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Racism, socioeconomic deprivation, and health in New Zealand

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Inequalities in health are deplored in modern democratic nations and equal opportunities are extolled in principle, if not in practice. Through the caste system, slavery, colonisation, aristocracy, apartheid, and Nazism, inequalities were institutionalised. The historical legacy of racism and economic inequality of opportunity casts its shadow even now, and the study by Ricci Harris and colleagues¹ in today's *Lancet* explores the idea.

Inequalities in health status, disease occurrence, and mortality are shaped by accumulated wealth, material circumstances, environmental quality, nutrition, a wide range of personal behaviours, genetic inheritance, and health services. Within multiethnic societies, European-origin White populations (henceforth, "White" as per Bhopal's glossary²) are characterised by being richer, more powerful, and enjoying better material circumstances, environmental quality, and health services than non-White ethnic-minority populations. Ethnic-health inequalities in such societies are inevitable.

Racism is the belief that some racial, ethnic, religious, and cultural groups are better than others. This belief, combined with power, leads to actions favouring the supposedly superior groups. The power to enact such beliefs is, currently, mostly in the hands of White populations. Some like to believe racism is unimportant in modern, industrialised, multiethnic societies, others believe that racism is at the heart of ethnic and racial disparities in health and health care.³ We need data to progress our understanding.

Equity is the core ethical principle underpinning equality of health care. It is based on fairness and justice. Most research studies present data from the White population as the standard against which to compare minority groups. Not every inequality shown is an inequity. Ethnic variations in smoking, for example, are not necessarily inequitable but such variations in access to smoking cessation services would be. Differences in life expectancy in different ethnic groups are usually inequitable, because they mainly result from other social injustices.

Epidemiological data are essential to the identification of inequities, and monitoring effectiveness of interventions to redress them.

Harris and colleagues' study is of special interest, not only because empirical research on racism and health is rare outside the USA, but because it concerns the Māori population, an Indigenous ethnic minority. The term indigenous is usually used to mean a population belonging naturally to a place in the sense of long-term ancestral origins—eg, Aborigine (it might also mean the majority population—eg, in the UK—as an alternative to the word White).²

Indigenous populations across the world have poor health, and many were decimated and demoralised in the colonial era. Compared with other Indigenous populations, including Native Americans and Australian Aborigines, the Māori population largely escaped such a fate. By contrast with other colonised Indigenous and migrant ethnic minorities, Māoris are perceived to be highly politically and socially organised, empowered, and in control. This perception, at least in part, is related to the negotiated Treaty of Waitangi of 1840 that enshrined Māori rights, and that still plays a major role in governing relations between Māoris and other New Zealanders.⁴ Nonetheless, Māori health is comparatively poor.

Bramley and colleagues⁵ compared the health inequalities in New Zealand and the USA, with the European (effectively White) and White population, respectively, in each of these countries as the point of comparison. They used a wide range of health and health-care indicators. The inequalities were massive—eg, life expectancy in Māori men was 8.9 years less than in European men in New Zealand, larger than the 7.4 year difference between American Indian or Alaskan native and White men in the USA. In virtually every indicator, inequalities were considerable, and greater in New Zealand than in US comparisons. The life-expectancy deficit in Australian Aboriginal and Torres Strait Islanders is closer to 20 years.⁶ By contrast, mortality differences between

major ethnic-minority populations in Europe are trivial.^{7,8}

Bramley and colleagues⁵ did not address social or economic status as factors explaining inequalities. Harris and colleagues tackled social and economic status with data from the cross-sectional New Zealand Health Survey, comprising 4108 Māori and 6269 European New Zealanders. They analysed indicators of racism and deprivation in relation to self-reported questions on: self-rated health, physical functioning, mental health based on the SF 36 measure, and cardiovascular disease. Their work advances the field by focusing attention on the issues, providing methods and approaches, and supplying empirical data collected for the purpose. The researchers are aware that their data, alone, do not yield cause and effect but the interpretation they favour is plausible—ie, racism contributes importantly to socioeconomic deprivation, and together these play a major role in causing health inequalities. There are alternative interpretations—eg, that Māoris who have poor health are more sensitive to perceived racism; that the findings arise from a lack of cross-cultural validity of the questionnaire or other artifacts; and that other risk factors that are associated with racism and socioeconomic deprivation are the causes of these inequalities (eg, smoking, lack of physical activity, obesity, depression/anxiety). Bramley and colleagues⁵ showed that smoking prevalence was 48.6% in Māori and 23.9% in European New Zealanders, and Māori were worse off in several other potential risk factors. Although Harris and colleagues' attempt to find the "independent" effects of variables, such as racism and deprivation, is easy from a statistical point of view, it is problematic in a biological causal model. Their statistical model contains few variables. The model could include a fuller range of factors that are likely to be associated with the four outcomes. It would be a mistake, however, to conclude as a result of further analyses that the other risk factors (eg, smoking) are necessarily confounding factors, or that racism and socioeconomic deprivation are innocent. It is equally, if not more, likely that these other

factors are on the causal pathway whereby racism and socioeconomic deprivation lead to the accumulation of intermediate risk factors, and the health effects are caused by joint direct and indirect effects. The complexity of the issues and the debates, in relation to understanding cause and effect, has been discussed elsewhere.⁹

Racism can cause death and despair in ways that are, with the exception of disease epidemics, almost unparalleled in human history, as in the effects of slavery and colonisation, and more recently the massacres in Nazi Germany, Bosnia, Serbia, and Rwanda. Antiracism activity sits squarely in the wider arena of the struggle against oppression. The health-care and research professions must participate in this struggle, and in publishing the paper by Harris and colleagues *The Lancet* is making its contribution.

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I declare that I have no conflict of interest.

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How have the SSRI antidepressants affected suicide risk?

Two conflicting claims have been made about the effects that the selective serotonin-reuptake inhibitor (SSRI) antidepressants have on suicide risk: that increased SSRI use has reduced suicide rates,¹ and that SSRIs increase

suicide risk in some patients early in treatment.² Without a gold-standard method for arbitrating these claims, we have to look for a convergence of imperfect evidence from a range of study types (table).

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