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Improving health equity among the African ethnic minority through health system strengthening: a narrative review of the New Zealand healthcare system

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Abstract

Background

In New Zealand, health equity is a pressing concern and reaching disadvantaged populations has become the goal to close the inequity gap. Building and strengthening health systems is one way to secure better outcomes. However, the discourse to date has predominately focussed on inequities in health outcomes for Māori. This study has interest in the African ethnic minority community in New

Zealand. It undertakes a narrative review of the New Zealand health system which aims to identify literature around the attainment of health equity of African minority by: (i) providing a critical overview of the healthcare delivery system using World Health Organization's six inter-related building blocks of health system strengthening; (ii) developing a summary and discussions of the research results and; (iii) identifying priorities and recommendations for future research.

Method

A narrative review of 27 articles published between January 2010 and June 2019 were selected from CINAHL, PubMed, Scopus, Google Scholar. Grey literature also informed the review. Articles excluded studies: (i) non-related to New Zealand; (ii) with no focus on equity on ethnic minority in the delivering of healthcare; (iii) had no full text available.

Findings

Literature on Africans health outcomes were scarce regarding the six building blocks. However, findings show inequities in accessibility of health services, a non-ethnic inclusive health workforce, a leadership and governance which lack political will on migrant health and resultantly an under-performing health information system which influences resource allocation.

Recommendation and conclusion

An improvement and well-functioning health information system is pivotal to capture the unmet needs of the African population. There is a need for research and political will to invest in African

minority health and diverse workforce that understands the background of the African population; and action to address structural and institutional racism and white privilege to address root causes of inadequate access and care processes for ethnic minorities.

Introduction

As the growth of migrant communities continues to raise globally, creating unique health challenges at a scale that has never been seen, there is renewed interest in and momentum for strengthening health systems [1, 2]. There is mounting evidence that health systems that deliver services equitably and efficiently achieve health for all [3]. Health system strengthening is therefore both critical and timely as it comes in the wake of the 2030 Agenda for Sustainable Development call to “*leave no one behind*”, where State governments are encouraged to integrate the health needs of migrants into national plans, policies, and strategies across sectors [4]. The G20 also recently reaffirmed the importance of continuing to strengthen global health systems as health systems have neither been responsive enough to the migrant influx, nor to the moral requirement to attend to migrants with dignity [5]. Table 1 presents the aims and desirable attributes of each building block. In light of above, there is growing recognition that the health of New Zealand citizens is inextricably related to the health of the estimated 1.2 million migrants residing in a community of 4.4 million [6]. Economic, human rights, and public health imperatives all point to the need to ensure that migrant populations have access to equitable, efficient and quality health services critical for

achieving improved health status [7, 8], in order to have an impact on the health outcome for the entire community [3]. The Migration Integration Policy Index – a government sourced document report the New Zealand government to have taken official measures to build responsive health systems which are culturally competent and committed to properly treating patients of diverse cultural backgrounds by use of the Pacific and Māori health models which have been adapted to serve immigrant communities [9]. However, independent research in New Zealand show inequities remain high [10, 11]. There are substantial challenges to attaining health equity for migrants, in particular ethnic minority groups. The African community is one such migrant minority group.

These ethnic minorities often have reduced entitlements in receiving societies. Not only do they have reduced access to health care for a number of political, administrative and cultural reasons which are not necessarily present for the native population [10, 24], they are exposed to poor working and living conditions and or resource-poor neighbourhoods [6, 25, 26, 27], which leads to poor health outcomes. New Zealand comprises of many ethnic groups with the dominant groups being European ethnic group which makes up the majority of the population (74%), with Māori - *the Tangata Whenua* - of Indigenous people, being the largest minority (15%), followed by Asian (12%) and Pacific (7%) [12]. Resultantly, the current trends in health equity studies have been heavily focused on Māori [13, 14, 15], the Pacific [16] and to a lesser extent the Asian community [17, 18]. The Treaty of Waitangi of Biculturalism and the principles of protection,

participation and partnership of the Māori indigenous of New Zealand, has therefore widely informed the health policies priorities and services in New Zealand [19]. The migrants from the Western Pacific regions came to New Zealand under the special arrangements between Pacific governments after attaining colonial independence; temporary seasonal work schemes and the family reunion and international/humanitarian streams in immigration policy; and more recently, the New Zealand’s special quota systems for Samoa and the New Zealand’s ‘Pacific Access Category’, which awards entree to a set number of migrants from Tonga, Kiribati and Tuvalu each year [20]. Therefore, the New Zealand health policies and services are informed by historical migration and within the protection of its indigenous Māori minorities. For that reason, it is of no surprise, that resources dedicated for migrants coming later in the early 1990s like African communities [21] have been lacking. The health and well-being of ethnic minority populations has therefore been historically and consistently underrepresented in New Zealand, yet New Zealand is a culturally diverse nation, which requires a set refugee and migrant health policies and strategies that respond to the health needs of migrants.

Table 1 The WHO health system framework

This article adopts the definition of ethnic minority to be an immigrant or racial groups or immediate descendant thereof [22], regarded by those claiming to speak for the cultural majority as distinct and

unable to adapt and adjust with ease into the New Zealand society due to differences in cultures and traditions [23]. The definition is ‘migrant oriented’ and aligns well with this article as ethnic minority grouping generally becomes noticeable due to migration, whether forced or voluntary and may only attain the position of an ethnic association as a result of migration [22, 23]. This paper set out to undertake a situational analysis of the New Zealand health system in improving health and health equity amongst African ethnic minority using the World Health Organisation (WHO) framework on health system strengthening.

WHO developed two of these frameworks. The first framework recognised fundamental goals of the health systems (health status, financial risk protection, and responsiveness) and four functions of health systems that determine how inputs affect health systems performance (resource generation, financing, service provision, and stewardship) [28]. In this framework, Musgrove and colleagues [28], defined health systems as including all actors, institutions, and resources whose primary intention were to promote, maintain, or restore health. The other WHO framework [3] built upon Musgrove’s framework by organizing health systems into six building blocks: service delivery, health workforce, information, medical products and technologies, financing, and governance and leadership. Since its launch in 2007, this framework has been used worldwide as it has been seen as the most comprehensive and it provides specific guiding blocks strengthening health system in many countries [3, 29]. This article, therefore adopted it to assess the New Zealand health system capacity to

manage ethnic minorities with specific reference to the African community.

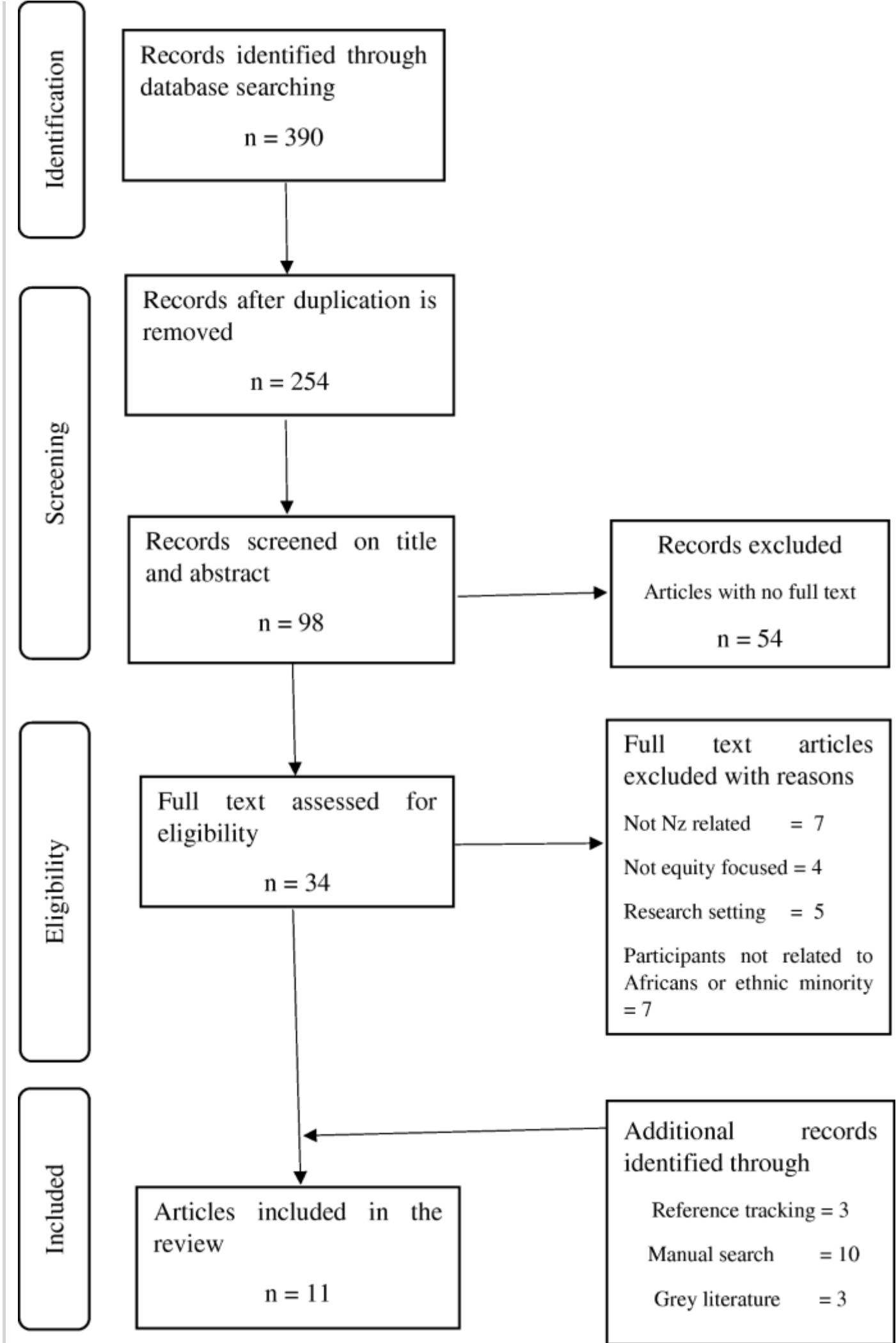
In this article, gaps and key constraints are critically reviewed for each building block where literature exists. Subsequently, recommendations are provided to government, stakeholders and health and social services professionals, which enables the management and the collaborations of the building blocks in ways that ensure the equitable and sustained improvement of health services and health outcomes for the African population.

Method

A critical narrative literature review was applied in this article. This was the preferred method in favour of the systematic review for its ability to cover current and a wide a comprehensive range of issues within a given topic [30, 31]. However, some features of systematic review methodology were used to reduce selection bias [32] by applying the Preferred Reporting Items for Systematic reviews and Meta-Analyses, which follows a protocol with clear methods that demonstrate [34] how many publications were identified and screened for eligibility, how many publications were excluded and why. The aim of the review was to identify literature on theoretical issues and evidence around the attainment of health equity of African minority within the New Zealand health delivery system. See Fig. 1. The electronic search included four databases, CINAHL, PubMed, Scopus, and Google Scholar published from 2010 onwards. Due to the drastic change in nature and growth of ethnic minority communities over the last two decades years, the authors believed that literature published before 2010 may have not provide the true picture

of the current trend of health equity of African minority within the New Zealand health delivery system. Search terms used to select relevant articles are presented in Table [2](#).

Fig. 1



Preffered Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart showing the process of including and excluding articles

Table 2 Search terms used to identify articles on health delivery system on African migrants

The above key words were combined with derivations of the terms `equity` OR `inequity` (i.e. equity/equitable/equitably/equities/equitability, with the same derivations for inequity). Papers were excluded if they did not meet the following criteria: (i) studies that included New Zealand; (ii) have a focus on equity that influenced ethnic minority health outcomes in the delivering of healthcare; and (iii) articles for which full text was not available. Key details of the papers were summarised to include the name of the study and author, year title, study design and main result in respect to the building blocks. See Table 3.

Table 3 Studies by author, year title, study design and main result

After an initial reading, the first author [BK] grouped the articles into five areas of the six WHO criteria for the six building blocks of health system strengthening concepts: 1) service delivery; 2) health workforce; 3) health information system; 4) health financing system; and 6) leadership and governance. Only one paper briefly mentioned the 5th criteria: equitable access to essential medical

products, vaccines and technologies, which also fell under the theme service delivery. All authors agreed on these grouping themes.

Results

The search retrieved 390 articles. After applying the criteria, 11 journal articles were included in the final analysis. Similar studies [34,35,36] with limited and or complex evidence, showed prescribed procedural search strategies to have failed to identify important literature. We therefore used informal approaches to retrieve grey literature using the same terms listed earlier, including international and New Zealand government websites and web archives known to specialise in ethnic minority health and which may provide important detail on the health system strengthening. The process also involved manually selecting relevant publications that were cited in the articles retrieved during the first search. The search found an additional 7 government documents on organisational websites: Auckland and Waitemata District Health Boards; Ministry of Business, Innovation and Development; and Ministry of Health and four from international websites. An additional included grey literature from media (three), and three from reference tracking brought the total number of articles included in the review to 27. Eight were qualitative studies, four were quantitative studies, two used a mixed methodology strategy, and nine studies were literature reviews. Four studies did not mention the methodology used. Of these 27, only nine explicitly mentioned the African community in New Zealand.

Findings

Service delivery: access and processes of migrant health services

18 peer-reviewed articles [[13](#), [14](#), [25](#), [37](#), [38](#), [39](#), [40](#), [41](#), [42](#), [43](#), [44](#), [45](#), [46](#)], one inter-government publication [[9](#)], one Ministry of health document [[47](#)], and one report from Auckland District Health Board [[27](#)] were found to focus on access and processes suggesting its importance in health care delivery analysis. According to the 2015 Migrant Integration Policy Index, the New Zealand's legislation confirm a range of rights regardless of legal status, including access to free basic healthcare [[9](#)]. However, there is contradictory evidence showing these rights not to be fulfilled, protected and promoted [[37](#), [38](#), [39](#), [40](#), [41](#), [42](#)]. For instance, in their measuring of health care system performance of 11 countries in the Organisation for Economic Co-operation and Development (OECD) with respect to care process, access, administrative efficiency, equity, and health care outcomes, Schneider et al., [[39](#)] ranked New Zealand in the eighth place, with a score of – 0.24. The performance score was based on the distance from the average of the 11 countries. Performance issues included: accessibility (language barriers and denial of access based on lack of documentation; negative healthcare provider attitudes and delays in the health system); equity; and health outcomes. Some findings argue the existing access and process of migrant health services is poor due to lack of information and communication. They report practical access to information and the provision of interpreters to be lacking [[44](#), [45](#)], which in turn are a requirement of ethnic minorities to address their

informational needs to facilitate access to and understand the operation of basic medical systems and services including a visit to the general practitioner, obtaining medicines, and gaining access to specialist care [37, 38]. The studies also acknowledged the limited cultural competence of providers and out-of-pocket costs (high co-payments to general practitioners), which were often unaffordable to the ensuing migrant communities.

There is also evidence to show a significant correlation between racial discrimination by healthcare providers with lower odds of preventive healthcare for ethnic minorities [13, 37, 42, 43].

Although majority of the studies specifically refer to the indigenous Māori ethnic group, these problems equally affect the African community, as evidence has reported racial discrimination by a health professional to be higher among non-European ethnic groups in different settings associated with multiple health outcomes and risk factors [25, 41, 48]. For example, one study showed Africans to have presented a higher cost of dispensed pharmaceuticals per person on Human immunodeficiency virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) related healthcare but a lower value of nominal costs per person for laboratory tests compared with others [25]. On the contrary, one study reported HIV/AIDS participants of African descent to receive a higher quality of HIV related healthcare in New Zealand than in Africa [46]. However, the authors noted the comments appeared to be related to fears of being deported and consequently losing the available care.

Findings also showed a mono-cultural practice, displayed as institutional racism, which systematises healthcare into one dominant cultural model in favour of the New Zealand European population to deter access and care processes.

Gooder [40] argued with the support of findings from other studies [39, 41, 42] that people from visible minority ethnic categories, like black Africans, are being racialized by the dominant New Zealand European culture. She described dominance not from a numerical perspective, but rather as cultural dominance illustrated by health system. This is in tandem with other studies which revealed concerns for Africans around inadequacy and or culturally inappropriate health education and promotion on sexual health, family planning and antenatal care, and mental health services [25, 45]. The studies, however, overlooked the examination of the overall health systems context or requirements for a more efficient network of services.

Limited African health workforce to provide healthcare to their communities

Findings show a paucity of health workers from African ethnic minority groups or those with a background understanding of the African community within the New Zealand health system [25, 49]. Although having a workforce from the African community does not automatically transfer to guaranteed health equity for Africans, some studies have recommended the delivery of healthcare, health promotion and education, health campaign by African health professionals and or those who understand the norms and cultural etiquette when working with African migrants as

key to improve health outcomes amongst Africans [25, 27, 45, 46, 49, 50]. Evidence shows New Zealand to source healthcare workers from the major English-speaking background OECD countries for the purposes of filling gaps in its ageing health workforce [49, 51, 52]. Low recruitment of health workers from Africa are attributed to codes of conduct that hinder targeted recruitment from developing countries who are experiencing shortages of healthcare staff [53, 54]. However, many African health care professionals who migrate on their own still fail to practise in New Zealand [40,41,42]. Rigorous assessment of foreign healthcare qualifications remains an important mechanism to ensure high standards and quality in healthcare delivery [40,41,42], but appears to serve largely to control inflows of foreign-trained workers [51, 53]. In addition, a number of studies also showed evidence in the differential treatment of ethnic minorities, across different providers whereby non-European New Zealand health providers were given shorter contracts and were more often than not under scrutiny [14, 41, 43].

Health information systems

There were no publicly available or accessible data or statistics on the health determinants, health system performance and health of African migrants within the Ministry of Health databases [47, 55], suggesting the health information system to have failed to produce, analyse, disseminate and the use of timely information on this group. On the contrary, the databases show references and published health reports on Māori and Pacific population dating back to the 1990s were available.

Similarly, health information reports on Asian migrants are better off than those for Middle East, Latin Americans and Africans (MELAA) groups [27, 56]. Findings show the struggle to meet health information needs, in terms of both the quality of data collected and the speed and clarity to which this information is made available is often related to the current New Zealand Demographic and Household Survey. This survey, continues to group Africans with Middle East and Latin Americans into a single category, commonly known as MELAA or under the 'other' category label, which group widely different cultures together in a perceived homogeneity with a common denominator of being poor, underdeveloped, and helpless. The same phenomenon has been found for Asian diverse ethnic groups [56].

Leadership and governance

Responsiveness at local level is not any better. Good governance is not possible without a strong health information system. The scarcity of research on how health policies and reforms have affected health equity for ethnic minorities, is not surprising. Suffice to say, migrant health is a priority in the Auckland Regional Settlement Strategy (Migrant and Refugee Health Action Plan) but not yet at national level [56]. Findings show the national policy environment to be giving unclear inconclusive direction on migrant health, with tensions between national and local strategic goals.

Health financing

As noted in Table 1, health financing aims to raise adequate funds for health, in ways that ensure people can use needed services, and are protected

from financial catastrophe or impoverishment associated with having to pay for them. Vote Health is the primary source of funding for New Zealand's health and disability system [57]. In 2018/19 financial year, findings show \$13,236 million (72.6% of the Vote) was provided to the 20 district health boards (DHBs) for services to meet the needs of each district's population, taking into account regional considerations, government priorities, and the strategic direction set for the health sector.

Generally, specific health care settings for ethnic minorities are often poorly resourced [57]. Not only did findings show a one off funding of NZD48,000.00 on stock take of New Zealand health system for migrant in the year 2017/18, no budget was set for 2018/19 to 2021/22, with exception for workforce allocation and the strategies for Asians [56]. As mentioned in the health financing system building block, the construct of an African ethnic grouping in New Zealand provides a banner or label under which the needs of this community are not recognised or visible enough to be worthy to finance its health issues. This includes financial inaccessibility of interpretation services which were found to be mostly located in specialised organisations and departments [9, 44]. Resultantly, no findings were found to show a clear dedicated budget for Africans. However, it is worthy to note financing for health services is not only an issue for the African migrant population in New Zealand, but for Middle East and Latin America with some exceptions for the Asian community [45, 56].

Accordingly, areas where Africans predominantly live in Auckland, Avondale-Roskill ward, is the most medically deprived in the city with

disproportionately high rate of hospital admissions [27, 47].

Discussion

The review shows a severe dearth of studies specifically related to the African ethnic minority population's health needs and challenges residing in New Zealand, within the WHO concept of health systems strengthening [3]; which incorporates six inter-related health system building blocks: 1) service delivery; 2) health workforce; 3) information; 4) medical products/vaccines/technologies; 5) financing; and 6) leadership and governance. In general, huge disparities exists across different building blocks of health systems addressing the health needs and rights of ethnic minorities, including those in African communities.

Historically, New Zealand health policies and services for ethnic minorities, has been more responsive to the needs of indigenous Māori ethnic group, than other ethnic minorities who came as migrant and refugees New Zealand. Therefore, the accounts offered in this review in regards to the building block – service delivery, describe governmental policies and programmes not to address factors hindering access to healthcare of ethnic minorities as they do with the Pacific and Asian community [17, 56]. Acknowledged is the lack of culturally sensitive and responsive health service delivery, which unfortunately manifests as a top-down and 'one size fits all' service. Consequently, the healthcare delivery system has not been culturally adapted and made sensitive for Africans alongside populations from Middle East and Latin American grouped as MELAA categorisation which

in itself is problematic when used to inform, plan, and monitor services [56] as many health differences are masked. This promotes the invisibility of African health inequity within all the other building blocks especially the health information system and health financing system. Accordingly, the New Zealand health information system has not been able to adequately capture the ethnic dimension of African communities. This may be attributed to the continuous use of an inaccurate description of an African migrant without any critical reflection on the inherent discrepancies it creates by underestimating the actual African population in New Zealand. Callister [58] notes the process and politics of ethnic enumeration to inform New Zealand policy formulation and resource allocation. Inaccurate numerical presentation of African migrant communities and subsequently inaccurate representation of their needs may explain to some extent the underfunding or lack of funding of migrant health services like interpretation services. It is therefore not surprising New Zealand amongst other countries which has migration inflows, has a publicly funded healthcare system which is correlated with out-of-pocket private health spending and not with public health expenditure. Further, targeted District Health Board funding outside of mainstream funding is limited due to the equity focus on Māori and Pacific health outcomes at present.

For a multi-cultural society like New Zealand, one would assume that a major feature of the country's health workforce would be a diversified workforce. Poynter et al., [59] viewed it as an implicit bias in the way services are set up, where a health workforce from English-speaking countries are

preferred, yet they are the least likely to stay, compared to overseas trained doctors from Africa, Middle East and Asia [49]. Although having health professionals of African backgrounds does not guarantee improvement of health services for African communities, yet when such professionals are available, awarding shorter contracts, or lack of African trained health professionals may be hindrance to the effectiveness healthcare service delivery to the African community. At the same time, the lack of African cultural understanding and African culturally appropriate education by the health service providers, have been noted to affect the confidence of African communities to approach services [25, 50]. African migrants have shown preferences for their own cultural context of care in their hospital encounters, an example of which includes traditional confinement practises for the mothers post natally [60], which are often contested within the western healthcare model [37]. Leadership and the governance of the New Zealand health systems for improving health outcomes for the poor often coincide with ethnic minority status. At the national level, uncertainty and incongruity on the inclusion of migrant health in the public health system, continue to be pose challenges to health equity. For example, Auckland (the largest city in New Zealand) has the highest number of immigrants, with 40% of its population being born overseas and almost half of the total African population, live, study and work in Auckland [6]. Ironically, the identified health needs of the migrants within the Auckland region were not catered for in the Auckland Regional Strategic Plan 2005–2010 as they were not recognised as a priority group in national health policy or in

reducing inequalities. Each District Health Board use discretion on what and how they allocate the population-based funding to their populations based on the equity needs of the Māori and Pacific community.

Recommendations and conclusion

The New Zealand health delivery system continues to perform reasonably well, but inequities remain high for visible ethnic minority migrants like Africans who have limited or no access to healthcare. There is a need to strengthen the health system derived from a well-informed funding allocation relevant for health services needed by the African communities. Furthermore, there should be strategic discussions followed by action to address structural and institutional racism and white privilege in order to explicitly address root causes of inadequate access and care processes for ethnic minorities.

The health information system must be strengthened to include employing context relevant household surveys or other means to gather specific demographic and health baseline data from African migrant communities. This would need to include a categorisation label for Africans in the health information system to allow for monitoring and timely dissemination of information. Such an initiative would in turn then assist in resource allocation and adjusting of some building blocks to meet the needs of this population. The New Zealand government should also start conducting time series reports that provide trends in health outcomes and utilisation of health services by the African minority group to allow for a more valid

and comprehensive picture of their health in New Zealand.

Workforce development is a key for ensuring improved health outcomes for Africans. It includes relevant training and the provision for a health workforce which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances; that is; there are enough numbers and ethnic mix of staff, fairly distributed; they are competent, responsive and productive. African health professionals already residents of New Zealand should receive equal opportunities for practicing in keeping with other professions from different ethnic backgrounds. Such engaged professionals would also be much less likely to have a racial bias which would have major implications on how services are delivered and acceptance by the African healthcare user.

There is generally a need for more research and political will to strengthen the WHO building blocks within the current New Zealand health system service deliveries to be more responsive to the health needs and rights of African minority and other ethnic minorities. Whilst, this review acknowledges the lack of quantitative research, it appraises qualitative research to be best suited to answer the questions of 'why' and 'how'. Such knowledge is needed to design interventions and take affirmative action. Nonetheless, the use of both qualitative and quantitative analysis is recommended to measure health equity within the health system for African minorities. Intrinsic to such research is a strong engagement with African minorities and the use of a multi-pronged data collection approach, and a reliance on an all-

encompassing use of a cultural element to maximise the trustworthiness of findings.

Study limitation

The results are presented as a narrative review due to a limited number of articles and data not well corresponding with the subject matter. However, to reduce such bias, the research strategy in the selection of articles adopted some aspects of systematic review methodology.

Availability of data and materials

All data generated or analysed during this study are included in this published article.

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Contributions

BK analysed the literature review and interpreted the data regarding the improvement of health equity among the African ethnic minority through health system strengthening. EH and SA verified the identified themes. All authors read and approved the final manuscript.

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