

I TE ROOPUU WHAKAMANA I TE TIRITI O WAITANGI

IN THE WAITANGI TRIBUNAL

WAI 2575

Wai 2747

KEI RARO I TE MANA O

te ture o te Tiriti o Waitangi 1975

IN THE MATTER

of the Treaty of Waitangi Act 1975

ME

AND

I TE TAKE O

te pakirehua Wai 2575 moo ngaa  
kereeme e paa ana ki te Health  
Services me Outcomes

IN THE MATTER

of the Health Services and Outcomes  
Kaupapa Inquiry (Wai 2575)

ME

AND

I TE TAKE O

ko John Kearns me Maeva Kearns i  
runga i te tono o te whaanau

IN THE MATTER

of a claim by John Kearns and Maeva  
Kearns for and on behalf of the Kearns  
whanau

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AMENDED BRIEF OF EVIDENCE OF JOHN KEARNS

Dated: 19th Mei 2025

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RECEIVED

Waitangi Tribunal

20 May 25

Ministry of Justice  
WELLINGTON

TamakiLegal

Barristers & Solicitors

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Counsel Acting: SJ Roughton / CR Smith

I, John Kearns, of Ooraakei, shipbroker, state:

Ko Kurahaupoo te Waka

Ko Pōhurihanga te Tangata

Ko Kohuroa te Maunga

Ko Paarengarenga te Wahapuu

Ko Te Hiku o Te Ika te marae

Ko Te Reo Mihi te Whare Tupuna

Ko Ngāti Kuri te iwi

Ko Te Ringa Maui te Hapu

1. I am the youngest son of Julia Norman, whose father was John Norman, eldest son of Henare Norman. I whakapapa to Ngaati Kuri and Te Rarawa. Raised on our whanau-built waka 'Kotahitanga', I spent most of my adolescence sailing around the world between 1976 and 1984. My wife Maeva and I, now live on her Papakainga on Takaparawha, Bastion Point in Taamaki Makaurau. Maeva and I have three daughters, Tamara Lawson, Taina Kearns, and Claudia Kearns, and three mokopuna.
2. On a professional basis, I've had a 30-year seagoing career and have worked on a diverse range of vessels in both the commercial and private sectors. Ten years ago, I formed a company and have since been working as a shipbroker which requires me to liaise with clients from New Zealand and around the world.

### **Renal Health Equity**

3. I have been very fortunate to have received three kidney transplants: the first in 1987, then 2002 and more recently, 2015. I have also received eight and a half years of dialysis between my transplants.
4. I have been a Consumer Representative on the National Renal Transplant Leadership Team since 2014 and recently with the Australia New Zealand

Society of Nephrologists. I am also a board member with the Auckland District Kidney Society since 2016 and Taakihi Hauora Aotearoa (Kidney Health New Zealand) since 2018. In these roles, I have represented the voices of others, particularly Maaori and Pasifika in the renal health space and have been involved in the commissioning and development of several projects including:

- a. Taakihi Hauora Aotearoa (Kidney Health New Zealand): *“Addressing Kidney Transplant Equity and Increasing Kidney Transplantation in New Zealand: An Integrated Strategy”* dated November 2021.
  - b. Taakihi Hauora Aotearoa (Kidney Health New Zealand): *“Clinical practice guidelines for management of chronic kidney disease for Māori in Aotearoa New Zealand (CARI guidelines)”*.
  - c. New Zealand Institute of Economic Research: *“Transforming Lives and Saving Money: The Golden Opportunity of Kidney Transplants and the System Changes Needed to Lift the Numbers”* dated 5 November 2021.
  - d. Taakihi Hauora Aotearoa (Kidney Health New Zealand): *“Aotearoa New Zealand Haemodialysis Infrastructure Survey: A Report on Aotearoa New Zealand’s haemodialysis service capacity”* dated 30 April 2023 and presented to National Renal Advisory Board, and Manatu Hauora.
5. A focus of this work has been on transplant equity. Taakihi Hauora Aotearoa has developed an integrated strategy<sup>1</sup> that was presented to the (Labour) Government in November 2021 to seek to ameliorate the high levels of transplant inequity especially for Māori. Transplant inequity is best exemplified by understanding that in 2019, there were under 4 transplants for every 100 Maaori dialysis patients, yet, for non-Maaori the figure was 14 out of every 100 patients. To support this mahi, we engaged the New Zealand Institute of Economic Research who undertook an analysis of the funding required and likely economic outcomes of greater transplant equity.

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<sup>1</sup> Taakihi Hauora Aotearoa (Kidney Health New Zealand): *Addressing Kidney Transplant Equity and Increasing Kidney Transplantation in New Zealand: An Integrated Strategy* dated November 2021

6. As a result of that work, the Government promised a \$13m fund to improve transplant equity. It is my understanding that this funding was to be provided by Te Aka Whai Ora, but I am not sure if it was ever paid out.
7. In addition, the Chair of the National Renal Transplant Team said to us that there should be a Maaori voice in the renal space as “we don’t want a bunch of white guys” telling Maaori what they need to do. So as a result, we did some work on a possible Maaori renal transplant task force. We had hoped that Dr Curtis Walker and Rachael Walker; Associate Professor of Nursing at Auckland University could join us on this. We wanted the task force to be done properly, so the consensus was that we would go through Te Aka Whai Ora to develop the task force. Without Te Aka Whai Ora, the task force hasn’t eventuated because the emphasis has gone away from dealing with inequities at a higher level. I think it is still important to the clinicians as they see the inequities every day, but the issue is with the ministers, and the messaging from the top is very clear, that inequities aren’t important anymore. Dr Curtis Walker and Rachael Walker joined us as board members recently. Prior, the board has been largely Paakehaa and I felt like the lone voice for Maaori so I am certainly more comfortable with them on the board and the broadened representation.
8. I think it is despicable to do what the government is doing to Maaori healthcare – Te Aka Whai Ora was an opportunity to change the statistics that dog Maaori, to address inequalities within the health system. Since the disestablishment, inequalities have gone off the radar within the health space. It’s not a talking point like it was before.
9. Most organisations take 4-5 years to get up and running, which wasn’t afforded to Te Aka Whai Ora. The decision they made wasn’t based on anything; it certainly wasn’t evidence-based decision making. My observation is that the privileged are getting even more privileged, while Maaori are being even more underprivileged. For example, changing the age of the bowel screening to being younger for non-Maaori and older for Maaori even though Maaori are known to be at higher risk.

## Alternative Plans

10. The Hauora Maaori Advisory Committee has no real teeth, and it is just a perception thing. The government is just going to keep going with what they have been doing and push their agenda. The Hauora Maaori Advisory Committee and the Iwi-Maaori Partnership Boards are not enough to represent Maaori health needs. Certainly, there hasn't been any engagement with Auckland District Kidney Society or Taakihi Hauora Aotearoa.
11. My daughter works in the mental health space, as an External Learning Facilitator for the national suicide prevention trainings; Mana Akiaki: LifeKeepers for Maaori and LifeKeepers General. She trains communities, corporates and government organisations in suicide prevention and has for about 9 years. She told me that she has noticed a big shift since this government has taken over. Even though rangatahi mental health is one of the population priorities for the Hauora Māori Advisory Committee,<sup>2</sup> funding has been pulled from community services. Funding has clearly dropped across the board in the mental health space, and no one knows what is going on.
12. The first clinical priority for Iwi-Maaori Partnership Boards identifies that chronic kidney disease (along with cardiovascular disease and diabetes) contributes to a third of the years of life lost for Maaori.<sup>3</sup> Prior to the disestablishment of Te Aka Whai Ora there were talks about research and funding for Maaori renal healthcare. Since Te Aka Whai Ora has been disestablished, I am not aware of any specific provisions for renal healthcare for Maaori.

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<sup>2</sup> Manatuu Hauora, *Population Priorities for Maaori Health* dated 24 January 2025, accessed at <<https://www.health.govt.nz/about-us/new-zealands-health-system/health-system-roles-and-organisations/health-committees-and-boards/hauora-maori-advisory-committee/population-priorities-for-maori-health>>.

<sup>3</sup> J Whaanga, *Bundle of supporting documents to the brief of evidence of John Norman Whaanga* p 164 – 450 dated 24 April 2025, Wai 2575, #M34(c), at 171.

## **Research into Maaori Healthcare**

13. I know of some research for renal care for Maaori, that 'ASSET Kidney Research' ("ASSET") is trying to get off the ground. The research is into why there are bottle necks for Maaori to get transplants. Before Te Aka Whai Ora was disestablished, there was some talk of the researchers being able to go straight to Te Aka Whai Ora for funding. If Te Aka Whai Ora believed that the research was worthwhile, they could provide the funding directly which is what was in talks at that time.
14. Not long before they were disestablished, some data was presented to Te Aka Whai Ora which showed that the areas where it is hard to access dialysis or require a lot of travel to get dialysis are areas where there is a high population of Maaori. Unfortunately, before that funding was provided by Te Aka Whai Ora, it was disestablished. The only option now is to try to access research funding from the Health Research Committee ("HRC"). Yet, ASSET is struggling to access necessary research funding.
15. They keep getting knocked back for funding and not told why by HRC, but it has been implied that the issue precluding the access to research funding is the fact that the biostatisticians are based out of Sydney. This even though they are very good at what they do. Irrespective of the biostatistician's location, the data is collected from Aotearoa. There is another round of applications for funding coming up under HRC, so they are going to try again. The research would have been well under way if Te Aka Whai Ora had been around to provide the funding or if the government had created an entity that picked up and progressed the priorities that Te Aka Whai Ora had in place.
16. It doesn't seem to me as though monitoring renal health outcomes is a priority for Manatuu Hauora or Te Whatu Ora. Maaori get lost in monitoring and my view is that it's just not a concern for the government.

## **Alternative Models for Renal Healthcare**

17. When I last got dialysis in a clinical setting (2002) I was on the afternoon shift and already, I could see that things were starting to change and the pressure on resourcing was getting worse.

18. At that time, in the clinical setting, there used to be two shifts of six hours, and those people receiving dialysis would receive it over six hours. The impact on the body was less severe than it is now. Now, clinical dialysis is facilitated in three shifts of four hours. That is because there aren't enough dialysis chairs and by moving to high flux dialysis and reducing the shift from six hours to four, you can fit a whole extra shift of patients in. The use of high flux dialysis is incredibly hard on the body and leaves you with a hangover as you strip your body of fluid.
19. The decision to change from six hours to four makes dialysis harder and leaves the patients dealing with more side effects. Patients have limited flexibility and are restricted to strict shifts/ times with many needing to travel to a clinic (usually a hospital). After high flux dialysis few patients are able to go to work whereas when I was doing the slower 6-8 hr dialysis, I could come off it and be at work an hour later. Considering these factors, it is very hard to continue to work while on dialysis in a clinical setting.
20. At the Kidney Society we have developed an alternative model to dialysis that is much better for patients and allows for life to continue as much as possible. We provide dialysis in shifts of eight hours so that it is easier on the body. We are also flexible with times, meaning that we will make appointments at times that suit the patients. Our model is community based, so it is essentially set up in a house where patients can come to get their dialysis in a comfortable environment. The goal is for them to be able to move to having their dialysis at their home, but it isn't always possible. For example, a landlord may not want the machinery in the house. Our model can support people to go into a homelike environment to get their dialysis which is much more comfortable. We have called our model, the Kidney Society Community Haemodialysis House Model. A copy of this model is **attached** as exhibit "A".
21. Our model is also much more cost effective than a clinical setting. When building a dialysis unit, it costs around \$900k per chair for Te Whatu Ora, on their own land. Whereas for the Kidney Society, it is around a third of the cost, including purchasing the land to build the facility. So, it is more cost effective and for those that end up in community-based dialysis, they prefer it to clinical settings. I have certainly seen better outcomes for community-based dialysis over clinical settings.

22. Our focus is needs-based. We want to set up community-based homes for dialysis where we see a real deprivation with access to dialysis. Our community dialysis is not targeted specifically at Maaori, but invariably where there is high need, the population is Maaori. We see real issues with getting to dialysis in rural areas, especially in Te Tai Tokerau and Tairaawhiti. Under the previous government, there was talk around renal care specifically for Maaori but now, that just isn't a part of the conversation. In March 2025, our Chief Executive Officer, Kath Eastwood wrote to the Hon. Simeon Brown, the Minister of Health seeking an opportunity to discuss addressing the challenge of accessing dialysis, and the Kidney Society community-based dialysis model. A copy of this letter is **attached** as exhibit "**B**".
23. The funding team at Te Whatu Ora is the roadblock to us being able to build these community dialysis units. We have the plans, and we have clinicians in support who are able and willing to work in the community dialysis units. The only issue is funding.
24. We are now having to look at public/ private partnerships ("**PPPs**") as it is the only way that we will be able to get the care out in the community. Partnering with private developers isn't the ideal option but with the lack of funding for Maaori renal care, we are going to have to. Even though with PPPs obviously incur some additional costs, it is still cheaper than Te Whatu Ora because Te Whatu Ora has so many additional regulations to meet so it drives their costs up.
25. We went all the way down the line for a development with ADHB a few years ago. At the last moment because interest rates came down, they were able to do the development on their own and pulled out of working with us. That project is called the 'Kereru Renal Unit' and is a clinical setting, although not in a hospital.
26. I also know that Whangaarei Hospital asked us to set up a community dialysis home in Whangaarei. Again, we had talks with them and but it didn't proceed any further. I think that that was a funding issue.
27. We run three successful dialysis homes in South Auckland, but we would like to roll it out across the country into areas that really need it but we are

constantly faced with the fact that funding is the roadblock. The first community-based dialysis home in South Auckland was set up around twenty years ago, and the most recent was around eight or nine years ago.

### **Other Issues in the Renal Space**

28. Maaori are much more likely than non-Maaori to suffer from renal crisis and equally have difficulty accessing dialysis and transplants.
29. I have several ideas that would help improve outcomes for Maaori in this space, which I have learnt from personal experience. In Aotearoa New Zealand, we lag far behind in OECD for organ donations. Increasing both live and organ donation after death will help to mitigate the deficits in renal donations. In addition, increasing tikanga processes within the renal space, and within general health practice where clinicians care about whakawhanaungatanga and find a way to relate to patients would go a long way. Being able to advocate for yourself and having health literacy is also a key component to successful health outcomes, and I believe that is part of the reason why I have had the outcomes that I have.
30. I don't see how the government's alternative plans to Te Aka Whai Ora will assist with improving health outcomes for Maaori. It is my belief that the work that we are doing in the Maaori renal space isn't solely good for Maaori, but it would benefit all renal patients across Aotearoa New Zealand. It is concerning that the government is ignoring these efforts and is failing to provide the much-needed funding and support we need.

**DATED at ORAAKEI this 19<sup>th</sup> day of Mei 2025**



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**John Kearns**