A decade ago, Sir Michael Marmot wrote that in order to achieve health equity, we needed to move beyond the contemporary concentration on the immediate causes of disease to a focus on the “causes of the causes—the fundamental structures of social hierarchy and the socially determined conditions these create”. Ten years later, Tobias asks if social rank is a risk factor whose time has come. Evidence for the effect of social rank on mortality, he said, is “now impossible to ignore”. Tobias was referring to the Stringhini et al multicohort study and meta-analysis of 1.7 million men and women looking at socioeconomic status against the World Health Organization’s 25x25 goal (to reduce non-communicable diseases by 25% by 2025). Social rank is strongly associated with ethnicity in New Zealand and continuing, and for some diseases widening, ethnic disparities in health outcome.

There is an increasing call for greater examination of “how society is structured” and supported via macroeconomic and social policy. However, this rhetoric is typically followed by regression to recommending ‘Western’-derived one-size-fits-all top-down public health strategies aimed at controlling single behaviours of recalcitrant individuals or groups, such as imposing fines for smoking in cars—a punishment that would disproportionately impact Māori women of whom 40% still smoke. The holistic Māori perspective or application of health equity assessment tools to project outcome by ethnicity and consider perverse outcomes such as increased criminal convictions due to thefts of tobacco are absent. Public health returns to a focus on single immediate causes of disease in a siloed way incommensurate with Māori solutions.

Reversion to a mono-cultural majoritarian decision-making policy environment that simultaneously accepts the universality of Western perspectives and marginalises Māori ways of knowing is a form of institutional racism. Institutional racism, that is the patterned differential “access to material resources and power which advantages one section of the population while disadvantaging another”, is recognised by the Ministry of Health as a key determinant of health. Came has previously described how in such an environment, Māori health concerns are “managed” to the margins through inadequate consultation, the privileging of international research over successful local Māori-led initiatives and under-investment. Getting Māori health priorities on to the health agenda is made all the more difficult by low representation of Māori within senior management levels. High staff turn-over, and therefore loss of institutional (Māori) knowledge, stalls Māori health initiatives as Māori state actors and external stakeholders constantly have to re-engage and re-educate upwards.

To ensure Māori health and wellbeing improves and that health inequities are reduced, Durie says we must change the way in which the health system has been functioning. In this issue of the Journal, Came and Tudor ask how can this occur when fundamental infrastructure designed to guide such change is systemically removed? They alert us to the disestablishment of the Ministry of Health’s Māori unit Te Kete Hauora—a unit ensuring partnership, Māori participation and the protection of Māori health. Further, they report that district health boards (DHB) are no longer required to develop a Māori health plan and they can scale back on consulting with their region’s Iwi (tribes) or Māori communities. Came and Tudor rightly question the Crown’s commitment to engagement with their Te Tiriti obligations through this undermining...
and undoing of the whāriki (flax mat) of Māori health infrastructure. This, they argue, will have far-reaching implications for Māori health, and threatens progress towards achieving equitable outcomes for Māori.¹¹

We share their concerns that these structural changes signal a watering down of Crown accountability under Te Tiriti o Waitangi. In particular, the deregulation threatens system capacity and commitment to achieve positive change and uphold Māori aspirations. The removal of roles dedicated to leading and ensuring Māori input shows an increasing loss of accountability in DHB performance for Māori. Similarly, the removal of reporting mechanisms undermines the ability of the health system to embed and monitor Tiriti-based policy analysis and practice.

Perhaps the Ministry of Health believes Health Targets can more effectively deliver improvements in Māori health and reduction in health inequities? There is some evidence that aggregated targets may deliver improvements to overall population health while failing to improve the health of indigenous people.¹⁴ In New Zealand for example, cardiovascular, infant and maternal mortality have been trending downwards, but this is happening more slowly for Māori and Pacific peoples. Intervention generated inequalities occur when there are disparities in service provision, response, access, uptake, compliance and long-term sustainability between socio-economic groups. Tobacco control is one area where intervention generated inequalities have emerged. While smoking rates have decreased across the population, Māori smoking rates have not statistically reduced over the last nine years.⁷ The low priority given to Māori public health initiatives combined with intervention-generated health inequalities arising from downstream initiatives that do not take into account structural determinants of health, illustrate the complexities associated with achieving Māori health gain and the need for robust Māori-centred policy-making frameworks.

Our title refers to a well-known whakatauki (Māori saying) that warns that if the heart of the flax bush is no longer, the Komako (bellbird) will have nowhere from whence to sing, warn or praise. With the loss of Te Kete Hauora and contractual requirements to plan to improve Māori health, the question remains: Who then will report on the potential of health interventions to, as proposed by Durie, shift a mauri that is languishing to a mauri that is flourishing?²⁰

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Nil.

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