Equity is the new black—and black lives matter
Curtis Walker

I tē wā a Te Mahuru, kua tukua te whakaputanga hauora oritetanga ō tēnei hau-taka rongonui. I tēnei wiki, kua tae mai te wiki ō Te Reo, nōrerira kua tae hoki he aheinga anō ki te whakanui i tēnei kaupapa-pa whakahirahira.

Health equity is the new black—and Black Lives Matter.

Renowned civil rights leader, Rev. Dr Martin Luther King Jr said: “Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane”.

Health equity matters: it is the right thing to do and the rights thing to do. It is of significance that all main political parties during election campaigning have indicated the importance of health equity as a necessary measure of success of our health system. Along with the recent Heather Simpson Health & Disability System Review,1 there now appears to be a societal consensus that equitable healthcare is a must.

Given we Kiwis like to think of ourselves as fair-minded, and equity is—at its heart—about fairness, this is perhaps not surprising. Although this is an encouraging place to find ourselves, saying something is important and then actually achieving it are quite different end-points. We must all do what we can within our personal and professional spheres of influence to ensure equity becomes reality.

Late last year the Medical Council of New Zealand (Council), in partnership with Te Ohu Rata O Aotearoa (Te ORA), released its Statement on Cultural Safety2 and He Ara Hauora Māori: A Pathway to Māori Health Equity.3 These statements set Council’s expectations of doctors and healthcare organisations in the delivery of culturally safe practice. In Aotearoa New Zealand, cultural safety is key to achieving equitable health outcomes for Māori—a right under Te Tiriti o Waitangi.

The move away from only the ‘cultural competence’ of the doctor, towards achieving ‘cultural safety’ for patients is deliberate and indicates a shift in thinking away from acquiring knowledge about the ‘other’, towards a focus on how patients receive their care.4 Research shows that simply learning about another’s culture does not result in positive change or improved health outcomes.5

Doctors (and other health professionals, and indeed the health system at large) have moral and professional obligations to strive for health equity in our practice. In order to do so, we need to understand the contributing factors to health inequity and our role in it.

The New Zealand Medical Council has just released an independent report6 on the state of cultural safety and health equity relating to doctors practicing in Aotearoa New Zealand and patients receiving care. The Report places Māori patients’ experiences front and centre; however, many of the challenges and solutions are applicable to other communities and populations who experience inequitable healthcare.

Findings from the Report show there is a strong need to acknowledge the systemic racism and privilege that prevails in the health sector. Doctors must reflect on their own cultural views and biases as a first step, then work to influence and support the places they work in and those they interact with, to improve how patients receive their care. Examples of racist beliefs and practices that proliferate in the health system were discussed in the last NZMJ editorial,7 and show there is considerable work to be done.

Significant structural barriers are also shown to impact patient care and cultural safety. These include short appointment times and a focus on only the immediate presenting needs, which limits the ability to

EDITORIAL
to build relationships and partner with patients and whānau.

Many patients and whānau feel disempowered, that their knowledge is underestimated, and that they are not involved in decision-making. This can lead to whānau feeling distanced from both the doctor and healthcare team, and from their own health. One of the intended outcomes of the Ministry of Health’s Whakamaua: Māori Health Action Plan 2020-2025 is that iwi, hapū, whānau and Māori communities can exercise their authority to improve their health and wellbeing. This is an important focus for collective action.

The Health and Disability System Review found that “Improving equity and wellbeing for Māori requires immediate improvements in the way the system delivers for Māori, a growth in the range and distribution of kaupapa Māori services, enhancements to rangatiratanga and mana motuhake”, and our findings support this. We need a diverse, culturally safe health workforce which reflects the communities we serve. This begins through selection into medical school, and continues through the training continuum to vocational specialisation.

Māori doctors often experience additional cultural demands on top of their day-to-day work. There is little evidence that such cultural activities and training of others is acknowledged and recognised in job descriptions or as a key element of professional development. Council is working with our partners to better support the Māori health and disability workforce and increase Māori leadership and participation in governance and decision making. Where representation is low, it requires being bold and courageous when highlighting issues for Māori.

There is overwhelming evidence of inequities in health outcomes for Māori—you need look no further than the previous issue of NZMJ or the Wai 2575 Māori Health Trends Report. COVID-19 also presents a concern for the likely disproportionate impact on Māori.

Council encourages all doctors, employers, training and professional organisations to consider the findings in the cultural safety Report, draw on the data, and use this as a basis for achieving long-term, positive change for the benefit of all patients and whānau.

While the Report offers an insight into current practice, it is only the first step on a long journey. It sets a baseline for ourselves and our stakeholders to use when developing programmes, strategies and policies that support us to drive change.

We are already seeing excellent work from the Medical Schools in selecting for medical workforce diversity, and the next generation of physicians in training will be “equity natives”. The specialist medical colleges, here and in Australia have Indigenous health and health equity embedded in their training and recertification programmes. Cultural safety training is increasingly (but far from universally) available, as is education on Te Tiriti within workplaces such as district health boards.

In exerting ourselves to success, we are reminded of the words of Tā Mason Durie, Māori doctor and academic, who writes “The potential within the Māori population has never been greater ... the potential to face the future with both the freshness of youth and the wisdom of age”. We should also be encouraged by the well-known whakatauki or tauparapara of Tā James Henare “Kua tāwhiti kē to haerenga mai, kia kore e haere tonu. He nui rawa o mahi, kia kore e mahi tonu.”
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Nil.

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