BEFORE THE WAITANGI TRIBUNAL **WAI 3565**
TE ROOPU WHAKAMANA I TE TIRITI O WAITANGI **WAI 2499**

IN THE MATTER OF the Treaty of Waitangi Act 1975

AND

IN THE MATTER OF Te Tinihanga o Ngā Mātāpono o te Tiriti – the Treaty Principles Reform Urgent Inquiry

AND

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

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BRIEF OF EVIDENCE OF ASSOCIATE PROFESSOR BRIDGET ROBSON

18 MAY 2026

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Waitangi Tribunal
18 May 26
Ministry of Justice
WELLINGTON

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E TE KAIWHAKAWĀ, TĒNĀ KOE.

I, Associate Professor Bridget Robson, of Wellington say:

INTRODUCTION

1. My full name is Bridget Helen Robson. I am the Director of Te Rōpū Rangahau Hauora a Eru Pōmare, the Māori health research centre established by the late Professor Eru Pōmare in the early 1990s to develop health research by Māori, for Māori, and to provide an environment where Māori can be trained in a variety of research techniques. The Rōpū is based at Ōtākou Whakaihu Waka, Pōneke, in the Department of Public Health. We also train undergraduate medical students in Hauora Māori in their clinical years.

2. My background is in Māori public health research and kaupapa Māori epidemiology. I have a BA in Māori studies and a postgraduate diploma in Public Health. I have over 30 years of experience in Māori health research (since 1992).

3. I am an associate member of Te Ohu Rata o Aotearoa (**Te ORA**), the Māori Medical Practitioners Association.

4. In Māori health research, my focus is on:

   (a) Achieving health equity for Māori, using kaupapa Māori research methods. Key areas of focus include kaupapa Māori epidemiology; monitoring Māori health, health equity and inequities, the social determinants of health, and underlying drivers of inequity.

   (b) Areas of research include cancer, breast screening, unequal treatment in health care, housing, oral health, tobacco use, reintegration after incarceration, international Indigenous health, the impact of racism on Māori health, impact of unemployment on health, ethnicity data quality.

CHANGES TO TE TIRITI PROVISIONS PROPOSED BY CABINET

5. My evidence focuses on the following proposals as agreed by Cabinet to repeal or amend Te Tiriti o Waitangi / Treaty of Waitangi ("**Te Tiriti**") provisions in legislation ("**Reforms**"), that relate to my area of expertise:

(a) repeal section 3AB in the Smokefree Environments and Regulated Products Act 1990 (**SERPA**), which requires the Minister to consider the risks and benefits to Māori before preparing regulations relating to requirements for smoked tobacco products; and

(b) make more specific and change the statutory directive from "give effect" to "take into account" in sections 3(e), 4 and 14 of the Data and Statistics Act 2022.

Effect of the proposed Reforms

Repeal of s 3AB in SERPA, which requires the Minister to consider the risks and benefits to Māori before preparing regulations relating to requirements for smoked tobacco products

6. The current coalition government's previous repeal of the tobacco endgame measures in the SERPA 2023 was widely opposed by Māori, who understood the positive impacts on health that achieving a smokefree generation would bring. Current inequities in smoking and nicotine product use are significant.[1] Weakening the Te Tiriti provision risks prioritising a 'total population' approach to smokefree policy, leading to widening inequity between Māori and non-Māori, and breaching the Tiriti principle of Oritetanga or Equity.

7. This, in conjunction with weakening Te Tiriti sections in the Data and Statistics Act 2022, potentially prejudices the ability of Māori to obtain high quality data to measure the impact of government policy on Māori smoking and use of nicotine products, and the attendant health consequences, and thus impacts the ability of iwi, hapū, Māori communities and Māori services to design and deliver effective smokefree and nicotine addiction programmes and interventions, impacting the Tiriti principle of Options.

[1] Nip J, Edwards R, Hoek J, Waa A, Teddy L. Smoking prevalence and trends: Important findings from the 2024-25 New Zealand Health Survey. Public Health Expert Briefing. 2025 Nov 26. https://www.phcc.org.nz/briefing/smoking-prevalence-and-trends-important-findings-2024-25-new-zealand-health-survey.

Amendments to sections 3(e), 4 and 14 of the Data and Statistics Act, which requires decision-makers and the Statistician to "give effect" to Tiriti principles

8. High quality data on the Māori population, includes ethnicity measured consistently between datasets (to avoid numerator- denominator bias) and with continuity over time over time (to ensure trends over time are visible)[2][3] and of sufficient depth and breadth for Māori (to achieve equal explanatory power).

9. High quality data are vital for both Māori and the Crown to be able to assess and monitor the effectiveness of planning, access to and quality of health services, aiming at achieving equitable health outcomes for Māori. It is critical for Māori to understand our own health needs and those of others to be able plan accordingly, including by district[4], region, rurality, age group, standard of living and housing, and other variables of importance to Māori, such as iwi affiliation, reo, and other cultural measures.[5] Such information is also required for the Crown to be able to fulfil the Treaty principle of good governance.

10. Section 3 (e) should continue to specify the obligation to give full effect to the principles of Te Tiriti o Waitangi. Amending the Treaty clauses in sections 3e, 4, and 14 to be no higher than 'take into account" diminishes the Crown's Te Tiriti obligations to ensure Māori rights to data by which to monitor Crown actions and inactions that affect health, a taonga whose protection is guaranteed in Article Two of te Tiriti.[6][7]

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[2] Te Rōpū Rangahau Hauora a Eru Pōmare. Counting for nothing: understanding the issues in monitoring disparities in health. Issue 14 July 2000 Social Policy Journal of New Zealand te Puna Whakaaro.

[3] Harris R, Paine SJ, Atkinson J, Robson B, King PT, Randle J, Mizdrak A, McLeod M. We still don't count: the under-counting and under-representation of Māori in health and disability sector data. NZ Med J. 2022 Dec 16;135(1567):54-78.

[4] For example Capital and Coast District Health Board Upoko ki te Uru Hauora Māori Health Profile 2015. Te Rōpū Rangahau Hauora a Eru Pōmare, www.otago.ac.nz/MHP2015.

[5] Te Rōpū Rangahau Hauora a Eru Pōmare (2002). Mana Whakamārama – Equal Explanatory Power: Māori and Non-Māori Sample Size in National Health Surveys. Wellington: Public Health Intelligence, Ministry of Health.

[6] Reid P, Robson B. (2007). Understanding health inequities. In B. Robson and R. Harris (eds), Hauora: Māori Standards of Health IV. A Study of the Years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, pp3-10.

[7] Paine S-J, Cormack D, Reid P, Harris R, Robson B. (2021) Kaupapa Māori-informed approaches to support data rights and self-determination. In indigenous data sovereignty.

Prejudice

The compounding prejudice that arises from removing protections for Māori health and the ability to understand Māori health data for the Crown to effectively respond to Māori health inequities and disparities

11. The prospect of repeal or amendment of s 14 (Duties of Statistician relating to Te Tiriti o Waitangi/Treaty of Waitangi) and the flow on effect of this on the other provisions of this Act relating to the duties and functions of the Statistician (ss 15, 17, 19, 35, 91, and part 5) is alarming. It may lead to a reduced or weakened requirement of the Statistician and Statistics NZ to engage with Māori, including when preparing a draft multi-year data and statistical programme (s 19), or in determining approaches to the Census (s 35), or when setting a standard (s 91), or when authorising access to data for research. It could reduce the requirement to build and maintain Te Tiriti o Waitangi capability and capacity within Statistics NZ, and/or to foster the capability and capability of Māori to collect, use, access and use data and to engage with the Statistician.

12. Any de-prioritisation of Māori data would have a material impact on the health sector, including Māori research groups such as Te Rōpū Rangahau Hauora a Eru Pōmare, Māori workforce organisations such as Te ORA, and other health agencies who require high quality data to plan for and evaluate health strategies, services, and interventions. It would impact on the effective functioning of Iwi Māori Partnership Boards, Māori health and wellbeing service providers, Whānau Ora commissioners and providers, as well as the Ministry of Health and Te Whatu Ora.

13. In addition, any reduction in the statistical tools for monitoring the Crown's actions and inactions related to Māori health inequities (such as removing the full-field Census and post-Censal surveys), and for monitoring our own health needs, prejudices our ability to plan, provide services, and advocate for our own and for other communities. given our duty as tangata whenua to "ensure the wellbeing of all people in our territories, Māori and tauiwi."[8] Data

and policy. In Eds Walter M, Kukutai T, Russo Carroll S, Rodriguez-Lonebear D. Routledge, pp 187-203.

[8] Reid P, Robson B. (2007). Understanding health inequities. In B. Robson and R. Harris (eds), Hauora: Māori Standards o Health IV. A Study of the Years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare. pp3-10.

of the depth and breadth to sufficiently support Māori data needs are critical to support the development of local solutions to health problems and to support a more nuanced response to national policy changes or events. Any diminishment of these important planks of good governance breaches the principles of active protection, equity, and options.

14. High quality data, including accurate ethnicity data, underpins our ability to monitor health equity, examine trends over time, understand who is being most affected, and whether we are heading in the right direction for Māori health equity. If the legislative requirement to give effect to the principles of te Tiriti is weakened, disaggregated data becomes discretionary, which impacts the ability to respond appropriately. Māori health inequities become harder to see, hard to prove, and harder to act on.

15. Māori data governance consistent with Te Tiriti o Waitangi and principles of Māori Data Sovereignty are not reflected in these proposals. Māori must be part of developing and deciding on methods, validating data, and approving use. If anything, what is still required is a strengthening of the Tiriti clause to oblige the Crown to ensure this happens. A Statutory Māori data governance board with equal partnership in Census design, administrative data inclusion, survey design and analysis, and access protocols should be established to uphold the rights of Māori to count what is important to Māori, and to be visible within national statistics.

Te Tiriti adequacy of opportunities for Māori to influence the proposed reforms

16. The Hikoi against the Treaty Principles Bill in 2024 showed that the will of the people, both Māori and tauiwi, was strongly against the Bill. Good governance responds to the will of the people, and the obligations of Te Tiriti. Implementing these amendments against the expressed wishes of Māori, iwi, hapū and communities, breaches the principle of good governance, and acting reasonably and in good faith. Select Committee submissions by Māori (and Tauiwi) have often been ignored by this government. It should not require an urgent Waitangi Tribunal hearing to have an opportunity for Māori to influence the proposed reforms. Full and ongoing engagement is essential.

Associate Professor Bridget Robson