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Informing Anti-Racism Health Policy in Aotearoa New Zealand

Abstract

Racism is firmly established as a determinant of health and an underlying cause of ethnic health inequities. As an organised system, racism operates at multiple levels (including structurally and interpersonally). Racism and its many manifestations are breaches of international human rights obligations and, in the Aotearoa New Zealand context, te Tiriti o Waitangi. This article considers approaches to anti-racism in health and disability policy in the 30 years following the foundational publication *Pūao-te-Ata-Tū* (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988), which was one of the first government publications to name and call out the harmful impacts of institutional racism. The article then examines the ways in which government health and disability sector organisations have talked about and responded to racism at a national level since 1980. The results of this research urge a stronger organisational-level approach to anti-racism in the health and disability system for more tangible results, requiring multi-level solutions, and transforming what is considered 'business as usual' in health and disability sector institutions.

Keywords racism, anti-racism, institutional racism, discrimination, health, organisations, health policy

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In Aotearoa New Zealand and internationally, racism contributes significantly to poorer health outcomes for Māori and other minority ethnic groups. Racism is an organised system that is underpinned by ideologies of superiority and inferiority, and shapes the structures that have defined, and continue to define, the functioning of society (Priest and Williams, 2018).

Racism operates at multiple levels, with various pathways to health (Williams, Lawrence and Davis, 2019). These levels have been conceptualised as intrapersonal (including internalised racism), interpersonal (or personally mediated) and systemic (structural or institutional) (Jones, 2018a; Williams, Lawrence and Davis, 2019). Intrapersonal racism involves attitudes, beliefs or ideologies often founded on understandings of supposedly innate superiority and inferiority that may be held by members of dominant social groups and/or oppressed ones respectively. Interpersonal racism refers to racism between people, with varying degrees of frequency and intensity, including manifestations from racially motivated assault to verbal abuse, ostracism and exclusion. Finally, systemic, structural or institutional racism involves the production of, control of and access to material, informational and symbolic resources within societal institutions, laws, policies and practices (Jones, 2018a; Williams, Lawrence and Davis, 2019). Institutional racism has harmful impacts on population health and has been referred to as the most embedded and powerful form of racism (Williams, Lawrence and Davis, 2019). Institutional racism reflects how deeply embedded racialised social structures are in society and how they ultimately determine the inequities arising from unequal access to the wide range of factors that drive health.

In the last 20 years there has been a 'remarkable growth in scientific research examining multiple ways in which racism can adversely affect health' (ibid., p.105), although indigenous peoples have always understood the harmful impacts of racism on wellbeing. The majority of research looking at racism and health has been undertaken in the United States, for both adults (Paradies, 2006; Paradies et al., 2015) and for children or adolescents (Priest et al., 2013).

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In Aotearoa New Zealand, routinely collected national surveys such as the New Zealand Health Survey, the General Social Survey and Te Kupenga (Māori Social Survey) all include questions that assess the experience of racial discrimination and reinforce the significance of racism as a health determinant and social wellbeing indicator. The New Zealand Health Survey has collected data over time regarding experience of racism overall and this data shows that Māori have a higher prevalence of reporting experience of racism than non-Māori (Ministry of Health, 2015), as well as higher prevalence for non-European groups, such as Asian and Pacific groups, compared to European (Harris et al., 2012a; Harris, Stanley and Cormack, 2018). Research demonstrates a consistent link between experience of racism and a range of negative health measures (such as mental and physical health measures, individual-level risk factors and health service experience and use) that may have a significant impact on ethnic health inequities (Talamaivao et al., 2020b).

Both quantitative and qualitative research shows that Māori experience racism in multiple domains (such as in health, employment or housing settings) over their lifetimes, with significant impacts on health and wellbeing (e.g. Barnes et al., 2013; Harris, Stanley and Cormack, 2018; Huria et al., 2014; Talamaivao et al., 2020b). Racism influences access to healthy environments and other conditions that are required for good health for Māori, as well as access to health care and experiences of healthcare interactions (Harris et al., 2012a, 2012b). The effects of experiencing racism can be transmitted intergenerationally, with research showing impacts from birth through childhood to adulthood (Hobbs et al., 2017; Paine et al, 2020; Thayer and Kuzawa, 2015).

Evidence of links between racism and poorer health outcomes ultimately presents as a breach of Aotearoa New Zealand's stated commitment to te Tiriti o Waitangi (Waitangi Tribunal, 2019), and also to human rights agreements internationally, specifically the United Nations Declaration on the Rights of Indigenous Peoples and the Convention on the Elimination of All Forms of Racial Discrimination (CERD). Aotearoa New Zealand's international human rights obligations stress the requirement and need to eliminate racial discrimination in all its forms and to recognise and address racism and its deleterious impacts, particularly for indigenous peoples.

Despite the substantial body of evidence which confirms racism as a determinant of health and work that continues to explore relationships between racism and health, there is still scope for new research into, and actions towards, the next steps – translating research into anti-racism interventions and initiatives that address and eliminate racism in health.

Approach to document analysis

A strategic review of a range of documents was undertaken to inform this article. These were scanned and assessed in order to identify organisational anti-racism policy approaches. First, a scan was undertaken of publicly available documents produced by central government agencies with reference to the health and disability sector in Aotearoa New Zealand. To be included in the review, these documents needed to reference racism in the content of the report; the intent was to see to what extent racism is acknowledged, and how that acknowledgement is linked with subsequent actions (or not). Documents

Table 1: Summary of central government policy documents that refer to racism/discrimination and health in Aotearoa New Zealand, 1980–August 2020

	Crown documents
Publication year	
1985–89	1
1990–94	1
1995–99	3
2000–04	5
2005–09	6
2010–14	2
2015–19	6
2020	4
Publication type	
Policy reports/strategies	20
Toolkits/action plans	8
Publication author	
Health sector agencies	25
Other government agencies	2
Human Rights Commission	1
Population focus of publication	
Ethnicity	
Māori	14
Pacific	1
Total population	13
Age group	
Child/youth	2
All age groups	26

were sourced via the Ministry of Health library and supplemented by further online searching and scanning of references to source further publications. Second, a scan of anti-racism interventions in health was conducted via academic search engines (Ovid databases and Web of Science) and was supplemented by using Google, Google Scholar and relevant websites (as some interventions are not featured in indexed publications). The methods used to identify anti-racism interventions for the health sector were based on earlier work, including a review of anti-racism interventions which was undertaken as part of a broader project on understanding racism as a determinant of child health and subsequent future health in adulthood (Cormack, Harris and Paine, 2018; Paine et al., 2018; Paine et al, 2020).

The overall approach to document analysis was shaped by the Public Health Critical Race Praxis (PHCRP) framework, which constitutes a set of anti-racism health equity research methods that are grounded in critical race theory (Ford and Jeffers, 2019). PHCRP is useful as an approach which centres the impact of racism at all levels and enables thinking about where the perspective of the 'racial/ethnic minority' sits (Ford and Jeffers, 2019). PHCRP supports the centring of indigenous peoples in its approach to understanding the focus of research. This aligns with a kaupapa Māori research approach, which by its nature should be transformative, beneficial to Māori, Māori-led and aligned with a structural determinants of health analysis (Curtis, 2016; Smith, 2012). Anti-racism in this context is seen as a broad range of activities and practices that counter racism.

Results

Anti-racism health policy and strategy

A scan of central government policy papers, strategies, action plans and toolkits connected specifically to the health and disability sector in Aotearoa New Zealand (from 1980 to August 2020) shows that racism has been explicitly mentioned in 28 policy documents (Table 1). A small subset of these explored the relationship between racism and poorer health outcomes and health inequities, or racism in relation to cultural competency, cultural safety and workforce development. It is important to note that the 28 documents identified over this period are in the context of a far greater volume of reports produced by government and the health and disability sector every year that have *not* included any references to racism (for example, the Ministry of Health website shows that over 30 publications have been released in the period 30 June 2020 to 16 October 2020).

Table 1 shows that racism is most commonly referred to in policy reports and strategies (20), and was referred to in eight toolkits or actions plans. Health sector agencies (primarily the Ministry of Health) were the predominant Crown author.[1] Policy reports and strategies comprise a mix of reviews commissioned by the government and health and disability sector frameworks and strategies that signal priorities for all (or part) of the health and disability sector. Toolkits or action plans detail the specific steps or deliverables expected in relation to a specific policy area.

There has been a significant increase in documents that refer to racism in recent years, with eight documents referring to racism published between 2019 and mid-2020. From 2015 onwards there has been an increase in reporting within health policy documents that not only references racism but begins to provide more examination of the role that institutional racism has in relation to advancing equity and addressing poor health, particularly for Māori. These policy reports coincide with a greater acknowledgement and prioritisation of equity in health and disability policy – for example, in the findings of the Waitangi Tribunal in stage one of its health services and outcomes kaupapa inquiry (Waitangi Tribunal, 2019), and the consideration of equity approaches in health and disability policy development. However, it is pertinent to note that one of the first policy reports (possibly the first) to refer to racism was the Māori perspective advisory committee report on the Department of Social Welfare, *Pūao-te-Ata-Tū* (day break), released in 1988 (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988). *Pūao-te-Ata-Tū* named institutional racism as the most 'insidious and destructive from of racism' and pointed to the impact of racism on the health and wellbeing of Māori in society (and in the Department of Social Welfare itself). It is compelling and concerning that the messages from *Pūao-te-Ata-Tū* remain very relevant and applicable over 30 years later.

Table 1 shows that there are far fewer documents that provide tools or toolkits that include reference to racism (eight), and none of those identified are focused on tackling racism in health as their primary purpose. The majority of action plans and toolkits (five) talk about institutional racism in discussion sections or theoretical underpinnings, and most have an explicit Māori health focus.

There was a noticeable decline in the number of policy documents where racism was referenced from about 2010 to 2014, which coincided with a change in government at the end of 2008 and subsequent implementation of new policy and legislation. From the mid-2000s there was also a reduction in references to te Tiriti o Waitangi in government documents, in the wake of a ministerially initiated, state sector-wide review of 'race-based' policies and programmes. This policy review, initiated in 2004 (New Zealand Government, 2004), was criticised in the context of Aotearoa New Zealand's human rights obligations, with the 2011 CERD committee, for example, voicing concern and noting that 'the review was adopted in a political climate unfavourable to the rights of Māori' (Human Rights Commission, 2012, p.11). The pattern over the period 2010–14 highlights that discussions about race and racism in government documents and within a wider governmental system are sensitive to political will and environments (specifically, the will of politicians), and are not always driven by evidence alone.

In 2020 the Ministry of Health released *Whakamaua: Māori Health Action Plan 2020–2025 and Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025* (Ministry of Health, 2020c, 2020a). These are the most recent reports (at the time of writing) to be released to the sector which reference racism. The Māori Health Action Plan is underpinned by the Ministry of Health's te Tiriti o Waitangi Framework (Ministry of Health, 2020b) and states that the health and disability system needs to address racism and discrimination in all its forms, as one of four high-level outcome areas. Actions pertaining to this outcome area specifically include the design and implementation of a programme of work to address racism and discrimination in the health and disability system, with most actions placed under the priority area of quality and safety.

While acknowledgement of racism as a health determinant and its importance is often present in the identified documents, many of the documents have minimal discussion of constructive ways that racism in all forms, and particularly institutional racism, can be addressed and eliminated. For example, the mention or acknowledgement of racism is often centred around actions of individuals or relates to workforce sectors (e.g., workforce training to address 'unconscious bias', cultural competency or cultural safety), which, while important, needs to be part of a wider, multi-level programme of addressing racism in the health sector. It is important that action to address racism takes place at many points within the health system (not only at an individual level), and importantly at locations of power, such as leadership and governance, funding and organisational functioning.

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There are also recent examples in Aotearoa New Zealand that exhibit how institutional racism remains entrenched in systems and structures and is not shifted by statements alone. For example, the revised *New Zealand Cancer Action Plan 2019–2029* (Ministry of Health, 2019) is explicit in stating that addressing all forms of racism and discrimination is central to achieving equitable cancer outcomes. However, when institutional racism was identified in the recent government policy on the eligibility criteria for the national bowel cancer screening programme, the government declined to address it, with spokespeople instead stating: '[w]hilst we acknowledge the need to extend the age range to increase health gains for Māori and Pacific peoples … the only viable and safe option is to introduce the change once the programme is fully rolled out' (Jones, 2020). This tends to indicate that assertions about addressing racism in all forms do not apply to government decision making, reflecting and perpetuating 'inaction in the face of need', one of the manifestations of institutional racism (Jones, 2018b). This can be understood as a form of what Sara Ahmed theorises as the 'nonperformativity' of institutional claims about commitment to anti-racism, where the acknowledgement or 'statement of commitment' becomes the action (Ahmed, 2006, 2012).

Discussion

Anti-racism interventions generally focus on individual acts of racism, discrimination or bias

There are minimal examples of interventions that are explicitly framed as 'anti-racism interventions' in Aotearoa New Zealand, with most focused at the health practitioner level in workforce training and education, centring around work in cultural safety (kawa whakaruruhau). Cultural safety had its genesis in the nursing education sector in the 1990s and had a focus on providers being aware of their own culture and beliefs (Ramsden, 2002), and is regarded as one of the most effective approaches that can be taken within the health and disability sector towards the achievement of health equity (Curtis et al., 2019).

The Health Safety and Quality Commission as part of its Patient Safety Week campaign in 2019 released a series of video talks focused on understanding 'bias', with three presentations exploring, understanding and addressing implicit bias, te Tiriti o Waitangi, colonisation and racism, and experiences of bias. In this campaign, racism is discussed more in the context of 'implicit bias'. Recent research has also investigated ethnic bias (as one form of expressing racism) in health education training (Cormack et al., 2018; Harris et al., 2018).

In Aotearoa New Zealand there is also dedicated teaching about racism and anti-racism in both undergraduate and postgraduate health sciences programmes, and a focus on indigenous-framed learning that includes anti-racist elements (e.g., Pitama, Huria and Lacey, 2014). Targeted admission schemes in health education and training have also successfully increased the representation of Māori in health professional programmes (Curtis et al., 2015). Recent objections to some admission schemes are an example of the challenges of implementing anti-racism interventions that sit within a colonised system and structure (Hook, Norton and Geddis, 2020).

There have been public awareness-raising campaigns such as the Human Rights Commission's 'Give nothing to racism' campaign (www.givenothing.co.nz), aimed at spearheading a nationwide response to racism, and, more recently, the 'Racism no joke' campaign launched online (on Facebook) in response to an increase in racism towards those from (or believed to be from) Asian ethnic groups during the Covid-19 pandemic.

Organisational practices in employment can be a site of anti-racism initiatives, such as refocusing organisational design and elements, including workforce systems for hiring, representation, protocols, leadership and mentoring (Paradies et al., 2009). Williams, Lawrence and Davis (2019) note that changes to organisational employment policy – such as practices where identifiable information is removed from employment applications – can reduce discrimination. Although very rare, there are also examples of anti-racist approaches taken by organisations in Aotearoa New Zealand, such as Auckland District Health Board's 'straight to interview' policy, whereby Māori and Pacific candidates who meet core criteria for a role are progressed straight to interview (Auckland District Health Board, 2019).

Outside government or health education, in 2014 the Public Health Association of New Zealand issued a policy statement on institutional racism which named the elimination of institutional racism as a key enabler in addressing health inequities and outlined priorities for action; this was updated in 2020 (Public Health Association, 2020). Similarly, in public health, the Stop Institutional Racism network works actively to name institutional racism and contributes to a range of anti-racism actions, such as training in anti-racism, advocacy and publishing on institutional racism (e.g., Came and Griffith, 2018).

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International comparisons

A scan of anti-racism health interventions internationally shows similar patterns to interventions in Aotearoa New Zealand. In most cases interventions are single-level (Talamaivao et al., 2020a). Single-level interventions are often one-off staff training (for instance, at a health provider) or based around professional training. While there is a recognised place and need for training staff (in particular non-indigenous staff) to understand the complexity of and harm caused by institutional racism and understand the need for meaningful organisational change to work towards and achieve equity, there is a caution that training in a cultural or anti-racism context will be ineffective on its own, 'given that the effect of institutional racism is driven by factors beyond the behaviour of individual staff' (Bourke, Marrie and Marrie, 2019, p.613).

Examples of multi-level anti-racism interventions within organisations (e.g., at health provider or NGO level) include an external assessment tool operating in a hospital setting in Australia, which has shown capacity to begin and progress a transformational process for an organisation (ibid.), and the US-based White Coats for Black Lives initiative; the latter focuses on addressing racism and spearheading change within the health system by using a 'racial justice report card' for medical institutions to assess areas for action in addressing racism in both medical schools and more widely in the health system (White Coats for Black Lives, 2018).

Evaluations of anti-racism interventions found that activities such as staff training can be effective in regard to awareness and understanding of anti-racism in health, but that 'care providers wanted tools to help them translate the abstract ideas behind equity-oriented health care into action' (Varcoe et al., 2019, p.2). Overall, however, there is limited evaluative information on the effectiveness of anti-racism measures on health provider behaviour in the long term. There is also little research available that goes further and explores the health benefits of anti-racism interventions (Kelaher et al., 2018; Kwate, 2014). Kelaher et al. explored the mental health benefits of participation in anti-racism interventions in Australia and found that such interventions may have positive mental health effects (e.g., confidence and self-esteem) for participants from minority ethnic groups.

Conclusion

In Aotearoa New Zealand's health and disability sector, most anti-racism interventions or initiatives are one-off, single-level approaches, often located at health practitioner or provider level. This is in line with published examples of anti-racism interventions internationally, and is perhaps a reflection of national-level policy and other statements, which acknowledge the injustices of racism as a determinant of health but fail to commit to tangible anti-racist action.

Incorporating anti-racism frameworks or approaches essentially means a reassessment of the power base, power relationships and 'the parallels, intersections, and distinctions between all forms of oppression and the ways they manifest themselves within an organization' (Greene, 2007, p.12). Lasting change in health systems can only occur when power imbalances are examined and addressed – for example, by reorienting funding structures, services, access and representation for and partnerships with indigenous peoples (Bourke, Marrie and Marrie, 2019).

As is the experience of embedding equity as 'business as usual' in the health and disability sector, all too often it is easy for embedded structures within which society operates to fall back 'to type' and for the system to revert to doing what it has always done. As Greene (2007) highlights, there are risks that anti-racism work gets pushed to the side when other 'pressing' matters take precedence as a matter of course. More recent challenges to the health system, such as the Covid-19 pandemic, show how timely it is to ensure that there is an embedded and effective anti-racism approach in health policy. This arguably has been evident during the ongoing Covid-19 pandemic response, where a lack of an equitable and anti-racism approach has been highlighted and failings identified in incorporating a meaningful te Tiriti o Waitangi partnership framework into tackling the Covid-19 health crisis (King et al., 2020; McLeod et al., 2020).

There is a strong platform of empirical knowledge regarding racism as a determinant of health in Aotearoa New Zealand (Talamaivao et al., 2020), and it is telling that the recommendations outlined in *Pūao-te-Ata-Tū* in relation to deleterious impacts of racism on health, and in particular Māori health, remain relevant decades on. An acknowledgement of racism as a public health crisis and call to action requires immediate attention across the state sector and society to meet Aotearoa New Zealand's te Tiriti o Waitangi and international obligations. This is echoed in a similar way across reports recently released (e.g., Waitangi Tribunal, 2019) and across the wider public sector (e.g., Office of the Children's Commissioner, 2020). It is important given the moving nature of political will and what is deemed in favour regarding government policy that actions to address institutional racism in government policy move forward to embed, capture and publish the 'where to from now' steps.

The recent review into Aotearoa New Zealand's health and disability system (Health and Disability System Review, 2020), and resulting government announcements of health and disability system transformation (Little, 2021), have been labelled a once-in-a-generation opportunity to truly re-set the health and disability sector to deliver on its long-stated equity and wellbeing goals (Health and Disability System Review, 2018). The government-endorsed changes critically include the establishment of a Māori Health Authority, which would sit alongside the Ministry of Health and another new entity, Health New Zealand. While the exact functions of the entities are still being shaped, the Māori Health Authority seems set to have a policy role as well as a commissioning (or purchasing) function. The government therefore has a unique opportunity to address institutional racism in the structuring of its health and disability institutions' health system design from the top down. However, as many commentators have noted, the devil will be in the details (Baker, 2021). In working through the details of the health sector transformation, ministers and their officials need to be considering both how to build anti-racist health organisations, and how to ensure appropriate monitoring and review of anti-racist approaches at a system and organisation level and resist the temptation to focus only on interpersonal racism at a practitioner level.

The need and demand to enact real actions for anti-racism change is pressing and urgent, particularly in light of the very real challenges to equity and reminder that racism still permeates our health sector structures and responses. An approach to an anti-racism health policy at the organisational level needs to be transformational, incorporate multi-level solutions, and be embedded into 'business as usual' through all levels of the health and disability sector. The organisational level is an important yet neglected site for anti-racism in the health and disability system and warrants further urgent focus in research and in policy, but most importantly in action.

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1 See https://www.otago.ac.nz/wellington/departments/publichealth/research/erupomare/publications/ for a list of the documents included in Table 1.

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