Call for action on equity from three angles

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Ka tangi ngā manu ā ngā hau e whā – the birds of the four winds cry
Ka tangi te iwi ā Aotearoa – the nation of New Zealand cries
He tangi ā tātou wairua katoa – our souls cry as one

The Christchurch mosque attacks at the hands of a white supremacist terrorist are a solemn and tragic product of a wider system of racism. The so-called triangle of racism shows us that hate crimes are at the active end of a continuum and that the extreme tip is held in place by a large underlying passive acceptance of the denial of racism and white privilege.\(^1\) Racism is an organised system that operates at multiple levels (both at a structural and personal level) with various pathways to health. Jones talks of inaction in the face of need as a hallmark of institutionalised racism\(^2\) and Harris has shown that active individual level racism is a determinant of health and ethnic health inequities in Aotearoa.\(^3\) It is well established that health inequities are the result of both active discrimination and passive inaction. Paradies reminds us that racism will not be removed from society without dedicated and directive effort, hence ignoring racism is not an option if we wish to achieve health equity.\(^4\)

Just 100 days after the election of the new Labour government, an article in *The Spinoff* presented views from a collection of Māori researchers.\(^5\) Their call was for a movement from a ‘reduction’ in ethnic health inequities towards a clear ‘elimination’ of inequity goal through “pro-equity and anti-racism” health services. A 2018 article by some of the same researchers called for “free, frank and fearless” discussions on equity and racism in which the voices of disadvantaged groups are privileged.\(^6\) In this volume of *The New Zealand Medical Journal*, three articles align with this vision for Aotearoa’s healthcare future. Explaining the patients’ perspective, Fuimaono et al\(^7\) present a narrative of the treatment journey for Samoan patients requiring renal replacement therapy. Walsh et al\(^8\) quantify health inequity in the most confronting of measures—avoidable mortality. Lastly, the viewpoint piece of Came et al\(^9\) articulates underlining policies and processes that have allowed inequities to develop and be perpetuated. Together these three papers are a call to action, and give guidance on the direction needed to improve health and achieve equity for marginalised or priority populations in Aotearoa.

Three key learnings are held in these pieces of work: to listen to the voice of our communities while sharing power with priority groups; to look closer at the role of health systems in creating and maintaining inequities; to talk, listen and reflect on racism within our homes, communities and work.

Good listening requires privileging the voices of priority communities through participation, power sharing and use of quality data—numbers and stories. Walsh et al give voice to Māori and Pacific communities, with the presentation of shortened life expectancies due to avoidable mortality. The 7.0–7.4 year shortened life expectancy for Māori and 5.9–6.0 year for Pacific is a travesty and a lost opportunity within families, communities and Aotearoa as a nation. Action to eliminate inequities is often put in the too hard basket. This paper highlights where prioritisation and focus should occur for healthcare and research funding. Planning staff working in health organisations would do well to have the leading avoidable causes of death figures as screensavers.

Fuimaono’s interviews with patients in their preferred tongue, and with clinicians, outlines the experience and pathway of care for Samoan renal patients. Without this investigation, the perspective of this community would have remained silent in understanding barriers and drivers of their lived disparity. The paper is an example of the focus and careful review needed along care pathways for priority groups.
A repeated message in these reports is encouragement to move away from the deficit focus on the individual and rather to a focus on the system itself; to turn a metaphorical mirror on the system. The papers approach this from different levels, but all call for a critique of service delivery. Fuimaono achieves this by outlining the clear mismatch in the pathway delivered by a healthcare system, with the pathway required by participants. Information such as this signpost the direction services need to take to mediate barriers and improve access for, and be responsive to, the communities they serve. Walsh argues in his paper that the gap in avoidable mortality seen between Māori or Pacific communities and non-Māori/non-Pacific, is a pure measure of inequity, as it presents death that has the potential to be amenable to quality and timely healthcare delivery. This group contends that the (inequitable and racist) system itself should be considered as a determinant of health. Correspondingly, Came reasons that inaction in the face of need is the cornerstone of the healthcare system’s role in inequity. These researchers call for an all-of-system plan, focused on structural change of policy and practice. As the predominance of power and resources sits with services, so too should the responsibility of aligning resourcing and service delivery to meet the need of priority communities. In the Minister of Health’s latest Letter of Expectations for district health boards and subsidiary entities, achieving equity within the New Zealand health system was the first clear recommendation presented and this was repeated throughout the letter.9 These NZMJ articles will help guide processes and actions needed to meet the Minister’s directive.

Racism is the ethnic health inequities elephant in the room. It is a term that causes quiet discomfort—or at times not quiet. Yet, if we do not talk about racism and call it by name, its ubiquitous hold on health cannot be challenged. Theories on racism in health have described the multiple levels of racism: internalised, interpersonal and institutionalised.2 Despite this, for most people, reference to racism inevitably leads only to thoughts of racist interactions between individuals. Came reminds us that the racism built into the system is insidious, invisible and injurious. It is at this systemic level, with the Crown and the Aotearoa health system, that Came’s team outline a process for change. They call for new work, well above interpersonal interventions such as education and cultural competencies, to change structures, policy, resourcing and practice. In both Walsh’s quantitative paper and Came’s policy viewpoint, racism is named as a fundamental determinant of health. And like many other determinants of health, racism is unevenly distributed across society.

Institutional racism and other systemic drivers of health inequities between ethnic groups are complex, multifaceted and highly resistant to change. At times, this means that obstacles to transformation are seen as insurmountable. But, with concentrated effort, at all levels of healthcare, from policy to delivery, eliminating racism and achieving equity is possible. Such an endeavour commands true partnership between all leaders, healthcare professionals and community members. Each of the three papers illustrate how such partnerships can embolden leadership for health equity. The three teams built on the strengths of their individuals, whether a Samoan medical student, Māori health researchers, a Samoan public health physician or Pākehā professors with years of challenging racist status quo. Such sharing of power and responsibility is necessary and will help develop a multi-pronged, highly-skilled health equity workforce.

In the aftermath of the shared mourning and tragedy in the Muslim mosques in Christchurch, we must be brave enough to reflect on how an event like this occurred in our Aotearoa. That, as outlined by Moana Jackson, such an event did not occur in a “non-contextual vacuum” but drew upon “shared ideas and history.”11 It is our hope that we are on the precipice of change that builds on work done thus far. And that it will be no longer acceptable to merely mention racism-free healthcare and equity as ephemeral and under-resourced goals. We hope we are instead moving to a stage where racism will not be tolerated, equity will be demanded and that critique of the role the health system plays in creating or maintaining inequities will become the norm. To achieve this, anti-racism and pro-equity activities can no longer be the work of the fringe, but must become a priority and core work for the entire healthcare service.

“Of all the forms of inequity, injustice in healthcare is the most shocking and inhumane.”

- Martin Luther King Jr
Competing interests:
Nil.

Acknowledgements:
We acknowledge Ricci Harris (Associate Professor, Te Rōpū Rangahau Hauora a Eru Pōmare, Department of Public Health, University of Otago) and Matire Harwood (Associate Professor and Director, Tōmaiora Māori Health Research Group, University of Auckland) for your comments and improvements on the final draft.

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