



# COVID-19 and Māori health – when equity is more than a word

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**As Māori academics, researchers and health professionals, we are extremely concerned about the impacts of the COVID-19 pandemic on our whānau and communities. We are also worried by the inadequate focus on Māori health equity in pandemic planning within the health and disability system, and in the whole-of-government ‘one-size-fits-all’ approach. And we are troubled by the local proliferation of commentaries on COVID-19 within multiple fora that either intentionally ignore the existence of health inequities within our society, frame equity as an add-on to a substantial list of other ‘equally’ important principles, or demonstrate “nonperformativity”<sup>1</sup> in reference to equity. Saying, ‘equity is important’ is different from actually making equity important via intentional actions to achieve it.**

Our collective historical, inter-generational and current experiences tell us that COVID-19 will have differential impacts on our whānau and communities. As Māori scholars have noted, for example, Māori death rates during the influenza pandemic of 1918 were seven

times higher than for NZ European/Pākehā.<sup>2-3</sup> During the H1N1 influenza pandemic of 2009, rates of influenza were twice as high for Māori compared with Pākehā.<sup>4</sup> Māori were also three times more likely to be hospitalised<sup>4</sup> and almost three times more likely to die than Pākehā.<sup>5</sup> Such outcomes are not only unjust and unfair, they are avoidable. They demonstrate the Crown's abject failure to "...avoid or overcome inequalities that infringe on fairness and human rights norms".<sup>6</sup> This is not an academic discussion for us. Equity is more than a word or an add-on at the end of a sentence supporting the value of 'diversity'. It represents the absence of the systematic, entrenched and pervasive inequities that we, our loved ones and our communities experience daily. For us, equity *means* something. It is about who will be left on our paepae, in our homes and in our communities.

Overseas, marked inequities are already being reported for population groups who experience marginalisation and oppression. Information from the United States has highlighted that Black/African Americans are already disproportionately impacted by COVID-19 infections, severe illnesses and deaths.<sup>7</sup> In the context of a COVID-19 pandemic within Aotearoa me Te Waipounamu, we have identified some of the factors that are likely to reproduce the existing and significant health inequities for Māori and other peoples who are marginalised by oppressive systems. These include increased risk of infection for Māori, greater risk of negative COVID-19 health impacts, and worsening of the current inequities in access to high quality healthcare for Māori negatively impacting on Māori health outcomes from both COVID-19 and non-COVID-19 conditions.<sup>8</sup>

Differences in living conditions for Māori compared with Pākehā mean that we are far more likely than Pākehā to be exposed to COVID-19 in the event of established community transmission. Evidence shows that transmission of infectious diseases is greater within areas of social deprivation, in situations of fuel and heating poverty, where there is poor quality housing, and within crowded households.<sup>9-10</sup> We know that household crowding affects Māori more than Pākehā<sup>9</sup> and we also know that the combination of all these factors results in profound inequities for Māori in rates of many infectious diseases.<sup>11-13</sup> The evidence to date from China has highlighted that, during community transmission, 78-85% of COVID-19 cases related to families in households.<sup>14</sup>

Information to date also tells us that the seriousness of illness and risks of dying from COVID-19 increases for people with underlying health conditions. For example, cardiovascular, respiratory and kidney diseases, diabetes and cancer.<sup>15-18</sup> We are more likely than Pākehā to have these conditions, we are more likely to get these conditions at a younger age, and we are more likely to have more than one health condition at the same time. This means that we will be more likely to experience severe COVID-19 outcomes.

Reported rates of death from European countries such as Italy show that those who are older are more likely to die from COVID-19.<sup>19</sup> However, it remains unclear how age works to increase risk. Older age may lead to worse outcomes because older people are more likely to have health conditions that lead to worse outcomes from COVID-19. If this is the case, then the current messaging around relative importance of older age<sup>20</sup> may be providing false reassurance to a younger Māori population. If older age is a risk factor over and above the presence of underlying health conditions, the mechanism by which it predicts worse outcomes may still work differently for Māori, particularly if severity of illness related to age begins earlier for Māori.<sup>21</sup> Thus, an equitable approach would ensure public health messaging highlights Māori as a priority population group around risks of serious COVID-19 illness, not just prioritise the older (mostly) Pākehā population.

Māori are also likely to face an increased burden of worsening outcomes from both COVID-19 and non-COVID-19 health conditions. Even without a pandemic, we already experience significant inequities in accessing healthcare,<sup>22-23</sup> have higher hospitalisation rates for avoidable and/or amenable conditions and receive lower quality care.<sup>24-25</sup> In addition, racism within the health and disability system drives inequities and poorer health for Māori.<sup>25</sup> Such drivers of inequitable access to high quality healthcare for Māori will be intensified if the health and disability system becomes overloaded. This can occur from factors relating to broader determinants of health (such as unemployment and loss of income) or increasing racism against Māori within the context of pressured decision-making by health professionals.<sup>26</sup> It can also occur through severe restrictions to a range of health services for non-COVID-19 conditions.

A number of models, guidelines and tools are being rapidly designed, informed by a focus on 'scarcity of resources', and intended to be used to prioritise which person gets what resource. These approaches often reflect judgements about which patients have the greatest likelihood of survival (with a primary focus on saving as many lives as possible) and as such have considerable potential to discriminate against Māori. There are known equity issues with such prioritisation and decision-making approaches and tools.<sup>27</sup> The perceived need to rapidly develop these approaches should not be a reason for poor processes that exclude Māori and whānau from the decision-making table and pay little attention to te Tiriti o Waitangi and the Code of Health and Disability Services Consumers' Rights.<sup>28</sup> In addition, the current shift to other forms of healthcare delivery, for example, telehealth, have real potential to discriminate against whānau and communities who may have less access to necessary technology and data.

Māori are actively resisting the COVID-19 pandemic and the impacts on our whānau and community that have been exacerbated by this pandemic. Māori are taking action to combat the impacts of COVID-19 and protect Māori health and well-being (for example, [www.uruta.maori.nz](http://www.uruta.maori.nz) and many others). We also call upon the Crown to honour te Tiriti o Waitangi and its obligations to upholding Māori Indigenous rights contained within the United Nations Declaration on the Rights of Indigenous peoples. This means that in partnership with Māori, the Crown must work to protect Māori health and place equity at the very heart of its response to the COVID-19 pandemic. Equity must be embedded from the outset, and cannot be an add-on or retro-fitted. Critically, we require real-time modelling and analysis of COVID-19 data using high quality ethnicity data and underpinned by principles of Indigenous Data Sovereignty. This is not only to inform and evaluate the impacts of interventions for whānau and communities but also to monitor and hold the Crown to account for its actions and inactions. Lastly, we will continue to witness and comprehensively document what is, and is not, happening for our whānau and communities. In doing so we call for the Crown, our Pākehā colleagues and broader society to engage in critical thinking and ethical behaviour, to recognise and acknowledge that decision-making around rationing and prioritisation of resources occurs within the broader colonial, capitalist and neo-liberal logics that position these situations as inevitable, rather than socially- and politically-constructed, and to place equity at the very heart of their own decision-making and actions.

## References

1. Ahmed, S. The nonperformativity of antiracism. *Meridians* 2006; 7(1):104.
2. Espiner E. New Zealand must learn lessons of 1918 pandemic and protect Māori from Covid-19. *The Guardian*

<https://www.theguardian.com/commentisfree/2020/mar/26/new-zealand-must-learn-lessons-of-1918-pandemic-and-protect-maori-from-covid-19> (accessed 08/04/2020).

3. Jones R. Why equity for Māori must be prioritised during the Covid-19 response. *The Spinoff*  
<https://thespinoff.co.nz/atea/18-03-2020/why-equity-for-maori-must-be-prioritised-during-the-covid-19-response/> (accessed 08/04/2020).
4. Baker MG, Wilson N, Huang QS, et al. Pandemic influenza A(H1N1) in New Zealand: the experience from April to August 2009. *Euro Surveillance* 2009; 14(34): pii=19319. <https://doi.org/10.2807/ese.14.34.19319-en> (accessed 08/04/2020).
5. Wilson N, Barnard LT, Summers JA, Shanks GD, Baker MG. Differential mortality rates by ethnicity in 3 influenza pandemics over a century, New Zealand. *Emerg Infect Dis* 2012; 18(1): 71–
6. World Health Organization. Equity. 2020.  
<https://www.who.int/healthsystems/topics/equity/en/> (accessed 08/04/2020).
7. Johnson A, Buford T. Early Data Shows African Americans Have Contracted and Died of Coronavirus at an Alarming Rate. *ProPublica*, 2020.  
<https://www.propublica.org/article/early-data-shows-african-americans-have-contracted-and-died-of-coronavirus-at-an-alarming-rate> (accessed 08/04/2020).
8. McLeod M, Gurney J, Harris R, Cormack D, King P. COVID-19: we must not forget about Indigenous health and equity. (Submitted paper under review), 2020.
9. Ministry of Health. Analysis of Household Crowding based on Census 2013 data. Wellington, New Zealand: Ministry of Health, 2014.
10. Johnson A, Howden-Chapman P, Eaube S. A stocktake of New Zealand's housing. Wellington, New Zealand: New Zealand Centre for Sustainable Cities, 2018.
11. Khieu TQT, Pierse N, Telfar-Barnard LF, Zhang J, Huang QS, Baker MG. Modelled seasonal influenza mortality shows marked differences in risk by age, sex, ethnicity and socioeconomic position in New Zealand. *Journal of Infection* 2017; 75(3): 225.
12. Baker MG, Martin DR, Kieft CEM, Lennon D. A 10-year serogroup B meningococcal disease epidemic in New Zealand: Descriptive epidemiology, 1991-2000. *Journal of Paediatrics and Child Health* 2001; 37(5): 13.
13. Baker M, Das D, Venugopal K, Howden-Chapman P. Tuberculosis associated with household crowding in a developed country. *Journal of Epidemiology and Community Health* 2008; 62(8): 715.
14. World Health Organisation. Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19). World Health Organisation, 2020.  
<https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf> (accessed 08/04/2020).
15. Wang D, Hu B, Hu C, et al. Clinical Characteristics of 138 Hospitalized Patients with 2019 Novel Coronavirus-Infected Pneumonia in Wuhan, China. *JAMA* 2020; 323(11):1061.
16. Huang C, Wang Y, Li X, et al. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. *The Lancet* 2020; 395(10223): 497.
17. Chen N, Zhou M, Dong X, et al. Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study. *The Lancet* 2020; 395(10223): 507.
18. Liang W, Guan W, Chen R, et al. Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. *The Lancet Oncology* 2020; 21(3): 335–
19. Onder G, Rezza G, Brusaferro S. Case-Fatality Rate and Characteristics of Patients Dying in Relation to COVID-19 in Italy. *JAMA* doi:10.1001/jama.2020.4683.
20. New Zealand Government. Vulnerable people. Unite Against COVID-19 – New Zealand Government Website, 2020.

<https://covid19.govt.nz/individuals-and-households/health-and-wellbeing/vulnerable-people/> (accessed 08/04/2020).

21. Chae DH, Wang Y, Martz CD, et al. Racial discrimination and telomere shortening among African Americans: The Coronary Artery Risk Development in Young Adults (CARDIA) Study. *Health Psychology* 2020; 39(3): 209–
22. Ellison-Loschmann L, Firestone R, Aquilina L, McKenzie F, Gray M, Jeffreys M. Barriers to and delays in accessing breast cancer care among New Zealand women: disparities by ethnicity. *BMC Health Services Research* 2015; 15: 394.  
<https://doi.org/10.1186/s12913-015-1050-6> (accessed 08/04/2020).
23. Ministry of Health. New Zealand Health Survey: Annual update of key findings 2012/13. Wellington, New Zealand: Ministry of Health, 2013.
24. Ministry of Health. Tatau Kahukura: Māori Health Chart Book 2015 (3rd edition). Wellington, New Zealand: Ministry of Health, 2015.
25. Waitangi Tribunal. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry, WAI 2575. Wellington, New Zealand: Legislation Direct, 2019.
26. Dovidio JF, Fiske ST. Under the radar: how unexamined biases in decision-making processes in clinical interactions can contribute to health care disparities. *American Journal of Public Health* 2012; 102(5): 945.
27. McLeod, M. Making health equity count: Incorporating health equity for Māori into cost-utility analyses (Doctoral Thesis). Dunedin, New Zealand: University of Otago, 2018.
28. Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) R

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