

Fact checking the Māori Health claims that have led to The Futures Health Bill

Māori health leaders have criticized the New Zealand Health System as being systemically racist and that this is the prime contributor to poor Māori health and reduced Māori longevity.

The five most common claims that have been made by them in this regard are as stated below. These have all been fact checked and found to be incorrect. This paper presents the evidence to support this view, based on Statistics New Zealand data and the census data from the Pacific region.

These claims are:

1. That Māori die seven years earlier than other New Zealanders.
2. That Māori have poorer health services than non-Māori.
3. That decolonising the health system will improve Māori health and longevity.
4. That a primary contributing factor for Māori ill health is “systemic racism”, “white privilege” and “unconscious bias” in the New Zealand Health system.
5. That non-Māori are not affected by inequitable health provision and services.

All the above statements are not correct, as shown by the following facts and evidence.

1. That Māori die seven years earlier than other New Zealanders.

The data on the life expectancies of people living in New Zealand in 2018 are (Ref 2,3)

	Males	Females
Chinese	87.2	90.1
Asian (other)	85.4	88.0
Indian	85.3	85.7
MELAA	82.6	84.7 (Middle Eastern, Latin American, African)
European	81.6	85.1
Samoa	77.6	82.2
Pacific	75.9	80.2 (Fijian Tongan, other Pacific)
Māori	74.2	78.2

Genetics have been estimated to account for between 7% and 33% of the variance in longevity. The standard accepted figure for this genetic impact is 25% (References 4, 5). Comparisons of different ethnicities regarding relative life expectancies must take this into account.

From the above figures, it can be seen that Māori have the lowest life expectancy. This is accurate. However, it is not accurate to say that Māori die seven years earlier than other New Zealanders as each race in New Zealand has its own genetically influenced life expectancy. That their cousins, the Cook Island Māori, who are genetically very similar, die at around the same age as New Zealand Māori, (ref 6) suggests, but does not prove, that this may be their natural life expectancy. It can be seen for example that Pakeha die nearly six years earlier than Chinese New Zealanders.

Using the same logic of the above claim, i.e., that Māori die seven years earlier because of the “systemically racist” Health Service, do we also claim that, as Pakeha are dying six years earlier than Chinese New Zealanders, it is due to a “systemically racist” Health System.

The logic is irrational. If genetics are not considered, then mistakes and faulty analysis occurs. This is what has happened here. It is disappointing that the Māori Health leaders who are doctors continue to quote this “fact” when they are all aware of the genetic determinants of longevity.

2. That Māori have poorer health services than Non-Māori.

The Te Ora report states that the number of hospital admissions that could have been prevented by access to timely and competent general practice care (Ambulatory Sensitive Hospitalisation – the ASH figure) were 2171/100,000 for the non-Māori population, and 3686/100,000 for the Māori population between the years of 2007 and 2018. Taking the population at 5,000,000 with Māori being 16.5%, and non-Māori 83.5%, then the number of possible preventable hospital admissions during that period were 30,409 for Māori, and 90,639 for non-Māori. The percentage for Māori is obviously higher than it should be based on the percentage of the population – it would be approximately 17,900 at the non-Māori ASH rate.

However, the Te Ora report neglects to mention that the 2016 ASH rate for Pacific adults was 8787/100,000 – a figure over twice as high as Māori, and the figure for Pacific children aged 0- 4 was 12079/100,000. (Ref 10) As the Pacific population is only 9% of the total population,

these figures are not seen when it is diluted with the 83.5% of the population comprising Pakeha, Asian and other non- Māori ethnicity groups.

There are also no ASH figures collected for the disadvantaged section of the Pakeha population. This is important as the poor health of the Pakeha in poverty is also “hidden” by the large bulk of the non-Māori population (83.5%) living above the poverty line. The size of this group of Pakeha living in poverty can be estimated to be to be 14.8% of the population according to Child Poverty figures for Stats New Zealand in 2020 (Ref 16), making this group the largest by far of any disadvantaged group of any ethnicity who have poorer access to health services.

Because the ASH figures have not been collected for these Pakeha living in poverty, it is not possible to state that Māori have poorer health services than other New Zealanders. The necessary research has not been done.

3. That decolonising the health system will improve Māori health and Longevity.

The comment that “decolonising the Health Service is necessary to improve Māori health and longevity” is not supported by the Cook Island experience.

One way to estimate the impact of colonisation, and other factors argued to be responsible for shorter life expectancy in Māori is, as mentioned above, to compare New Zealand Māori demographic data to a genetically similar population, namely Cook Island Māori who are still resident in the Cook Islands. The latter have also been subject to a degree of colonisation but have been decolonised for 56 years.

From the figures above, when comparing the Cook Islands life expectancy figures for 2018 (Ref 6) it can be seen that Cook Island females living in the Cook Islands have a life expectancy of 79.2 years, whereas Māori females living in New Zealand have a life expectancy of 78.2 years. For males, the relevant expectancies are 73.3years (Cook Island males living in the Cook Islands) and 74.2 years (Māori males living in New Zealand). These differences are not significant and taken together do not support an argument that a 56-year period of decolonisation has had neither a positive nor negative effect on the longevity for Cook Island Māori.

Perhaps more helpful to this consideration of colonisation and its effect on longevity is that all Pacific Islanders, irrespective of their origin, have significantly increased their life

expectancy by migrating to New Zealand – despite living in lower socioeconomic areas in New Zealand, and despite having to use the allegedly “systemically racist” health system.

For example, using the 2018 census data from Samoa (Ref 7), Tonga (Ref 8) and Fiji (Ref 9) the life expectancies for Pacific people living in the Pacific Island compared to living in New Zealand are:

	Longevity in Pacific Island	Longevity in New Zealand	Increase in Longevity
Samoan (Males)	71.2 years	77.6 years	6.4 years
Samoan (Females)	75.3 years	82.2 years	6.9 years
Pacific (Males) (see *)	67.2 years	75.9 years	8.7 years
Pacific (Females). (See**)	70.6 years	80.2 years	9.6 years

* Combination of Tongan (68.8 years in Tonga) and Fijian (65.6 years in Fiji) figures (Ref 8,9)

** Combination of Tongan (72.2 years in Tonga) and Fijian (69.1 years in Fiji) figures (Ref 8,9)

The average life expectancy for Pacific males (Fijians and Tongans) living in Fiji and Tonga is 8.7 years less than Pacific males living in New Zealand, and for Pacific females (Fijian and Tongans) living in Fiji and Tonga it is 9.6 years less than Pacific females living in New Zealand (See table above).

These data showing a very significant increases in life expectancy for Samoans, Tongans and Fijians living in New Zealand also shows that the key social determinants of health – poverty, unemployment, low educational level, and poor housing - which presumably have been prevalent in the less economically developed Pacific nations - are the prime factors in determining good health and improved longevity, along with a health system that provides a more complete service than that available in the Islands. The fact that the 77.2% of Pacific people who are choosing to use the NZ Health system is higher than any other ethnicity (76.5% or lower for Pakeha, Asian, and other non – Māori ethnicities - Ref 10) suggests that they do not perceive the system to be “systemically racist” or having an “unconscious bias” against Pacific peoples.

Thus, if shortened longevity for Māori is attributed to a "systemically racist" health system that Māori state discriminates against Māori, as claimed by the Waitangi Tribunal and Te Ora, how is this phenomenon of a higher utilisation of the health services by Pacific peoples as compared to Pakeha and other non-Māori ethnicities, explained? What also explains the significantly increased life expectancy of Māori living in the Marlborough region where Māori

males have a life expectancy of 79.9 years (a 5.7-year increase) and Māori females have a life expectancy of 83.4 years (a 5.2-year increase). (Ref 11)

Is the health system not “systemically racist “down there? It does not make sense that the 80,000-health worker are racist for Māori but not racist for Tongans, Fijians and Samoans, or the health workers in Marlborough are not racist but the workers in the rest of New Zealand are. The logic in the Waitangi Tribunal and the Te Ora report regarding systemic racism is not rational.

4. That primary contributing factor for Māori ill health is “systemic racism,” “white privilege,” and “unconscious bias” in the New Zealand Health system.

The third of the above core statements - that “systemic racism”, “white privilege” and “unconscious bias” in the health system are key contributors to reduced Māori longevity, is listed as the primary cause in the Te Ora report. What is “a systemically racist health system”? It is a system of health delivery in which services are separated, financed, and delivered on the basis of race. This is what existed in South Africa under apartheid.

To understand what these accusations mean, we must analyse each of the terms separately. Under apartheid, the separate areas that had been the historical tribal homelands of the various tribes, were allocated to each tribe. In these areas, the tribe governed itself and administered their own health systems including hospitals. In the remaining area of South Africa itself, the public health system was divided into two – one system for “whites” and one system for “non-whites.”

There were separate hospitals, separate ambulances, separate services, and separate funding provided for “white” and “non-white” patients who lived in South Africa. In the private health sector, separate waiting rooms and separate consulting rooms were required for the “white” and “non-white” racial groups. There was vastly different government funding per head of population in the health budgets for the various races as per government policy. The standard of medical care on offer varied significantly with the “white” and “non-white” groups.

These are the characteristics of a "systemically racist" health system. Until now, none of these basic criteria for a systemically racist system exists in the New Zealand Health Service.

Thus, for the Chairman of the New Zealand Medical Council, the two Associate Ministers of Health, and the CEO of the Ministry of Health, to state that we have "systemic racism" in the New Zealand health system, is just not factually correct. The New Zealand system does not compare to the internationally criticised South African health system that was legislated to be completely systemically racist. Under the Code of Disability and Consumer Rights, we have a health system that legislates for equal services and access for all races, as also required by the UN Declaration of Principles on Human Rights, the Declaration of Commonwealth Principles, and the New Zealand Bill of Rights. Had there been any discrimination on racial grounds, there would have been prosecutions. There have been none.

Racism in the New Zealand medical context has been levelled at the health system when the cultural norms of the patient were not adhered to in primary practice or in the hospital environment. However, a lack of cultural knowledge is not racism, and allowing for the inherent cultural competency problems that arise when the New Zealand health workforce is so dependent on immigrant health workers (44% are immigrants - NZMC and Nursing Council data,) accusations that the 80,000 workers of all ethnicities, who are the New Zealand health system, are collectively racist, is wrong, and has caused significant resentment amongst medical and nursing staff.

The phrase "white privilege" implies that there are less obstacles in the way of non - Māori people to access health than Māori people. Where is the evidence? Pakeha, Polynesians, and other non- Māori races who are affected by unemployment, poverty, poor education, poor housing or living in rural areas, have as much difficulty in accessing health as Māori in the same socioeconomic or geographical situation. From 2018 figures, there were approximately 90,100 non-Māori unemployed compared to 40,300 Māori over a similar period. That these Pakeha, Polynesian or other races have "white privilege" is not correct. All these people battle and need assistance irrespective of their ethnicity.

The statement "unconscious bias" - refers to a strongly held belief that exists in memory and influences decision making. These beliefs arise from childhood conditioning and because they seem so normal, we are unaware they are affecting our decisions. All people, from all races, including Māori, have unconscious bias – it is part of being a human being, and some people in all races will have an unconscious bias against members of a different race - this is

the racial bias that is referred to in Te Ora. People in different races often believe that their culture is best or that their culture is not being treated fairly- this is the commonest unconscious bias that exists and is very much present in this discussion on health in New Zealand. As example of this, the current low vaccination rates amongst Māori, the lowest of any ethnicity, has been blamed on “systemic racism” and “government incompetence” by both Associated Ministers of Health (Ref 14).

Their unconscious belief in the complete responsibility of the government and the racist Health Service for poor Māori health statics, stops them from considering that the same factors that are causing poor vaccination rates in other communities and countries, may be contributing to vaccine hesitancy in Māori – e.g.: anti vax sentiment, fear concerning genetic engineering, concern re the injection of foreign particles into the body, problems in getting off work, rumours of infertility, rumours of DNA issues, religious issues, needle phobia, tapu issues, concern re adverse long-term effects, other misinformation/side effects etc. Why would these concerns not be affecting Māori in the same way as they are affecting a significant number of New Zealanders and millions worldwide? They are off course and even Derek Fox has commented recently that a significant minority of Māori refuse to take the vaccination for their own reasons.

The Medical Council chair has stated that doctors have an unconscious racial bias against Māori. The bias presumably means that doctors believe that Māori are somehow inferior and therefore they are not treated as well as patients from other non-Māori races. Where is the evidence for this? The fact that the highest utilisation by ethnicity of the health services is by Pacific peoples, (Ref 10) suggests that they do not think that an unconscious bias exists for them. We have had a Health and Disability support system for patients for over 20 years. If specific examples exist, where Māori have been treated with an inferior service due to their race, why have they not been prosecuted?

Throughout the reports, the poor Māori health outcomes documented in the Waitangi Report 2575 and the Te Ora report, are statements only of poorer health outcomes.

There is no documented, factual evidence presented regarding the causes.

For example, the Te Ora Report, states, without evidence, that the following are the causes of poor Māori health outcomes:

- "Systemic racism," "white privilege" and "unconscious bias" in the health system
- The need for longer consultations

- The doctor getting to know the patient better
- Lack of Māori spiritual knowledge
- Not having one doctor on an ongoing basis in Primary Health Clinics
- Māori knowledge is not incorporated into the consultation and diagnosis
- The effects of colonisation

Aside from colonisation contributing to poverty, which has the greatest impact on health, the other nominated causes are not consistent with international medical opinion that states that disease prevalence and presentation is strongly related to the range of social deprivation factors which exist external to the health system, and for which the health system is not responsible.

5. That non-Māori are not affected by inequitable health services.

The absolute number of non – Māori (Pakeha +Asian +Pacifica +others) with avoidable hospital admissions in the Te Ora report - 90,000 - is three time higher than the absolute Māori number. This is an enormous number of non- Māori patients who have not had access to timely or competent primary health care.

The proposed restructuring of the Health System does not recognise these disadvantaged multi-ethnic non-Māori New Zealanders who are patients on the fringes of the non – Māori society. The figures for below from Stats NZ indicate the size of this non-Māori medical underclass living in poverty in 2019.

Ethnic groups. (Child Poverty figures for children living in New Zealand) Stats NZ 2020 (Ref16)

Measure	Year	European	Māori	Pacific people	Total population
Percentage of children living in households with less than 50 percent of the median equivalised disposable household income after housing costs are deducted (for the 2017/18 base financial year)	Year ended	14.8	21.1	21.0	18.4
	June 2020 percentage	(114,300 children)	(61,000 children)	(30,700 children)	(210,500 Children)
	Sample error on change	2.0	3.3	4.0	

From the above there are twice as many children living in poverty in the non-Māori (Pakeha + Pacific group) – 145,000 children -- as compared to the Māori group - 61,000.

An alternative view of the same figures is that there is a significantly greater number of Pakeha children living in poverty as than the total number of Māori and Pacific children. In the opening submission to the Tribunal Hauoras Enquiry, the Crown counsel accepted that “there is no need for this Tribunal panel to enquire into the question of whether Māori health status is significantly worse than for non-Māori at a population level; this is well established and not disputed”

This statement is incorrect. As poverty is the principal driver of health inequity, the health of these Pakeha in poverty will be adversely affected, as are the Pacifica experiencing poverty.

The mortality, morbidity and ASH figures for Pakeha living in poverty has not been collected. Why not? They are the biggest cohort of New Zealanders with poor health.

As **poverty is the prime determinant of health outcome**, this was a mistake on behalf of Crown council, who also appear to have had a limited knowledge of health statistics.

As this new Health Act states that its role is to

- a) Protect, promote, and improve the health of **all New Zealanders**; and
- b) Achieve equity by reducing health disparities among New Zealand’s population groups, for Māori; and
- c) Build towards Pae Ora (healthy futures) for **all New Zealanders**.

To not address the needs of this exceptionally large non-Māori medical underclass, twice the size of the Māori medical underclass, and selectively increase the per capita funding for Māori, is an infringement of the UN Declaration of Human Rights, the Commonwealth Declaration of Principles, and the New Zealand Bill of Rights. Each of these pieces of legislation require equality of access to health care for equally disadvantaged groups, irrespective of race, gender, sexuality, religion, age etc., as a basic human right. The \$200,000,000 recently allocated to Māori to encourage vaccination is an example of this.

Where was the funding for the non- Māori un-vaccinated to help them get vaccinated? As +/-20 % of the population of 5,000,000 remained unvaccinated when this funding was given, assuming Māori were one third of this - 330,000 - then there were, and still are, an estimated

666,000 non- Māori unvaccinated who will be bulk of the extremely ill and many of whom will die.

As this \$200,000,000 funding was based purely on race, and which ignored the other 660,000 equally deserving but non- Māori New Zealand citizens, it is in breach of our Bill of Rights which states.

“The Human Rights Act protects people in New Zealand from discrimination in a number of areas of life. Discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances.”

It is also in breach of our international obligations under the UN Human Rights Agreements and Commonwealth Human Rights Agreements to which we are signatories.

Discussion

The World Health Organisation makes the following statement of the social determinants of health.

“The SDH have an important influence on health inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.” **World Health Organisation - Social Determinants of Health (SDH).**

The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:

- **Income and social protection**
- **Education**
- **Unemployment and job insecurity**
- **Working life conditions**
- **Food insecurity**
- **Housing, basic amenities and the environment**
- **Early childhood development**
- **Social inclusion and non-discrimination**
- **Structural conflict**
- **Access to affordable health services of decent quality.**

Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health. For example, numerous studies suggest that SDH account for between 30-55% of health outcomes. **In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector.**

Addressing SDH appropriately is fundamental for improving health and reducing longstanding inequities in health, which requires action by all sectors and civil society.” World Health Organisation (Ref 12).

Since 2000, most Māori health services for Māori enrolled on the Māori electoral roll in both rural and urban regions have been provided by seventy-seven Māori Health providers (Ref 13). They have been funded by the state but completely managed by iwi throughout New Zealand during this time. They were created twenty years ago to provide a “by Māori, for Māori” health service as a solution for the Māori health problems – the identical reason as for this current bill.

While some of the hauora have provided an excellent range of public health measures and personal health services, others have not been so successful. However, this network of hauora have not had the breakthrough in improving Māori health statistics that had been hoped would occur with a “by Māori, for Māori” service provider. The reasons for this are debated with Māori claiming inadequate funding was the cause and the funding agency stating failure to reach agreed health targets, poor management, and incorrect spending priorities were to blame. The Waitangi Tribunal, when starting the investigation into the report on Māori health, refused to publish their findings into the reasons that this health service delivery system failed, stating it was “sensitive”. (Waitangi Report 2575) This is irrational as that information is crucial to assisting with the success of this new Act.

As the ASH figure is a measure of a poor level of accessing and utilising general practice during this time, then the reasons that Māori do not access their own iwi owned and operated primary health services must be clearly identified. Without clarity around the causes, there will be a repeat of the failure of the system of the last 20 years, where services have been provided by Māori, for Māori, but have not significantly improved Māori health as was hoped.

However, the cause, as shown by the WHO above, is that **the primary determinants of health are not found in the health system**, and never will be. They are found in the social determinants which lie outside of it.

The fact that the Māori health leaders are aware of the primary importance of the social deprivation determinants on health, and yet persist with blaming “systemically racist health system” when this cannot be relevant in the seventy-seven “by Māori, for Māori” health providers who have been responsible for most rural Māori primary health requirements over the last twenty years.

While it is the right thing for Māori Doctors and Māori leaders to advocate for better health for the Māori people, it is not right that they attribute all Māori ill health to a “systemically racist” system with “unconsciously biased” doctors and health service staff, or that they lay the blame for all shortcomings in Māori health on “racism”. These accusations have caused huge resentment amongst health workers. If this is believed to be the cause, then the problems will never be solved.

It is also wrong that health statements made by various Māori leaders and the Waitangi Tribunal are taken at face value and not challenged. As pointed out, Māori doctors have known that the five statements discussed initially are factually incorrect but have persisted with stating them. They are also aware of the WHO social determinants of health (Ref 12) which they chose to ignore in this discussion. The Waitangi Tribunal is aware of the reasons for the lack of success of the current “by Māori, for Māori system,” but refuses to release their findings as they are “sensitive” (Ref 15).

However, the points that I make, are not an argument against addressing equity issues which exist for the lower socioeconomic groups of all ethnicities in New Zealand. I fully support the argument that a significantly increased number of Māori doctors must be produced on an annual basis to help solve the Māori health problem. It is exceedingly difficult for a non-Māori doctor to assist with mental health, spiritual or psychiatric issues in traditional Māori patients who live in the traditional Māori world. These patients require a doctor with an understanding of that world view. The significantly increased number of Māori medical graduates, now approaching 120 a year – 30% of the total graduates - will be the solution to this problem.

It is also undeniable that many Māori in remote rural, lower socioeconomic groups have poorer health than many others living in urban New Zealand, and the need for improvement for these people is unquestionable, as it is for the non-Māori of all ethnicities who are in the same situation and are not accessing timely and competent primary health care.

However, the argument that "systemic institutional racism" is responsible for Māori living relatively shorter lives than other New Zealanders is incorrect.

The causes for groups within Māori and non-Māori ethnicities not accessing primary health providers in a timely manner, and therefore scoring higher on ASH figures, are multiple. I believe that the Medical Council, the Māori Medical Practitioners group, the Waitangi Tribunal, and it appears, the Ministry of Health, are afraid to properly call out the real causes of not only Māori poor health, but the poor health of a large percentage of health problems for all racial groups, Pakeha included.

Pakeha and all other ethnicities present with obesity, hypertension, addictions, smoking, coronary artery disease, depression, anxiety disorders, gout, cancers, diabetes, respiratory problems, genetic disorders etc., on an ongoing basis. The fact that Pakeha males, the creators the health system, and the sector of society accused of privilege, **are in the lower half of life expectancy when compared to the other ethnicities in New Zealand,** (see table 1) does not fit at all with any "white privilege" or the "systemic racism " theory. It does fit well with the internationally accepted medical opinion that disease prevalence and presentation is strongly related to multiple social deprivation factors outline above, to which Pakeha and Pacifica re not immune, **and that these factors 'sit' outside the health system and require their own research and solutions.** The New Zealand experience of very significantly improved life expectancies for all Pacific peoples who now live in New Zealand confirms the this.

The primary causes, according to the WHO, are not the responsibility of the Ministry of Health and funding the Ministry of Health to solve the inequity in health will not solve the problem.

This is not an argument against addressing equity issues in healthcare for all peoples of New Zealand and specifically regarding Māori having a separate medical system - they have effectively had this for the last twenty years for most rural and some urban Māori under the iwi managed health providers.

However, as stated in the preamble to the Act, the Futures Health Bill is intended to "protect, promote, and improve the health of all New Zealanders". **Then, by definition, there must be equality in funding of the medical underclass of all ethnicities.**

This must be acknowledged in the Act, as required by the intentions of the Act, and the New Zealand Bill of Rights and international Human Rights treaties to which we are signatories.

This submission also argues for a more comprehensive assessment of the real causes of the high ASH scores affecting the health of the under privileged Māori and non – Māori. Essentially, how can access and utilisation of their primary health provider – their GP – be improved, and what focused interventions in social determinants will really make a difference. At this point, we do not know this as research into the causes has not been done. The interview of twenty-four Māori families for the Te Ora report is not adequate.

For this to occur, consideration of both the relative role of health services and the large range of internationally accepted social determinants of health is necessary, before the current simplistic analyses, accusations of racism and factually incorrect statements continue to be translated into this substantive policy and structural changes favouring one ethnicity.

Conclusion

- 1. Systemic racism is not the cause of Māori health issues, but without clarity around the actual causes of the problems, it is not possible to successfully target the cause of the health issues that do exist. This bill should be delayed until the necessary data has been collected, and defined and measurable targets decided upon. If this is not done, nothing will change, except for additional administration costs of between \$0.5b and \$1.0 b per year.**
- 2. Funding the Health System without dealing with the Social Determinants of Health will not solve the problem.**
- 3. The government can allocate any amount of funding it wishes to Māori health but must also fund other equally medically underprivileged groups with the same per capita amount. Not to do so is in breach of New Zealand Bill of Rights and the stated aim of the Pae Ora (Health Futures) Act - to improve the health of all New Zealanders.**

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