Structural reform or a cultural reform? Moving the health and disability sector to be pro-equity, culturally safe, Tiriti compliant and anti-racist

Papaarangi Reid

Forty years ago, in 1980, Professor Eru Pōmare published the first volume in the series *Hauora – Māori Standards of Health.* That volume documented patterns of mortality, comparing Māori with non-Māori between the years of 1955 and 1975. Although we now know that data at that time undercounted the number of Māori deaths, this work drew attention to inequities for Māori for most of the common and amenable diseases in Aotearoa. Since that time, efforts have been made to improve the quality of ethnicity data and the literature detailing health inequities has expanded, including another three volumes in the *Hauora* series.

Health inequities are defined as “the presence of systematic disparities in health between groups.” Within Aotearoa and internationally, significant work has sought to understand how inequities arise, how they are maintained and how they can be eliminated. Internationally, the work of Professor Sir Michael Marmot has provided leadership, and in 2011 the New Zealand Medical Association hosted Professor Marmot on his visit to Aotearoa. It is generally understood that inequities in health are bad, not only for those who suffer from inequity, but also for the public health of a nation. Social and political willingness to invest in the elimination of inequities fluctuates over time. We are currently in a time of some political willingness to address equity.

On 21 April this year, the Minister of Health, Honourable Andrew Little, released details of the proposed programme of reform for the New Zealand health and disability sector. This proposal follows the publication of reports from a review of the sector, led by Ms Heather Simpson, and from Stage 1 of the WAI 2575 Hauora claim to the Waitangi Tribunal. Both reports highlighted comprehensive, consistent and compelling health inequities for Māori as motivations for reform, and noted that the health and disability system continues to underperform for Māori.

While New Zealanders are generally proud of the work that our health system is able to achieve, many of us would also agree that the system faces very significant challenges from repair, replacement or development of critical infrastructure; integration of new technologies; ensuring access to services and timely primary care across our unique geography; health workforce development and appropriate distribution; elimination of duplication of planning and administration functions; seeking ways to increase publicly funded services such as dental health and new cancer therapies; becoming more sustainable with a decreasing carbon footprint; reducing waiting lists that have become longer with COVID-19; all the while being responsive to our changing demography. Further, we must not forget the production and reproduction of ethnic inequities—our health system must
become culturally safe. Change is needed but the health and disability system is a big and complex beast.

The Minister proposes a set of structural changes. The Ministry of Health will retain its function of sector stewardship and leadership of strategy, policy advice and monitoring. A new entity, Health New Zealand, will be tasked with developing a national plan for health and amalgamating all 20 district health boards (DHBs) and arrange them into four regions and a number of localities. Health New Zealand will have a lead role commissioning health services through these regional and locality bodies. Another new entity, the Māori Health Authority (MHA), will also be created. It will have a number of roles: providing strategy, policy and monitoring in parallel to the Ministry of Health; commissioning health services for Māori in addition to co-commissioning health services for the total populations in parallel with Health New Zealand. That is a lot of roles for the MHA—most of them aim to ensure the health system performs equitably.

Many Māori are excited by the proposed MHA, but there are still questions. Most of the proposed functions of the MHA exist already. The Ministry of Health, DHBs and Te Puni Kōkiri already have legislative and regulatory abilities to perform many of these roles. But they just don’t prioritise them, or they choose not to perform them. If we want our health system to change and become equitable and Tiriti compliant, we need to ask ourselves: What is our theory of change? What changes are necessary to achieve the outcomes we seek? Will the proposed structural change lead to different outcomes? Can equitable outcomes be achieved without a culture change within the health sector, to a culture of willingness to prioritise equity and compliance with guarantees of Te Tiriti o Waitangi?

These are big questions for the Government, the health and disability sector and health practitioners. The fundamental issue underpinning our culture change is to overcome our addiction to sameness. We have a reliance on singular ‘one size fits all’ policies and processes as a demonstration of ‘treating everyone equally’. This has led to inequitable outcomes because different groups experience different barriers to access opportunities in health. This culture change is a necessary prerequisite to achieving the stated objectives of the health reforms. Are we in the health sector ready and committed to this culture change?

The contributions to this volume of the New Zealand Medical Journal assist our focus in this regard. Some describe inequities and highlight important areas for change and future monitoring. Manuel and colleagues describe the public health importance of hearing loss and note significant inequities for kaumātua Māori accessing hearing services. Gee et al also focus on kaumātua and explore frailty and the range of issues that influence outcomes.

Gabrielle Baker and colleagues highlight missed opportunities in the Health and Disability System Review to uphold the Tiriti rights of Māori with lived experience of disability. Other contributions focus on proposals that are necessary to achieve equitable outcomes. In workforce, Sandra McDonald notes the importance of kaupapa Māori approaches to training the Māori nursing workforce, and Came et al describe the potential of health professional regulatory bodies to drive Tiriti compliance.

Whitehead and colleagues are concerned with the equity of the COVID-19 vaccine rollout and have modelled which of the different delivery localities across a DHB for larger-scale programmes have the least equity barriers. Hoek et al report on urgent work that needs to be done to achieve Smokefree 2025.

Three other contributions are important because they call out racism in the health system. It is easy to be a ‘racism denier’, but the broader impacts are just as dangerous as being a ‘COVID denier’ or a ‘climate denier’. In effect, if a system displays systematic ethnic inequities, it displays racism. It is at the heart of the culture that needs changing.

Elsewhere, renowned academic and anti-racism researcher Dr Camara Jones noted that naming racism is important and the first part of addressing it. But we need to go further and ask: How is racism operating here? What structures, policies, practices, norms and values are operating that permit racist outcomes and prevent us acting to overcome them?
Dr Wil Harrison has written an open letter to medical professionals after a racist incident was called out at a medical conference. Although the individuals and college involved have begun restorative work, he challenges the profession to be honest and reflect on what we can learn individually and collectively about racism in our own lives and practice. From this reflection he seeks collective commitment and action against racism.

Dr Julie Bennett and a collective of colleagues committed to the prevention of acute rheumatic fever and devastating rheumatic heart disease call on us to demand the establishment of a national register. This step to address one of our national shames is long overdue.

Dr Mel McLeod and colleagues present another clear agenda for our immediate collective support. There has been a debate back and forth about the age range of the Bowel Screening Programme (BSP) and whether the current age range (60–75 years for all New Zealanders) ignores important Māori demography that predicts that the BSP will deliver inequitable outcomes. This paper provides clear epidemiological arguments for an age extension of the BSP rollout to begin screening Māori at a younger age. Inaction in the face of this evidence would seem to constitute institutional racism.

Health professionals often expect recognition of leadership within the health and disability sector, especially in times of change. In order for the proposed structural reforms to the health and disability sector to be truly effective for Māori and therefore equity, a culture change must occur—within the health system, within the health professions and within us. We must accept the overwhelming evidence that ‘sameness’ creates inequity. Silence and inaction show us to be complicit in these inequitable and racist outcomes. Our advocacy and action is overdue. Mauri ora.

Competing interests:
Nil.

Acknowledgements:
Thanks to colleagues who have contributed to my thinking on these issues.

Author information:
Papaarangi Reid: Tumuaki, Faculty of Medical & Health Sciences, University of Auckland.

Corresponding author:
Papaarangi Reid, Tumuaki, Faculty of Medical & Health Sciences, University of Auckland
p.reid@auckland.ac.nz

URL:

REFERENCES
2. NZMA. Health Equity Position Statement
9. Baker G, King PT, Jones B, Ingham TR. Meeting the
Crown's Te Tiriti o Waitangi commitments and obligations to Māori with lived experience of disability through the Health and Disability System Review. NZ M J. 2021 May 21;134(1535):44-54

10. McDonald S. Manatu ki waheke in nursing education: a legend for an example. NZ M J. 2021 May 21;134(1535):88-90


15. Harrison W. It’s time to end racism in our profession: an open letter to the New Zealand medical community. NZ M J. 2021 May 21;134(1535):91-92
