Ongoing leadership and effort needed to keep the focus on improving Māori health

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Colonialism has left a legacy of health inequalities affecting indigenous peoples in many countries, including New Zealand. Crown recognition of the impact on the wellbeing of multiple generations of Māori communities has been acknowledged in the apologies that are important components of New Zealand’s Treaty of Waitangi settlements.

Increased understanding of historical injustices has contributed to a shift from victim-blaming (where the problem lies with Māori) to a focus on how systems create or maintain inequalities.

Two important problems with unequal health outcomes are featured in this edition of the NZMJ. For one (coronary heart disease) gaps are closing.¹ For the other (acute rheumatic fever) gaps are widening.² Both are strongly associated with social determinants, both are preventable, and both are amenable to medical care.

In the 1980s, Eru Pomare cautioned that Māori were under-represented in coronary bypass statistics and over-represented in deaths.³ In the 1990s, Colin Tukuitonga revealed that Pacific people were also underserved.⁴ Scrutiny has continued.

Two decades later it is heartening to see Kerr and colleagues—in this edition of the NZMJ—recognise that equity is intrinsic to quality improvement in their thoughtful analysis of care received by patients with acute coronary syndrome at Middlemore Hospital (Auckland, New Zealand).¹ It is also reassuring to see the reduction in disparities, although lower rates of angiography among Māori and Pacific patients and lower revascularisation among Pacific patients require further attention. The All New Zealand Acute Coronary Syndrome-Quality Improvement (ANZACS-QI) register will assist cardiac services throughout the country to be just as vigilant in their efforts to mitigate and undo the inverse care law.

Pennock and colleagues—also in the edition of the NZMJ—highlight, again, the terrible burden of rheumatic fever on Māori and Pacific communities in New Zealand.² The history of our health system’s engagement with rheumatic fever is a blend of commitment and neglect and, as the authors point out, health system restructuring in the relatively recent past prompted the dropping of Hamilton’s rheumatic fever register in the early 1990s. The current government’s focus on rheumatic fever is welcome.

From a research perspective this disease continues to be bewildering. The fact that only half of cases in the Waikato over a 10-year period had a documented sore throat preceding their episode of rheumatic fever only stresses further our need to understand more about the disease. Nevertheless, while the causes of its distribution and the relative importance of genetic influences still remain the subject of speculation and research, it stands as a beacon of condemnation of our divided society.
where the poorest (notably Māori and Pacific communities) are blighted by what is commonly regarded in rich nations as a largely historic disease.

The boundaries between New Zealand’s health system and the wider society are porous. It is therefore no surprise that the health system has cast itself as both part of the problem and part of the solution when it comes to systematic health inequalities between Māori and Pākehā (European New Zealanders).

The past two decades have seen major gains in the health system’s responsiveness to Māori health needs thanks to the wide acceptance by health professionals and managers that the status quo was not, and continues to be not acceptable.

For the momentum to be sustained we must keep our focus on doing all we can do to provide services which actually make a difference to health outcomes for Māori. As the authors in this edition of the Journal demonstrate, we are well able to measure and evaluate our efforts.

Concerted action continues to be required.

**Competing interests:** Nil.

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