

Pacific children in the statistical record: the need for ethnic-specific data in New Zealand

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Introduction

Children of Pacific Island ethnic origins comprise 10% of all NZ children aged 14 and under, and are a significant group in terms of social and health needs. The collapsing of census and health data into pan-ethnic and broad age categories makes it difficult to identify specific health needs of children from different ethnic groups, and at different developmental levels. Ready access to age-specific and ethnic-specific data could facilitate allocation of limited health resources.

This paper prefaces the review on asthma among Tongan children in New Zealand reported in this publication and provides a context for some of the issues raised there. The paper argues that the collapsing of census and health data into broad age groups masks the specific health needs of all children at different developmental levels, irrespective of ethnic group. The exclusion of Pacific ethnic categories, or the collapsing of these Pacific ethnic categories into a single Pacific Island group, render Pacific children in general, and Tongan children in particular, even more invisible than other NZ children. This paper highlights some of the barriers to extracting ethnic-specific and age-specific health data from various data bases, and raises some implications of failing to identify specific health needs of various Pacific island groups and children of different ages.

Invisibility of children in census and health data

Childhood is characterised by rapid social and physical development, especially in the first few years of life. In Western societies, there is an emerging awareness of the lack of data on children as a social group.^{1,2} While there is

a growing Western European literature on children as active contributors to their family relationships, (e.g. Dunn, 1991³, Mayall, 1996⁴), children in Pacific societies are not often afforded such an active role. Irrespective of children's visibility within their own social groups, the invisibility of children in census and health data masks the very real health needs of children, and at different developmental stages. Children have widely differing health needs at different stages of development, which are not apparent when census and health data are collapsed into a single category of "child". In line with many categories for children (e.g. Ministry of Health, 1998⁵), this paper refers to children aged fourteen years and under.

Many reports of census and health data break childhood into discrete categories, for example 0-1, 1-4, 5-9, and 10-14 years.⁶ While this differentiation is preferable to a single category of "child", it can still mask important age differences in health status and health needs. For example, healthy new-born babies comprise 10% of hospital discharges between 0 and five, and are included in hospital discharge data, which is often used as a measure of morbidity.⁷ Moreover, using a single age category for pre-school-aged children can be problematic. For example, there are marked differences in the number of hospital discharges of Tongan children with asthma at one, two, three and four years (See Mavoa, in this issue).

Invisibility of specific Pacific ethnic groups

People from various Pacific Islands acquire a hypothetical, pan-ethnic identity⁸ of "Pacific Islander" when they enter New Zealand. The term "Pacific Islander" was constructed by outsiders in an attempt to understand and/or manage and ethnic minority group.⁸ The category of "Pacific Island/er" continues to be used in many reports on social and health status of people from various Pacific origins (e.g. Davey, 1993⁷; Ministry of Health, 1998; Jackson et al., 1996⁹). The concept of "Pacific Islander" as a single social group is often explicit, for example, Davey⁷ refers to three ethnic groups, namely Maori, European and Pacific Island. The use of a single pan-ethnic category of "Pacific Island" is not exclusive to outsiders, increasingly, the term is used among people of Pacific islands ethnic origin.

While most reports on health acknowledge the diverse nature of people of Pacific ethnic origins, they often use a

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single pan-ethnic category when describing health status. For example, while hospital admission records currently have 13 possible ethnic categories for people from Pacific islands, published data are often collapsed into a single "Pacific Island" category. While the collapsing of ethnic categories may be desirable in many circumstances, it can be problematic when identifying ethnic differences in health status and health needs.

Problems with ethnic categorisation of Pacific peoples in general

In addition to lack of recognition of specific Pacific groups in health data, there are a number of problems with the ethnic classification of Pacific peoples in general. Various changes in ethnic affiliations in the last two decades makes it difficult to make longitudinal comparisons with current census and health data. Prior to 1981, people of Pacific island ethnic origins were categorised as "Pacific Island Polynesian", irrespective of whether or not they came from Polynesia, Melanesia or Micronesia. Moreover, various agencies used different ethnic categories. For example, births and deaths defined ethnic group biologically, that is in terms of one or both parents' ethnic affiliation.¹⁰ Census data has used as an array of ethnic classifications, with four changes in the last two decades. In the 1991 census, people were able to nominate up to three ethnic groups with which they were affiliated, and data on ethnic affiliation may be drawn from one or more of these three categories. These historical changes in designation of ethnic affiliation require authors to be specific about the ethnic categories to which they refer. First, it must be clear how ethnic identification was determined. Secondly, it must also be clear whether ethnic affiliation refers to: 1) the first listed ethnic group only or 2) two or three ethnic categories.

While the collapsing of ethnic categories may be desirable in many circumstances, it can be problematic when identifying ethnic differences in health status and health needs.

People from Pacific islands are also often included within broader ethnic categories; for example, people with 50% Pacific Island Polynesian and 50% Maori origin were categorised as Maori⁶ before 1986. This exclusion of any Pacific category is evident in some recently published health data where ethnic categories are confined to either Maori or non Maori.⁹ People of Pacific ethnic origins are variously included in either group. Pacific people are most often included in the "non Maori" category, which encompasses people from all ethnic groups other than Maori.^{7,9} Other studies have included people of Pacific ethnic origin in the category of "Maori" (e.g. Pattemore, 1989¹¹; Pattemore, 1991¹²), presumably on the basis of their common Polynesian background.

The changes in, and various uses of, ethnic categorisation are further confounded by the potential for inaccurate recording of ethnic affiliation. For example, while there has been provision for self-identification of up to three ethnic categories in hospital records since 1996, inaccurate recording of ethnic affiliation may occur when data are completed by admission personnel rather than family members.

Finally, the possible under-reporting of people from Pacific Islands in census data has been well documented; Simmonds et al (1994) suggest that discrepancies could be as high as 32%.¹³ Several studies have demonstrated that the ethnic category Maori is under-reported in hospital records, and it is likely that there is also under-reporting of Pacific ethnic categories in hospital data.¹⁴ This is most likely to occur when hospital admissions staff and families speak different languages, and/or when families are under stress.

Country of birth and length of time in New Zealand

Published health data do not always include information on country of birth and length of time that people have resided in New Zealand. It is likely that recently arrived residents have different health needs as they adapt to a new environment compared with families who have lived in NZ for one or more generations. Importantly, health beliefs and health care practices are influenced by previous experiences. Pacific people who have recently arrived in New Zealand are likely to be more heavily influenced by health beliefs and practices from their country of origin than New Zealand-born caregivers of Pacific ethnic origin.

Children of Pacific origin

Children of Pacific ethnic origins comprise 10% of all New Zealand children,¹⁵ and are a significant group in terms of social, educational and health needs, therefore. Children of Pacific islands ethnic origin are doubly hidden in data which is presented as broad categories: first, they are homogenised into "Pacific Island/er", and second, along with other New Zealand children, their specific developmental needs are often obscured by broad age groupings. The collapsing of children from all Pacific Islands into a single ethnic category fails to take into account the specific health needs of children from different ethnic groups. For example, Samoan children living in New Zealand may have very different needs from Tongan children. Many Samoan parents of New Zealand-born children were also born in New Zealand, and the health needs of this second or third

generation of New Zealand-born children are likely to differ from first generation NZ-born Samoans.

Where are the Tongan children?

The 13,359 Tongan children reported in the 1996 New Zealand census comprised 43% of the Tongan population in New Zealand.¹⁶ Moreover, Tongan children comprised 22% of NZ children from various Pacific island groups and 1.6% of all New Zealand children.¹⁶ While Tongan children are clearly a significant group of New Zealand children in terms of social, educational and health needs, we know little about the specific health status of Tongan children, vis a vis children from New Zealand children in general, and children from other Pacific islands in particular.

Extracting ethnic-specific and age-specific data

While specific data on ethnicity and age are available, these categories are not standardised. There have been moves to redress the inequity in ethnic categorisation. For example, the categories used for collecting hospitalisation data concurs with that of census data.¹⁰ The long delay between data collection and publication means that available data are often outdated; for example, some 1991 census data was not published until 1996. The extraction of these data is a financially and logistically demanding exercise. The high cost of extracting health data from NZ Health Information Services limits access to well-resourced government departments and research groups. For example, extracting age-specific data on asthma among Tongans resident in New Zealand incurred a four-figure charge.

Implications of broad ethnic and age categories for health care

The specific health status of children from various Pacific islands is not apparent in reports, which publish data under broad ethnic and age categories. While many reports acknowledge the diverse nature of people from Pacific islands living in New Zealand, they often fail to identify specific ethnic affiliation, which renders children, their families and communities invisible. Currently we do not know whether children from different Pacific islands have different health needs, and whether or not these needs differ according to age, country of birth and the length of time spent in New Zealand. In terms of age categories, the wide variation in hospital discharges of Tongan children with asthma at aged one, two, three, four and five (see Mavoa, this volume) underscores the need to have access to data which allows us to better predict age-specific health needs. Only then will we be able to optimise the use of health resources by targeting the very specific needs of children from different backgrounds and at different stages of development.

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