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Race Relations Conciliator

New Zealand Public Health & Disability Bill

Submission to the Health Select Committee

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This submission is made by the Race Relations Conciliator. The Conciliator has responsibility for administering the race grounds of the Human Rights Act 1993 ('the Act').

The Act consists of two Parts. Although the individual complaints based jurisdiction in Part II is the most well known, Part I is equally significant. Part I establishes the Human Rights Commission and the Race Relations Office and outlines a number of their functions, including advisory, reporting and public relations roles. Under section 5(1)(h)(iii) the Conciliator is required to consider the implications of any proposed legislation that may affect human rights in relation to race, colour, ethnicity or country of origin.

Part I refers to the international agreements as a way of gauging New Zealand's performance in human rights matters. The principle instruments, such as the *Covenant on Civil and Political Rights* and the *Covenant on Economic Cultural and Social Rights*, apply equally to all people but several others have particular significance for race and ethnicity. While the most important of these is the *Convention on the Elimination of All Forms of Racial Discrimination*, the reports of the *Sub-Commission on the Prevention of Discrimination and Protection of Minorities* and its off-shoot, the *Working Group on Indigenous Populations*, are also relevant and establish standards with which Government policy can be compared.

Reference to the Treaty of Waitangi

The Conciliator is aware of the anxiety in the community relating to the Treaty of Waitangi and is concerned about the resulting implications for race relations in New Zealand. Much of the apprehension would, he believes, be alleviated if, rather than wide ranging, general legislative provisions, the government's intention was spelt out in greater detail identifying more precisely what it wishes to achieve. New Zealanders are not unreasonable people. Most appreciate the need to address the health needs of certain groups, as well as acknowledging the importance of providing health services in a culturally sensitive manner. But, equally, if the reason for introducing certain measures is not clear, they are likely to feel aggrieved and view provisions which appear to advantage one group over another as inequitable and unfair.

The Bill contains a number of clauses which refer specifically to the Treaty and Maori, including the requirement that the legislation is interpreted in a manner consistent with the principles of the Treaty of Waitangi (clause 4) and that it "recognises and respects" the principles in the provision of (available) funding for health and disability services for New Zealanders (clause 3). The Conciliator is of the view that clause 4 in its present form is likely to exacerbate the negative attitude currently being conveyed to him.

The Conciliator believes that including clause 4 in the legislation would be inappropriate for the following reasons.

i. It would contravene the standards set out in the international instruments;

ii. The human rights (and Bill of Rights) implications have not been fully considered;

iii. There is no reason to believe that the principles would not be read into the legislation; and

iv. It is inappropriate to include a provision in this form in social policy legislation which could be seen as privileging one race over another.

· International background

While the experience of the office suggests that the reference to the Treaty is likely to be divisive and have repercussions for race relations domestically, its inclusion also has implications for New Zealand's international commitments.

The right not to be discriminated against by reason of one's race is enshrined in all the major international instruments beginning with the *United Nations Declaration of Human Rights*[1]. The most significant is the *Convention on the Elimination of All Forms of Racial Discrimination.* The Race Relations Act 1971 was introduced specifically to enable New Zealand to ratify the Convention and it formed part of the long title until the Act was incorporated in the Human Rights Act 1993. The principles in the Convention remain central to the interpretation of the legislation.

The right to health is also reflected in a number of international instruments. Read together, these agreements seek to ensure what the Constitution of the World Health Organisation described in 1946 as the "enjoyment of the highest attainable standard of health … without distinction of race, religion, political belief, economic or social condition".

The following international instruments cite health care as a basic right:[2]

- the *Universal Declaration of Human Rights* adopts a plenary approach, stating that everyone has the right to a standard of living adequate for health and well being, including medical care[3];

- the *International Covenant on Economic, Social and Cultural Rights* requires States Parties to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health[4];

- the *Declaration of the Rights of Disabled Persons* refers to the right to necessary treatment, rehabilitation, education training and other services to develop skills and capabilities to they maximum;

- the *United Nations Principles for the Care and Protection of People with Mental Illness* requires that the best available health care is provided to people suffering from mental illness[5]and

[1] Article 2; Article 26 ICCPR & Article 2(2) ICECSR
[2] The right to health is often used in international law as a synonym for the right to health care. While such agreements cannot be enforced until they are incorporated into domestic law, they are powerful precedents and exert considerable moral pressure.
[3] Article 25
[4] Article 12(1)
[5] Principles 3 & 7

- agreements targeted at specific groups such as women[6] and children[7], also frequently include the right to satisfactory health care.

The reference to the Treaty in public health legislation creates a potential clash between the right not to be discriminated against and the right to be provided with the best form of health care. The conflict is highlighted in Art. 5 of CERD which explicitly enjoins States Parties to prohibit and eliminate racial discrimination in the enjoyment of the right to public health, medical care, social security and social services.[8]

It has been suggested that, in some situations, the international obligations undertaken by the Government require additional measures to redress existing discrimination[9]. International commentators such as Professor Ananya argue that indigenous peoples, in particular, should have access to affirmative action measures in order to eliminate the legacies of discrimination.[10]

While the requirement to take positive action to remedy past injustices is found in many of the international instruments - including CERD[11] - it is debatable whether the provision of health services at the expense of another racial group would fall within this requirement[12].

- **Domestic legislation**

The right not to be discriminated against and the lawfulness of affirmative action measures are reflected in the New Zealand Bill of Rights Act 1990[13] and the Human Rights Act 1993.[14]

i. Human Rights Act 1993

The Human Rights Act applies to the provision of goods and services. The provision of health care is explicitly described as a service in both the Health and Disability Services Act 1993 and the proposed legislation. The Human Rights Act makes it unlawful to treat a person less favourably in the provision of health care[15], or refuse them treatment[16], because of their race, colour or ethnicity.

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[6] Convention on the Elimination of Discrimination Against Women, Article 12
[7] Convention on the Rights of the Child, Article 24
[8] UN G.A Res. 2106A (XX) (1965)
[9] Chen & Palmer *The Human Rights Act, the Treaty of Waitangi and Affirmative Action*. Paper prepared for Te Puni Kokiri
[10] Anaya James, **Indigenous Peoples in International Law** (New York: Oxford University Press 1996) page 98
[11] Supra fn 9, Art. 1(4) & 2
[12] See, for example, the list of what would qualify as internationally accepted norms in terms of customary law which States should comply with: Chen & Palmer (supra) at 29 citing Chapter 4 of Anaya.
[13] Ss 19(1)(2) BORA
[14] Ss 44 & 73 BORA
[15] Section 44(1)(b) HRA

The Race Relations Office frequently receives complaints about health programmes which target specific ethnic groups. Among them have been complaints about:

- hepatitis B screening programmes for particular races;
- campaigns targeting young Maori women who smoke;
- programmes which provide free contraceptive advice to Maori and Pacific Island women;
- a mobile Maori community nursing service for people with chronic cardiovascular conditions; and
- flu inoculations offered free to Pacific Island and Maori people over 65.

It is usually argued that such measures can be justified under section 73 which permits measures to ensure equality. If a programme is implemented in good faith, for the benefit of a group against whom it is otherwise unlawful to discriminate, and it can be demonstrated that it is necessary for the group to achieve equality with the relevant comparator group, then it may be justified as an interim measure until equality is achieved. Following the decision in Amaltal Fishing Co. Ltd v Nelson Polytechnic (No.2)[17] the criteria necessary to justify such measures have become more stringent and it is no longer possible to defend affirmative action simply by referring to general disadvantage or Government policy.

Even accepting that there is a demonstrable need, it may not be appropriate to rely on section 73 in relation to health measures[18]. Affirmative action programmes are designed principally to redress the effects of historical disadvantage. When equality with the appropriate comparator group has been achieved, the measure must end. Technically, therefore, when a public health programme aimed at a specific race has reduced the incidence of the disease or disorder to a level commensurate with the rest of the population, the measure should cease. However, if the targeted group retains a genetic predisposition to the disease, then the possibility and ease of infection remains a live issue, arguably defeating the point of the measure in the first place.

For example, the Hepatitis B programme referred to is directed at Maori and Pacific Island people who have a greater likelihood of contracting Hepatitis B than Europeans. The purpose of the measure, therefore, should be to equalise the incidence of the disease between Maori and

[16] Section 44(1)(a) HRA
[17] [1996] NZAR 97
[18] It is also important to note that section 73 is aimed at groups. See Maclean J. *Equality and Anti-discrimination Law* in Huscroft & Rishworth: **Rights & Freedoms**, Brookers, 1995 at 266. Whereas health issues reflect individual concerns.

Pacific Islanders and Europeans. However, given that Maori and Pacific Island people have a greater propensity for contracting the disease, all that this would ensure would be a residual source of infection in the wider community, which would impact more on Maori and Pacific Island people.

From past experience it appears that, while New Zealanders are ready to accept affirmative action programmes promoting gender equity, they are less keen to accept similar programmes relating to race. Should the legislation be enacted in its present form, there will continue to be complaints about health programmes which are perceived as favouring one race over another and which may prove difficult to justify in terms of the Human Rights Act.

ii. New Zealand Bill of Rights Act 1990 ('BORA')

The BORA applies to public authorities[19] and replicates the right not to be discriminated against on any of the grounds listed in the Human Rights Act[20]. It also permits affirmative action in more generous terms than section 73[21].

A decision by Government to establish programmes to benefit a particular race could possibly be justified under section 19(2). However, this would only apply to the decision. At the point that the policy came to be implemented in practice, the human rights legislation would apply.

Various memoranda to the Cabinet Social Policy and Health Committee state that introducing the reference to the Treaty would give effect to the Government's policy commitment (among other things) of "accelerating progress towards parity between Maori and non-Maori health". They also note that "implications of the Treaty provision for the Human Rights Act (and Bill of Rights Act) will be considered as the wording is developed".

Given the difficulties outlined above, and the increasing number of complaints on health related issues received by the Office, it seems reasonable to assume that there will be a negative response to the inclusion of the provision within the legislation. Litigation (not only of a constitutional nature but also under the Human Rights Act about whether the criteria of section 73 are satisfied) is inevitable.

One of the Cabinet memorandums notes that,[22]

> *While it is difficult to predict the extent to which litigation may occur, there may be some initial "testing of the waters" for the purpose of*

[19] Section 3
[20] Section 19(1)
[21] Section 19(2)
[22] *Memorandum to Cabinet Social Policy and Health Committee - Treaty of Waitangi in Health Legislation*: Office of Minister of Health page 5 para 27.

establishing the bounds of the law. This would direct resources from other areas of health and disability funding but could be considered a desirable constitutional process.

The health sector is constantly facing budgetary constraints. It is debateable that directing funding towards legislative challenge of a provision that may not be entirely necessary is in the public interest, or likely to be received with enthusiasm by the taxpayer.

· Reference to the principles of the Treaty

It is generally accepted that the Treaty principles are now so important to New Zealand society as to be presumed mandatory[23]. Indeed, advice by Crown Law in the memoranda to cabinet indicates that an argument for special treatment for Maori can be made out - whether or not there is specific legislative reference.[24]The question is, therefore, if it is necessary to include clause 4 at all, particularly in view of the fact that it would still theoretically be possible to include the reference in clause 3(d) and the more specific requirements such as that in clause 5(3)(c).

There is a significant difference between an acknowledgment of the importance of recognising and respecting the principles of the Treaty, and interpreting legislation in manner consistent with the Treaty. The relevant Cabinet memorandum notes that including the reference to the Treaty in the purpose clause would acknowledge the Government's commitment to the Treaty. However, this is not the case with a generic clause (such as clause 4) which is more directive in its effect

The requirement to interpret public health legislation in a manner consistent with the principles in the Treaty could lead to questions about the allocation of funding and access to health services, with the outcome that the Courts could become involved in deciding what the standards, or levels of public funding or provision of health services, should be. The Courts have resiled from involvement in relation to the debate on rationing, commenting for example, that

the Court … ha[d] no knowledge of competing claims to a health authority's resources and is in no position to express any view as to how it should elect to deploy them.[25]

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[23] New Zealand Maori Council v Attorney General (HC Wellington, CP.40/96, 26 March 1996, McGechan J); Barton-Prescott v Director General of Social Welfare [1997] 3 NZLR 179 or Ngai Tahu Maori Trust Board v Director- General of Conservation [1995] 3 NZLR 553. See also Majurey P & Andrew P: *Maori & Treaty Issues - developments in law & practice*, Auckland District Law Society CLE Seminar 7 October 1999

[24] Supra page 2 para 12

[25] Donaldson MR Re J (a minor) [1992] 3 WLR 507 at 517 approved by Salmon J in Northland Health v Shortland (unreported, High Court, Auckland, M75/97, 20 Sept 1997)

The same reservations might apply in relation to apportioning of resources in accordance with the Treaty.

· Including the Treaty reference in health legislation

As with its predecessor[26] the legislation will permit resource constraints. This need to ration health care is not unique to New Zealand. It is endemic in all countries with a national health system and all are experiencing the difficulties of rationing resources equitably and fairly.

A South African judge has observed about rationing health care,[27]

> *Traditional rights analyses have to be adapted so as to take account of the special problems created by the need to provide a broad framework of constitutional principles governing the right of access to scarce resources, and to adjudicate between competing rights bearers. When rights by their very nature are shared and independent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should be seen as … defining the circumstances in which rights may be fairly and effectively enjoyed.*

The historical ambivalence towards viewing health as a human right is changing rapidly. It is now considered a fundamental right. To attempt to suggest that one race should have preference over another in determining access to health care (even notionally) is to invite resentment and anger from the group who is denied the service. This underlies the importance of ensuring that health services are shared equitably and decisions about allocation are not contentious.

All New Zealanders are entitled to access to social services such as the provision of health care, housing and education, regardless of their race. This derives from their citizenship in a democratic society, not because of their race.[28] Clause 4, which is seen as having the potential to privilege Maori over other New Zealanders in the sensitive area of access to health resources, has already led to controversy[29]and will give rise to further criticism if left in its current form.

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[26] Section 8 Health and Disability Services Act 1993
[27] Sachs J, Soobramoney v Minister of Health (Kwazulu-Natal) CCT 32/97, 27 November 1997
[28] See Graham, D. *Health warning - this may damage your treaty*, **NZ Herald** 30/8/00
[29] Graham (supra): *"Wrongs done in the past do not justify unbalanced decisions now."*

Maori representation on District Health Boards

The Bill will disestablish the present funder/provider split, abolishing the Health Funding Authority and creating 22 new District Health Boards which will be responsible for providing public health services (through their hospitals and other facilities) and for purchasing care from the community (eg from general practitioners). This indicates a significant change in policy and, despite the assertion that the purpose behind establishing the structure is the desire to involve local communities[30], it will have the effect of returning at least some control and responsibility for public health to central government[31].

To ensure that Boards adequately reflect the Government's commitment to the principles of the Treaty and concern to reduce health disparities between Maori and other New Zealanders, they will have a minimum of 2 members who are Maori and more in areas with high Maori populations.

Under the Human Rights Act 1993 it is unlawful to discriminate in employment by reason of race. Crown Law has advised that, while the requirement is open to challenge under the Act, it is unlikely to be successful because Board Members are not "employed" for the purposes of the legislation[32].

This is debatable. "Employment" is not defined in the Act, but "employer" is. The Act lists a number of situations in which a person will be deemed to be an employer for the purposes of the Act. However, the use of the word "includes" in the definition suggests that it is not limited to those situations. The Courts have agreed that human rights legislation is to be given a fair, large and liberal interpretation[33]. Given this and, that the area of employment covers the activities of industrial and professional organisations, qualifying bodies and vocational training bodies, the possibility of appointees to DHB being considered employees is a

[30] Memorandum to Cabinet Social Policy and Health Committee - Equitable representation of Maori on DHB page 2 para 12
[31] See, for example, the views expressed in ***Counsel***, legal bulletin distributed by Chapman Tripp, 31/8/000.
[32] Supra, appendix 2
[33] Coburn v Human Rights Commission [1994] 3 NZLR 323; New Zealand Van Lines Ltd v Proceedings Commissioner [1995] 1 NZLR 100

possibility. This interpretation is given extra force by the fact that board members will be paid[34].

If DHB members can be considered to be employees, then the appointment of people to these Boards because they are Maori is likely to be challenged.

The explanatory note refers to the intention that the Ministerial appointment process will ensure that each board has the *best mix of skills and knowledge* …. And, by way of example, states that in those areas where Pacific people form a large part of the population, the board will need to have the appropriate skills to consider the needs of Pacific people. Surely these criteria should apply to Maori representatives as well. This is the Conciliator's preferred method of signalling the importance of having appropriate skills on DHBs.

To this end, the Conciliator has always recommended that to avoid breaching the Act in relation to employment, it is important to emphasise the qualities required to do the job. Assuming that a person is able to do a job simply because they are of a particular race is illogical and potentially unlawful.

[34] Schedule 3, clause 4(b)

Recommendations

The Conciliator recommends the removal of clause 4. Including the direction that the legislation is interpreted in a manner consistent with the principles of the Treaty of Waitangi could be unduly divisive and would not promote positive race relations in New Zealand. This is particularly important in view of the acknowledgment that the implications of the Human Rights Act 1993 have not been fully considered. There have been concerns with section 44 in the past as it relates to health services[35]. It cannot be assumed that section 73 will always apply and, if does, whether it is appropriate.

The Conciliator agrees that it is appropriate to adopt measures which will address Maori poor health. However, this should not be at the expense of other New Zealanders. There are better ways of addressing this, for example, targeting high risk groups. If there are a disproportionate number of Maori within those groups, then they stand to benefit from the measure in greater numbers.

The Conciliator is not opposed to requiring specific Maori representation on District Health Boards, but those appointed should be appointed for their particular skills and knowledge of the health area rather than because they are Maori.

[35] See avoidance of doubt provision which was proposed in the Human Rights Amendment Bill #1.