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Social determinants of health – towards an equitable Pacific health workforce

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Welcome!

Each issue tells you about a current research, evidence and thought on an important issue for your work in health promotion. All articles are peer reviewed. This edition is on social determinants of health – towards an equitable Pacific health workforce. We also acknowledge the reviewers of this paper.

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1. Introduction

The social determinants of health (SDH) approach has gained global currency in addressing avoidable health inequities – that is, the avoidable differences in health status of different populations between and within countries. This approach acknowledges that health is socially determined as well as shaped by biological and clinical factors. The World Health Organisation(WHO) defines SDH as the "conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels" (2008, p.4). This brief review is in two parts. Firstly, a brief overview of the SDH approach and its implementation in New Zealand. The second part focuses on one key aspect of the model; having access to a range of ethncially diverse health providers as a strategy to reduce ethnic health disparites in multicultural societies.

2. Overview of the Social determinants of health approach

The concept of social determinants of health, as we know it today, originated from the work of McKeown (1979). McKeown argued that the improvement in health over the last two centuries can be attributed to improved economic and social conditions rather than to specific medical advances or public health initiatives. At the time of writing, McKeown's assertion that social conditions are fundamental causes of disease caused controversy, particularly amongst medical and public health professions, some of whom continue to question the legitimacy and validity of McKeown's thesis particularly in regards to defining what exactly SDH is (Colgrove, 2002).

The challenges of defining what the social determinants of health are and the need for evidence to support the concept resulted in the WHO establishing the independent three-year project, the Commission on Social Determinants of Health (CSDH) in 2005, led by Sir Marmot. The main objective of this Commission was to understand the social determinants of health, how they operate, how they can be changed to improve health, and to link this knowledge with action (Marmot, 2005). The final report, *Closing the gap in a generation: Health equity through action on the social determinants of health*, was launched in 2008 with the Commission identifying three overarching recommendations: improve daily living conditions; tackle the inequitable distribution of power,, money and resources: and measure and understand the problem and assess the results of action (World Health Organization, 2008, p.3). The WHO have since published a series of documents and reports on SDH including specific sectoral papers on housing, education, transport and social protection (WHO, 2013).

The current popularity of the social determinants of health approach lies in its acknowledgement that health inequities and inequalities are a reflection and manifestation of broader structural inequalities within societies. Since McKeown's thesis, the social determinants of health approach has broadened to include recognition that there are many influences on health (Wilkinson and Marmot, 2006). The approach forces people to examine broader social and structural factors of society such as politics and economics and how these relate and affect one another at the macro and meso level to impact on the health and wellbeing of individuals at the micro level. In order to

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devise effective health policy to improve the health of populations all these factors need consideration (Glouberman and Millar, 2006).

Recent trends in international government health policies and strategies demonstrate the prominence of SDH to improve health outcomes. This international trend was initiated in 1974 with the publication of the Lalonde report commissioned by the Canadian government (Graham, 2004). The report is often cited as the first official working government document to identify social factors as important health factors and served as the catalyst for the Canadian Health for All (HFA) charter in the late 1970s. In 1981 the HFA charter was subsequently adopted by the World Health Organisation (WHO) and since the 1980s, governments have adopted the social determinants approach in designing, delivering and developing public health policy (ibid.).

Since the conclusion of the CSDH the WHO have reemphasised the SDH approach which led to the adoption of the Rio Political Declaration in 2011 by Member States. The declaration calls on members to act on the follwing five areas:

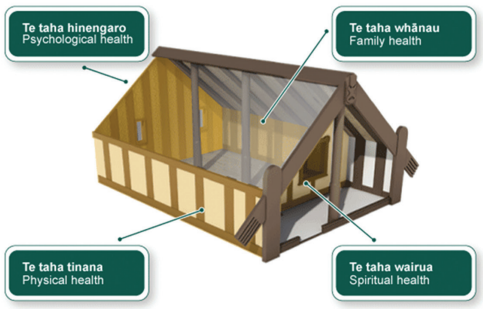
1. Adopt improved governance for health and development
2. Promote participation in policy-making and implementation
3. Further reorient the health sector towards promoting health and reducing health inequities
4. Strengthen global governance and collaboration
5. Monitor progress and increase accountability

The SDH approach is likely to continue dominating the health agenda in the international arena given the weight of evidence in support of the approach and it's inclusion in policy documents internationally, nationally and locally.

3. Social Determinants of Health models – a local focus

Despite the recent currency of social determinants of health , the foundational concept of health as socially determined predates the work of McKeown. Many nonwestern societies and indigenous communities have always viewed health as a holistic phenomenon. For example Mason Durie's Maori health model Te Whare Tapa Wha based on the image of a Maori whare (house), as shown below in Figure 1, illustrates that the four cornerstones of Maori wellbeing are whanau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health).

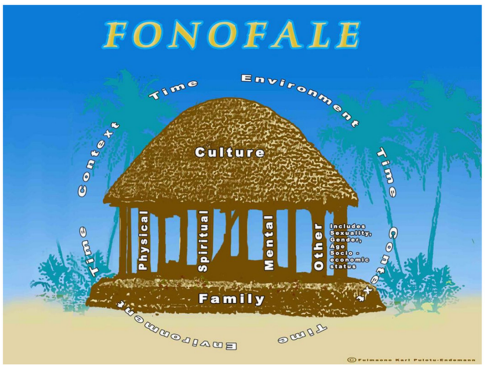
Figure 1: Te Whare Tapa Wha Model



Source: Careers New Zealand (2013)

Pulotu-Endemann's (1995) Fonofale model of health in Figure 2, also illustrates an interpretation to Samoan health beliefs using a Samoan fale (house) to depict the key concepts of health for Samoan and Pacific communities.

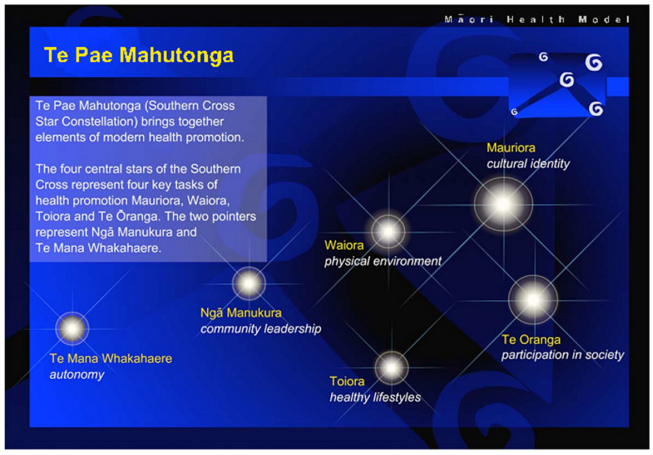
Figure 2: Fonofale Model



Source: Pulotu-Endemann (2001)

More recently, Durie has developed a more nuanced Maori health model, Te Pae Mahutonga (Southern Cross Star Constellation) that incorporates the health promotion concepts of cultural identity, physical environment, participation in society and health lifestyles. Figure 3 below illustrates;

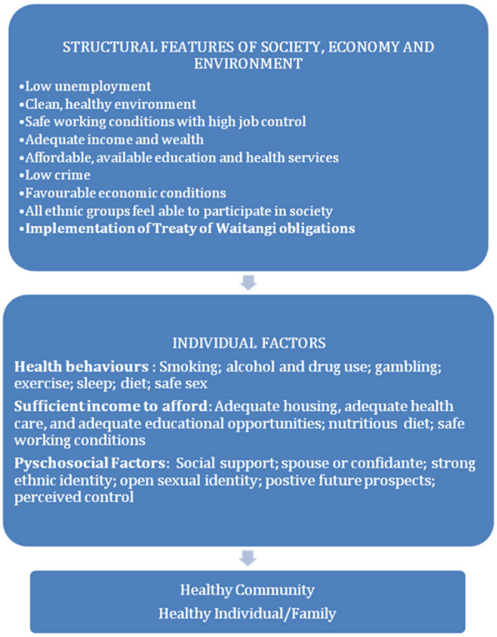
Figure 3:Te Pae Mahutonga Model



Source: Ministry of Health, 2012

To date, the academic literature and research into understanding social determinants of health is voluminous (Bambra et al., 2009). Since the writings of McKeown (1978), academic research has continued investigating social determinants of health as a framework to understand why health disparities exist between different groups and communities along ethnic and socioeconomic lines. As such, a number of models have been developed in order to illustrate the concept of social determinants. Figure 4 below is adapted from Howden-Chapman and Tobias (2000), illustrating their interpretation of SDH for New Zealand.

Figure 3.2: Social Determinant's of Health Model for New Zealand, adapted from Howden-Chapman and Tobias (2000), my emphasis



The Ministry of Health have adopted the above model in their health strategy (Ministry of Health, 2000).

A social determinants of health approach suggests that to reduce ethnic inequalities by improving access to quality healthcare services, the health workforce should reflect the communities and population that it serves. For Pacific communities in New Zealand this translates to increasing the representation of Pacific health workers in all sectors of the health workforce including clinicians, public health workers, and health managers. This is important given the disproportionate health burdens facing Pacific populations in New Zealand compared to the rest of New

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Zealand (Ministry of Health, 2013). A recent paper published by the Ministry of Health (2013) based on the 2011/12 New Zealand Health survey identified that a key challenge to improving the health of Pacific peoples is improving access to health care and that health services are appropriate and responsive to their needs.

Increasing the Pacific health workforce is necessary but not sufficient to address all the Pacific health needs. Health is socially determined and factors such as income and education are equally important to the health of individuals and communities. However, the disproportionate health burden facing Pacific people, provides a compelling rationale for increasing the Pacific health workforce.To develop a robust Pacific health and disability workforce Pacific representation is needed across all levels of the sector from community workers to medical specialists and general managers. At the very least the proportion of Pacific providers and health professionals should be commensurate with the Pacific population in New Zealand (that is, 6%).

4. A culturally diverse workforce

Increasing the ethnic diversity of health workforces as an intervention to reduce health inequalities in multicultural societies like New Zealand, the United States and Canada is a contested issue.There are many nonminority health workers who serve and provide excellent care for minority patients and clients, and likewise, there are many minority health workers who provide excellent care for nonminority patients and clients. There are also some patients who are indifferent to the ethnicity of health workers as long as they are suitably certified and qualified. Thus there are multiple factors that affect the relationship between health provider and patient. In some relationships ethnicity and culture are more important than in others. The advantage of ethnic diversity in healthcare extends beyond the immediate relationship of providing culturally competent healthcare between provider and patient. In broader terms ethnic diversity in healthcare also affects access to care, patient choice and satisfaction. It has been argued that minority health workers are more likely to work in minority communities that are typically medically underserved (Bush et al., 2009).

Generally, advocates for increased ethnic diversity of the health workforce, including those in New Zealand, have argued that a more ethnically diverse health workforce improves the quality of care for ethnic communities (Wright and Hornblow, 2008). Ethnic health workers are better able to address language and cultural barriers such as different health belief models amongst ethnic patients compared to nonethnic health workers (La Viest, 2005, p.236). For example, Pacific health workers have a better understanding of Pacific health cultural beliefs that impinge on Pacific people's health-seeking behaviour compared to non-Pacific health workers. Pacific workers and community healthcare providers have traditionally taken a multidisciplinary approach to healthcare (Pacific Health Research Centre, 2003). This is in response to the holistic approach to health as practiced by Pacific people and the diverse health needs identified by Pacific health practitioners in New Zealand (Ministry of Health, 2008). This illustrates how Pacific health workers might be better able to respond to the needs of Pacific communities at least to deliver health services and resources in a culturally appropriate manner. This argument resonates with Pacific communities as demonstrated in the mid-1990s during health consultations with the Ministry of Health, which stated a strong preference for "by Pacific for Pacific" models of care and service provision (Perese et al., 2009).

Despite many commentators supporting an increased commitment to greater ethnic diversity of the health workforce there are very few studies that have directly researched whether patient outcomes are affected by doctor-patient ethnic concordance (Betancourt et al., 2003). Betancourt and colleagues (2003) acknowledged the lack of strong quantitative data but argued that, "a plethora of anecdotal evidence suggests that lack of diversity in the leadership and workforce of healthcare organisations results in structural policies, procedures, and delivery systems inappropriately designed or poorly suited to serve diverse patient populations" (p. 296).

Most research in patient-doctor 'racial concordance issues', or in other words, ethnic specific health services, has been conducted in the United States. For example Lau and Zane (2000) compared mental health treatment outcomes between cohorts of Asian-American clients using ethnic specific providers with a matched cohort utilising mainstream providers. The study was conducted using Asian-American consumers from an outpatient mental health facility in Los Angeles. There were a total of 3,178 clients with 1,981 clients receiving services from ethnic specific agencies and 1,197 clients receiving services from mainstream agencies. To examine the effects of ethnic specific services, data from the Automated Information System were analysed. To analyse treatment outcomes researchers used the Global Assessment Scale score at intake and following discharge. Results revealed that after controlling for demographics, pre-treatment severity and diagnosis, the cohort using ethnic specific providers showed better treatment outcomes such as correct and prompt diagnosis and more cost effective treatment outcomes. This study is based on quantitative data and it is one of the few outcome studies based on ethnic-specific health services. Qualitative data, such as interviews with clients and service providers, would be helpful to build on the quantitative data to gain a better understanding in the differences in treatment outcomes.

Mental health services as a sector is considered a leader in the area of Pacific health workforce development. This is based on the reports and research undertaken in regards to analysing and exploring treatment outcomes for Pacific mental health consumers (Tamasese et al., 2005). For example, the New Zealand Mental Health Classification and Outcomes study by Pulotu-Endemann, Annandale and Instone (2004) based on a Pacific perspective is similar to Lau and Zane's study (2000). The study used a case-mix method with mental health services provided by eight district health boards, including two Pacific teams. Although the study did not explicitly focus on Pacific users' outcomes, the results showed that Pacific people have a holistic view of mental health, yet the services that are currently offered to them are based on mainstream conceptual models of mental health that do not acknowledge the importance of family and cultural values. It is unsurprising that Pacific consumers reported negative experiences of these mental health services as the delivery of these services failed to recognise their holistic approach to mental health. Despite the limitations of the study, one being the small numbers of Pacific consumers, the authors suggested that those who deliver mental health services need to be aware of cultural sensitivities, and that Pacific mental health workers are better placed to meet the needs of Pacific mental health patients.

The research so far has suggested that Pacific healthcare workers could address many of the health problems of Pacific peoples because of their understanding of how cultural health belief models impact on health and health-seeking behaviour. In addition, services that are more responsive to underserved groups can reduce barriers to access and encourage access thereby improving outcomes for these groups. The above studies on ethnic health outcomes are useful in firstly, establishing that quality and access to healthcare is a real problem

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for minority populations in New Zealand, and secondly, beginning a dialogue in addressing some of the structural issues and barriers in New Zealand's healthcare. These studies are similar to studies in the United States which show that when given the choice, African-American and Hispanic patients tend to choose health practitioners of the same ethnic background (Smedley, 2007).

Although studies are beginning to emerge from New Zealand's research about the problems of access to health services for Pacific peoples, there has yet to be any substantive study to evaluate the effectiveness of Pacific health workers in improving health outcomes for Pacific patients. Awareness of the benefits and advantages of having an ethnically diverse workforce have seen the public sector in New Zealand actively recruit and promote diversity in the workforce (Faleafa and Ng Shiu, 2008). Across the public sector there has been an intense focus by organisations to have their workforce reflect the communities in which they serve. Diversity in the workplace is viewed as being central to delivering services and outcomes effectively to the New Zealand public (State Services Commission, 2004). In 2003, the State Services Commission initiated the Human Resource Framework project in which one of its objectives was to "enhance the ability to attract and retain diverse and capable talent" (p. 3). This project has encouraged the public service to focus attention on setting targets and initiatives on recruiting Pacific staff members.

Researchers who advocate for increasing ethnic diversity in the health workforce have begun to investigate the low achievement of medical health students from ethnic minoritised communities at University (Yates and James, 2006). Wat and others (2010) from the University of California Los Angeles (UCLA) published an article in the California Journal of Health Promotion stating that Pacific Islander communities in California suffer disproportionately from illnesses and diseases and thereby arguing for the need to increase the local Pacific health workforce. The authors also evaluate and describe the Pacific Islander Health Careers Pipeline program, a community-university partnership with UCLA to increase the local Pacific health workforce (Pacific Islander Health Careers Pipeline Program, 2009). Additionally, the authors also examine how understanding barriers to education for Pacific students impacts on the efforts to address Pacific health disparities in their community.

At present there are a number of scholarship and grant schemes that are Pacific specific to address the financial barriers to study. For example, the Ministry of Health has provided financial assistance through the Pacific health workforce awards since 2009. The awards provide financial assistance to any Pacific student enrolled in an accredited health and disability course or program of study (Le Va, 2012). Le Va provides mental health and addictions scholarships through their Futures that work program (Le Va, 2012). An evaluation on the effectiveness of these scholarship programs in developing the capacity within the Pacific health workforce would be beneficial.

5. Conclusion

The need for ethnic diversity in the health workforce is wider than just the medical and clinical setting. Patient and client satisfaction and choice in accessing quality healthcare are indeed important issues. As previously stated, Pacific representation is important in all sectors of the health workforce. Pacific health leaders, researchers and policymakers are just as important as Pacific clinicians and medical personnel in New Zealand. Developing a capable and robust Pacific health workforce requires a commitment from the government, Pacific communities, and educational institutions in order to ensure that young Pacific school leavers choose health as a career pathway, are able to meet the requirements necessary to enter tertiary institutions, and are supported and encouraged to complete their studies and enter the health workforce.

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