BEFORE THE WAITANGI TRIBUNAL **WAI 2575**
TE ROOPU WHAKAMANA I TE TIRITI O WAITANGI **WAI 2499**

IN THE MATTER OF the Treaty of Waitangi Act 1975

AND

IN THE MATTER OF a claim by **DAVID MARK JANSEN AND OTHERS** on behalf of themselves as individual Māori, Te Ohu Rata o Aotearoa, and on behalf of all Māori generally

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BRIEF OF EVIDENCE OF DR RAWIRI JANSEN

22 DECEMBER 2017

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WELLINGTON

KAHUI LEGAL
Solicitors
PO Box 1654
Telephone: (04) 495 9999
Facsimile: (04) 495 9990
Solicitors: P T Walker / K J Tarawhiti
WELLINGTON

KJT-101761-1-365-V6

Introduction

1. My name is Dr Rawiri Jansen.

2. My qualifications are MBChB (Auck), FRNCGP, Grad Cert Clin Teach, BHB, BA, DipTch. I am the Medical Director at Papakura Marae Health Centre, the Clinical Lead for the Mana Kidz programme serving 27,000 primary school children in South Auckland, and the Clinical Director Networks and Integration for the National Hauora Coalition. My tribal affiliation is Ngati Raukawa.

3. This brief of evidence is filed on behalf of Te Ohu Rata o Aotearoa (**Te ORA**), the Māori Medical Practitioners Association. It has been prepared in conjunction with other members of Te ORA.

4. Te ORA is a professional body representing Māori medical students and doctors working as clinicians, researchers and teachers. With approximately 340 active members, Te ORA represents the majority of the Māori medical workforce. Te ORA's vision is to provide Māori medical leadership to the health sector to effect Māori health development. Te ORA's mission is to enable key strategies including:

    - increasing the Māori medical workforce towards population parity
    - improving access of Māori to medical and health education, research and knowledge
    - influencing the agenda for Māori health development
    - developing and engaging with clinical leaders to support long term responsiveness to Māori health.

5. Te ORA has formalised relationships with health organisations, participates in key health committees, provides secretariat support to projects, sponsors summer studentships and provides Māori clinical advice and leadership across the broader New Zealand health sector.

6. Te ORA has a governing board elected by its membership and an office based in Te Whanganui ā Tara (Wellington).

Purpose of Evidence

7. This brief of evidence is filed to supplement the brief of evidence of John Hazeldine filed on behalf of the Ministry of Health (**Ministry**), dated 3 July 2017.[1] Mr Hazeldine's brief of evidence provided an overview of the New Zealand health system from the Crown's perspective, including an outline of the functions of the Ministry, District Health Boards (**DHB**), Health Sector Crown Entities and Non-Government Organisations.

8. The purpose of this evidence is to provide the Tribunal with further relevant information regarding the New Zealand Health System from the perspective of Te ORA in order to assist the Tribunal with its examination of Māori health services and outcomes.

9. In particular, this brief of evidence provides an overview of the New Zealand health system and its impacts on Māori health as follows:

   (a) It outlines further elements of the Crown or Crown-controlled health system not referred to in Mr Hazeldine's evidence, including:

      i. Expanding on the purpose and function of the New Zealand Public Health and Disability Act 2000 (**NZPHD Act**) within the New Zealand health system;

      ii. Describing the broader legislative framework relating to health services and outcomes;

      iii. Describing other relevant Crown or Crown-controlled agencies involved in health services and outcomes in New Zealand;

   (b) Outlines elements of the New Zealand health system which are not Crown-owned or controlled, but which still influence health services and outcomes in New Zealand.

   (c) Identifies the importance and recognition of the social determinants of health within the New Zealand health system.

[1] Wai 2575, #A1.

(d) Provides brief comment on how, despite settings with stated aims to reduce or remove inequities, the New Zealand health system continues to produce and maintain inequities in health outcomes for Māori.

10. This brief of evidence should be read in conjunction with Te ORA's health system overview presentation prepared by Dr Rhys Jones, filed concurrently with this brief of evidence as **Attachment A**.

Crown or Crown-controlled elements of the health system

New Zealand Public Health and Disability Act 2000

11. The NZPHD Act is the central piece of legislation with the "public health system" in New Zealand and provides for:

(a) the public funding and provision of personal health services, public health services, and disability support services;

(b) the broad organisational framework for the delivery of these services;

(c) the responsibilities of the Minister of Health;

(d) the role, structure, planning framework and requirements and accountability of District Health Boards (**DHBs**);

(e) other publicly-owned health and disability organisations such as:

i. Pharmaceutical Management Agency (**PHARMAC**);

ii. New Zealand Blood Service;

iii. Health Promotion Agency; and

iv. Health Quality and Safety Commission; and

(f) certain provisions relating to special health inquiries.

12. The purpose of the NZPHD Act is as follows:

> **..3 Purpose**
>
> (1) The purpose of this Act is to provide for the public funding and provision of personal health services, public health services, and

disability support services, and to establish new publicly-owned health and disability organisations, in order to pursue the following objectives:

(a) to achieve for New Zealanders—

(i) the improvement, promotion, and protection of their health:
(ii) the promotion of the inclusion and participation in society and independence of people with disabilities:
(iii) the best care or support for those in need of services:

(b) to reduce health disparities by improving the health outcomes of Māori and other population groups:

(c) to provide a community voice in matters relating to personal health services, public health services, and disability support services—

(i) by providing for elected board members of DHBs:
(ii) by providing for board meetings and certain committee meetings to be open to the public:
(iii) by providing for consultation on strategic planning:

(d) to facilitate access to, and the dissemination of information to deliver, appropriate, effective, and timely health services, public health services and programmes, both for the protection and the promotion of public health, and disability support services.

(2) The objectives stated in subsection (1) are to be pursued to the extent that they are reasonably achievable within the funding provided.

(3) To avoid any doubt, nothing in this Act—

(a) entitles a person to preferential access to services on the basis of race; or

(b) limits section 73 of the Human Rights Act 1993 (which relates to measures to ensure equality).

(4) In giving effect to the purposes set out in subsection (1), the Crown and DHBs must endeavour to promote the integration of all health services, especially primary and secondary services.

(5) In giving effect to the purposes set out in subsection (1), the Crown and DHBs must endeavour to provide for health services to be organised at either a local, regional, or national level depending on the optimum arrangement for the most effective delivery of properly co-ordinated health services.

13. Significantly for the Waitangi Tribunal's Wai 2575 Health and Services and Outcomes Inquiry, the purpose of the Act includes reducing health disparities by improving the health outcomes of Māori and other population groups (section 3(1)(a) of the Act).

14. This stated purpose is repeated in the objectives of DHBs under the NZPHD Act. These objectives are outlined at section 22(1) of the Act and include:

> ..(e) to reduce health disparities by improving health outcomes for Māori and other population groups:
>
> (f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders..

15. There are no references in the NZPHD Act to inequity (or equity) in health, although this term is in common use by the Ministry.

16. An overview of other references in the NZPHD Act relevant to Māori health services and outcomes is set out at **Attachment B**.

Other Relevant Legislation

17. The NZPHD Act is a significant part of the legislative framework for health services and outcomes for Māori, but it is not the whole system. There is other legislation which contributes significantly to health services and outcomes (and inequities) for Māori.

18. Relevant legislation which forms part of the legislative framework for health services and outcomes for Māori includes the following, to varying degrees of influence (and contemporary relevance):

(a) Alcohol and Drug Addiction Act 1966;

(b) Accident Compensation Act 2001;

(c) Health Act 1956;

(d) Health and Disability Commissioner Act 1994;

(e) Health and Disability Services (Safety) Act 2001;

(f) Healthy and Safety at Work Act 2015;

(g) Health Practitioners Competence Assurance Act 2003;

(h) Health Research Council Act 1990;

(i) Māori Community Development Act 1962;

(j) Māori Trust Boards Act 1955;

(k) Medicines Act 1981;

(l) Mental Health (Compulsory Assessment and Treatment) Act 1992;

(m) Ministry of Māori Development Act 1989;

(n) Misuse of Drugs Act 1975;

(o) Oranga Tamariki Children's and Young People's Well-being Act 1989;

(p) Psychoactive Substances Act 2013;

(q) Sale and Supply of Alcohol Act 2012

(r) Social Security Act 1964; and

(s) Vulnerable Children Act 2014.

19. I do not propose to detail the influence or relevance of the above legislation to health services and outcomes for Māori at this stage of the Inquiry, other than to record that

(a) In addition to the legislation above, there is other legislation which is relevant to health services and outcomes for Māori.

(b) The web of legislation relating to health services and outcomes for Māori is complex. This legislation is administered by or relevant to a similarly complex web of Crown and non-Crown agencies.

Ministry of Health

20. The Ministry is the primary Crown agency responsible for the New Zealand's health and disability system. Core activities of the Ministry include:

(a) policy advice and ministerial servicing;

(b) purchase of healthy and disability services;

(c) health sector information systems;

(d) payments service;

(e) regulatory and Enforcement services; and

(f) sector planning and performance advice.

21. The Ministry produces a range of planning, reporting and policy material in relation to its functions in the New Zealand health system.

22. The Ministry's Statements of Intent are intended to outline the Ministry's role in delivering on and contributing to priorities for the health and disability system. These Statements are also intended to describe how the success of the Ministry's work in respect of these priorities will be measured.

23. The Ministry's Annual Reports are produced under sections 43 and 44 of the Public Finance Act 1989. These Annual Reports generally outline what the Ministry has delivered each year in respect of its strategic priorities, its contribution to wider priorities, financial performance and related matters.

24. The Ministry also produces the New Zealand Health Strategy and He Korowai Oranga: Māori Health Strategy, which have already been filed with the Tribunal in this Inquiry.

25. The Ministry's organisational structure consists of the following business units:

(a) Strategy and Policy;

(b) Service Commissioning;

(c) Protection, Regulation and Assurance;

(d) Technology and Digital Services;

(e) Finance and Performance; and

(f) People and Transformation.[2]

26. In addition, there are also the following components and positions:

(a) Office of the Director-General;

[2] Ministry of Health website at: https://www.health.govt.nz/about-ministry/ministry-business-units

(b) Māori Leadership (one position);

(c) Chief Nursing Officer;

(d) Chief Medical Officer; and

(e) Critical Projects.[3]

27. In previous years, the Ministry had a specialist Māori health business unit (Te Kete Hauora). Te Kete Hauora had been established in 1993 as a result of a report prepared by Hekia Parata and Sir Mason Durie for the then Department of Health entitled "*Māori health review: A report for the Department of Health on how it can meet the government's Māori health objectives*".

28. In 2016, Te Kete Hauora was disestablished and its functions integrated across other Ministry business units. The Ministry's stated view is that this approach boosts the whole Ministry's capability and capacity to address Māori health inequities.[4]

29. Under the NZPHD Act, the Ministry has an explicit role in reducing health disparities by improving the health outcomes of Māori. The Ministry also has a stated position about addressing Māori health inequities.

30. Despite this stated position, the brief of evidence filed on behalf of the Ministry makes no mention of Māori health disparities or inequities arising within in and as a result of the New Zealand health system.

31. Māori health disparities and inequities are described in a number of the publications included on the publication list filed on behalf of the Ministry in July 2017.[5] Among other matters, these publications describe how policy, unequal power, unequal access to resources and unequal treatment are organised and positioned to entrench privilege, disparities and inequities.

DHBs

[3] Ministry of Health website at: https://www.health.govt.nz/about-ministry/ministry-business-units

[4] Ministry of Health website at: https://www.health.govt.nz/our-work/populations/maori-health

[5] Wai 2575, #3.1.61(a).

32. Critical to successful and equitable health services and outcomes within the present health system is the delivery of health services by DHBs, and the monitoring and evaluation of DHB performance in achieving these standards.

33. In this respect, the Ministry has a critical function under the NZPHD Act in monitoring DHB progress. This includes monitoring DHB progress in achieving key priority indicators through an annual planning process.

34. DHBs are expected to consider and include actions in their Annual Plans that will help them to achieve health equity for all of their populations, including Māori. Despite these requirements, the Ministry's own corporate publications (including annual reports and statements of intent) continue to record persistent inequities for Māori.

35. It is unclear whether and how the Ministry monitors and sanctions DHBs in respect of the expectation that DHBs achieve health equity for all of their populations, including Māori. Further information on this role may be provided in due course in the context of this Inquiry.

36. Between 2011/2012 and 2017/2018, there was a requirement by the Ministry on DHBs to prepare standalone Māori Health Plans. This requirement is not prescribed in the NZPHD Act and followed a report by the Office of the Auditor-General in 2011 that such an approach would be useful in focusing DHBs annual planning and reporting.

37. Following the introduction of these Māori Health Plans, there was a general failure of DHBs to meet their targets under these Plans, with varying degrees of success among DHBs.

38. In 2017/2018, the Ministry abolished the standalone Māori Health Plans and reverted back to a requirement for the incorporation of actions in DHB Annual Plans that will help DHBs reduce disparities for Māori and achieve health equity for all their populations.

39. In terms of reporting, DHBs are not presently required to report by ethnicity.

40. The NZPHD Act provides that the Minister must ensure that Māori membership of a DHB is proportional to the number of Māori in the

DHBs resident population, and in any event that there are at least 2 Māori members of every DHB.[6]

41. It is not clear the extent to which the Crown monitors or enforces this provision, particularly the issue of proportionality to the number of Māori in a DHBs resident population. In a number of regions, DHBs have also failed to meet the threshold of having at least two Māori members. For instance, currently it is evident that there are DHBs that do not meet this requirement. The Ministry may report further on these matters during the substantive phase of the Inquiry.

42. Primary care is a key part of the New Zealand health system. It is a gateway to access further investigations and diagnostic tests, to receive referrals and coordination of care with other parts of the system, to receive services for immediate health care need and to receive definitive care for long term conditions.

43. Primary care has a critical role in health promotion, population health services including screening and prevention services as well as clinical assessment and management for individuals and their particular health needs.

44. Differential access to health care and differences in the quality of primary care is well documented in the New Zealand health system literature (Reid, Robson, 2006). The inequalities in health outcomes and health system responsiveness are clearly demonstrable within primary care services. Specifically this includes how resources are "distributed unevenly between Maori and non-Maori populations." (Robson 2004). Inequalities of Maori access to primary healthcare have been well described. (Davis, 1986a; 1986b; 1987a; 1987b; Pōmare et al., 1995; Ministry of Health/Manatū Hauora, 2004b; 2006).

45. Overall, in the current system it is clear (including from the Ministry's own publications) that Māori have less access to primary health care compared to the whole population, especially when the burden of disease is taken into account. Poor access to primary health care for Māori is considered a key factor in higher rates of illness and

[6] NZPHD Act, section 29(4).

hospitalisations amongst Māori, in generating poorer health outcomes for Māori, and in the inequalities in health in Aotearoa/New Zealand (Pōmare et al., 1995; Ministry of Health/Manatū Hauora, 2006). A select bibliography of further relevant publications relating to these matters is set out at **Appendix 1**.

Te Puni Kōkiri

46. The brief of evidence filed on behalf of the Ministry of Health does not make reference to the role of Te Puni Kōkiri (the Ministry of Māori Development) in respect of health services and outcomes for Māori.

47. Te Puni Kokiri was established under the Ministry of Māori Development Act 1991. Under that Act, the responsibilities of the Ministry of Māori Development include:

> **5. Particular responsibilities of the Ministry for Māori Development**
>
> i. Promoting increases in the levels of achievement attained by Māori with respect to:
>
> i. education:
>
> ii. training and employment;
>
> iii. health;
>
> iv. economic resource development;
>
> ii. monitoring, and liaising with, each department and agency that provides or has a responsibility to provide services to or for Māori for the purpose of ensuring the adequacy of those services.

48. Te Puni Kōkiri administers or has a central role in the following legislation or policy:

(a) Māori Community Development Act 1962;

(b) Māori Trust Boards Act 1955;

(c) Ministry of Māori Development Act 1989;

(d) Whānau Ora;

(e) Ārai Whakamomori Rangatahi Māori (Rangatahi Māor Suicide Prevention);

(f) Ngā Waowaotanga Tukino a Whānau (Whānau-centre Family Violence Interventions);

(g) He Ratonga Hauora Matua (Targeted Heath Services);

(h) Oranga Rangatahi (Rangatahi Suicide Prevention Fund);

(i) He Tikanga a-Whānau mō te Whakakore Tūkino (Whānau-centred family violence interventions)

49. In its Briefing to the Incoming Minister this year, Te Puni Kōkiri recorded that:

> Most large scale government programmes that affect Māori are led by other government agencies, such as Oranga Tamariki (the Ministry for Vulnerable Children) and the Ministry of Health and District Health Boards. In this case, our role is to influence the lead agency to ensure that the needs of iwi, hapū, whānau and Māori will be met at each stage of the cycle. We can support you to have the same discussions with the relevant portfolio Ministers.[7]

Whānau Ora

50. The brief of evidence filed on behalf of the Ministry makes no reference to the Whānau Ora policy.

51. Te Puni Kōkiri has a central role in the delivery of Whānau Ora, including providing advice to the Minister for Whānau Ora.[8]

52. According to Te Puni Kōkiri's website, Whānau Ora is about increasing the wellbeing of individuals in the context of their whānau and it differs from traditional social and health approaches that focus solely on the needs of individuals and was created in response to recognition by Government that standard ways of delivering social and health services was not working and outcomes particularly for Māori whānau were not improving.

53. Te Puni Kōkiri has a significant role in monitoring and evaluating Whānau Ora. Whanau Ora outcomes are measured according to

[7] Te Puni Kōkiri *Briefing to the Ministry for Māori Development* (December 2017) at 8.
[8] For further information on Whānau Ora, see https://www.tpk.govt.nz/en/whakamahia/whanau-ora .

seven Whanau Ora outcomes. Te Puni Kokiri releases annual reports into the delivery and achievements of Whanau Ora.

54. Implementation of Whānau Ora now sits with three non-government Commissioning Agencies. The Commissioning Agencies are contracted by Te Puni Kōkiri to invest in initiatives and services in communities. The three Commissioning Agencies and their relevant areas of responsibility are:

    (a) Te Pou Matakana, based in the North Island.

    (b) Te Pūtahitanga o Te Waipounamu, based in the South Island; and

    (c) Pasifika Futures, which works with Pacific Island families across New Zealand.

55. There is a Whānau Ora Partnership Group comprising 6 representatives from iwi and six Ministers (Whānau Ora, Finance, Health, Education, Social Development, Business, Innovation and Employment). The Partnership Group is supported by a Strategic Advisors Group and Whānau Ora Officials Group, comprised of officials across a range of agencies including the Ministry of Health.

Other Elements of the Health System – Non-Crown

56. In addition to agencies and organisations which fall under the immediate control of the Crown, there is a complex set of non-Crown organisations that make up and significantly influence the wider health system in New Zealand and health services and outcomes for Māori.

57. These organisations include, but are not limited to:

    (a) New Zealand Medical Council;

    (b) New Zealand Medical Association;

    (c) Royal New Zealand College of General Practitioners;

    (d) Royal Australasian College of Surgeons;

    (e) Australia and New Zealand College of Anesthetists;

    (f) Nursing Council of New Zealand;

(g) Dental Council;

(h) Pharmacies; and

(i) Rest homes.

58. A number of these organisations exert significant influence on the New Zealand health system and the Crown agencies within it. This influence and its impact on health services and outcomes for Māori will likely be addressed later in the Inquiry.

Social Determinants of Health

59. The Crown acknowledges the social determinants of health and their impact on health outcomes in New Zealand, and for Māori. In the Ministry's briefing to the incoming Minister of Health this year, the Ministry recorded:

> Our social, economic and physical environments strongly influence our physical and mental health, as well as our ability to adopt and maintain a healthy lifestyle.[i]
>
> Our social environment comprises our family and whānau structure, social connectedness, culture, and exposure to crime and violence, as well as our level of education. This environment influences our health literacy, our social norms, our lifestyles, the value we place on health and our ability to cope with life's adversities. In terms of economic environment, income and poverty, employment status and occupation are strongly related to health and wellbeing.[9]

60. And later, with reference to the current state of New Zealand health services:[10]

Current health care services are not achieving equitable outcomes	Overall, most New Zealanders engage with health services, and our health is good. Despite this, the health of Māori, Pacific peoples and people living in lower socioeconomic areas is worse than average.[ii] Services do not always work well for some of the most vulnerable people, and sometimes miss them entirely. We need to better understand why this happens, and how we can improve our services to meet individual needs.

[9] Ministry of Health *Briefing to Incoming Minister of Health* (December 2017) at 7.

[10] Ministry of Health *Briefing to Incoming Minister of Health* (December 2017) at 12.

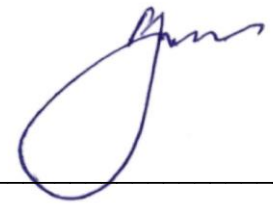
Current health care services are not meeting the needs of Māori	Māori adults have higher rates of cardiovascular disease, psychological distress, arthritis, asthma, diabetes and chronic pain than non-Māori adults.[iii] Māori children have higher rates of asthma, eczema and poor oral health than non-Māori children.[iv] Māori report encountering barriers to accessing care at a higher rate than the population as a whole. They have a greater level of unmet need for primary health care than non-Māori; for example cost may be a barrier to accessing prescription medications. Māori adults and Māori children are more than twice as likely as non-Māori to have not collected a prescription due to cost.[v]

61. The interaction and significance of the social determinants of health within the New Zealand health system will need to be examined later in this Inquiry, given the strong influence of these determinants on physical and mental health and overall quality of life in Aotearoa.

Inequities in Health Outcomes

62. It is apparent, supported by the evidence of the Ministry's publications, that despite a stated position of addressing and resolving inequities, the Ministry along with the many other components of the New Zealand health system have failed to make progress on addressing Māori health inequities. This must reasonably generate a question as to whether the current health system is willing or able to do so, and reasonably whether other solutions must be entertained, matters which will likely be considered further later in this Inquiry.

DATED at Auckland this 22nd day of December 2017



Dr R Jansen

APPENDIX ONE
SELECT BIBLIOGRAPHY RELATING TO PRIMARY CARE

Davis, P. (1986a). “Office Encounters in General Practice in the Hamilton Health District II: Ethnic Group Patterns among Employed Males, 15-64.” New Zealand Medical Journal (99): 265-268.

Davis, P. (1986b). “Office Encounters in General Practice in the Hamilton Health District III: Social Class Patterns among Females, 15-64.” New Zealand Medical Journal (99): 573-576.

Davis, P. (1987a). “Office Encounters in General Practice in the Hamilton Health District IV: Ethnic Group Patterns among Females, 15-64.” New Zealand Medical Journal (100): 127-130.

Davis, P. (1987b). “Office Encounters in General Practice in the Hamilton Health District V: Social Class and Ethnic Group Patterns among Children." New Zealand Medical Journal (100): 615-617.

Gribben, B. (1992). “Do Access Factors affect Utilisation of GP Services in South Auckland?” New Zealand Medical Journal (105): 188-190.

Jansen, P. & Smith, K. (2006). “Māori Experiences of Primary Health Care: Breaking Down Barriers.” New Zealand Family Practitioner 33 (5): 298-300.

Ministry of Health/Manatū Hauora. (2004b). A portrait of health: Key results of the 2002/03 New Zealand health survey. Public Health Intelligence Occasional Bulletin No 21. Wellington:

Ministry of Health/Manatū Hauora. Ministry of Health/Manatū Hauora. (2006). Tatau kahukura: Māori health chart book. Wellington:

Ministry of Health/Manatū Hauora. Ministry of Health/Manatū Hauora & University of Otago. (2006). Decades of disparity III: Ethnic and socioeconomic inequalities in mortality, New Zealand 1981-1999. Public Health Intelligence Occasional Bulletin No.31. Wellington: Ministry of Health/Manatū Hauora and University of Otago.

Pōmare, E., Keefe-Ormsby, V., Ormsby, C., Pearce, N., Reid, P., Robson, B. & WāteneHaydon, N. (1995). Hauora: A study of the years 1970-1991. Te Ropu Rangahau a Eru Pōmare/Eru Pōmare Māori Health Research Centre, Wellington School of Medicine and Health Sciences, University of Otago.

Reid, P. & Robson, B. (2006). “The State of Māori health.” In M. Mulholland and contributors. State of the Māori nation: Twenty-first-century issues in Aotearoa. (pp.17-31). Auckland: Reed Publishers.

Reid, P., Robson, B. & Jones, C. (2002). “Disparities in health: Common myths and uncommon truths.” Pacific Health Dialog 7: 38-47.

Robson, B. (2004). Economic determintants of Māori health and disparities: A review for Te Ropu Tohutohu i te Hauora Tumatanui (The Public Health Advisory Committee of the National Health Committee). Wellington: Te Ropu Rangahau a Eru Pōmare/Eru Pōmare Māori Health Research Centre, Wellington School of Medicine and Health Sciences, University of Otago.

Robson, B., Purdie, G. & Cormack, D. (2006). Unequal impact: Māori and non-Māori cancer statistics, 1996-2001. Wellington: Ministry of Health/Manatū Hauora.

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[i] Ministry of Health. 1998. *The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health: A Report from the National Advisory Committee on Health and Disability*. Wellington: Ministry of Health.

[ii] Ministry of Health. 2016. *Annual Update of Key Results 2015/16: New Zealand Health Survey*. Wellington: Ministry of Health.

[iii] Ministry of Health. 2016. *Annual Update of Key Results 2015/16: New Zealand Health Survey*. Wellington: Ministry of Health.

[iv] Ministry of Health. 2016. *Annual Update of Key Results 2015/16: New Zealand Health Survey*. Wellington: Ministry of Health.

[v] Ministry of Health. 2016. *Annual Update of Key Results 2015/16: New Zealand Health Survey*. Wellington: Ministry of Health.