

Ethnicity is an evidence-based marker of need (and targeting services is good medical practice)

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Last week, Cabinet released a circular to government organisations, giving effect to the coalition Government agreement commitment to “*issue a Cabinet Office circular to all central government organisations that it is the Government’s expectation that public services should be prioritised on the basis of need, not race.*”¹ The term “race” originates from a long-discredited presumption of a biological hierarchy of human beings from white to black, and for decades the New Zealand health system has instead used ethnicity. This return to discredited terminology suggests that the foundations of white superiority are still alive and well in New Zealand today. The Government expresses its concern that “*agencies may use ethnic identity or other forms of personal identity as a proxy for need, and therefore a justification in itself for targeted services.*”¹ The circular imposes additional requirements for agencies considering targeting services to specific population groups to engage their ministers early, and to provide a strong analytical case for any targeting, recognising that there are “*many variables that can be used to identify and assess need, and that all variables should be considered before ethnic identity is automatically used to determine need.*”¹ They must include an assessment of any opportunity costs for all New Zealanders, and “*where culturally specific models are used, eligibility should not be restricted to the specific population group unless there is a strong rationale (e.g. value for money).*”¹

This directive, and the political discourse surrounding it, is an affront to scientific and public health knowledge, and requires explicit rejection from health professionals and the scientific community.

This directive is one of several recent policy actions from the coalition Government² that directly threaten the collective efforts of the health and scientific community to identify and address ethnic health inequities. We revisit the key basic scientific tenets behind ethnic targeting

in our health system, and why this practice needs to be strengthened rather than hindered, including enhancing our access to high-quality ethnicity data.

Ethnicity is an evidence-based marker of need

While not forgetting or diminishing that Māori have inalienable rights to health, and right-based arguments for addressing health inequities, there is a strong connection between current Māori health needs and the denial of these rights.³ The Government’s directive is based on a false and unsubstantiated assumption that previous ethnicity-based targeting in health has not been based on robust analysis of need. For those professionals at the frontline of policy development, service commissioning and monitoring, the prevailing problem is the opposite: a mountain of robust analysis demonstrating higher Māori health need, and a trickle of initiatives to specifically target this need.⁴ The very presence of continued inequity for Māori in life expectancy,⁵ exposure to risk factors,⁶ access to care⁶⁻⁸ and health outcomes^{7,8} is evidence that measures to date have not been adequate to meet Māori need. Inequities in health need, access and outcomes persist for Māori at all levels of socio-economic deprivation and rurality.⁹

Ethnicity is superior to many other markers of need

In requesting that other variables be considered before ethnicity, the Government erroneously singles out ethnicity to require a higher standard of proof than allocations based on any other population risk characteristic (e.g., rurality, sex or age). Comprehensive, consistent and long-standing evidence demonstrates that ethnicity is a stronger marker of need than other commonly accessible variables such as rurality and the New Zealand Index of Deprivation (NZDep).^{6,9,10,11} Our most widespread

marker for socio-economic deprivation, NZDep, does not assess individual characteristics, but is based on a collective neighbourhood score.¹² By using age-based criteria alone, and ignoring that Māori have a younger population age structure, the bowel cancer screening programme failed to recognise that over half of Māori cancers occurred before the screening threshold of 60 years.¹³ Suggesting that these “colour-blind” variables may be better proxies for health need than ethnicity is blatantly untrue and misleading, and encourages weak analytical science and will likely lead to greater waste of public resources due to less effective targeting of resources towards groups with highest need. Racism distributes the determinants of health along ethnic lines and impacts health directly,^{14,15} so until racism is eliminated, ethnicity will be a valid marker of need.

Using population patterns to assess risk is at the core of evidence-based medical practice

Using multiple characteristics (of an individual or of a group) to refine clinical hypotheses and assess health risks is a fundamental tool of medicine in clinical fields and population health. Suggesting we ignore some of these characteristics asks us to ignore important analytical tools that are essential for health professionals to efficiently serve our patients and communities and most efficiently target scarce health resources. Similarly, there is no basis for using the individual exception (e.g., “I’m Māori and I don’t have high health needs”) as a justification for not targeting high-risk populations. This represents a fundamental misunderstanding of individual versus population risk and applies to any population characteristic, not just ethnicity. Most women do not get breast cancer, but at a population level, their higher risk of disease means that we fund breast screening for women over a certain age, based on their risk as a group. Any suggestion that personal or population characteristics should not be used in the design, delivery or monitoring of health services is an attack on evidence-based medicine and must be rejected.

Targeting by ethnicity is evidenced-based and leads to better resource allocation

Like every country, we have a duty to allocate scarce health resources to those most at risk,

and to use all available risk characteristics to identify those most in need as sensitively and specifically as possible. New Zealand is in no way unique in seeking to focus extra health system activity on ethnic groups that have been systematically disadvantaged and under-served.^{16–18} The Cabinet circular itself notes that New Zealand has a well-established legal and constitutional framework of non-discrimination, and that services targeted or designed for specific population groups are a feature of good government supported by the *New Zealand Bill of Rights Act 1990*, international convention and law.¹⁹ These measures are crucial to address discrimination that already exists in our health system—we must remember that the status quo is not a neutral starting point, but instead has a pre-existing ethnic bias towards our dominant ethnicity.²⁰ The Government’s directive that when culturally specific models are used, “*eligibility should not be restricted to the specific population group unless there is a strong rationale*”²¹ completely undermines the whole purpose of targeting resources towards those most at need, and risks irresponsible wastage of scarce health resources. For the same reason it would be an irresponsible use of public funds to allow males to receive funded breast cancer screening, it is fiscally and ethically unjustifiable to enable anyone to access services that have been specifically targeted to meet a particular health need for a high-risk group.

Ethnicity data quality and analysis must be strengthened

To support implementation of this directive, the Government has signalled its intention to strengthen the ability for agencies to access timely, high-quality, granular data, and the capability to extract, analyse and present it,¹⁹ although it makes no mention of the need to specifically strengthen the quality of ethnicity data collection and analysis. We need to further strengthen ethnicity data quality to enable better identification and monitoring of need. There is a significant risk that the needed improvements to ethnicity quality and capability^{21,22} will not be invested in, and the dismissal of the value of ethnicity will result in changes to ethnicity data collection and reporting that will compromise our ability to identify and monitor ethnic health needs over time.

The Government’s directive is not just an attack on Māori, but an attack on science and good

medical practice. Anyone who supports this directive, either actively or complicitly through their silence, is supporting the undermining of our collective scientific knowledge and commitment to evidence-based medical practice. The real risk is in how this message is interpreted and implemented by the sector. Our concern is that this circular will be interpreted as shorthand for “no more ethnicity-based anything” when this is not what the directive actually says, and certainly not what is needed. More so than ever, health professionals must remain true to our science/evidence-based principles, which remain unchanged:

- Ethnic health inequities in New Zealand are unjust and avoidable and it is our job as health professionals to use all tools at our disposal to intervene;
- Ethnicity is a strong marker of health need in New Zealand, and is an evidence-based way of targeting healthcare resources; and
- Analyses based on good-quality ethnicity data should be routinely used to identify need, design health interventions and monitor the effectiveness of the health system.

COMPETING INTERESTS

Nil.

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