BEFORE THE WAITANGI TRIBUNAL

WAI 2575
WAI TBC

IN THE MATTER OF	the Treaty of Waitangi Act 1975
AND	
IN THE MATTER OF	a claim brought by Leanne Te Karu on behalf of Māori generally
AND	
IN THE MATTER OF	the Health Services and Outcomes Kaupapa Inquiry

STATEMENT OF CLAIM

25 November 2019

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MAY IT PLEASE THE TRIBUNAL:

Introduction

The claimant

1. This statement of claim is filed on behalf of Leanne Te Karu ("the claimant").

2. The claimant holds the following qualifications:

    a. DipPharm (Distinction);

    b. PGCert Pharm (Herbal Meds);

    c. PG Dip ClinPharm (Distinction);

    d. PGCertPharm (Prescribing);

    e. MHsc (Hons); and

    f. is a PhD candidate at the Department of General Practice University of Auckland.

3. She is currently:

    a. the Associate Dean Māori in the School of Pharmacy at the University of Otago;

    b. a Pharmacist Prescriber with primary health care clinics in Turangi and South Auckland;

    c. an appointee to the Medsafe Medicines Adverse Reactions Committee; and

d. the lead contractor/facilitator to a Pharmac funded initiative called ‘He Rongoā Pai, He Oranga Whānau’ a marae-based programme that aims to increase the awareness and understanding of the optimal use of medicines alongside traditional practices. Wānanga have been held from Te Rau Aroha in Bluff to Kaitaia.

4. The claimant has held multiple roles over time which assert she is the health professional in Aotearoa who has engaged the most substantively with whānau on medicines optimisation. Alongside her many roles in the health sector this provides a unique lens. These previous roles have included:

    a. an appointee to the Pharmacy Council of New Zealand;

    b. a founder of Ngā Kaitiaki o te Puna Rongoā o Aotearoa – Māori Pharmacists’ Association of which she was President for its first decade;

    c. a member of the Ministry of Health appointed Pharmacy Steering Group Committee;

    d. an expert advisor to the Health Quality and Safety Commission; and

    e. the deliverer of a Ministry of Health contract to build whānau health literacy in a marae-based setting.

5. The claimant is committed to addressing inequities within the New Zealand health system and has published extensively on this topic[1].

6. She is of Muaūpoko and Whanganui descent.

The claim

7. At its heart, this claim is about ensuring that Māori are the recipients of individualisation, rationalisation, optimisation of prescription medication. It is brought to ensure that Māori receive high quality, evidence-based health care and in particular that they

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[1] Norris, P., Tordoff, J., McIntosh, B., Laxman, K., Chang, S. Y., & Te Karu, L. (2016). Impact of prescription charges on people living in poverty: A qualitative study. Research in Social & Administrative Pharmacy, 12(6), 893-902; Dalbeth, N., House, M. E., Horne, A., Te Karu, L., Petrie, K. J., McQueen, F. M., & Taylor, W. J. (2013). The experience and impact of gout in Māori and Pacific people: A prospective observational study. Clinical Rheumatology, 32(2), 247-251; Jackson, G., Wright, C., Thornley, S., Taylor, W. J., Te Karu, L., Gow, P. J., Arroll, B., Gribben, B., Dalbeth, N., Winnard, D. (2012). Potential unmet need for gout diagnosis and treatment: Capture-recapture analysis of a national administrative dataset. Rheumatology, 51(10), 1820-1824; Winnard, D., Wright, C., Taylor, W. J., Jackson, G., Te Karu, L., Gow, P. J., Arroll, B., Thornley, S., Gribben, B., Dalbeth, N. (2012). National prevalence of gout derived from administrative health data in Aotearoa New Zealand. Rheumatology, 51(5), 901-909; Norris, P., McIntosh, B., Tordoff, J., Te Karu, L., & Chang, S. Y. (2015). Poverty, medicines and health care: It's the little things.... Journal of Primary Health Care, 7(2), 170-171; Dalbeth, N., Winnard, D., Gow, P. J., Boswell, D. R., Te Karu, L., Lindsay, K., Arroll, B., Stamp, L. K. (2015). Urate testing in gout: Why, when and how. New Zealand Medical Journal, 128(1420); Dalbeth, N., Gow, P., Jackson, G., Shuker, C., Te Karu, L., Gerard, C., Winnard, D. Gout in Aotearoa New Zealand: are we going to ignore this for another 3 years? New Zealand Medical Journal. 2016 Jan 29;129(1429):10-3; Te Karu, L., Bryant, L, Elley, C R. Maori experiences and perceptions of gout and its treatment: a kaupapa Maori qualitative study. Journal of Primary Health Care. 2013 Sep 1;5(3):214-22; Davis A, Davis K, Gerard C, Goyal S, Jackson G, James C, Loe E, Nicolls B, O'Rourke MA, Shuker C, Te Karu L. Opioid rain: opioid prescribing is growing and practice is diverging. New Zealand Medical Journal. 2016 Aug 19;129(1440):11-7; Martini N, Bryant L, Te Karu L, Aho L, Chan R, Miao J, Naidoo C, Singh H, Tieu A. Living with gout in New Zealand: an exploratory study into people's knowledge about the disease and its treatment. Journal Clinical Rheumatology. 2012 Apr;18(3):125-9; Jackson G, Dalbeth N, Te Karu L, Winnard D, Gow P, Gerard C, Minko N. Variation in gout care in Aotearoa New Zealand: a national analysis of quality markers. New Zealand Medical Journal. 2014 Oct 17;127(1404):37-47 ; Te Karu, L., Bryant, L, Harwood, M, Arroll, B. Achieving health equity in Aotearoa New Zealand: the contribution of medicines optimisation. Journal of Primary Health Care, 2018. 10(1): p. 11-15.

are prescribed medicines in a whānau – owned, safe and effective way to ensure people obtain the best possible outcome from medicines.

8. It concerns the prejudicial effects Māori suffer in both accessing medicine as well as the provision of prescription medicines at both primary and secondary care levels within the current health system ("prescription inequity").

9. Prescription inequity is one dimension of institutional racism that pervades the New Zealand health system. Institutional racism in this context is defined as institutional inaction in the face of obvious obstacles Māori face in meeting their health needs.

10. Prescription inequity is a significant contributing factor in the overall health inequities Māori suffer and includes:

    a. inequitable access to appropriate, high quality health care for Māori and in particular inequitable prescription by qualified health professionals of subsidised medicines; and

    b. inequitable health system funding for medicines, administered by key government agencies (e.g. Ministry of Health and the Pharmaceutical Management Agency ("Pharmac")).

11. The claimant alleges that prescription inequity in the health system is inconsistent with the principles of te Tiriti o Waitangi / the Treaty of Waitangi ("the treaty") in that the Crown has failed to:

    a. provide for the equitable treatment of Māori patients;

    b. actively protect the health of Māori;

c. sufficiently provide for Māori within the pharmaceutical policy framework in New Zealand;

d. ensure that Māori have adequate decision-making authority in the design and delivery of prescription services; and

e. ensure that Māori have access to culturally appropriate healthcare.

Background

Medicines as a health intervention

12. Medicines are the most common tools used in health care. They can decrease morbidity and mortality by both preventing and treating illness.

13. All medicines can cause adverse effects. The aim therefore is to ensure optimal use of medicines whereby decreased morbidity or mortality from illness is achieved and drug-related morbidity or mortality is mitigated.

Medicines optimisation for Māori

14. Inequity in access to medicines exists for Māori as does provision of prescription medicines at both primary and secondary care levels.

15. For example, researchers who collated evidence of prescription medicines for Māori across all medicine groups found the inequity was so substantial it became known as “the missing million prescription paper”.

16. According to the research, Māori were much less likely to receive medicines according to the burden of illness as well as more likely to receive medicines which do not prevent or treat the cause of illness. These medicines instead tended to provide symptomatic resolution.

17. Research also indicates that despite Māori being the highest need demographic population in terms of health, on average their appointments with physicians are the shortest.

18. Types of medicines which Māori are under-prescribed include:

    a. heart disease medication;

    b. antibiotics;

    c. mental health medicines;

    d. diabetes and renal medicines

    e. cancer drugs; and

    f. respiratory medicines.

19. The cause of this disparity is multi-faceted but includes:

    a. financial barriers that disproportionately impact Māori, driven by co-payment for prescription medicine;

    b. Māori being less likely than non-Māori to receive information on medicines including their rationale, their side effects and how to use or administer medicine in the correct manner;

c. lack of culturally appropriate interactions with health professionals involved in the medicines optimisation pathway;

d. inability to access prescriber services, e.g. through a general practice or prescribing pharmacist – driven by a range of factors including cost of service co-payments, location of services and hours the services are open; and

e. variance in prescribing patterns/competence of prescribers.

Treaty principles and duties

20. The treaty envisages that the relationship between Māori and the Crown "*should be founded on reasonableness, mutual cooperation and trust*." This reflects that the treaty "*creates responsibilities analogous to fiduciary duties*" between the Crown and Māori.

21. The Crown has ongoing obligations arising from the Treaty to Māori. Relevant duties include:[2]

a. partnership;

b. good faith[3];

c. active protection[4], particularly the protection of taonga;

[2] *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641 from 660]"*Lands"* case].
[3] *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641 from 660]"*Lands"* case].
[4] *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641 from 660]"*Lands"* case].

d. equity – noting that the Tribunal has previously held this extends to substantive and not merely formal equality[5]; and

e. options.

22. The Privy Council has held that if a taonga is in a vulnerable state, it may require the Crown to take especially vigorous action, particularly where the vulnerable state can be attributed to past breaches of its treaty obligations[6].

Breaches of the treaty

23. The claimant alleges that prescription inequity is inconsistent with the principles of the treaty.

First cause of action: The Crown has failed to provide for the equitable treatment of Māori patients

24. Māori suffer prescription inequity in:

a. access to medicines - Māori are less likely to receive medicines according to the burden of illness;

b. incorrect provision of prescription medicines – Māori are more likely to receive medicines which do not prevent or treat the cause of the illness; these medicines that are over-prescribed are more likely to cause significant side-effects.

[5] See for example: Waitangi Tribunal, *Maori Electoral Option Report* (1994, Wellington, Brooker and Friend at p 12; Waitangi Tribunal, *Maori Electoral Option Report* (2001, Wellington, Legislation Direct) at p 64.
[6] *New Zealand Maori Council v Attorney-General* [1994] 1 NZLR 513 (PC) [*Broadcasting* case].

This includes gastric ulceration, kidney damage, cardiovascular disease and sudden death.

c. appointments with physicians – evidence suggests that Māori appointments with prescribers are shorter than non-Māori.

25. The types of medicines which Māori are under-prescribed include but are not limited to:

a. heart disease medication;

b. antibiotics;

c. mental health medicines;

d. diabetes and renal medicines;

e. cancer drugs; and

f. respiratory medicines.

26. Thus, the claimants allege that the Crown has failed to provide for the equitable treatment of Māori patients.

Second cause of action: The Crown has failed to actively protect the health of Māori

27. Prescription inequity has resulted in poor outcomes for Māori.

28. For example, Māori have the poorest health outcomes and shortest life expectancy of all ethnicities residing in New Zealand.

29. The major health conditions causing death for Māori are long-term conditions, namely:

    a. heart disease;

    b. lung disease;

    c. stroke; and

    d. diabetes.

30. In children, infectious and respiratory disease are more prevalent for Māori than for non-Māori.

31. Prescription inequity is a significant contributor to the prevalence of all of these diseases amongst Māori.

32. The legislative framework does not provide for the active protection of Māori health. For example, Pharmac does not have equity as a legislated objective, unlike District Health Boards ("DHBs"). There is also a lack of public reporting from Pharmac on how well it is doing for Māori in achieving equity. While Pharmac has recently committed to a goal of medicines access equity, the goal is self-imposed with no statutory requirement to report on its progress. The generality of the goal also does not reflect the special status of Māori as tangata whenua.

33. Thus, the claimants allege the Crown has failed to actively protect the health of Māori.

Third cause of action: The Crown has failed to ensure that Māori are sufficiently provided for within the pharmaceutical policy framework in New Zealand

34. The design of the pharmaceutical policy framework in New Zealand is another contributing factor to prescription inequity.

35. The framework is comprised of a number of different bodies that can affect pharmaceutical policy, including the Ministry of Health, District Health Boards, the Health Quality and Safety Commission and Pharmac.

36. Pharmac has direct control over medicines that will be funded. Sections 46 - 53 of the New Zealand Public Health and Disability Act 2000 ("the 2000 Act") established Pharmac and set out its purpose and functions.

37. Pharmac has four main roles:

    a. managing the New Zealand Pharmaceutical Schedule ("the schedule") of about 2000 Government-subsidised community pharmaceuticals;

    b. promoting the optimal use of medicines;

    c. managing the subsidy of medicines and some medical devices used in public hospitals; and

    d. managing the Named Patient Pharmaceutical Assessment policy (a mechanism for people to receive funded medicines not available through the Schedule).

38. Since 2001, Pharmac have produced a Māori responsiveness strategy. They also have an equity goal. However, during the 18

years since the strategy has been implemented there has been no tangible progress in achieving health equity.

39. The pharmaceutical framework also includes:

    a. the Ministry of Health, which sets policies that influence medicines (e.g. through Medsafe, through professional regulation, and through pharmacy ownership which dictates that pharmacies should be majority owned by pharmacists);

    b. District Health Boards and their funding; and

    c. the Health Quality and Safety Commission which has the objective of monitoring and improving the quality and safety of health services under the NZ Public Health and Disability Act.

40. The situation outlined in the previous causes of action increasingly demonstrates that Māori are disproportionately under-represented in access to key pharmaceuticals. Further, even when pharmaceuticals are prescribed, Māori are not always provided with understandable information that enables self-management.

Fourth cause of action: The Crown has failed to ensure that Māori have adequate decision-making authority in the design and delivery of the overall healthcare delivery model resulting in prescription inequity

41. The overall healthcare delivery model, including the role and functions of the health workforce, are also relevant to prescription inequity.

42. Factors which contribute to prescription inequity in the current model include:

a. availability of services especially kaupapa Māori services;

b. location of services;

c. length of appointment, with many appointment windows only lasting 15 minutes;

d. cultural safety of services including the small number of Māori pharmacists (the percentage of pharmacists identifying as Māori is less than 2% and is declining); and

e. cost of services.

43. There is also serious concern that programmes co-designed by Māori which are effective in addressing prescription inequity have significant difficulty in securing funding from Crown organisations.

44. Thus, the claimants allege the Crown has failed to ensure Māori have adequate decision-making authority in the design and delivery of the overall health care system.

Fifth cause of action: The Crown has failed to ensure that Māori have access to culturally appropriate healthcare

45. Section 118i of the 2000 Act requires that Regulatory Authorities must set standards of cultural competence which should be weighted equally against clinical competency and ethical conduct. Further section 118i is explicit with respect to Māori stating 'cultural competency (including competencies that will enable effective and respectful interaction with Māori).'

46. Despite this provision, no regulatory authority has a robust monitoring mechanism to ensure healthcare is delivered in a culturally safe way.

47. There is evidence before this Tribunal that a lack of cultural competence/safety contributes to Māori reluctance to engage in the health system which in turn contributes to prescription inequity.

Prejudice

48. Prescription inequity has and will continue to cause prejudice to Māori by:

    a. providing an unequal standard of care to Māori within the health system;

    b. excluding Māori from properly participating in the design and delivery of prescription services; and

    c. continuing to contribute to Māori having the poorest health outcomes and shortest life expectancy of all ethnicities in Aotearoa New Zealand.

Recommendations

49. The claimant seeks the following recommendations grouped by urgency of implementation:

    Short-term

    a. an apology;

b. the full and proper resourcing of culturally safe practitioners with advanced applied pharmacotherapy knowledge;

c. Pharmac to have robust Māori systems and structure that enable medicines equity;

d. Māori health providers and Māori are resourced to be able to deliver medicine empowerment to communities;

e. further investment in an integrated primary care workforce;

f. more investment in an integrated primary care workforce;

g. legislative reform enabling Māori pharmacy ownership;

Medium-term

h. legislative reform to ensure effective monitoring mechanisms of outcomes for Māori;

i. equal funding of Māori led programmes, provides and consumers;

Long-term

j. an independent hauora authority; and

k. any other recommendations the Tribunal deems appropriate.

Dated 25 November 2019

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Alice McCarthy / Winston McCarthy
Counsel for the Claimant