Te Rūnanga o NGĀI TAHU

TE TAURAKI
Kia maiea te kupu tauraki

Te Rūnanga o Ngāi Tahu and Te Tauraki joint response to the proposal to change special authority access criteria for type 2 diabetes medicines

Submitted by
Te Tauraki and Te Rūnanga o Ngāi Tahu

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Submission to
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1. Position summary

Te Rūnanga o Ngāi Tahu (**Te Rūnanga**) and Te Tauraki Limited (**Te Tauraki**) strongly oppose the proposed removal of the Māori and Pacific ethnicity pathway from the Special Authority access criteria for empagliflozin, liraglutide, and dulaglutide. This pathway is saving lives. Pharmac has produced no evidence that removing it will not cost them.

We are appalled that a 14-day consultation window was considered adequate for a decision of this consequence, We acknowledge that another 14 days were added just prior to the deadline, but we had already rushed to get our response prepared. Māori already die seven years earlier than non-Māori. Decisions that will widen that gap, such as the one you have proposed, demand more than four weeks of public input. The brevity of this process is not a procedural oversight. It is a signal of how Māori lives are being weighted in this decision.

We respond with urgency.

2. Who are we

Ngāi Tahu holds and exercises rangatiratanga within the Ngāi Tahu Takiwā (Takiwā) and has done so since before the arrival of the Crown. The Ngāi Tahu Takiwā covers most of Te Waipounamu and its surrounding islands. The Crown has recognised and affirmed the enduring nature of Ngāi Tahu rangatiratanga through:

a. Article II of Te Tiriti o Waitangi (Te Tiriti);
b. the 1997 Deed of Settlement (Deed of Settlement); and
c. the Ngai Tahu Claims Settlement Act 1998.

Te Rūnanga is the statutorily recognised representative body of Ngāi Tahu Whānui and encompasses 18 Papatipu Rūnanga who uphold mana whenua and mana moana in their respective rohe.

Te Tauraki is a wholly owned and established subsidiary of Te Rūnanga with a mandate to advance Ngāi Tahu health and wellbeing aspirations. Te Tauraki operates as both a Whānau Ora commissioning agency and Iwi Māori Partnership Board (IMPB), providing a significant statutory conduit for Māori voice and accountability in the health system. The vision of Te Tauraki is: Whānau Māori living healthy lives. This is a commitment grounded in the values of Ngāi Tahu rangatiratanga and intergenerational responsibility.

We make this submission from that position of authority and responsibility.

3. Our position

We strongly oppose the proposed removal of the Māori and Pacific ethnicity pathway from the Special Authority access criteria for empagliflozin, liraglutide, and dulaglutide.

The proposal to lower the five-year cardiovascular risk threshold from 15 percent to 10 percent is not a substitute for the ethnicity pathway. These two mechanisms address fundamentally different barriers. Both are needed but removing one to introduce the other is not widening access. It is a trade. And it will be Māori and Pacific people who pay the price.

Pharmac has framed this proposal as a move toward clinical needs-based criteria. We reject the premise that the current pathway is not needs-based. The ethnicity criterion exists precisely because Māori and Pacific peoples experience documented and measurably higher clinical need for these medicines and face documented structural barriers to accessing them through the standard pathway. Needs-based access must account for both clinical condition and the realities of how the system operates – differently, and worse – for Māori and Pacific peoples.

4. Why these medicines matter for Māori and Pacific

SGLT2 inhibitors and GLP-1 receptor agonists actively protect the heart and kidneys in ways that metformin does not. This distinction is at the clinical core of why the ethnicity pathway exists and why its removal has life-altering consequences.

The burden of type 2 diabetes for Māori is severe and measurable:

- Māori experience 1.96 times higher all-cause mortality and 1.93 times higher cardiovascular mortality from type 2 diabetes compared to non-Māori [1,2]
- For Māori men aged 0-19 with type 1 diabetes, the loss of remaining life expectancy is 17.1 years [1,2]
- Māori are around twice as likely to live with diabetes compared to non-Māori, and develop it approximately a decade earlier [1,2]
- 13.3 percent of end-stage renal disease and 14.3 percent of premature mortality among Māori is attributable to ethnicity beyond deprivation – the unmistakable fingerprint of structural racism [2]

For Māori and Pacific patients who already carry this burden of cardiovascular and renal disease, being prescribed metformin rather than SGLT2 inhibitors or GLP-1 receptor agonists is about the difference between organ protection and organ failure; between dialysis and a functioning kidney; between a heart attack and a grandparent who lives to see their mokopuna grow.

The proposal to remove the ethnicity pathway means that Māori and Pacific patients go back to starting on metformin, a medicine doctors are demonstrably less likely to prescribe equitably to Māori and Pacific communities, while other New Zealanders progress to better organ protection. That is a policy guarantee that the health gap will not close.

5. The access gap is structural. The ethnicity pathway corrects for it

A core argument for this proposal is that “ethnicity shouldn't decide what funded options you can access.” This is a moot point. The ethnicity pathway does not exist because of ethnicity. It exists because of a system that has consistently failed Māori and Pacific patients at every stage of the care pathway, from delayed diagnosis to fewer prescriptions, and racism in clinical settings to the financial cost of accessing a General Practitioner (GP).

As Pharmac and the wider government should know, the system treats Māori worse at every step – longer waits, shorter appointments, fewer prescriptions, fewer referrals. Equal treatment does not preserve inequality but goes a step further, worsening perverse outcomes for Māori over time.

The proposed alternative – a lower cardiovascular risk threshold – requires patients to first have their cardiovascular risk formally assessed and recorded. Large-scale analysis of clinical records spanning 2018-23[3] show that Māori are significantly less likely to have completed cardiovascular disease risk assessment than non-Māori. Cost is a direct barrier: 22 percent of Māori report cost barriers to seeing a GP, and 14 percent report cost barriers to collecting a prescription, compared with 13 percent and 5 percent respectively for non-Māori.

A patient whose cardiovascular risk has not been assessed cannot access a risk-threshold pathway, regardless of their actual clinical risk. The ethnicity pathway bypasses this structural dependency. Removing it does not make the system more equitable. It relocates the barrier to an earlier and less visible point in the care pathway, where Māori and Pacific patients are most likely to fall through.

Research has further demonstrated that the ethnicity pathway was working. In the first one to three years following its introduction, more than 50 percent of Māori and Pacific people with type 2 diabetes accessed empagliflozin, liraglutide or dulaglutide. That’s compared with 30-40 percent of people of Asian and European ethnicity. In the six months following funding, 47 percent of approved Special Authority applications used the ethnicity pathway. This is clear-cut evidence that the pathway was doing exactly what it was designed to do.

Removing something that is working, without evidence that an equivalent outcome will result from its replacement is regressive.

6. This does not stand alone – the cumulative policy context

Te Tauraki and Te Rūnanga are deeply concerned that this proposal, as damaging as it is, sits as part of a wider, systemic policy movement that is progressively dismantling structural supports for Māori health equity:

- The disestablishment of Te Aka Whai Ora removed the only national structure in which Māori health decisions were made by Māori, for Māori
- The repeal of the Smokefree generation policy reversed a measure modelled to reduce the Māori/non-Māori mortality gap for older women by 23.4 percent by 2040
- No-cause evictions reintroduced through the Residential Tenancies Amendment Act 2024 destabilise whānau in overcrowded housing, impairing management of chronic conditions
- Signals to scrap mandatory cultural safety training for health professionals would further erode the quality-of-care Māori receive in clinical settings
- And now: the proposed removal of the only ethnicity-based equity criterion Pharmac has ever introduced

Each of these decisions is presented as independent. Collectively, they constitute a health strategy by negation, via the steady dismantling of the structural protections that determine who, in Aotearoa, gets to live a healthy life and who does not.

7. Te Tiriti o Waitangi obligations

The Crown has obligations under Te Tiriti o Waitangi to actively protect Māori health and tino rangatiratanga. These obligations are binding. They have been affirmed repeatedly by the Waitangi Tribunal, including through the Wai 2575 Health Services and Outcomes Kaupapa Inquiry, which found systemic Crown failures in Māori health access.

The ethnicity criterion for these diabetes medicines was Pharmac's first-ever ethnicity-based criterion. It was introduced in 2021 with explicit acknowledgement that Māori and Pacific peoples faced documented, systemic inequities in access. Removing it without demonstrated evidence that an equivalent outcome will be achieved is a breach of the Crown's active protection obligations under Te Tiriti.

The Waitangi Tribunal's Wai 2919 has specifically documented prescription inequity within the New Zealand health system, including under-access to diabetes, cardiovascular, and renal medicines for Māori. The "missing million prescriptions" [4] analysis makes the scale of this structural failure impossible to ignore.

Pharmac has a legal and moral obligation to demonstrate how Māori health outcomes will improve if this criterion is removed. That demonstration has not been provided.

8. Recommendations

Te Tauraki and Te Rūnanga urge Pharmac to:

- Retain the Māori and Pacific ethnicity pathway within the Special Authority criteria for empagliflozin, empagliflozin with metformin, dulaglutide, and liraglutide
- Proceed with lowering the cardiovascular risk eligibility threshold from 15 percent to 10 percent as an additional, not replacement, access pathway

- Publish a formal Treaty analysis of the proposed criteria change before any final decision is made
- Commission and publish ongoing ethnicity-disaggregated prescribing monitoring, with a commitment to act if access gains for Māori and Pacific peoples are not maintained
- Undertake a formal equity impact assessment before removing any targeted equity provisions
- Engage directly and meaningfully with IMPBs, Māori clinicians, and Māori health providers before finalising any changes
- Model and consult on universal HbA1c-based eligibility at 53 mmol/mol as a genuinely needs-based pathway that would ensure no patient who would benefit is excluded.

9. Closing.

The vision of Te Tauraki is whānau Māori living healthy lives. This response is made in service of that vision and from the authority of a people, who have exercised rangatiratanga in Te Waipounamu since long before the Crown arrived.

We are not asking Pharmac to do something novel or untested. We are asking it to retain something that is working, that is evidence-based, and that has already delivered measurable gains for Māori and Pacific patients, who have waited long enough for a health system that treats them as though their lives matter equally.

The case for retention is clinical. It is epidemiological. It is legal. And it is moral.

Pharmac introduced this criterion in 2021 in explicit acknowledgement of documented, systemic inequity. Removing it now, without equivalent evidence of equivalent outcomes, is not a refinement of policy. It is a reversal of accountability. It tells Māori and Pacific communities that the Crown will acknowledge inequity when it is politically convenient and walk that acknowledgement back when it is not.

The Waitangi Tribunal has found systemic Crown failures in Māori health access. The “missing million prescriptions” is not a metaphor. These are real people with real organ failure, facing real deaths that policy could prevent.

We expect Pharmac to honour its own equity framework, the Crown’s obligations under Te Tiriti, and the people who depend on both. Retain the pathway. Extend the threshold. Do not make Māori and Pacific patients pay for a system that was already failing them.

Nāku noa, nā

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