HEALTH POLICY

EVERY LIFE IS WORTH THE SAME

The case for equal treatment

Bryce Wilkinson
Foreword by Des Gorman

THE NEW ZEALAND INITIATIVE

www.nzinitiative.org.nz

THE
NEW ZEALAND
INITIATIVE

Published by
The New Zealand Initiative
PO Box 10147
Wellington 6143
New Zealand
www.nzinitiative.org.nz

ISBN
978-1-99-115802-4 (print)
978-1-99-115803-1 (online)

RR71

Printing arranged by True North New Zealand Ltd

EVERY LIFE IS WORTH THE SAME

The case for equal treatment

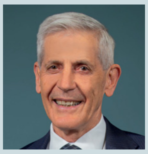
Bryce Wilkinson
Foreword by Des Gorman

About the New Zealand Initiative

The New Zealand Initiative is an independent public policy think tank supported by chief executives of New Zealand businesses. We believe in evidence-based policy and are committed to developing policies that work for all New Zealanders.

Our mission is to help build a better, stronger New Zealand. We are taking the initiative to promote a prosperous, free and fair society with a competitive, open and dynamic economy. We are developing and contributing bold ideas that will have a profound, positive and long-term impact.

ABOUT THE AUTHOR



Dr Bryce Wilkinson is Senior Research Fellow with the New Zealand Initiative and Director of Capital Economics limited, a Wellington-based economic consultancy. He worked in the New Zealand Treasury until 1985 when he joined a share broking firm to undertake capital market research. He set up Capital Economics Limited, a Wellington-based economic consultancy in 1996. The current report follows from his 2020 report for the New Zealand Initiative, *Pharmac: The Right Prescription?* He is the co-author of four earlier publications by the New Zealand Initiative related to social policy: *Investing for Success: Social Impact Bonds and the Future of Public Services* (2015), *Poorly Understood: The State of Poverty in New Zealand* (2016), *The Inequality Paradox: Why Inequality Matters Even Though it has Barely Changed* (2016) and *Welfare, Work and Wellbeing: From Benefits to Better Lives* (2017).

Bryce holds a PhD in Economics from the University of Canterbury and was a Harkness Fellow at Harvard University.

Contents

Figures

Table

Foreword

The time to address real causes is overdue

As a medical practitioner who identifies as *Māori*, it worries me that, on average, *Māori* have shorter and sicker lives than other New Zealanders. I have experienced this first-hand in my patients and *whānau*.

The question then is why would I agree to provide a foreword to a paper that will inevitably generate criticisms that the author's arguments are racist. Dr Wilkinson's first observation is that neither the government nor the Ministry of Health (MOH) could produce any objective data to support their argument that institutional racism underpins the relative ill-health of *Māori*. Dr Wilkinson's critics will see this as an ironic manifestation of the very problem he is depreciating. I predict that his paper will induce a significant "cancellation" response.

This is unlikely to be mitigated by his second observation; that aggregating health-risk to the level of a race as compared to individual determinations inevitably results in actuarial 'anomalies' and 'inequities'.

So, why did I agree to write this foreword? The reason is that I care enough about the relative ill-health that *Māori* experience to believe that relevant aetiological hypotheses need to be tested robustly. This is essential if there is to be a positive wellbeing and financial return on consequent investment.

We can all agree that the time to address the underlying causes of this inequality is well overdue. However, what is needed are objective data about what leads to improved outcomes rather than political rhetoric.

I am not arguing that racism does not exist in our 'health' system. Indeed, as the Australian philosopher Peter Singer points out, racism is an inherent human characteristic that lies somewhere in the spectrum between a mother's special love for her own children and speciesism. This is the reason why our health worker education programs commit so much time to introduce both non-*Māori* and *Māori* students, many of whom are not strong in *tikunga*, to the spiritual, philosophical and cultural domains of *Māori* wellbeing. These efforts are unfortunately undermined by our unsustainable and extensive reliance on overseas trained doctors and nurses.

Rather, I am suggesting we should focus on what has been shown to be effective in improving *Māori* wellbeing. This is all about valuable outcomes, where value is determined by the community rather than by providers and funders. The issue of value has been a cornerstone of debate about health system performance since it was highlighted by Michael Porter almost 20 years ago. At about the same time, Michael Marmot wrote his influential paper on the social determinants of health inequalities. It is self-evident that the value of any health system *per se*, as compared to an injury or illness management system, will depend upon a focus on and attention to these social determinants.

Dr Wilkinson sought objective and preferably published data from the government and the MOH, which is eminently reasonable. Such data are needed to separate the relative impact of genetics and epigenetics, from the direct impacts of social factors such as housing, education and employment, from any inherent and institutionalised racism within our 'health' system. This is no easy task given that these factors are intrinsically interrelated, interdependent and consequential.

It comes as no surprise that Dr Wilkinson was not shown any objective data to establish a causal relationship between institutionalised racism and relative ill-health for *Māori*. This has much to do with the quantity, quality and nature of the relevant research, and the difficulty in identifying and measuring valuable outcomes. However, beyond the issue of cause, is the perhaps more critical issue of the vulnerability of causal factors to interventions that will make a positive difference.

Dr Wilkinson's paper is brave. It is also important, not so much in respect to his specific observations but more so in his willingness to shift the debate from unhelpful rhetoric to pragmatic science. This is much to be encouraged and hopefully will form the basis on which the new *Māori* Health Authority determines its investments.

Des Gorman MD PhD
Emeritus Professor of Medicine
The University of Auckland

Introduction

The New Zealand Initiative stands for a competitive, open and dynamic economy and a free, prosperous, fair and cohesive society.

For more than a decade we have been greatly concerned that far too many New Zealanders are missing out for multiple reasons.

Our reports on education have identified troubling and growing shortcomings in pupils scores in literacy and numeracy. Unchecked truancy abounds. Yet we have a government that shut down partnership schools regardless of performance.

On the welfare state we have lamented the "intergenerational transmission of misery" that now exists. We supported the now lapsed "social investment" approach introduced by the John Key-led government. It aimed to find out "what works", what programmes help people extricate themselves from their predicaments, rather than perpetuate them. Now it seems as if few care.

We have opposed workforce policies that help the relatively well-off by making it harder for the most marginal would-be workers to get a job.

This report arises from our interest in Pharmac.[1] Pharmac needs to excel in assessing the therapeutic value of contending medicines, commercial procurement techniques and assessments of value for money. Expertise in these matters does not depend on race, or gender.

Nor is Pharmac a prescribing agent. Others are responsible for tailoring access to the subsidised medicines. They are not accountable to Pharmac for their decisions.

For these reasons, it was a considerable surprise to read in the Pharmac Review Panel's interim report in 2021[2] that, in essence, Pharmac should:

- employ more Māori, with 16.5% being mentioned, but not necessarily endorsed, as an indicative yardstick, and
- spend more on subsidies for treatments for conditions, such as bowel cancer, that disproportionately benefit Māori, and less on other treatments.[3]

Our curiosity was aroused because these race-based issues did not come up as significant concerns in the research that underlay our 2020 report. More to the point, inducing Pharmac to employ according to ethnicity or race rather than merit surely risks reducing its ability to achieve its statutory function, namely, to:

> … secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided.[4]

This statement is admirably neutral as to creed, gender, religion, race or ethnicity. What matters is achieving the best health outcomes for eligible people overall within a capped budget, taking all

---

[1] Bryce Wilkinson, "Pharmac: The Right Prescription?" (Wellington: The New Zealand Initiative, 2020).

[2] Pharmac Review Panel, "Pharmac Review: Interim Report" (Wellington: Ministry of Health, 2021).

[3] To reduce the risk of misrepresentation from the above paraphrasing, the Appendix to this report cites the interim report directly in these respects.

[4] Section 47 (a) of the New Zealand *Public Health and Disability Act 2000.*

people as they are. This statement treats every life as of equal value.

Equal treatment means that people with equal needs are treated the same. Equal treatment does not mean insensitive, impersonal treatment. The European Commission defines the principle of equal treatment as:

> The principle that there shall be no direct or indirect discrimination based on racial or ethnic origin, sex, religion or belief, disability, age or sexual orientation.[5]

The Panel claimed to have justified its race-based recommendations on grounds of its view of equity, and its view of principles required by the Treaty. Yet, why would anyone who wants a technical job done care about the provider's nationality, race, gender or religion? Whether you want your car fixed, or surgery, the key concern is the quality of the work.

There are good reasons why, in general, government policies should treat people in equal circumstances as being of equal value, regardless of gender, race, religion, creed or group affiliation. Tax policy gets this right. People with the same taxable income pay the same amount in personal tax. Race, gender and religion are irrelevant. Such "horizontal equity" is a long-standing tax policy principle.

Why would government schools, hospitals and welfare agencies not treat people as being of equal value? If two households are experiencing the same levels of extreme hardship, why would the state treat them as different priorities because of irrelevant differences? To do so is to affront individual human dignity.

The large differences in average health, educational and economic outcomes across racial groups in New Zealand are troubling. The reasons for them should be rigorously identified. But raw differences do not justify discriminating against those in other racial groups who are doing as badly, or worse. Nor do they justify better treatment for those doing better in a 'priority' group than those doing worse in other groups. Christianity surely decrees that compassion should be race neutral. It is your individual circumstances that should count, not your group classification.

Finding out what assistance works best for the individual should, of course, respond to relevant differences in cultural and other norms. That is an important delivery issue.

The interim report's recommendations above depart from these "equal treatment" principles in two ways. The first is the elimination of the concepts of individuality and individual need. Group membership is what matters. Diversity of need within the group is almost irrelevant. The second is the focus on race.

Rather than treat individuals as being of equal worth, as would the Initiative, the Panel repeatedly endorses the concept of "priority populations". The implication is that a well-off member of a priority population is more deserving than someone outside the group who might be a lot worse off.

The Panel's final report was released on 1 June this year.[6] It endorses the interim report's themes.

How many priority populations might be deemed to exist in New Zealand is not clear from the material reviewed in this report, but the Panel was clear that they include Māori, Pasifika and disabled people.[7]

The final report mentions diabetes and lung cancer instead of bowel cancer as conditions that

---

[5] European Commission, "Principle of equal treatment," Website.

[6] Pharmac Review Panel, "Pharmac Review: Final Report" (Wellington: Ministry of Health, 2022).

[7] Ibid at 1 (Chair's overview), 11, 62, 122.

disproportionately affect Māori.[8] It reiterates its concerns that Pharmac should employ more Māori.[9] It adds that the skills of those appointed to Pharmac's board "should include expertise in te Tiriti o Waitangi and tikanga Māori and, more generally, lived experience with relevant populations who suffer inequity."[10] It also wants Pharmac to employ more disabled people, again without reference to merit.[11]

The final report primarily aims to embed Pharmac in the system of race-based preference that is the key feature of the government's wider health 'reforms'. It even recommends amending Pharmac's statutory objective to:

> … state that, in securing the best health outcomes for those needing pharmaceuticals, it should secure equitable health outcomes for Māori and other at-risk population groups and work collaboratively with the Ministry Health NZ and the Māori Health Authority.[12]

It further recommends that the clause "securing the best health outcomes" be strengthened to state that this includes "securing equitable health outcomes for Māori and other populations."[13] Note again the focus on "population group", rather than individual health need.

Its ethnic group focus is illustrated by a word count summary. The word counts for "Māori", "Pasifika" and "Asian" are 267, 10 and zero, respectively. "New Zealanders" appears 29 times. The words "equity", "equitable", "Waitangi" and "Tiriti" appear 141, 40, 27 and 20 times, respectively. (Hence the 267 counts for "Māori".) "Priority populations" appear 11 times. "Partnership" appears 19 times.

In short, everything hinges not on individual wellbeing but on the official interpretation of what is equitable, and whom political processes deem to be priority groups.

There is potentially a lot to lose from weakening Pharmac's procurement performance. Our report documented great gains for the community from Pharmac's singular focus on procurement. These gains were both on a 'before and after' measure and relative to an improving Australia.

A poorer procurement performance by Pharmac might double or triple the price it negotiates for the same medicine, compared to what might have been achieved. Pharmac would fail against its statutory objective if it allowed that to happen.

It is also vital to understand that Pharmac has a fixed budget. It can only subsidise one medicine by not subsidising at least one other medicine. That means it can only bias its subsidy in favour of one group at the expense of everyone else. Indeed, as Chapter 1 explains, compared to neutral treatment it could even make the preferred group worse off.

In delving into the basis for the Panel's race-based preferences, it became clear that it was taking its guidance from the MoH in respect of overall health policy. Chapter 2 examines the basis for the Ministry's, and indeed the government's, official position on the causes of the indisputably relatively poor average health outcomes for Māori.

The issues come down to an idiosyncratic concept of equity and a belief that departing from equal treatment will improve health outcomes for Māori. Chapters 3 and 4 address these aspects, respectively. Chapter 5 draws two main conclusions.

---

[8] Ibid. 41.

[9] Ibid. 35, 58, 63.

[10] Ibid. 35.

[11] Ibid. 11.

[12] Ibid. 29.

[13] Ibid. 30.

CHAPTER 1

Why racial preference for Pharmac is a negative sum game

To oblige Pharmac to fund medicines according to race or ethnicity is to propose that a unit of quality-adjusted life year (QALY) for Māori is worth more than a unit for non-Māori, regardless of any other consideration.

Table 1: How race-based funding reduces well-being

Illustrative Example: Valuation implications of funding according to race-based illness incidence		
Initial assumptions		
Pharmac Budget	$100	
Total Population	100	
Māori Population	15	
Medicine-specific assumptions	**Medicine**	
	A	**B**
Cost per treatment	$10	$20
QALY gain per treatment	2	2
Proportion of non-Māori needing treatment	11%	5%
Proportion of Māori needing treatment	7%	13%
Implications		
Cost per QALY Gain	$5.00	$10.00
No. of Māori needing treatment	1.05	1.95
No. of non-Māori needing treatment	9.35	4.25
No. of total population needing treatment	10.4	6.2
Treatments that the budget could fund	10	5.0
Those that can receive treatment as a proportion of need	96%	81%
No. of Māori receiving treatment	1.01	1.57
No. of non-Māori receiving treatment	8.99	3.43
No. of QALY gains all New Zealanders	20	10.0
of which, QALY gains for Māori	2.02	3.15
and, QALY gains for non-Māori	17.98	6.85
Conclusions		
Net QALY gains for all New Zealanders from medicine A compared to B	10.00	
Net QALY gain (+) for Māori from medicine A compared to B	-1.13	
Net QALY gains for non-Māori from medicine A compared to B	11.13	
Weight that needs to be put on a Māori QALY to justify funding medicine B	9.9	
Weighted QALY gains for Māori	19.95	31.08
QALY gains for non-Māori	17.98	6.85
Total weighted QALY gains for New Zealanders	37.93	37.93
To fund medicine B because the ailment disproportionally affects Māori is, in this example, to propose that each QALY gain for Māori is worth 9.9 QALY losses for non-Māori.		

Table 1 illustrates this. Medicine B treats an ailment that affects Māori disproportionally (13% of Māori need treatment, but only 7% of non-Māori do). But medicine A is cheaper and just as effective therapeutically. As such, it can benefit a lot more people within Pharmac's Budget. If all lives were of equal value Pharmac would fund A, not B.

To require Pharmac to fund medicine B instead would, in this example, halve (from 20 to 10) the QALY benefits that Pharmac can achieve for New Zealanders within its given budget. To justify that, an analyst would have to assume each Māori QALY gain as worth 9.9 QALY non-Māori losses.[14] If this did not antagonise and polarise a community, it is hard to imagine what else would.

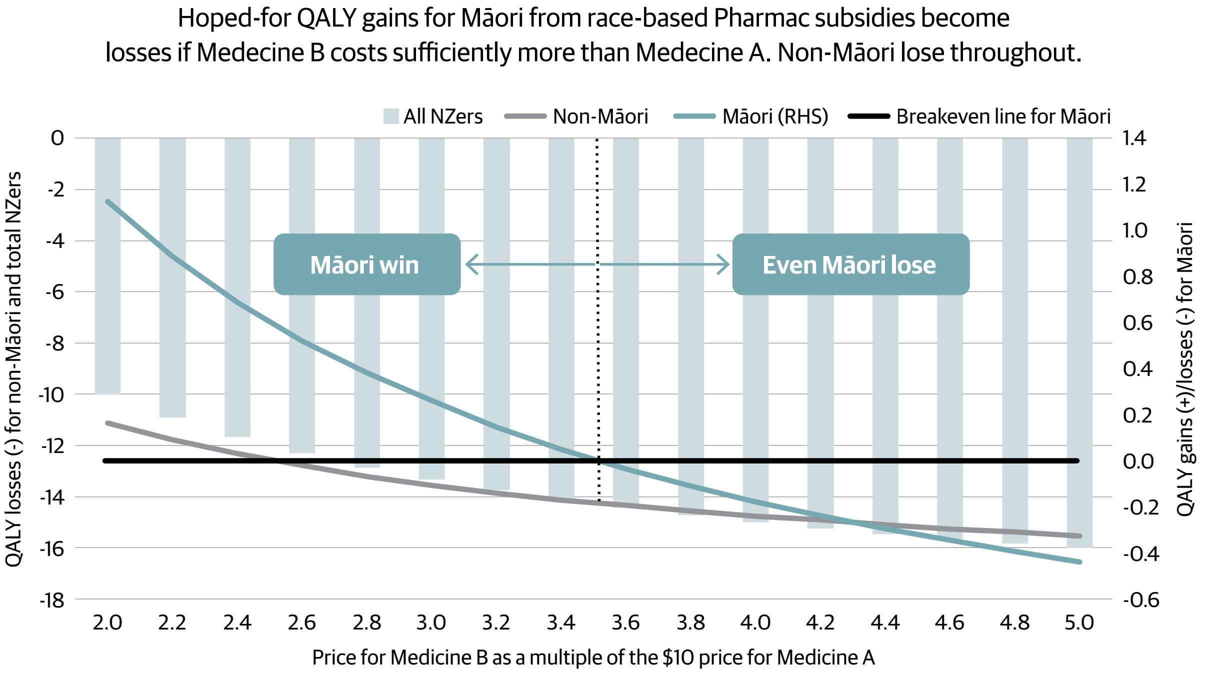
Different numbers will change the proportions, but not the key finding. The Panel's proposal to force Pharmac to fund on racial grounds is inconsistent with its statutory objective to achieve the best health outcomes for the eligible population from the given budget.

It is even conceivable that this policy could be worse for Māori. Māori are more likely to lose from subsidising medicine B the smaller is the QALY gain per dollar spent on medicine B. The following chart illustrates this simply by allowing the cost of medicine B rise from $20 as in Table 1 to $50. The higher the price, the fewer the people who can be treated within the given budget.

In the example in Figure 1, even Māori are worse off if medicine B is subsidised when it costs over 3.45 times more than medicine A.

It also shows that New Zealanders overall are worse off regardless (see the rectangular columns). They are worse off by between 10 and 16 QALYs. That is why failing to treat all QALY gains as being of equal value will make New Zealanders worse off overall from the subsidy budget.

Figure 1: Win-lose could even be lose-lose



---

[14] Different assumptions will, of course, produce different results. The author can supply the spreadsheet on request to make it easier for readers to assess the implications of different assumptions.

Another wellbeing point is that the fewer the gains for Māori from medicine B, the higher the implied relative value for a Māori QALY. In the above example, if the treatment with medicine B costs three times that for medicine A, the value of a Māori QALY would have to be 53.5 times more valuable than a non-Māori QALY to justify funding medicine B. This is up from 9.9 times when B merely cost twice as much.

The Panel does not acknowledge that its recommendation could make both Māori and non-Māori worse off. New Zealanders' wellbeing is not its concern. It focused instead on what it calls "equity". (See Chapter 3.)

CHAPTER 2

Beyond Pharmac – The Māori lens for Health Policy overall

Those involved in health policy, from the Prime Minister down, appear to see the inferior health outcomes for Māori as a group as proof in itself of inequity and, indeed, in some cases, of institutional racism.

Exhibit one is the Prime Minister's Waitangi Day Address in February 2022.

> … we have an obligation to make sure everyone has access to the healthcare they need, and that you don't die younger than everyone else in New Zealand **because you are Māori.**
>
> **And yet that is not the case.** Here we have such an obvious example of where we must do better, and where we are not passing the test of **our partnership** together. Yet efforts to address this have been described by some as separatist. This statement ignores the reality that:
>
> - Māori die at twice the rate as non-Māori from cardiovascular disease.
> - Māori tamariki have a mortality rate one-and-a-half times the rate found in non-Māori children.
> - Māori are more likely to be diagnosed and die from cancer.
> - And Māori die on average 7 years earlier than non-Māori.
>
> That is the problem that we have to address. And if we are to make progress as a nation, we have to be willing to question practices that have resulted over and over in the same or even worse outcomes. [Emphasis added.]

On the Prime Minister's last point, we should indeed be asking whether our welfare, education and labour market system of the last 50 years has served *in the long-term* to perpetuate misery and hardship rather than prevent it. One question that could be asked is "what would success look like"? Should not the proportion of those of working age who are dependent on state support fall as real wage rates rise over 50 years?

Everyone who cares about wellbeing in New Zealand should indeed feel great discomfort about the persistence of real hardship for a great many children and others.[15] But those who want to do something to change that had better be careful to be sure of the cause. Remedies directed at symptoms rather than causes could exacerbate the problem.

The Prime Minister's reference to a partnership is a controversial assertion. This issue is beyond the scope of this paper to address, as is the issue of 'treaty principles'. Michael Bassett's book on David Lange makes it clear that Cabinet Ministers had little idea what was meant when they inserted the fictional concept of treaty principles into the State-Owned Enterprises Act 1986. However, the then deputy prime minister assured them that the insertion would be of little consequence.[16] How wrong can a constitutional expert be?

---

[15] The New Zealand Initiative's 2016 report, *Poorly Understood, the State of Poverty in New Zealand,* reviewed the extent of hardship in New Zealand. Its 2017 report, *Welfare, Work and Wellbeing: From Benefits to Better Lives,* endorsed a path forward for improving outcomes for all in hardship.

[16] Michael Bassett, *Working with David: Inside the Lange Cabinet* (2008), 289.

Anthony Willy's recent assessment of the subsequent Court of Appeal case assessing what those principles might be is clear that the Court did not find that the Treaty of Waitangi created a legal partnership.[17] Others who have independently made recent contributions contesting aspects of prevailing views include Dame Anne Salmond, Professor Elizabeth Rata at the University of Auckland and Professor James Allan at the University of Queensland.[18]

Independently of these controversies, in the above speech the Prime Minister unequivocally asserted that persistent inferior health outcomes for Māori occur "because you are Māori". This is a statement of causation.

The author made an OIA request to the Prime Minister's office for the most authoritative empirical analysis the Prime Minister had received on the causes of the disparities listed in her speech.

The MoH replied on 22 March on her behalf. The reply referred to pages 23–39 (chapter 3) in the March 2020 Final Report of the Health and Disability System Review. The review was chaired by Heather Simpson. The only reference in those pages to causation was a statement on page 23. It merely said that the interim report in 2019 had examined the causes of inequities in detail.

On inspection, the interim report cited no material causative empirical analysis that established that Māori have poor average health outcomes "because they are Māori". Instead, it provided useful international material on health "risk factors" (Figure 2 replicates Figure 3 from the report.) These factors are silent about causation.

The same OIA response referred to four other documents: the Wai 2575 Māori Health Trends Report data and resources; Whakamaua Quantitative Dashboard: Year one publication; the Ministry of Health's Health and Independence Reports; and the New Zealand Health Survey Reports.

This material largely reports evolving statistics. They show stark differences in average outcomes across groups. None of the material constituted a causative statistical analysis.[19]

In short, the MoH was unable, on request, to identify any authoritative empirical analysis of the causes of the disparities listed in the Prime Minister's speech.

US family physician and epidemiologist Camara Jones observed in a US context that race-associated differences in health outcomes are "routinely documented", but "for the most part their basis remains poorly explained".[20] It seems that New Zealand is not different.

Exhibit two, indicative of top officialdom, is the following statement in 2018 by the Director-General of Health, Dr Ashley Bloomfield:

> So socio-economic deprivation for Māori impacts on their ability to access good health but it is compounded by other factors including racism. The impact of personal and institutional racism is **significant** on both the determinants of health and on access to and outcome from

---

[17] Anthony Wally, *Fairy Tales for the Gullible,* (1 June 2022).

[18] Elizabeth Rata, "The Road to He Puapua – Is there really a Treaty partnership?", Democracy Project (July 2021). Website. David Farrrar, "Anne Salmond on the Treasury and co-governance", Kiwi Blog (21 May 2021). Website. James Allan, "The report of Professor James Allan: The radical prescription for undermining democracy and the rule of law", Democracy Action (2022). Website.

[19] New Zealand GP Lawrie Knight has critically examined some claims of this nature. See Lawrie Knight, "Fact Checking the Māori Health claims that have led to the Futures Health Bill" (New Zealand Centre for Political Research (29 March 2022).

[20] Camara Phyllis Jones, "Invited Commentary: 'Race,' Racism, and the Practice of Epidemiology," *American Journal of Epidemiology* 154:4 (2001).

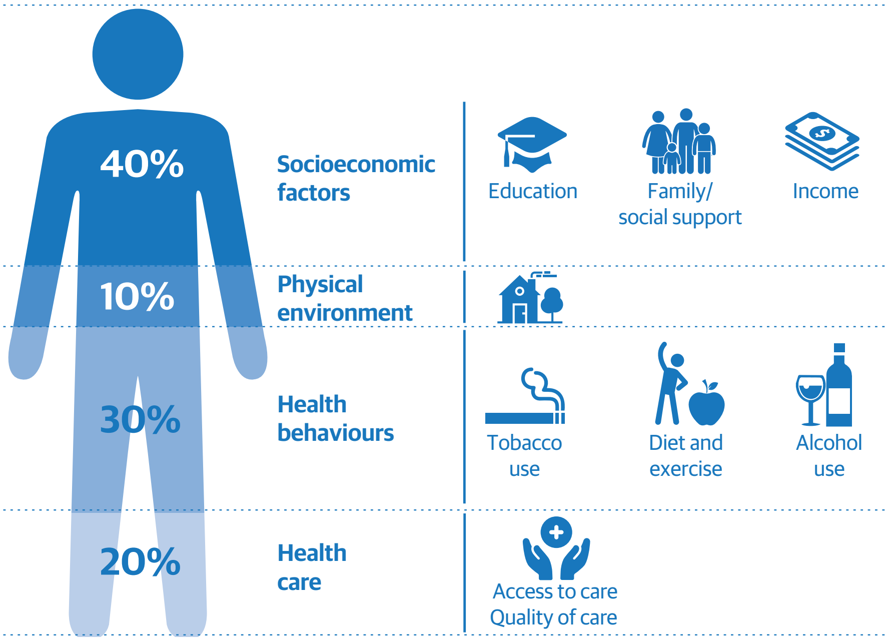
> health care itself. Racism is associated with poorer health, including poorer mental health." [Emphasis added.][21]

Bloomfield's second sentence above asserts that personal and institutional racism is a *significant* cause of relatively poor outcomes, over and above socio-economic deprivation. It begs the question of how causation had been determined and how its magnitude has been quantified.

The question is relevant because the Ministry of Health's view is that the significant determinants of health outcomes can be quantified, and the contribution of health services is quite small (Figure 2).[22] (Why the Ministry regards these orders of magnitude as being relevant to New Zealand is unclear. Why is there no New Zealand research it can cite?)

The Ministry's focus is on the "health care" component, which is only 20% of the total. Pharmac's contribution to that supposed 20% might be quite small. After all, if it had not achieved such low prices governments might have offset that by giving it a larger budget.

Figure 2: MoH's view of the determinants of health outcomes



Source: Ministry of Health (2020)

The author put in a separate OIA request to the MoH for the most authoritative empirical work that established that the effect of institutional racism was significant. The same request also asked for the definition of institutional racism and how it was measured.

The Ministry replied in February this year that the Director-General of Health's statements "are supported by the New Zealand Health Survey Data, Tatau Kahukura 2015 publication, the various works of Te Rōpū Rangahau Hauora A Eru Pōmare (University of Otago), supplemented

---

[21] The Waitangi Tribunal cited this paragraph in its Hauora Report (2019), but the source document containing the Director-General's full brief of evidence for the Tribunal's Health Services and Outcomes Kaupapa Inquiry is document WAI 2575 (7 September 2018) (paragraph 32).

[22] This diagram is on page 8 of its 2020 Briefing for the Incoming Minister of Health.

with international perspectives." The response also listed eight supporting academic publications.

On inspection, the New Zealand Health Survey Data reports statistics, not causes. So does the Tatau Kahukura Māori Health Chart Book. They are an example of what Dr Camara Jones referred to above as "charts of unexplained differences".

The academic publications emanating from the University of Otago and other universities provided the best hope for a useful answer to the causation question.

A few publications involving some University of Otago researchers provide empirical evidence on the question of whether factors other than self-reported racism might adversely affect self-reported health status. For example, a 2018 academic article by academics Ricci Harris, James Stanley and Donna Cormack did assess whether poor self-reported health status was associated with self-reported experiences of racism independently of some included socio-economic variables.[23] They did find an additional statistical effect. (This might be expected given the Ministry's assessment of the quantitative importance of non-socio-economic factors (see Figure 2). However, the authors could not assess causation from a cross-sectional study. Nor could they assess the contribution to poor health status of all other relevant factors. That meant they could not assess materiality.

The September 2020 issue of the New Zealand Medical Journal contained the most relevant of the articles overviewing such research. It is exhibit three.

The most relevant article in this issue is a systematic review of quantitative studies of racism and health in "Aotearoa New Zealand". Its opening sentence makes the following bald causative assertion:

> Racism has been firmly established as an important determinant of health and an underlying cause of ethnic health inequities in Aotearoa New Zealand and internationally.[24]

In contrast to this unequivocal statement, the body of the review article is careful to record that the research it reviews is reporting correlations. Its first sentence in its discussion of its findings uses the associative word *linked*:

> This systematic review confirms that quantitative research on racism and health in New Zealand generally shows experience of racial/ethnic discrimination to be linked to poorer health outcomes.[25]

Without further ado, the article draws a causative inference:

> The evidence is clear that experience of racism is a determinant of health that has a negative impact across a broad range of health outcomes in New Zealand.[26]

The abstract of the article makes the same cavalier jump from correlation to causation. Under the sub-heading "Results" it reports an association:

> The systematic review identified 24 quantitative studies reporting associations between self-reported racial discrimination across a wide range of health measures including mental health, physical health, self-rated health, wellbeing, individual level health risks, and healthcare indicators.[27]

---

[23] Donna Cormack and Harris Stanley, "Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data," *International Journal for Equity in Health* (2018).

[24] Natalie Talamaivao, Ricci Harris, Donna Cormack, Sarah-Jane Paine, and Paula King, "Racism and health in Aotearoa New Zealand: A systematic review of quantitative studies," *New Zealand Medical Journal* 133:1521 (2020), 55.

[25] Ibid. 63.

[26] Ibid. 64.

[27] Ibid. 55.

In the very next paragraph, under the heading "Conclusions", the abstract jumps in successive sentences from correlation to causation to a call for action.

> Quantitative racism and health research in New Zealand consistently finds that self-reported racial discrimination is associated with a range of poorer health outcomes and reduced access to and quality of health care. This review confirms that experience of racial discrimination is an important determinant of health in New Zealand, as it is internationally. There is a pressing need for effectively designed interventions to address the impacts of racism on health.[28]

Note that a statistically significant correlation is silent as to both causation and the order of magnitude of the effect. Something might be statistically significant, but of minor importance. Other factors might be far more important.

Having similarly conflated correlation with causation and totally ignored the issue of materiality, the body of the article stridently concludes that:

> Now is the time for action in identifying and implementing policy initiatives/interventions to address the **irrefutable** negative impact racism has on health.[29] [Emphasis added.]

Correlation has become irrefutable proof of causation. But if so, surely the call for action goes far beyond health policy. By the same logic, the irrefutable negative impact [of] racism" must be behind the relatively poor outcomes for Māori for education, housing and employment.

Changes in the delivery of health services in isolation seem unlikely to do much to close the health gaps if they are only working on 20% of the problem – which is what Figure 2 suggests. Even worse, if wellbeing is the objective and if racism abounds in housing, schools, and the workplace, and experiences of it are bad for health, they must surely be bad for it whether health service delivery changes or not. Health policy alone might polarise without achieving much.

An editorial in the same issue of the New Zealand Medical Journal is more careful in summarising this review article. Its key statement is that "the reviewers found that experiencing racism is "associated with" worse health-related outcomes.[30] That statement is silent on causation, materiality and the nature of the adverse experience (prejudice versus discrimination).

Even so, the same editorial could not conceive that anything other than racism could explain persistent large differences in average group outcomes.

> The fact that there are large and enduring differences between Māori and non-Māori in most health outcomes is evidence of the fact that institutional racism occurs in New Zealand.[31]

Why these differences are not due to some of the risk factors set out in Figure 2 is not explained.

At least one of the authors of the editorial actually had a much stronger view. In December 2020, Rod Jackson, professor of epidemiology at the University of Auckland, reportedly told *Newsroom* that:

---

[28] Ibid. 55.

[29] Ibid. 65.

[30] Vanessa Selak, Jamie-Lee Rahiri, Rod Jackson, and Matire Harwood, "Acknowledging and acting on racism in the health sector in Aotearoa New Zealand," Editorial, *New Zealand Medical Journal* 133:1521 (4 September 2020), 8.

[31] Ibid. 10. This was the opening sentence in rebuttal of the proposition that institutional racism was an opinion, not a fact. Also in context is the preceding paragraph in the editorial that disparaged the relevance of individual choice.

> Any society that has substantial measurable differences in health outcomes, by ethnicity, has systemic racism. Full stop, nothing about it.[32]

This comes close to defining institutional racism as a situation in which large gaps persist. As such it is a description of a state, not a cause. The causes must be elsewhere. Perhaps persistent differences in cultural attitudes to diet, weight, and socio-economic status unrelated to racism, conventionally understood, are now components of institutional racism. In the absence of proper analysis, who can know?

The editorial is sure that "most of these differences [in health outcomes across ethnicities] are avoidable and unjust (i.e., they are inequities not inequalities"). Unfortunately, the editorial provides no analysis of what is avoidable and no discussion of fairness or justice.[33]

The presumption that persistent inferior unequal outcomes for Māori, unadjusted for any other factors, are unethical, unjust and due to racism is now widespread in official health circles.

The following statement in 2019 by the Health Quality and Safety Commission illustrates this:

> The Commission is committed to achieving equity as defined here, in the first instance for Māori, as tangata whenua and partners with the Crown under te Tiriti o Waitangi, but also for the many populations and groups that make up Aotearoa New Zealand's diverse population.
>
> Māori live on average seven years less (Figure 1) and die from diseases that health care can address at a rate two-and-a-half times higher than non-Māori (Figure 2). These inequities have steadily improved over time but remain apparent. (Page 14)

In short, such unequal outcomes are proof in themselves of inequity. If everyone had poor health there would be no health inequity, and so no call for action.

The Commission also has a clear view about causation:

> Injustices and inequity in broader society, many of which can be related to or are a consequence of colonisation, are a major cause of unequal health outcomes.

This statement begs the question of why outcomes are very unequal both within Māoridom and within other large groups. Can colonisation really be a major cause of those differences? Where is the authoritative evidence that other considerations are collectively of minor importance?

Again, in all the above cases the focus is on the group, rather than the person. There is no recognition that individuality exists. The only thing that these statements consider is whether the group in question is a priority group. Here is the Health Quality and Safety Commission's utopian vision statement in 2019:

> We have a vision of an Aotearoa New Zealand where no avoidable, unfair or unjust health inequities exist that are based on differences in ethnicity, socio-economic circumstances, geography, gender, sexuality, age, specific health conditions or disabilities, or combinations of these.[34]

The MoH is of much the same view:

> Inequalities in health are unfair and unjust. They also are not natural; they are the result

---

[32] Laura Walters, "Doctors still denying 'undeniable' racism," *Newsroom* (16 December 2000).

[33] Vanessa Selak, et al. op. cit. 11.

[34] Health Quality and Safety Commission, "A window on the quality of Aotearoa New Zealand's health care 2019 – A view on Māori health equity" (2019), 8.

> of social and economic policy and practices. Therefore, inequalities in health are avoidable.[35]

A striking aspect of these documents is their disregard for the values of those who earned the income that is to be spent. In a democracy, taxes are levied with the broad consent of those being taxed. Why would taxpayers at large not be concerned about all those in dire straits, regardless of race or other characteristics?

How anyone could think that equality in health outcomes could ever occur, naturally or unnaturally, is hard to comprehend. People are born with different genetic vulnerabilities. Cultural attitudes to food and flab differ. Religions differ about lifestyle choices. People and groups differ in willingness to put themselves at risk. Luck and chance alone will ensure unequal health outcomes, even amongst clones.

People have diverse priorities, and some put good health at risk, as road deaths illustrate. Many poor immigrants put their own welfare at risk to increase the opportunities for their children. Housing and food are competing priorities.

The above utopian views are a striking manifestation of what Thomas Sowell called, in 1996, "The Quest for Social Justice". What is impossible to achieve will not be achieved, but the costs of the pursuit of equality of outcome will be high and socially dangerous.[36]

Health disparities are surely a symptom of a broader malaise. Tinkering with health service delivery overall cannot hope to do much about the real causes. Pharmac can have even less of an effect.

It is only polite to assume that the above material constitutes the best evidence the MoH can provide for the Prime Minister's and the Director-General of Health's causative assertions about racism. Disturbingly, but perhaps happily, it has been unable to provide any authoritative empirical evidence that racism is a material causative factor.

Of course, racism exits, it always has and surely always will. People are inherently tribal. Prejudices abound, particularly in the absence of any credible analysis.

Those who are serious about wanting to close the gaps must be serious about assessing causes and finding what works. On the above evidence, Officials do not appear to have a serious interest in assessing the causes of poor outcomes for Māori and others.

The most nuanced paper that the research for this report uncovered on the formal empirical aspects of Māori socio-economic disparity was published more than 20 years ago. It was written by Simon Chapple, then in the Department of Labour's Labour Market Policy group. His assessment was careful, wise and insightful. He summarised his views in 2000 as follows:

> There is an *on average* disparity between Māori and non-Māori along a range of labour market outcomes and this *disparity is stable or falling*. At the same time Māori ethnicity is a particularly poor predictor of labour market success or failure and there is considerable overlap between Māori and non-Māori outcomes. It is sole Māori with low literacy, poor education, and living in geographical concentrations that have labour market problems, not the Māori ethnic group as a whole (there are probably also sub-cultural associations with benefit dependence, sole parenthood, early natality, drug and alcohol abuse, physical violence,

---

[35] Ministry of Health, "Achieving Equity in Health Outcomes: Highlights of important national and international Papers" (Wellington: New Zealand Government, 2018), 17.

[36] Thomas Sowell, "The Quest for Cosmic Justice", *The Free Press,* New York(1999).

> and illegal cash cropping). In other words, the policy issue may need to be viewed primarily at a sub-cultural and socio-economic level rather than the coarse macro ethno-cultural level of Māori/non-Māori binaries.[37]

In the same article, Chapple emphasised the dangers for policymakers of focusing on mere differences in group averages. Variations in outcomes for people within each of Māori and non-Māori are "far greater than the inter-ethnic group variation". "The dangerous trap of reading into Māori ethnicity a negative socio-economic destiny needs to be avoided."

None of these insights and cautionary remarks appear to inform any of the material the MoH cited in responses to the above Official Information Act questions. Careful diagnosis is vital for good health care, but apparently not for good health policy. Mere assertions suffice.

Shortly before the publication of this paper, the New Zealand Work Research Institute published an empirical analysis of ethnic pay gaps in 2019 and 2020 by academics Bill Cochrane and Gail Pacheco. Unlike most of the material examined above, this analysis did include many relevant socio-economic and other variables. It found that its measures of differences in individual, educational, regional and job-related characteristics explained most of the average pay gap between Europeans and Māori. However, they explained less than half the (smaller) average gap between European and Pacific average and much less than half that between Europeans and Asians.[38]

The authors properly observed that the large unexplained portions of the pay gap for the Pacific group could be due to many factors not included in the study. Their examples of excluded factors, included differences in literacy, field of qualification, cultural preferences, unconscious bias and discrimination. The role of these and other omitted factors could not be untangled in their analysis.

Nonetheless, an item on TV1 News immediately asserted that racism, discrimination and unconscious bias "are likely behind" this allegedly "damning new research".[39] This is not what the author's found. Just as illogically, TV1 could have concluded that very little of the pay gap with Māori can be due to racism whereas with Asians it is of major importance.

One can only hope that quality researchers will persevere with professional empirical analyses of these issues and not be put off by those who can see differences only through a racial lens.

---

[37] Simon Chapple, "Māori Socio-Economic Disparity," Paper for the Ministry of Social Policy (2000).

[38] Bill Cochrane and Gail Pacheco, "Empirical analysis of Pacific, Māori and ethnic pay gaps in New Zealand", (New Zealand Work Research Institute, Auckland, 2022, tables 3 and 4.

[39] Samantha Worthington, "Most of the Pacific pay gap is unexplained", 19 July 2022.

CHAPTER 3

The problems with equity as a social goal

As shown above, the official public policy view in New Zealand is that unequal group outcomes are inequitable, unfair, unjust and significantly due to racism.

All these terms invoke a moral response. Who could support inequitable, unfair or unjust outcomes? "Unequal" lacks that moral punch. Only clones may be fully equal.

Of course, public policy should treat people fairly and justly. But exactly what does this mean to the lay person?[40]

The standard Collins English dictionary (1994 edition) defines "fair" in its first two instances as:

> 1. Free from discrimination, dishonesty, etc. just, impartial. 2. In conformity with rules and standards; legitimate, a fair fight.

The concept that freedom from discrimination is akin to fairness and justice has been turned inside out in the past 70 years. The prevailing proposition now is that 'positive' discrimination by government is fair and just. Perhaps so, but governments may have a political incentive to discriminate even if the means are unfair, unjust and ineffectual in relation to their ostensible goals. "Positive" discrimination proposals should be examined on their merits, not their intentions.

The public does not assume unequal outcomes are necessarily unfair. Government-run lotteries guarantee unequal outcomes. What counts is fair process. Unequal outcomes are just because no one is forced to buy a ticket and everyone who buys a ticket agrees to rules known in advance. Participants expect the outcome to increase wealth inequality.

People also pay top prices to see top performers. They do so freely. They do not see it as unfair or unjust that exceptional merit is rewarded exceptionally.

The concept of a fair trial is similarly about fair process rather than outcome. The outcome – the determination of guilt or innocence – can be a judgment call. The presumption of innocence until proven guilty intentionally biases the system against wrongly convicting the innocent. But it is beyond human wisdom to create perfect systems of justice.

The concepts of equity and equitable treatment are closely related to fairness. The MoH also sees unequal health outcomes as inequitable. The Director-General of Health, Dr Ashley Bloomfield, signed off on the following definition of equity in March 2019.

> In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. *Equity* recognises different people with different levels of advantage require different approaches and resources to get *equitable* health outcomes.[41] [Emphasis added.]

---

[40] A vast academic literature debates and dissects the concepts of equity and fairness. For a self-deprecating discussion of the difficulties with discussing fairness, see Richard Epstein, "Fairness in a Liberal Society" (Wellington: New Zealand Business Roundtable, 2005), 1–2. The references to these terms in a current New Zealand health policy context do not seem to be much informed by this literature.

[41] Ministry of Health, "Achieving equity," Website.

This definition is too vague and coded to be operational. It begs too many questions:

- How does anyone know to what extent differences in health outcomes are avoidable, or even should be avoided? Are the costs of avoiding them irrelevant? Should not individual preferences as to risky lifestyle choices be respected?
- What is meant by "different levels of advantage"? Is someone born with genes conducive to longevity or born in a household that encourages healthy lifestyles 'advantaged'? If so, why would policy aim to treat their need for an extra QALY as less worthy than the like need of others? To do so is to deny equal treatment.
- In the absence of any serious causative evidence, how can anyone know to what degree differences in outcomes are unfair and unjust? Who is being unfair to whom and why are the courts not delivering justice?
- To what degree are differences in health outcomes due to factors beyond the Ministry of Health's control? What is health policy to do about poor health outcomes due to poor housing, poor schooling, illiteracy, abused childhood and the absence of good parental role models? Which of these disadvantages most justifies priority for health care services? What remaining level of inequality of outcome is "equitable"? How are health care providers expected to know that?

The outcome-based focus of the Ministry's definition of equity contrasts with the standard definitions that focus much more on fair process. For example, the Collins dictionary defines "equity" as:

> 1. The quality of being impartial or reasonable: fairness. 2. an impartial or fair act, decision, etc. 3. *Law.* a system of jurisprudence founded on principles of natural justice and fair conduct that supplements the common law and mitigates its inflexibility as by providing a remedy when none exists at law. 4. *Law.* An equitable right or claim.

All four aspects of this definition invoke fairness of process or judgment. None invoke equality of outcome.

Equal treatment for equal cases looks inherently fair. Teachers may have favourites – that is only human. But they had better not practice favouritism.

The same dictionary defines "equitable" in the first instance as "1. impartial or reasonable; fair; just: *an equitable decision*." Justice from a judge or jury requires no less.

Again, this concept is about process, not outcome. A fair jury might find out later that it had made the wrong decision.

There is nothing in these examples of common usage that justifies a presumption that equal outcomes are fair or just. Most would agree that it would be unfair and unjust for a hard-working student who achieves a good score in a test to be given the same score as a lazy student who fails to answer any of the questions. Why bother with the test if it achieves nothing?

None of this is to make the opposite case – that unequal outcomes must be acceptable. The point instead is that whether they are depends on the context.

How the public service perceives disadvantage

How the MoH defines 'advantage' is elusive. It appears to mean that those benefiting from caring parenting, merit, aptitude, hard work, thrift, or good living are 'advantaged'. The problem here is the connotation of generalised unfairness. A sedentary smoker with black lung disease who drinks a bottle of whisky a day is undeniably at a 'disadvantage' with respect to actual and prospective health outcomes.

Apparently, the Ministry of Health's definition of equity requires health services to be disproportionately delivered to the relatively disadvantaged to get whatever is deemed to constitute "equitable health outcomes".

The following schema was commended to the author by a senior public servant in response to a quest to understand why no account seemed to be taken of either morality or wellbeing in the advocacy of more equal outcomes, regardless of cause or cost.

The essential notion in the schema is that if three or more people differ on any dimension – for example on height – they experience inequity.

Figure 3: Equal v equitable

In this illustration the first picture shows what happens when everyone gets the same. In the second picture we can see that each person gets the support they need to see the game. The third picture shows everyone being able to watch the game without additional supports because the systemic structures and biases that cause the inequity have been removed.

Source: Health Navigator, "Health equity," Website.

In the first frame, equal treatment is presented as requiring ensuring everyone has a box to stand on regardless of need. The tallest does not need the box, so why does 'equal treatment' give him one? This is not explained. Surely, the MoH would not give crutches to the lame and the mobile alike under an equal treatment policy.

More formally, the first frame cannot show equal treatment for equal needs because the three children have unequal needs. No one proposes equal treatment of unequal needs. One patient might need a foot amputated. Equal treatment does not mean that the next one, who merely has a broken finger, gets a foot amputated too.

The frame does not show what it purports to show. Equal treatment, properly construed, is very important for civil society.

In the second frame, the tallest has forgone his box in favour of the shortest who now has two boxes and can see over the fence. In context, this would likely occur spontaneously in the absence of government. The tall guy can get the box back after the game and is not doing anything else with it in the meantime. Perhaps the small child or his brother promised to buy the tall guy an ice cream. Perhaps the small guy is the big guy's brother. Or perhaps the tallest owned the box and the government forced an uncompensated transfer.

Regardless, the second frame purports to show equitable treatment. But it does not do so. All it shows is the *outcome* from an undisclosed process. The reader knows nothing about the fairness, impartiality or justness of that process. Was the tall child beaten up along the way? The diagram's indifference to equity of process implies that only the ends matter.

The third frame simply removes the fence and the boxes. The fence was apparently serving no worthwhile purpose. From up high, it was just a 'systemic barrier'. We do not even need to know whose fence it was and whether they were compensated and whether other people were being charged for admission. This is apparently the ideal policy action for getting equal outcomes.

This diagram illustrates the Ministry of Health's problem. By defining equity as a desired equal outcome, it ignores the issues of cost, reward for effort, and fair and just process, actions and judgments.

The Ministry of Health cannot hope to eliminate avoidable differences in health outcomes because poor health is often a symptom of a non-health cause.

Or course, policy analysts would widely agree that governments that remove unjustified barriers to individuals' attempts to improve their circumstances should make it easier for such individuals to achieve greater wellbeing. Outcomes would be more efficient, as defined in welfare economics.

Equality of outcome versus wellbeing and efficiency

The most elemental utilitarian efficiency proposition in welfare economics is that optimality is achieved when no alternative allocation could make someone better off without making at least one other person worse off.

Since in the above schema the fence was apparently serving no useful purpose, its costless removal would allow it and the boxes to be used to increase wellbeing elsewhere. Under these assumptions, the third frame is the most efficient of the three options. It consumes the fewest resources, and thereby allows the game to be enjoyed by those who wish to do so at least cost.

However, under the efficiency criterion, the validity of those assumptions would also be examined. That fence might have been serving a useful purpose and it would not be costless to remove.

In short, the diagram is too simplistic. It avoids the questions that need to be asked if fairness and justice are relevant considerations.

Problems with the pursuit of equal outcomes

The efficiency criterion makes no presumption about equality of outcome in terms of wellbeing. In the above schema, each is watching from a different perspective. They will be watching different players and the crowd in different proportions. One may love the game; another might be bored, only being there to look after his brothers.

Equality of outcome, in the sense of people sharing equally in the benefits from productive economic activity regardless of contribution, is a utopian and impossible goal. There will be very little productive economic activity if merit, hard work, risk bearing, and the assumption of leadership responsibilities has no reward. Humans respond to incentives.

The parable of the little red hen who made bread from wheat herself when none would help is a morality tale. Those who did not help when asked were morally not entitled to the fruits of her labour. Certainly, equality of outcome would have been achieved if she had let the wheat rot on the ground. But that outcome would be inefficient. By making the bread herself she raised her welfare without lowering that of anyone else, envy aside.

The efficiency criterion takes incentives into account. The MoH 's concept of equity as equality of outcome pays no attention to incentives, and thereby to wellbeing.

More than 20 years ago, philosopher Cathy Buchanan and economist Peter Hartley (both US-based academics) wrote a book for a New Zealand audience assessing equity as a social goal.[42] They discussed the issues raised, and more, in depth.

Buchanan and Hartley made the following seven points about why equality of outcome is suspect as a policy goal:

1. Net benefits depend on individuals' diverse tastes and preferences. They are subjective, evolving and impossible to measure;
2. Even if consumption bundles were identical, or nearly so, people would not enjoy them equally. Other dimensions matter, such as capacity to enjoy leisure time and family life;
3. Compassion is a laudable motive for redistribution, but envy is not. Policies to appease envy are more likely to redistribute in favour of the envious than the poor;[43]
4. Forced redistribution that does not reduce poverty is costly. Taxes on productive activity reduce and distort it. Redistributive programmes induce people to change their behaviour so as to make themselves eligible. Both aspects reduce the resources available to meet people's needs. These costs may reduce efficiency (i.e., overall living standards and wellbeing);
5. Policies to 'level up' by alleviating poverty are less suspect as a means of 'closing gaps' than policies to 'level down' by 'soaking the rich';
6. A policy measure that reduced the highest incomes in the population without reducing those of anyone else would reduce income inequality according to most measures (e.g. the gini coefficient, Atkinson's measure, and the 80:20 ratio or similar ratios). Yet only a predatory policy pandering to envy would regard this as an improvement in overall wellbeing.
7. Income is a poor measure of needs and the ability to consume for those at the bottom of the income distribution. Actions to alleviate poverty need to look deeper into needs and resources. If this is not done, policies to equalise measured incomes could exacerbate poverty and inequities.

Concepts of equality that are consistent with wellbeing as a policy goal

Buchanan and Hartley explain why policies that treat equally situated people equally are a worthy social goal. (Economists refer to this goal as horizontal equity.) Such policies are likely to build civil society rather than divide it.

Vertical equity is the proposition that those in greatest need should get more assistance than those who are better placed to fend for themselves.

---

[42] Cathy Buchanan and Peter Hartley, "Equity as a Social Goal" (Wellington: New Zealand Business Roundtable, 2000).

[43] The authors accept, from Kant's categorical imperative, that intentions matter, but point out that mere good intentions are not good enough to assess the quality of a policy. Outcomes also matter.

Equality before the law requires those administering the law to be also bound by the law. That prohibits them from making unlawful decisions that privilege some people relative to others – for partisan, corrupt or even well-intentioned reasons.[44]

How might equity or fairness be best pursued?

Buchanan and Hartley summarise their philosophical and economic conclusions on equity and fairness policies as follows:

> In summary, equity or fairness can best be achieved by safeguarding each individual's right to personal safety and personal property by ensuring that each individual is equal before the law, by promulgating a belief in the power and beauty of families and private charities to help the indigent, and by creating a limited government welfare program to aid those in need who fail to receive familial or charitable assistance.[45]

Note the emphasis on the individual. Only individuals can experience wellbeing.

Officials do not have to agree with these conclusions. But they should be familiar with this literature and be capable of giving coherent reasons for advocating policies that are so radically different and lack any discernible wellbeing focus.

---

[44] The subtleties of this concept and its distinction from the related concepts of equal protection of the law and equality under the law are discussed in the Regulatory Responsibility Taskforce's 2009 report, 41–42. Buchanan and Hartley appear to conflate equality before the law with equality under the law. The latter is associated with constraints on the law itself, the former constrains only its administration.

[45] Cathy Buchanan and Peter Hartley, op. cit. 234.

CHAPTER 4

The false hopes for affirmative action

> **Affirmative action** refers to a set of policies and practices within a government or organization seeking to include particular groups based on their gender, race, sexuality, creed or nationality in areas in which they are underrepresented, such as education and employment.[46]

Are government policies to 'close gaps' likely to be successful? Even if they are, is that likely to be more beneficial than other things the government might do with limited resources?

Where the drive to 'close gaps' is political, neither question may be welcome. Instead, the proponents will want acceptance of both propositions to be unquestioned.

The government's current drive for positive/discrimination/affirmative action extends far beyond the health sector. The discussion in this chapter looks at the broader picture.

Government policies to 'close the gaps' in outcomes by discriminating for or against categories of people are in the ascendancy.

Both the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993 made it easier for New Zealand governments to go down a broad and open-ended discriminatory path. These Acts welcomed government discrimination "taken in good faith". In doing so, they undermined private freedom of association.[47]

Yet discriminatory actions are bound to fail unless they are directed at the deep causes of those gaps. Currently, the willingness in government agencies to search for deep causes is almost invisible. This matters because ill-justified discriminatory policies that fail to achieve their objectives are polarising. They likely breed resentment and undermine civil society.

Safeguards are weak. That makes it too easy for governments to redistribute in favour of self-interested supporters or politically important interest groups at the expense of overall community wellbeing. Governments will always argue that their measures are made in good faith and in the interests of all New Zealanders.

Inevitably, both opportunistic rent-seekers and the well-intentioned will lobby in support of discriminatory laws. Economists widely use the term "Bootleggers and Baptists" as shorthand for such unholy alliances.[48] Once embedded, the beneficiaries will come to see the benefits as entitlements that inevitably fail to meet their expectations. Affirmative action laws can easily become entrenched.

Buchanan and Hartley state that "[a]ffirmative action amounts to an official sanction of discrimination against people who are not members of protected groups."[49]

---

[46] Wikipedia, "Affirmative action," Website.

[47] US law professor Richard Epstein dissects New Zealand's misguided *Human Rights Act* in Richard Epstein, "Human Rights and Anti-Discrimination Legislation" (Wellington: New Zealand Business Roundtable, 1996).

[48] "Bootleggers and Baptists" describes a situation in the US in which both the illegal industry and the religious community lobbied against existing legal sales of alcohol, undoubtedly for opposing reasons.

[49] Cathy Buchanan and Peter Hartley, "Equity as a Social Goal," op. cit. 211.

Of course, it does not follow that all openly targeted laws are bad. Some differences between groups can justify discriminatory laws. The more severe penalties for males who assault females are an example.

Finding, and defending, constitution-preserving limits to discriminatory laws is a challenge but must be done if frictions approaching civil war and beyond are to be avoided.

Problematic aspects of affirmative action laws – in principle

One problematic aspect has already been mentioned – the absence of a credible timeline for ending the discriminatory measure allows it to become entrenched.

Many other aspects of affirmative action laws are problematic and concerning. Following is a brief and incomplete list:

1. the partial nature of the 'gap' measure;
2. the choice of the group to be favoured;
3. deciding who is a member of the group;
4. tarring everyone in the favoured category with the same brush;
5. telling people they are victims of oppression is demotivating;
6. the failure to distinguish between prejudice – which is cheap and omnipresent – and self-harming discrimination, such as the failure to hire on merit; and
7. discriminatory laws that poorly compensate for past wrongs.

1 The partial nature of the measure

People are not equal, unless they are clones. As individuals we are unequal on multiple dimensions. "Gaps" are the norm. Their existence may or may not be materially due to improper discrimination or bias.

At the group level, different cultures likely differ in their preferences and behaviours. There will be 'gaps' between group averages in preferences and inclinations as between lifestyles, cultural attitudes to work, gender roles, saving, welfare, wealth accumulation, culinary habits, sports, literary, academic and musical achievements, and cultural activities.

Faced with all this diversity, concerns about unequal outcomes are selective. Inevitably, groups will seek governments to discriminate in their favour in respect of gaps that are partial in nature. For example, in 2019, 85% of primary teachers in New Zealand were female according to the World Bank, but the government's focus has been on achieving 50% of women on public sector boards and agencies and in reducing a crude pay gap measure.

The selection of which gaps government should attempt to close is not a value-free exercise. Nor is the decision as to how best to close them. Should government aim to improve outcomes for all or benefit one group at the expense of another?

2 Which group is to be favoured?

In a democracy, the favoured groups will naturally be those that have the greatest political clout. They may be well-organised minorities or a simple majority. Politically, the real causes of the 'gap' may not be a welcome topic of discussion.

The Review Panel provides no evidence on the health outcome gaps for groups other than Māori or Pasifika. Yet people can be allocated to groups in multiple ways. There are probably groups in the community where nearly everyone is experiencing serious material deprivation (e.g. for a start, it is concentrated in sole parent households with dependant children. A subset of these will also be experiencing family violence and disfunction.)

The focus on group averages does no justice to individual needs. No one is pretending that all Māori are suffering inferior health outcomes compared to the national average. Many non-Māori will be in more dire circumstances than many Māori.

In the absence of an analytical basis for identifying groups with the most adverse outcomes, the MoH's choice looks political.

3 Who decides who is a member of the favoured group?

Where distinctions are clear cut, as they once were between men and women, the group is easy to categorise.

Where they are based on skin colour – as in the "black/coloured/white" trichotomy in South Africa under apartheid – much injustice occurs around the boundary lines. Siblings with identical bloodlines but who differ in skin pigment might find themselves in separate race categories.

When discrimination is based on bloodlines, the degree of inter-marriage makes sharp distinctions problematic and offensive at the margin.

But when governments discriminate on the basis of race, someone has to decide. Most likely, it will be those at the top of the hierarchy in accessing and distributing the resources and opportunities arising from affirmative action laws will play a disproportionate role in deciding this. They are unlikely to be impartial spectators. Those who are least organised and politically sophisticated are somewhat at their mercy.

4 Tarring everyone in the group with the same brush

If the group is broad, its members will have diverse abilities and backgrounds. As with any broad cross-section of the community, some will have a high IQ, be well-educated, hard-working, rich in work experiences and skills, self-disciplined, and holding down responsible paid jobs. There will be others in the group who are at the opposite end of the spectrum in every aspect. Most of the group will be in between the group extremes.

The difference in the group's mean on some measure (e.g. income) from that for a different group might be dwarfed by the differences within each group. To focus on 'the gap' based on mean differences is to fail to focus on the reasons for below group-mean outcomes.

A related problem is that benefits for those who are already well-off on the measure in question violate horizontal or vertical equity for the population as a whole. Suppose two citizens need the same cancer treatment and they have the same socio-economic status. If one gets preferred access to treatment because of affirmative action, then horizontal equity has been violated. If one has superior socio-economic status but gets preferential treatment because of affirmative action, vertical equity has been violated.

In essence, the public policy problem has been that affirmative action changes the policy focus from alleviating individuals' and households' dire needs to something much more divisive and unsavoury.

5 To tell people they are victims of oppression is demotivating

The case for affirmative action may have to be justified by claims that those who are deemed to be 'advantaged' have oppressed the 'disadvantaged' group historically and/or currently.

In New Zealand today, it is easy to assert that inferior group outcomes for Māori relative to the population average are some combination of a legacy of white colonialisation, historic land confiscation, violation of treaty rights, and conscious or unconscious institutional racism.

A problem with such advocacy is that it is demotivating for those the advocates deem to be disadvantaged. It turns them into victims. It implies that anything they can do personally will not make much of a difference. Thomas Sowell, US academic and critic of affirmative action, expressed the concern as follows:

> Where poorer people are lacking in human capital – skills, education, discipline, foresight – one of the sources from which they can acquire these things are more prosperous people who have more of these various forms of human capital. This may happen directly through apprenticeship, advice, or formal tutelage, or it may happen indirectly through observation, reflection, and imitation. However, all these ways of advancing out of poverty can be short-circuited by an ideology of envy that attributes the greater prosperity of others to "exploitation" of people like themselves, to oppression, bias, or unworthy motives such as "greed", racism, and the like. Acquisition of human capital in general seems futile under this conception and acquisition of human capital from exploiters, the greedy, and racists especially distasteful.[50]

6 Prejudice is one thing, discrimination is another

Humans are inherently tribal. We care most about those closest to us. Most parents will devote vastly more resources to bringing up their own kids than to others. Indeed, personal responsibility decrees that parents should do this.

Despite this tribal instinct, it is a great virtue of open societies that people can freely trade for mutual benefit even though they might detest each other should they ever come face to face.

Under free trade, merit is all. As with great works of art, what counts is the value of the product or service, not the personal vices or virtues of those from whom it emanated. A dollar is a dollar. Competitive open markets reward dollar merit on an undiscriminating basis.[51] As Sowell and others have pointed out, governments have had to pass discriminatory laws to force businesses to discriminate when it is not in their commercial interests to do so.

Government discrimination can be the most damaging because no individual can stand against the power of the State. Hitler's Germany epitomises this tragedy. Laws permitting slavery in some countries now and in the past are of the same ilk.

Freedom of association is important.[52] People should be free to form women-only or men-only clubs. Religious groups will want their own meeting places (e.g. churches). Ethnic groups might also want their own sports teams and competitions. None of this is oppressive when adequate choice prevails.

These points do not dispose of the serious and troubling objection that racial profiling is widely known and agreed to be a material problem nonetheless, for example, in rental housing. Sowell discussed the issue of racial profiling in the context of New York cab drivers. Apparently, by 1999, New York cab drivers were more loath to stop to pick up black American customers than was the case when Sowell was younger. This was so even if the drivers were black themselves. Sowell does not blame the drivers. On the assault statistics, it is rational self-defence. He took to using rental cars to go out at night instead.[53]

7 Discriminatory laws poorly compensate for past wrongs

Taxing people who caused no harm to the people being compensated is akin to land confiscation for no good reason. Around 25% of New Zealanders today are overseas born.

---

[50] Thomas Sowell, *The Quest for Cosmic Justice* (1999) as cited by Cathy Buchanan and Peter Hartley, "Equity as a Social Goal," op. cit. 210.

[51] This is not to deny that in a culture that is strongly biased against minority groups, many businesses will comply with the group norm because they will not suffer much of a loss if all their important competitors are doing the same.

[52] Richard Epstein, "Human Rights and Anti-Discrimination Legislation," op. cit.

[53] Thomas Sowell, "Sorting by Race" in *Controversial Essays*, Hoover Institution (2002).

Of course, past wrongs to people long dead must leave a legacy. As Shakespeare wrote, the evil that men do lives after them. Europe's history features endless invasions and massacres on ethnic and other grounds. But past wrongs do not make every descendant worse off than those bearing the burdens that affirmative action demands.

As always, it is better to direct assistance for those in poverty at remedial causes of their situation. For example, if the problem today is poor education, fewer skills, no work history, and/or drug dependency, targeted assistance with these matters is surely best. In contrast, raising the minimum wage and reducing educational choices by knee-capping partnership schools can be expected to exacerbate their plight.

But since alleviating poverty is a desirable policy goal, horizonal equity requires that policies to help those in the same circumstances should be non-discriminatory.

Cut to the chase: does 'closing the gaps' work in practice?

Given all the above concerns, one might have thought that countries adopting affirmative action policies might have given serious consideration to their likely consequences. Sowell has found that this is not so:

> Innumerable principles, theories, assumptions, and assertions have been used to justify affirmative action programs—some common around the world and some peculiar to particular countries or communities. What is remarkable is how seldom these notions have been tested empirically, or have even been defined clearly or examined logically, much less weighed against the large and often painful costs they entail. Despite sweeping claims made for affirmative action programs, an examination of their actual consequences makes it hard to support those claims, or even to say that these programs have been beneficial on net balance—unless one is prepared to say that any amount of social redress, however small, is worth any amount of costs and dangers, however large.[54]

Arguably Sowell has done more than anyone to assess empirically, for the US and a handful of other countries the evidence on the efficacy of affirmative action laws. Here is one of his summaries of what it shows:

> - Preferential programs, even when explicitly and repeatedly defined as "temporary," have tended not only to persist but also to expand in scope, either embracing more groups or spreading to wider realms for the same groups, or both. Even preferential programs established with legally mandated cut-off dates, as in India and Pakistan, have continued far past those dates by subsequent extensions.
> - Within the groups designated by government as recipients of preferential treatment, the benefits have usually gone disproportionately to those members already more fortunate.
> - Group polarization has tended to increase in the wake of preferential programs, with non-preferred groups reacting adversely, in ways ranging from political backlash to mob violence and civil war.
> - Fraudulent claims of belonging to the designated beneficiary groups have been widespread and have taken many forms in various countries.[55]

Nor is the evidence encouraging in the New Zealand context. Back in 2006, the MoH found that:

---

[54] Thomas Sowell, "Affirmative Action Around the World," *Hoover Digest* (2004), 4.

[55] Thomas Sowell, "Affirmative Action: A Worldwide Disaster," *Commentary* (December 1989).

> As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand. This is not acceptable, and the Government and the Ministry of Health have made it a key priority to reduce the health inequalities that affect Māori. If Māori are to live longer, have healthier lives, and fulfil their potential to participate in New Zealand society, then the factors that cause inequalities in health need to be addressed (Ministry of Health 2002).[56]

Despite this key priority and two decades of supposed effort, the gaps [inequities] persist. A recent inquiry commented:

> The Crown has invested some $220 billion dollars into the health system alone since 2000, with what appears to be little measurable improvement to Māori health outcomes. In a system that is meant to be focused, in part, on reducing health disparities suffered by Māori, this is of great concern.

What is needed is a proper analysis of the reasons for this. One is that health services are a relatively small contributor to differences in health outcomes. Another is the weak incentives to determine what is really causing the differences in health outcomes. The dominant drive instead is to fight over the power to spend the government's health budget. The incentives of not-for-profit statutory monopoly providers to provide a good customer experience are quite weak. As long as customers cannot shop around, they get what they are given.

University of Auckland professor Elizabeth Rata has examined what has been happening to the programmes intended to benefit Māori at large and concluded that the benefits are most clearly going to the well-educated and well-positioned supporters and leaders of those programmes.[57] Michael Bassett documented the lax accountability for the use of public funds being channeled to Māori under the Lange Government.

Previous government's process of settling "full and final" Treaty of Waitangi claims iwi by iwi has empowered those who can determine who are members of the particular iwi. Struggling, ill-educated and equipped urban Māori are ill-empowered in this situation.

Moreover, settlement amounts are too small to close gaps. Effective measures to increase employable skills and thereby wages on a permanent basis would make a much larger difference. Problems of distressingly high school truancy, and distressingly low and declining levels of literacy and numeracy, are crippling the prospects of far too many school children, Māori and non-Māori.

None of this is to argue against voluntary discriminatory action. Indeed, charities, iwi groups and others dedicated to specific compassionate activities could be the best hope, given the apparent inability of government agencies to analyse the problems and respond effectively.[58] US Constitutional expert, Richard Epstein, discusses the issue of corresponding discriminatory behaviour by non-monopoly government service providers. He argues that government providers should be able to tailor assistance to particular groups to the extent that their private sector counterparts do.[59]

---

[56] Ministry of Health, "Tatau Kahukura: Māori Health Chart Book," Public Health Intelligence Monitoring Report No. 5 (Wellington: New Zealand Government, 2006), 1.

[57] Elizabeth Rata, *An Overview of Neotribal Capitalism* (Boston: Lexington Books, 2000).

[58] For some examples, see Bryce Wilkinson and Jenesa Jeram, "Welfare, Work and Wellbeing: From Benefits to Better Lives" (Wellington: The New Zealand Initiative, 2017).

[59] Richard Epstein, "Affirmative Action: The US Experience and Implications for New Zealand" (Wellington: New Zealand Business Roundtable, 2005).

CHAPTER 5

Concluding observations

Two main conclusions emerge from this research.

First, the articles cited by the MoH in support of the Prime Minister's speech and of the Director-General of Health's statement fail to support either the assertion of racist causation or the assertion of its significant materiality.

This is a disturbing finding. Perhaps rigorous empirical analysis does exist that establishes both causation and materiality. That remains an open question. But if the MoH has such evidence, it would have surely cited it in its response to the OIA request. Instead, it seems that it is making strong assertions of a polarising nature that it cannot justify when asked.

Second, the Pharmac Panel's recommendation to force Pharmac to depart from treating all New Zealanders as of equal value when making subsidy decisions must result in less health benefits for New Zealanders overall from its given Pharmaceutical Budget. It could even make Māori worse off.

Public policy formation on the MoH appears to have fallen into the very traps that Simon Chapple warned against more than 20 years ago in a labour market context.

Those who are serious about wanting to close the gaps should be serious about assessing causes and finding what works. On the evidence reviewed in this paper, Officials are not seriously interested in assessing the causes of poor outcomes for Māori and others. This is a very discouraging finding; billions of dollars are being spent annually. No wonder outcomes remain poor.

The strident insistence in the material reviewed above that poor health outcomes on average for Māori are due to ethnicity and racism disempowers all Māori. It makes them victims and conceals the fact that many Māori do better than many non-Māori. People need to have hope that they can improve their circumstances with their own efforts. Self-agency matters.

As with health care itself, health policy cannot hope to solve real problems if it does not first identify real causes. The causes of poor health outcomes for Māori and non-Māori alike may be alleviated by good health policy, but probably not by much. Poor health outcomes, like poor educational and housing outcomes, poor welfare and imprisonment outcomes, are symptoms rather than causes.

The hand of government is heavy across all such outcomes. There is much that could be done to identify the deep causes and find out which programmes to improve matters work. What is evidently missing is the political and institutional will to undertake the necessary research.

Sadly, what this report has uncovered is obfuscation on a grand scale. Unequal outcomes are conflated with inequity and racism. Correlation is taken to be causation. Materiality is merely asserted. On the assessment of more expert authors cited in this study, contentious fictions are promoted about partnership and Treaty principles. Strident assertions discourage reasoned debate.

The Pharmac Panel's recommendations are derivative of a broader political drive to divide New Zealanders on racial lines with unequal treatment. The Panel has gone with the flow.

There needs to be a return to real concern with poor outcomes for far too many households, regardless of racial classification. It is invidious to treat people as being of different value because of their ethnicity or race.

None of this is to deny the existence of invidious and harmful prejudices that divide people into categories based on actual and perceived differences, whether they be race, colour, gender, age, religion, political views, height, weight, strength, literacy, academic attainment, and much else.

Race is a particularly harmful one. Unsupported accusations of racism are dangerously irresponsible. Those who really care about public policies to help those who are struggling will really care about doing something about the real causes. Otherwise, they are merely doing their best with symptoms, perpetuating misery instead of turning things around.

This report is not denying there is a serious problem. There is a massive welfare problem as we explained in our 2016 report, *Poorly Understood, the State of Poverty in New Zealand.*

Nor is this report making a case that nothing should be done. Much that is vital to do well is not being done.

Specifically, deep causes must be identified, and policy must seek to rectify them at source. Second, programmes to help people must be rigorously evaluated to determine whether they really work. Good intentions are not good enough if people really are to be helped to live better lives.

The time to identify and address real causes is long overdue.

APPENDIX: The Interim Report on Māori employment and preference

Panel 1 below documents the Panel's employment recommendation in its interim report. Note the appeals to "equity". Pharmac needs to eliminate "inequity in its work" and to build equity "capability".

The interim report did not raise the issue of employment on merit or ability. The word count for "merit" was zero. "Skill" had one mention, and that appeared to be in the context of skill in Māori aspects.[60]

The report did not assess how many Māori applicants might be qualified to do the tasks Pharmac is required to perform. The implication is that race or ethnicity (it is not clear which) should dominate merit as an employment consideration.

Nor did the report explain how hiring more Māori could hope to improve Pharmac's performance against its statutory objective. Pharmac's briefing to the incoming Minster of Health in 2017 focused on its performance alone.

Panel 1

Case study: building a Pharmac workforce with equity capability and increasing the number and influence of Māori staff

…

Pharmac has in particular emphasised the focus of this strategy on strengthening Māori leadership and advice. Recently it appointed an inaugural Chief Advisor, Māori role (part of the Pharmac executive team). Previous Māori-specific roles have not been this senior. This is a positive development. However, as a review we cannot ignore the fact this is only one position in the context of nearly 150 people and is not proportionate to the level of commitments to building the influence and number of Māori staff Pharmac has made in the past. A stakeholder told the review Pharmac "should look at who they are employing. There seems to be a high turnover of staff, lack of ethnic variety to reflect society. They have done better at engaging the community a bit more, but they also work a lot behind closed doors and emails. Need more Pacific and Māori staff and clinical staff not just clerical".

…

We assume Pharmac aims to have a workforce reflecting the wider population – which means Māori would make up 16.5 per cent of Pharmac's employees.

Pharmac has provided ethnicity breakdown of its staff annually since 2015. Table 6 below shows there has been both a slight decrease in the number of Māori staff employed and a drop in the proportion of staff who identify as Māori, and at 2.2 per cent it is well short of 16.5 per cent.

…

Pharmac also needs to build the overall capacity and capability across all its staff to be more responsive to Māori and to build the organisation's capability to address inequity and the elimination of inequity in its work. We understand this still requires considerable work by Pharmac, some of which is planned for the 2021/22 year.

Source: Pharmac Review: *Interim Report,* September 2021, pages 36–37.

---

[60] Pharmac Review Panel, "Pharmac Review: Interim Report," op. cit. 32.

Panel 2 documents the subsidy bias point. It quotes verbatim from page 31 of the interim report. Māori are a "population priority" – again in the name of equity.

Panel 2

Adopting different analytical perspectives to achieve equity

The inequities across the health and disability system mean there is not a universal health and disability system experience in Aotearoa New Zealand. A clinician group told the review that "Equity should be one of the primary considerations for all funding applications, applications should have to outline what benefits the medication or device has to [sic] priority population, and what engagement and partnership they have undertaken in their process (if any). Applications that have a higher equity focus and bigger potential for gains in achieving health equity should be prioritised. This may also result in some positive research and engagement of our priority populations".

The standard approach to assess the degree of health gain that can be achieved for a given cost is Quality Adjusted Life Years (QALY) and is commonly used for medicines investment decisions internationally. However, while the average benefit to cost ratio of an individual health intervention (whether that is prescribing a medicine or some other activity) may be high, whether such an investment moves the population towards equitable health outcomes depends upon distributional considerations.

Assessing health investment is more complicated than people might think. It is possible to fund services or pharmaceuticals with positive cost-benefit ratios that will improve health for some while at the same time increasing inequity. Bowel cancer screening illustrates this point. Screening is highly cost-effective compared to other healthcare interventions. But since the disease had a relatively lower incidence among Māori, this could increase inequity by focusing on a disease less common among those with the greatest health needs.

We need to make investment decisions in such a way that they move the population towards equity, rather than away. That means thinking meaningfully about the overall burden of disease and what difference an intervention will make for people with different starting points in terms of their burden of disease and their health need.

Source: Pharmac Review: *Interim Report,* September 2021, page 31.

Bibliography

Bassett, Michael. *Working with David: Inside the Lange Cabinet* (2008).

Buchanan, Cathy and Peter Hartley. “Equity as a Social Goal” (Wellington: New Zealand Business Roundtable, 2000).

Chapple, Simon. “Māori Socio-Economic Disparity,” Paper for the Ministry of Social Policy (2000).

Cochrane, Bill, and Gail Pacheco. ”Empirical analysis of Pacific, Māori and ethnic pay gaps in New Zealand” (Auckland, New Zealand Work Research Institute, 2022).

Cormack, Donna and Harris Stanley. “Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data,” *International Journal for Equity in Health* (2018).

Epstein, Richard. “Affirmative Action: The US Experience and Implications for New Zealand” (Wellington: New Zealand Business Roundtable, 2005).

———. “Fairness in a Liberal Society” (Wellington: New Zealand Business Roundtable, 2005).

———. “Human Rights and Anti-Discrimination Legislation” (Wellington: New Zealand Business Roundtable, 1996).

European Commission. “Principle of equal treatment,” Website.

Health Quality and Safety Commission. “A window on the quality of Aotearoa New Zealand’s health care 2019 – A view on Māori health equity” (2019).

Health Navigator, “Health equity,” Website.

Jones, Camara Phyllis. “Invited Commentary: ‘Race,’ Racism, and the Practice of Epidemiology,” *American Journal of Epidemiology* 154:4 (2001), 299–304.

Knight, Lawrie. “Fact Checking the Māori Health claims that have led to the Futures Health Bill” (New Zealand Centre for Political Research (29 March 2022).

Ministry of Health. “Achieving Equity in Health Outcomes: Highlights of important national and international Papers” (Wellington: New Zealand Government, 2018).

———. “Achieving equity,” Website.

———. “Tatau Kahukura: Māori Health Chart Book,” Public Health Intelligence Monitoring Report No. 5 (Wellington: New Zealand Government, 2006).

Pharmac Review Panel. “Pharmac Review: Final Report” (Wellington: Ministry of Health, 2022).

———. “Pharmac Review: Interim Report” (Wellington: Ministry of Health, 2021).

Public Health and Disability Act 2000.

Rata, Elizabeth. *An Overview of Neotribal Capitalism* (Boston: Lexington Books, 2000).

Regulatory Responsibility Taskforce. “Answering the $64,000 Question: Closing the income gap with Australia” (Wellington: New Zealand Government, 2009).

Selak, Vanessa, Jamie-Lee Rahiri, Rod Jackson, and Matire Harwood. “Acknowledging and acting on racism in the health sector in Aotearoa New Zealand,” Editorial, *New Zealand Medical Journal* 133:1521 (4 September 2020).

Sowell, Thomas. “Affirmative Action Around the World,” *Hoover Digest* (2004).

———. “Affirmative Action: A Worldwide Disaster,” *Commentary* (December 1989).

———. “Sorting by Race” in *Controversial Essays*, (Hoover Institution, 2002).

———. “The Quest for Cosmic Justice” (The Free Press, New York, 1999).

Talamaivao, Natalie, Ricci Harris, Donna Cormack, Sarah-Jane Paine, and Paula King. “Racism and health in Aotearoa New Zealand: A systematic review of quantitative studies,” *New Zealand Medical Journal* 133:1521 (2020).

Wally, Anthony. *Fairy Tales for the Gullible* (2022).

Walters, Laura. “Doctors still denying ‘undeniable’ racism,” *Newsroom* (16 December 2000).

Wikipedia. “Affirmative action,” Website.

———. “Bootleggers and Baptists,” Website.

Wilkinson, Bryce and Jenesa Jeram. “Poorly Understood, the State of Poverty in New Zealand” (Wellington: The New Zealand Initiative, 2016).

———. “Welfare, Work and Wellbeing: From Benefits to Better Lives” (Wellington: The New Zealand Initiative, 2017).

Wilkinson, Bryce. “Pharmac: The Right Prescription” (Wellington: The New Zealand Initiative, 2020).

Taxpayers commonly work hard to earn the money that governments take in taxes. Knowing the effort sacrificed they naturally want governments to spend that money wisely and well.

Value for money from pharmaceutical spending depends on the medicine's efficacy for treating an accurately diagnosed condition.

The skills going into the discovery and production of medicines do not depend on the country of origin, creed, religion, or race of those involved. Neither do diagnostic skills.

Accuracy of diagnosis is as important in public policy as in medicine.

Average health outcomes for Māori are poor. No one disputes that troubling fact. The critical first thing is diagnosis.

As documented in this report, the dominant political and official diagnosis in current health policy is that racism is a significant cause of those poor outcomes. Overt racial preferences for staffing and delivery are part of the remedy.

Start with that diagnosis. This report evaluates the most authoritative empirical evidence the Ministry of Health could provide in support of the Director-General of Health's testimony that personal and institutional racism is a significant cause of the poor health outcomes for Māori.

On examination, the supplied material is shockingly silent overall about both causation and significance.

Where there is no serious interest in rigorous evidence-based diagnosis, there can be no serious interest in the quality of the outcome. Taxpayers, Māori and non-Māori deserve better.

The report uses the case of Pharmac to show how the prescribed remedies depart from the principle of equal treatment for equal need, regardless of race or ethnicity.

Those wishing to see better health outcomes for all New Zealanders will have to wait until there is a serious policy interest in problem diagnosis and remedy evaluation.

THE
NEW ZEALAND
INITIATIVE

www.nzinitiative.org.nz

$25.00

ISBN
978-1-99-115802-4 (print)
978-1-99-115803-1 (online)

The New Zealand Initiative
PO Box 10147
Wellington 6143