, health promotion, and health education in New Zealand were largely invisible to the health authorities and government. In this chapter we examine the ways in which Pacific people responded to this situation, first with modest initiatives to improve their health and access to health services and, during the 1990s, stepping into and claiming new spaces to establish Pacific health as a permanent element of the New Zealand health system. Pacific health professionals, both women and men, were at the forefront of these events. Still few in number, these professionals were acutely aware on a day-to-day basis of the need to improve health services for Pacific people. Strong personal identification with their islands of origin and the wider Pacific community in New Zealand drove them to act on their concerns about the poor health they witnessed. Government and national and local health authorities responded slowly to the problems of access that Pacific communities faced and Pacific health leaders’ first efforts were to convince the health bureaucracy, who controlled health funding out to the community, of the need for dedicated Pacific health services. During the 1990s, the Auckland-based regional health authority, North Health, led the way in developing initiatives and policy aimed at improving access and services for its Pacific population. Significantly, health data published in the early 1990s confirmed anecdotal awareness of poor Pacific health status and cemented acceptance of the need for change (see Chapter 3).

At a political level, a chain of health system reforms during the 1990s changed the traditional model of centralised health funding and service provision. The frequent change was disruptive but the health reforms were positive for Pacific health development (Southwick 2005). Population-based funding and the requirement for health boards (later RHAs—Regional Health Authorities and CHEs—Crown Health Enterprises) to identify and target services for those in greatest need created opportunities for the establishment of Pacific health services. Partly taking a lead from developments in Māori health from the 1980s, a “by Pacific for Pacific” general practice and primary health sector arose (Ministry of Health 2003c:62).

By 2000, the landscape of Pacific health service provision was undergoing fundamental change, and a philosophy of seeking Pacific solutions to Pacific health problems was increasingly embedded (see Wright and Hornblow 2008:28-30). However, meaningful improvement in health outcomes occurs over decades rather than years, and the project of overcoming Pacific health inequalities can still be judged only as work in progress. In this chapter, our narratives of the development of Pacific health services in New Zealand emphasise the decades of the 1980s and 1990s and have been drawn from interviews with Pacific health professionals, personal papers and government archival records as well as published works. As the majority of New Zealand’s Pacific population live in Auckland, developments in that city are accentuated in this chapter.

Pacific healing and concepts of health

By the time Pacific peoples began arriving in large numbers in New Zealand, most had had a hundred or more years to deal with Western visitors and their diseases and to become familiar with Western health services. There are many differences between Pacific cultures in health beliefs and practices but some underlying themes are detectable (Capstick et al. 2009) and it is possible to make some rather crude generalisations. Pacific concepts of illnesses and healing had expanded (as Macpherson (1985) said of Samoan medicine) to deal not only with completely new diseases such as measles, flu, tuberculosis and sexually transmitted infections, but with Western medicine and Christian ideas about health, illness and suffering. In addition, other medical traditions, especially Chinese, but also from various parts of Melanesia (Macpherson and Macpherson 1990), were introduced into some island groups. The transnational lives and communities that constitute Pacific peoples are nowhere more evident than in perceptions and practices of health, illness and healing. What are called traditional healing practices, therefore, are not fixed but expand and change over time and may include aspects of several healing systems and Western home remedies as well.

The concept ‘health’ does not translate very directly into Pacific languages. Living (well) (‘ora’anga meitaki’, ‘ola lei’) and being strong (e.g., ‘ola malosi’), are approximate glosses which perhaps better translate the more social idea of ‘well being’ rather than health. In some places, e.g., Tonga, a phrase was developed ‘mo’u i lelei’ to translate the word health (Parsons 1985:89). Illnesses (‘ma’i, maki, mahaki’), which do not always relate closely to Western concepts of disease, are readily identifiable in traditional health systems. Illness
is an expected, though disruptive, aspect of life which is caused by problems in relationships with the social, spiritual and natural world (and these are interrelated) (Kinloch 1985b). Bodies, internal organs and relationships, including relationship with spirits who may be deceased ancestors, need to be restored to good order, harmony and balance to relieve the illness (Macpherson and Macpherson 1991). In this social model of illness the person suffering the illness may not be the person involved in the transgression or disruption as a person’s well being can be affected by others. In contrast, some illnesses, in some circumstances, may also be thought to be ‘just sickness’ and happen because a person has got cold in the rain, eaten bad food or tripped over (Baddley 1985, Hooper 1985).

Pragmatism and strategy are important aspects of health practices. Across most Polynesian island groups there is a common division between local illnesses (e.g., ma‘i Samoa; ma‘i papalagi) and ‘European’ ones. Local illnesses can be explained by indigenous concepts of health and illness and are best dealt with, sometimes only able to be dealt with, by local health experts. European diseases are best dealt with via doctors and nurses and European medicine. The trick is to tell which is which, and this may be a matter of seeking God’s guidance or of trial and error: if biomedical care does not have good results then maybe it is a Samoan or Tongan or Cook Island illness—and vice versa (Laing and Mitaera 1994, Macpherson and Macpherson 1991). Privacy and avoidance of certain social consequences, especially shame and blame, might be secured by going to Western services, whereas community help and redress for transgressions and disruption as a person’s well being can be affected by others. In contrast, some illnesses, in some circumstances, may also be thought to be ‘just sickness’ and happen because a person has got cold in the rain, eaten bad food or tripped over (Baddley 1985, Hooper 1985).

A study of infant care practices with four different Pacific groups in Auckland in the late 1990s found that it was common for pregnant women and new-born babies to receive healing massage and other assistance for good health from a range of traditional healers, as well as to be attended by midwives and other experts in the formal health system (Abel et al. 2001). Sometimes these were close family members such as mothers, grandmothers or aunties who would massage the baby or the pregnant woman for preventative and restorative purposes, but at other times these were healers who had wider reputations and might even come from a different island group. The care given to pregnant women and new mothers and babies was also evocative of descriptions of such care in the islands one to two decades earlier (Chambers 1986, Kinloch 1985b). These included physical, nutritional, emotional and social support and calmness for expectant mothers, ‘good’ behaviour from the expectant father, and rest and care for the new mother and baby, ideally supplied by female relatives. As Drozdow-St. Christian (2002:76) discovered in his research in Samoa, concepts and practices of “balance, propriety, and organic flow” are central to pregnancy, inheritability, infant development and socialisation.

This illustration exemplifies that a person is not imagined as an isolated individual: their health and wellbeing can be influenced by the actions of others—living people as well as spirits. For example, should the husband of a pregnant or breast feeding woman not abstain

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**Box 5.1 Complementarity in health care: a Samoan example**

A Samoan boy was admitted to Hutt hospital in the Wellington area in 1978 after a family altercation. The boy was uncommunicative and this was the second time he had been in this state. The earlier episode also involved some conflict. In Western medical terms he appeared to be having visual and auditory hallucinations and thought disturbances. He did not improve in hospital and did not clearly fit any diagnostic category although childhood schizophrenia was favoured. A Samoan Health Assistant was invited to consult and have a counselling session with the boy, admittedly with some scepticism by the hospital staff. She confirmed a case of spirit possession. Leave was sought for the boy to attend a Samoan expert in exorcism and to go to church with his family. The spirit of the boy’s maternal grandfather was exorcised and the boy returned to hospital. He improved markedly after that and was discharged from hospital after five days and continued well over the follow-ups which lasted a year. He had no memory of the episode. In this case initially the mother had thought the boy suffered from a Samoan sickness and wanted to take him to a healer, but the father had insisted on taking him to the general practitioner. Counselling revealed there was spousal conflict and abuse and this was often ‘worked out’ through the boy. In this case, the involvement of a Samoan healer was seen as an experiment by hospital staff, but successful outcomes from situations where both groups of healers work together provide pragmatic evidence for the benefits of cooperation, and lay a path of trust.
from sex, this can impact the health of the mother and babe (Anae et al. 2000). Bad relationships somewhere in the family may similarly have health effects on ‘innocent’ family members via the actions of ancestors who are displeased with the behaviour, as was the case with the Samoan boy described by Kinloch above, and can be replicated in many of the studies cited here.

The recourse to traditional healers is varied among Pacific people in New Zealand. As early as the 1960s, McCreary (1965) and his students’ interviews with Cook Islanders and Niueans living in Auckland found that, in the case of sickness, only 12 percent would consult with relatives, only one percent with friends and only four percent would approach a priest or minister. In contrast, 78 percent reported that they would consult the doctor or go to a hospital. The remaining five percent would consult a variety of other people. A study of access to primary care in the late 1990s in Auckland found that, while traditional healing remained important for all the Pacific groups studied, New Zealand born Pacific peoples were less likely to believe in and have resort to Pacific healing practices. Some of the younger generation were reluctant to use traditional medicine with their children and their attitudes varied from scepticism to aversion to the whole idea. Participants who did use traditional healing also used Western medicine and saw these as “complementary rather than in opposition” (Pacific Health Research Centre 2003:9).

From time to time, concerns are expressed, especially by Western medical experts, about the use of herbal remedies which may interfere with biomedical treatment or have bad effects due to their active compounds. Massage in pregnancy has also been the target of criticism and debate, with a connection made to intracranial bleeds in the baby from inexpert or overly vigorous massage, which is not part of traditional pregnancy care (Pacific Health Research Centre 2003). Diagnostic delays have been cited as a problem or potential problem, for example, when a healer is asked to treat a cough that turns out to be TB. However, if experts in both systems readily advise their patient to seek appropriate care and, as long as the patient or family inform both sets of practitioners about their complementary care, these plural practices can be managed. This was the position taken in a North Health documentary in 1995 in its “Pacific Vision” series which explained some aspects of traditional healing and consulted a panel of ‘experts’, including Pacific medical doctors and health researchers, who were sympathetic to and had benefitted from it (North Health 1995).

The importance of Pacific and non-Pacific health workers being aware of the content and diversity of ideas and practices around health, illness and healing has been proclaimed in successive health policy documents and in research papers (Southwick 2005). In addition, health research and health-care relationships appropriate to Pacific peoples have been discussed, codified and promulgated. Specific Pacific primary care and health promotion programmes can embody Pacific health concepts and practices. However, it is much more challenging to ensure that other primary care organisations and secondary and tertiary levels of health care, which the majority of Pacific peoples attend, can provide care contexts which are respectful and safe without assuming homogeneity among Pacific peoples and without overrating ‘culture’ at the expense of human commonalities or the socio-economic realities of life. Despite these critical reflections there is no doubt that Pacific peoples have successfully claimed space in the provision and reception of health services.

Health contexts evolved rapidly in the second half of the 20th century in New Zealand and in the islands. Health knowledges and practices in the islands were very different in the 1950s from those which more recent migrants both left behind and brought with them as models for what to do to keep well or when illness struck. Similarly, the health and health service contexts in New Zealand which greeted the earlier migrants were markedly different by the end of the 20th century. Pacific people who arrived in the third quarter of the century have had to grapple with constant change in health service provision during the final quarter also, as have all other New Zealanders. This is one further aspect of diversity in this already diverse population, cautioning us in any tendency to over-generalise.

Access to general practitioners and primary health care

From the time Pacific peoples began arriving in New Zealand and through into the 1990s, they found themselves interacting with a health system that was more extensive and usually more formal than that experienced in island Polynesia. For many years it was also largely blind to differences in understandings of health and to what were potentially the specific health needs of different ethnic groups.

Pacific families had to adjust to the New Zealand system of primary health care, with its combination of paid appointments for general practitioners (GPs), some health services provided free of charge, such as the care of newborns through the Plunket Society,1 and a Public Health nurse and District nurse system that provided domiciliary care for a variety of conditions. Pacific people were undoubtedly used to receiving medical services in their home countries, often provided by New Zealand ex-patriate professionals. As long as the services existed, access was very direct. Otago University medical student, Peyroux, observed on Rarotonga in the 1960s (Peyroux 1962:14). Samoan-born Aseta Redican worked as a physiotherapist at Middlemore Hospital in Auckland during the early 1960s and was
very aware that Pacific people did not understand the New Zealand general practitioner system:

…in Samoa there were no GPs, everybody had to go to the hospital, and so of course when they came here [New Zealand] they all went to the hospital.

…[once at the hospital] they get told you shouldn’t have come here you should go and see your GP and so people got totally confused. GPs? Who’s the GP? And they don’t have a relationship with the GPs out there and we didn’t even have a handful of Pacific GPs at the time (Redican 2010).

Many Pacific families and New Zealand doctors would have struggled to understand each other’s languages and perspectives. However Pacific families also adapted quickly to the New Zealand system and were prepared to travel some distance to see a ‘good’ doctor. Two of the South Auckland families interviewed by Sainsbury (1971) travelled some distance across Auckland to see the doctor of their choice. One family chose to do this because that doctor went to greater trouble to explain treatment in their own language and understood their problems better than other local doctors. Doreen Arapai is New Zealand-born of Niuean descent and her family lived in Parnell in the 1950s but travelled to visit a woman doctor in the suburb of Panmure ten kilometres away:

…so Friday, when there was some money in the family, there would be about eight kids and four adults, we would jump on the bus, two buses, to get to Panmure and see this doctor and come back (Arapai 2010).

Arapai’s family lived with two other families, including her aunt’s. There was another room in the house where young single Pacific men stayed. One man developed TB and spent time in Green Lane Hospital. The family was very systematic about hygiene after his return. His crockery and cutlery were kept separate and the children were forbidden to use any of his things. Arapai thought her mother’s nurse training in Samoa contributed to her knowledge about TB. The emphasis on hygiene in the house came from Niuean traditions of pride in the home, as well as new knowledge the women were gaining through working alongside palagi [European] women in factories (Arapai interview 2010).

Many Pacific immigrants arrived in New Zealand with basic or no English language, and this presented challenges within a medical context, often for a number of years after arrival. The barrier language posed to effective medical care and advice was identified by researchers and medical professionals working with Pacific people, although overcoming that obstacle proved to be an ongoing task. Among Sainsbury’s (1971) 15 Pacific families from South Auckland’s new housing estates, he found that, in those families in which English language skills were limited, they often did not fully understand the nature of the work of the agency they were dealing with. It could be difficult for Pacific families to communicate their problems to medical professionals and, conversely, they might not fully understand the advice and instruction given. Sainsbury observed five families in which the parent had very poor English and was reliant on young children to interpret. At the other end of the spectrum, in two families, one parent’s English was judged to be excellent. Sainsbury saw it as the responsibility of medical and social services professionals to ensure that Pacific families understood the nature of their illnesses and treatment and commented in passing on the high level of TB in the families he visited; five of the 15 families had current or recent cases among their members.

Other studies (Butler 1976, Hopper 1957) also recognised the issue of language as a barrier to Pacific people accessing medical services. Butler’s study on malnutrition in Pacific children in Auckland City found that most Pacific families spoke their native language at home and, although parents usually had some English, it was their school age children who spoke that language well and often translated for the older generation. In recommending the need for health education for mothers about infant and child care and contraception, Butler concluded that such education must be carried out in their own language, suggesting health talks to groups of Pacific mothers, and booklets and posters in Plunket and doctors’ rooms. Butler observed that Pacific people with good education had few problems adapting to New Zealand life, and that there were few socio-medical problems within this group. He urged, however, that the medical establishment become more familiar with the cultural and social backgrounds of Pacific peoples, so they could better treat them.

Some New Zealand studies in the 1960s and 1970s showed that Pacific families regularly used public health nurse and Plunket services, for social as well as health reasons. Individual nurses within both services helped families with informal interpretation and as a link with other social services organisations, such as Family Planning and State Advances Corporation which handled housing applications (Christmas 1971, Sainsbury 1971). This infant care advice was appreciated by many (Redican 2010) although the Plunket nurses noted many Pacific mothers did not make the transition from home visits to attendance at clinics (Hopper 1957, Butler 1976).

For a number of decades, Pacific peoples’ needs tended to be met informally by the limited number of Pacific professionals working throughout the primary and secondary health system. For many years, there were just small numbers of Pacific health professionals working in New Zealand. Medical and nursing qualifications obtained in Fiji or other Island nations were
not recognised in New Zealand and so many trained people took work at lesser levels within the health system. Samoan Dr Semisi Ma‘ia’i trained in Fiji prior to migrating to New Zealand in 1956 where he was one of the few Pacific doctors to retake his entire medical training at the University of Otago to gain New Zealand registration (Redican 2010). In 1970 he became a GP at Kumeu, a rural district just northwest of Auckland, and his experience illustrated the desire of Pacific people to consult Pacific doctors as well as how few they were in number. The distance from metropolitan Auckland was no deterrent to Pacific patients wanting to consult a Pacific doctor. Medical social worker Taufao Lurch visited Ma‘ia’i one day and was astounded at the number of Pacific patients who had made the journey from the city (Lurch 2010). As Ma‘ia’i himself said “Once they knew I was out there they came out from Auckland city in carloads!” (Fitzsimons and Beckford 2010:7).

New Zealand’s hospital system operated on a largely monocultural basis into the 1980s. A survey in 1974 of patients at Wellington Hospital reflected a lack of interest in the ethnic differences of patients. The 237 patients who completed the questionnaire were not asked about their race or ethnicity. Two hundred and thirty patients were interviewed and the interviewers noted the person’s race as either ‘European’ or ‘Non-European’, with just six percent of the interviewees in the ‘non-European’ category (Salmond et al. 1977). The 1976 Census showed that New Zealand’s population was much more diverse than this. Of those who declared their ethnic origin in the Census, 11.9 percent of the total population declared they were ‘non-European’, being made up of 8.8 percent Māori, 2.1 percent Pacific Islands and the remainder Indian and Chinese (Department of Statistics 1980:8). The greater urban areas of Auckland and Wellington had higher proportions of non-Europeans than the total country, 18.9 percent in Auckland and 15.2 percent in Wellington (Department of Statistics 1980:50-1).

The first formal interpreting service in New Zealand hospitals began at Middlemore Hospital in 1991. Prior to that date, Pacific hospital staff, such as nurses, orderlies, and cleaners, often found themselves taking on the role of interpreter for Pacific patients who lacked a family member to carry out the task. Cook Islander, Neti Herman, was a nurse at Auckland Hospital in the 1970s and recalled being sent all over the hospital to act as an impromptu interpreter (Herman 2010. See also Tukuitonga 2010). Doreen Arapai, of Niuean descent, worked as a registered nurse at Auckland Hospital from the 1960s through to the 1980s, and was called on to interpret for Pacific patients. She was not a fluent Niuean speaker and recalled the difficulties that posed, especially when explaining medical concepts and terminology. At times, she would phone her mother to ask for a Niuean word she needed. Arapai recognised patients’ bewilderment at their situation:

...when you saw someone lying in bed who had no understanding … well, very small understanding of the English language and very small understanding of the procedures and processes that they had to undergo. I used to struggle to communicate with them. But I tell you, all of a sudden, the eyes would light up … recognition … here’s someone who is trying to speak Niuean who is Niuean and able to trace descent back to a common ancestor. “Oh, I know your family”… so straight away there would be an accord (Arapai 2010).

Arapai was very aware of the inadequacy of informal interpreting:

...if there was people working in the hospital, mainly orderlies in the kitchen, they used to get them to come up and interpret but that was not a very good practice because people would not often share what was wrong because there was that feeling that there would be no confidentiality, that everybody would know that so and so was in hospital and then the whole hospital would know. So they would never open up and if they did open up, quite often the person interpreting did not have an understanding of the terminology … and so there was always a risk (Arapai 2010).

The problem of understanding medical terminology was recognised early on by Samoan and Otago trained doctor, Dr Semisi Ma‘ia’i. Over many years, he built up a Samoan glossary of medical terms which was published in 1991 (Fitzsimons and Beckford 2010).

In spite of these problems, Pacific health workers provided an array of informal assistance to Pacific patients. Samoan Aseta Redican trained as a physiotherapist at Otago University and worked within Auckland’s hospitals from the late 1960s into the 1980s. She was frequently approached by Pacific patients for help as they navigated the hospital and specialist system. People assumed that, since Redican worked within the hospital, she would be able to explain their diagnosis, and help them get access to medical specialists and treatment. Redican in turn understood the vulnerability of Pacific patients in the hospital system and felt a special sense of responsibility for them (Redican 2010. Also Lurch 2010, Tukuitonga 2010).

Pacific self-help organisations

In the absence of government-led strategies in the early years to improve Pacific health, the first seeds of Pacific-led organisation occurred from the mid 1970s. The high profile organisation, P.A.C.I.F.I.K.A. Incorporated, was formed by Pacific women in 1975 as a response to the social needs of Auckland’s rapidly growing Pacific population. Pacific women took their lead from the well known Māori Women’s Welfare League to
advance their people’s well being and P.A.C.I.F.I.K.A. represented a shift towards permanence in the process of Pacific settlement in New Zealand. Health was one of P.A.C.I.F.I.K.A.’s many concerns (Arapi 2010, Redican 2010).

With the few Pacific health professionals being reminded every day of the need for more specialised Pacific health services, this knowledge led to the establishment of Pacific Island Health & Welfare Society (PIHW) in 1977. PIHW was the initiative of Samoan Dr Semisi Ma’ia’i and Tongan Dr Leopino Foliaki, a Fiji-trained doctor unable to practise in New Zealand. Foliaki was older than Ma’ia’i. He did not retrain as a doctor but instead in the 1950s he became a medical social worker within the Auckland hospital system. Later he was member of the South Pacific Medical Research Committee of the Medical Research Council. The men recognised the health needs of Pacific New Zealanders and they formed PIHW to be a forum and resource for Pacific health professionals and social workers and an advocate to the Department of Health and local hospital boards on Pacific health issues. PIHW met regularly, strengthening the networks between Pacific ethnic groups, sharing information and updating each other on health issues in different districts. The wide range of PIHW activities are shown in the agenda of a regular meeting in 1988. The committee discussed the possibility of mass screening for Hepatitis B, received an explanatory visit from the director of the Auckland Lifeline and Kids Line services, and was visited by an Auckland Area Health Board social worker for a discussion on child sexual abuse. At the same meeting, the committee agreed to make a submission to the Auckland Board on psychiatric services, and stated specifically that those services were currently “not meeting Pacific Island needs”.3

Dr Leopino Foliaki reflected later that the most significant day-to-day social problems faced by Pacific people were communication difficulties with European doctors, the health pressures resulting from low incomes and living in poor quality and overcrowded housing, as well as the differences in lifestyle from the islands. He regarded health promotion and primary health care as the answer to these issues (Ministry of Health 2003c). Pacific Islands Health & Welfare influenced the early development of Pacific health services. It emerged out of the Pacific community to become a forum for those working in Pacific health and made the issue of Pacific health more visible to the national and local health services; the leadership of health clinicians and some officials in the health bureaucracies in establishing health services; the involvement of men and women in multiple community organisations and the personal and professional networks that arose from that; and the banding together under a Pacific umbrella to work effectively within the New Zealand bureaucracy while retaining strong individual Island identities.

Barriers to health care

Historian Margaret McClure has described the changing shape of government service and social welfare provision in the years from 1984 to 1998 as a time of ‘the reluctant state’. Both Labour and National governments during this time sought to restrict government spending and deregulate the economy (McClure 1998:210). As new immigrants with generally low levels of formal education and training, Pacific peoples already occupied the lower socioeconomic strata of New Zealand society. Pacific peoples, along with Māori, were disproportionately negatively affected by these structural social and economic changes. Subsequent research showed the results of inequitable access to primary care that existed during this period for Pacific peoples (Tukuitonga 1999, Young 2000), for Māori (Crengle, Crampton, and Woodward 2004, Crengle, Lay-Yee and Davis 2004, Davis et al. 1997, Malcolm 1996) and generally for people on low incomes (Barnett and Coyle 1998, Barnett 2000). On a social level, language and communication difficulties and the location of general practices continued as major barriers to health care for Pacific peoples (Pacific Health Research Centre 2003). A lack of cultural awareness among primary care professionals (Pacific Health Research Centre 2003) and an entire health system that was fundamentally monocultural into the 1980s were also significant stumbling blocks (Dow 1995).

In New Zealand, primary medical care services were and are the first point of contact with the health system. During the 1980s and 1990s, primary care was still delivered almost exclusively through general practices, which were privately owned by GPs. Although hospital care was fully publicly funded through taxation, primary care was a user-pays system of care, with a means-tested partial government subsidy. This cost to consumers was a significant obstacle to primary care for low-income groups (Barnett and Coyle 1998, Scott et al. 2003, Raymont et al. 2004).

More recent research has confirmed how inequalities in New Zealanders’ access to primary and secondary health care, with GPs in the gate-keeper role, increased over time (Scott et al. 2003). For Pacific peoples, those inequalities were translated into poorer health outcomes across the lifespan and in shorter life expectancy (see Chapter 3). Blakely et al. (2004) showed there was little, if any, decline in Pacific mortality rates during the 1980s.
and 1990s, compared to significant declines in mortality rates for non-Māori, non-Pacific New Zealanders. These differences reflected not only higher rates of some types of disease, but also inequitable access to health care. For example, despite Pacific peoples having a higher incidence of cardiovascular disease than non-Māori non-Pacific people, Tukuitonga and Bindman (2002) found they had lower rates of cardiac revascularisation procedures (i.e., operations to restore blood flow to and from the heart). Disparities in access to primary care by children were shown by higher rates of Pacific paediatric hospitalisation than both Māori and non-Māori, made necessary by lack of community prevention and care (Tukuitonga et al. 2000). Similarly, from 1994 to 2004, Pacific peoples had lower survival rates for all causes of cancer, in comparison to non-Māori non-Pacific. This was linked to the presence of advanced disease at the time of diagnosis: an indicator of restricted access to primary care (Haynes et al. 2008).

During the 1980s, the growing number of Pacific people presenting at New Zealand’s urban hospitals and clinics brought tentative attempts to better meet their needs. The urgency of building the Pacific health workforce led to the Māori and Pacific Admissions Scheme at the University of Auckland in 1983 (University of Auckland 2010). Similarly, the long history of encouraging Māori students to study medicine at the University of Otago was extended to include Pacific students (Page 2008). The purpose was to encourage and support Pacific and Māori students to enter and succeed in medical and health studies, although, once there, those students often found medical school an intimidating and isolating environment (Grace 2010). In 1985, Middlemore Hospital established its first Pacific liaison officers to work with its large Pacific clientele and the Canterbury Hospital Board appointed a Pacific community worker in 1986 (Ministry of Health 2003c).

Such developments were positive but also minimal. They were a glimpse of the future rather than a meaningful improvement in Pacific health services at the time.

The permanent place of Pacific people in New Zealand society was increasingly recognised by Government in the 1980s. Pacific issues were part of the Department of Māori Affairs from the 1940s (known as Māori and Pacific Island Affairs from 1972 to 1984). In 1984, the Fourth Labour Government acknowledged Pacific peoples’ status as a substantial minority group (three percent of the population in the 1981 census) with multiple cultures and distinct needs. The Pacific Island Affairs Unit was set up within the Department of Internal Affairs and a Minister and Advisory Council appointed (Bassett 1997). In 1990, an independent Ministry of Pacific Island Affairs (MPIA) was established, with Apii Rongo-Raea as the first Chief Executive Officer, giving Pacific issues including health a permanent and authentic voice at government level (Ministry of Health 2003c, Macpherson and Anae 2008).

Separate developments in the use of health statistics and health governance helped to substantiate the need for health policies targeted at Pacific needs. Population-based hospital funding was introduced nationally from 1983 in response to large variations in the quality and availability of health services across the country (Fougere 1994). In parallel, 14 area health boards were gradually established across New Zealand from 1983 to 1993. This process decentralised responsibility for service provision from the Department of Health. It aimed to emphasise preventive over curative health care and establish national health targets and strategies. Under population-based funding, Auckland’s share of health spending increased to better match its share of the country’s population. More in-depth data collection and analysis underpinned the concept that different groups in society had different health profiles and may need specific services. However, it was Niuean physician Dr Colin Tukuitonga’s (1990) public health thesis that drew the existing statistical snapshots of Pacific people’s mortality and morbidity into a coherent picture that clearly revealed their poor health status (Tukuitonga 2010, Foliaki 2010).

Following the decade of transition from hospital boards to area health boards, successive governments restructured New Zealand’s health services with the aim of reducing costs, overcoming inefficiencies and alleviating geographic and social inequities of service delivery. In 1991, the new National Government introduced extensive reforms designed to introduce a competitive health market and to rationalise and reduce the cost to government of obtaining and providing health services. From 1993, the Department of Health was replaced by the Ministry of Health, and the funding and provision of health services were separated and decentralised. Four regional health authorities with broadly equal populations were established to contract services from either public or private health providers.

The country’s hospitals were reorganised into 23 Crown Health Enterprises to be run on a ‘business’ and then a ‘business-like’ basis (Barnett and Barnett 2005:183).

The regional health authorities were funded on a population basis and required to monitor and respond to the health needs of their region’s population. Northern Regional Health Authority (known as North Health) took in the entire Auckland region. North Health immediately turned its attention to the resounding health inequalities Pacific people experienced and published a demographic profile of its Pacific population (Walker 1993). On a national level, the short-lived Public Health Commission (1994) launched The Health of Pacific Islands People in New Zealand. The need to better understand the differing health status of New Zealand’s ethnic groups led to a change in the way ethnicity was defined for births and deaths. Until 1995, ethnicity was biologically determined, i.e., “the degree of Māori or Pacific Island blood” was asked. Those people...
with less than half of such ancestry were grouped as Non-Māori non-Pacific Island, with the result that the actual numbers of Māori and Pacific people were being under-estimated. From September 1995, this biological distinction was no longer made and parents or next of kin stated a person or baby’s ethnicity. In the northern region, recorded Pacific Island live births increased from 15 to 20 percent following this change (Walker and Armstrong 1998).

The requirement for health providers to analyse and meet the health needs of their populations meant both funders and providers paid more attention to the effectiveness of the services they were providing, especially for minority sectors of the population. As the regional health authority with by far the greatest Pacific population, North Health led the way with its emphasis on Pacific health. From 1993, it engaged directly with Pacific communities, holding fono (meetings or assemblies) and appointing Pacific staff to formulate strategy and policy. Aseta Redican, previously Co-ordinator of the Pacific Island Heartbeat programme at the National Heart Foundation, was made Manager: Issues affecting Pacific People at North Health and Debbie Sorenson was appointed team leader to project manage the Northern Region Pacific Health Strategic Plan which received targeted funding of $2.6 million in 1994.6 Tongan-born Sorenson had trained as a psychiatric nurse and moved into health management within the psychiatric hospital system (Ministry of Health 2003c, Quin 2009, Sorenson 2010). In 1996, Lita Foliaki was appointed full-time team leader of the North Health Pacific Islands team which saw itself as “accountable to Pacific Island communities as well as North Health”.6 Dr Colin Tukuitonga was made Pacific Director of South Auckland Health in 1998 (Ministry of Health 2003c).

The health system underwent further change after the 1996 general election when the National and New Zealand First parties established the first coalition government under the new Mixed Member Proportional (MMP) electoral system. The compromises of coalition government led to a change away from the controversial competitive health model to a more cooperative one. The separation between funder and providers paid more attention to the effectiveness of the services they needed, especially for minority groups to craft individual responses to the services they needed. The report (p.5) concluded that, because data systems were ‘not driven by a need to understand patient demographics, there is a lack of knowledge of the patient base among managers’. The report showed that 15 years after population funding of health in New Zealand had been launched, health data generally, and an understanding of the health status of Pacific people in particular, remained rudimentary. As this and earlier chapters show, this limited understanding of Pacific peoples’ health status is a continuing brake on the provision of effective services and the improvement of Pacific health statistics.

Gauld (2009) has argued that the changing structures of the health system during the 1990s brought disruption and division across all levels of New Zealand’s health services. From the perspective of Pacific-centred health services, however, the emphasis on population funding and the political shift from universal to targeted services meant new spaces were created for minority groups to craft individual responses to the services they needed. Tukuitonga, Redican, Sorensen and Foliaki has each observed the importance during this time of North Health’s role as the chief driver of policy and purchasing for Pacific health services. They view North Health as being ahead of and influencing Government and Ministry of Health thinking about Pacific health. Sorenson found National Government Health Ministers Bill English and Jenny Shipley both open to innovative services for Pacific people because, for the first time, proposals were based on reliable health statistics and the need for the services was tangible (Sorenson 2010, Tukuitonga 2010, Redican 2010, Foliaki 2010). During this decade also, Pacific health leaders grasped the opportunities that arose. They established new Pacific models for primary health care and general practice and worked with health authorities to target Pacific health issues.

Pacific primary health initiatives

From the late 1980s in New Zealand, ‘third sector’ (non-governmental, non-profit) primary care organisations formed as alternatives to the dominant general
practice model. They tended to adopt the broad definition of primary health care outlined in the Alma-Ata Declaration (WHO and UNICEF 1978) and, in contrast to private general practice, they served a higher proportion of Māori and Pacific patients (Crampton 2001, James 2007). Along with having community governance and salaried clinicians, many worked within a community development framework (Crampton 2001). These organisations were more likely than ‘for profit’ general practices to try to reduce barriers to access through lower patient charges. They tended to employ staff whose ethnicity matched that of the patients and to operate larger, more diverse staff teams. They were also more likely to carry out locality service planning and community needs assessments and usually served larger, largely non-European and low-income populations, who presented with a somewhat different array of problems (Crampton 2001). Clearly, these third sector primary care organisations reduced both financial and cultural barriers to accessing primary care for Pacific peoples (Foliaki 2010, Tukuitonga 2010, Nicholson 2010).

From the late 1980s, some of these third sector organisations were established as ethnic-specific services. While these were initially established by Māori, and primarily in rural areas (Crengle 1999), Pacific people in urban centres grasped the opportunity to create primary care providers with the goal of improving health access for Pacific peoples (Tukuitonga 1999). These organisations became known as ‘by Pacific for Pacific’ health services (Ministry of Health 2003c).

The first Pacific community practice was Pasifika Healthcare (later West Fono), which was set up in West Auckland in 1989 by a group of Pacific health professionals and community leaders. What began as a health promotion fono through Waitakere Hospital grew into a community nursing service, and then a North Health funded general practice clinic. A very active community forum including a Pacific Islands committee had developed in West Auckland as a result of the 1980s Area Health Board legislation requiring active community engagement. Pasifika Healthcare was the initiative of members of that Pacific committee, Mary Watts, Epa Auimatagi and Dr Colin Tukuitonga. Some people were apprehensive about how successful the clinic would be but the numbers of patients quickly ‘went through the roof’ (Tukuitonga 2010). Pasifika Healthcare turned the conventional general practice model on its head. It opened for extended hours during the evenings and on Saturdays and Sundays, so that Pacific parents could visit outside work hours. Fees were low at $5 or $10 per visit and outreach nurses visited families in their homes especially for services such as child immunisation. Staff from doctors and nurses to receptionists spoke Pacific languages and families quickly realised that certain doctors were available at certain times; Niueans sought out the Niuean doctor, Tongans the Tongan doctor, and so on. The convenience and low cost of these services appealed to many and patients were not only Pacific but included Māori and European (Tukuitonga 2010, Foliaki 2010). Health promotion and education sessions delivered by Pacific health professionals became a central part of Pasifika Healthcare’s primary health mandate. Other Pacific health services followed in Auckland. Health Star Pacific formed in 1994 and focused on health education and illness prevention (Ministry of Health 2003c).

In 1996, members of Auckland’s Tongan community formed the Tonga Health Society, with the purpose of setting up a health centre. The Tongan Nurses Association, which had been set up with the encouragement of Dr Leopino Foliaki in the 1980s, was the driving force behind the centre. The Society worked with the Northern Regional Health Authority and the Langimalie Health Centre opened in Penrose in December 1997 with Dr Sitaleki Ata’ata Finau as the first chief executive officer (Tongan Health Society 2010). Tongan nurses and doctors worked without pay for the first six months of Langimalie’s operation. As ‘Eseta Fifita Finau has said ‘That’s what it took to make that dream come true’ (Fitzsimons and Beckford 2010:84) Langimalie was the first ethnic-specific Pacific health care provider in New Zealand. The Tongan Health Society knew they wanted a service firmly based on Tongan protocol, culture and language and overcome Ministry of Health reluctance and fear of accusations of racism. ‘Eseta Finau gave an example of the type of misunderstanding between patients and doctors that Langimalie was intended to overcome:

Sometimes they [a Tongan patient] would go and see a palagi doctor and say things like, “I’ve got this cold feeling. I can feel death coming up my leg.” The palagi doctor would refer them to the psychiatrist because they thought they were nutty. But it was a Tongan term to describe a feeling. It didn’t mean they were mentally disturbed. It was the sort of statement that would only be understood by a Tongan (Fitzsimons and Beckford 2010:84).

South Seas Healthcare in Otara opened in 1999 and offered nursing and medical care services. Samoan Dr Debbie Ryan had been in general practice in the suburb of Glen Innes throughout the 1990s. She knew first hand from the large number of her patients who travelled across the city to her practice that the place of greatest need was South Auckland. She and nine others took up new Health Funding Authority money and started South Seas in the Otara shopping centre, with each doctor working part-time. As the number of patients grew, Ryan committed full-time to South Seas. A child health contract, South Seas Kids, was added to the centre’s general practice contract enabling the employment of nurses and, in just a few years, South Seas employed up
to 50 people and had a patient roll of 7,000. The practice’s close focus on Pacific health issues led to innovations. South Seas hosted clinics by hospital specialists, began a general practitioner service at Otahuhu College, and ran high profile health promotion campaigns such as for child and adult vaccination (Fitzsimons and Beckford 2010, Nicholson 2010). Pacific health organisations were also established in Hamilton and Wellington and, in Christchurch, Pacific Trust Canterbury offered a wide range of services with a strong focus on primary health care aimed at Pacific people (Ministry of Health 2010).

These early Pacific community medical centres were characterised by their not-for-profit status, their Pacific workforce and their broad emphasis on primary services, from general practice to health promotion. Importantly, their health promotion programmes were aimed more broadly than their existing patients and they deliberately tried to engage with the hard-to-reach segments of the Pacific community. Pacific health centres are not exclusively non-profit. An example is Pacific Integrated Health Care Limited, a centre on the North Shore of Auckland, which is privately owned but retains a strong emphasis on affordable services and extensive primary care for Pacific peoples (Arapai 2010, Foliaki 2010). By 2000, Wright and Hornblow (2008:29) report that 30 Pacific-owned health provider organisations existed.

**A professional hospital interpreting service**

An important practical and symbolic development in the provision of hospital services for Pacific people occurred early in 1990. The barrier that language posed to the care of Pacific people within the hospital system since the 1950s has already been discussed; this obstacle had continued to be addressed since only in the most haphazard of ways. For 40 years, Pacific family members and hospital staff had provided informal interpreting services for Pacific patients. In Auckland, there had been calls for a professional health interpreter service since 1963 but neither hospital boards nor area health boards considered them seriously because of the perceived costs. However, in 1988, the Inquiry into Cervical Cancer at National Women’s Hospital (known as the Cartwright Inquiry) recommended that Auckland’s hospital authorities address the necessity of providing professional interpreting services. The recommendation was one of a series based on the principles of ethical practices and a patient’s informed consent about treatment. The authority of the Cartwright Report ensured that an interpreter service could no longer be ignored.

Auckland Area Health Board’s Cartwright Implementation Taskforce reported in June 1990. The need for such a service was evident from the 1987 Auckland hospitals admissions data which showed 12,000 Māori, 5,000 Samoan, 2,000 Tongan, 2,000 Cook Islanders, 1,000 Niuean, 781 Indian and 635 Chinese, many of whom would have had difficulty understanding English. A range of interpreting service options was canvassed and the Working Party recommended a pilot scheme where the board employed Interpreter Liaison Officers to coordinate a contract interpreter service. Middlemore Hospital was the obvious choice for the pilot. It had the most patients from migrant groups (17 percent) and had made some preparation for such a service. An Interpreter Advisory Group was established in August 1990 to drive through the establishment of the new service, known as HITS (Health Interpreting and Translation Service). The advisory group’s membership reflected the degree to which Pacific Island peoples were expected to utilise the new service; of 11 members, two were Cook Island, two were Tongan, two were Samoan and one was Māori.

The new visibility of Pacific health inequalities was seen also in the ultimately unsuccessful attempt by the National Government to define a set of core public health services for New Zealand. This national conversation took place as part of the health reform and rationalisation process of the early 1990s and representatives of interest and minority groups including Pacific Island peoples were invited to take part (Campbell 1995). Nevertheless, the Pacific Island Health & Welfare Society’s submission on core services expressed its concern that Pacific Islands people were not adequately represented on the National Core Services Panel. The Society also judged that Pacific families would be among those most adversely affected if hospital charges were introduced. Its emphasis on community over individual needs can be seen in the perception that the Government’s true interest was in productivity and efficiency rather than service provision, with the danger that non-productive groups (for example, the elderly, disabled and multi-handicapped) could well be excluded from an eventual definition of core services. At a time when universal public funding of health and hospital services was seen to be under threat, PIHW articulated the precarious week-to-week finances of so many Pacific Island and other low income families, and the consequences to that group of increased charges for health care.

**Developing the Pacific health workforce**

Although there were only small numbers of Pacific nurses, doctors, physiotherapists and other health professionals for many years, it is clear that those individuals helped many Pacific patients navigate the hospital and health systems. The Pacific health workforce grew slowly from the 1970s, partly through personal motivation but also significantly out of a sense of collective responsibility to help improve the health of fellow Pacific people (Foliaki 2010). Both personal career paths and the services offered to Pacific people were transformed as a result.
Moera Grace trained as a nurse at Middlemore Hospital in the 1970s. She worked at Middlemore, National Womens’ and Waitakere Hospitals before she and her family moved to Australia from 1980 to 1985. Grace was a charge nurse in Australia and, after returning to Waitakere Hospital, became their in-service educator. She belonged to the New Zealand Nurses Association and became involved in the broader union movement, especially as a delegate on the combined union health committees and the Polynesian sections of those committees. Grace used the organisational skills learned within the union movement to capitalise on the developing support for interpreting services in hospitals and equal employment opportunities for Pacific peoples. Her politicisation coincided with the first round of health reforms and she worked with colleagues to create spaces for Pacific patients and employees within Auckland’s hospitals (Grace 2010).

The career of Taufao Lurch has evolved since his arrival in New Zealand. He is Samoan and trained as a teacher in Fiji then taught in Samoa before coming to Auckland as part of the annual quota of workers in 1974. Lurch worked in a South Auckland aluminium factory but became involved in helping fellow workers. Many had poor English and management would call on him to assist in settling disputes within the factory and increasingly give assistance with other problems such as housing and legal problems. He said ‘I became conscious that I had to devote my time more on assisting people rather than working in the factory. So hence, when I saw the ad for the social work course, I applied and fortunately I got in’ (Lurch 2010). Lurch was one of two Pacific students in the first ever social work course in Auckland in 1981 at the Auckland College of Education (now Faculty of Education, The University of Auckland). On completing the course at the end of 1982, Lurch took up a job as social worker at Middlemore Hospital and has remained in the health field ever since. He chose health because of the obvious Pacific health needs and because he felt there was a positive opportunity to empower and assist people (Lurch 2010).

In 1976, young mother Maine Andrew came to Auckland from Aitutaki in the Cook Islands. Andrew’s aunt worked at Auckland Hospital and helped her get a job as a nutritionist. She learned on the job, studied part-time and enjoyed being able to explain about diet and food intake to Pacific patients while also becoming very aware of community concerns about the health of Pacific women and children. During the 1980s, she shifted jobs to work as a counsellor at the Auckland Help Foundation (sexual abuse counselling). There, she and a handful of Pacific and Māori colleagues developed policies and practices that recognised the particular needs of Māori and Pacific women:

We really believed that we were a group of women who we, Māori and Pacific Island women, would work far better with Māori and Pacific Island community. We had our papa’a women, women colleagues, who were of some assistance. Because I think we then did recognise the need for the support from our papa’a colleagues which was very much a shared role in developing policies (Andrew 2010).

Andrew realized she needed a formal qualification and completed a diploma in social work in 1991. She has since worked for both Auckland and Waitemata Health Boards and been part of health initiatives that have sprung from the community and from fellow professionals such as the Cook Islands Health Network Association, the Pacific Women’s Health Project and Pasifika Healthcare (Andrew 2010).

Another Cook Island woman also from Aitutaki, Metua Faasisila, and her family came to Auckland in 1962. She was educated in New Zealand and then trained as a nurse at the Sydney Adventist Hospital in Australia from 1975. Faasisila returned to New Zealand after training and did theatre nursing full-time, and then part-time after her marriage. During the 1980s, she was based in theatre at Middlemore Hospital and did a lot of in-service training. By 1990, she was looking for a challenge and applied for the Advanced Diploma in Nursing (ADN) at Auckland Institute of Technology (now AUT University). Faasisila explained how the course opened her eyes:

…during our cultural competency component where we did Treaty of Waitangi, they talked about Pacific health. And I thought Pacific health? How is that different than anybody else’s? Having come from a clinical background… The thing is in theatre, things that frustrated me slightly, were things like [at] Middlemore … lots of Pacific people coming through. How are these people who can’t speak English, how are they looked after?

…It worried me ... because I was married to a Samoan and I’m a Cook Islander and so, as the Samoan and Cook Islands patients came through pre and post op, I could speak what bush jungle language I could …. But I thought, Tongans? I haven’t got a hope ... of communicating with them if they don’t speak English and I thought that is such a big disadvantage for those patients… (Faasisila interview 2010).

Faasisila’s exposure to the Pacific lecturing staff on the course was formative. Niuean nurse Doreen Arapai, Samoan nurse Moera Douthett (later Grace), Tongan social worker Lita Foliaki and others made Faasisila think carefully about how Pacific health differed from the health of other New Zealanders, and the role of language in those differences. Faasisila’s special
project for her ADN was to collect the current medical terminology being used at Middlemore Hospital and help develop an interpreting course in preparation for the new interpreting service at the hospital. After graduation in 1991, she was appointed Pacific Island Cervical Screening Co-ordinator for the Auckland Area Health Board. She went on to set up the Pacific Family Support Unit at Starship Children’s Hospital between 1997 and 2000, and completed an MBA degree through Otago University in 2001 (Faasisila 2010).

At a political and bureaucratic level, the growing understanding of Pacific health inequalities meshed with the concept of equal employment opportunity (EEO) and the need to build a qualified Pacific health workforce emerged as significant issue. In the early 1990s, the Auckland Area Health Board initiated regular meetings of Pacific employees as a result of a policy of equal employment opportunity. Within that forum, Pacific staff discussed how they engaged in their work environment as Pacific people, and as each cultural group. Staff began to plan their future careers and management gained greater insight into Pacific staff and their skills. When the first wave of health reforms dismantled the area health boards in 1993, the existing EEO structures and regular meetings of Pacific staff subsided also. However, voluntary mentoring of junior staff by senior Pacific staff carried on and, notably, the Pacific Health & Welfare Society stepped into the vacuum, holding meetings so that Pacific staff could continue to discuss issues of importance to them (Douthett and Bennett 1997).

An understanding that Pacific health was an issue that required its own solutions, including a stronger and larger Pacific health workforce, gathered momentum within the health professions, the community, local health bureaucracy, and central government. Within the Ministry of Health, Rosaline Stanley-Finlay was appointed Pacific Advisor in 1993 and Michelle Vanderlain-Smith was appointed first Senior Advisor Pacific Health in 1996 (Ministry of Health 2003c). In 1997, the Ministry of Health published Making a Pacific difference: Strategic initiatives for the health of Pacific people in New Zealand which called for Pacific professionals to be involved at all levels of Pacific health planning, provision and monitoring. That document had indeed been written largely by Pacific professionals and was directly focused on the health needs and problems of Pacific peoples in New Zealand (Ministry of Health 1997a). Along with this document, a companion consultation document was provided (Ministry of Health c.1997b) aimed at enabling interested parties to have their say in the formulation of policy. The next year, Making a Pacific Difference in Health Policy was published by the Ministry of Health (1998). This represents a remarkable amount of activity and attention to Pacific health at the end of the century.

Also in 1997, the Ministry of Health’s Health Services Research Centre’s Research Report No. 9: Development of the Public Health Workforce, authored by George Salmond and Sharron Bowers drew attention to the urgent need for increased Pacific and Māori participation in the public health workforce and in training. They identified the “disarray” of public health services as a consequence of the repeated health restructuring and a trend of decreased funding. On the positive side, they recognised new opportunities in the greater flexibility of service provision to allow local responses to local health problems and a stronger basis for future policy because of improved data collection and analysis. In fact, these opportunities were already being taken up by Pacific health leaders in the form of community health centres and stronger Pacific policy development.

Douthett and Bennett (1997) wrote a section in Salmond and Bowers that articulated the ineffectiveness of much public health policy and service from a Pacific point of view. The report quoted one respondent’s call for recognition of Pacific Islands health policy in law, saying:

> Until this is implemented, Pacific Islands people become pawns or are subjected to the vagaries of any political party in power…Pacific Islands public health issues become the flavour of the month when political parties want funding or the Pacific Islands vote. Or on the other hand Pacific Islands people are ignored or of no account as witnessed in the recent coalition government negotiations for health. Fragmentation of services complicates matters and at the end of the day money is wasted and Pacific Islands people are no better off (pp.20).

Another respondent pointed out the “waste of money funding services who [sic] have no idea at all how to maximise Pacific Island access to information and services” (pp.20-1). The report’s wide ranging recommendations were for a Pacific public health infrastructure to support Pacific health aspirations and address their public health priorities. It called for suitable courses for the Pacific health workforce, both mainstream and Pacific, the development of community and health promotion educators, an increase in Pacific health providers and Pacific ownership of services. Whitireia Polytechnic’s nursing programme was credited as a rare example of effective Pacific workforce development. Pacific staff occupied positions at high levels within the programme and specific policies and strategies had been developed to actively aid Pacific students. The polytechnic attracted many Pacific nursing students and supported them throughout their course; 96 percent of Pacific nursing students at Whitireia completed their studies.
Pacific health promotion

Between 1980 and 2000, health promotion became established internationally as an approach to addressing public health problems (Wise and Signal 2000, Hyde 2005). Health promotion philosophy was founded on Ottawa Charter (WHO 1986) values and practice which included a focus on equity, social justice, comprehensive interlinked strategies of community action, the development of personal skills, supportive environments, intersectoral collaboration, healthy public policy and the reorientation of the health system towards prevention and promotion. Providers of health promotion were diverse and uncoordinated; a New Zealand Health Promotion Forum discussion paper as late as 2007 was prefaced by the statement: “Current health promotion sector is fluid, disorganized and with no shared sector standards of practice that are visible and easily accessible”. Providers could include specialist health promotion services, primary health care services, non government organisations, community organisations, iwi groups and Pacific health care providers. By 2000 there were over 200 member organisations of the Health Promotion Forum (Wise and Signal 2000).

In spite of the strategic frameworks that embraced a broad definition of health, the proportion of the New Zealand health budget invested in health promotion in the 1980s and 1990s was very small: less than two percent has been suggested (Wise and Signal 2000:242). However, this was supplemented by the work of various Foundations and Societies, such as the Health Sponsorship Council, established in 1990 from tobacco taxation. A broad framework of health goals was developed in the late 1980s and revised from time to time (Ministry of Health 1997c). In addition to more specific goals, such as reducing injuries, diabetes or hearing loss, was the broad goal of reducing the adverse health effects of unemployment and income inequalities. Note the phrasing was ‘reducing the adverse effects’ and not the upstream problem of inequality itself. While the breadth of the framework allowed for the choice of priorities to be made by ‘communities’, it had the disadvantage of lack of coordination and consistency. For example, whether there was local expertise and resource available influenced what priorities were attended to (Wise and Signal 2000).

By the mid-1990s it was possible to focus on reducing health inequalities in Māori and Pacific communities, and children were a priority population, highly relevant to the youthful demographic profile of Pacific peoples. However, whether such programmes were designed and implemented depended on whether committed people championed them and had the resources and support to do so as well as the nature of the relationships and processes involved (see Greenaway et al. 2004).

Because the history of health promotion is poorly documented and its practice is very fragmented—partly because of the constant health ‘reforms’ and tinkering that took place in the 1980s and 1990s and partly because of the large number of organisations involved—it is difficult to find research-based evidence of Pacific health promotion during this time. We have addressed this gap by our interviews with several Pacific people who were key players at that time. Health promotion also exists in a contested domain between clinical services on one hand and health protection on the other, between an individually-focussed approach and one which concentrates on upstream determinants (Hyde 2005). A manager of a regional health promotion unit at the time explained that funders were unconvinced of the effectiveness of health promotion in addressing broader social equity goals, and conflicting ideologies and interests inhibited the development of coordinated health promotion programmes (Jennifer Hand pers. comm.). A good example of this situation was the resourcing of organisations of GPs to provide health promotion to their communities which they did by passing on health advice during consultations. Undertaking a health promotion consultation with a GP group at that time, one of our research group members, who was then employed in health promotion, questioned the GPs as to what they understood as ‘their communities’. The answer was ‘our patients’. This of course meant that, for those people who were not on the books of this GP practice, there was no health promotion. Yet the people who were most in need of support, likely to be the newly arrived and people with inadequate housing, low incomes and so on, were the very ones who were less likely to have a GP (see above “Barriers to Healthcare”). Consequently, inadequate access to clinical services and social problems such as poor housing and poverty which were having such negative effects on health were often overlooked in day-to-day practice, despite policy documents and research programmes that drew attention to their importance in the health of populations.

By 2000 health promotion approaches had moved to a greater concentration on addressing the determinants of health. The evidence of negative health impacts from the socioeconomic hardship of the 1990s created an appreciation of how public policies in all sectors could influence health. There was greater acceptance of the use of the mass media, of action engaging non-health sectors and of working in settings such as education and housing. For example the Healthy Schools—Kura Waiora—programme was endorsed by education and health sector agencies (Public Health Commission 1995). 31

Through all the changes and high-level policy work, the provision of health information remained a fundamental pillar of public health work but its style of delivery sometimes remained old fashioned, with a preference for written formats and for information that was generic rather than tailored to different cultural and
linguistic communities. As an example, even though Pacific Island language brochures about tuberculosis were first introduced in the 1970s, and the necessity of providing information acceptable and effective for people of different cultures was advanced by researchers from the late 1950s onwards (Butler 1976, Hopper 1957, Sainsbury 1971), as late as 2003 it was again noted that “there is little translated material for Pacific Peoples” (The Guidelines for Tuberculosis Control in New Zealand 2003:9). Of the 10 TB education resources listed at that time, two were translated into Cook Island Māori, one into Samoan and one into Tongan. Six were available only in English.

Official guidelines for producing health education resources were promulgated by the Ministry of Health for Pacific peoples in 1995 and revised two years later. These confirmed the need for culturally specific process, formats and language. The Auckland Regional Health Promotion Service had already created positions for Māori and Pacific Resource Development and some smaller community-based health organisations were producing health education information tailored to their communities. However, at a national level the combination of limited resources and a lack of evaluative information about effectiveness resulted in a patchy rather than strategic approach. For example, the pamphlet “Keeping Well with Diabetes” produced for the Ministry of Health in 2000 is available in the Samoan, Cook Islands Māori, Tongan, and Niuean languages, four of the seven commonly used Pacific languages in New Zealand (the others being Tokelauan, Tuvaluan, Fijian) (Ministry of Health 2000).

If there was official sluggishness in introducing targeted Pacific health promotion, the Pacific community itself was more energetic. The 1990s saw a diverse mix of community-led public health initiatives. The Pacific Island Heartbeat community network programme at the National Heart Foundation broke new ground in a way Colin Tukuitonga regarded as exceptional among the large health charities (Tukuitonga 2010). In 1991 Aseta Redican commenced as Pacific Island Heartbeat Coordinator and began extensive work with all the Pacific groups. Redican set up and trained a network of Pacific Heartbeat community leaders to talk to groups at home, in schools, at work, in churches, sports clubs, and community organisations. Her approach confirmed that different groups respond to their different solutions. The concept of cottage meetings had been unsuccessfullly tried with palagi people by the Heart Foundation, but Redican felt instinctively that it would suit the Pacific style. She also felt she had to draw on all her diplomatic skills to persuade “people to examine their priorities without offending them”. She felt Pacific people tended to put others before themselves and encouraged them to think about ways of including healthy living in their daily lives. One of the principles of the Pacific Island Heartbeat programme was to reduce reliance on paper-based information such as brochures in favour of direct interaction with Pacific communities. The Pacific Women’s Health Project contributed to the Pacific Heartbeat project and the concept of the Healthy Food Shell for Pacific food came through a logo competition run through Auckland secondary schools. Pacific Heartbeat received practical support from prominent Pacific people such as Samoan artist Fatu Feu’u and rugby hero Michael Jones (Andrews 2010, Redican 2010. See also Lurch 2010).

Pacific Islands Health & Welfare has given regular health advice in Pacific Islands languages through regular broadcasts in Samoan, Cook Islands Māori, Tongan, Niuean, and Fijian on Access Community Radio and later Planet FM. For 20 years, language coordinators, often with medical or health training, but always highly respected within their own community, have been contracted to arrange for speakers on a vast range of health topics. For example, in the first week of October 1993, there were talks on Tuberculosis and Pacific Islanders in Tongan, on Home Support in Samoan, on Immunisation in Niuean, as well as health sessions in Cook Island Māori and Fijian.

North Health’s early leadership on Pacific health can be further seen in its contracting of Pacific-owned Oasis Resources in 1994 to deliver immunisation programmes to Pacific communities. Oasis had devised...
the Immunisation Health Information Project and went on to develop other Pacific health promotion and education projects (Calvert 1997).

Redican and others have spoken of the role conflicts they faced as they worked “inside and in between” Pacific peoples and mainstream organisations. For example, Redican highlights the importance of not just consulting with Pacific organisations but of slowly building an understanding of the issues with Pacific people themselves:

… when you take it out to Pacific people, you have to work so hard and oh, … discussing, discussing, discussing. The systems don’t understand when we say we have to set up these meetings. They say we are not paying you this kind of money just to meet with people and talk but, with Pacific people, you have to keep meeting with them, you have to keep talking to them, they might say yes today, you go back tomorrow and they have changed their minds and you have to start all over again (Redican 2010).

Similarly, Doreen Arapai argues that Pacific health organisations understand the need to gradually build trusting and long-term relationships with Pacific communities and individuals. She has found that, from experience, they have become very wary of pilot schemes in particular:

If would be like a pilot, dangle the carrot, and the communities would think oh, this is good, oh yes, and they would come along and the funding would stop and the communities would lose interest, lose faith, because it’s a short-term thing. It wasn’t developed to be on-going so people could continue to go. I don’t know why they had pilots and things because, I mean … No, a bloomin’ waste of time some of them (Arapai 2010).

Yes, the thing is though when you work in the community you don’t set them up and then take things away because they will never trust you, you’ve lost them, it’s hard work to get them back on board (Arapai 2010).

The importance of service continuity was a theme in North Health’s 1997 report on the provider development workshops held for the Pacific Island Church Groups Information Project. The Niuean Group made the point most directly: ‘Please North Health, do not abandon us two years down the track’ (North Health 1997:31). Annual contracts, pilot projects and other short term engagements had the effect of eroding the good will and enthusiasm of providers.

Despite these often ‘stop-start’ arrangements, relationships between community groups and the Ministry of Health or other government funded health agencies developed and grew so that by the end of 2000 there were approximately 24 contracts for health promotion and health education activities held by Pacific churches and approximately 30 Pacific-owned health providers who typically also had active health promotion programmes (Wright and Hornblow 2008:29).

Conclusion

Pacific people migrated to New Zealand in increasing numbers from the 1940s. Most found it difficult to understand New Zealand’s health system which was more complex than that of most Pacific countries. Whereas in many islands one only had to walk along to the local clinic or hospital and wait one’s turn in the sociable waiting areas, in New Zealand there were several layers of care to understand, and gatekeepers, appointments, transport, fees and time off work to all be negotiated, very often in the foreign language of English. In addition, Pacific understandings of health and wellbeing did not always readily translate into Western biomedicine and vice versa. New Zealand’s clinicians and health politicians tended to see Pacific peoples and their health in terms of a series of ‘problems’ that did not fit within the one-size-fits-all system.

In this chapter we have shown the significant ways in which individual leaders recognised the needs of fellow Pacific people caught up in the hospital system or unaware of how to get primary health care, and the developments that resulted from their efforts. These leaders’ interest in health was often based on their own professional training but it was always complemented by a strong Pacific identity and a drive to overcome the health inequalities experienced by Pacific people who aspired to better lives and education for their children and struggled with an unfamiliar health system. Not until the 1990s did the momentum build for policy and practice more attuned to Pacific peoples and to ‘by Pacific, for Pacific’ services. The niches created by the health reforms of the 1990s, the interpreting services instigated following the Cartwright enquiry, work by North Health and the Ministry of Health, and many individual and group efforts, provided the grounds for these developments.
Chapter Six

A window on the struggle for health: Tuberculosis and Pacific peoples in New Zealand

Introduction

This chapter explores the historical experience of tuberculosis for Pacific peoples in New Zealand and is drawn from research carried out as part of our research group’s earlier project on the political ecology of this disease as well as our current project. In the post-World War two period, when our story of Pacific health in New Zealand opens with the arrival of Pacific peoples in significant numbers, the sphere of public health was dominated by the New Zealand Department of Health’s population-wide campaign against TB. Our use of TB as a window into Pacific health helps us better understand the relationships between Pacific peoples and the New Zealand health system over time and clearly illustrates themes that continue to resonate. These themes include: the recognition that new Pacific immigrants were a resident group who required specific initiatives within the health system; the need to balance that recognition and targeting against the potential for stigmatization; the difficulties of language, access to and understanding of the health system and its services; and the need to develop the Pacific health workforce and facilitate primary health services by and for Pacific peoples. This chapter shows the many difficulties Pacific settlers faced in achieving good health and access to health care in their new home. Correspondingly, it demonstrates that New Zealand’s health professionals and bureaucracy were tested by the need to recast an embedded public health strategy on tuberculosis to meet the changing ethnic profile of the disease. This focus on TB helps make visible the processes by which health experiences change over time.

When Pacific people appeared as a new group ‘at-risk’ for TB from the 1950s, New Zealand’s health authorities treated the problem first and foremost as an immigration issue and health checks were instituted for Pacific immigrants before they departed for New Zealand. However, Pacific immigration had an informal element to it that undermined these plans to some extent and, together with socioeconomic hardship and difficulties in accessing health services, TB among Pacific peoples continued as a difficult issue for the Health Department. Auckland TB physicians were quick to identify Pacific TB as a problem and some challenged the Health Department’s nationwide view that the rapid decline of TB meant the disease was no longer a significant public health issue.

Becoming established in New Zealand was a hard road for most Pacific immigrants and many experienced the social difficulties associated with TB of low pay, poor housing and especially overcrowding (see Chapter 2), despite their quest for ‘better lives’ (Southwick 2005). Pacific people had to learn how the New Zealand health system—primary and secondary—worked. Difficulties with language meant there were barriers to understanding services, treatments and public health messages (see Chapter 5). Health authorities were confronted by a new at-risk group that did not respond to the population-wide campaign against TB. Those authorities were slow to change that campaign to target Pacific people specifically. The medical profession assumed at this time that tuberculosis would soon be eradicated through early diagnosis, vaccination and drug treatment. However, the high risk of TB among New Zealand’s Pacific people showed that the social determinants of TB were still highly relevant, even in the era of drug treatment. A pattern of ethnically diverse TB rates became entrenched and the early goal of eradication was shown to be unrealistic. Since 1950, non-communicable diseases have become the most important health problem for New Zealand’s population. Notwithstanding this shift away from infectious disease, tuberculosis and other infectious diseases have persisted as significant health issues for the country’s Pacific peoples and infectious diseases still accounted for a high proportion of hospitalisations into the 2000s (see Chapter 3).

The mass anti-tuberculosis campaign

New Zealand’s mass anti-tuberculosis campaign was initiated in 1942 and paralleled campaigns in countries such as Australia, Canada, England and the USA. It was motivated first by the promise of early diagnosis through mobile mass miniature X-ray and active protection of at-risk groups through Bacillus Calmette-Guerin (BCG) vaccination and, subsequently from the 1950s, by the availability of effective drug treatment. New Zealand’s first mass X-ray unit was established in Taranaki in 1946, and a nationwide fleet of units was progressively deployed from 1952. BCG vaccination was the preventive element of the campaign. It was introduced from 1948 for especially at-risk groups and from 1952 in a mass scheme aimed at all secondary school children. By the time BCG vaccination and mobile mass X-ray were truly up and running, they were complemented by effective drug treatment, which sent TB death rates and then incidence rates tumbling. The concept of a comprehensive and mass campaign in the 1940s reflected the extent to which TB was a
disease that threatened not just high-risk groups such as Māori but the entire population. However, the broad population-wide risk shifted more swiftly than expected with the result that, very quickly, a mass campaign was being conducted against a disease centred increasingly on just a small part of the population (Dunsford 2008). New Zealand’s Pacific peoples were one of the pivots in the changing profile of TB in New Zealand and the public health responses to it.

The 1948 Tuberculosis Act drew existing laws and regulations on tuberculosis into one piece of legislation. Notification of diagnosed or suspected new or relapsed cases was still required and health authorities had the power to require an infectious but uncooperative patient to undergo treatment. Notably, the new Act allowed the Health Department to insist on the provision of consistent standards of TB treatment, control and inpatient accommodation by hospital boards throughout New Zealand. Public hospital and sanatorium treatment and all outpatient clinical services and drug therapy for TB were provided free of charge to New Zealand residents. Some practical help was granted to TB patients through the Act but benefit payments were provided through the broader social security system. The 1948 Tuberculosis Act has continued as the basis of TB control, although amendments and regulations since 1948 have taken into account the changing incidence of TB within the New Zealand population and new developments in clinical treatment and thinking about prevention (Dunsford 2008, New Zealand Government 2009).

The extent to which immigrants and visitors from countries with high TB rates were screened for TB before entry to New Zealand has been adjusted from time to time, and this has been driven by ongoing tension about TB in non-residents and recent immigrants. Recent immigrants (i.e., permanent residents, those on work visas) with TB might be regarded by some as expensive and unsuitable citizens (Littleton et al. 2010) but they are entitled to receive treatment free of charge. A more difficult problem that has persisted among the Pacific communities in New Zealand has been that those without official resident status (visitors or ‘ overstayers’) may have preferred to avoid diagnosis than face expensive treatment or the possible attention of immigration officials. The problem of requiring payment from non-residents for treatment was an issue in the 1970s and subsequently. The importance of treating TB can be seen, however, in the pattern of health authorities providing treatment and then attempting (often unsuccessfully) to recover the fees afterwards (see later in this chapter for debate over hospital boards treating non-resident patients for TB). If, however, any person, regardless of residency status, is required under Section 9 of the Tuberculosis Act 1948 to undergo treatment, such treatment is free to the patient.

The independent New Zealand Guidelines Group was set up in 1996 to provide expertise and evidence-based guidance on the prevention and treatment of medical and health conditions of concern to New Zealand. Funded by the Ministry of Health, the Group produced Tuberculosis Guidelines in 1996, subsequently updated in 2003 and 2010. The guidelines give prominence to the continuing principle that TB treatment is free of charge to all New Zealand residents (New Zealand Government 2009, Ministry of Health 2002), however a potential TB diagnosis continues to pose considerable problems of payment and possible deportation for people with uncertain immigration or visitor status (Hay 2009, Miller 2007).

Pacific TB—a problem of public health or immigration?

Pacific Island people arrived in New Zealand eager to take advantage of the work and educational opportunities offered by a larger, more developed economy. They were welcomed by New Zealand’s employers as a solution to the country’s unskilled and semi-skilled labour shortage and the number of people in New Zealand of Pacific Island origin or descent rose from 2,159 in 1945 to 65,694 in 1976 (Boyd 1993) (and see Chapter 2). New Zealand’s health statistics show that tuberculosis rates for both European and Māori populations decreased steadily after World War II, spurred on by the extension of antibiotic therapy (Figure 6.1). In spite of this decline, mortality and morbidity rates of tuberculosis in 1965 were still approximately ten times higher among Māori than non-Māori (Donovan 1969). At this time there were no accurate figures published for Pacific peoples either in the island Pacific (where rates could be inaccurate for a variety of reasons, see Futter-Puati 2010 and Resture 2010) or in New Zealand where the national figures were blurred by the grouping of all non-European ethnicities into one group.

The nationwide anti-tuberculosis campaign was the primary public health campaign in the 1950s and 1960s and formal medical examination requirements for immigrants including checks for TB were instigated in the early 1950s. Prospective Pacific immigrants were required to provide a clear X-ray before they could depart for New Zealand. At that time the Cook Islands, Tokelau and Niue were New Zealand territories, Western Samoa (now Samoa) was a New Zealand protectorate and Fiji and Tonga were protectorates of Britain. These differing statuses had implications for migrants. Cook Islanders and Niueans, for example, were not technically immigrating to New Zealand but the colonial administrators in those islands accepted that a medical examination to exclude TB needed to be part of the pre-departure process. Many Pacific arrivals were not long-term immigrants but short term arrivals who ended up staying in New Zealand permanently. The Pacific immigration process had elements of fluidity, with some people passing through the medical checks but not others. From the
1950s, there was anecdotal and local statistical evidence of higher rates of TB among Pacific peoples in New Zealand. Auckland, as the country’s main reception port, confronted the issue. The city’s TB physicians identified recent Pacific arrivals with TB as a problem and inconsistent screening of immigrants before departure as the cause. Over the next 20 years, some Auckland clinicians and hospital board politicians lobbied for more rigorous TB checks. They acknowledged the socioeconomic factors in Pacific TB, but saw the solution as regulating immigration in the first instance.

In contrast, the Health Department did not at first regard increased immigrant screening as the answer and were mostly happy with the procedures already in place. In 1955, in response to the Auckland Hospital Board’s lobbying, Health Department Deputy Director-General Dr Harold Turbott suggested that the length of time many Pacific TB patients had been in the country indicated they had not arrived with the disease but had developed it since arrival. Later that year when 17 Pacific people (from Niue, Samoa, the Cook Islands and Fiji) who had TB were under discussion, it was shown over a third of those cases would probably have developed TB disease after their arrival in New Zealand. In 1960, the Health Department reassured the Auckland Hospital Board that just two Pacific Island TB cases had been notified within two years of arrival in New Zealand. The Department of Health believed that pre-immigration medical checks were sufficient but checked they were being carried out as prescribed nevertheless.

The marked decline in TB deaths and notifications, coupled with the rhetoric of eradication accompanying the public health campaign, meant that for the general public the disease lost much of its significance and associated stigma. However, in 1965, there was an increase in Auckland TB notifications and the New Zealand Herald reported TB was "still a big health problem". Of the 310 Auckland cases in 1965, 118 were Māori or Cook Islands people. The increase was attributed to better case-finding through the mass X-ray campaign, and an increase in the New Zealand Pacific population who were described as “susceptible to tuberculosis”. Although the nationwide trend was of declining TB incidence, notification spikes such as the one in Auckland undermined TB physicians’ confidence that they had the disease under control. In response, the Health Department instituted a new centralised case index system in 1968. In 1971, the race categories for TB were enlarged to include Māori, European, Islander and Other and questions about country of birth and length of residence in New Zealand were asked. The Director-General of Health recognised the complexity of the health problems of many ‘urban Polynesian’ people and the potential impacts on the population as a whole, as in the case of TB.

It was becoming clear that Pacific peoples in New Zealand experienced high rates of active tuberculosis and, in 1972, the issue was debated by Auckland’s TB physicians and in the New Zealand Medical Journal, and occasionally reached the mainstream press. The Health Department was aware of alarm in March 1972 over “florid pulmonary TB in recent arrivals” from Samoa. Such advanced cases were at odds with the supposed medical screening undertaken in the islands.

Figure 6.1  New Notifications of TB in New Zealand 1943-2009 (Dunsford 2008)
In debates replicated with other ethnic groups in earlier years (Littleton et al. 2010), the issue of tuberculosis and immigration became a source of contention with Pacific Islanders at the centre. In 1972, A. R. Kerr, Secretary of the Thoracic Society wrote to the editor of the New Zealand Medical Journal about their concern with the high incidence of active tuberculosis among recently arrived Pacific Island immigrants. He included in his letter the following from Dr Ryan, the tuberculosis officer for the Auckland Hospital Board:

The arrival of active cases of tuberculosis from overseas constitutes a public health hazard and represents a financial burden to the New Zealand taxpayer. To date this year (1972) 100 cases of active tuberculosis have been diagnosed in the Auckland Health district and of these 37 are Pacific Islanders. The fact that many of these people enter New Zealand on a temporary work permit without any medical examination or chest x-ray seems altogether wrong. I understand from the Immigration department that some 2,000 Samoans enter each year on this basis. Many of these out-stay the limit of their temporary permits and it is from this group of people that our major problems arise as regards the control of tuberculosis in the community. When a case of active tuberculosis is diagnosed the hospital board has the right to charge for any period of hospitalisation. The majority of these patients are, of course, unable to meet such financial commitments and the Auckland Hospital Board writes off the bulk of these claims without settlement. Many individual cases can be cited and I would recommend that if tuberculosis is to be controlled in the community these temporary visitors be thoroughly checked either immediately before leaving the Islands or on arrival in New Zealand... Based on the 1966 census the Māori and Pacific Islander population groups combined represent just over 9 percent of the total population in the Auckland Health Board District. Thus from the preceding figures it is seen that this 9 percent of the population is responsible for 53 percent of the total disease incidence in our area, and the same group claims more than 75 percent of the cases under 15 years of age... Over the years 1969, 1970 and 1971, 34 percent of the Māori and Pacific Islanders listed were from the Pacific Islands. The proportion of Pacific Islanders arriving in this country seems to have increased sharply and this year they represent 37 percent of all new cases of tuberculosis in the Auckland Health District which of course is only one of three Health Districts for which the Auckland Hospital Board is responsible.

In summary, if tuberculosis is to be controlled in our community I consider that the people arriving from relatively high incidence areas should be checked medically much more thoroughly than is done at present and that the medical examination must be compulsory and include a radiological examination of the chest with interpretation of the x-ray film by a qualified radiologist or chest physical of acceptable qualifications.” (Ryan quoted in Kerr 1972: 295).

Two months later, a response was published from J.B. Mackay in Wellington demonstrating the difficulty of disentangling issues of immigration and TB. He writes:

In the first place I am not convinced that there is a high incidence of tuberculosis in recently arrived Pacific Islanders; certainly in Wellington there is no evidence of this at the present time...

Of the 18 Pacific Islanders notified in the Wellington Health District in the last two years, six were born in New Zealand and all but three of the remainder have lived in New Zealand for more than four years. All three who had lived in New Zealand for less than four years had been x-rayed before leaving the Islands.

Dr Ryan gives figures for the Auckland Health District and of the 100 notifications this year; 37 are Pacific Islanders, but we know that 15 of these were born in New Zealand and a further 13 have lived in New Zealand for more than four years.

During 1970 and 1971, 28 immigrants to New Zealand were discovered to have tuberculosis within one year of arrival, but only six of these were immigrants from the Pacific Islands.

I do not know if there is a high incidence of tuberculosis in the Islands or if there are in fact any reliable figures to support this suggestion, but I am aware that there is a high incidence of tuberculosis in the Polynesian within New Zealand, whether Islander or Māori. It is my impression that the majority of Pacific Islanders acquire the disease in New Zealand.

While not decrying the value of chest x-rays many of the Pacific Islanders I see have had chest x-rays before leaving to come to New Zealand, and I do not think this is the answer to the problem of tuberculosis among Polynesians in New Zealand. It has been my contention for many years that the best method of prevention would be to BCG vaccinate all Polynesians both here and in the Islands. Vaccination could be offered to all Polynesian children soon after birth and again at the age of five when they first attend primary school. Surely this is the policy the Thoracic Society should be advocating to the Government, to the Department of Health, and to the Polynesians.

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Box 6.1  ‘Immigrant’ TB in New Zealand Medical Journal in the 1970s

In debates replicated with other ethnic groups in earlier years (Littleton et al. 2010), the issue of tuberculosis and immigration became a source of contention with Pacific Islanders at the centre. In 1972, A. R. Kerr, Secretary of the Thoracic Society wrote to the editor of the New Zealand Medical Journal about their concern with the high incidence of active tuberculosis among recently arrived Pacific Island immigrants. He included in his letter the following from Dr Ryan, the tuberculosis officer for the Auckland Hospital Board:

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pre-departure. There was also the problem of short-term Pacific Island visitors and visits home by New Zealand-resident Pacific people, neither of whom underwent any medical testing. Some in the TB field suspected that existing TB checks in the islands were ineffective and proposed a series of compulsory chest X-rays—before departure, on arrival and three months after arrival.\textsuperscript{13} Green Lane Hospital chest specialist Dr James Ryan added to the debate by stating that many TB cases (37 in particular) originated in the Pacific Islands. Assistant Director of the Division of Public Health Dr C M Collins protested that, of the 37 Pacific Island cases, 15 had been born in New Zealand, 13 had been resident for between four and 20 years, one for between one and two years, and eight for less than one year. Collins allowed there was a problem of TB among Pacific Island people but rejected the simplistic solution of tightening up on new immigrants.\textsuperscript{14} Dr John Mackay of the Wellington Hospital Chest Department confirmed in more detail the greater likelihood of Pacific Islanders acquiring TB disease in New Zealand in 1972. The correspondence around this issue in the \textit{New Zealand Medical Journal} (see Box 6.1) highlights the transnational complexity of Pacific TB in Auckland in the 1970s. This was more than a problem of immigration and there were conflicting views over the right solution.

Early in 1973, the Auckland Hospital Board proposed a general rule to prevent immigrants with TB arriving in New Zealand; all intending permanent migrants to New Zealand would need to have a prior medical examination and X-ray. However, the Board also argued that the Pacific Islands were a special case and, instead of following the general rule, \textit{all Pacific arrivals, whether a visitor, temporary or permanent migrant,} should have to produce a chest X-ray to a Health Department Inspector on arrival in New Zealand.\textsuperscript{15} The Health Department’s view of the problem and the best policies seemed in some flux at this time. On one hand, it took the nationwide perspective that TB rates were declining and did not recommend blanket screening of all Pacific arrivals. On the other hand, the Department’s 1973 report focused on the problem of the border and identified the lack of immigration control over Pacific Island people who arrived in New Zealand on three-month visitor permits as a factor in the TB increase.\textsuperscript{16} Proposed medical examination requirements that included these short term visitors, and even \textit{all} visitors from the Pacific Islands, became the axis of debate over the next decade and the Health Department seemed to shift its stance on TB checks for Pacific immigrants. When a further increase in TB notifications occurred in 1975, a Tuberculosis Advisory Committee (TAC), made up of TB specialists from across the country, was formed to advise the Health Department on how to deal with the problem (Dow 1995).\textsuperscript{17}

A study at this time further confirmed the confusion of statistics as far as Pacific peoples were concerned. Swinburn (1973) analysed the ethnicity of 470 TB admissions to Green Lane hospital from 1967 to 1971 (see Table 6.1). Swinburn found a lower proportion of Pacific Islanders among the tuberculosis cases in Auckland than cited by Ryan for 1972 (see Box 6.1: 15.5 percent compared to 37 percent) and a lower percentage in relation to Māori (28.2 percent of all Māori and Pacific Islanders versus 34 percent in Ryan). Neither place of birth for those affected nor their length of residence in Auckland was indicated in Swinburn’s figures. Nevertheless, Pacific Islanders and Māori were more than six times as likely as Europeans to have tuberculosis. What was also notable (although the statistical significance cannot be assessed) was that Polynesians (i.e., Pacific and Māori) predominated among the young TB admissions. These youthful admissions indicated active, intergenerational transmission within New Zealand; young children are unable to pass TB on to one another. Swinburn explained these different patterns with reference to a notion of epidemiological transition, noting that the age and gender patterns of Pacific peoples with tuberculosis in Auckland was comparable to European patterns 50 years earlier, with Māori occupying an intermediate position. A later survey of Green Lane Hospital admissions (1980-82) by Brett et al. (1986) showed that Pacific people comprised a higher proportion of the patients, against declines in the percentage of European and Māori patients and an increase in the ‘Other’ group (comprising refugees and migrants from non-European/non-Pacific regions). He also explored the relationship between length of

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% among admissions (n=470)</th>
<th>% among Auckland’s population (1971 Census = 698,400)</th>
<th>Relative risk (NB not age-standardized)</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>45.1 %</td>
<td>87.0 %</td>
<td>1.0</td>
</tr>
<tr>
<td>Māori</td>
<td>39.4 %</td>
<td>7.0 %</td>
<td>6.3 (5.6-6.9)</td>
</tr>
<tr>
<td>Islanders</td>
<td>15.5 %</td>
<td>4.0 %</td>
<td>5.8 (4.8-7.1)</td>
</tr>
</tbody>
</table>

Table 6.1 Ethnicity of 470 admissions to Green Lane Hospital, 1967-71 (Swinburn 1973) and relative risk of tuberculosis based on Auckland’s population 1971
residence in New Zealand and diagnosis of tuberculosis. While the majority of people in the ‘Other’ category had been resident in New Zealand for less than one year before a diagnosis of active TB disease, 83 percent of Pacific people with tuberculosis had been present for longer than one year with the median duration between arrival in New Zealand and the diagnosis of active disease calculated at eight years. This suggested significant reactivation of latent infection or transmission of new infection within New Zealand.

While in terms of the absolute numbers, Pacific Islanders comprised a greater proportion of cases, the overall incidence was declining rapidly from close to 300 per 100,000 in 1974 to 54.7 per 100,000 in 1983 among notifications in Auckland (Taylor et al. 1986). The difference between Pacific and European rates declined from approximately 30 times to seven times. The closing of the gap was not sustained. By 1985-90 (which covers the period of the smallest number of cases) the European rate had declined to 1.9 per 100 000, Māori to 9.3, Pacific Islander to 19.6 (10 times the European rate) and Other was 29.7 per 100 000 (Stehr-Green 1992). From 1995-99, the age standardised rate for Europeans was 2.65, Māori 23.55, Pacific people 51.8 and ‘Other’ 109.25 (Das, Baker and Calder 2006). Simply waiting for the wave of historical infection (Swinburn 1973) to ebb was not going to result in a New Zealand free from TB.

New Zealand was not the only country anxious about high rates of TB among immigrant populations and, in May 1975, the World Health Organization (WHO) addressed these concerns. WHO reassured host countries that, although immigrant workers arrived with the higher risk of TB of their country of origin, usually they did not pose a danger to the host population. The development of active TB disease was attributed to the difficult living conditions and their hard work in their new country. WHO recommended medical examinations and chest X-rays of immigrants before or on arrival, as well as further checks until immigrants were integrated into the health service of the host country. The WHO advice aligned with New Zealand’s moves towards stricter medical checks for Pacific peoples. In 1976, all Fijians, Tongans, Samoans and Cook Islanders over 12 years of age coming to New Zealand for more than two months, even on a temporary work permit, needed a clear chest X-ray and to be free of TB. Suspicious X-rays triggered recalls for follow-up X-rays at six and 12 months. However, New Zealand did not pick up on the second part of the WHO’s advice relating to ongoing health checks and active integration of Pacific immigrants into the health system (as shown in Chapter 5).

The system of requiring follow-up X-rays proved a nuisance for Auckland’s public health staff. X-rays often arrived well after a person’s arrival and contact addresses were out of date. X-rays were not required for visitors of less than two months although extensions to these permits were frequently granted and X-rays were supposed to be taken then. There were frustrations about name changes and the use of several names, changing home and work addresses, and the return to the islands of people before their X-ray was due, without advising the Department. A proportion of temporary workers remained illegally after their permits ended, becoming ‘ overstayers’, and they actively avoided contact with officials of any type. In 1977, Dr Gabrielle Collison, an Auckland Deputy Medical Officer of Health labelled the programme “a failure”. Four years later, the Public Health Team based in Takapuna (part of the Auckland region) judged that the programme’s substantial workload brought minimal result. There had been no cases of tuberculosis in Takapuna’s Samoan, Tokelauan, Tongan or Fijian communities in the 1980 year. Takapuna’s Dr M. R. Kellett recommended that immigrants from these four Pacific Island groups be followed up only if there were abnormalities at the time of entry. He thought it worth continuing to offer X-rays at six and 12 months after arrival to two higher-risk groups, Cook Island Māori and Indo-Asian refugees.

Health concerns were not the only influences on immigration procedures. New Zealand had followed international practice in 1978 by removing race as a determinant for immigration (Brawley 1993) and this led the Labour Department to protest the requirement for TB and leprosy clearance from South Pacific visitors and immigrants. The Labour Department objected that the checks were not only discriminatory, offensive to Island people and damaged New Zealand’s reputation, but also produced few cases of either TB or leprosy. The checks for leprosy were quickly removed but not those for TB. The Tuberculosis Advisory Committee reviewed the issue but, rather than advising a reduction in checks, it recommended they be extended to all visitors from the Pacific. This proposal by a group of tuberculosis physicians reflected their commitment to fighting the disease but was never likely to win broader acceptance. When hospital boards later advised the numbers of Pacific people in the country under two months who had been diagnosed with TB, the answers showed just seven in 1977 and 13 in 1978.

The Tuberculosis Advisory Committee stuck with its recommendation although it and the Health Department, who also supported the proposal, were fighting a losing battle. Both the Departments of Foreign Affairs and Labour (Immigration) pointed to the discriminatory nature of the policy and suggested tartly that the Health Department focus on reducing TB within the Pacific Islands rather than on preventing Pacific people with TB coming to New Zealand. In fact, the Committee already monitored Pacific TB rates and offered help, such as the use of MMR units after they were decommissioned in New Zealand. One such MMR unit in Apia probably contributed to the decline in TB in Western Samoa by late 1980, and
an MMR visit was suggested for Tonga. The Cook Islands Government especially resented the chest X-ray requirement, seeing it as an abuse of their New Zealand citizenship and, by 1979, had simply stopped carrying out the policy for chest X-rays before departure. At this time, TB rates in the Cook Islands were low and falling, having experienced a steep decline since the 1960s (Futter-Puati 2010). New Zealand eventually accepted the Cook Islands’ position and suggested sending an MMR unit, as well as help with training, laboratory testing and the doctor-exchange scheme. TAC’s recommendation that all visitors from the Pacific Islands be X-ray screened was not introduced, and the critique of the plan’s discrimination and logistical difficulties prevailed. In 1983, the Immigration Department lengthened the period of stay without requiring a pre-arrival chest X-ray for visitors from Fiji, Tonga and Samoa without reference to the Health Department. This effectively ended almost 30 years of concern over Pacific TB as a problem of immigration.

As much as the Health Department and Auckland TB physicians might have preferred otherwise, policies around the screening of immigrants with TB in the post-war years were not developed solely in response to public health needs but were influenced by immigration, labour and economic policies, trade and international relations. As TB incidence fell from the late 1970s, the Government prioritised immigration goals over the claims of TB specialists that TB from the Pacific Islands was a major public health threat. The emphasis by some in the medical profession on the need for more vigilant border control of at-risk groups also over-simplified the complexity of TB in immigrant groups which revolved around the combination of elevated exposure to TB they brought from their country of origin and the socioeconomic hardships and poor health care they experienced in New Zealand.

Medical research also emphasised the transnational links between New Zealand and the Pacific. Drug resistant TB was identified as a particular concern in the 1970s (MacKay 1978). MacKay, having identified drug resistance among TB strains in the Apia laboratory, Samoa, undertook a survey of selected New Zealand laboratories over a 30 month period identifying resistance in 39 samples including seven Pacific people, primarily Samoan. Karalus (1986) also identified among the Auckland notifications (1980-84) a high rate of isoniazid resistance among Western Samoans and this concern about treatment of tuberculosis within the Pacific continued throughout the 1990s (Cameron and Harrison 1997, Bradley et al. 1994) with calls for either more thorough screening (Harrison et al 1999) or for attention to be paid to conditions in the Pacific Islands. As Karalus wrote: “It is suggested that this problem may be best approached by providing assistance with the tuberculosis programme in the Pacific Islands themselves rather than by altering immigration procedures (Karuus 1988:49).”

Tackling the problem of Pacific and Māori tuberculosis

Auckland experienced a dynamic period of population growth and change from the 1950s as it absorbed new arrivals from the Pacific and elsewhere, Māori from rural New Zealand and as many babies were born. As a whole, Auckland followed the nationwide decrease in new TB cases but it did so to a lesser extent than the rest of the country.

Over time Auckland accounted for a mounting proportion of New Zealand’s TB cases (from 29 percent in 1966 to 38.4 percent in 1979) and Pacific cases played an important part in this. The same year, there were 66 Pacific cases (or 32 percent of the Auckland total) and 31 of these were under 15 years of age. The combined trend of high numbers of Pacific and Māori TB cases, many of whom were children, was reflected in the number of Pacific and Māori children with TB in Auckland’s hospitals. A second children’s TB ward at Auckland Hospital was re-opened in 1959 in direct response to the need to admit Pacific and Māori cases. At a time when most TB patients were treated as outpatients from an early stage, Auckland paediatricians felt some children needed a long stay in hospital to ensure they received treatment correctly. The Auckland Hospital Board established a convalescent hospital for children at Birkenhead, especially for long stay non-infectious TB cases. This hostel accommodation was required for social rather than medical reasons and was viewed as part of a new potentially permanent pattern of TB control. However, by 1969, hostel accommodation was regarded less favourably and greater home support for Pacific and Māori families was instigated.

Nationally, the decline in New Zealand’s TB rate meant fewer New Zealand children and youth were being seriously exposed to TB infection and did not develop the disease, although Māori children’s rates remained elevated in comparison to European children. National tuberculin testing between 1955 and 1958 had shown a steady decrease in positive reactions for the 0 to 14 age group. Yet some Pacific families had large numbers of people very sick with TB and required intensive domiciliary help. In 1969 Auckland Hospital asked for a public health nurse to visit a Niue Island family at home twice daily. The family’s five children, aged from four months to five years, had been in hospital with TB and domiciliary help would be required to administer streptomycin and oral medication twice a day at home. The alternative was that the children would remain in hospital to ensure treatment.

Auckland’s TB physicians were aware of the social and economic factors impacting on Pacific and Māori TB rates and they understood the difficulties encountered by new settlers. In 1959 Dr T.G. Fox identified the poor and overcrowded housing of many families. However, the problems tended to be viewed in terms of the difficulties they presented to management within the health
system. Families were said to change address often and were hard to follow up; names were changed and the spelling varied; parents were seen to have a “nonchalant attitude to the disease”; language difficulties led to a high appointment failure rate.39

In 1960, medical statistician R. J. Rose’s report, *Māori-European Standards of Health*, revealed the depth and breadth of the disparity in Māori and European health status, although the bi-cultural comparison did not adequately reflect the complexity of Auckland’s developing ethnic mix. A conference of Medical Officers of Health met to discuss Rose’s findings in October 1960. The briefing paper on the Auckland situation saw Māori health problems in the city as synonymous with low socioeconomic and/or immigrant status. The anonymous writer emphasised social deprivation as the common denominator of poor health and stated that, in Auckland, the deprived group was not only Māori but consisted “largely of Māori and Polynesian people but included Indians, Asians and to some extent European sections”.40 The Health Department was aware of the links between housing, immigration, urbanisation, and health and social issues. Some insight into their thinking on access to health services by Māori and presumably also Pacific peoples is shown in Director of the Division of Public Health Dr Gordon Dempster’s optimism in 1965 that the move to the city would eventually lead to better health because a fuller range of treatments and services would be accessible. The reality of the difficulties of accessing health services by Pacific peoples are discussed later in this chapter. The Health Department did make efforts to improve their staff’s engagement with Pacific Island cultures. For example, nurses attended a seminar on Polynesian families in 1967.41

In those regions with high numbers of Pacific and Māori people and high rates of TB, local Health Department staff used their discretion to extend BCG vaccination policy. From the 1960s, the Lower Hutt office held TB clinics in certain suburbs and advised Māori mothers to vaccinate their babies.42 Auckland’s public health nurses held special BCG clinics and increased tuberculin-testing in some suburbs with a high proportion of Pacific and Māori people. They tried to remove barriers to BCG vaccination for Pacific and Māori TB contacts by giving the Heaf test (a skin test for contact with TB) in the home and holding special BCG vaccination clinics locally. By comparison, other TB contacts were referred to the central Auckland office for test and vaccination.43 One who actively took up the discretion allowed for at-risk groups was child health researcher and departmental medical officer Dr Shirley Tonkin who consistently offered BCG vaccinations to Māori and Pacific Island newborns at National Women’s Hospital in the 1960s (Tonkin 2006). In 1966, staff at the Health Department Auckland office and Auckland Hospital Board recommended that BCG be offered to all Māori and Pacific infants born at National Women’s and St Helens Hospitals but nothing eventuated at that time.44

Some professional groups, like The Paediatric Society of New Zealand and the 1964 Conference of Chest Physicians, urged the Health Department to introduce routine vaccination of all Pacific and Māori babies or adults.45 The Director-General of Health conferred with the Māori Health Committee, who rejected the proposal to vaccinate all Māori babies.46 This rejection fitted with the dislike Māori had shown previously for being singled out for health reasons, especially TB.47 Both Māori leadership and the Health Department were highly aware of the potential for stigma from emphasising negative Māori health statistics and this awareness was carried through to Pacific health statistics. The vaccination of Pacific and Māori babies continued at the discretion of each health district.

Routine BCG vaccination of all Pacific and Māori infants was eventually introduced to Auckland’s obstetric hospitals in 1976. This policy occurred on the back of a rise of 78 new TB notifications in the Auckland and South Auckland health districts in 1972. Of these, 35 cases were under 10 years old, well below the BCG screening net of the secondary school programme. It seemed clear that another strategy was required to stop Māori and Pacific children developing TB, and the routine vaccination of Māori and Pacific newborns looked likely to happen. However, a meeting of Auckland chest physicians and paediatricians made their support conditional on an additional suite of policies that addressed what they saw as the larger problem of Pacific and Māori TB. They suggested additional measures of compulsory X-ray of immigrants coming from high risk TB areas and compulsory mass X-ray of the entire population. The Health Department believed these extra policy demands were logistically and politically unworkable and let the whole matter rest.48 The viewpoints evident here demonstrate the frustration that existed in Auckland as Pacific and Māori TB rates confounded the falling rates in the majority of the New Zealand population.

It was not until 1976 that the Health Department decided that Auckland’s Māori and Pacific Island children as a whole constituted an at-risk group and began to offer BCG to all ‘Polynesian’ newborns in St Helens, Auckland and National Women’s Hospitals on a voluntary basis.49 The policy was instituted at National Women’s Hospital on 1 July 1976 and 1282 vaccinations were given in the first six months. There were five ‘abnormal’ reactions but none required anti-tuberculosis therapy.50

The high rates of Pacific and Māori TB influenced the operation of the secondary schools BCG programme also. This scheme started in 1952 and was progressively terminated over 30 years on a district by district basis.51 In 1964, as the scheme ceased in the South Island, it was still regarded by Auckland TB Officer, Dr Herbert
King, as a vital part of TB prevention in the city for the high risk Pacific and Māori group. The Auckland and South Auckland districts still found TB cases through the secondary school tuberculin-testing and vaccination programme and outbreaks occurred in other places. The BCG secondary schools scheme continued on the basis of the overall TB rates within each district, rather than targeting high-risk groups within a district. To restrict vaccination to schools within a district with large populations of Māori and Pacific students would have been too stigmatising. After the secondary school BCG scheme ended in the early 1980s, BCG remained as a discretionary option for district medical officers of health to use in secondary schools. It signalled a final shift to a TB policy based on at-risk groups which included TB contacts, Māori, young and recent Pacific migrants and South East Asian refugees (Dunsford 2008).

The TB patient and the health system

As already discussed in Chapter 5, to the newcomer, New Zealand’s system of hospital and specialist treatment could be confusing and disjointed. The system of TB clinics and wards at Auckland was a prime example. In the 1950s and 1960s, the suburban Green Lane Hospital was the main chest hospital, with wards and outpatient clinics for TB patients. However, there were at times TB wards at the central Auckland Hospital and the children’s TB ward was at Queen Mary Hospital on the Auckland site.

The children’s outpatient clinic was not run from either hospital but from the Health Department’s Marinoto clinic in central Auckland although the drugs associated with those visits were dispensed separately and monthly from Green Lane or Auckland Hospitals. This meant that parents of child patients needed to attend Marinoto for clinic appointments but then travel across town monthly to collect the child’s medication. The logistical difficulties this created for some Pacific and Māori parents was evident in the drugs left uncollected. The Auckland Hospital Board, together with the Health Department, actively tried to solve these types of problems. After discussion, drugs for children were dispensed from Marinoto.

Nurses became increasingly involved in delivering and administering drugs to patients. In 1965, the difficulties public health nurses sometimes encountered when dealing with Pacific TB patients were under discussion. These revolved around getting the cooperation of patients and contacts for X-ray and vaccination. It was decided that a male social worker or tuberculosis field officer would ‘have natural advantages in demanding the correct action’ from those being uncooperative. A Samoan man, who had trained as a doctor in Fiji but could not practise because he did not qualify for New Zealand medical registration, was identified to take on the role. Tuberculosis in particular required a long period of treatment which created compliance problems for both individuals and health professionals.

Pacific perspectives on tuberculosis

The New Zealand public’s awareness of tuberculosis declined swiftly in tandem with the reduction in general TB rates from the 1950s. The effectiveness of drug treatment meant far fewer people had direct family experience of the disease and medical confidence about treatment was widely disseminated and eliminated much of the fear that had accompanied TB in the past. Just how rapidly this occurred can be seen in New Zealand trainee doctor Eru Pomare’s (1965:1) account of contracting tuberculosis as a secondary school pupil around 1960:

The seriousness of this once killing disease was made to seem insignificant by the casualness, confidence, and assurance, with which my medical advisors handled my case. I can remember my friends asking me what this strange disease was, that I had, but I’m ashamed to say I was just as ignorant as they. That it was an infection of sorts and that the BCG vaccinations given us four years previously at school should have given lasting immunity to this disease, I could forward no further information, on this seemingly little discussed and unimportant disease.

As has been shown, many Pacific people in New Zealand were only partially engaged with the health system and would have been unaware of medical developments around tuberculosis in the post-war decades. Their prior experience of TB in the islands was likely to have been shaped by feelings of uncertainty and stigma. Cook Islander Dr Tom Davis described the limited understanding of Western medicine in his homeland after his return from Otago University Medical School in 1946 (Davis and Davis 1955). Lita Foliaki was aware of tuberculosis during her childhood in Tonga (her father was a GP there). Foliaki said that she remembered TB as a shameful thing to have:

[TB patients] were quarantined in a special building in the hospital and the homes were quarantined and they had yellow flags put in the homes to identify that this place had TB.

[In Auckland also] there was a lot of shame attached to somebody having TB. Like if a boy had TB his prospects of getting a girlfriend were dramatically affected. I think the fear that it led to death, whether it did or not, but that’s the kind of impression…(Foliaki 2010).

Foliaki’s view was that many Pacific people still fear someone with tuberculosis today. She recalled someone who in recent years visited a family member in hospital and was:
…in the room before it kind of really dawned on her [that the patient had TB]. And so she talked about how she was caught in the situation where she did not want to portray to the family member that she did not want to see her because of what she had but, at the same time, she was stuck and she felt really bad if she did turn around and go. But she said, if she had recognised a bit earlier before she actually got to the room and if the family member wouldn’t have known that she turned away, then she would turn away (Foliaki 2010).

Chapter 5 discussed Pacific peoples’ layered conceptions of health, with social and spiritual causes of illness often dominating bio-medical knowledge about bacterial origins of disease and the available treatments (see also, Capstick et al. 2009). Three recent New Zealand studies support Foliaki’s view and show how Pacific peoples in New Zealand often regard TB as a morally shameful disease and draw on cultural perceptions and past fears about its contagion and incurability (van der Oest et al. 2005, Ng Shiu et al. 2008, Hill and Calder 2000).

The mass anti-TB campaign and its impact on Pacific people

An intrinsic part of New Zealand’s post-war anti-tuberculosis campaign was the public health message that all New Zealand adults should protect their chest health by presenting for regular chest X-rays. The health promotion activities associated with the mobile mass X-ray units were based on a view of TB risk that encompassed the entire population and were apt in 1952. Just a decade later, however, at-risk groups accounted for a significantly larger proportion of those with TB, yet it took time for those same groups to be specially targeted in health promotion terms. The 1964 mass X-ray campaign in Auckland is an example. The established pattern of a whole-population message took precedence over the developing understanding that certain at-risk groups needed to be closely targeted.

The 1964 Auckland campaign was initiated because of Auckland’s high incidence of cases. Tuberculosis was the city’s most common infectious disease, with a rate of 13 Māori and Pacific Island cases to every one European and high rates for young people and children. The campaigners had hoped to get a good response from Pacific and Māori, although neither group was targeted specifically. The thinking behind this non-targeted strategy was that services should be offered without discrimination. However, when the low turnout from the Pacific and Māori communities was considered after the event, Dr Harold Turbott, a longtime researcher into Māori health, summed up the campaign as “an excellent example of what will inevitably happen unless you seek the closest co-operation of the people in touch with these communities”.

The disappointment of this campaign led the Health Department to actively approach the Department of Māori Affairs in an effort to improve future health promotion efforts. It was suggested that TB health education and screening be channelled through the Polynesian Federation and church leaders, and attempts were made to engage more with both groups. An X-ray unit was positioned outside a Ponsonby church at the same time as immunisation clinics were held during 1966, and the Health Department introduced some Pacific Island language brochures in the 1970s. These were clearly useful but, as straight translations of existing brochures, they lacked specific traditional and cultural references to Pacific understanding of TB, its causes and curability. It seems that New Zealand’s TB education efforts from the 1950s to the 1970s made little impact on the country’s new Pacific Island population. Its anti-TB propaganda was formulated in the 1940s with a largely homogeneous message to a population familiar with, and increasingly confident of, modern bio-medical success.

Tuberculosis in the 1980s and 1990s

Tuberculosis was relegated to the back seat in public health terms during the 1980s and 1990s. Other infectious diseases, such as AIDS (declared notifiable in 1984), Hepatitis B and the Group B Meningococcal epidemic assumed greater public health significance. By the 1980s, TB rates were settled at low levels and, as late as 1983, the Health Department stated in its Annual Report that the disease could be eradicated by 2000. As Figure 6.2 indicates, this has not happened. Although the total rate has tended to remain steady, the significantly higher rates among Pacific peoples relative to Māori and European have persisted.

Auckland’s ongoing difficulties with TB management were still visible as late as 1980, in disagreements between local chest physicians and the Health Department’s Head Office. The conflict still centred on Auckland chest physicians’ view that the Department did not fully appreciate the issues they faced managing TB in Auckland’s Pacific population. This tension can be seen in 1979 and 1980. The Health Department set out to simplify the management of TB - a disease in decline throughout New Zealand and the developed world - and instructed hospital boards to stop dispensing TB drugs to outpatients from hospital pharmacies. Instead patients were to collect them from retail pharmacies. The senior medical staff of Green Lane Hospital’s chest medical unit objected to this change, primarily on the basis that outpatients would “frequently fail to collect their drugs from retail pharmacies and we will be totally unaware of this failure”. They stated that this problem related “particularly but not exclusively [to] Polynesians” and foresaw problems of incorrect dosages leading to longer than necessary treatment, the risk of drug resistant strains developing, and the need to treat more patients in
hospital rather than at home. Health Minister George Gair urged the Auckland Hospital Board to follow the policy in the same way as other boards, which had not reported the problems the Aucklanders were predicting, while also offering a compromise of restricting the hospital pharmacy supply of drugs to those TB patients “likely to have a history of non-compliance with medication”. Green Lane Hospital Chest Physician, Dr James Ryan, thought this impractical since Auckland’s TB patients were 60-65 percent Polynesian and a further 20 percent were problem drinkers—both groups apparently regarded as unreliable. His view hints at the extent to which Auckland’s TB services were failing to meet the needs of Pacific patients. In spite of Auckland’s objections, the policy of retail supply of TB drugs went ahead. The problems faced by Auckland can

Figure 6.2  Averaged rate of tuberculosis incidence per 100,000 of the population, 1990-2006 based on data from ESR and the census data for 1991-2006 (not age-standardised)

Figure 6.3  Tuberculosis cases by ethnicity for 1989-94 and 1997-2000 based on data from ESR
be inferred from Figure 6.3 which documents nationally the ethnic breakdown of TB cases per year. Pacific peoples comprised a significant and steady proportion of all cases (only European cases show any sustained decline) and, given the high numbers of Pacific people and non-Māori/non-European people in Auckland (the largest percentage of cases by the end of the 1990s), the difficulties peculiar to Auckland are apparent.

As New Zealand’s overall TB rates continued to decline, a full review of the Auckland Area Health Board’s TB programme was instigated in 1989. The recommendations reflected the need to fine tune policy for the conflicting TB profiles within Auckland’s population, and the working party stated that immigration from the Pacific Islands and South East Asia was slowing the decline in TB incidence in the city. Nevertheless, the low overall TB incidence shaped changes in strategy. The working party returned to the basics of the pre-drug era, calling contact tracing and early case finding “the mainstay of tuberculosis prevention and control”.

Mobile mass X-ray and BCG vaccination, the major elements of the anti-TB campaign for over 30 years, were no longer important parts of the solution. The one remaining mobile X-ray caravan was deemed an ineffective use of resources and ceased operation. The BCG secondary schools programme had ended in 1983 but the working party suggested that tuberculin testing in schools continue to ensure any surge in incidence was quickly identified. It was also agreed that the need for routine BCG vaccination of Pacific and Māori infants had passed but that babies in families of untreated immigrant tuberculin reactors should be given BCG.

The ongoing problem of TB in Auckland was reflected in the creation of the position of tuberculosis coordinator. Green Lane Respiratory Manager and physician Dr Harry Rea was appointed.

During the 1990s it again became apparent that dealing with Pacific TB in New Zealand was not just a case of waiting for the declining wave of infectivity to work its way through. During this decade, Pacific TB existed in an environment of rising rates of non-communicable diseases and poor socioeconomic conditions and some increase in cases was evident. Given the relatively small numbers of TB cases from the 1980s onwards, the shifts in TB are better observed by looking at raw numbers of cases rather than population rates. Computerised case records were introduced from 1989 although, as Figure 6.4 shows, change to the way ethnicity was recorded makes the data discontinuous. Across the entire period from 1989 to 1996 there was a small decrease in the number of cases per year, however, this seeming decline was offset by peaks (1995, 1998-9) representing outbreaks where TB was transmitted beyond the household. These outbreaks made it clear that TB was a problem associated with life in New Zealand, not simply with immigration.

These outbreaks have been described in a series of papers which document the interaction of poor socio-
economic conditions, inter-household movement, uncertain migration status, and various institutions (school, church, prison) with the TB bacillus. In 1997-8 an outbreak of TB was identified centring upon a South Auckland school. In all, 12 children and adolescents were involved: nine from the school and three younger children in one of the households (Calder et al. 2000). Many of those involved were from Pacific families and the majority (including the suspected index case) were born in New Zealand pointing to the significance of local living conditions. The authors point to the impact of distressing publicity and stigmatising attitudes both within and outside the community on successful contact tracing and diagnosis.

Hill and Calder (2000) reported on a 1999 TB outbreak in a Pacific Island church group in Auckland. The culture positive index case was a 13 year-old and contact tracing was performed in 160 contacts. Five months after the index case was reported, a 32 year old woman with smear and culture positive pulmonary TB was noted as the source case. From the contact tracing, 27 people were diagnosed with TBD and 57 with LTBI. Most of the TBD cases were household or church contacts and they were also mostly young children. The source case was a long-standing member of the church and in regular contact with the children of the church community.

Hill and Calder (2000) noted that a major issue in the delay between identifying the index case and the source case was denial and stigma surrounding the disease within the community. In addition, members of the community feared repercussions from identifying their contacts and this also led to a delay in screening and identifying the source case. The increase of transmission to church contacts compared to school contacts highlights the importance of church and community within the Pacific island community, a cultural context that needs to be considered when doing contact tracing and transmission investigation. Hill and Calder noted that, although most TB transmission occurs with sustained contact and crowding, transmission after brief and casual contact has been noted.

De Zoysa and Shoemack (2001) described the contact tracing and patient characteristics of a TB outbreak that occurred in several North Island health regions between 1996 and 2000. The strain was the Rangipo strain, a single TB strain that has accounted for a large majority of TB cases in Hawke’s Bay. The index case was a 19 year old woman who presented to hospital in 1996. Contact tracing slowly identified cases throughout her extended family. One of her contacts served time in Rangipo prison during what is believed to be the incubation time of his disease. Within months of his release, a prison contact presented with TB symptoms in Wellington and, throughout the following years, new cases of the same strain of TB appeared in the North Island following the movement of ex-inmates. There were extensive gang connections between many of the cases who had spent recent time in the prison. At the time of the outbreak, the prison was often at maximum inmate capacity and, as a low-security facility, prisoners had frequent and prolonged contact between each other.

The Rangipo strain was first identified in Hawke’s Bay in 1991. Since then, it has been part of six other outbreaks within the area. Commonalities between all the outbreaks are that all the index cases were born in New Zealand, were all of Māori or Pacific island ethnicity, and all had, or had immediate family with, gang connections. It is believed that socioeconomic deprivation, crowded living conditions and limited utilisation of health-care may be present in Hawke’s Bay and contribute to disease transmission, including increased contacts and delayed diagnosis. In addition, the index case of this outbreak admitted to non-adherence to treatment.

A further outbreak in Hawke’s Bay in 2002 was also of the Rangipo TB strain (McElnay et al. 2004). Fifty-five household and close social contacts of the man who was the index case were identified and nine were found to have tuberculosis disease (TBD) and eleven latent tuberculosis infection (LTBI). He worked as a floor cleaner in a meat processing plant and, of 342 co-workers investigated, 10 were found to have TBD and 29 to have LTBI. Analysis of these outbreaks highlights the importance of early recognition and initiation of treatment. They also accentuate the measurable impacts that denial and the stigma of a tuberculosis diagnosis have in helping to delay diagnosis or make contact tracing more difficult (Ng Shui et al. 2008, Hill and Calder 2000).

Another window into the extent of Pacific TB is provided by Lum and Koelmeyer’s (2005) reanalysis of autopsies in Auckland. They reviewed 13,866 cases in the Auckland Coronial Autopsy Service between 1994 and 2004 and found that, of the 30 cases of tuberculosis, 70 percent were undiagnosed in life. Especially notable in this Auckland study was that 14 cases (47 percent) were ‘Polynesian’. Over half of the cases of all ethnicities were over 65 years of age.

For TB, early diagnosis and effective treatment is a key factor in prevention (Calder et al. 2003). But early diagnosis, where it is not part of contact-tracing, is dependent on good access to primary care: namely a GP. While GP clinics might not present great problems in physical access, to find a culturally competent GP, as Chapter 5 has shown, may involve a drive right across town, or, in the early years, may have been completely impossible. Reluctance to visit the doctor results in diagnostic delay and the likelihood that others will be infected. Other deterrent factors are also involved. They may include time off work, the need and cost of arranging childcare and the costs of transport. The GP’s fees may also be significant: GP visits were and are only partly subsidised. That very first, crucial step towards diagnosis, the GP visit, is the step that requires
payment. Treatment becomes free only after diagnosis is made, yet several GP visits may be required before an accurate diagnosis is reached. As a preventable and treatable condition, successful TB control and care relies upon the services available and the ease with which people can access those services (see Chapter 5).

**Conclusion**

The arrival of Pacific peoples in New Zealand coincided with the availability of effective drugs against tuberculosis and a population-wide campaign against the disease in New Zealand. Drug treatment rapidly altered TB from being a disease that affected the whole population to one centred on certain groups including the Pacific peoples. At first, New Zealand’s health professionals tended to regard Pacific TB as primarily a problem of immigration and border control, rather than one of prior exposure, socioeconomic hardship and access to health care, although these views have tended to see-saw over the decades. There was a poor understanding of the interplay between the strong cultural concepts and bio-medical understanding of health and disease among Pacific peoples. New Zealand’s one-size-fits-all health system did not serve Pacific people well during the ‘new settler’ decades of Pacific settlement in New Zealand. It must be acknowledged, however, that targeting of sections of the population, especially for a stigmatised disease such as tuberculosis, is an extremely sensitive issue and, as such, has often been avoided.

Since TB requires both community and hospital-based health services, ‘by Pacific, for Pacific’ primary health services do not by themselves constitute a culturally responsive TB service. Hospitals and clinics also need that competence. Thus successful TB control in Pacific populations in New Zealand is a good indicator that the health services as a whole are being responsive to Pacific peoples and their needs. Although Pacific TB rates did decrease slowly alongside the greater national decline, the increase during social welfare cutbacks of the 1990s confirms that social hardship remains a critical factor in TB incidence in spite of the availability of drug treatment.
Chapter Seven

Conclusion: Better lives?  

Pacific peoples came to New Zealand to have better lives. Some young people were sent by their parents. Mums and dads came with their children, they worked very hard, often in low paying jobs, so the children could have a good start in life, become educated, get better jobs and still be good Samoans, Tongans, Cook Islanders, Niueans, Tokelauans, Tuvaluans. Sometimes, better health or better health care was a reason to migrate. But better health was not always a consequence of migration. In fact, it was often quite the reverse, as the Tokelau Island Migrant Study showed.

Our monograph shows that while many aspects of Pacific health are still causes for concern there are bright spots, such as a decrease in infant mortality, and some real highlights. One particular highlight is the agency exercised by Pacific leaders and communities in the spaces, sometimes just tiny niches, in initiatives and actions enabled through successive health reforms. The leadership and commitment shown by particular individuals, their ability to make allies outside their own communities and make a real difference in the lives of their kinsfolk is an inspiring part of this story. As Wright and Hornblow (2008:30) note, the effectiveness of these initiatives may take some time for conclusive results in terms of health effects, but some indicators, such as certain immunisation rates and enrolment in primary health organisations, are promising.

These bright spots are very valuable because much of the story is less encouraging. Causes for concern include high rates of particular infectious (e.g., tuberculosis and other respiratory infections) and non-communicable diseases (e.g., diabetes) which are part of a set of syndemic relationships involving poverty and sometimes discrimination. A thread running through the story is that of recurrent surprise that there are such high levels of certain health problems often described as ‘third world’ diseases, such as rheumatic fever, which make their appearances as sources of shocked surprise in nearly every decade. The ‘rediscovery’ of this bad news at regular intervals signals a lack of historical consciousness; more practically, it signals that the underlying conditions created by social policies and broader economic conditions have not been addressed: child poverty, inadequate housing, insufficient income, job creation and so on (Ministry of Social Development 2010).

In the 1950s, when numbers of Pacific peoples in New Zealand started to increase, they were largely invisible in the statistics and in other forms of official recognition. Called “Pacific Islanders”, the implication was that they were really ‘over there’ in the islands and only ‘here’ in New Zealand as migrants, perhaps rather short term ones. As time went on and the health of Pacific peoples in New Zealand did begin to attract attention, their ethnicity rather than their living and working conditions was sometimes given prominence in analyses. Gradually, as more and more of the Pacific population in New Zealand were born here, it was realised that Pacific peoples were here to stay. Further, that although they were here to stay, many were living transnational lives as part of extended transnational families. Yet, this aspect of Pacific lives has not yet been thoroughly embedded in the provision of health services.

Taking an historical view over five decades also reminds us that history on a more personal level is also important to health. Because the health of an adult is shaped by his or her experiences growing up, and even by the experiences and habits of his or her parents’ or grandparents’ generation, some health gains which are already in place will not be seen for a generation. For example, the reduction in tobacco smoking by Pacific men and women increases their own life chances and enables healthier environments for their children who should experience better health and longer adult lives. Similarly the increasing provision of culturally appropriate health services should encourage ‘matter of course’ access by adults in families which will in turn allow their children to simply take for granted that they will receive good treatment, and therefore reduce delays in health visits and in treatment of streptococcal throat infections and thus prevention of rheumatic heart disease.

A prominent theme in the early decades of this migration/circulation was the expected convergence of Pacific people’s health with that of the general population. What happened was a convergence with Māori health profiles. However, while Māori health in many respects has steadily improved, Pacific health has not, or not to the same extent. The traditions and trajectories which gave rise to the similarities are not the same for Māori and other Pacific peoples in New Zealand. Although some of the solutions are the same and require a multi-layered approach across society—the elimination of poverty, deprivation, and discrimination, for example—other solutions are likely to be uniquely Pacific and differentiated ‘by Pacific, for Pacific’ to respond to the myriad differences within Pacific communities.
Post script

In the decade since the review period covered by this report, i.e. during the first decade of the 21st century, there have been many developments which aimed to improve the status of Pacific Health. These include the establishment of a Pacific Health section in the Ministry of Health in 2000 (Wright and Hornblow 2008), the increasing reach of Pacific health providers, greater emphasis on the accessibility of all health services for Pacific people, work to increase the Pacific health and health research workforce, initiatives such as Healthy Housing programmes and “Let’s Stop Diabetes”, and successful immunisation programmes against deadly infectious diseases, such as meningococcal B. Each of these has an important contribution to make to reduce disparities in Pacific health.

The publication ‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2010-2014 (Ministry of Health and Ministry of Pacific Island Affairs, 2010), sets out outcomes and actions to improve Pacific health for those five years. ‘Ala mo’ui is glossed as ‘pathways to the essence of life force’. This official document, produced by the Ministries of Health and Pacific Island Affairs in 2010, candidly acknowledges the continuing poor health outcomes for Pacific peoples and strongly indicates that not just Health but Housing, Education and other ministries and agencies such as DHBs, as well as local government and communities, will be engaged in the actions proposed to achieve the health goals listed. ‘Ala Mo’ui also includes reference to health in the island Pacific, a very encouraging feature. However, despite acknowledging that income and employment (along with education) are key determinants of health, few actions are proposed to reduce disparities in those two key areas. Until as a nation we can address these fundamental problems of job creation and income distribution, the health disparities which our report has demonstrated so adversely affect Pacific children and therefore all Pacific lives, will continue. What Tukuitonga (1997:4) wrote has not changed: “Pacific children and young people appear to be particularly vulnerable to the socio-economic circumstances of their families”. Unfortunately, the vulnerability of Pacific children to tuberculosis disease contracted in New Zealand is an enduring testament to this fact, as a major paediatric outbreak in 2003 attests (Voss 2006).
Chapter 1

1 Two historical studies have been undertaken focusing on Tuvalu (Resture 2010) and Cook Islands (Futter-Puati 2010) while contemporary studies are currently in progress by two doctoral candidates (Evelyn Marsters and Tufoua Panapa) and two graduate students (Sagaa Malua and Rochelle Newport).

2 ‘Low’, according to the WHO standard is a rate lower than 20 per 100,000 of population. New Zealand’s annual incidence is between 9-11/100,000.

Chapter 2

1 There were also about 2,300 born in Fiji but many of these were Indo-Fijians so are generally identified with the ‘Indian’ rather than the ‘Pacific’ or ‘Polynesian’ population.

2 Note that in 1956 there were also about 1,300 “Polynesians (not including N.Z. Maori)” who were New Zealand born.

3 All census and labour force information comes from published or unpublished data from the former Department of Statistics and the current Statistics New Zealand.

4 In the Housing Survey regulations of the time this was more than 3 ½ persons (counting children between 1-10 years of age as half persons and not including infants) in a room 190 sq. ft. or more.

5 However, some Samoan households resisted the forces of gentrification or participated in the process themselves. This is witnessed by the fact that in 1996, 53 percent of all adult Samoans in Grey Lynn lived in an ‘owned’ house, whereas the proportion of those of European ethnic origin in the same category was slightly less. Of course, care should be taken in interpreting this statistic since the overall proportion of Pacific population is still declining in Grey Lynn, so those who are still there are a selective sample of a decreased population.

6 Note that in Table 2.3 the base populations are ‘full-time labour force’ while in Table 2.4 they are all population aged 15 or more, including those not in the labour force.

7 After the 1991 and 1996 Censuses, a series of publications were produced profiling each of the main Pacific groups; for example the reference for Cook Islands in 1996 is Statistics New Zealand (1998), Cook Islands People in New Zealand – Pacific Islands Profiles, Statistics New Zealand, Wellington.

Chapter 3

1 A secular trend is one which is sustained over the long term.

2 Blood pressure is assessed through measuring the pressure between heart beats (the diastolic pressure) and when the heart contracts (the systolic pressure). Increases in either measure are significant in relation to hypertension.

3 Microalbumin are small amounts of protein which, when found in urine, are an early indicator of kidney disease since the kidney should be filtering it out.

4 The ‘good’ cholesterol – low levels are associated with increased risk of heart disease.

Chapter 4

1 Even with higher birth rates for Maori and Pacific peoples, this is a high involvement, given that the percentage of Christchurch people claiming ‘New Zealand Maori’ ‘ethnic origin’ was 2.4% and any ‘Maori descent’ was only 5% at the time. Only 1% of the Christchurch population identified as ‘Pacific Island Polynesian’ (Department of Statistics 1982, 25).

2 More recent research has shown that having one copy of the cystic fibrosis gene is protective against TB and that cystic fibrosis is found in higher levels in populations with a long history of TB, even when the current rates are very low (MacKenzie 2006).

Chapter 5

1 The Plunket Society is a New Zealand community organisation and charity, founded in the 1920s, which has paid staff and volunteers. It is contracted by the Government to provide health care to babies and social support to families from shortly after a baby’s birth to age five. It also benefits from donations (See Bryder 2003).


4 See Table 2.1 of this report.


Chapter 6

1 http://www.ck.govt.htm.nz 19/9/2006. From August 1965, the Cook Islands established a form of full self-government in free association with New Zealand. They may at any time in future, if they so desire, move into full independence, or any other status that may become practicable, by a unilateral act, that is, one which New Zealand has denied itself power to countermand.

http://www.indexmundi.com/tonga/independence.html

http://www.indexmundi.com/niue/independence.html

http://www.indexmundi.com/fiji/independence.html

http://www.indexmundi.com/samoa/background.html 4/2/2008. After occupying the German protectorate of Western Samoa in 1914, New Zealand administered the islands as a mandate and then as a trust territory until Western Samoa’s independence on 1 January 1962.


2 T. T. Romans, Chief Medical Officer, Cook Islands Administration, to C. H. King, TB Officer, Auckland, 10 September 1954. H 1 246/41/6 28768, ANZW.

3 Deputy DGH to Auckland Hospital Board, 27 June 1955. H 1 246/41/6 28768, ANZW.

4 C. H. King to DDT, 27 October 1955. H 1 246/41/6 28768, ANZW.

5 File note, 20 January 1960. BAAK 25/40(9) A358/139b, ANZA. While diagnosis of TBD within months of arrival might be indicative of active tuberculosis crossing borders, two years represents the outer limits for this scenario to be likely.

6 Resident Commissioner, Niue Island, to Secretary, Department of Island Territories, 29 July 1963, & Resident Commissioner, Cook Islands, to Secretary, Department of Island Territories, 29 July 1963, & Resident Commissioner, Rarotonga, to Secretary, Department of Island Territories, 22 August 1963. BAAK 25/40(11) A358/140a, ANZA.

7 TB Officer, Green Lane Hospital, to DOH, 11 February 1966, & Cutting, NZH, 28 May 1966. BAAK 25/40(11) A358/140a, ANZA. At the time, people from the Cook Islands were commonly referred to in New Zealand as ‘Rarotongans’ as in this article. Rarotonga is the main island in the Cook Islands group. For consistency, we refer only to Cook Islands people.


11 DGH to MOH, Auckland, 30 April 1972. BAAK25/40(12) A358/140d, ANZA.

12 DGH to MOH, Auckland, 30 March 1972. BAAK 25/40(12) A358/140d, ANZA.

13 Cutting, NZH, 29 September 1972. AAFB 632 W3463/122 48400 246/1, ANZW.

14 Memo, C. M. Collins to H. J. Hiddlestone, 9 October 1972. ZABV 4638 A1073/716a 62/6. ANZA.

15 Auckland Hospital Board, Special Meeting Minutes, 1 March 1973. YCAS 88/1/6/3 A740/238e, ANZA.


17 AHJR, 1975, E-10, p.25.

18 WHO Press Release EURO/445, 15 May 1975. AAFB 632 W3463/122 48400 246/1, ANZW.


20 Meeting paper, ‘Health Requirements for Pacific Island Visitors and Immigrants’, 16 May 1978, & Table 3. ABQU 246/5 632 W4415/515 50106, ANZW.

21 G. Collison to DGH, 23 November 1977. AAFB 632 W3463/89 47757 246/1, ANZW.


23 Department of Labour to DGH, 8 February 1978. ABQU 632 W4415/515 50106 246/5, ANZW.

24 DGH to Department of Labour, 6 March 1978. ABQU 632 W4415/515 50106 246/5, ANZW.
25 ‘Health Requirements for Pacific Island Visitors and Immigrants’, meeting paper, 16 May 1978, & Minutes of Meeting of Advisory Committee on Tuberculosis, 30 May 1978. ABQU 632 W4415/515 50106 246/5, ANZW.


27 Minutes of meeting, 3 September 1979. ABQU 632 W4415/515 50106 246/5, ANZW.

28 Record of Tuberculosis Advisory Committee Meeting, 14 December 1979. ABQU 632 W4415/515 50106 246/5, ANZW.

29 R. C. Begg to Secretary, Foreign Affairs (FA), 5 December 1979, & A. J. Sinclair, Principal Medical Officer, International Health, to WHO, Fiji, 14 April 1980. ABQU 25/40(9) 632 W4415/516 52339, ANZW.

30 R. C. Begg to Secretary, Foreign Affairs, 12 October 1979, & Notes of visit, 22 September 1981, & NZ Representative, Rarotonga, to T. R. A. H. Davis, 21 April 1980, & reply, 29 April 1980. ABQU 25/40/6 632 W4415 520 503135, ANZW.

31 Circular Memo, 11 August 1983. The time period was extended from two to three months. In addition, if short-term visitors applied to extend their permit to the twelve-month maximum, it would normally be granted without the need for an X-ray. While those applying for extensions would be encouraged to have an X-ray, it was anticipated by the Department of Health anticipated that the numbers doing this would not be great. ABQU 632 W4415/520 57660 264/41/6, ANZW.


33 T.G. Fox to H.S. Kenrick, Superintendent-in-Chief, Auckland Hospital Board, 17 April 1959, & T. G. Fox, paper, ‘Tuberculosis in Children’. BAAK 25/40 (9) A358/139b, ANZA.

34 Minutes of meeting of Hospital Committee of Auckland Hospital Board, 3 August 1959. ZABV 4638 A1073 801df 95/1/36/4, ANZA.

35 W.H. McDonald to Superintendent-in-Chief, Auckland Hospital Board, 5 September 1966, & File Memo from Assistant Secretary, Hospital & Welfare Services, 5 October 1966. ZABV 4638 A1073 801df 95/1/36/4, ANZA.

36 T.G. Fox to W.E. Henley, 18 September 1969. ZABV 4638 A1073 801df 95/1/36/4, ANZA.

37 AJHR, 1959, H-31, p.103.

38 T.G. Fox to N.T. Barnett, DoH, two letters dated 29 September 1969. ZABV 4638 A1073 801df 95/1/36/4, ANZA.


40 Paper, ‘Discussion on Maori Health in the Auckland Urban Area, Medical Officers of Health’s Conference 1960’. BAAK 14(9) A358/87c, ANZA.


43 Circular Memorandum to Public Health Nurses, 17 June 1963. BAAK 25/40(11) A358/140a, ANZA.

44 MOH, Auckland, to DGH, 17 June 1966. H 1 246/64 34419, ANZW.

45 J. M. Watt to G. O. L. Dempster (extract), 13 April 1964. H 1 246/64 34419, ANZW.

46 Circular Memorandum 1965/11, 13 January 1965. H 1 246/64 34419, ANZW; Minutes of meeting of Maori Health Committee, 2 December 1964, pp.2-3. H 1 29/22 30230, ANZA.

47 Taranaki Herald, 1 August 1946, p.3.


50 D. Bonham to MOH, 18 June 1976, & MOH to Medical Superintendent, National Women’s Hospital, 22 June 1976, & file note, 2 July 1976, & Deputy MOH to T. G. Fox, Auckland Hospital, 7 June 1977. BAAK 25/20/4/1(3) A358/131a, ANZA.


54 T. G. Fox, Children’s Tuberculosis Clinic, to Superintendent-in-Chief, Auckland Hospital Board, 17 April 1959, 6 June 1961, 15 June 1961. BAAK 25/40(10) A358/139c, ANZA.

55 W.H. McDonald to Superintendent-in-Chief, Auckland Hospital Board, 28 June 1965, & J.F. Ryan to Medical Superintendent-in-Chief, Auckland Hospital Board, 30 June 1965. YCAS A740 346a 95/1/33 Pt 2, ANZA.

When multiple ethnicity was first used in 1995, other ethnicity was not recorded with the exception of 'other European'. The 1995 number of cases of other ethnicity was therefore calculated from the table of specific ethnicities rather than the multiple ethnicity categories.

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Letter, Minister of Health, to Chief Executive, Auckland Hospital Board, 25 August 1979. ZABV 4638 Acc A1073 555a 95/1/33 Pt 3, ANZA.

Memo, J.F. Ryan, Chest Physician, Green Lane, to Chief Executive, Auckland Hospital Board, 15 August 1980. ZABV 4638 Acc A1073 555a 95/1/33 Pt 3, ANZA.

The introduction of multiple ethnicity in 1995 makes it difficult to calculate comparable figures for 1995-6, from 1997 multiple ethnicity is used but this graph is based on prioritised categories for Maori and then Pacific.

Chapter 7

1 Better Lives creates a historical basis for the contemporary work of the ‘Transnational Pacific Health Project’ in conjunction with two Masters in History theses, focussed on the Cook Islands and Tuvalu respectively (Futter-Puati 2010, Resture 2010).
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