



The Orewa Speech

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As with education, policy decisions on positive funding initiatives in healthcare have always been based on providing support for those people with the greatest capacity to benefit. In New Zealand over the past decade or so, sentinel data (such as mortality rate¹ and access to surgery) have shown that Maori do not enjoy the same benefits as the rest of the population.

The reasons for this disparity are multifactorial and the subject of much research. Last year, Don Brash referred to this difference in his famous 'Orewa Speech'.² The essence of his approach to healthcare was that health in Maori is poor because of socioeconomic factors alone. These comments have found much support in parts of the New Zealand populace.

In this issue of the *Journal*, Towns et al³ provide a comprehensive rebuttal of the opinions of Don Brash. Their article highlights the constitutional and legal support of Maori in the Treaty of Waitangi, although a review of research findings is the main focus of their article. The evidence contained in their viewpoint article clearly identifies that, when all other variables are factored out, ethnicity remains a significant health determinant—and they state that, ethically, we should prioritise scarce funding resource to those persons in greatest need and with greatest capacity to benefit. Therefore, the principles underlying the Ministry of Health's decisions to fund Maori health initiatives (or, as Dr Brash puts it, 'race-based' funding) seem to have good support, as Maori ethnicity is shown to be an independent marker of increased need.

In New Zealand, a review produced for the National Health Committee states that the 'root causes' of disparities are significant determinants of poor health among Maori. While they cite socioeconomic deprivation as an important factor, they, like Towns, identify that there are poorer outcomes for Maori compared to other ethnicities in the same socioeconomic group (horizontal inequity). Indeed, looking at mortality figures, one sees that Pakeha (white European) people in the lowest socioeconomic quintile still do better than Maori in the highest quintile (vertical inequity).

In this context, one should note that ethnicity-based disparity is not unique to this country and that racism has impacted on health outcomes all over the world. For example, Karlsen and Nazroo⁵ identified that the various manifestations of racism (in England and Wales) all have independent detrimental effects on several health indicators.

The exact mechanism for these causes is uncertain, and is the subject of research. Socioeconomic factors, while contributing to the overall poor state of Maori health, are insufficient in themselves to explain these outcomes. New Zealand's National Health Committee reviewers state that one has to look beyond this to wider factors. Like Karlsen and Nazroo, they identify racism as an important factor.

Although many ethnic groups suffer from racism (whether this be institutional discrimination, interpersonal violence, or socioeconomic disadvantage), Maori have also been affected by the impact of colonisation. Specifically, dispossession of lands, forestry, and even language result in systematic exclusion from the economy of the country.

Access to high quality care is more critical for those persons with a high disease burden. This statement, while seeming obvious and trite, means that health services are more important for Maori health gain than for Pakeha health gain—as Maori carry the greater burden of chronic disease and acquired health problems such as smoking. The reality, as Towns et al point out, is that not only do Maori have poorer access for those in greater need but also suffer poorer access for those with equivalent need.

Structural policies in tax, labour, and education all act to oppose health equity. The cumulative effect is that Towns et al are able to point out the widening health data between Maori and the rest of the population, as have others before them.

For Dr Brash to suggest, therefore, that these health data are no more than a result of socioeconomic factors, is disingenuous at best and, at worst, risks the future balance of appropriate prioritisation of health funding for those with greatest need and capacity to benefit.

While the level of additional funding for ethnicity can continue to be vigorously debated, the principle that ethnicity is a valid independent factor for health must be accepted, and must generate positive discriminatory policy until disparity is shown to have been corrected. This issue is vital not only for Maori but also for the physical, social, and economic health of the whole of this country.

In fact, after reading the evidence, one could conclude that the demonstrated ‘excess need and ability to benefit’ in the Maori population might demand policy that supports even more targeted funding for Maori health!

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