

Ethnic Differences in the Uptake of Child Healthcare Services in Aotearoa

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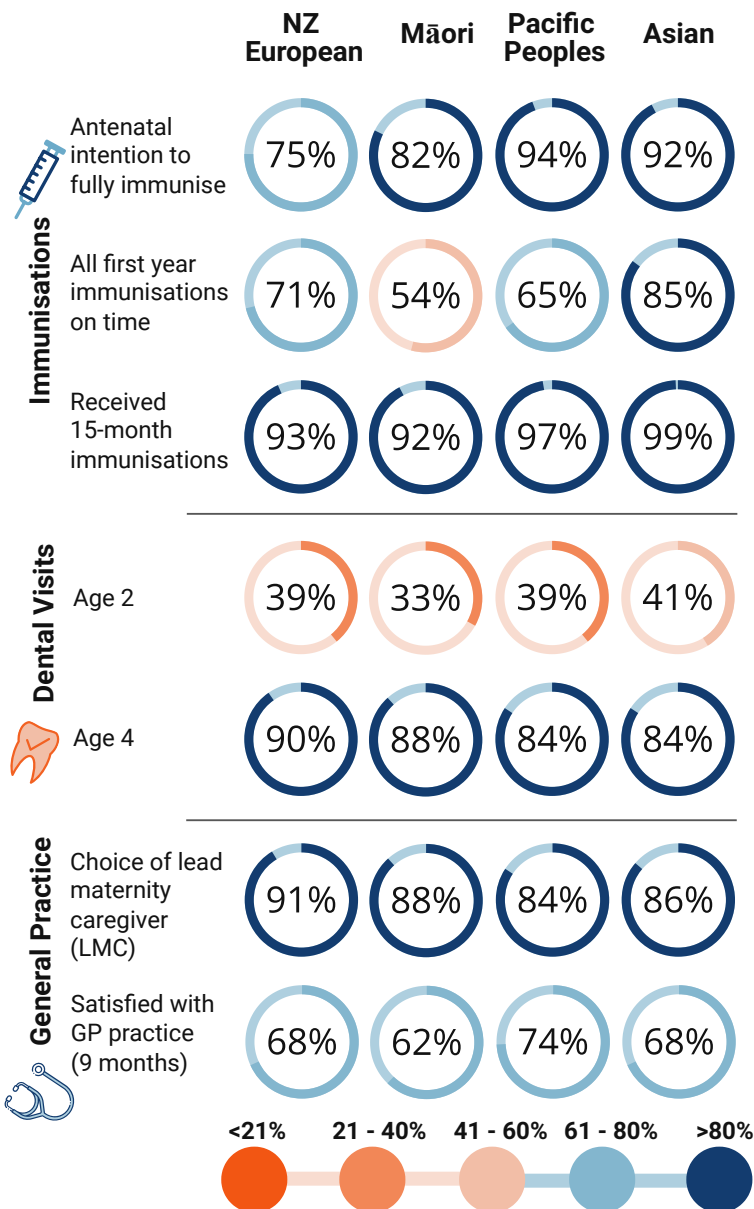
Overview

This research summary covers key statistics and findings from a mixed-methods research programme exploring inequities in accessing and using GP services, childhood immunisations, and dental care. We acknowledge funding primarily from the Health Research Council (HRC#19/236), with additional support from the Ministry of Social Development, and Te Whatu Ora | Health Promotion. The published research papers that underlie the following results are available [here](#).

Quantitative Methods

Growing up in New Zealand (GUINZ) data tracks the growth and development information of a birth cohort of children born between 2009 and 2010. 6,822 mothers were enrolled during the antenatal survey, and children were followed up at 9-months, 2-years and 4-years. Multivariable regressions (and decomposition analysis) were used to adjust for mother, child, household, socioeconomic, mobility and social factors.

Healthcare uptake and experience – Outcomes of interest



Quantitative Findings

- Asian and Pacific peoples have higher likelihood of child immunisation relative to NZ Europeans and Māori. Except for all first-year immunisations on time.
- Discouragement by family has the largest marginal effect on immunisation. Encouragement by health professionals had the largest positive influence.
- Ethnic gaps for Māori and Pacific peoples relative to NZ Europeans for dental visits are largely unexplained by individual and household characteristics.
- Perceived discrimination by a health professional was associated with a lower likelihood of attaining 1st choice LMC, and lower satisfaction with child's GP.

Assessing the behaviour effect of past immunisation

Immunised at t-1	Immunised at t		Total t-1
	No	Yes	
No	71%	29%	7%
Yes	4%	96%	93%
Total t	9%	91%	

- Of those that didn't immunise at the last event, 71% also didn't immunise at the next milestone; of those that did immunise at the last event, 96% also immunised at the next milestone.
- This dependence was stronger for Māori, and for mothers who stated antenatally they didn't know whether they would immunise.

Qualitative Methods

We conducted semi-structured interviews and focus groups with 145 Māori, Pacific, Asian (Chinese and Indian), and European caregivers across Tāmaki Makaurau (Auckland) and Te Tai Tokerau (Northland). We analysed the data utilising reflexive thematic analysis. While many commonalities were shared by ethnicity, unique to Indigenous Māori caregivers were the colonial traumas that impact their ability to trust health providers and the health system.

Qualitative Findings

Hierarchies of knowledge and trust

Caregivers used multiple sources of health information, such as health professionals, their network of family and friends, and traditional healers, that they trusted to varying degrees. Māori caregivers described a mistrust of health professionals and how they resisted criticisms and racism they experienced by exerting their rangatiratanga (self-determination).

"I wouldn't let them operate until he [healthcare professional] signed, he would operate as if he was operating on his own child. I brought the whole operating team into her room, and we did karakia." (Māori caregiver)

Relational versus transactional health encounters

Caregivers saw appointments as an opportunity for authentic whakawhanaungatanga (building relationships) with health professionals. However, most caregivers' experiences with health professionals were often rushed and transactional.

"It's like we just have to go through this checklist ... 'sorry I have to ask these questions'. She [nurse] just wants me to say 'no' to everything." (European caregiver)

Bad mother vibe

Mothers shared their struggles with motherhood, but often felt judged by health professionals when accessing care if they did not appear to 'have it all together'. Mothers felt pressure to conform to health professionals' recommendations even when it was at odds with what was best for their whānau (family).

"In my generation we were always judged... in that moment of crisis and need, you shut your mouth." (Māori caregiver)

The 'slow burn' of waiting

Caregivers were often frustrated by how slow and fragmented the health system was, which was particularly distressing if their child was unwell or required referral.

"It's the time frame of waiting that really, really discouraged them..... often they'd come home and they'd go 'oh, we have to wait for two hours.' They just decided not to take the kids there for check-up." (Pacific caregiver)

Navigating complexity

Caregivers had to be proactive and assertive to ensure their child received care amidst the numerous barriers they faced. Migrant caregivers were particularly unaware of health services available during pregnancy.

"Due to the language barrier, I have a sense of insecurity... I would be concerned that what if I cannot understand the doctor." (Chinese caregiver)

Policy Implications & Recommendations

1. Additional policies and strategies to reduce direct and indirect costs of accessing health services

- All childhood health services should be free regardless of child's citizenship or immigration status
- Policies to alleviate the indirect costs (e.g., transportation, opportunity costs)

2. HCPs to develop trusting relationships and delivery culturally safe care in supportive health environments

- Importance of encouragement for immunisations (earlier the better)
- Policies to address systemic racism

4. Better support for mothers postpartum and take a more whānau-centred approach

5. System-level changes to health system so it is less complex, offers more choice, and is more inclusive

- Improve navigation of health system and bridge care between various services
- Better access to interpreter services
- Offer welcome orientation sessions