

IN THE WAITANGI TRIBUNAL

WAI 2575

WAI 2672

UNDER

The Treaty of Waitangi Act 1975

AND

IN THE MATTER OF

The Health Services and Outcomes Kaupapa
Inquiry

AND

IN THE MATTER OF

a claim by Donna Washbrook (Wai 2672)

AMENDED STATEMENT OF CLAIM

DATED 17 DECEMBER 2019

RECEIVED

Waitangi Tribunal

17 Dec 2019

Ministry of Justice

WELLINGTON

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MAY IT PLEASE THE TRIBUNAL

Claimants

1. The claimant is Donna Washbrook of Ngati Korokoro (“the claimant”).
2. For 44 years the claimant along with her whānau journeyed with her son Anthony through the Public healthcare system. Whilst the claimant is grateful for all the medical support they received, caring for and supporting the health needs of Anthony was not an easy journey. The claimant lives in Hokianga and the provision of healthcare for Māori living in this rural area of New Zealand is stark in contrast to those living in the main city centres.

The Claim

3. One in five Māori are living with some type of disability, and this represents a large proportion of whānau, hapu and iwi.¹
4. Māori disabled make up approximately 5400 (16%) of people who access the Ministry of Health-funded disability support services. As a group, Māori disabled are predominantly youthful, with over a third (37.8%) under 15 years of age and 49% aged under 25 years. Māori disabled mainly have intellectual disability (50.9%) or physical disability (32.2%), and some Māori disabled have significant support needs, with 23% having very high levels of need.²
5. Most live in the Auckland (26.4%), Waikato (12.3%) and Northland (10.6%) regions. Māori disabled predominantly live in urban areas (89%) rather than rural areas (11%). Those living in rural regions are mainly based in Northland (45.2%), Bay of Plenty (24.1%) and Gisborne (25.6%)³ and this is highly relevant given that the claimant lives in Northland.

¹ Ministry of Health. 2012. Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services 2012 to 2017. Wellington: Ministry of Health. Pg iii.

² Ministry of Health. 2012. Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services 2012 to 2017. Wellington: Ministry of Health. Pg 4.

³ Ministry of Health. 2012. Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services 2012 to 2017. Wellington: Ministry of Health. Pg 4.

6. There are five parts to this claim. The first part concerns data quality issues that are impacting on the planning, purchasing, development and delivery of disability support and disability services for disabled Māori. The second part of this claim concerns the provision of funding and healthcare for Māori living with disabilities. The third part concerns the involvement of and the support available for the whānau of disabled Māori. The fourth part concerns the provision of culturally appropriate healthcare and support. The fifth part concerns disability support advisory committees and representation of Māori and Māori disabled.

7. The claimant's son Anthony was born with spina bifida and later encountered further health issues and complications which affected his quality of life. Anthony and his whānau became very familiar with the healthcare system as Anthony spent a lot of time going in and out of hospital and needed a lot of specialised healthcare and support. Whilst Anthony faced issues with some of the medical care provided to him, this is not a claim concerning medical negligence. Rather this claim concerns the prejudice suffered by the claimant and her whānau through the provision of resources and funding that is based on inaccurate data. This claim concerns the inadequate provision of healthcare services and support provided for Anthony who lived in rural Northland, and his whānau who supported him.

The Treaty of Waitangi Act 1975

8. The claimant says that this claim falls within section 6(1) of the Treaty of Waitangi Act 1975 namely:
 - a) That she is Māori; and
 - b) Has been and continues to be or is likely to be prejudicially affected by the various Acts and Crown policies, practices, acts and omissions adopted by, or on behalf of the Crown or its agents.

PART A: Data and Research

Duty

9. The Crown has a duty to accurately obtain data and undertake research in relation to Māori living with disabilities in order to be able to actively monitor and to seek to improve the healthcare services available to Māori living with impairment and disability.
10. The Crown has a duty to actively assist Māori living with impairment and disability to be able to live a quality life.

Breach

11. The Crown has failed to undertake a thorough investigation and failed to adequately inquire into the extent of impairment and disabilities affecting Māori.
12. Because the Crown has failed to adequately investigate the extent of impairment and disabilities affecting Māori the Crown is failing to adequately address the needs and issues that are facing impaired and disabled Māori.
13. The Crown is failing to actively assist Māori living with impairment and disabilities to improve their quality of life.

Particulars

14. There are wide disparities between the Māori and non-Māori experience of impairments and disability, with the impact on Māori being more severe. The consequences of disability for Māori extend beyond the individual to whānau who have limited resources and capacity to provide necessary care and support. In this context, high quality disability support services for Māori are critical in minimising inequitable impacts on Māori individuals, whānau, and communities.⁴

⁴ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) Hauora: Māori Standard of Health IV. A Study of the years 2000-2005. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 189.

15. Data quality issues continue to undermine disability support service planning, purchasing, development and delivery for Māori. There are definitional and data collection problems which include inconsistencies in definitions of ethnicity, variable collection methods, and a limited range of data being collected.⁵
16. While conventional measures of impairment and functioning will continue to be useful there are other indicators that may be equally important in understanding Māori impairment and disability, such as outcome measures that capture positive functioning and culturally specific measures.⁶
17. A framework for Māori disability information recommended that Māori-specific data collection should include not only ethnic data but also cultural data such as hapū and iwi affiliation, access to Māori networks, whānau support, and other information related to those factors that strengthen Māori identity and may reflect positive functioning within Māori cultural contexts. Information about Māori understandings of disability and support service preferences could also be collected. This broader cultural data would inform the development of disability support services tailored to the specific needs of Māori.⁷
18. Despite specific Māori data limitations, it is possible to get some indication of the extent of impairment among Māori. The New Zealand 2001 Household Disability Survey and the Disability Survey of Residential Facilities provide the most comprehensive Māori impairment profile.⁸

⁵ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 190.

⁶Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 190.

⁷ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 190.

⁸ New Zealand 2001 Household Disability Survey and the Disability Survey of Residential Facilities. Ministry of Health 2004.

19. There are both quantitative and qualitative differences between the Māori and non-Māori experience of impairment and disability that reflect wide inequalities. Māori experience higher rates of single and multiple impairment in all age groups and more severe impairment at younger ages and overall. Further, disabled Māori are more deprived socioeconomically and have higher unmet needs for disability support services and special equipment.
20. Despite compelling evidence of wide inequalities, there has not yet been a comprehensive effort to identify distinctive Māori disability support needs nationally and to action a strategy to address those needs in a co-ordinated way, but a need to do so clearly exists.

Prejudice

21. Māori affected by impairment and disability are not adequately having their needs investigated, assessed and addressed by the Crown.
22. Because the Crown has failed to adequately investigate impairment and disability specifically affecting Māori, the Crown's response or lack of response is therefore culturally inappropriate, generates further inequalities for Māori and puts extra pressure on Māori who are trying to support their whānau with impairment and disability.

PART B: Funding

Duty

23. The Crown has a duty to actively protect the wellbeing of all Māori and to provide timely and adequate healthcare and support for Māori living with disabilities.
24. The Crown has a duty to provide sufficient healthcare funding in order to equip and assist Māori living with disabilities to achieve their wellbeing and to fulfil their aspirations to live a full life.

Breach

25. The Crown has failed to provide timely and adequate healthcare and support for Māori living with disabilities and particularly for Māori who live rurally.
26. The Crown has failed to provide sufficient funding for rural Māori living with disabilities to enable them to live a full quality life.

Māori Disability Statistics and Māori Disparities

Particulars

27. The Ministry of Health funds a range of disability support services for people (mostly aged under 65 years) who have been assessed as having a physical, intellectual or sensory disability (or combination of these) that is likely to continue for a minimum of 6 months; resulting in a reduction of independent function; and that require ongoing support. Some of these services are offered by Māori providers or other organisations offering services specifically for Māori.⁹
28. As at June 2011, almost two-thirds (64%) of disability support services funding from the Ministry of Health for Māori disabled was allocated to residential care, followed by home support (19.7%) and day programmes (5.2%).¹⁰
29. The amount of funding provided for residential care is not consistent across regions and the amount of funding available for one whānau may differ to the amount available to other whānau depending on their location.
30. Disabled Māori experience more severe socioeconomic living conditions than non-Māori. In 2001, disabled Māori living in households were approximately two and a half times more likely (43% compared to 17%) to live in the areas of greatest deprivation (NZDep2001 deciles 9–10) than disabled non-Māori.¹¹ Therefore,

⁹ <http://www.health.govt.nz/our-work/disability-services/Māori-disability-support-services>.

¹⁰ Ministry of Health. 2012. Whāia Te Ao Mārama: The Māori Disability Action Plan for Disability Support Services 2012 to 2017. Wellington: Ministry of Health. pg 4.

¹¹ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) Hauora: Māori Standard of Health IV. A Study of the years 2000-2005. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 191.

disabled Māori live in households that are among the most marginalised and have fewer financial resources.¹²

31. The implication here is that where the burden of providing necessary care and support to disabled Māori falls on whānau, the capacity of whānau to fulfil this role is compromised.¹³
32. There are indications that, based on need, Māori receive lower levels of income support and health and disability services than non- Māori. Māori children in beneficiary households are less likely to receive the Disability Allowance (a means tested allowance for those with an impairment or chronic illness of at least six months duration) than non-Māori children in beneficiary households (3.2% compared to 7.4%). Further, the average dollar value received by Māori children is less than that of non- Māori (\$11.05 per week compared to \$15.46 per week).¹⁴
33. There are also indications that there are disparities in access to the Disability Allowance for Māori adults. Further, Māori have expressed concern that policy that provides lower rates of remuneration for caregivers who are whānau is inequitable given a Māori preference for whānau care.¹⁵
34. Disabled Māori living in households have indicated higher levels of unmet need for health services (23% compared to 14% for non-Māori) and transport costs (17% compared to 7%). Māori reported less usage of disability-related equipment (23% used equipment compared to 31% of non-Māori), despite more severe Māori disability. Māori also indicated a greater unmet need for special equipment (15% compared to 11% for non-Māori). This is consistent with Māori concerns that there

¹² Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 191.

¹³ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 191.

¹⁴ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 191-192.

¹⁵ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 192.

are insufficient assessment, treatment, and rehabilitation services to meet Māori needs.¹⁶

35. There are distinct issues of concern for older Māori. Māori experience an earlier onset of age-related disease and impairment. For example, Māori women aged 45 years and over have a significantly higher rate of impairment caused by disease/illness than non- Māori, similar to the profile expected for the non-Māori 65 and over age group. As well, Māori have a shorter life expectancy than non- Māori and therefore fewer Māori survive to old age. The implication is that disability support service funding criteria based on age (e.g., eligibility restricted to those aged 65 years and over) discriminate against Māori and advantage non-Māori due to their longer life expectancy.¹⁷ Older Māori report poor access to disability support services, and cost as a barrier to access to medical services.¹⁸
36. Criteria that make good sense when funding services for non-Māori are not necessarily equitable and transferable to Māori.¹⁹
37. The Ministry of Health's Intervention Framework to Improve Health and Reduce Inequalities ("the framework") describes inequalities in health in New Zealand and sets out principles that can be used at national, regional and local levels by policy-makers, funders, service providers and community groups to take action to reduce inequalities in health.²⁰

¹⁶ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 192.

¹⁷ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 191.

¹⁸ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 191.

¹⁹ Keri Ratima, Mihi Ratima. Māori experience of disability and disability support services. In Robson B, Harris R.(eds) *Hauora: Māori Standard of Health IV. A Study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare. Pg 189-198. At pg 191.

²⁰ Ministry of Health, 2012, *Reducing inequalities in health*. pg iii.

38. The framework identifies the need for action that targets amongst other matters, health and disability services and the impact of poor health and disability on economic and social wellbeing.²¹
39. Despite the framework suggestions, funding is at the end of the day allocated by the Ministry of Health's Population Based Funding Formula tool and decisions on the allocation of this funding are made by regional health boards and service providers.

Northland District Health Board

40. Northland has one of the most deprived populations in the country. While 20 percent of New Zealand's population is in the lowest quintile of the deprivation index, the equivalent measure for Northland is 35 percent. The most deprived local authority area is the Far North District Council with 51 percent of the population in the lowest quintile; within this district the most deprived areas are Hokianga (83 percent), Whangaroa (41 percent) and north of the Mangamukas (55 percent).²²
41. The Northland District Health Board's ("NDHB") activities involve funding and delivering health and disability services in a variety of ways to the community.²³
42. Responsible for providing or funding the provision of health and disability services for the people of Northland, the NDHB covers a large geographical area from Te Hana in the south to Cape Reinga in the north.²⁴
43. In the NDHB 2016 Annual report it is recorded that the target for independence for those with impairments or disability support needs was met for all three of the indicators (home and community support clients receiving interRAI assessments, home and community support providers certified, providers of aged-related residential care with three-year certification).²⁵

²¹ Ministry of Health 2012, Reducing inequalities in health. pg iii.

²² A Healthier Northland: Northland District Health Board Annual Report 2016, pg 5.

²³ A Healthier Northland: Northland District Health Board Annual Report 2016, pg 97.

²⁴ A Healthier Northland: Northland District Health Board Annual Report 2016, pg 5.

²⁵ A Healthier Northland: Northland District Health Board Annual Report 2016, pg 31.

44. However the data is not specifically just for Māori and therefore it is unclear if these targets are being met specifically for Māori living in this area.²⁶

Prejudice

45. Because there is a lack of Māori specific disability data, funding for Māori is not necessarily equitable and this prejudices disabled Māori from being able to seek their full potential and to fulfil their aspirations.
46. Rural Māori suffer from high deprivation rates and those living in rural areas with disabilities face further hardship and have higher needs. Because funding is not based primarily on need but rather population Māori in rural areas are instantly prejudiced.

PART C: Whānau Support

Duty

47. The Crown has a duty to provide adequate support and resources to enable and empower Māori to care for their whānau who live with disabilities.

Breach

48. The Crown has failed to provide sufficient resources and support for the whānau of disabled Māori to empower them to adequately care for their whānau.

Particulars

Action Plan - Whaia Te Ao Marama

49. After talking with disabled people, their families, providers and the wider disability sector, the Ministry of Health has developed, and is testing, a new model for

²⁶ A Healthier Northland: Northland District Health Board Annual Report 2016, pg 31.

supporting disabled people. The aim of the new model is for disabled people and their families to lead good everyday lives. It will increase people's control and choice, and the flexibility of their supports, as well as ensuring information and support are available in their local communities.²⁷

50. The aim of Whāia Te Ao Mārama: Māori Disability Action Plan 2012 to 2017 (“action plan”) is to establish priority areas of action for achieving the aspirations of Māori disabled and their whānau, and to reduce barriers that may impede Māori disabled and their whānau from gaining better outcomes.²⁸
51. Under the action plan there are a number of priorities that have been identified. These priorities if put into action and completed would be a step forward in assisting and benefitting Māori disabled:²⁹
52. There are however remaining actions that are a priority and were identified by the Māori Disability Leadership Group but were not included in the action plan. In relation to providing better support for whānau these included:
 - a) Develop indicators to measure whānau outcomes.
 - b) Support parents with disabled children, particularly in the areas of behaviour support and whānau-centred respite care.
 - c) Ensure whānau are involved in the funding, planning and delivery of disability services, including the development of service specifications.
53. Whānau are not being consulted and they are unable to participate in decisions regarding the funding, planning and delivery of disability services or the development of service specifications that would help to support their whānau.

²⁷ Whāia Te Ao Mārama: Māori Disability Action Plan 2012 to 2017, Pg 4.

²⁸ Whāia Te Ao Mārama: Māori Disability Action Plan 2012 to 2017, Pg 1.

²⁹ Whāia Te Ao Mārama: Māori Disability Action Plan 2012 to 2017, Pg 8.

Prejudice

54. Whānau of disabled Māori are failing to receive adequate support as indicators to measure health outcomes for whānau looking after disabled Māori are not available and are not being adequately monitored.
55. Support for parents with disabled children in respite care is not being appropriately addressed or funded and health outcomes for these whānau are unlikely to improve without adequate support.
56. The Crown are failing to work in partnership with whānau who have little say in relation to the decisions being made regarding the funding, planning and the delivery of disability services which impact their whānau.

PART D: Culturally Appropriate Care

Duty

57. The Crown has a duty to ensure all its employees and representatives, including those from Government created agencies such as District Health Boards are aware of and comply with the Treaty of Waitangi and the unique principles which arise within Māori and Crown relations.
58. The Crown has a duty to ensure all employees providing public healthcare to Māori disabled, provide care which is equal to that of non-Māori disabled.
59. The Crown has a duty to ensure all employees providing public healthcare to Māori disabled provide healthcare which is adequate and meets the needs of Māori disabled.
60. The Crown has a duty to ensure that all healthcare employees are culturally competent, and provide culturally appropriate care for Māori disabled and their whole whānau.

Breach

61. The Crown has failed to ensure that all employees who provide healthcare services to Māori disabled adequately understand and comply with the Treaty of Waitangi and its principles.
62. The Crown has failed to ensure all employees providing public healthcare to Māori disabled provide equal care to that of non-Māori disabled.
63. The Crown has failed to ensure all employees providing public healthcare to Māori disabled are culturally competent, and provide healthcare which is adequate and culturally appropriate for the needs of Māori disabled, and their whānau.

Particulars

64. Surgeons, doctors, nurses, clinical staff and physiotherapists all play an integral role in the delivery of public healthcare for Māori disabled and non Māori disabled.
65. Access to healthcare should be equal to Māori disabled and non Māori disabled alike; however the healthcare received by Māori disabled and non Māori disabled, varies regionally, and within healthcare institutions and hospitals themselves.
66. A lack of cultural competency, awareness and empathy by healthcare staff can make accessing adequate and culturally appropriate healthcare difficult for Māori disabled and their whānau.
67. The claimant spent a lot of time navigating the public healthcare system with Anthony.
68. The claimant and her whānau had to fight hard to access healthcare resources for Anthony which they were entitled to, but were informed were not available to them.
69. The claimant and her whānau have made personal and financial sacrifices in order to ensure Anthony received the best care he could and had the best quality of life.

70. The claimant and her whānau were told by hospital staff on more than one occasion that Anthony would not survive.
71. The claimant and her whānau were told that Anthony would not be admitted back to Intensive Care at Whangarei Hospital and the Department of critical care in Auckland if he had another respiratory incident.
72. The claimant had mistakenly been told on more than one occasion by hospital staff that Anthony had died.

Prejudice

73. The claimant and her whānau have suffered physical, financial and emotional hardship from a healthcare system which has failed to provide adequate training to staff to ensure they are aware of and comply with the principles of the Treaty of Waitangi.
74. The claimant and her whānau have suffered physical, financial and emotional hardship from a healthcare system which has failed to provide adequate resources for Anthony to live the upmost quality life.
75. The claimant and her whānau endured many lows which were avoidable if staff were culturally competent and appropriately trained to understand the cultural needs of Māori.
76. The claimant and her whānau have not received equal care to non-Māori disabled and their whānau.

PART E: Health and Disability Support Advisory Committees

Duty

77. The Crown has a duty to ensure Māori tino rangatiratanga over their taonga which includes Māori living with disabilities, is freely exercised.
78. The Crown has a duty to work in good faith and partnership with Māori to assist and support the overall health and wellbeing of Māori, including Māori living with disabilities.

Breach

79. The Crown is failing to ensure Māori can exercise their tino rangatiratanga in respect of their people and decisions which impact upon the health of their people, including Māori living with disabilities.
80. The Crown is failing to work in good faith and partnership with Māori to ensure disability support advisory committees are adequately representative of Māori and Māori living with disabilities.
81. The Crown is failing to provide a standalone disability support advisory committee for the Northland region and is failing to adequately promote and support the needs of Māori disabled.

Particulars

82. Under the New Zealand Public Health and Disability Act 2000 (“NZPHDA”) all District Health Board’s (“DHB’s”) must establish three committees within 3 months of the commencement of the NZPHDA.
83. Under section 34 of the NZPHDA the board of a DHB must establish a committee, to advise on health improvement measures, called the community and public health advisory committee, and must provide for Māori representation on the committee.

84. Under section 35 of the NZPHDA the board of a DHB must, within 3 months of the commencement of this Act, establish a committee, to advise on disability issues, called the disability support advisory committee, and must provide for Māori representation on the committee.
85. Under section 36 of the NZPHDA the board of a DHB must, within 3 months of the commencement of this Act, establish a committee, to advise on matters relating to hospitals, called the hospital advisory committee, and must provide for Māori representation on the committee.
86. The NDHB has created the Community & Public Health and Disability Support Advisory Committee (“CPHAC/DiSAC”). There are nine members on the CPHAC/DiSAC.
87. The CPHAC/DiSAC advises the NDHB Board on the health needs of Northlanders, including disability supports needs, and any factors it believes may adversely affect the overall health status of the population. That advice must ensure that all service interventions funded and provided maximise the overall health gain such as the independence in society of people with disabilities.³⁰
88. Instead of having a standalone committee dedicated to advising about disability support; time and resourcing of the CPHAC/DiSAC is shared by one committee, who according to their terms of reference, advise the NDHB on the following matters³¹:
- a) The needs, and any factors that the Committee believes may adversely affect the health status, of the resident population of the NDHB;
 - b) Priorities for use of health funding provided;
 - c) The aim of the Committee’s advice is to ensure that the following maximise the overall health gain for that population:
 - i) All service interventions the NDHB has provided or funded in the community or could provide or fund in the community for the care of that population;
 - ii) All policies the NDHB has adopted or could adopt for the care of that population across the two communities; and

³⁰ <https://www.northlanddhb.org.nz/about-us/board/governance/>.

³¹ <https://www.northlanddhb.org.nz/assets/Board/CPHAC-DiSAC-TOR-Jan-2017.pdf>.

- iii) The kinds of disability support services the DHB has provided or funded or could provide or fund for those people.

89. According to the terms of reference the CPHAC/DiSAC is responsible for:³²

- a) Monitoring the health status and needs of the Northland population;
- b) Monitoring the progress of the Northland Health Services Plan;
- c) Advising the Board on the implications for planning and funding of nation-wide health strategies;
- d) Advising the Board on strategies to reduce the disparities in health status;
- e) Advising the Board on priorities for health improvement and independence as part of the strategic and annual planning process and monitoring progress on targets;
- f) Ensuring disability support services and public health are considered in conjunction with personal health; and
- g) Advising the Board on issues related to the delivery of health services accessed by people with disabilities including how it can effectively meet its responsibilities towards the government's vision and strategies for people with disabilities.

90. CPHAC/DiSAC advice may not be inconsistent with national policies and strategies such as the New Zealand Health Strategy and the New Zealand Disability Strategy.³³

91. The NDHB has effectively merged two of the three committees required by sections 34-36 of the NZPHDA together. The merging of the two committees to the CPHAC/DiSAC is problematic as it reduces the capacity of committee members to effectively manage resources and carryout all their functions expeditiously.

92. By combining the two committees the workload of the CPHAC/DiSAC is doubled and the ability of the CPHAC/DiSAC to prioritise, fund, specifically support, and address the needs of Māori disabled is compromised.

93. Furthermore whilst sections 34-36 of the NZPHDA does make specific mention of the need for Māori representation to be provided for in each of the three committees, it is

³² <https://www.northlanddhb.org.nz/assets/Board/CPHAC-DiSAC-TOR-Jan-2017.pdf>.

³³ <https://www.northlanddhb.org.nz/assets/Board/CPHAC-DiSAC-TOR-Jan-2017.pdf>.

unclear how Māori representation is supposed to be attained and what proportion of the committee needs to be Māori.

94. The NZPHDA does not prescribe what Māori representation should look like on the committees and it is unclear whether Māori have always been represented and to what extent on the NDHB committees.

95. According to the CPHAC/DiSAC terms of reference³⁴:

- a) Membership of the Committee shall be determined by the Board;
- b) Appointment of members must comply with the requirements set out in Clause 6 Schedule 4 of the Act; and
- c) The Board will appoint the Chair of the Committee.

96. Māori are not given a say in relation to who the members of the CPHAC/DiSAC should be. These decisions are determined by the Board who have either been voted in themselves as members of the NDHB or appointed by the Minister.

97. There is no requirement for representation of Māori disabled on the CPHAC/DiSAC.

Prejudice

98. Māori disabled are unable to freely exercise their tino rangatiratanga and do not play a role in advice provided by CPHAC/DiSAC which impacts upon the overall health and wellbeing of Māori disabled and their whānau.

99. Māori disabled do not have adequate representation on committees including the CPHAC/DiSAC.

100. The lack of Māori and disabled Māori representation on CPHAC/DiSAC affects and limits the support and resources available to disabled Māori and their whānau.

³⁴ <https://www.northlanddhd.org.nz/assets/Board/CPHAC-DiSAC-TOR-Jan-2017.pdf>.

Findings and Recommendations

101. The claimant welcomes a finding that this claim is well-founded.

102. The claimant seeks the following findings and recommendations:

- a) Full research, investigation and assessment of disability and impairment affecting Māori.
- b) That the Crown increase the funding, support and resources available for Māori living with disabilities to enable them to live a full life.
- c) That the Crown increase the funding available for Māori living with disabilities in rural areas to assist in providing more timely healthcare, support and services.
- d) That the Crown provide adequate support and resources for whānau to provide the appropriate care and support for those whānau members living with disabilities.
- e) That the Crown act in partnership and in consultation with Māori to plan, develop, design and fund disability services that will improve the health outcomes for disabled Māori and their whānau.
- f) That all workers within the healthcare system undertake Māori cultural training to ensure all staff are aware of and sensitive to the cultural needs of Māori, and comply with the principles of the Treaty of Waitangi.
- g) That resources available to Māori disabled and their whānau be at an equal level to those resources available to non Māori disabled.
- h) That resources available to Māori disabled and their whānau be equally sufficient compared to healthcare provided to non disabled.
- i) That resources and funding available to Māori disabled and their whānau be equal to non Māori disabled and non disabled; no matter which region Māori disabled may live in.
- j) That the NDHB set up rehabilitation centres throughout Northland to support people who have physical, intellectual or mental health impairment.
- k) That the NDHB provide funding to set up Respite Care homes for people aged 30 to 60 years living with disabilities in the community which their families can access for support.
- l) That the NDHB employ health advocates in Northland who can respond to Māori disabled health concerns and provide assistance in a timely manner.

- m) That the NDHB employ more workers across the disability sector, including specialised staff to work with people with high disability support needs.
- n) That the NDHB employ more workers particularly in rural areas which are understaffed or lack any permanent staff who can work onsite in rural locations.
- o) That the NDHB create a standalone Disability Support and Advisory committee which includes Māori and Māori disabled representatives.
- p) Any specific findings the Tribunal considers to be appropriate.

DATED at Auckland this 17th day of December 2019.



David Martin Stone Catherine Leauga Kelly Davis
Counsel for the Claimant

TO: The Registrar, Waitangi Tribunal; Crown Law Office; and those on the notification list for the Wai 2575 Health Services and Outcomes Kaupapa Inquiry.