Acknowledging and acting on racism in the health sector in Aotearoa New Zealand

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"I think New Zealand is the best place on the planet, but it's a racist place."

Taika Waititi (9 April, 2018)[1]

"I grew up believing that New Zealand was a country with limitless opportunities. Success was there for those who worked hard, and was therefore deserved by those who achieved it. And if certain groups in New Zealand weren't achieving, it was most likely because they weren't working hard enough. After all, my parents had achieved financial success in my lifetime despite arriving in New Zealand without any money or the ability to speak or write English. This belief persisted and was reinforced as I succeeded academically at school before earning and, I thought, deserving, a place in medical school. Once I got to medical school, this belief extended to health. After all, so many of the conditions I was learning about were caused, and/or significantly exacerbated, by modifiable 'lifestyle factors'. Throughout this time, I believed myself to be a good person. My aim in medicine was to 'help people' and I considered myself to be 'colour blind': I would treat everyone the same, irrespective of their ethnicity. But if they chose not to attend or follow my instructions, that was their choice and outside of my responsibility as a clinician. It wasn't until I embarked upon training in public health medicine that I began to realise (and am continuing to realise) how mistaken I have been about many of my core beliefs, and about how, through my ignorance, I have contributed to racism in New Zealand."

Vanessa Selak (personal reflection, 9 August 2020)

The purpose of our editorial is twofold. First we will highlight some of the false beliefs that persist, and contribute to, ongoing racism within the health sector in Aotearoa New Zealand. Such racism, albeit often unconscious, has been identified in recent studies of New Zealand medical students.[2,3] We will use examples of false beliefs we have encountered through the academic peer review process, as Māori (MH) and Pākehā (VS, RJ) researchers exploring and addressing differences in cardiovascular disease (CVD) risk factors and outcomes by ethnicity. This work builds on a paper by Reid, Robson and Jones, that explored and debunked common myths regarding disparities in health 20 years ago,[4] and draws on the excellent articles highlighting ethnic inequities in this issue of the *NZMJ*. Second we recommend some appropriate ways for the *NZMJ* and Pākehā health professionals/researchers to contribute to research and peer review that will support culturally safe research and equitable outcomes for Māori and other groups experiencing inequities.

Before we begin, it is important to define racism, and understand how it affects health. Racism is often thought of as the belief that certain races of people are by birth, or nature, superior to others. Professor Camara Jones' definition provides a much more useful definition of the complex nature of racism, conceptualising three types of racism: (1) institutionalised ("*differential access to the goods, services and opportunities of society by race*"), (2) interpersonal ("*prejudice and discrimination*", which can be intentional or unintentional) and (3) internalised ("*acceptance by members of the stigmatised races of negative messages about their own abilities and intrinsic worth*").[5] Jones highlights the importance of using such a framework to help to understand the reasons for differences in health outcomes by race, rather than simply adjusting for or ignoring these, and to thereby inform appropriate action to address the differences.[5] She notes that "*Ignoring the etiologic clues embedded in group differences impedes the advance of*

scientific knowledge, limits efforts at primary prevention and perpetuates ideas of biologically determined differences between the races." Action to address racism in the health sector should consider the three main pathways by which racism affects health: (1) differential access to the determinants of health or exposures (which leads to differences in disease incidence), (2) differential access to healthcare and (3) differences in the quality of care received.[6] Reid and Robson, and a more recent publication by the Health Quality and Safety Commission (HQSC), have provided evidence of each of these pathways operating in the New Zealand health system.[6,7]

In this issue of the *NZMJ*, Talamaivao and colleagues report their findings of a systematic review that investigated the quantitative association between experiencing racism and health in New Zealand.[8] Consistent with international literature, the reviewers found that experiencing racism is associated with worse primary healthcare experience, lower healthcare utilisation and poorer health (particularly mental health) outcomes in studies that were predominately cross-sectional. The reviewers conclude that, because racism is experienced more frequently by Māori, Asian and Pacific groups than Europeans, these groups are disproportionately affected by the effects of racism on health outcomes. The reviewers note that there is a need for research into the longitudinal effects of racism on health outcomes as well interventions to combat racism and its adverse health consequences.

However, there is also a need for a healthy and safe 'article review' process in order for such research to be published. Some examples of incorrect and racist beliefs we have encountered through peer review of our research are discussed below.

Māori are immigrants, like other immigrant groups, as there are no Indigenous people of New Zealand

The ancestors of Māori were the first human inhabitants of New Zealand, settling here by 1,300, having travelled here from East Polynesia.[9] They began to identify as tangata māori (meaning the ordinary or usual people) in the 1800s, in part to differentiate themselves from immigrants to New Zealand, who they were referring to as Pākehā by 1815.[10] Māori, as tangata

whenua, are the Indigenous people of New Zealand.[11] While there is no internationally adopted definition of Indigenous peoples,[12] the 2007 United Nations Declaration of the Rights of Indigenous Peoples[13] recognises the right of Indigenous peoples to self-determination, including their right to self-identify as and be recognised as Indigenous.[11] Māori clearly meet all definitions of Indigenous people provided in an overview by the United Nations.[12] For example, the Martinez Cobo Study has proposed a working definition of "*communities, peoples and nations ... which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing in those territories, or parts of them*".[12] Another definition notes four key factors of importance when defining indigeneity: (1) "*priority in time, with respect to the occupation and use of a specific territory*", (2) "*the voluntary perpetuation of cultural distinctiveness*", (3) "*self-identification ... as a distinct collectivity*" and (4) "*an experience of subjugation, marginalisation, dispossession, exclusion or discrimination, whether or not these conditions persist*".[12]

The distinction between Indigenous and other ethnic (immigrant) groups in New Zealand must be acknowledged and honoured.[11] In addition to UN covenants which endorse the right of Māori as tangata whenua to determine their individual and collective identities, Māori status as tangata whenu is affirmed by te Tiriti o Waitangi.[11]

Māori experienced development, not colonisation

Development and colonisation, though related, are different concepts that need to be considered separately. First, in terms of development, while the way in which development occurred was strongly influenced by colonisation, any assumption that without colonisation development would not have occurred in New Zealand is incorrect. Development had occurred in New Zealand prior to the arrival of Europeans, and continued to occur after the arrival of Europeans and prior to colonisation. Had New Zealand not been colonised, Māori would no doubt have continued to trade and share ideas/advances with non-Māori as they had prior to colonisation. Colonisation changed the way in

which development occurred for Māori. Post-colonial theory argues that the *"colonial practices of progressive developmentalism"* contributed to the trauma of colonisation itself by undermining the value and role of Indigenous identity and structures through the development process.[14] According to subalternism, another relevant theory, Indigenous people of a colonised state are subalternate because they are *"politically, economically and socially excluded from the power structure"*.[14] Through subalternatism the process of colonisation is seen to cause Indigenous people to *"shift from a state of self-reliance and autonomous personal dignity to dependency and humiliation"*.[14] Both theories help to explain how the trauma of colonisation is perpetuated and reinforced as Indigenous peoples *"remain subalternate in the state and even attempts by the state to change this status through development only serve to reinforce this power inequality, by reinforcing the idea that Indigenous people need 'developing'"*.[14]

Colonisation was, and continues to be, a traumatic experience for Māori.[6,14–16] This is fundamentally because the process of colonisation results in a forced relocation of power and resources from Indigenous people to the colonisers who, however well intentioned, construct new systems according to their own, not Indigenous, values, and these new systems ultimately redistribute power and resources to the advantage of colonisers.[6] Despite the assertion that such *"new systems provide equal opportunity for all participants"* they cannot, and clearly do not, because they are imbued with the values of the colonisers: *"they promote new ideas about who is normal (and therefore who is not); who is knowing and who is ignorant; who is civilised and who is barbaric; who is deserving and who is undeserving; and who is good and who is bad"*.[6] The process of colonisation has therefore resulted in moving Māori, the tangata whenua, from being normal, to being seen by Pākehā as different and classified as outsiders.[6] Further, Māori are then framed as being to blame for their own inferior health outcomes compared with Pākehā, without acknowledgement of the structural bias that is inherent in our health system because it is designed to advantage Pākehā over Māori.[6]

Health differences between Māori and non-Māori are inequalities, not inequities

The New Zealand Ministry of Health definition of equity is *"In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."*[17] This definition has been informed by Te Tiriti o Waitangi obligations (which go *"beyond just remedying disadvantage and reducing inequities, enabling Māori to flourish and lead their aspirations for health"*), as well as international literature on equity.[18] The World Health Organization (WHO) defines equity as *"the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically"*.[19] The purpose of the Ministry of Health developing and providing their definition of equity was to enhance the coordination and hence effectiveness of action to achieve equity in health across the health and disability sector and other government agencies that address the broader socioeconomic determinants of health in New Zealand.[18]

WHO notes that health inequities *"involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms"*.[19] WHO further notes that *"reducing health inequities is important because health is a fundamental human right and its progressive realisation will eliminate inequalities that result from differences in health status (such as disease or disability) in the opportunity to enjoy life and pursue one's life plans"*.[19]

In addition to meeting international legal obligations, addressing inequities between Māori and non-Māori is required to meet New Zealand government obligations under te Tiriti o Waitangi and health sector obligations under the New Zealand Public Health and Disability Act 2000.[7] The ongoing inequities experienced by Māori in their health outcomes is the subject of the Waitangi

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Tribunal Health Services and Outcomes Inquiry (Wai 2575), which was initiated in November 2016.

In their viewpoint article in this issue of the *NZMJ*, Gurney and colleagues note that there is considerable evidence of enduring inequities between Māori and non-Māori in cancer incidence and mortality, and that cancer is an important contributor to the life expectancy gap between Māori and non-Māori.[20] In addition to data on the most commonly diagnosed cancers and causes of cancer death among Māori between 2007 and 2016, Gurney et al found higher morbidity and mortality from most of these cancers for Māori compared with non-Māori. They note that, reflecting on the commitment from central Government to close the cancer gap for Māori, the country's new Cancer Action Plan 2019–2029 is focused on achieving equitable cancer outcomes for all New Zealanders by being equity-led and achieving equity by design.

Behavioural risk factors wholly reflect individual choice

Behavioural risk factors are strongly influenced by broad contextual factors, often referred to as the social determinants of health or the causes of the causes. The importance of considering social determinants of health when determining how to intervene effectively to support equitable health outcomes has been extensively investigated internationally over many years by many authors, most notably Professor Michael Marmot[21] and including a very well articulated Position Statement on Health Equity approved by the New Zealand Medical Association in 2011.[22] A lack of understanding of the effect of social determinants of health on health behaviours may lead to healthcare professionals inappropriately blaming individuals for their health behaviours, rather than seeing that behaviour as the consequence of their wider social context and therefore considering what strategies might genuinely assist and support that individual to address the behaviour.

Institutional racism is an opinion, not a fact, in the New Zealand health sector

The fact that there are large and enduring differences between Māori and non-Māori in most health outcomes is evidence of the fact that institutional racism occurs in New Zealand. A recent publication by the HQSC notes: "*The Aotearoa New Zealand health system has generated and continues to reinforce inequities in health outcomes between Māori and non-Māori.*"[7] The HQSC explains that "*institutional racism is a systemic pathway to inequity. It occurs and continues because people at all levels of the system make decisions that disadvantage one group in relation to another*" and that "*such racism encompasses both action and inaction*".[7]

In considering how cancer inequities between Māori and non-Māori should be addressed, Gurney and colleagues note that these inequities are "*driven by disparities in the social determinants of good health, determinants that are structural in nature and not controlled by Māori*".[20] Gurney and colleagues label the inequities as a systems-level problem, that require a system-level solution. They further note that "*there is compelling evidence that Māori have poorer access to timely best-practice treatment compared to non-Māori*" and that therefore "*cancer care services have an important role to play in reducing the cancer burden for Māori*".[20] And finally, noting that the International Agency for Research on Cancer has identified the following key drivers of equitable access to cancer care as the three A's (availability, affordability, acceptability), Gurney and colleagues state "*we can identify our own system within these three A's, and how these are likely to be contributing to poorer cancer outcomes for Māori*".[20]

Egan and colleagues present their narrative review of disparities between Māori and non-Māori men in prostate cancer in New Zealand in this issue of the *NZMJ*.[23] They found that despite being less likely to be diagnosed with prostate cancer, Māori men are more likely than non-Māori men to die from prostate cancer. They note that addressing this inequity for Māori will require a number of systems solutions, including addressing social determinants of health (especially economic disparity), racism within health services and the development of culturally appropriate models of healthcare delivery for Māori.

Institutional racism is also likely to be important in addressing novel health challenges such as COVID-19. Steyn

and colleagues estimated that the likely COVID-19 infection fatality rates for Māori would be up to 2.5 times higher and for Pacific would be almost double that for Europeans.[24] They note that actual inequities could be even higher because, compared with Europeans, Māori and Pacific people are more likely to experience multimorbidity, avoidable hospitalisation ("*reflecting broader and more complex structural disadvantage*"), and "*widely reported racism within the healthcare system*".[24]

Recommendations

In order to support culturally safe research and equitable outcomes for Māori, and other groups experiencing inequities, we make the following recommendations.

New Zealand Medical Journal (NZMJ)

We note that the *NZMJ* is the official journal of the New Zealand Medical Association and New Zealand's "*leading online scientific information journal for medical practitioners and health professionals*" (http://www.medconnect.co.nz)". The NZMA published an excellent Position Statement on Health Equity nearly a decade ago[22] and "*welcomes the Waitangi Tribunal's Report on stage one of the Health Services and Outcomes Kaupapa Inquiry*".[25] The NZMA notes that "*To achieve that necessary equity NZMA supports the two broad recommendations made in the report – namely amendments to the New Zealand Public Health and Disability Act to include a Treaty of Waitangi clause and enshrining in that Act the Crown's and sector's commitment to achievement of equitable outcomes for Māori*".[25] We consider that in order to support these objectives of the NZMA, the pervasiveness of racism within the health sector and to fully realise the role of the *NZMJ* in Aotearoa New Zealand, the NZMJ should:

1. Assign a Māori co-editor
2. Develop a code of practice on racism in their peer review process

3. Commit to an open peer review process so that peer reviewers are no longer anonymous.

Pākehā health professionals and health researchers

In addition to drawing on the experiences and expertise of our numerous Māori and Pacific colleagues, we recommend the following, based on the advice of Randy Vince[26] in his recent article in *JAMA*:

1. Review and understand the history of race and racism within this country
2. Undertake and mandate antiracism/implicit bias training (eg, Project Implicit https://implicit.harvard.edu/implicit/)
3. Do not accept differences in health outcomes on the basis of ethnicity because most of these differences are avoidable and unjust (ie, they are inequities not inequalities)
4. Support and encourage the development of our Māori and Pacific colleagues throughout their careers as we need health services to be designed, delivered and researched by Māori and Pacific to ensure that the needs of Māori and Pacific people are optimally addressed and equity is achieved.
5. Undertake and facilitate the implementation of culturally aware mentorship training for all health professionals and researchers, to ensure that we all have the opportunity to reflect on our identities and, "*using the thoughts from this reflection to examine (our) biases toward people from other cultural identities*".[26]

Editor's note

The NZMA publishes the *NZMJ*, however the *NZMJ* has full editorial independence via its Editor-in-Chief.

The *NZMJ* is the principal scientific journal for the profession in New Zealand.

The *NZMJ* has had a Māori/Pasifika associate editor for the past 10 years.

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Nil.
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