**IN THE WAITANGI TRIBUNAL** **WAI 2575**

**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 Tuta Ngarimu regarding Tairāwhiti DHB funding and the Crown failure to address, design and implement a suicide prevention strategy that works for Maori.

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**STATEMENT OF CLAIM**
**DATED 6 OCTOBER 2017**

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**MAY IT PLEASE THE TRIBUNAL**

**Claimants**

1. The claimant is Tuta Ngarimu of Ngati Porou ("the claimants").

**The Claim**

2. There are two main aspects to this claim. The first issue concerns the Tairāwhiti District Health Board ("TDHB") and the allocation of funding to the TDHB and the impact this has on the provision of healthcare for Māori living in the district.

3. The second aspect concerns the lack of culturally appropriate and Treaty compliant services for those suffering from mental health issues.

4. Funding provided by the Ministry of Health to District Health Boards is based on population rather than actual need.

5. As per the 2006 census the Tairāwhiti region has a population of 44,499.

6. Of this population a total of 44% are Māori.

7. Tairāwhiti has the highest level of deprivation than any other district, with two thirds of the population (65%) living in Decile 8-10. This trend is further exacerbated when split by ethnicity, with 77% of Māori in Tairāwhiti living within Deciles 8-10, and 78% of Māori children under 10 living in Deciles 8-10. This remains the most important determinant of health for Tairāwhiti and its continuing inequity poses the biggest challenge in improving health and reducing inequality.[1]

8. As a result of the population make-up, Tairāwhiti has the worst health burden nationally. Tairāwhiti has the highest rates of overall avoidable mortality and morbidity, and high rates of ambulatory sensitive hospitalisations. Access to some health services are the poorest nationally.[2]

[1] http://www.tdh.org.nz/about-us/tairawhiti-our-region/.
[2] Above n 1.

9. The principal iwi serviced by the TDHB are Ngai Tamanuhiri, Rongo Whakaata, Te Aitanga-a-Mahaki and Ngati Porou.

**The Treaty of Waitangi Act 1975**

10. The claimant says that this claim falls within section 6(1) of the Treaty of Waitangi Act 1975 namely:

    a. That he 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.

11. The claimant brings this claim on behalf of those Māori living with and suffering from mental health issues in the East Coast.

**PART A: Funding**

**Duty**

12. The Crown has the duty to actively protect the wellbeing of Māori.

13. The Crown has the duty to provide adequate and sufficient healthcare funding in order to address, enable and provide for Māori healthcare needs.

14. The Crown has the duty to minimise Māori health disparities.

**Breach**

15. Rather than provide funding based on need the Crown provides funding to DHB's based primarily on population thereby failing to prioritise the wellbeing of Tairāwhiti Māori.

16. The Crown has failed to adequately address and provide for the actual healthcare needs of Tairāwhiti Māori.

17. Tairāwhiti Māori continue to suffer from disproportionate health disparities.

**Particulars**

18. The Population Based Funding Formula ("PBFF") is a technical tool that is used every year to distribute the bulk of the DHB funding share of Vote Health between New Zealand's 20 DHB. The PBFF does not determine the total amount to be distributed as this is determined by the Budget process. In 2015/16 the PBFF distributed a total amount of $11.4 billion among the DHBs.[3]

19. The PBFF has been used to allocate funding to DHBs since 2003/04. It was last updated in 2007/08 with the results coming into effect in the 2009/10 financial year. Census 2013 is the basis of the current PBFF review which will come into effect in 2016/17.[4]

20. The PBFF covers the devolved health services that DHBs fund. It covers primary care, hospital and community care services, health of older people and mental health. It does not cover younger Disability Support Services and Public Health.[5]

21. The PBFF does not:

    a. require Boards to expend a specific amount in any service area
    b. compensate for additional costs of providing inter-regional/tertiary services, or
    c. set service level expectations ie, require average intervention rates.[6]

**The Core Model**

22. The PBFF comprises two parts:
    a) the core model that determines relative health need; and
    b) the adjusters that modify the funding allocations between DHBs that take into account, unmet need, rurality and overseas visitors and refugees.[7]

[3] Review of the Population Based Funding Formula 2015-Office of the Minister of Health Cabinet Business Committee. Pg 1. (http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards/accountability-and-funding/population-based-funding-formula).
[4] Above n 3.
[5] Above n 3 at 2.
[6] Above n 5.
[7] Above n 5.

23. The most important factor in the core model is the number of people in each DHB.[8]

24. In addition to the number of people, the PBFF share is adjusted for the demographic profile (age, socio-economic status (currently NZDep06), ethnicity (Māori, Pacific or Other), and sex).[9]

25. The PBFF cost weights in the core model (cost of providing health care services) are then applied to each DHB population grouping, which gives the estimated PBFF share the DHB needs to provide for the range of healthcare services to its local population.[10]

**The Adjusters**

26. In addition to the demographic variables the model also includes three adjustments to the costs of providing health services: in rural areas, for non-resident populations and a policy adjustment for the unmet health needs of populations with poor health status.[11]

27. The Unmet need is a policy based adjustment to target funding at population groups with access issues to health services. The current target groups are Māori, Pacific people and those living in areas of high deprivation.[12]

28. The Rural adjuster compensates DHBs for having to provide services in more rural areas. The current adjuster is designed to top up funding based on diseconomies of scale for smaller facilities, community services, inter-hospital transfers, travel & accommodation costs.[13]

29. The Overseas eligible and refugees adjuster adjusts for unavoidable costs of providing services to eligible overseas visitors and is derived from recent costs. It includes an allowance to meet the high health costs of new refugees to New Zealand (NZ)[14].

[8] Above n 5.
[9] Above n 5.
[10] Above n 5.
[11] Above n 5
[12] Above n 5.
[13] Above n 5.
[14] Above n 5.

30. It also includes cover for NZ citizens domiciled overseas who return to NZ for treatment, and patients for whom there is a reciprocal arrangement (United Kingdom and Australia and some Pacific Islands).[15]

**Figures**

31. In the 2015/2016 year the TDHB received the third lowest DHB funding package.[16]

32. In the 2013/2014 year approximately 10.8 billion was provided for core variables.[17]

33. In the 2013/2014 year approximately 165 million was provided for the unmet need.[18]

34. In the 2013/2014 year approximately 169 million was provided for rural adjusters.[19]

35. In the 2013/2014 year approximately 30.4 million was provided for the Overseas eligible and refugee adjuster.[20]

**Prejudice**

36. Māori living in areas which have a small population are instantly prejudiced by the PBFF tool.

37. Whilst there are adjusters these adjusters are subsidiary to the primary factor that is population.

38. The Crown is failing to effectively address and improve Tairāwhiti Māori health disparities as it fails to distribute funding based on Māori need.

39. The Crown is failing to provide sufficient funding to the TDHB to enable and equip the TDHB to prioritise health issues and disparities facing Tairāwhiti Māori.

[15] Above n 5.
[16] Above n 3 at 56.
[17] Above n 3 at 13.
[18] Above n 17.
[19] Above n 17.
[20] Above n 17.

40. Tairāwhiti Māori continue to have the highest level of deprivation than any other district.[21]

41. Tairāwhiti has the highest rates of overall avoidable mortality and morbidity, and high rates of ambulatory sensitive hospitalisations.[22]

## Part B: The Crown failure to implement suicide prevention strategies that work for Maori

### Duty

42. The Crown has a duty to adequately address the youth suicide epidemic among Māori.

### Breach

43. The Crown is failing to adequately address the Māori youth suicide epidemic in New Zealand: the statistics show that youth suicide has decreased for non-Maori but have increased for Maori.

### Particulars

44. 129 Māori committed suicide last year[23] and Māori deaths from suicide accounted for 21.57 percent of all suicide deaths in New Zealand that year. The age-standardised rate of Māori suicide deaths in 2012 was 17.6 per 100,000 Māori population, compared with 10.6 per 100,000 non-Māori population[24]. In recent years suicide death rates have generally declined for non-Māori but there is no obvious trend for Māori[25]. This means that:

    a. Māori are over represented in respect of suicide;
    b. What the Crown is doing to address suicide is working for non-Māori, but it's not working for Māori; and

[21] Above n 1.
[22] Above n 1.
[23] http://www.stuff.co.nz/national/health/85449334/nz-suicide-toll--unacceptably-high
[24] http://socialreport.msd.govt.nz/health/suicide.html
[25] Above n 24.

c. In recent years matters have worsened for Māori.

45. The age-specific suicide death rate for Māori youth (15–24 years) in 2012 was 48.0 per 100,000 Māori youth population, compared with the non-Māori youth rate of 16.9 per 100,000[26]. That means the Māori youth suicide rate was **three times** higher than non-Māori.[27] This is unacceptable.

46. This claim then concerns the disproportionate over representation of Māori suicide, particularly youth suicide, and the Crown's failure to remedy the same. Crucial to this claim is the core allegation that the Crown was advised what it should do to address the over representation of Māori suicide but ignored that advice and instead implemented its own suicide strategy – and it has not worked. Further, this claim alleges that in respect of suicide the Crown placed its own political agenda before the best health outcomes for Māori.

47. The Crown has failed to design and implement a system adequate enough to address the disproportionate over representation of Māori suicide in particular Māori youth suicide.

48. This Crown failing includes but is not limited to:

a) Failing to implement recommendations from Māori about how best to address, design and implement a system to address Māori youth suicide.

b) Only relatively recently putting funding into Māori suicide prevention with a plan of action led by Te Rau Matatini.

c) Failing to acknowledge the underlying reasons for Māori youth suicide.

d) Failure to acknowledge the role of Self-determination, Māori knowledge, worldviews, Te Reo and Tikanga in the design of suicide prevention programmes.

[26] Above n 24.
[27] Above n 24.

e) Failure to encourage a comprehensive application of whakapapa in the design of suicide prevention programmes, including the failure to provide for the restoration of a whakapapa process of reconnecting youth into their whānau, hapū and iwi.

f) Failure to provide a social and cultural development programme grounded in history and identity construct of whakapapa in suicide prevention programming.

g) Under resourcing those placed to carry out suicide prevention programmes, including a lack of strategic direction and professional training.

h) Failure to provide a suicide prevention programme that makes reference to the extensive evidence and research about the role of multigenerational, intergeneration trauma in suicide outcomes and the manufacture of health disparities, rates of diagnosed mental illness etc. in Māori.

**Prejudice**

49. As a result of the Crown breaches alleged in this claim, the claimants and Tairāwhiti Māori have suffered. That suffering includes:

a. Poor mental and physical health and all that it entails.
b. Inadequate resources to address their health care needs.
c. Death.
d. Loss of wairua.
e. Suffering.

**Findings and Recommendations**

50. The claimants welcome a finding that this claim is well-founded.

51. The claimants seek the following findings and recommendations:

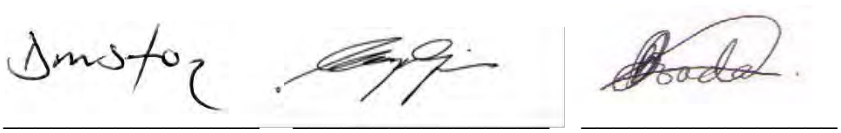
a. That the Crown has failed Tairāwhiti Māori in respect of providing sufficient and adequate healthcare funding that prioritises the health needs of Tairāwhiti Māori.

b. A complete change of the PBFF funding process provided to DHB's in New Zealand so that population is not the primary consideration but is rather subsidiary to the real needs of Māori and the rest of the population.

c. Any specific findings the Tribunal considers to be appropriate.

d. That the Crown in conjunction with Maori design and implement a suicide strategy that works for Maori.

**DATED** at Auckland this 6 October 2017.



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