



Breaking the inequity loop

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PUBLIC HEALTH

PRIORITIES SERIES

Summary

History shows us that the best way to improve Māori health is to support Māori to lead and drive the improvement ourselves. That means more Māori across all aspects of health: not just doctors, nurses and other clinical workforce, but also more Māori epidemiologists, health scientists, health policy experts, and even politicians.

The all-of-population approach has failed for more than a century to address Māori health inequalities. Government policy needs to accommodate tino rangatiratanga and allow Māori the resources and time to address our challenges. This includes supporting initiatives such as the Te Aka Whai Ora, the new Māori Health Authority

At the turn of the 20th century, New Zealand's first stream of Māori doctors – legendary figures like Maui Pomare and Peter Buck (Te Rangi Hīroa) – faced an extreme crisis in the health of their people.^{1,2} With infectious diseases rampant within Māori settlements, and fears that an epidemic of bubonic plague could strike at any moment,³ there was an acute need for rapid improvement in Māori living conditions. In many ways, Pomare, Buck and others were also forced to become New Zealand's first Māori epidemiologists: assessing population health within their communities, establishing the key determinants of disease, and then advocating for actions that would address those determinants.

Through the collective action of these rangatira and their supporters, local Māori councils were established to support the improvement of conditions within Māori settlements. Supported by 'native sanitary inspectors',⁴ Pomare, Buck and other Māori clinicians paid regular visits to settlements, treating individual patients as Māori doctors, and then assessing the quality of the water supply, housing and general sanitation as Māori epidemiologists.^{1,2} Pomare was even known to take a microscope with him on some of these visits, to wānanga local iwi and hapu and show them the microorganisms that threatened their whakapapa.¹

The impact on Māori health was profound. Best-guesses of Māori population size from back then – they're only best-guesses, since even in 2023 we're still trying to count Māori properly⁵ – suggest that after falling by more than two-thirds from around 150,000 pre-Te Tiriti to less than 50,000 by the turn of the 20th century, the number of Māori finally plateaued and started to grow again around the time of Pomare and Buck's intervention.⁶ The reasons for this revival in Māori population health are multifactorial – but there is little doubt that the actions of those Māori doctors very likely prevented a public health catastrophe for Māori, who had already been brought to the brink of extinction by the rapid impact of colonisation.³

Over the next decade, the role of Māori councils waned as tensions grew between the Crown and Māori regarding their rangatiratanga – their ability to take charge of things that mattered the most to their people, and to determine the best way to improve Māori health and wellbeing.⁴ For the Crown, the belief was in the primacy of kawanatanga (loosely translated as 'governorship'), meaning that all activities by Māori should be vetted and subject to Crown veto. Resourcing for the sanitary inspectors also dried-up, and they were soon abolished.^{1,4} Pomare and Buck moved from medicine into politics, and continued their tireless work to improve Māori population health from inside the political tent.^{1,2}

The above historical snapshot provides a case study from which key lessons can be drawn and applied to the current state of Māori population health. Firstly, it reminds us that inequities in health have existed between Māori and Pākehā in New Zealand since the birth of our nation. While Māori may have avoided extinction, we still fair significantly worse than Pākehā in every important health outcome. Among other outcomes, Māori are:

- More likely to develop cancers with a poor prognosis (e.g. stomach, liver and lung cancers),⁷ and have poorer survival outcomes than non-Māori once diagnosed for 23 of the 24 most common cancers in New Zealand;⁸
- More likely to have cardiovascular disease, including cardiac arrhythmia, congestive heart failure and hypertension;⁹⁻¹¹
- More likely to suffer a stroke and the consequent morbidity and mortality;¹²
- More likely to have Type-2 diabetes mellitus,¹³ and to suffer the consequent complications including lower-limb amputation;¹⁴
- More likely to have renal disease, with a corresponding increased risk of renal failure and need for dialysis;¹⁵
- More likely to require treatment for mental health disorders,¹⁶ including schizophrenia.¹⁷

These disparities in health outcomes have seen little in the way of improvement over time. For example, despite heightened awareness and increased focus on cancer disparities, the 30% disparity in lung cancer survival between Māori and non-Māori has remained unchanged for at least the last two decades.⁷ These enduring disparities are the focus of the WAI-2575 claim, with the Waitangi Tribunal noting that the existing health system *'has not addressed Māori health inequities in a Treaty-compliant way, and this failure is in part why Māori health inequities have persisted.'*¹⁸

With that in mind, our historical snapshot also teaches us that the best way to improve Māori health is to support Māori to lead and drive the improvement ourselves. That means more Māori across all aspects of health: not just doctors, nurses and other clinical workforce, but also more Māori epidemiologists, health scientists, health policy experts, and even politicians. In 2020, the all-of-system Health and Disability System Review recommended the establishment of an independent Māori health authority as one means of combatting the lack of progress toward equity.¹⁹ Although there was some disagreement within the Review committee regarding whether this organisation should be able to commission its own programmes of work – in other words, the same *tino rangatiratanga* versus *kawanatanga* argument that killed the Māori councils in the early-20th century – the Government committed to the creation of this authority as part of its wide-reaching health reforms.²⁰ Te Aka Whai Ora, our Māori Health Authority, was born.

However, our historical snapshot also reminds us of the political and social fragility of initiatives that primarily focus on closing the substantial gap in health outcomes between Māori and Pākehā. If a change in government occurs later this year, there are strong indications from the current leading opposition party that Te Aka Whai Ora would be swiftly disestablished, and Māori health disparities instead addressed within a single health authority²¹ – despite these disparities being intransigent to change for over 100 years within the previous single health authority.¹⁸

The complexity of this landscape, and the importance of the upcoming election as a determinant of Māori health in-and-of itself, require us to revisit some fundamental concepts regarding equity and privilege.



Let's start with the basics: in the context of health outcomes, what does equity really mean? You may have noticed that so far in this article we have largely used the term *disparities* as a descriptor for the differences in health outcomes experienced by Māori and Pākehā. This word is dispassionate; it tells us that there are differences between these groups, but does not tell us the direction of this difference, or whether it is good or bad. On the other hand, the word *equity* evokes a sense of fairness, and the term *inequitable* is synonymous with the word *unfair*.²²

For any health system, there is a tried-and-true recipe for the creation of inequities in health outcomes between population groups.^{22,23} Firstly, the recipe requires us to ensure that there are differences between population groups – in this case, Māori and Pākehā – in terms of the social determinants of health, or in exposure to the things that lead to disease. The downstream impact of colonisation has already ensured that this is the case for Māori in New Zealand, with these social determinants driving the disparities in disease incidence noted earlier in this article. Secondly, the recipe requires us to ensure that there are differences between groups in terms of access to health care. There is striking evidence that Māori find it more difficult to access care than Pākehā, for a multitude of reasons including the availability, affordability and acceptability of care.²⁴ For example, Māori with liver cancer need to travel twice as far as Pākehā to receive their primary surgery.²⁵ Thirdly, the recipe requires us to ensure that even if Māori are able to access care, the quality of that care is of an inferior standard to that received by Pākehā. Here, too, there is evidence from the cancer context: a previous study showed that Maori with Stage III colon cancer were less likely undergo aggressive surgical resection commensurate with international indices of surgical quality, and also were less likely to receive adjuvant

chemotherapy than non-Maori with the same disease – with those Māori who did receive chemotherapy waiting around eight weeks longer to receive it than non-Māori, potentially compromising its effectiveness.²⁶

When it comes to health in New Zealand, we have been passively adhering to this recipe for generations. Māori health pioneers like Maui Pomare and Peter Buck, and countless other Māori and non-Māori leaders since, understood intuitively that undoing inequities in health outcomes for our Indigenous population requires us to disentangle Māori health from overall population health – because they aren't the same thing. The generational endurance of Māori health disparities is clear evidence that we cannot solve Māori health problems by continuing to take an all-of-population approach. And yes – that means that we may need to invest more per capita in the health of Māori than we do for other groups. As noted by Papaarangi Reid and Bridget Robson: *“Equity, like fairness, is an ethical concept...it does not necessarily mean that resources are equally shared; rather, it acknowledges that sometimes different resourcing is needed in order that different groups enjoy equitable health outcomes.”*²²

This disproportionate investment in Māori health – like, say, establishing a Māori Health Authority with a budget to commission work programmes – is often toxically reframed as Māori privilege. This kind of reframing is often coupled with the notion that directing resource toward one ethnic group is a form of racism in-and-of itself, and that any investment should be shared ‘equally’ across the population. Of course, rather than being racist, targeting Māori health outcomes in ways that will specifically work for our people is not only a way for our society to lift up a substantial minority of the New Zealand population, it's also likely that doing so will invariably improve systems to achieve optimal outcomes for many disadvantaged groups. Secondly, the Māori privilege reframing ignores the fundamental importance of Te Tiriti o Waitangi as our nation's founding document, the principles of which require the Crown to take active measures to restore balance in situations where Māori have been disadvantaged.²⁷ This places in sharp focus Te Tiriti's initial promise of tino rangatiratanga for Māori, but with the later interpretation that this must be subservient to kawanatanga by the Crown. Thirdly, rather than being viewed as Māori privilege, directly investing in Māori health should instead be viewed as an act of partially de-privileging Pākehā. Since more than two-thirds of our population are Pākehā, designing and running a health service or programme so that it is the ‘same for every New Zealander’ invariably means that it will be primarily designed to work for the majority – which means that it will always work better for Pākehā than it does for Māori.

For Māori, the occasions when we have been able to exercise tino rangatiratanga have resulted in significant success and benefited Aotearoa New Zealand as a whole. The 28th Māori Battalion fought with distinction in the Second World War under Māori leadership;²⁸ the development of Kohanga Reo and Kura Kaupapa in the 1970's and 1980's followed by tertiary Wānanga has increasingly normalised a Te Ao Māori-based education;²⁹ iwi Tiriti settlements have provided housing, healthcare and services while growing the Māori economy and asset base to over NZ\$65 billion nationally;³⁰ while tertiary institute partnerships have increased the numbers of Māori in tertiary education up to 13% of all graduates annually.³¹ Most recently, the COVID-19 response highlighted the weaknesses of an all-of population response in reaching and caring for Māori communities, and demonstrated the strengths of Kaupapa Māori programs lead by iwi and urban Māori organizations.³²

These examples demonstrate that tino rangatiratanga-based initiatives have the power to

create lasting change for Māori, and as such are worthy of investment. It is worth considering how those who reframe any ear-marked investment in Māori health as Māori privilege might react if the shoe were on the other foot in terms of health outcomes; it is also worth remembering that since Cook first stepped foot on Kaiti Beach in Gisborne, privilege has only run in one direction – and it isn't toward Māori.³³

Summarising the complexity of the upstream determinants of inequities in health outcomes for Māori and their downstream ramifications for our people is not straightforward. However, if we were to select a few key messages to convey ahead of this year's election, we would first challenge those in leadership (or vying for it) to acknowledge where the real inequities lie in Aotearoa New Zealand, and who really holds the privilege. This election, we mustn't let our leaders use the 'same for every New Zealander' escape hatch, but rather ask them what their plan is for addressing the enduring and unacceptable inequities in health experienced by our Indigenous peoples. Secondly, and relatedly, we argue that the most pressing threat to Māori health right now is the threatened scrapping of Te Aka Whai Ora before it has had a chance to work. Those up for election must be pressed to put their policy regarding the future of Te Aka Whai Ora in black-and-white, so that we can vote accordingly. Lastly, government policy, irrespective of party, must accommodate tino rangatiratanga and allow Māori the resources and time to address our challenges. Kawanatanga has failed too often. It's time to try something else; to take a different path.

Kāpā he ara i te wao, tēnā te ara nā Hine-matakirikiri i waiho; e kore e tūtuki te waewae.

It is not as if it were a forest path, this is the path left by Hine-matakirikiri [the personification of sand and gravel], where the foot will not stumble.

What's new in this briefing

- Key lessons from history are applied to the current state of Māori population health, highlighting the need for Māori leadership across all aspects of health to improve Māori health equity.
- We reiterate that equity should be framed as equitable health outcomes, not simply equal sharing of resources.

Implications for policy and practice

- The persistence of Māori health disparities is clear evidence that we cannot solve Māori health problems by continuing to take an all-of-population approach.
- Government policy must accommodate tino rangatiratanga and allow Māori the resources and time to address our challenges.
- Te Aka Whai Ora—the Māori Health Authority—should not be scrapped before it has had a chance to work.

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PRIORITIES SERIES

This article is part of the Public Health Priorities Series, coinciding with the launch of the Public Health Communication Centre. These articles highlight some of Aotearoa's most pressing issues and policy solutions to be considered in light of the upcoming general election. You can read more articles from the series as they are published [here](#).

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