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HAUORA

Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry

WAI 2575

WAITANGI TRIBUNAL REPORT 2019

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The cover design by Cliff Whiting invokes the signing of the Treaty of Waitangi and the consequent interwoven development of Māori and Pākehā history in New Zealand as it continuously unfolds in a pattern not yet completely known

The karakia on pages xviii and xix is from H H Wahanui, whakapapa manuscript (unpublished, 1894), and from page 56 of Pei Te Hurinui Jones, *He Mahi Mārei-kura: A Treasury of Sacred Writings* (Hamilton: Aka and Associates, 2013)

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Waitangi Tribunal
Te Rōpū Whakamana i te Tiriti o Waitangi
Kia puta ki te whai ao, ki te mārama

The Honourable Dr David Clark
Minister of Health

The Honourable Nanaia Mahuta
Minister for Māori Development

The Honourable David Parker
Attorney-General

Parliament Buildings
WELLINGTON

28 June 2019

E ngā Minita tēnā koutou

Introduction

We enclose our report *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry.*

On 30 November 2016, the chairperson of the Waitangi Tribunal prioritised an inquiry into nationally significant health issues. This signalled the commencement of the Health Services and Outcomes Kaupapa Inquiry (Wai 2575).

There are numerous health-related claims before the Waitangi Tribunal. After hearing from the claimants and the Crown, we decided to take a phased and thematic approach to this inquiry, hearing claims in three stages, namely:

- priority themes that demonstrate system issues (stage one);
- nationally significant issues and themes that emerged (stage two); and
- remaining themes of national significance, including eligible historical claims (stage three).

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Tāhū o te Ture

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In stage one, we inquired into two claims brought by the Māori Primary Health Organisations and Providers claimants and the National Hauora Coalition claimants. We decided to hear from them because they:

- raised urgent and current issues of a significantly discrete nature in relation to Māori health;
- raised concerns that exemplify system issues; and
- were brought by claimants who were ready to proceed.

Our stage one report addresses claims concerning the way the primary health care system in New Zealand has been legislated, administered, funded, and monitored by the Crown since the passing of the New Zealand Public Health and Disability Act 2000 ('the Act').

As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand. We also received uncontested statistical evidence demonstrating that, despite reform and readjustments, Māori health inequities have persisted in the nearly two decades since the Act was introduced. All parties to stage one of this inquiry, including the Crown, consider the poor state of Māori health outcomes unacceptable.

Notwithstanding that the determinants of health are complex and that the Crown cannot be held totally responsible, in our report we explore whether the persistent inequitable health outcomes suffered by Māori are indicators of Treaty breach. In doing so, we ask whether a cause of the inequitable health statistics suffered by Māori is the legislative and policy framework of the primary health care system itself.

The stage one claimants alleged that the primary health care framework has failed to achieve Māori health equity and is not sufficiently fit for that objective in its current state. The claimants raised concerns about the role of, and resourcing for, Māori primary health organisations and health providers, broadly arguing that Māori are not able to exercise tino rangatiratanga in the design and delivery of primary health care.

Our first three hearing weeks took place at Tūrangawaewae Marae, Ngāruawāhia, in October and November 2018. The significance and symbolism of commencing this inquiry at Tūrangawaewae Marae was not lost on us. Not only was it the first occasion that the Waitangi Tribunal had formally sat at that marae: we did so on the centenary of the Spanish flu pandemic, a health crisis that so profoundly affected the nation at the time. A further hearing was held at the Waitangi Tribunal Unit's offices in Wellington in December 2018, with closing submissions being heard at the same venue on 12 and 13 March 2019.

The stage one inquiry progressed at pace. The claimants and the Crown urged us to release our report by mid-2019 so that the Government's Health and Disability System Review could take our analysis, findings, and recommendations into account.

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In approaching our task, we identified four main thematic issues to focus on for this stage of the inquiry: the Treaty-compliance of the Act and framework; funding arrangements for primary health care; accountability arrangements for primary health care; and the nature of Treaty partnership arrangements in the primary health care sector.

Our findings

In answer to the question of whether the legislative, strategy, and policy framework that administers the primary health care sector is Treaty-compliant, we found that the framework fails to state consistently a commitment to achieving equity of health outcomes for Māori. We also found that the Treaty clause in the Act is not so much an elaboration as a reductionist effort at a Treaty clause: it simply does not go far enough in ensuring that the whole health system complies with the Treaty and its principles. We found that provisions in the Act that are intended to provide for greater Māori participation in the work of district health boards do not work effectively to afford Māori Treaty-consistent control of decision-making in relation to health design and delivery. We found that the attempt at an articulation of Treaty principles in the health system is out of date. Finally, we found that the omission of specific Treaty references in lower-level documents amounted to a concerning omission of the health sector's Treaty obligations.

On the topic of funding, we found that Māori primary health organisations were underfunded from the outset. We further found that ongoing resourcing was a significant issue too: the funding arrangements for the primary health care system disadvantage primary health organisations and providers that predominately serve high-needs populations, particularly Māori primary health organisations and providers. The Crown has been aware of these failures for well over a decade but has failed to adequately amend or replace the current funding arrangements.

The amount of money spent in the health sector is enormous. The Crown has invested some $220 billion into the health system since 2000, with little measurable improvement to Māori health outcomes. In the 2017–18 financial year, the appropriation for Vote Health was $15.910 billion, of which $907 million was spent on various capitation-based funding sources for primary health organisations and providers. Based on the recorded number of Māori enrolees in all primary health organisations, $167 million was allocated for Māori patients, with $28.7 million of funding going to Māori primary health organisations.

Such large-scale public funding invites the question of what accountability measures exist in the system. We were repeatedly told that

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the design of the primary health system was deliberately 'permissive' and semi-devolved. While we can see that this approach was intended to foster local innovation and control, we found that it has significant drawbacks and has resulted in grave impacts on both Māori organisations and Māori patients. We found that the Crown does not collect sufficient qualitative or quantitative data to fully inform itself how the primary health care sector is performing in relation to Māori health. Furthermore, the Crown does not use the data it does collect effectively, nor does it make it easily accessible to, and understandable by, the public. Despite the significant, persisting inequities that Māori experience, Māori health outcomes are not systematically separately measured and reported on. Furthermore, we found that Te Puni Kōkiri has failed to carry out its statutory duty to monitor the health sector by failing to conduct agency reviews. While the Crown knows enough to establish that the situation for Māori is urgent and serious, it has not adequately informed itself as to why this situation might be persisting nor sought the necessary information needed to improve the performance of the primary health care sector.

In our fourth area of focus, we concentrated on the experiences of Māori working within the primary health care system and their relative decision-making power and influence. We found that the Crown did not design the primary health care framework in partnership with Māori. We noted that Māori are significantly under-represented across a range of health professions and in the Ministry of Health itself. We were particularly concerned at the disestablishment of Te Kete Haurora, a unit in the Ministry of Health focused on Māori health, and the impact that had on the efficacy of Māori-specific policy-making and advice at the Ministry of Health level. We were concerned that those managers responsible for Māori health within district health boards appeared hamstrung by the ambit of their role and the very minimal budget-holding functions they often hold.

We found several breaches in relation to district health board governance and concluded that the governance arrangements for district health boards do not, when taken together, reflect the Treaty partnership. Māori members of district health boards are always in the minority and do not necessarily reflect mana whenua interests, nor the Māori population or the district they serve. Ultimately, board members are appointed by and answerable to the Minister of Health, which does not reflect a true partnership model. While every district health board partners with a Māori relationship board, these arrangements do not have statutory recognition, and the extent of their role and influence upon the operation of district health boards varies considerably throughout the country.

Māori primary health organisations and health providers are intrinsic

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to sustaining Māori health and wellbeing, and are expressions of tino rangatiratanga. That the Crown fails to adequately resource these organisations, and further fails to govern the primary health care system in a way that properly supports them to design and deliver primary health care to their communities, is a serious Treaty breach. Overall, we concluded that the primary health care framework does not recognise and properly provide for tino rangatiratanga and mana motuhake of hauora Māori.

Recommendations

We have made two overarching recommendations, that:

(a) The legislative and policy framework of the New Zealand primary health care system recognise and provide for the Treaty of Waitangi and its principles. To that end, we recommend an amendment to the New Zealand Public Health and Disability Act 2000 to include a new Treaty of Waitangi clause. We have also gone on to recommend several principles for adoption and use in the primary health care sector.

(b) The Crown commit itself and the health sector to achieve equitable health outcomes for Māori. To that end, we recommend an amendment to section 3(1)(b) of the New Zealand Public Health and Disability Act 2000.

In relation to structural reform of the primary health care system, we have made an interim recommendation that the Crown commit to exploring the concept of a stand-alone Māori Primary Health Authority. Furthermore, we recommend that the Crown and the stage one claimants design a draft term of reference to explore that possibility. We have directed the parties to report back to us by 20 January 2020 on progress.

In relation to funding, we have made an interim recommendation that the Crown and the stage one claimants agree upon a methodology for the assessment of underfunding of Māori primary health organisations and health providers. That methodology should include an assessment of establishment and ongoing underfunding since the commencement of the Act. We have directed the parties to report back to us by 20 January 2020 on progress.

On the broader question of funding generally for the primary health care system, we recommend that the Crown conduct an urgent and thorough review of funding for primary health care, to align it more closely with the aim of achieving equitable health outcomes for Māori.

In relation to accountability arrangements, we recommend that the Crown commit to reviewing and strengthening accountability mechanisms and processes in the primary health care sector that impact upon Māori.

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We go on to make several specific recommendations concerning: He Korowai Oranga (the Māori health strategy); the New Zealand Health Strategy; the Primary Health Care Strategy; and the strategies' relevant action plans. We also recommend that the Crown, in conjunction with Māori health experts, co-design a primary health research agenda.

We have made several specific recommendations concerning the collection and use of data and information relevant to Māori health outcomes; Māori health plans for district health boards and primary health organisations; and the inclusion of Treaty references in all health sector contracting documents. We also recommend that the Crown review, with a view to redesigning, the current arrangements for the monitoring of the Ministry of Health by external agencies.

We have made an interim recommendation that the Crown, after considering our analysis and findings, review, with a view to redesigning, its current partnership arrangements across all levels of the primary health sector. We recommend that review process be co-designed with Māori health experts. That recommendation is made on an interim basis because we await the Crown and claimants' response to progress in the exploration of a stand-alone Māori Primary Health Authority.

Finally, we recommend that the Crown acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health care system to improve Māori health outcomes since the commencement of the New Zealand Public Health and Disability Act 2000.

Our interim recommendations require the Crown and the stage one claimants to report back to us on progress, and for some recommendations we anticipate the need for a broader discussion to take place with the wider primary health sector, including Māori and non-Māori stakeholders. Where we have made interim recommendations, we reserve the right to review those recommendations depending on the feedback we receive from the Crown and the stage one claimants.

Acknowledgements

I would like to acknowledge the contributions of the stage one claimants, the interested parties, and their witnesses and counsel in the lead up to and throughout the hearings for stage one of this inquiry. We received a huge volume of evidence; the agreed bundle alone is more than 16,000 pages. We heard from 44 witnesses, many of them experts in primary health, and received lengthy and detailed submissions, all within the confines of a very tight timetable. To get through our work required a great deal of cooperation, particularly on the part of counsel. I thank all persons for the part they played in making that happen. It was only with

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that cooperation that we have been able to hear and report back within the timeframe requested by parties.

Finally, I would like to acknowledge the role the Crown played in this inquiry, specifically Crown counsel and the Ministry of Health. Although we have made findings of Treaty breach, a close reading of this report reveals that we relied heavily upon Crown acknowledgements, statistics, and evidence. From the date of the first judicial conference held on 11 and 12 May 2017, Crown counsel signalled an intention to act in a cooperative fashion. The hope was expressed by them that we provide a report that would assist in improving the Treaty-compliance of the primary health care legislative and policy framework. Throughout stage one they remained true to their word, and we are grateful for the cooperative and proactive role they played in the provision of information to the Tribunal. Suffice to say that a similar approach by the Crown will be necessary if the Waitangi Tribunal is to get through the work of the kaupapa inquiry programme that it has set itself.

Tēnā koutou, tēnā tātou katoa,

Judge Stephen Clark
Presiding Officer
Nā Te Rōpū Whakamana i te Tiriti o Waitangi

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Pūnganangana ki tawhito-o-te-rangi e tū nei
He ngana riri; he ngana tauā;
Ue-ue 'Nuku; Ue-ue Rangi
Tē tūngia te kawaru rā
Ko te hau tonga ka maranga mai rā

Toki nui te toki
Toki roa te toki
Toki tā wahie
Ka whanatu au
Ka hahau i te takapū
O Rangi e tū nei
Ka hinga
Ka mate

Whakataka te hau ki te muri
Whakataka te hau ki te tonga
Kia mākinakina ki uta
Kia mātaratara ki tai
Kia hiia ake te ātākura
He tio,
He huka.
He hau-hūnga!

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Forbidding the sky above, full of dread,
Angrily raging; striving
The earth quakes; the heavens quiver
Nought stands before the shattering gale
The southerly winds blowing forth

Grasping the renowned adze
The famed long handled adze
The adze rending asunder the great trees
I stride forth boldly
Striking the base of the tree,
Tho' sky-piercing
It falls
It expires.

Cease now O wind from the west
Cease now O wind from the south
Murmuring breezes sigh o'er the land
The stormy and boisterous seas subside
And the red evening sky shines resplendent
With a sharpened air
A touch of frost
A promise of a glorious day.

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GLOSSARY

aroha	love, concern, compassion, empathy
hapū	sub-tribe
hauora	holistic health and wellbeing
iwi	tribal grouping
kaupapa	central purpose, initiative, issue
kāwanatanga	government, governorship
mana	prestige, authority, control, power, influence, status
mana motuhake	autonomy, self-determination, sovereignty, self-government
mana whenua	territorial rights, power from the land, authority over land or territory, jurisdiction over land or territory, power associated with possession and occupation of tribal land
mātauranga Māori	the Māori worldview, Māori knowledge, traditional knowledge
mirimiri	indigenous massage therapy
rangatiratanga	chieftainship, authority, right to exercise authority, chiefly autonomy, chiefly authority
rongoā	indigenous medicine and treatment
rūnanga	a council or board to discuss community issues
taihoa	stop, wait
take	cause, subject
tangata whenua	people of the land, local people
te ao Māori	the Māori world
tikanga	correct procedure/protocol, a system of values and practices
tino rangatiratanga	the fullest expression of rangatiratanga, autonomy, self-determination, sovereignty, self-government
wairuatanga	spirituality
whānau	family
whānau ora	family wellbeing

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
app	appendix
ASH	ambulatory-sensitive hospitalisation
BOP	Bay of Plenty
CA	Court of Appeal
CEO	chief executive officer
ch	chapter
cl	clause
COPD	chronic obstructive pulmonary disease
DHB	district health board
doc	document
DOC	Department of Conservation
ed	edition, editor
ED	emergency department
GFC	global financial crsis
GP	general practitioner, general practice
HIV	human immunodeficiency virus
IPA	Independent Practitioner Association
KPI	key performance indicator
ltd	limited
memo	memorandum
MHP	Māori health plans
MP	member of Parliament
n	note
no	number
NZLR	*New Zealand Law Reports*
NZPHD Act 2000	New Zealand Public Health and Disability Act 2000
p, pp	page, pages
para	paragraph
Pharmac	Pharmaceutical Management Agency
PHC	primary health care
PHCS	Primary Health Care Strategy
PHO	primary health organisation
PSAAP	primary health organisation service agreement amendment protocol
pt	part
ROI	record of inquiry
s, ss	section, sections (of an Act of Parliament)
SC	Supreme Court

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SUDI	sudden unexplained death of an infant
tbl	table
v	and
VLCA	Very Low Cost Access
vol	volume
Wai	Waitangi Tribunal claim

Unless otherwise stated, footnote references to briefs, claims, documents, memoranda, papers, submissions, and transcripts are to the Wai 2575 record of inquiry. Copies of select indexes to the Wai 1315 urgency application record and the Wai 2575 record are reproduced in appendixes IV and V. Full copies of the indexes are available on request from the Waitangi Tribunal.

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CHAPTER 1

INTRODUCTION

Pūnganangana ki tawhito-o-te-rangi e tū nei

1.1 The Health Services and Outcomes Kaupapa Inquiry – Stage One

1.1.1 Introduction

The New Zealand Public Health and Disability Act 2000 determines the structure and function of the nation's primary health care system. A range of operational policies and strategies govern the design and delivery of primary health care in accordance with the Act.[1] Together, these policies and strategies constitute the primary health care framework, which the claims in stage one of this inquiry refer to.

This report addresses two claims concerning the legislative and policy framework of the primary health care system. Primary health care encompasses services provided in the community by general practitioners, nurses, pharmacists, counsellors, dentists, and others. The core aim of primary care is the treatment and prevention of health issues before they become serious enough to need care at a higher level.

These claims were heard late in 2018 after being highlighted as a priority issue in the Health Services and Outcomes Kaupapa Inquiry. Their central allegation is that the Crown's primary health care framework has failed to achieve Māori health equity and, further, that the framework is not sufficiently fit for that purpose in its current state. In particular, they raised concerns about the role of, and resourcing for, Māori-led primary health organisations and health providers, and they broadly argued that Māori were not able to exercise tino rangatiratanga in the design and delivery of primary health care to their own people.

In all, the parties generally agreed on the fundamental basis for this stage one inquiry: that the state of Māori health outcomes indicates persistent, systemic problems in the primary health care sector. For these and other reasons, Māori are affected by the policies and legislation that underpin this sector, whether they are staff of health organisations or people who need to use health services. While this inquiry has been tightly defined, the stakes of its investigation are high.

1. The primary health care framework means the legislation, regulation, policy, and practice that determine the delivery of primary health care in New Zealand. It includes the New Zealand Public Health and Disability Act 2000, the Crown Funding Agreement, the Operating Policy Framework, the New Zealand Health Strategy, the New Zealand Primary Health Care Strategy, the PHO Minimum Requirements, the PHO Services Agreement, Additional Services Contracts, the New Zealand Disability Strategy, and He Korowai Oranga: Māori Health Strategy.

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1.1.2 The inquiry process to date

1.1.2.1 *The initial application for urgency*

A statement of claim concerning health issues on a national scale was received on 11 November 2005 from Taitimu Maipi, Tureiti Moxon (now Tureiti Lady Moxon), Elaine Tapsell, and Hakopa Paul on behalf of a coalition of Māori Primary Health Organisations and Providers. This claim is registered as Wai 1315.[2] Along with their statement of claim, the claimants filed several affidavits in support of an application for an urgent inquiry into the primary health care system on the basis that there was an imminent threat to the survival of their organisations.[3]

On 22 December 2005, then Chief Judge Joe Williams convened a judicial conference for 25 January 2006 to further consider the application for urgency.[4] This judicial conference was ultimately deferred until 17 August 2006 at the request of parties.[5] At the judicial conference, leave was granted to the claimants to submit further evidence in support of an urgent inquiry and to engage directly with the Ministry of Health through the Primary Health Care Strategy Implementation Work Programme.[6]

Through the period August 2006 to August 2008, counsel requested several adjournments of judicial conferences and consideration of the urgency application, while the claimants worked closely with the Ministry of Health to attempt to resolve the issues in their claim.[7]

On 14 August 2008, the claimants filed a memorandum of counsel renewing their request for an urgent inquiry. Counsel informed the Tribunal that the claimants' engagement with both the Primary Health Care Strategy Implementation Work Programme and a more recent Ministry of Health effort, entitled the Sustainability Project, had failed to resolve their issues.[8] The memorandum was accompanied by six updated briefs of evidence.[9]

On 22 August, Chief Judge Williams delegated the task of determining the application for urgency to Judge Craig Coxhead.[10] Judge Coxhead requested and received a Crown response to the application on 3 November 2008.[11]

After considering the urgency application and the Crown's response, on 5 November Judge Coxhead deferred a decision on the claimants' application for an urgent hearing to see whether phase II of the Ministry's Sustainability Project would reveal potential prejudice to the claimants.[12] Judge Coxhead's decision was

2. Claim 1.1.1, p 2.
3. Document A24; doc A26; doc A28; doc A29; doc A30.
4. Wai 1315 ROI, memorandum 2.1.1, p 1.
5. Wai 1315 ROI, memoranda 2.5.1- 2.5.2.
6. Wai 1315 ROI, memorandum 2.5.3.
7. Wai 1315 ROI, memoranda 2.5.4–2.5.7.
8. Wai 1315 ROI, memorandum 3.1.11, para 6.
9. Wai 1315 ROI, memorandum 2.5.8, para 1; docs A31, A32, A33, A34, A35, A36.
10. Wai 1315 ROI, memorandum 2.5.8, para 3.
11. Wai 1315 ROI, memorandum 2.5.9, para 4; Wai 1315 ROI, memorandum 3.1.12.
12. Wai 1315 ROI, memorandum 2.5.10, paras 15–16.

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confirmed on 24 November in response to a request for a recall of that decision by claimant counsel. The claimants were invited to file responses to Crown submissions if they wished to.[13]

In memoranda submitted on 16 December 2008 and 25 February 2009, claimant and Crown counsel indicated that the claimants were continuing discussions with the Crown and would defer submitting responses to Crown submissions.[14] On 23 November 2009, counsel informed the Tribunal that they would not be pursuing the urgency application until they could assess the impact of the then-new Government's health policy. In response, Judge Coxhead directed on 24 November 2009 that the application for urgency would remain adjourned until the Tribunal received further submissions or information from counsel.[15] The claimants ultimately did not resume their application for urgency.

1.1.2.2 *The kaupapa inquiry programme*

In April 2015, the Waitangi Tribunal announced its kaupapa inquiry programme, which provides a pathway for the hearing of nationally significant claims that affect Māori as a whole or a section of Māori in similar ways.[16]

The chairperson of the Waitangi Tribunal, Chief Judge Wilson Isaac, when announcing the kaupapa inquiry programme, set out several key issues for prioritising claims for inclusion in the programme: '[the potential] removal of the Tribunal's ability to inquire; the immediacy of the take (issue) or potential remedy; the seriousness of the alleged breach or prejudice; and the importance of the take to claimants, Māoridom and the nation'.[17]

Applying these criteria, Chief Judge Isaac, in a memorandum dated 30 November 2016, prioritised an inquiry into nationally significant health issues. The memorandum signalled the commencement of the Health Services and Outcomes Kaupapa Inquiry (Wai 2575).[18] The chief judge identified 100 claims that raised health issues. The claims included grievances concerning:

- the primary health care framework;
- the delivery of services to the deaf, blind, and mentally ill;
- reducing causes of ill-health amongst Māori caused by smoking and HIV/AIDS;
- an alleged disparity in the quality of health services provided to Māori and non-Māori;
- the accommodation of mātauranga Māori and rongoā Māori in health policy and the delivery of mainstream health services; and
- disparities in health outcomes for Māori and non-Māori.

13. Wai 1315 ROI, memorandum 2.5.11.
14. Wai 1315 ROI, memoranda 3.1.14–3.1.15.
15. Wai 1315 ROI, memorandum 2.5.12, para 5.
16. Chief Judge Wilson Isaac, memorandum concerning kaupapa inquiry programme, 1 April 2015, para 11.
17. Ibid, para 5.
18. Memorandum 2.5.1.

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The memorandum also identified that some of the claims raised historical issues whilst others had a more contemporary focus. After setting out certain eligibility issues, the memorandum called for submissions from claimants who wished to participate. In these same directions, Judge Stephen Clark was appointed the presiding officer.[19]

On 15 March 2017, Chief Judge Isaac appointed Dr Angela Ballara, Miriama Evans, Associate Professor Tom Roa, and Tania Simpson as Tribunal panel members.[20] Ms Evans resigned from office in September 2017, and Professor Linda Tuhiwai Smith was appointed as a replacement panel member.[21]

1.1.2.3 *A staged approach to hearing health-related claims*

On 11 and 12 May 2017, an initial judicial conference was held at Pipitea Marae in Wellington to give the parties an opportunity to express their preferences for the approach of the inquiry process.[22] Following this judicial conference, we noted 'there was a will amongst claimants, interested parties, their counsel and Crown counsel to work together to address issues around inquiry scope, focus, priorities and inquiry process'.[23]

As such, we invited all the parties to hold round-table discussions over the course of three months to discuss these issues and come to a consensus on the possible progression of the inquiry.[24] Those round-table discussions resulted in the Tribunal receiving 16 submissions over the course of September to November 2017 concerning the inquiry design, scope, priorities, and approaches.[25]

On 11 October 2017, Henare Mason and Simon Tiwai Royal submitted a claim on behalf of the National Hauora Coalition arguing that the flaws they identified with the primary health care system required an immediate investigation.[26] The claim was registered as Wai 2687.

On 2 November 2017, we issued a memorandum indicating that we would be considering how best to approach the scale of the Health Services and Outcomes Kaupapa Inquiry.[27] We met as a panel on 27 and 28 November to consider the submissions about scope, priorities, and approaches to the inquiry.

On 8 December 2017, after considering the submissions received concerning inquiry design, we issued a memorandum. In it, we noted that, whilst the parties could not agree upon a list of priority matters to be heard, they had suggested that we should take a phased and thematic approach in three stages, namely:

19. Memorandum 2.5.1, para 12.
20. Memorandum 2.5.4.
21. Memorandum 2.5.12.
22. Memorandum 2.5.2, paras 15, 21; memo 2.5.6.
23. Memorandum 2.5.8, para 12.
24. Ibid, para 13.
25. Memorandum 2.5.17, para 4.
26. Claim 1.1.2, para 17(b)(iii).
27. Memorandum 2.5.14, para 7.

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- priority themes that demonstrate system issues (stage one);
- nationally significant system issues and themes that emerge (stage two); and
- remaining themes of national significance, including eligible historical claims (stage three).[28]

We decided to hear the Māori Primary Health Organisations and Providers (Wai 1315) and National Hauora Coalition (Wai 2687) claimants as stage one of the inquiry. In doing so, we were attracted by the fact that their claims:

- raised urgent and current issues of a significantly discrete nature in relation to Māori health;
- raised concerns that exemplify 'system issues'; and
- were brought by claimants who stated they were ready to proceed.[29]

We decided these two claims were appropriate for stage one because they focused on a discrete but significant part of the health system and its alleged flaws, allowing for a targeted inquiry.[30] Rather than referencing particular aspects of primary health care, these two claims focused their allegations solely on the underlying structures that establish, and direct, primary health care in New Zealand. The specific emphasis of these claims allowed for stage one to both consider urgent health issues on a national scale and be completed in a timely manner.[31]

On 1 February 2018, the Māori Primary Health Organisations and Providers claimants (Wai 1315) amended their statement of claim.[32] The claimants further confirmed that they did not require additional evidence and were ready to proceed to hearing.[33]

Several other parties challenged the decision to hear these two claims at stage one and filed submissions to that effect. A judicial conference was held at the Māori Land Court, Hamilton, on 15 March 2018 to consider the matter. On 29 March 2018, we confirmed that the claims to be inquired into during stage one would be the Wai 1315 and Wai 2687 claims.[34] The two claims were consolidated under the Health Services and Outcomes Kaupapa Inquiry on 7 May 2018.[35]

Accordingly, stage one of our inquiry focuses on the Treaty-compliance of the legislative and policy framework of primary health care. On 7 May 2018, the parties were directed to file suggestions for the statement of issues, which were received by the end of that month.[36] After consideration of these submissions, we released the Tribunal statement of issues for stage one on 1 June 2018 and added it to the record of inquiry.[37]

28. Memorandum 2.5.17, paras 5–7.
29. Ibid, para 9.
30. Memorandum 2.5.25, para 80.
31. Memorandum 2.5.17, para 11.
32. Claim 1.1.1(a).
33. Memorandum 2.5.17, para 13.
34. Memorandum 2.5.25.
35. Memorandum 2.5.26, para 31
36. Memorandum 2.5.27, paras 3–5.
37. Ibid, para 8.

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The statement of issues posed several questions for the stage one participants to consider in the preparation of their evidence and submissions and related both to the legislative and policy framework itself as well as to elements of its implementation in practice. It was a guideline to the issues we wanted the parties to address during stage one and was not intended to straitjacket the participants. The questions posed covered the following topics: equity; the primary health care framework; Māori-designed solutions; funding; policy and strategy; accountability; social policy; Treaty principles; prejudice; and recommendations.

We have previously signalled our intention that stage two should focus on other emergent nationally significant systems issues and themes, which we stipulated will be mental health, alcohol and substance abuse (including tobacco use), and Māori with lived experience of disabilities.[38] We intend that stage three will focus on further themes of national significance, including eligible historical claims, and will be refined pending the outcomes of stages one and two.[39]

The stage one report's discussions, analysis, and conclusions on central aspects of the primary health care framework will provide a foundation for the remainder of this kaupapa inquiry.

1.1.2.4 *The stage one hearings*

The first and second weeks of hearings for stage one of our inquiry took place at Tūrangawaewae Marae, Ngāruawāhia, from 15 to 19 and 23 to 26 October 2018. We note the significance and symbolism of commencing this inquiry at Tūrangawaewae Marae, which many kaikōrero mentioned during the pōwhiri. This was the first occasion that the Waitangi Tribunal had sat at Tūrangawaewae Marae. Further, that these hearings occurred on the centenary of the Spanish flu pandemic weighed heavily on the minds of those in attendance. That health crisis, which so profoundly affected all Māori, prompted Te Puea Hērangi to nominate Māhinārangi Whare at Tūrangawaewae Marae as the site for a Māori-run hospital. Her vision was ultimately thwarted.[40]

Four further days of hearing were held at Tūrangawaewae Marae on 1 and 2 November 2018 and at the Waitangi Tribunal Unit's offices in Wellington on 17 and 18 December 2018. Closing submissions were heard at the unit's offices on 12 and 13 March 2019. Written reply submissions from counsel for the claimants were received by 20 March 2019.

1.2 THE STAGE ONE PARTICIPANTS

In this section, we introduce the stage one participants and their broad positions on the issues in stage one.

38. Memorandum 2.5.17, para 17; memo 2.5.29, paras 2, 11, 18.
39. Memorandum 2.5.17, para 6.
40. Ann Parsonson, 'Te Kirihaehae Te Puea Herangi', in *The Dictionary of New Zealand Biography*, Ministry for Culture and Heritage, https://teara.govt.nz/en/biographies/3h17/herangi-te-kirihaehae-te-puea, accessed 4 April 2019.

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1.2.1 The claimants

The two claims considered in this stage one report were made on behalf of several individuals and groups and on behalf of all Māori.[41]

1.2.1.1 *Māori Primary Health Organisations and Providers claim (Wai 1315)*

The named claimants in the Māori Primary Health Organisations and Providers claim (Wai 1315), which was amended on 1 February 2018, are:

- Taitimu Maipi, on behalf of himself and Raukura Hauora o Tainui Trust, Papakura Marae Health, and the claimants in the Wai 1818 Ngāti Paretekawa claim;
- Tureiti Lady Moxon, on behalf of herself and a coalition of health care organisations including Te Kohao Health Limited, Te Runanga o Kirikiriroa, the Taumarunui Community Kokiri Trust, the Hauraki Primary Health Organisation, and the Waikato District Health Board Iwi Māori Council;
- Hakopa Paul, on behalf of himself and Te Kupenga a Kahu (which ceased to operate in 2005); and
- Janice Kuka, on behalf of herself and Ngā Mataapuna Oranga, Te Manu Toroa, Turuki HealthCare, and Piripi Hikairo.[42]

At the time they filed their original statement of claim in 2005, the named claimants were involved with several kaupapa Māori health providers and three Primary Health Organisations. By the time the stage one inquiry started, only one of these organisations – Ngā Mataapuna Oranga – was still a Primary Health Organisation. The rest either are no longer operating or have become health providers.

Taitimu Maipi has been deeply involved in health initiatives and organisations in Waikato for over 30 years. He is the current patron and former director of Raukura Hauora o Tainui, a Waikato-based Māori provider, and the former co-chair of Te Kupenga a Kahu (previously Te Kupenga a Hoturoa), a Māori primary health organisation, and the Northern Waikato Māori Primary Health Organisation. Neither of these organisations operates as a primary health organisation today. Maipi is also a former member of the Waikato District Health Board and its Māori relationship board, the Iwi Māori Council, and he is the current chair of the Waahi Whaanui Trust, a Māori health provider.[43]

Tureiti Lady Moxon is the managing director of Te Kōhao Health Limited in Hamilton, a Māori provider that operates under the Hauraki Primary Health Organisation.[44] She has had a longstanding involvement on boards and in an advisory capacity to Crown health entities since the 1990s, and she has been on the Waikato District Health Board Iwi Māori Council since 2002.[45] Lady Moxon was also the former chief executive officer of the Toiroa Primary Health Organisation

41. Memorandum 2.5.25, para 67.
42. Claim 1.1.1(a), para 1.
43. Document A28, para 1; doc A10, para 1.
44. Document A11, paras 3, 40.
45. Ibid, para 2.

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from 2003 to 2012. (Toiroa ceased to operate as a primary health organisation in 2013.[46])

Hakopa Paul was formerly a trustee of Te Kupenga a Kahu, a Rotorua-based Māori primary health organisation that ceased operating in 2005.[47]

Janice Kuka has been the managing director of Ngā Mataapuna Oranga, a Māori primary health organisation, since 2010. She is also the chair of Māori health providers Pirirākau Hauora and Te Manu Toroa Trust.[48] All of these organisations are based in Tauranga.

In a memorandum from claimant counsel filed in late November 2018, we were informed that two of the named claimants, Taitimu Maipi and Hakopa Paul, had come to favour a different approach and emphasis concerning the recommendations sought by their fellow named claimants Tureiti Lady Moxon and Janice Kuka.[49] At a judicial conference on 17 December, it was resolved that, for the remainder of stage one, Moxon and Kuka would continue to be represented by Roimata Smail of Smail Legal Limited, while Maipi and Paul were to be represented by Jamie Ferguson of Kahui Legal.[50]

Lady Moxon and Kuka claimed that Māori-led primary health organisations and providers are inadequately funded and supported by the Crown compared with non-Māori primary health organisations and providers. They further alleged that the funding is not enough to design and provide the innovative services that are needed in relation to the primary health care needs of Māori. In addition to inadequate funding, the claimants alleged that the constantly changing policy environment places further strain on Māori primary health organisations and providers with regard to resourcing.[51] They claimed that, taken together, these failures constitute breaches of the Treaty principles of active protection, equity, tino rangatiratanga, and partnership.[52]

Lady Moxon and Kuka seek recommendations that the Crown apologise and provide redress for the lack of support and underfunding of Māori primary health organisations and providers. In addition, they seek Māori control of the design and implementation of Māori health services, enshrined in legislation that affirms Māori tino rangatiratanga and mana motuhake.[53]

Maipi and Paul similarly claim that the Crown does not adequately 'empower or resource' Māori primary health organisations and health providers, emphasising the inadequate recognition of tino rangatiratanga and mana motuhake as their primary concern.[54] They argued that the current primary health care legislative and policy framework 'is not sufficiently contributing to the achievement of Māori

46. Document A11, paras 6, 38.
47. Document A13, paras 12, 15.
48. Document A12, paras 3–4.
49. Memoranda 3.2.17, 3.2.18; memo 2.6.8, para 25.
50. Memorandum 2.6.8, paras 25–27.
51. Submission 3.3.18, para 5.
52. Ibid, para 129.
53. Ibid, para 153.
54. Submission 3.3.23, paras 4, 32.

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health equity.'[55] Accordingly, they claim that the Crown's insufficient action in relation to primary health for Māori and its inadequate support of Māori tino rangatiratanga in the health sector constitute breaches of the Treaty, particularly the principles of partnership, active protection, and equity.[56]

The claimants stated that primary health care legislation and policy require urgent reframing.[57] Maipi and Paul see iwi as the most appropriate designers and funders of health care for local Māori populations in a new primary health care system.[58] Accordingly, they seek recommendations endorsing an 'iwi-specific approach to improve the state [of] Māori health'.[59]

1.2.1.2 *The National Hauora Coalition claim (Wai 2687)*

Henare Mason and Simon Tiwai Royal are the named claimants in the National Hauora Coalition claim (Wai 2687).[60] The National Hauora Coalition, formed in 2012 through the merger of several Māori-led primary health organisations, is a national kaupapa Māori primary health organisation, operating in five district health board catchment areas across the North Island (Counties Manukau, Waitematā, Waikato, Whanganui, and Auckland).[61] The coalition was represented throughout by Karen Feint and Erin James of Thorndon Chambers.

The National Hauora Coalition claimants stated that, going forward, the Crown should 'empower mana Māori motuhake [separate authority] in primary health care for Māori'.[62] They claimed, like the Wai 1315 claimants, that the Primary Health Care Strategy, and the primary health care framework more generally, do not adequately focus the primary health sector to achieve Māori health equity.[63] The claimants argued that a reset of the existing primary health care system is required as it remains structurally prejudicial to Māori wellbeing.[64] Broadly, they argued that the primary health care framework (and particularly the district health board model) undermines a national approach to Māori health issues, to the detriment of Māori who use primary care services and also to the Māori health entities working in the sector.[65] They particularly highlighted the alleged failure to integrate the Māori health strategy, He Korowai Oranga, as 'a missed opportunity'.[66] Further, they alleged that various arrangements for funding and accountability are inadequate and need to be strengthened or amended.[67] These failures, they claimed, are breaches of the Treaty principles.

55. Ibid, para 7.
56. Ibid, para 44.
57. Ibid, para 9.
58. Ibid, para 32.
59. Ibid, para 48(c).
60. Claim 1.1.2, para 1.
61. Document A23, paras 2, 14; submission 3.3.30, para 5.86.
62. Submission 3.3.30, paras 1.4.
63. Ibid, paras 2.8.8.
64. Ibid, paras 2.5, 2.6.2.
65. Ibid, paras 2.8.4, 2.8.5, 2.8.7, 2.8.12.
66. Ibid, paras 2.8.9.
67. Ibid, paras 2.8.10–2.8.13.

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The National Hauora Coalition claimants sought recommendations that the Treaty principles, especially the guarantee of Māori tino rangatiratanga, should be thoroughly embedded within the primary health care framework and guide its policy-making.[68] They alleged that the Treaty clause in the New Zealand Public Health and Disability Act 2000 is not Treaty-consistent, as it emphasises participation as opposed to applying the principles of partnership and tino rangatiratanga.[69]

In particular, the claimants stated mana motuhake needs to be enshrined in the primary health care framework in the context of Māori health policy and services. In essence, Māori must have not only full control of kaupapa Māori organisations but also a real stake in policy-making and implementation in the whole health sector.[70] To this end, the claimants proposed what they call a Hauora Authority: an independent, statutory health body with oversight of policy, research, and funding, which would have a role in ensuring mana motuhake in the primary health care system.[71] The claimants see this entity as necessary because it would avoid 'the prospect of the Crown misinterpreting how to provide for tino rangatiratanga in the health system'.[72] They also suggested a number of interim recommendations that they claim would improve the situation under the current primary health care framework while the details of this new, radical approach are finalised and implemented.[73]

1.2.2 The Crown

The Crown was represented by the Ministry of Health, district health boards, and Te Puni Kōkiri. The Ministry of Health and the district health boards are responsible for administering the primary health care system under the New Zealand Public Health and Disability Act 2000. Te Puni Kōkiri has a statutory responsibility both to promote increases in the levels of achievement attained by Māori in health and other social sectors and to monitor the performance of other Crown agencies on their engagement with and servicing of the Māori population.[74]

Crown counsel throughout the proceedings were Craig Linkhorn, Geoffrey Melvin, and Abbey Lawson.

The Crown accepted that Māori health outcomes are inequitable, amongst other acknowledgements regarding the inadequacies of the primary health care framework.[75] The Crown argued it is 'well-founded' that New Zealand's health care system is comparatively strong by international standards.[76] The Crown argued an ongoing commitment to improving the many features of primary health care

68. Submission 3.3.30, paras 7.4–7.5.1.
69. Ibid, paras 2.17–2.20.
70. Ibid, para 7.8.
71. Ibid, paras 7.8, 7.22–7.24.
72. Ibid, para 7.22.
73. Ibid, paras 7.34–7.54.
74. Document A76, para 9.
75. Submission 3.3.32, para 35.
76. Ibid, para 1.

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defines New Zealand's internationally highly regarded model. This commitment, it said, fundamentally contributes to greater individual and societal wellbeing. The Crown acknowledged, however, that the Māori health experience remains inequitable and, therefore, unacceptable.[77] The Crown emphasised that the intentions of the framework are good and that the fundamental aims and settings of the system are sound but that the framework has simply not been effectively implemented.[78]

Crown counsel submitted that Māori are free to assert mana motuhake and tino rangatiratanga through engagement with Māori models of health care, as is provided for under the legislative and policy framework. The Crown submitted that this reflects the Treaty and its principles and that overall the Treaty informs primary health care services.[79]

The Crown submitted that the existence of Māori health inequities themselves is not a Treaty breach. Rather, it must be established, accounting for prevailing factors, whether the Crown has attempted to address these inequities to the degree required by the Treaty and its principles and obligations.[80] To this end, Crown counsel submitted that eliminating health inequities remains a significant, difficult problem to solve.[81] The Crown asserted that advancing Māori wellbeing requires strong leadership by the Ministry of Health and collaboration with other Crown agents, such as district health boards, and State sector agencies. Further cooperation outside of the health sector is also required to affect broader health determinants.[82] Having noted these difficulties, Crown counsel largely did not dispute the evidence submitted by the claimants. Indeed, Crown counsel expressed that the Crown had attempted to engage in the stage one inquiry constructively, with potential solutions firmly in mind. Overall, Crown counsel said, the Crown wants to improve its 'efforts to address' Māori health inequities 'consistent with Treaty principles'.[83]

1.2.3 The interested parties

A total of 76 health-related claimant groups were granted interested party status during stage one, with varying levels of participation, including the cross-examination of witnesses and provision of evidence and submissions on particular topics.[84] These interested parties broadly supported the allegations raised by the stage one claimants. Here, we provide brief summaries of the positions of those interested parties who were the most active before us.

77. Ibid, para 35.
78. Ibid, para 24.
79. Ibid, paras 5–6.
80. Ibid, para 142.
81. Ibid, paras 15–16.
82. Ibid, para 4.
83. Ibid, para 16.
84. Memorandum 2.5.31, paras 2–3; memo 2.6.1(a). A full list of interested parties and their involvement in the inquiry appears as appendix II.

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1.2.3.1 *The Ngā Ariki Kaipūtahi claim (Wai 507)*

Owen Lloyd, of Ngā Ariki Kaipūtahi, supported the remedies sought by the stage one claimants in principle. However, he argued that a more specific reform of district health board structure and governance to empower iwi and hapū authority should be the priority for stage one.[85] Accordingly, he sought a recommendation that the minimum Māori representation on district health boards be increased to 50 per cent and that these representatives be appointed by iwi and hapū.[86]

1.2.3.2 *Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2064, Wai 2165, and Wai 2382*

Tamaki Legal filed two sets of closing submissions that cover the same issues for several interested parties pleading health-related allegations.[87] They argued on behalf of these groups that the funding, accountability, and rural health care access arrangements for primary care services, as well as what they see as the health sector's inadequate recognition of kaupapa Māori, are breaches of the Treaty.[88] They accordingly sought an apology and the review and amendment of policy affecting these issues, including amendments to the Act.[89]

1.2.3.3 *The Ngāti Kiore and Te Kohatutaka hapū of Mangataipa claim (Wai 1732)*

The Ngāti Kiore and Te Kohatutaka hapū of Mangataipa alleged that the Crown acted in a way inconsistent with kāwanatanga obligations by failing to protect hapū hauora (health and wellbeing).[90] Counsel submitted that the existing primary health care framework fails both to account for the cultural and spiritual needs of Māori and to give priority to hapū wairuatanga (spirituality), thus severely affecting collective wellbeing.[91] They further argued that the alienation of Māori from decision-making has resulted in an inability to deliver effective and integrated health care.[92]

1.2.3.4 *The Māori Health Disparities (Te ORA) claim (Wai 2499)*

Dr David Jansen and others on behalf of themselves and Te Ohu Rata o Aotearoa (the Māori Medical Practitioners Association or Te ORA) submitted that the Crown had failed in its responsibility to Māori, as shown by persisting inequalities in Māori health outcomes, in Māori access to services, in primary health system responsiveness to Māori health issues, and in Māori experience of other social determinants of health.[93] They also submitted that, given the limited scope of the stage one inquiry, a broader, more thorough inquiry into primary care is

85. Submission 3.3.14(a), para 55.
86. Ibid, para 56.
87. Submissions 3.3.12–3.3.13.
88. Submission 3.3.13, paras 246–262.
89. Ibid, paras 273–274.
90. Submission 3.3.17, para 5.
91. Ibid, para 6.
92. Ibid, para 9(c).
93. Submission 3.3.22, para 9.

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required.[94] They, nonetheless, sought recommendations that aim to commit the Crown and the primary health care sector to achieving Māori health equity more robustly.[95]

1.2.3.5 *The District Māori Council claim (Wai 2623)*

Persons representing five District Māori Councils submitted that, under te Tiriti, Māori were guaranteed tino rangatiratanga over their health systems and services.[96] They argued there was a correlation between the Crown's ongoing denial of this tino rangatiratanga and poor health and wellbeing outcomes for Māori.[97] The only Treaty-compliant solution, in their estimation, was to transfer Māori health systems and services completely to Māori, along with the necessary funding and technical support, so that Māori could design, operate, govern, control, and administer those systems and services.[98]

1.2.3.6 *Wai 2634, Wai 2643, Wai 2647, Wai 2650, and Wai 2688*

Oranganui Legal acted on behalf of five interested parties and cross-examined several stage one witnesses. They variously alleged prejudice suffered as a result of Crown actions and omissions in health care policy regarding smoking, mental health, alcohol and substance abuse, cancer, obesity, and suicide rates.[99] They also alleged prejudice in relation to access to care and to rongoā (indigenous medicine and treatment) services.[100] Broadly, they contended that the Crown has not provided adequate health services in these areas, contrary to its Treaty obligation to do so.

1.2.3.7 *The New Zealand Māori Council Health claim (Wai 2644)*

The New Zealand Māori Council argued that 'inequitable outcomes largely define Maori experiences with the current Primary Health Care system'.[101] It sought recommendations that health care for Māori should be provided by Māori and should more adequately recognise the particular needs of high-needs patients.[102] The council further claimed that the Crown should be compelled by the Tribunal to acknowledge the Māori–Crown partnership in the health sector and further recognise Māori mana motuhake.[103] To this end, it sought the establishment of a

94. Ibid, paras 59–63.
95. Ibid, para 71.
96. Submission 3.3.31, paras 18, 21. The closing submissions were supported in full by the closing submissions of the Wai 179 claimants (submission 3.3.25) and the Wai 996 claimants (submission 3.3.26).
97. Submission 3.3.31, paras 19, 21.
98. Ibid, paras 21, 280.
99. See the statements of claim for Wai 2634, Wai 2643, Wai 2647, and Wai 2650.
100. Wai 2688 ROI, claim 1.1.1.
101. Submission 3.3.21, para 3.
102. Ibid, para 5(a).
103. Ibid, para 5(b)–(c).

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'Maori Health Care Agency' with similar responsibilities and constitution as the agency outlined by the National Hauora Coalition claimants.[104]

1.2.3.8 *The Counties Manukau Health claim (Wai 2702)*

The Counties Manukau health claim focused on the Treaty and statutory compliance of district health boards, arguing that the state of health inequity in Counties Manukau is evidence that the Crown is not meeting its statutory obligations to reduce health disparities.[105] The claimants sought recommendations that each district health board should have an Independent Māori Statutory Board to hold them specifically accountable, and for amendments to the Act and policy that broadly strengthen the language around the Crown's Treaty obligations in the health sector.[106]

1.2.3.9 *The Māori Nurses claim (Wai 2713)*

Along with broadly supporting the submissions of the stage one claimants on the persistence of Māori health inequities as evidence of insufficient Crown action, the Māori Nurses submitted that 'building a sustainable and properly paid Māori nursing and health workforce is essential to addressing inequities and disparities in Māori health'.[107] They argued that the institutional racism inherent in the health system is to the detriment of Māori and to themselves as Māori nurses, and accordingly they sought recommendations relating to workforce issues such as pay parity and the cultural competency of staff in mainstream health entities.[108]

1.2.3.10 *The Health Services (Tamihere) claim (Wai 2720)*

John Tamihere, representing Te Whānau o Waipareira, the Manukau Urban Māori Authority, and the National Urban Māori Authority, submitted that Māori were guaranteed tino rangatiratanga over their health systems and services, and the denial of this tino rangatiratanga was correlated to poor health and wellbeing outcomes for Māori.[109] Counsel submitted that the solution was to transfer Māori health systems and services completely to Māori, along with the necessary funding and technical support, so that Māori could design, operate, govern, control, and administer them.[110]

1.2.3.11 *The Natural and Indigenous Health Care Treatments claim (Wai 2727)*

Tanya Filia, of Ngāpuhi, alleged prejudice as a result of a lack of funding for, public promotion of, and access to mirimiri and other indigenous health treatments.[111] Filia also argued that the primary health care system does not adequately account

104. Submission 3.3.21, para 5(d)–(h).
105. Submission 3.3.15, paras 4–6, 10.
106. Ibid, para 177.
107. Submission 3.3.20, paras 8.
108. Ibid, paras 28, 30.
109. Submission 3.3.27, paras 18–19, 21.
110. Ibid, paras 21, 300
111. Wai 2727 ROI, claim 1.1.1, paras 6, 8.4.

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for 'Maori tikanga, values and practices when dealing with Maori and treating Maori patients'.[112]

1.2.3.12 *The Mental Health and Addiction (Fergusson-Tibble) claim (Wai 2738)*

Kahurangi Fergusson-Tibble asserted that urgent action is needed to reverse inequity suffered by Māori, and he argued that the current primary health care framework should be replaced with a new system designed and founded upon full partnership.[113] He endorsed the other parties' focus on mana motuhake in the health system. In particular, he argued that the Crown does not adequately support tikanga Māori consistent approaches to care. His counsel argued that these ongoing systematic failures are gravely prejudicial to Māori.[114]

1.2.3.13 *Additional claims represented by Te Mata Law Limited*

Te Mata Law's submissions on behalf of multiple interested parties[115] focused on both the alleged existence of institutional racism in the primary health care framework and system and the impacts of the social determinants of health.[116] These interested parties submitted that a 'revamping' of the primary health care framework is required to remedy Māori health inequity, including more robust clauses in legislation and policy explicitly referring to Treaty principles, a requirement that district health boards prioritise equity, and changes to accountability and funding arrangements.[117]

1.3 THE SCOPE OF THIS REPORT

Stage one of the Health Services and Outcomes Kaupapa Inquiry is concerned with the Treaty-compliance of certain aspects of the primary health care framework. Both the Crown and the stage one claimants urged us in submissions, in evidence, and throughout the hearings to release our report on stage one issues by mid-2019, so that the Government's Health and Disability System Review, led by Heather Simpson, could take it into account.[118]

Elsewhere, we have expressly stated that stage one was not intended to be a broad, all-purpose inquiry into primary health. We said that in stage one we would specifically inquire into and report on the Māori Primary Health Organisations and Providers (Wai 1315) and National Hauora Coalition (Wai 2687) claims and

1 12. Ibid, para 8.5.

1 13. Submission 3.3.29, paras 135.2, 135.3.

1 14. Ibid, para 2.

1 15. Including: Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2638, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, and Wai 1832.

1 16. Submission 3.3.15, para 5; submission 3.3.16, paras 3–5.

1 17. Submission 3.3.15, para 177; submission 3.3.16, para 167.

1 18. Submission 3.3.23, para 51; submission 3.3.32(a), p 3; transcript 4.1.8, pp 45, 65, 70, 176–177.

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the issues they raised, as set out in the statement of issues.[119] We were assisted in that process by hearing evidence and submissions from various interested parties illustrating points in response to questions posed in the statement of issues. These points referred to the primary health care framework as well as to various issues related to its implementation in practice.

Having considered the allegations raised in the two claims, the statement of issues, the evidence before us, and the tight timeframe requested by the stage one claimants, we have identified four main thematic issues to focus on for this stage one report, broadly: the Treaty-compliance of the Act and the framework for primary health care; the funding arrangements for primary health care; the accountability arrangements for primary health care; and the nature of Treaty partnership arrangements in the primary health care sector. In our analysis of those four areas, we have drawn upon and addressed many of the issues posed in the statement of issues. We record, however, that we have not structured our report to respond individually to every issue. We considered that approach to be unnecessary. As the inquiry proceeded and our thinking developed, we concentrated our efforts on those areas that we think most greatly affect Māori primary health care.[120]

1.4 THE STRUCTURE OF THIS REPORT

In chapter 2, we present the immediate context to our inquiry into the primary health care framework.

In chapter 3, we discuss the Treaty principles relevant to the specific issues we are addressing in this report.

In chapter 4, we provide an overview of the functions and operation of the primary health care system as it relates to our stage one inquiry.

In chapters 5 through 8, we present our analysis of the four main thematic issues and our findings.

In chapter 9, we set out our findings on prejudice and our recommendations.

119. Memorandum 2.5.25, para 90; memo 2.5.30, para 19; see also statement of issues 1.4.1.

120. We foreshadowed this in the statement of issues, where we said that the statement of issues was intended to provide a guideline to, but not straitjacket, the claimants, Crown, and interested parties.

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CHAPTER 2

WHY IS THIS INQUIRY NEEDED?

He ngana riri; he ngana tauā

2.1 Introduction

Why is this Waitangi Tribunal inquiry into Māori Health Services and Outcomes necessary? And why have we decided that the first stage of this inquiry is to hear and report on the legislative and policy framework of New Zealand's current primary health care system, together with flaws in the system as they impact on Māori, as alleged in the two claims before us?

In the evidence before us, primary health care was referred to as 'often the first port of call for sick New Zealanders' and the 'front-line of the health system . . . For most, this will be a visit to their family doctor.'[1]

The present system of primary health care was established under the New Zealand Public Health and Disability Act 2000. It is primarily funded and overseen by the Ministry of Health and district health boards, which are responsible for the system and its performance. The Crown, therefore, plays a paramount role in primary health care.

Notwithstanding the reforms ushered in by the Act, Crown witnesses acknowledged before us that the reforms had failed to ensure equitable outcomes for Māori health. The Director-General of Health, Dr Ashley Bloomfield, stated:

> [the] state of health for Māori is unacceptable and it is the core business of the New Zealand health and disability system to respond effectively – as required by the New Zealand Public Health and Disability Act 2000[,][2]

and:

> there is still considerable work needed to achieve equitable health outcomes between Māori and non-Māori. This has been an ongoing issue for the primary health care system and one that is not acceptable or tolerable.[3]

Crown counsel acknowledged in opening submissions that 'there is no need for this Tribunal panel to inquire into the question of whether Maori health

1. Submission 3.3.3, para 2.
2. Document A59, para 22.
3. Document A65, para 65.

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status is significantly worse than for non-Maori at a population level; this is well-established and not disputed'.[4] The director-general acknowledged that the system has not sufficiently ensured good health outcomes for Māori nor enabled effective Māori participation.[5]

In this chapter, we provide a broad overview of the persisting inequities in health outcomes experienced by Māori.

2.2 MĀORI HEALTH OUTCOMES AT THE TURN OF THE TWENTY-FIRST CENTURY

Professor Jacqueline Cumming, an independent expert witness called by the Crown, told us that, prior to the present health system being established, Māori already had 'poorer health status than other New Zealanders and . . . should have been using primary care services more than other populations'.[6]

Professor Peter Crampton, an expert witness called by the Māori Primary Health Organisations and Providers (Wai 1315) claimants, told us that New Zealand has long experienced 'significant and enduring health inequities in relation to both ethnicity and socioeconomic deprivation. The most consistent and compelling ethnic inequities are between Māori and non-Maori.' These marked health inequities existed prior to the present system being established and continue to exist today.[7]

Statistics made available to us by the Crown paint a grim picture. By 2001, as a population group, Māori had on average the poorest health status of any ethnic group in New Zealand.[8]

Crown witness Dr Frances McGrath, a chief adviser in the Office of the Chief Medical Officer, told us that, as at 2001, the life expectancy of Māori males at birth was eight years fewer than that of non-Māori males. For Māori females, life expectancy was nine years fewer than for non-Māori females. From 1950 to 1997, the life expectancy of all non-Māori females had increased from 71.3 years to 79.6 years, and from 67.2 years to 74.3 years for non-Māori males.[9] But Māori had not shared in this increased life expectancy, theirs remaining virtually static from the late 1970s.[10]

Dr McGrath also recorded that Māori experienced a higher rate of disability than non-Māori (24 per cent to 17 per cent), higher rates of mental ill-health, and more negative health impacts from addiction than any other ethnic group in New Zealand.[11] During 1997 and 1998, Māori experienced age-standardised rates

4. Submission 3.3.2, para 9.
5. Document A59, para 20.
6. Document A60, para 16.
7. Document A9, para 13.
8. Document A63, para 138.
9. Ibid.
10. Ministry of Health, *Tatau Kahukura: Māori Health Chart Book*, Public Health Intelligence Monitoring Report 5 (Wellington: Ministry of Health, 2006), pp 29–30; doc A63, para 136.
11. Document A63, para 139.

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of potentially avoidable hospitalisations 60 per cent higher than non-Māori New Zealanders.[12] In 2002, the avoidable mortality rate for Māori was more than twice that of other New Zealanders.[13]

In its assessment of the statistics recording Māori health outcomes, the Ministry's first *Tatau Kahukura* report, discussing the years 2000 to 2005, recorded:

> Total cardiovascular disease mortality was more than two-and-a-half times higher for Māori than for non-Māori; Māori were twice as likely to be hospitalised for cardiovascular disease than non-Māori[;]
>
> Stroke mortality was nearly twice as high in Māori than in non-Māori, and the stroke hospitalisation rate for Māori was twice that of non-Māori[;]
>
> The heart failure mortality rate for Māori was almost three times the rate for non-Māori. Māori were five-and-a-half times more likely to be hospitalised for heart failure than non-Māori[;]
>
> Rheumatic heart disease mortality was more than eight-and-a-half times higher in Māori than in non-Māori[;]
>
> Māori rates of mortality from all types of cancer were twice those of non-Māori[;]
>
> Māori females had a breast cancer registration rate 1.3 times that of non-Māori females, but a breast cancer mortality rate twice that of non-Māori females. For cervical cancer, Māori females had a registration rate twice that of non-Māori; however the mortality rate for Māori females was disproportionately higher at four times that of non-Māori females[;]
>
> Māori females had a lung cancer registration rate four-and-a-half times that of non-Māori females. The relative disparity was slightly higher for lung cancer mortality, with Māori females having a rate five times that of non-Māori females[;]
>
> Māori male lung cancer registration and mortality rates were three times those of non–Māori males[;]
>
> For Māori males, the liver cancer registration rate was five-and-a-half times that of non-Māori males[;]
>
> Rates of stomach cancer registration and mortality were almost three times higher for Māori males than for non-Māori males[;]
>
> For many cancers the rate ratio for Māori compared with non-Māori is higher for mortality rates than for registration rates. This suggests that Māori with cancer may be more likely to die from their cancer than non-Māori[;]
>
> Prostate cancer registration was lower for Māori males than for non-Māori males. However, Māori males had a prostate cancer mortality rate twice that of non-Māori males[;]
>
> Māori aged 5 to 34 were twice as likely to be hospitalised for asthma as non-Māori . . . Maori aged 15 to 45 years reported an asthma prevalence rate one-and-a-half times that of non-Māori[;]
>
> Māori aged 45 years or more had a COPD [chronic obstructive pulmonary disease] hospitalisation rate four times that of non-Māori. The relative inequality was greatest

12. Ibid, para 144.
13. Document A9, para 14.

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for females: Māori females had a COPD hospitalisation rate almost five times that of non-Māori females. COPD mortality rates were three times higher for Māori aged 45 years or more. Again, the ethnic disparity was greatest for females[;]

Population rates of renal failure with concurrent diabetes (aged 15+) were 9.4 times higher in Māori compared with non-Māori. While some of this prevalence can be attributed to the higher prevalence of diabetes among Māori, among people with diabetes, Māori are three and a half times more likely to have renal failure than non-Māori[; and]

Similarly, population rates of lower limb amputation with concurrent diabetes were five times higher for Māori compared with non-Māori. Therefore, among people with diabetes, lower limb amputations for Māori can be estimated as occurring at nearly twice the rate of non-Māori.[14]

Similar statistics were presented for sudden unexplained deaths of infants (SUDI), and other categories such as self-harm among Māori males compared to non-Māori males, suicide mortality rates, mortality rates of victims of violence, unintentional injury, and in other classes of illness and injury.[15]

2.3 Why are Māori Health Outcomes So Bad Compared with those of Non-Māori?

The parties before us all accepted that Māori health inequities are not only caused by health issues but influenced by a wide range of factors, including income and poverty, employment, education, and housing – termed the social determinants of health.[16]

The parties also accepted that Māori health inequities are influenced by the cumulative effects of colonisation. Counsel for the National Hauora Coalition claimants submitted that '[c]olonisation has had a severe impact on Māori in terms of all relevant determinants of health'.[17] Professor Papaarangi Reid, an interested party witness, called its impact 'a health legacy from previous Treaty breaches'. She said that colonisation permitted '[t]he confiscation and misappropriation of Māori resources through the colonial processes impacted both by historical trauma . . . and by impoverishment'. According to Professor Reid '[t]his legacy of colonisation has not been weakening'.[18] In other words, it is an ongoing process, not something begun and ended in the nineteenth century. Crown counsel, after acknowledging the negative influence of the cumulative effects of colonisation, further acknowledged that it was not necessary for the Tribunal to establish a causative link between colonisation and the disparities that exist today. They submitted that, if we concluded that some of the steps the Crown is taking in primary health are not

14. Ministry of Health, *Tatau Kahukura*, pp37, 39–47.
15. Ibid, pp50–58.
16. Document A60, para 9; doc A59, paras 21, 28. These factors include health determinants within the remit of the health sector that relate to issues outside of the scope of our stage one inquiry.
17. Submission 3.3.4, para 62.
18. Document A51, para 17.

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Treaty-consistent, then our task is to identify recommendations for what should happen next.[19]

The legacy and ongoing impacts of colonisation now partly manifest as a form of discrimination often termed institutional racism. Dr Heather Came-Friar, an interested party witness in our inquiry, said institutional racism is 'broadly defined as a *pattern* of differential access to material resources, cultural capital, social legitimation and political power that disadvantages one group, while advantaging another' (emphasis in original).[20] Institutional racism partly manifests as:

> the outcomes of mono-cultural institutions which simply ignore and freeze out the cultures of those who do not belong to the majority. National structures are evolved which are rooted in the values, systems and viewpoints of one culture only. Participation by minorities is conditional on their subjugating their own values and systems to those of 'the system' of the power culture.[21]

The failure to address negative social determinants, then, can be considered a form of institutional racism. Institutional racism was defined by witnesses in our inquiry as 'inaction in the face of need'. This inaction can be conscious or unconscious; it can manifest through the deliberate actions of individuals or result simply from 'the routine administration of public institutions that produce inequitable social outcomes'.[22]

In giving evidence on behalf of the Crown, Director-General Dr Bloomfield stated:

> So socio-economic deprivation for Māori impacts on their ability to access good health but it is compounded by other factors including racism. The impact of personal and institutional racism is significant on both the determinants of health and on access to and outcome from health care itself. Racism is associated with poorer health, including poorer mental health.[23]

The 1990s saw many health reforms as successive governments grappled with persisting inequities in health care. Reforms included the introduction of the Community Services Card, allocated on the basis of income, which entitled general practitioners to claim a subsidy, thus lowering the fee charged to the patient; the formation of four Regional Health Authorities that held all funding for health and disability care, only to be replaced by the national Health Funding Authority; and the rise and growth of Independent Practitioner Associations, groups that

19. Memorandum 3.1.155, para 1.11.
20. Document A57, para 10.
21. Māori Perspective Advisory Committee, *Puao-te-ata-tu: The Report of the Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare* (Wellington: Department of Social Welfare, 1988), p 19.
22. Document A57, para 14.
23. Document A59, para 32.

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represented and negotiated on behalf of general practitioners.[24] The reforms also saw the growth and funding of Māori-led providers of primary and community care.[25]

Nonetheless, these reforms were inadequate for tackling Māori health inequity. In addition to the complex social determinants of Māori health, and the co-morbidities that many Māori experience, it appeared that the arrangement of the health system itself contributed to Māori health inequities. Crown officials, and the health sector more broadly, recognised that further reform was needed, both to identify bottlenecks in the system and to rethink health care strategies.

2.4 THE RESET OF THE PRIMARY HEALTH SYSTEM, 2000–02: A SENSE OF HOPE

A change of government in 1999 saw a period of accelerated activity in the period 2000 to 2002, when the primary health system was substantially altered by the New Zealand Public Health and Disability Act 2000.

Pursuing a reduction in health disparities by improving the health outcomes of Māori and other population groups is a stated purpose of this Act.[26] The Ministry strategies and policy documents developed to direct the implementation of the Act, particularly the Primary Health Care Strategy released in 2001 and the Māori health strategy, known as He Korowai Oranga, released in 2002, similarly indicated that the new primary health care system would focus on equity, including Māori health equity.[27] We discuss the Act and the relevant policies and strategies further in chapters 4 through 8.

Witnesses before us in this inquiry, from all parties, emphasised that, while the updated legislative and policy framework for primary health care had its weaknesses, it was still light-years ahead of anything that had gone before. Strategies and policies utilised Māori vocabulary and various Māori concepts barely mentioned in earlier official documents. They indicated what the problems were and the means to counter them in the pursuit of reducing health inequities.

Professor Crampton spoke about a sense of optimism at the commencement of the new primary health care system, remarking that the Primary Health Care Strategy of 2001 was 'a very strong piece of policy' that 'clearly identified equity for Māori and other communities' as its driving force.[28]

The parties particularly highlighted the formation of primary health organisations, which broadly superseded Independent Practitioner Associations, as a real opportunity for community-owned and -driven care. Claimant Janice Kuka similarly spoke of the 'great hope' inspired by the Act with its references to the Treaty of Waitangi. She stated that it provided hope for 'real partnerships between us and

24. Document A60, para 22.
25. Document A63, para 82; doc A9, para 11.
26. New Zealand Public Health and Disability Act 2000, s 3(1)(b).
27. Ministry of Health, *The Primary Health Care Strategy* (Wellington: Ministry of Health, 2001), pp vii, 2–3, 10–11.
28. Transcript 4.1.4, p 574.

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the Crown to improve Māori health'. The Act provided an opportunity to build an alternative model to the existing private general practice: Māori organisations would be able to provide, in Kuka's words, 'our kaupapa Māori based philosophy and operation from a not-for-profit paradigm'.[29]

2.5 MĀORI HEALTH INEQUITIES PERSIST

Despite a few years of hope at the beginning of the twenty-first century, and some areas of improvement since 2000, the statistics before us still paint a grim picture of the state of Māori-health. Director-General Dr Bloomfield summarised statistics from the years 2010 to 2014. Figures from the third edition of the Ministry's *Māori Health Chart Book 2015* are the main source of the statistics.[30]

Director-General Dr Bloomfield highlighted the following statistics, amongst many others, for this inquiry:

> In 2013, 23.5 percent of Māori lived in decile 10 (most deprived) areas (compared with 6.8 percent of non-Māori)[;]
>
> In 2013/14, Māori adults were almost twice as likely as non-Māori adults to have experienced racial discrimination in their lifetime[;]
>
> Overall the gap in life expectancy at birth between Māori and non-Māori is 7.3 years for males and 6.8 years for females[;]
>
> Ischaemic heart disease is the leading cause of death for [the] Māori population in 2010–12, except for Māori females, for whom lung cancer is the most common cause of death[;]
>
> While New Zealand performs well internationally in terms of cancer outcomes, Māori experience a disproportionate burden of cancer. Māori with cancer have a higher risk of dying from their cancer than non-Māori (1.7 times as likely) in 2010–12[;]
>
> Māori adults aged 25 and over had significantly higher cancer registration rates than non-Māori adults for total cancers in 2010–12. The total-cancer mortality rate among Māori adults is more than one-and-a-half times as high as that among non-Māori adults in 2010–12[;]
>
> There are screening programmes for both breast and cervical cancer in New Zealand. For both these programmes, coverage rates to 31 March 2015 were lower for Māori than for non-Māori[;]
>
> In 2010–12, the total cardiovascular disease mortality rate among Māori was more than twice as high as that among non-Māori[;]
>
> In 2010–12, Rheumatic heart disease mortality is over five times that of non-Māori, while rheumatic heart disease hospitalisation is almost six times that of non-Māori[;]
>
> Māori aged 5–34 years were more than twice as likely as non-Māori in the same age group to have been hospitalised for asthma in 2012–14[;]

29. Document A12, paras 16, 25.

30. Document A59, para 21; Ministry of Health, *Tatau Kahukura: Māori Health Chart Book 2015*, 3rd ed (Wellington: Ministry of Health, 2015).

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2.5

The chronic obstructive pulmonary disease (COPD) mortality rate among Māori aged 45 and over is almost three times that of non-Māori in the same age group in 2010–12. Māori aged 45 and over had a COPD hospitalisation rate over four times that of non-Māori in the same age group in 2012–14[;]

In 2014, 88.9 percent of Māori children at the age of eight months had completed age-appropriate immunisations, compared with 91.9 percent of total New Zealand children. By two years of age, the coverage rates were 91.9 percent for Māori children and 92.8 percent for total New Zealand children[;]

The SUDI [sudden unexplained death of infants] rate among Māori infants is nearly five times as high as that among non-Māori infants in 2010–12[;]

Māori babies were significantly less likely than non-Māori babies to have been exclusively breastfed when they were three months (13 weeks) old and six months (26 weeks) old in 2013/14[;]

Māori children and adults had significantly higher unintentional injury hospitalisation rates in 2012–14 and mortality rates in 2010–12 than non-Māori. In 2010–12, for all age groups, motor vehicle traffic accidents is a common cause of death and for older people aged 65 years and over, falls were the most common cause of death by unintentional injury[;]

Amenable mortality rates among Māori aged 0–74 . . . were almost two-and-a-half times as high as those among non-Māori at the same age group in 2010–12[;]

Ambulatory-sensitive hospitalisation (ASH) rates among Māori aged 0–74 . . . were almost twice as high as those of non-Māori at the same age group in 2012–14[;]

Māori are more likely than non-Māori to access services later and to experience serious disorders and/or co-existing conditions[;]

Māori adults are less likely than non-Māori adults to report having seen a GP in the last 12 months in 2013/14[;]

In 2013/14, compared with non-Māori, Māori children and adults are more likely to report cost as a barrier to seeking health care from a GP. A lack of transport is also more likely to be a barrier to accessing GP or after-hours services for Māori than non-Māori[; and]

Māori children and adults were more likely than non-Māori children and adults to have reported not collecting prescriptions due to cost in 2013/14.[31]

While we were preparing this report, the Crown filed more recent health outcomes statistics as part of its Māori Health Trends 1990–2015 project.[32] These indicate some gains, but the overall picture remains the same: Māori experience health inequities in nearly all these measures.

At the 2018 hearings for stage one of this inquiry, Director-General Dr Bloomfield stated: 'As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand.'[33]

31. Document A59(a), pp11–16.
32. Documents B1–B21.
33. Document A59, para 23; doc A63, para 138.

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It is striking to us that the director-general was repeating in 2018, word for word, a statement published in 2006 in the *Māori Health Chart Book* referenced earlier in this chapter. This Crown report goes on to say: 'This is not acceptable, and the Government and the Ministry of Health have made it a key priority to reduce the health inequalities that affect Māori.'[34]

Despite this 'key priority', set in 2006, the Crown has confirmed in the evidence and submissions before us that this situation has not measurably improved. This is particularly concerning to us, as it is no doubt to all parties to this inquiry. Despite attempted reforms and readjustments since 2000 intended to deal with inequities, and despite Government policy statements and reports acknowledging failure in this regard, these inequities in Māori health status persisted in the nearly two decades since the Act was passed. The Crown has invested some $220 billion dollars into the health system alone since 2000, with what appears to be little measurable improvement to Māori health outcomes.[35] In a system that is meant to be focused, in part, on reducing health disparities suffered by Māori, this is of great concern.

We, like all of the parties to this inquiry, consider the poor state of Māori health outcomes to be utterly unacceptable. Notwithstanding that the determinants of health are complex and that the Crown health entities cannot be held wholly responsible, we inquire into whether such dire and persistent inequitable health outcomes are indicators of Treaty breaches resulting from Crown actions, insufficient actions, or omissions. The extent and nature of Māori health inequities compel an urgent review by this Tribunal of the legislative and policy framework of the primary health care system. This Tribunal is uniquely placed to undertake this review, as a body that provides a specific lens on the environment and experiences of Māori and the circumstances of their Treaty rights.

We are faced with the prospect of whether an important – and hitherto insufficiently recognised – cause of the inequities suffered by Māori as a population group in the last two decades is the legislative and policy framework of the primary health care system itself.

34. Ministry of Health, *Tatau Kahukura*, 3rd ed, p 1.

35. This figure is calculated from the Treasury 'Vote Health' Supplementary Estimates of Appropriations for the years 2000–01 to 2017–18.

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CHAPTER 3

TREATY PRINCIPLES

Ue-ue 'Nuku; Ue-ue Rangi

3.1 Introduction

The Treaty of Waitangi Act 1975 established the Waitangi Tribunal and confers its jurisdiction. Section 6 of the Act provides that any Māori may make a claim to the Tribunal that they have been, or are likely to be, prejudicially affected by any legislation, policy, or practice of the Crown that is inconsistent with the principles of the Treaty. If the Tribunal finds that a claim is well founded, it may, having regard to all the circumstances of the case, make recommendations to the Crown to compensate for or remove the prejudice or to prevent others from being similarly affected in the future.

This chapter identifies the Treaty principles that we will need to apply to consider the two claims in this first stage of our inquiry. We have considered what previous Tribunal reports have said in relation to health issues and the health system. We have also considered what the Tribunal has said about the application of the Treaty to the social sector and State policy more broadly. The various parties in this inquiry also discussed what they saw as the Treaty principles most relevant to the issues and evidence before us. We use this Tribunal jurisprudence and the parties' submissions before us to inform how the Treaty specifically applies to the issues defined in stage one.

We have identified the following Treaty principles as particularly applicable to this stage of our inquiry:

- the principle of partnership;
- the principle of active protection;
- the principle of equity; and
- the principle of options.

3.2 Partnership

The Treaty established a relationship akin to a partnership and imposed on both Treaty partners an obligation 'to act towards each other reasonably and with the utmost good faith'.[1] The principle of partnership itself is expressed through the necessary balancing of the concepts of kāwanatanga and tino rangatiratanga

1. *New Zealand Maori Council v Attorney General* [1987] 1 NZLR 641 (CA), p667.

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expressed in articles 1 and 2 of the Treaty.[2] In the Te Whanau o Waipareira Inquiry, the Tribunal concluded that partnership 'serves to describe a relationship where one party is not subordinate to the other but where each must respect the other's status and authority in all walks of life'.[3]

Thus, the Treaty of Waitangi was based on the fundamental exchange of kāwanatanga, the right of the Crown to govern and make laws for the country, in exchange for the right of Māori to exercise tino rangatiratanga over their land, resources, and people. The Crown's right of kāwanatanga is not unfettered. The guarantee of tino rangatiratanga requires the Crown to acknowledge Māori control over their tikanga, resources, and people and to allow Māori to manage their own affairs in a way that aligns with their customs and values.[4]

In the *Napier Hospital and Health Services Report*, the Tribunal stated that the duty of good faith conduct establishes 'the general character of the relationship' between Māori and the Crown.[5] Neither the right of Māori to manifest and direct their rangatiratanga nor the Crown's right to govern is absolute: 'each must be conditioned by the other's needs and the duties of mutual respect'. However, because the power imbalance in the Māori–Crown relationship favours the Crown, it is the Crown's Treaty responsibility to ensure that Māori are not disadvantaged in that relationship.[6]

The principle of partnership is also of particular importance when assessing the nature and implementation of State policy. The Tribunal in several inquiries has found that the principle of partnership requires the Crown to consult and partner with Māori genuinely in the design and provision of social services, including health care.[7]

Partnership also recognises that Māori have the right as a Treaty partner to choose how they organise themselves, and how or through what organisations they express their tino rangatiratanga.[8] This means that the Crown needs to be willing to work through the structures Māori prefer in the circumstances, whether through iwi, hapū, and whānau or any other organisation.[9]

The requirement for the Crown to partner with Māori in the development and implementation of policy is especially relevant where Māori are expressly seeking

2. Treaty of Waitangi Act 1975, sch 1, arts 1, 2.
3. Waitangi Tribunal, *Te Whanau o Waipareira Report* (Wellington: GP Publications, 1998), p xxvi.
4. Waitangi Tribunal, *Tū Mai te Rangi! Report on the Crown and Disproportionate Reoffending Rates* (Wellington: Legislation Direct, 2017), p 21.
5. Waitangi Tribunal, *The Napier Hospital and Health Services Report* (Wellington: Legislation Direct, 2001), p 66.
6. Waitangi Tribunal, *Te Whanau o Waipareira Report*, pp xxvi, 16, 30.
7. Ibid, p 232; Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p 59; Waitangi Tribunal, *Te Urewera*, 8 vols (Wellington: Legislation Direct, 2017), vol 8, p 3783; Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims concerning New Zealand Law and Policy Affecting Māori Culture and Identity, Te Taumata Tuarua*, 2 vols (Wellington: Legislation Direct, 2011), vol 2, p 559.
8. Waitangi Tribunal, *Te Whanau o Waipareira Report*, p 25.
9. Waitangi Tribunal, *Matua Rautia: The Report on the Kōhanga Reo Claim* (Wellington: Legislation Direct, 2013), pp 64–65.

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an effective role in this process. Further, the requirement for the Crown to partner with Māori is heightened where disparities in outcomes exist.[10]

The Tribunal's *Ko Aotearoa Tēnei* report provides important, future-oriented guidance for a Treaty-compliant modern partnership between Māori and the State. In assessing the Treaty's modern relevance to social policy, the Tribunal strongly endorsed a modern Treaty partnership that empowers Māori communities to be actively involved in policy decision-making in matters affecting Māori communities. For example, in identifying Treaty standards for a partnership arrangement for the social sector, the Tribunal advocated for 'a partnership in which the State provides logistical and financial support and the Māori Treaty partner exercises decision-making responsibility'.[11]

In *Te Urewera*, the Tribunal stated that partnership is critical for pursuing socio-economic equity for Māori: '[The Crown] cannot simply present Maori with its own solutions . . . at minimum it must consult with Maori, and ideally it will either form a partnership with, or deliver funding and autonomy to, Maori organisations.'[12] In the *Napier Hospital and Health Services Report*, the Tribunal stated that partnership means the Crown should be 'empowering *Maori to design and provide health services* for Maori' (emphasis in original).[13]

The Tribunal has also found that any practical arrangement or framework that is intended to implement partnership requires constant evaluation to ensure that it continues to fulfil its purpose in meeting Treaty obligations. For instance, the Tribunal noted in *Ko Aotearoa Tēnei* that provisions in the Resource Management Act 1991 intended to foster Māori involvement and influence in local resource management decisions had considerable promise. However, the Tribunal found that, because those provisions were either being ignored or being used ineffectively, the Resource Management Act system is now not Treaty-compliant.[14] While the formative process of the Resource Management Act was seen by the Tribunal as Treaty-compliant, the partnership arrangements themselves failed in their implementation.

Similarly, in *Tū Mai te Rangi! Report on the Crown and Disproportionate Reoffending Rates*, the Tribunal found that the Department of Corrections' declaration of commitment to engage with Māori groups was compliant with the Treaty principle of partnership; however, the Tribunal found that, if in future it became apparent that this commitment had not been realised, that would constitute a Treaty breach.[15]

In other words, what might appear at the time to be a Treaty-consistent partnership arrangement may not have lived up to its promise. We emphasise this point because the Tribunal in the *Napier Hospital and Health Services Report* found that

10. Waitangi Tribunal, *Tū Mai te Rangi!*, pp 62–63.
11. Waitangi Tribunal, *Ko Aotearoa Tēnei: Te Taumata Tuarua*, vol 2, p 559.
12. Waitangi Tribunal, *Te Urewera*, vol 8, p 3773.
13. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p xxvi.
14. Waitangi Tribunal, *Ko Aotearoa Tēnei: Te Taumata Tuarua*, vol 1, p 284; vol 2, p 705.
15. Waitangi Tribunal, *Tū Mai te Rangi!*, p 64.

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the New Zealand Public Health and Disability Act 2000, in committing the Crown and its health agencies to several specific obligations to Māori, was consistent with the principles of partnership and equity. That finding was made shortly after the advent of the then-new Act.[16] We discuss these findings later in our report.

3.3 Active Protection

The principle of active protection also arises from the Treaty partnership, through the exchange of kāwanatanga and tino rangatiratanga.[17] This includes the Crown's obligation to protect actively Māori tino rangatiratanga, including the Māori right to autonomy.[18] Thus, in the modern context, the Tribunal has considered that the Treaty guarantee of tino rangatiratanga affords Māori, through their iwi, hapū, or other organisations of their choice, the right to decision-making power over their affairs.[19] As the Tribunal noted in the *Ngāpuhi Mandate Inquiry Report*, 'the capacity of Māori to exercise authority over their own affairs as far as practicable within the confines of the modern State' is key to the active protection of tino rangatiratanga.[20]

The Tribunal has affirmed that the Treaty guarantee of tino rangatiratanga was a promise of active protection of Māori autonomy. In encompassing autonomy and self-government to the fullest extent possible, tino rangatiratanga is an equivalent term to mana motuhake.[21] Together, these statements provide clear indications of a Treaty-compliant partnership that recognises tino rangatiratanga adequately, including the Māori 'right to autonomy and self-government, and their right to manage the full range of their affairs in accordance with their own tikanga'.[22]

However, the guarantee of tino rangatiratanga is not absolute and unqualified. Whilst the obligation is consistent, the Crown is not required to go beyond what is reasonable in the prevailing circumstances. What is reasonable will change depending on the circumstances that exist at the time.[23]

16. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, pp 314.
17. Waitangi Tribunal, *The Whakatōhea Mandate Inquiry Report* (Wellington: Pre-publication version, 2018), p 23; Waitangi Tribunal, *Tū Mai te Rangi!*, p 21; *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641 (CA), p 664.
18. Waitangi Tribunal, *Tauranga Moana, 1886–2006: Report on the Post-Raupatu Claims*, 2 vols (Wellington: Legislation Direct, 2010), vol 1, p 22; Waitangi Tribunal, *The Ngāpuhi Mandate Inquiry Report*, p 23; Waitangi Tribunal, *Te Whanau o Waipareira Report*, p 215.
19. Waitangi Tribunal, *The Ngātiwai Mandate Inquiry Report* (Wellington: Legislation Direct, 2017), p 27; Waitangi Tribunal, *Te Whanau o Waipareira Report*, p 215; Waitangi Tribunal, *Ngāpuhi Mandate Inquiry Report*, p 24; Waitangi Tribunal, *Turanga Tangata Turanga Whenua: The Report on the Turanganui a Kiwa Claims*, 2 vols (Wellington: Legislation Direct, 2004), vol 2, p 739.
20. Waitangi Tribunal, *The Ngāpuhi Mandate Inquiry Report*, p 23.
21. Waitangi Tribunal, *Tauranga Moana*, vol 1, p 20; Waitangi Tribunal, *He Maunga Rongo: Report on the Central North Island Claims*, 4 vols (Wellington: Legislation Direct, 2008), vol 1, p 172; Waitangi Tribunal, *The Taranaki Report: Kaupapa Tuatahi* (Wellington: Legislation Direct, 1996), pp 6, 20.
22. Waitangi Tribunal, *Te Mana Whatu Ahuru: Report on Te Rohe Pōtae Claims – Pre-publication Version, Parts 1 and 11* (Wellington: Waitangi Tribunal, 2018), p 189.
23. *New Zealand Maori Council v Attorney-General* [1994] 1 NZLR 513 (PC), p 517.

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The Tribunal in its report for the Napier Hospital inquiry found that the principle of active protection includes the Crown's responsibility to protect actively Māori health and wellbeing through the provision of health services:

> Combating ill health amongst Maori, whether by medical or other means, was therefore part of the agenda of active protection that the British rulers took on under the Treaty of Waitangi. In so far as Western medical technology was considered capable of contributing towards that goal and to the extent that was reasonably practicable, the Crown was duty bound to provide resources or programmes delivering appropriate health services to Maori.[24]

In terms of the application of the principle of active protection to health issues, the Tribunal in the Napier Hospital inquiry found that the Crown cannot be held wholly responsible for the causes of Māori ill health.[25] Nonetheless, the principle of active protection also requires the Crown to make available to Māori, as citizens, health services that reasonably and adequately attempt to close inequitable gaps in health outcomes with non-Māori.[26] The Crown's responsibility for the health and wellbeing of Māori cannot be diluted: it does not matter whether the services are being provided by the Crown directly or by a mix of publicly and privately owned organisations, as is the case in today's primary health care sector. The Crown cannot avoid its obligation to ensure Māori rights receive active protection by delegating functions to non-Crown entities.[27] Further, the Tribunal has established, including recently in its *Tū Mai te Rangi!* report, that 'the failure actively to protect Māori Treaty rights when necessary is as much a breach of the Treaty as the active removal of those rights'.[28]

Part of active protection is ensuring that health services are culturally appropriate. In the *Napier Hospital and Health Services Report*, the Tribunal found that the Crown needs to ensure that State-controlled and publicly funded health institutions respect tikanga Māori. The Tribunal concluded that providing a culturally appropriate health service is 'essential for the delivery of effective health services to Maori' and, as such, the principle of active protection extends to the incorporation and practice of tikanga Māori in mainstream health institutions.[29]

An approach to health care that assumes that the needs of all patients are largely the same not only undermines the recognition of tikanga Māori but may also result in a failure to recognise and provide for the particular health needs

24. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p 53; see also *Tauranga Moana*, vol 2, p 806; Waitangi Tribunal, *The Wairarapa ki Tararua Report* (Wellington: Legislation Direct, 2010), pp 357–358; Waitangi Tribunal, *He Whiritaunoka: The Whanganui Lands Report*, 3 vols (Wellington: Legislation Direct, 2015), vol 3, p 1175; and Waitangi Tribunal, *Te Urewera*, vol 8, p 3783.

25. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p xxvii.

26. Waitangi Tribunal, *He Whiritaunoka*, vol 3, p 1505.

27. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p xxiv; Waitangi Tribunal, *Tū Mai te Rangi!*, p 22.

28. Waitangi Tribunal, *Tū Mai te Rangi!*, p 22.

29. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, pp xxvi, 57–58.

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of Māori. For example, a greater proportion of Māori occupy the most deprived deciles of the population when compared to other ethnic groups.[30] Māori are not the same as other ethnic groups, including Pākehā, also living in deprived areas. As such, inequities may result when Māori are forced by lack of choice into Pākehā styles of professional health interaction and treatment; in other words, a one-size-fits-all approach may not be sufficient to provide active protection. In its 2015 *Te Urewera* report, the Tribunal said:

> A 'one size fits all' model tends in practice to suit the needs of the majority, who are rarely the group in most need of help. Even when they can access mainstream aid and services, minority groups such as Māori have often found that what is being provided simply does not work for them, or is so alienating that they prefer to disengage.[31]

As part of active protection, the Crown is required to keep itself informed of the relevant circumstances as they apply to Māori needs, including ensuring equitable access.[32] Further, the Crown must ensure its agents are performing well and, where they are not, the Crown must make a reasonable effort to improve performance.[33] This applies both to those agents who are responsible for any part of health services design and provision and to those agents responsible for monitoring these activities.

The Tribunal has found that active protection includes an obligation on the Crown to focus specific attention on inequities experienced by Māori and, if need be, to provide additional resources to address the causes of those inequities. This is particularly urgent when Māori interests and rights derived from the Treaty are under grave threat. The Tribunal has also applied this aspect of active protection to Māori health issues and the provision of health services. The Tribunal in the *Napier Hospital and Health Services Report* stated that, while the principle of active protection does not automatically 'privilege Maori as a group', the existence of significant health disparities requires the Crown to implement positive steps to provide for the pursuit of Māori health equity. The Crown's obligation of active protection is heightened where 'adverse disparities in health status between Maori and non-Maori are persistent and marked'.[34] Thus, in such circumstances, active protection may compel the Crown to target more resources according to need 'in order to reduce structural or historical disadvantage'.[35]

In its inquiry into Tauranga Moana post-raupatu claims, the Tribunal also considered the Crown's Treaty obligation of active protection with regard to Māori health, and it concluded that the persistent Māori health disparities evident in that inquiry should have compelled the Crown to 'do all it could' to achieve Māori

30. Document A59(a), paras 4–5.
31. Waitangi Tribunal, *Te Urewera*, vol 8, pp3776–3777.
32. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p362.
33. Ibid, p175.
34. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, pp53–54; see also Waitangi Tribunal, *Tū Mai te Rangi!*, p27.
35. Waitangi Tribunal, *Tū Mai te Rangi!*, p54.

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health equity.[36] The Tribunal also observed that, given the Crown's knowledge of the persistence of Māori health disparities since the mid-twentieth century, it would be reasonable in Treaty terms to expect the Crown to implement positive steps to reduce these disparities.[37]

In the *Napier Hospital and Health Services Report*, the Tribunal found that, until adverse health disparities are resolved, the Crown has a Treaty obligation to prioritise Māori health outcomes explicitly and to set specific goals for those outcomes.[38] In a similar vein, the Tribunal in *Tū Mai te Rangi!* stated: '[f]or the Crown to act consistently with the Treaty principles of active protection and equity in these circumstances it must urgently prioritise and commit, and be seen to be prioritising and committing, to the reduction in the rate of Māori reoffending'.[39]

The Tribunal in that report continued that the Crown must specifically target disparities that affect Māori as a population group and that this targeting cannot be subsumed into a more general goal toward a reduction in the reoffending rate.[40] The principle of active protection also requires the Crown to make it clear to, and easily understood by, the public why and how they are taking this action. The Tribunal in the *Napier Hospital and Health Services Report* further found that a 'failure to set Māori health as a health gain priority would be inconsistent with the principle of equity'.[41]

3.4 Equity

A further condition of the Treaty relationship is the Crown's duty to act with fairness and justice to all citizens. Article 3 of the Treaty confirms that Māori have all the rights and privileges of British subjects.[42] The Tribunal has found that this article not only guarantees Māori freedom from discrimination but also obliges the Crown to positively promote equity.[43] It is through article 3 that Māori, along with all other citizens, are placed under the protection of the Crown and are therefore assured equitable treatment from the Crown to ensure fairness and justice with other citizens. As the Tribunal states in its pre-publication report, *Te Mana Whatu Ahuru: Report on Te Rohe Pōtae Claims*, 'the Crown could not favour settlers over Māori at an individual level, and nor could it favour settler interests over the

36. Waitangi Tribunal, *Tauranga Moana*, vol 2, p 811.
37. Ibid, pp 809–810.
38. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p 64.
39. Waitangi Tribunal, *Tū Mai te Rangi!*, p 28.
40. Ibid, p 60.
41. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p 64.
42. Treaty of Waitangi Act 1975, sch 1, art 3.
43. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, pp 48, 62; Waitangi Tribunal, *Report on the Crown's Foreshore and Seabed Policy* (Wellington: Legislation Direct, 2004), p 133; Waitangi Tribunal, *The Mohaka ki Ahuriri Report* (Wellington: Legislation Direct, 2004), p 27; Waitangi Tribunal, *The Te Arawa Mandate Report* (Wellington: Legislation Direct, 2004), p 94; Waitangi Tribunal, *The Offender Assessment Policies Report* (Wellington: Legislation Direct, 2005), p 13; Waitangi Tribunal, *He Maunga Rongo*, vol 2, p 428.

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interests of Māori communities'.[44] Further, the Tribunal has found that the Treaty principle of equity obliges the Crown to 'meet a basic standard of good government', by acting in accordance with its own laws and ensuring that Māori rights and privileges as citizens have the protection of the law in practice.[45] To this end, in its inquiry into Te Rohe Pōtae claims, the Tribunal said that the Crown 'should be accountable for its actions in relation to Māori and subject to independent scrutiny'.[46]

In this way, the principle of equity is closely linked to the principle of active protection. Alongside the active protection of tino rangatiratanga is the Crown's obligation, when exercising its kāwanatanga, to protect actively the rights and interests of Māori as citizens. At its core, the principle of equity broadly guarantees freedom from discrimination, whether this discrimination is conscious or unconscious. Like active protection, for the Crown to satisfy its obligations under equity, it must not only reasonably ensure Māori do not suffer inequity but also actively inform itself of the occurrence of inequity. Thus, as signalled in section 3.3, the Crown is obliged by the principle of active protection to provide health services that Māori need, in order to pursue actively the achievement of equitable outcomes for Māori. In turn, the principles of active protection and equity also mean these services must not only treat their patients equitably but be equitably accessible and equitably funded.

And yet, despite the Treaty's assurance of equitable protection and treatment, claimants have expressed in previous Tribunal inquiries, over time and across the country, that an inequity of health outcomes between Māori and non-Māori exists. In those reports, the Tribunal has agreed with the claimants.[47]

When considering Te Urewera claims, the Tribunal found that the principle of equity applies regardless of the cause of the disparity.[48] In relation to health, the Tribunal noted in the *Napier Hospital and Health Services Report* that equity of health outcomes is 'one of the expected benefits of the citizenship granted by the Treaty'. It also noted that achieving this long-term goal would be dependent on a broad range of State policies and services.[49]

The Tribunal has also explained that, when considering this principle, equity of service may differ from equality of outcome. A policy or a service that establishes equal standards of treatment or care across the whole population may still result in inequitable outcomes for Māori. This could be the case, for instance, if other barriers (such as cost, geography, or racism) prevent Māori from accessing services,

44. Waitangi Tribunal, *Te Mana Whatu Ahuru – Pre-publication Version, Parts 1 and 11*, p185.
45. Waitangi Tribunal, *He Maunga Rongo*, vol 2, pp428–429.
46. Waitangi Tribunal, *Te Mana Whatu Ahuru – Pre-publication Version, Parts 1 and 11*, p189.
47. See for example Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p55; Waitangi Tribunal, *Tauranga Moana*, vol 2, p811; Waitangi Tribunal, *The Hauraki Report*, 3 vols (Wellington: Legislation Direct, 2006), vol 3, p1182.
48. Waitangi Tribunal, *Te Urewera*, vol 8, p3773.
49. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p64.

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treatment, or care.[50] The Treaty principles of equity and active protection therefore require the Crown to make every reasonable effort to eliminate barriers to services that may contribute to inequitable health outcomes. This, as discussed previously in this chapter, may require additional resources, proportionate to address the inequities that exist. The Tribunal accordingly found in the *Napier Hospital and Health Services Report* that failing to remove such barriers would be inconsistent with the principle of equity.[51]

3.5 Options

The Tribunal has also identified the principle of options, which broadly determines that, as Treaty partners, Māori have 'the right to choose their social and cultural path'.[52] This right derives from the Treaty's guarantee to Māori of both tino rangatiratanga and the rights and privileges of British citizenship. The principle of options, therefore, follows on from the principles of partnership, active protection, and equity and protects Māori in their right to continue their way of life according to their indigenous traditions and worldview while participating in British society and culture, as they wish.[53]

It follows that, in its modern application, the principle of options requires that the Crown must adequately protect the availability and viability of kaupapa Māori solutions in the social sector as well as so-called mainstream services in such a way that Māori are not disadvantaged by their choice.[54] In terms of health services, the Crown has a Treaty duty to enable Māori to have available the options of Māori or mainstream providers as they wish, and that either or both of these pathways are ensured equitable protection by the Treaty. Both pathways should be sufficiently supported by the Crown, meaning that each option offers a genuine, well-supported choice for Māori.[55]

The principle of options is jointly sustained by the principles of active protection, partnership, and equity. As outlined in section 3.3, the Tribunal affirmed in the *Napier Hospital and Health Services Report* that ensuring the accommodation and incorporation of tikanga Māori in mainstream health services flows from the principle of active protection.[56] In the following paragraphs, we explain how the other principles sustain this obligation under the principle of options.

50. Ibid, p 62.
51. Ibid.
52. Ibid, p 65.
53. Waitangi Tribunal, *Report of the Waitangi Tribunal on the Muriwhenua Fishing Claim* (Wellington: Waitangi Tribunal, 1988), p 195; Waitangi Tribunal, *The Ngai Tahu Sea Fisheries Report 1992* (Wellington: Brooker and Friend Ltd, 1992), p 274; Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p 65; Waitangi Tribunal, *The Tarawera Forest Report* (Wellington: Legislation Direct, 2003), p 28.
54. Waitangi Tribunal, *Matua Rautia*, p 68.
55. Waitangi Tribunal, *Te Tau Ihu o te Waka a Maui: Preliminary Report on Customary Rights in the Northern South Island* (Wellington: Legislation Direct, 2007), p 6.
56. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, pp 44, 57, 65, 175.

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In the *Napier Hospital and Health Services Report*, the Tribunal further found that the principle of partnership obliges the Crown to support adequately, particularly through resourcing, Māori entities and organisations that influence the design and implementation of health care policy or that are involved in health care provision.[57] This guarantee fulfils the Crown's Treaty obligation to ensure that Māori are able to exercise their authority and autonomy over their own affairs on their own terms.[58] For example, in observing the role of Māori councils in the first half of the twentieth century in the Wairarapa ki Tararua District Inquiry, the Tribunal criticised the fact that the Crown gave Māori councils some responsibility for public health and then hampered them from undertaking this work by severely underfunding them.[59]

Through the Treaty's guarantee of active protection of tino rangatiratanga, the Crown is obliged to empower and support actively kaupapa Māori organisations that provide health services or are otherwise involved in the health sector. A particularly relevant example is the Tribunal's observations in the *Tauranga Moana Report on Post-Raupatu Claims* regarding the development of Māori health providers in the early days of the current primary health care framework. In that report, the Tribunal cautiously stated that, as organisations that were Māori-controlled and could foreseeably provide a viable alternative to mainstream health services, Māori health providers represented 'an important advance towards true partnership (and also the recognition of rangatiratanga)'.[60] The Tribunal in that report then asserted: 'the Crown's obligation is now to ensure that Tauranga Māori organisations are supported adequately in any existing or future efforts to deliver culturally appropriate and medically effective health services to their own people'.[61]

Finally, the principle of equity ensures that each of these options – culturally and medically responsive mainstream health services and properly resourced and supported kaupapa Māori health services – are equitably maintained and made available to Māori. In *Matua Rautia: The Report on the Kōhanga Reo Claim*, the Tribunal phrased this as the Crown's obligation to ensure 'equality of treatment and the privileges of citizenship'.[62] To satisfy this obligation, the Tribunal found that the Crown must ensure that, where Māori choose kōhanga reo, 'they must, at the least, receive the same level of support as other New Zealanders'. The Tribunal also found that the Crown must ensure that Māori are fully informed about the advantages and disadvantages of choosing kōhanga reo rather than mainstream early childhood education centres.[63] In this way, the principle of options obliges the Crown to provide Māori with a real choice, rather than a choice only in name.

57. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, pp 170–171.
58. Waitangi Tribunal, *Te Mana Whatu Ahuru – Pre-publication Version, Parts 1 and 11*, p 189.
59. Waitangi Tribunal, *The Wairarapa ki Tararua Report*, vol 1, pp 345–346.
60. Waitangi Tribunal, *Tauranga Moana*, vol 2, p 811.
61. Ibid.
62. Waitangi Tribunal, *Matua Rautia*, p 67.
63. Ibid, p 68.

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3.6 Conclusion

As this first stage of the inquiry is focused on the legislative and policy framework that underpins the primary health care system and its services, the Treaty-compliance of this framework for health services is the focus for our report. The facts and discussion laid out in chapter 2 are especially relevant to our discussion of Treaty principles. We stress that, given the grave, persisting health inequities experienced by Māori, the Crown's Treaty obligations with respect to health care design and delivery are especially heightened.

Having considered the two claims before us at stage one of this inquiry, the Tribunal statement of issues, and the relevant Treaty principles, we identify the following questions as issues we need to address in this report.

3.6.1 Is the New Zealand Public Health and Disability Act Treaty-compliant?

All parties to this inquiry are aware of the inequitable health outcomes for Māori. The Crown said that an overarching goal of the health system is to deliver more equitable health outcomes for Māori, and it acknowledged that this has not been achieved.

In chapter 5, we examine whether the Act and its direction for the primary health care sector, including how it is implemented through major strategies, policies, and contracts, is Treaty-compliant. In particular, we examine the Treaty principle of equity as it applies to Māori health, and we test it against the stated goals in the New Zealand Public Health and Disability Act 2000 and throughout the legislative and policy framework for primary care. We also examine the expectations of equity for district health boards and primary health organisations. We look at the ways in which the legislation and policies that underpin the primary health care sector recognise and provide for the Treaty and its principles, particularly partnership and tino rangatiratanga.

3.6.2 Are the funding arrangements for the primary health care system Treaty-compliant?

All the parties acknowledged that the funding arrangements for the primary health care system are inadequate. In chapter 6, we assess the Treaty-compliance of funding for primary health care, particularly the ways it both facilitates or impedes the achievement of Māori health equity, and further whether funding for the provision of primary care allows Māori primary health organisations and providers to operate sustainably.

3.6.3 Is the way health entities are held to account Treaty-compliant?

As with funding, all the parties acknowledged that the way the primary health care framework holds entities to account is not always sufficient to encourage the pursuit of equity by improving Māori health outcomes. In chapter 7, we look at the accountability mechanisms for reducing Māori health inequities. We also look at how the Ministry measures health entities' actions in pursuit of this goal.

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3.6.4 Is partnership for Māori in the primary health care framework Treaty-compliant?

The claimants and interested parties have signalled that the recognition of the Treaty partnership as it relates to the primary health care system is key to their claims and to the future of a more effective primary health care framework. The Crown, similarly, has acknowledged that Crown agents do not always engage with and facilitate Māori views in a Treaty-compliant way. The Crown has signalled that it is particularly interested in receiving findings and recommendations from a Treaty-based perspective on the 'design and delivery' of our primary health care system.[64] The Crown has also expressed an openness to the claimants' calls for more influence and authority by Māori in the primary health care sector. Further to allegations about an insubstantial Treaty partnership, the claimants, in particular, urge the recognition of their tino rangatiratanga and mana motuhake in relation to primary care.

In chapter 8, we assess how recognition of the Treaty partnership plays out in practice in the sector, and the resulting effects for Māori and their rights as afforded by the Treaty partnership.

64. Submission 3.3.32, para 8.

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CHAPTER 4

THE PRIMARY HEALTH CARE LEGISLATIVE AND POLICY FRAMEWORK

Tē tūngia te kawaru rā

4.1 Introduction

Having set out the Treaty principles we will apply in our stage one inquiry, we now summarise those parts of the primary health care framework that we see as relevant to the stage one inquiry. The description that follows is taken primarily from Crown evidence and publicly available material.

Our report will go on to discuss issues relating to expectations of equity, funding, accountability measures, and the recognition of partnership; accordingly, this chapter provides a technical description of the structure of the health care system as determined by the framework, with particular attention to the four thematic issues this report will focus on.

We must stress at the outset that this chapter is intended to be neutral and descriptive and does not indicate that we endorse or disapprove of the mechanisms and provisions outlined in the following sections. We lay out the technical detail of the framework here and use it as context for our assessment of the parties' positions and evidence in chapters 5 through 8 and our recommendations in chapter 9.

We include this chapter also because the health and disability system is a large and complex network, delivering services through a broad range of organisations. The entire system extends beyond the Ministry and district health boards to ministerial advisory committees, other Crown health entities, primary health organisations, public health units, private providers (including Māori and Pacific providers), and independent general practitioners. It includes professional and regulatory bodies for all health professionals, including medical and surgical specialities, nurses, and allied health groups. Also, many non-government organisations and consumer bodies provide services and advocate for the interests of various groups.[1]

1. Document A3, paras 20, 24, 29.

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4.2 THE STRUCTURE OF THE PRIMARY HEALTH CARE SYSTEM

4.2.1 The New Zealand Public Health and Disability Act

The New Zealand Public Health and Disability Act 2000 (the Act), came into effect on 1 January 2001.[2] It established a semi-devolved health system structure.[3] The system of health and disability services is organised to achieve several objectives, including:

- the improvement, promotion, and protection of people's health;
- the best care or support for those in need of health services;
- the reduction of health disparities by improving health outcomes for Māori; and
- the provision of information about, and access to, appropriate, effective, and timely public health services and programmes.[4]

The Act includes a Treaty clause in section 4:

> In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision making on, and to participate in the delivery of, health and disability services.[5]

Director-General Dr Bloomfield characterised the policy environment for the primary health care system that flows from the Act as 'permissive' by design, in that the Crown sets out a broad direction and structure for the system but is not overly prescriptive about what the primary health care system should look like in practice.[6]

4.2.2 The role of the Minister of Health

The Act sets out the responsibilities of the Minister of Health (the Minister). The Minister has overall responsibility for the health and disability support system. The Minister can direct activity in the sector in several ways and at differing levels of control. In the first instance, the Minister, along with Cabinet and the wider Government, develops the overall policy direction for the health and disability sector. The Minister is then responsible for setting the health and disability system's strategic direction, including, with the support of stakeholders, preparing and progressing the strategies that provide the framework for the system.

The Minister is responsible for approving the Ministry of Health's Statement of Strategic Intent, which states the strategic objectives that the Ministry intends to achieve or contribute towards.[7]

Beyond setting the system's strategic direction, the Minister is responsible for the performance of district health boards and other health-related Crown entities.

2. Document A63, para 129.
3. Document A3, para 30.
4. New Zealand Public Health and Disability Act 2000, s3.
5. Ibid, s4.
6. Document A59, para 20.
7. Document A3, paras 10, 26, 46–49.

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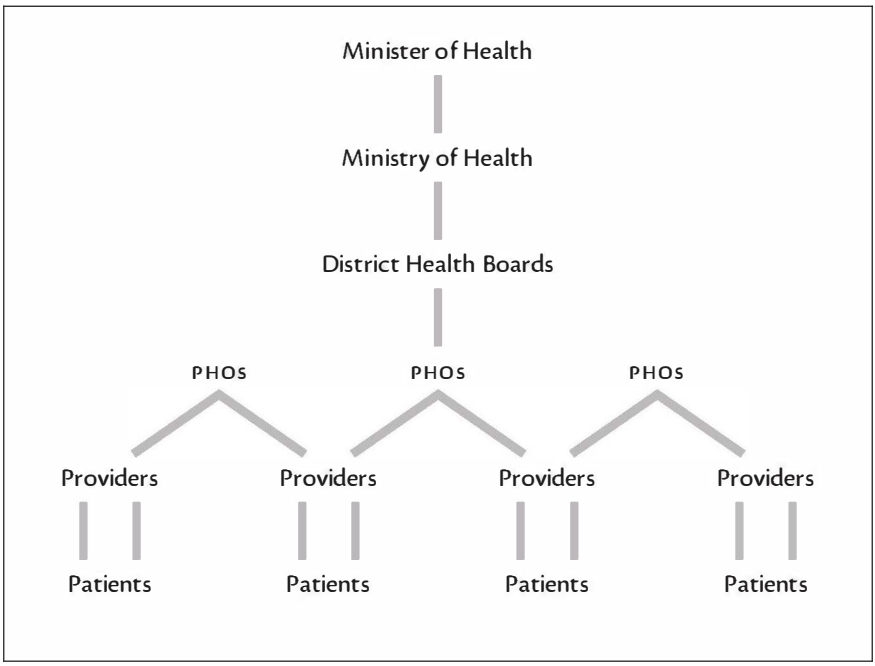

Figure 1: A basic outline of the devolved layers of the primary health care system

The Ministry of Health is responsible for monitoring these entities on behalf of the Minister and for providing regular advice to the Minister on their performance. District health boards and other Crown health entities are accountable to government through the Minister. The Minister has several ways to hold these entities to account.[8]

The Minister sets the preferred objectives for the performance of a Crown entity through an annual statement of performance expectations. First, the Minister provides a letter of expectations that sets out the Government's strategic priorities for health and the Minister's expectations for the entity. The entity's board chair and chief executive officer then sign off on the statement of performance expectations and a statement of intent. The statement of performance expectations lays out the outcomes and objectives that the entity intends to achieve over the coming year.

A Crown entity's statement of intent sets out the strategic objectives that the entity intends to achieve or contribute to. The Minister can require amendments to a statement or a new statement. Entities are accountable to Parliament through these documents, which are tabled in Parliament by the Minister. The entity reports on how it performed against those expectations and intentions in its annual report to Parliament.[9]

8. Ibid, para 50.
9. Document A3, paras 52–53, 132, 134, 136, 198, 201–202.

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In some cases, depending on the nature of the Crown entity and its governing Act, the Minister can give a direction on Government policy. An example is the Health and Disability Services Eligibility Direction 2011, which defines the group of people who are eligible for publicly funded (free or subsidised) health and disability services. This is a direction made by the Minister under section 32 of the Act to all district health boards.[10]

The Minister can, at any time, request information on performance and operations, review them, and ask the State Services Commissioner to act on issues (under the State Sector Act 1988).

The Minister has the power under the New Zealand Public Health and Disability Act to order inquiries into:

- the funding or provision of health or disability support services or both;
- the management of district health boards or other Crown health entities established under the Act; and
- a complaint or matter that had arisen under the Act.[11]

An example of this was the 2018 Mental Health and Addictions Inquiry, established under the Inquiries Act 2013.[12]

The Minister also recommends appointments and reappointments to the boards of Crown health entities (including the chair). For Crown agents (including district health boards), the Minister sets the terms and conditions of appointment such as remuneration and can set expectations about induction. The Minister is also central to the removal of board members of Crown entities and can appoint Crown monitors to the board or replace the board with a commissioner.[13]

4.2.3 The role of the Ministry of Health

The Minister is primarily supported in these duties by the Ministry of Health. The Ministry is the Government's primary agent for implementing health priorities and policies within the health and disability sector.[14] In addition to being the principal adviser and source of support to the Minister, the Ministry has overall responsibility for the stewardship of the health and disability system.[15] By statute, this includes a responsibility to work directly with communities, advocates, and health practitioners to set a vision, goals, and accountabilities for the sector.[16]

The Ministry's stewardship role includes a duty to keep an overview of the whole system to ensure that the capabilities and connections across organisations

10. Ibid, para 54; 'Eligibility Direction', Ministry of Health, https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/eligibility-direction, last modified 15 April 2011.
11. Document A3, para 61; New Zealand Public Health and Disability Act 2000, ss71–72.
12. Document A3, para 61; Office of the Minister of Health and Office of the Minister of Internal Affairs, 'Establishing the Government Inquiry into Mental Health and Addiction', paper to Cabinet, 23 January 2018.
13. Document A3, paras 56–58.
14. Ibid, para 17.
15. Ibid, para 10.
16. Ibid, paras 15, 65.

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work together to deliver a health service that strives to improve, protect, and promote the health and wellbeing of all New Zealanders. Among the ways it seeks to achieve this is by directly purchasing several national health and disability support services and by providing health sector information and payment services.[17]

In terms of Māori health, the Ministry's leadership role is intended to set a direction for Māori health, by working directly with Māori consumers and health providers and then guiding the health and disability sector to improve services and outcomes for Māori.[18]

In 1993, the Ministry established Te Kete Hauora, an internal business unit focused on Māori health, as well as the Deputy Director-General Māori Health position in the senior leadership team.[19] In 2016, Te Kete Hauora was disestablished and had its functions spread across several other business units.[20] That same year, the Deputy Director-General Māori Health was replaced by another senior position, Māori leadership.[21]

In October 2018, the Ministry established a new Māori health directorate and re-established the Deputy Director-General Māori Health position.[22]

The Ministry is required by statute to perform monitoring, regulatory, and protective functions. To this end, the Ministry should:

- maintain the regulatory environment and national policy settings, including ensuring that legislative requirements are being met;
- fund, monitor, and regulate the performance of district health boards and other Crown health entities;[23]
- support the planning and accountability functions of district health boards and other Crown health entities; and
- work with the Accident Compensation Corporation and the Health Quality and Safety Commission to support their respective leadership roles.[24]

The Ministry has a wider responsibility to coordinate action with other Government agencies, such as the Ministry of Social Development and the Ministry of Education, to deliver on the Government's agenda across the spectrum of social sector services.[25]

17. Ibid, paras 16, 31, 32, 65, 69.
18. Ibid, paras 15, 34.
19. Document A2, para 27; doc A63, para 47.
20. Document A2, para 28.
21. Document A3, para 38; 'Ministry of Health Makes Senior Appointments', Ministry of Health, https://www.health.govt.nz/news-media/media-releases/ministry-health-makes-senior-appointments, last modified 22 April 2016.
22. Transcript 4.1.5, p 372; Ministry of Health, 'Delivering on the Ministry's Sector Leadership and Stewardship Roles: Final Decision Document on Changes to the Ministry's Second-tier Structure' (confidential internal paper, Wellington: Ministry of Health, 2018), pp 9, 16.
23. Examples of other Crown health entities include the Health Promotion Agency, the Health Research Council of New Zealand, the New Zealand Blood Service, and the Pharmaceutical Management Agency (Pharmac).
24. Document A3, paras 10, 18, 19, 33, 72.
25. Ibid, paras 17, 77.

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The Ministry is also responsible for administering the health and disability system's funding, which the Government sets for Vote Health each year ($15.910 billion in 2017–18), and for allocating funding to district health boards.[26]

4.2.4 The roles of district health boards

New Zealand has 20 district health boards. The Act created the boards and set out their objectives, which include:

- improving, promoting, and protecting the health of people and communities;
- promoting the integration of health services, especially primary and secondary care services;
- seeking the optimum arrangement for the most effective and efficient delivery of health services to meet local, regional, and national needs;
- promoting effective care or support of those in need of personal health services or disability support;
- promoting the inclusion and participation in society, and independence of people with disabilities; and
- reducing – with a view to eliminating – health disparities by improving health outcomes for Māori and other population groups.[27]

District health boards implement the Government's health and disability policy. They administer most of the day-to-day business of the health and disability system and nearly three-quarters of the funding from Vote Health. The boards have two main functions. The first is planning, managing, and purchasing all publicly funded health services for the population of their district. This planning, managing, and purchasing is undertaken by planning and funding units of the district health board (the funder arm). The second function is to provide hospital (secondary, tertiary) and public health services for their population. A district health board owns and runs these services through its hospital (the provider arm).

For non-hospital services, the relationship is structured differently, occurring through a cascading series of contracts. For example, district health boards buy services by contracting with primary health organisations, who in turn contract with general practitioners and other providers to deliver services to a population. Consequently, district health boards have an ownership interest in hospitals that they do not have for other services, such as aged care services, services delivered by Māori and Pacific providers, mental health support, and medication management.

District health boards are expected to show a sense of social responsibility, to foster community participation in health improvement by working directly within the community and with local iwi, and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations. They are also responsible for ensuring health services are effective and efficient for all New Zealanders.[28]

District health boards are Crown agents, under the Crown Entities Act 2004.

26. Memorandum 3.2.95, para 2(a).
27. New Zealand Public Health and Disability Act 2000, s 22.
28. Document A1, paras 8, 11, 12; doc A3, paras 12, 182, 183, 184; doc A63, para 130; doc A43(a), p 14.

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This means they must give effect to a Government policy that relates to the entity's functions and objectives if directed to by the Minister (see the Health and Disability Services Eligibility Direction mentioned in section 4.2.2 for an example).[29]

District health boards are governed by a board of up to 11 members, seven of whom are elected by the community every three years and up to four of whom are appointed by the Minister. The board's chair and deputy chair are also appointed by the Minister. In making appointments to the board, the Minister must ensure that at least two members are Māori and must endeavour, by law, to ensure that Māori membership on the board is proportional to the number of Māori in the board's resident population.[30]

The Minister has a discretionary power to remove a board member from office and may also appoint a Crown monitor to the board or even dismiss an entire board and replace it with a commissioner if the Minister is seriously dissatisfied with the board's performance.[31]

Each district health board has at least three advisory committees:

- a Community and Public Health Advisory Committee;
- a Disability Support Advisory Committee; and
- a Hospital Advisory Committee.[32]

Each of these three committees must have Māori representation. Also, while not stipulated by the Act, all district health boards have entered into formal arrangements with local Māori, usually representatives from iwi and Māori communities.[33] These arrangements are usually reflected in the establishment of an iwi/Māori relationship board. The roles of these entities and the level of involvement they have in advising district health boards vary for each district health board.[34]

4.2.5 The role of primary health organisations and providers

As required by the Act, district health boards fund primary health organisations and providers to provide primary health care services.

Primary health organisations are not-for-profit, local organisations responsible for providing essential primary health care services to people who are enrolled with them. They provide the services mostly through general-practitioner-led practices, the majority of which are for-profit businesses. Primary health organisations can also contract with primary health care providers to provide other health care services, such as physiotherapists, mental health professionals, and occupational therapists.[35]

29. Document A3, paras 127, 128.
30. New Zealand Public Health and Disability Act 2000, s 29.
31. Document A1, para 8; doc A3, p35 tbl 2, paras +192–195; doc A60, para 26.
32. Document A1, para 9.
33. Document A3, para 242.
34. Ibid, para 243.
35. Ibid, para 258; 'Primary Health Care Providers', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/primary-health-care-providers, last modified 8 July 2014.

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4.2.5

Enrolment in a practice that belongs to a primary health organisation enables people to access primary health care with an individual practitioner or a small team of health practitioners. This system is intended to ensure continuity of well-coordinated care that is delivered in a timely way, thereby promoting better quality care and lower individual and health system costs.[36]

Primary health organisations take a population-based approach that organises services around defined populations rather than just responding to individuals who access services. Primary health organisations are expected to identify and understand the needs of their enrolled population and deliver services that meet that population's needs, which include:

- delivering health promotion services, disease prevention programmes, and disease management initiatives that enable people to make individual and collective choices to improve their health;
- developing strategies to deliver services to diverse groups, particularly groups previously not being reached by existing services; and
- consulting and working with community members and clients to design services that reflect their needs and priorities, for example by:
  - identifying different ethnic communities and providing services in a culturally appropriate way;
  - delivering services in appropriate settings, including marae, homes, schools, and workplaces; and
  - establishing specific health services for Māori and partnering with Māori communities to meet their needs and aspirations.[37]

In this way, primary health organisations have the capacity to be both owned and run by the community. The population-based approach also aims to ensure that general practice services are linked with other health services, so that people can gain the benefits associated with a population approach and receive continuity and coordination of health care. For example, primary health organisations are expected to coordinate and link with providers from other service areas for members of their enrolled population who need significant care from other providers, such as people with disabilities, people with mental health and addiction issues, and older people.[38]

Primary health organisations' governance arrangements are expected to reflect primary health care teams founded on the idea of interdisciplinary teamwork.[39]

New Zealand now has 31 primary health organisations (South Canterbury District Health Board operates as its own primary health organisation and is sometimes referred to as the 32nd primary health organisation), which vary in size and structure, including the remaining four Māori primary health organisations.

36. Document A63, para 185.
37. Ibid, paras 187–194.
38. Ibid, para 207.
39. Ibid, para 209.

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A Māori primary health organisation is defined as an organisation that is owned, governed, and operated by iwi or a Māori organisation (or both).[40] The four Māori primary health organisations are:

- Ngā Mataapuna Oranga, which operates in the Bay of Plenty region and is represented in this inquiry by named claimants in the Wai 1315 claim.[41]
- National Hauora Coalition, which operates across five district health boards in the North Island and is represented in this inquiry by named claimants in the Wai 2687 claim.[42]
- Ngāti Porou Hauora Charitable Trust, which operates in the East Coast region.[43]
- Ora Toa PHO, which operates in the Wellington region.[44]

Māori health providers are contracted by district health boards to deliver health and disability services to predominantly Māori clients, although other clients are not excluded. The district health boards also contract other health providers who are significant providers of services to Māori. Māori health providers are distinguished from those other providers by their kaupapa and delivery framework, which is distinctively Māori, including delivering Māori-centred health care models by Māori practitioners in the home, on marae, and in schools as well as in health centres.[45]

4.2.6 Relevance to this stage one inquiry

The claimants argued that the primary health care framework's intention for community owned and driven primary health care, while promising in principle, has not been fulfilled in practice and falls well short of the Treaty guarantee of tino rangatiratanga. They were critical of the Ministry's permissive approach to the system, which they alleged has allowed for health entities to ignore their responsibilities to Māori, amongst other allegations. In particular, the allowances for Māori perspectives at senior levels in Crown health entities, such as representatives on district health boards and senior staff and business units within the Ministry, are charged as inadequate. Both claimant groups argued for far greater input into and control of the design and implementation of primary health services in ways that are not facilitated by the structure of the primary health care system as set out by the Act.

40. Document A3, paras 257, 259.
41. Document A12, paras 3–4, 16–17.
42. Document A23, paras 2, 14.
43. 'About Us', Ngāti Porou Hauora Charitable Trust, https://www.nph.org.nz/about-us, accessed 13 February 2019.
44. 'Ora Toa PHO', Ngāti Toa Rangatira, http://www.oratoa.co.nz/, accessed 13 February 2019.
45. Document A63, para 196; 'Māori Health Providers', Ministry of Health, https://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers, last modified 14 February 2014.

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4.3 SETTING THE FRAMEWORK FOR PRIMARY HEALTH CARE

4.3.1 The New Zealand Health Strategy

The New Zealand Health Strategy (the strategy) was introduced in December 2000 to provide an overall framework for the health sector, with the aim of directing health services at those areas that would ensure the greatest benefits for New Zealand's population groups. It is focused particularly on tackling inequalities in health. Primary health care was one of five service priority areas in the strategy.[46]

In 2016, the Ministry refreshed the strategy. The 2016 strategy has five strategic goals that are intended to guide the health system:

- 'People-powered' – this goal relates to providing people with the information they need to make decisions about how to manage their own health care and taking a more 'people-centred' approach to providing health services.
- 'Closer to home' – this goal relates to providing care closer to where people live, learn, work, and play so that services can be more convenient and more clinically and financially sustainable.
- 'Value and high performance' – this goal is intended to recognise the need to make better use of resources, including funding, so that New Zealanders receive high-quality services that are affordable and sustainable.
- 'One team' – this goal is intended to require people within the system to have a clear view of their own roles, responsibilities, and accountabilities and to work together for the benefit of people and their families.
- 'Smart system' – this goal is intended to direct health entities to make the best use of innovation, research, and emerging technologies to enable better performance and more effective collaboration with other Government agencies in other sectors.[47]

4.3.2 The Primary Health Care Strategy

Following the introduction of the New Zealand Health Strategy, the Government released the Primary Health Care Strategy in 2001, intended to provide a direction for the future development of primary health care in New Zealand. This strategy sits under, and reflects the direction of, the New Zealand Health Strategy and the New Zealand Disability Strategy 2002 (which was still being developed at that time). The Primary Health Care Strategy was prepared in response to a problem: the delivery of primary health care services was not working well for everyone. Publicly funded health services (particularly primary care services) were not reaching some population groups to the degree needed (such as Māori, Pacific peoples, youth, people with disabilities, and those on low incomes), nor successfully addressing all barriers to access (including cost and opening hours).[48]

46. Document A63, paras 216–217.
47. Document A62, paras 334–336; Minister of Health, *The New Zealand Health Strategy 2016: Future Direction* (Wellington: Ministry of Health, 2016), pp15–36.
48. Document A63, paras 178–180.

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The Primary Health Care Strategy sets the direction for the primary health care system to be more responsive to the needs of those groups experiencing poor access to health care and poor health outcomes, with the aim of achieving health equity across the population. In New Zealand, that means that primary care is the 'gatekeeper' to all publicly funded services. In most instances, primary health care will be a person's first point of contact with the health system. Primary health organisations are expected to develop innovative ways of providing services in different settings to ensure people who experience difficulties accessing services receive the care they need.[49]

The Primary Health Care Strategy emphasised population health and public health approaches, the role of the community, health promotion and preventive care, the need to involve a range of health professionals, and the advantage of funding based on population need rather than fee-for-service. Population-based funding is intended to respond to the relative needs of populations, taking account of factors such as age, sex, deprivation level, and ethnicity. This approach is intended to reduce inequalities by directing resources to communities with the greatest health need, such as Māori and those living in rural areas.[50]

This strategy identified six key directions for the primary health sector to achieve the vision. Primary health care services should:

- work with local communities and enrolled populations;
- identify and remove health inequalities;
- offer access to comprehensive services to improve, maintain, and restore people's health;
- coordinate care across service areas;
- develop the primary health care workforce; and
- continuously improve quality using good information.[51]

The Primary Health Care Strategy introduced three major changes by:

- providing an increase in funding to support primary health care, with the aim of reducing the fees that patients pay for services, extending eligibility for Government funding of primary health care to the entire enrolled population, and expanding the services provided;
- mandating the development of primary health organisations as local non-governmental organisations to serve the primary health care needs of their enrolled patients; and
- changing the method of allocating the public share of primary health care funding from fee-for-service subsidies at the practitioner level to (largely) capitation funding of primary health organisations.[52]

The Primary Health Care Strategy was introduced within a context of broader reforms to New Zealand's health and disability system, with several other health

49. Ibid, paras 192, 202.
50. Ibid, paras 182, 198.
51. Document A60, para 36; doc A63, para 183.
52. Document A60, para 37.

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strategies introduced or prepared at the time. One of these was He Korowai Oranga, the Māori health strategy.[53]

4.3.3 He Korowai Oranga

He Korowai Oranga, released in 2002, expanded the principles and objectives for Māori set out in the New Zealand Health Strategy, the Primary Health Care Strategy, and the New Zealand Disability Strategy 2001 by providing more detail on how Māori health objectives could be achieved. This strategy, in turn, intended to set the direction for Māori health in other service or population-group strategies, including the Primary Health Care Strategy, the Health of Older People Strategy, and the Public Health Strategy.[54]

The overall aim of this first iteration of He Korowai Oranga was the concept of whānau ora (family wellbeing): to support Māori families to achieve their maximum health and wellbeing. The strategy recognised that whānau is the foundation of Māori society, and, as a principal source of strength, support, security, and identity, whānau plays a central role in the wellbeing of Māori individually and collectively.[55]

He Korowai Oranga sought the following outcomes for whānau:

- whānau should experience physical, spiritual, mental, and emotional health and have control over their own destinies;
- whānau members should live longer and enjoy a better quality of life; and
- whānau members (including those with disabilities) should participate in te ao Māori and wider New Zealand society.[56]

The vision for the first iteration of He Korowai Oranga was intended to affirm Māori approaches by:

- supporting Māori holistic models and wellness approaches to health and disability and support;
- supporting Māori in their desire to improve their own health;
- supporting Māori-led initiatives to improve the health of whānau, hapū, and iwi; and
- recognising that the desire of Māori to have control over their future direction is a strong motivation for Māori to seek their own solutions and to manage their own services.

It aspired to improve Māori outcomes through:

- a gradual reorientation of the way that Māori health and disability services are planned, funded, and delivered in New Zealand; and
- the whole health and disability sector taking responsibility to deliver improved health services for Māori.[57]

53. Document A63, para 231.
54. Ibid, paras 220–221.
55. Ibid, para 222.
56. Ibid, para 223.
57. Ibid, para 224.

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He Korowai Oranga was updated in 2014. The new web-based strategy and its accompanying guide – *The Guide to He Korowai Oranga: Māori Health Strategy* – expanded the aim of He Korowai Oranga from whānau ora to pae ora, which the Ministry defined as 'healthy futures'. This approach is intended to increase Māori participation across the whole health and disability system and play a pivotal role in shifting that system from focusing on disease and illness to promoting health and wellness.[58]

4.3.4 Relevance to this stage one inquiry

The claimants alleged that, while the direction for the primary health care system set by these overarching strategies is promising, the implementation of these strategies falls well short of adequately addressing inequitable Māori health outcomes. The promise of He Korowai Oranga and the efficacy of its practical implementation was a key area of concern for the claimants. We also received evidence about the Ministry's interpretation of Treaty principles and the declared promises of partnership with Māori in the primary health care sector.[59]

4.4 Funding Arrangements for Primary Health Care

4.4.1 Vote Health funding

Vote Health, the Government funding administered by the Ministry, totalled $15.910 billion in 2017–18.[60] Additional significant funding for health comes from the Accident Compensation Corporation; other Government agencies such as the Ministry of Social Development, the Department of Corrections, the Ministry of Education, and the Ministry of Business Innovation and Employment; local government – for prevention and public services; and private sources such as insurance and user fees.[61]

In 2017–18, the Ministry allocated $12.683 billion to district health boards using a population-based funding formula.[62] This formula allocates funding based on the size and composition of the population living in the district according to the results of the national census. The formula takes account of factors such as population age, sex, relative measures of deprivation status, and ethnicity (Māori, Pacific, and other). The formula is then adjusted by taking into account rurality, the clustering of high-needs populations, and the economic implications of the large size of the health system and the significant number of patients it serves (termed diseconomies of scale). As mentioned above, this approach to funding is

58. Document A62, para 331.
59. Submission 3.3.18, paras 102–104; submission 3.3.30, paras 4.42, 5.49.3, 5.57.4.
60. Memorandum 3.2.95, para 2(a).
61. Document A1, para 5; doc A3, paras 43–44; New Zealand Treasury, *Vote Health*, vol 6 of *The Estimates of Appropriations 2018/19*, B5, 10 vols (Wellington: New Zealand Treasury, 2018).
62. Memorandum 3.2.95, para 2(e).

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intended to help reduce inequities by directing resources to communities with the greatest health need.[63]

In general, district health boards have flexibility in the allocation of funds to specific services to reflect the needs of their populations, except for mental health services where a specified amount of funding has been set aside. District health boards also receive discretionary funding from the Ministry, also known as marginal funding, that the boards can invest in their services, at their discretion. Evidence in this inquiry indicates that discretionary funding typically makes up around 5 per cent of the total funding for district health boards.[64]

The Service Coverage Schedule (a schedule to the Crown Funding Agreement, which is discussed below) outlines the national minimum range and standard of health and disability services to be publicly funded, and district health boards are required to ensure their populations have access to all these services. Boards may provide the services directly or contract with third parties.[65]

4.4.2 Capitation funding for primary health care

Before the implementation of the Primary Health Care Strategy, general practices received a fee-for-service subsidy from the Government each time they saw a patient. In the early 2000s, New Zealand moved to capitation funding for primary care. This system is called capitation because it is based on a payment per capita (per head). Now, primary health organisations and their general practices are paid according to the number of people enrolled on their register, not the number of times a provider sees patients. We note that the capitation rates for primary care are calculated on different factors than the population-based funding formula, which calculates the funding provided to district health boards and is outlined in the preceding section.

The capitation model was intended to provide certainty of income to primary care providers so that they could focus on prevention and health promotion as well as cure. Capitation would ideally ensure that primary care providers would understand their patients in the context of their everyday lives, not simply look narrowly at a range of physical symptoms. Capitation was intended to reduce out-of-pocket fees for patients so they could afford to seek timely care because, under the fee-for-service model, co-payments had become a barrier to access.

Capitation rates provide a specified subsidy for different types of patients and are calculated annually. Payments to practices are calculated by applying the capitation formulas to the practice's enrolled population. Currently, funding is delivered in quarterly bulk payments to each primary health organisation. The full suite of formulas used to fund primary health care services discussed in this and the following section are summarised in table 1. This table is drawn from the

63. Document A3, paras 11, 45, 236–237; doc A63, para 198. An example of district health board populations and funding for 2017–18 is shown at document A3, p 50 tbl 3.
64. Transcript 4.1.7, pp164, 272.
65. Document A3, paras 238–239.

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evidence of Amy Downs, who completed a study of primary care funding in New Zealand in 2017.[66]

The major capitated funding stream is called first level services or first contact funding, which comprised 71 per cent of capitated funding for primary health care in the 2017–18 financial year. First level services are the full range of primary health care services delivered, along with coordinating care. Funding is based on patient demographics taken from the national census and is adjusted for age, gender, and whether the patient has a high-use health card. It is not adjusted for ethnicity. Eligibility for the high-use health care card is determined when the patient needs to visit a health practitioner at the practice they are enrolled in 12 or more times in one year for an ongoing condition. It is important to note that capitation funding does not remove out-of-pocket payments from primary care. Primary care providers can still charge patients fees, which are called co-payments (as they are in addition to the Government subsidy).[67] Patients who are not enrolled with a primary health organisation can be seen for treatment but pay the full cost of the consultation.

Patient co-payments are paid by patients at point of service. Most practices are allowed to set their own fees, unless they are part of schemes that provide capped fees under the Very Low Cost Access scheme or free services to certain populations, such as the zero fees for under-6s scheme.

In 2006, due to concerns about access to care associated with increasing patient fees, the Government introduced Very Low Cost Access funding (VLCA). VLCA was introduced as a mechanism to reduce co-payments for the practices' enrolled population. Participating practices were offered a 'top-up' to the base capitation funding in return for limiting patient fees for all adults. At the time it was introduced, any practice could participate in this funding scheme.

From 2009, while practices already in the VLCA scheme could remain, eligibility to enter the scheme was limited to general practices that have an enrolled population in which at least 50 per cent of patients are high needs (defined as Māori, Pacific, and/or living in deprivation areas 9–10).[68]

As well as the VLCA scheme, in 2008 the Government rolled out the zero fees for under-6s scheme. This scheme aimed to improve child health outcomes by removing financial barriers to accessing both daytime and after-hours general practice and prescription medicine. Practices that did not participate in the VLCA payments were eligible to apply for the under-6s payment if they committed to providing free standard consultations to children under six years old (this was extended to under-13s in July 2015 and to under-14s in December 2018). Practices that received the VLCA payments were not eligible for the under-6s payment.

66. Document A43(a).

67. Document A9, para 17; doc A43, paras 7, 11–12; doc A43(a), p15; doc A60, para 44; doc A62, paras 105–107; 'Capitation Funding', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/capitation-funding, last modified 8 July 2014.

68. Document A43, para 13; doc A43(a), pp15–16; doc A62, paras 214–217.

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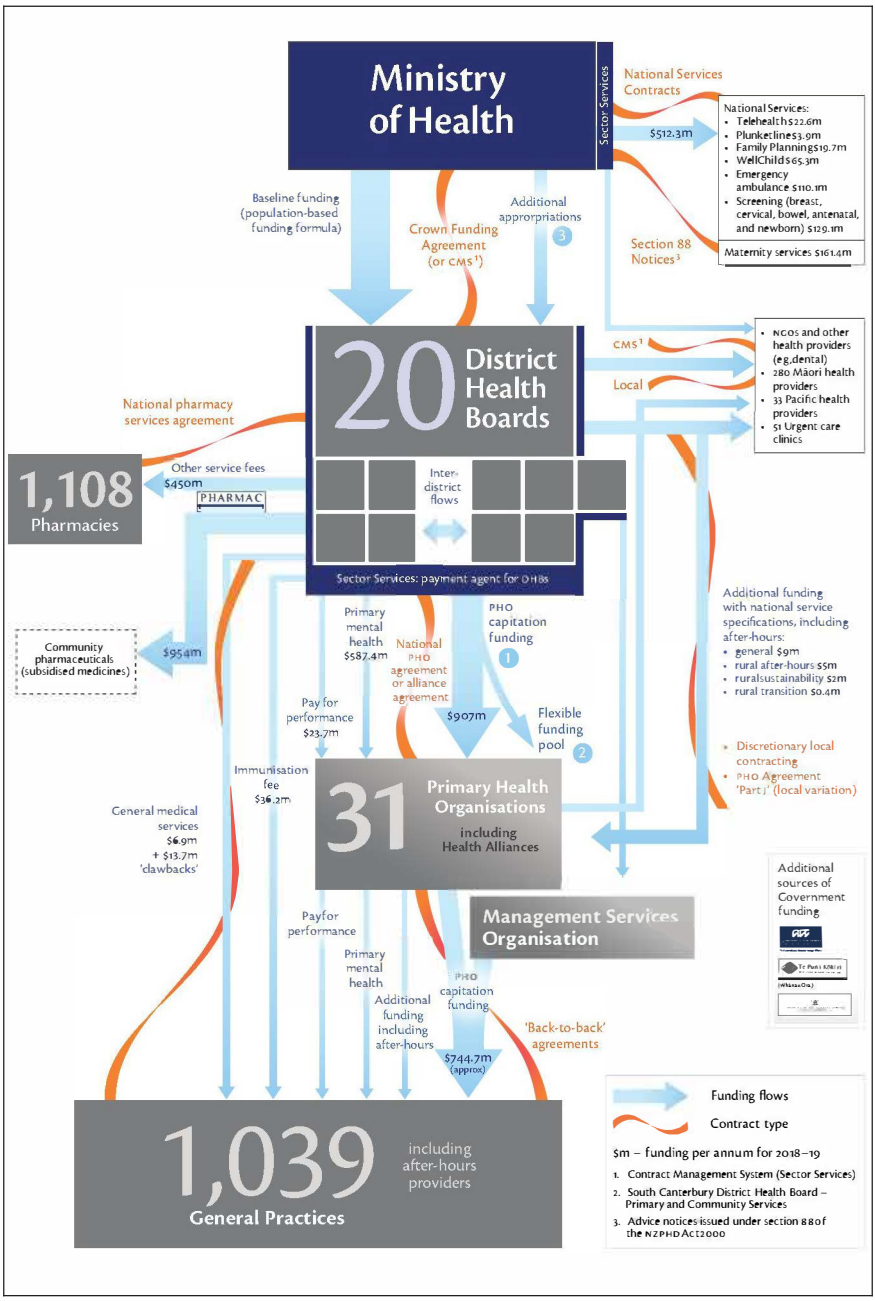

Figure 2: The relationships between funding and contracting for primary health care services

Source: 'Primary Health Care Services Funding and Contracting', Ministry of Health, https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-services-funding-and-contracting, last modified 3 October 2018

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Both sets of practices, however, had to be participating in the PHO performance programme, a pay-for-performance programme designed to improve the health of enrolled populations and reduce inequalities in health outcomes.[69]

4.4.3 Other capitated funding streams

The capitation funding discussed in the previous section does not include a specific adjustment for ethnicity. However, other funding streams do – specifically Services to Improve Access, Health Promotion, and Care Plus. The formulas for these three funding streams include age, gender, ethnicity, and level of deprivation.[70] In 2017–18, the total funding provided through these schemes was $195.405 million.[71]

Services to Improve Access funding was established in 2002 to enable primary health organisations to introduce new approaches to reach people with high health needs who might not be accessing the services they need because of various barriers such as language, distance, and transport. Some examples of these approaches included primary care nurses and community nurses taking a key role in delivering primary care services in collaboration with schools, marae, and community groups.[72]

Health Promotion funding was also introduced in 2002 for population-based initiatives that provide education and information promoting health, such as the promotion of healthy eating and physical activity. Primary health organisations are required under the PHO Services Agreements to agree with their district health board on the health promotion activities that the organisation will carry out. This includes agreement that the primary health organisation will work with whānau, hapū, iwi, community groups, consumers, public health service providers, and regional public health units to plan and deliver health promotion programmes. The activities must be consistent with population health objectives and public health programmes.[73]

Care Plus funding provides additional funding to improve access to coordinated and quality care for patients with two or more chronic conditions.[74]

These three existing funding streams were merged under the Better, Sooner, More Convenient primary care policy. This policy was an acknowledgment by the Government that, while some progress had been made in improving access to primary health care, further work was needed to implement the wider service delivery improvements envisaged under the Primary Health Care Strategy. In 2010, the Government established a Flexible Funding Pool that merged these three funding streams into one pool, along with another funding stream called the

69. Document A62, paras 218–220; doc A60, paras 47–48; Pete Hodgson, 'More Support for Free Doc Visits for Under-6s', New Zealand Government, https://www.beehive.govt.nz/release/more-support-free-doc-visits-under-6s, last modified 28 August 2007.
70. Document A43, para 19; doc A60, para 49; doc A62, paras 109, 130, 216.
71. Memorandum 3.2.95, para 2(c).
72. Document A9, para 26; doc A62, paras 128–129.
73. Document A62, paras 132–134.
74. Document A43, para 20; doc A62, para 140.

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Type of funding	Age	Gender	Race or ethnicity	Deprivation	Other factors	Estimated amount 2017–18 ($ million)	Percentage of total funding 2017–18
Capitation funding							
First contact	x	x			HUHC status and practice formula type*	651.2	71
Zero fees for under 6s/13s	x	x				34.2	4
Very Low Cost Access (VLCA)	x	x			50% high needs entry criteria from October 2009†	55.3	6
Flexible funding pool							
Services to improve access	x	x	x	x	Non HUHC holders	51.6	6
Health promotion	x	x	x	x	Non HUHC holders	10.9	1
Care plus	x	x	x	x		68.2	7
Management fees					Size of PHO‡	30.6	3
Other							
After hours under 6s/13s	x	x	x	x	Slight adjustments for rurality, unmet need, and other factors	14.0	2

* Additional funding is provided for individuals who have had 12 or more primary care visits in the last year and have a high-use health card (HUHC). Additional funding is provided for children younger than 14 who are enrolled in practices that were historically deemed as having issues related to access.

† From October 2009, eligibility to enter the Very Low Cost Access scheme is limited to general practices that meet the 50 per cent high-needs criteria (defined as Māori, Pacific, and/or living in a New Zealand deprivation 9–10 area).

‡ The management services fee varies depending on the total number of enrolled patients.

Table 1: Factors used in formulas for Government funding for primary care organisations and public primary care funding 2017–18, featured in Amy Downs's written evidence. The factors included under each formula are marked 'x'.

Source: Document A43(a), p 35

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management service fee. This fee supports primary health organisations to carry out their management functions related to enrolment and reporting to district health boards. The management services fee is paid on a per enrolled person basis.[75] The underlying objectives were to improve integration across the health care sector, increase use of primary and community care, and provide services closer to patients' homes. In 2010, nine national pilot sites that were collaborations between district health boards and primary health organisations (also called alliances) were launched to test these goals. Services associated with this initiative did not receive additional funding.[76]

Taking into account first level services funding and other supplementary capitated funding, in 2017–18 primary health organisations received $907 million in capitation funding. The Ministry estimates that $167 million of this went to Māori patients enrolled in both Māori and non-Māori primary health organisations. The four Māori primary health organisations received $28.7 million and, based on the number of Māori enrolled in those organisations, $10.17 million was spent on Māori patients of primary health organisations.[77]

4.4.4 Other funding to primary health organisations

Primary health organisations receive establishment funding from district health boards to assist them when setting up. The Ministry also provides some funding if the establishment of a new primary health organisation costs more than the district health board has allocated. Once a primary health organisation is established, the Ministry provides funding through a primary health organisation management fee.[78]

The new priorities and focuses of the Primary Health Care Strategy, released in 2001, had implications for the sector as it adjusted to its new arrangement and the new entities provided for by the reforms to primary health care. The newly forming primary health organisations were made up of staff with varied histories, areas of expertise, and prior experience and infrastructure to perform the management functions and population health planning required of a primary health organisation. Many primary health organisations' memberships were made up of Independent Practitioner Associations, organised groups of general practices established in the 1990s. Under the previous system, Independent Practitioner Associations had received funding to build infrastructure to budget hold and administer schemes (such as community referred radiology, medication management); some had already received considerable investment to develop management capacity.[79] This capital, infrastructure, and experience, gained under

75. Document A62, paras 135–136, 283.
76. Document A43(a), p16; doc A62, paras 269–274.
77. Memorandum 3.2.95, pp3–4.
78. Document A62, para 121.
79. Ross Barnett and Pauline Barnett, 'Primary Health Care in New Zealand: Problems and Policy Approaches', *Social Policy Journal of New Zealand* 21 (March 2004); Pauline Barnett, Judith Smith, and Jacqueline Cumming, *The Roles and Functions of Primary Health Organisations* (Wellington: Health Services Research Centre, 2009).

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the previous system, provided a significant financial base for those Independent Practitioner Associations that decided to form primary health organisations after the reforms to primary care in the early 2000s.

Some primary health organisations also received Government funding during the establishment phase through the Māori Provider Development Scheme. This scheme was established by a Cabinet directive in 1997 to provide grants to support the development of Māori health and disability support service providers. The scheme provides organisational development support for Māori health and disability providers, as well as financial assistance to students undertaking health-related tertiary studies through the Hauora Māori Scholarships.

The scheme is intended to support the Māori health sector by:

- providing a contestable development fund for Māori health providers to support their capacity and capability building, including audit compliance, health and safety compliance, infrastructure development, and workforce capability; and
- providing contestable scholarships annually for Māori health students pursuing study in medicine, nursing, midwifery, allied health, dentistry, and community health work.[80]

The scheme currently provides for $9 million per annum for these initiatives. This budget has not materially changed since the scheme was established in 1997.[81]

4.4.5 Relevance to this stage one inquiry

These funding arrangements are of particular importance for this inquiry. As we signalled in chapter 1, the parties in this inquiry have all variously highlighted that the funding formulas are not sufficient to achieve the goal of Māori health equity, and never have been. The formula for first level services funding, in particular, has been singled out as in urgent need of review.

These funding arrangements are also relevant to the sustainability of Māori primary health organisations and providers and their ability to design and deliver effective health care services to Māori patients using a tikanga Māori framework.

4.5 Holding Entities to Account for Performance

District health boards are accountable to the Government through the Minister. The Minister has several ways to direct and hold entities to account.

4.5.1 Government expectations and directions

As well as the annual letter of expectations that the Minister sends to all Crown health entities, the Ministers of Finance and State Services send an enduring letter of expectations periodically to all Crown entities. This letter sets out more general

80. Document A62, paras 122, 176–180; doc A63, para 98.
81. Document A62, para 176.

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expectations, including the need for strong entity performance and the need to achieve value for money.[82]

In addition to giving district health boards directions that specify who is eligible to receive services funded under the Act (such as the Health and Disability Services Eligibility Direction 2011), the Minister can also require district health boards to provide or arrange for the provision of certain services. The Minister may also state how administrative, support, and procurement services within the public health and disability sector should be obtained. The Minister may also direct district health boards to comply with stated requirements for supporting Government policy on improving the effectiveness and efficiency of the public health and disability sector. District health boards 'must give effect to' policy directions.[83]

4.5.2 Planning documents

4.5.2.1 *Annual plans*

District health boards are required by law to produce an annual plan that sets out their expected planned performance for the financial year. These annual plans are intended to provide accountability direct to the Minister, as each district health board must agree its plan with the Minister.

District health boards are expected to consider and include actions in their annual plan to achieve health equity for their resident population, including Māori. District health boards previously produced Māori health plans each year to set out how they planned to reduce health disparities between Māori and non-Māori. From 2017, district health boards were no longer required to produce separate Māori health plans; instead, the Ministry has directed the boards to include more information on what they are going to do to address Māori health inequity in their annual plans.[84]

Priority areas are identified in the annual plans, based on priorities set by the Minister through the annual letter of expectations. District health boards are required to include, in their annual plans, appropriate equity actions for Māori for every priority area. An example of a Māori equity action in a priority area is a self-management education programme tailored for Māori to reduce inequity in the proportion of Māori and non-Māori with diabetes.

The annual plan is meant to be prepared in conjunction with a wide range of local partners and stakeholders. Some district health boards involve iwi, hapū, and whānau in this process to support Māori health aspirations at a local level. In most district health boards, equity expectations are set by the entity's board in collaboration with what are commonly referred to as iwi/Māori relationship boards.

82. Document A3, paras 132, 133.
83. Ibid, para 235; New Zealand Public Health and Disability Act 2000, ss32–33(b).
84. Document A3, para 216.

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District health boards are required to deliver on their annual plan under a Crown Funding Agreement (see below). They report progress in delivery on either a quarterly or a six-monthly basis, depending on the priority area. The Ministry has a structured web-based feedback process in place for each deliverable. Summary reports are provided to the Minister each quarter. These reports are also shared with district health boards' chairs and chief executives and central government agencies.

4.5.2.2 *Regional service plans*

District health boards also produce regional service plans. These identify a set of goals for a region and set out how these goals will be achieved. Collaborating regionally is intended to increase efficiency and provide a better standard of care across a greater area than if each district health board were to act alone. The Minister approves the plans, and the regions provide regular reports to the Ministry on their plans.[85]

The regions are:

- the northern region, which comprises the Northland District Health Board, the Waitemata District Health Board, Auckland District Health, and the Counties Manukau District Health Board;
- the midland region, which comprises the Waikato District Health Board, the Bay of Plenty District Health Board, the Lakes District Health Board, the Tairawhiti District Health Board, and the Taranaki District Health Board;
- the central region, which comprises the Capital & Coast District Health Board, the Hawke's Bay District Health Board, the Hutt Valley District Health Board, the MidCentral District Health Board, the Wairarapa District Health Board, and the Whanganui District Health Board; and
- the South Island region, which comprises the Nelson Marlborough District Health Board, the West Coast District Health Board, the Canterbury District Health Board, the South Canterbury District Health Board, and the Southern District Health Board.[86]

4.5.3 Relevance to this stage one inquiry

The claimants and many of the interested parties claimed that the requirement that district health boards no longer prepare specific Māori health plans and instead include what they are going to do in the general annual plans has led to a loss of focus on Māori and a loss of prioritising of Māori health issues.

4.5.4 Accountability documents

District health boards' performance is measured, and is intended to be held to account, by Parliament and the public, through their accountability documents.

85. Document A3, para 224; doc A3(a), app 6, pp 37–39.
86. Ministry of Health, *Regional Services Planning: How District Health Boards Are Working Together to Deliver Better Health Services* (Wellington: Ministry of Health, 2012).

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4.5.4.1 *Statement of intent*

At least once every three years, each district health board must publish a statement of intent setting out its high-level objectives and strategic focus for the next four financial years. For example, a statement of intent published in 2019 would cover the 2019–20, 2020–21, 2021–22, and 2022–23 financial years.

The board members prepare the statement of intent, with comment from the Minister. As noted above, the Minister can require amendments or a new statement of intent. The board signs off on the statement and the Minister tables it in Parliament.[87]

4.5.4.2 *Statement of performance expectations*

Each district health board includes its statement of performance expectations in its annual plan. As well as setting out the non-financial performance measures against which the entity's performance can be assessed, it also contains the forecast financial statements for the current year. The board signs it off and the Minister tables it in Parliament.[88]

4.5.4.3 *Crown Funding Agreement*

The Minister and district health boards also enter into a Crown Funding Agreement that sets out the public funding the entity will receive in return for providing services to its resident population. The Ministry monitors the entity's performance under the Crown Funding Agreement on behalf of the Minister.

One of the schedules to the Crown Funding Agreement is the *Operational Policy Framework*, a set of business rules, policies, and guideline principles that outline the operating functions of district health boards. One of these is an obligation of district health boards to improve Māori health. Paragraph 3.10 specifically states that each district health board must aim to reduce health disparities by improving health outcomes for Māori. It must do this by establishing processes for Māori to participate in, and contribute to, strategies designed to improve Māori health. Further, district health boards must contribute to increasing Māori capacity to participate in and contribute through Māori provider and workforce development.[89]

Another schedule included in the Crown Funding Agreement is the *Service Coverage Schedule*. This sets out the required minimum level and standard of health services to be made available to the public by both district health boards and the Ministry. For some services, the schedule also covers subsidies and user charges, as well as specific quality and audit requirements. The *Service Coverage Schedule* is updated annually.[90]

87. Document A3, paras 201–202; Crown Entities Act 2004, s 139.
88. Document A3, paras 204–205; Crown Entities Act 2004, s 149(e).
89. Document A3, paras 208–209; doc A3(a), app 7, p 64; New Zealand Public Health and Disability Act 2000, s 10.
90. Document A3, para 210; doc A3(a), app 8, pp177–178.

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4.5.4.4 *Annual report*

District health boards are required to report on their performance for the year against the measures set out in their statement of performance expectations and current statement of intent. Other information must be included in the report, such as:

- a statement of service performance;
- an annual financial statement for the entity;
- any direction given to the district health board by the Minister;
- the amount of remuneration paid to district health board members and employees in the year; and
- an audit report, produced on behalf of the Auditor-General.

The annual report must be signed off by two board members and provided to the Minister within 15 working days of the district health board receiving its audit report. The Minister tables the report in Parliament.[91]

District health boards also produce annual quality accounts by which health care providers account for the quality of the services they deliver. These are produced with guidance from the Health Quality and Safety Commission. District health boards can use these reports to show examples of how they have been improving their services. The quality accounts are published on the district health boards' websites.[92]

4.5.5 Financial and non-financial performance measures

The Ministry monitors the district health boards' financial and non-financial performance throughout the year. District health boards provide financial data to the Ministry after the end of each month. The information is then analysed by the Ministry, and net results against planning are reported to the Minister. Following this, a further report presents an overview of the whole district health board sector (highlighting where the sector or an individual district health board reports a significant variance against plan or against comparable performance within the sector). Interpretation of the data provided enables areas of financial pressure and risks to be identified.

Non-financial performance measures include health targets and the System Level Measures. Health targets are a set of national performance measures designed to improve the performance of health services that reflect significant public and Government priorities. The Ministry has six health targets for district health boards; three focus on patient access (shorter stays in emergency departments, improved access to elective surgery, and faster cancer treatment) and three on prevention (increased immunisation, better help for smokers to quit, and raising healthy kids). District health boards report their progress to the Ministry four

91. Document A3, paras 211–212; Crown Entities Act 2004, ss150–151.

92. Document A3, paras 213–214; 'Planning Documents', Auckland District Health Board, http://www.adhb.health.nz/about-us/planning-and-funding-2/planning-documents/, accessed 5 February 2019; 'Publications and Consultations Documents', Capital & Coast District Health Board, https://www.ccdhb.org.nz/news-publications/publications-and-consultation-documents/, last modified 20 December 2018.

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times a year, and the Ministry provides the results to the Minister and the public. The Government has directed the Ministry to prepare a new set of performance measures to improve health outcomes for New Zealanders. While this work is underway, district health boards will continue to report to the Ministry on these targets but the Ministry will be publicly publishing only the raw data.[93]

System Level Measures, implemented in July 2016, are nationally set measures that focus on helping children, youth, and vulnerable populations.[94] For 2017–18, the measures are:

- reducing hospital admission rates for children aged up to four years old;
- reducing how long people stay in hospital;
- reducing amenable mortality;[95]
- improving patient experience of care;
- increasing the proportion of babies living in smoke-free homes at six weeks post-birth; and
- improving youth access to and use of appropriate health services.[96]

District health boards need to work through district alliances to ensure these measures are implemented to improve health outcomes. District alliances are local partnerships with primary, hospital, and community care providers. All district health boards and their primary health organisations must be members of the alliance. Alliance membership is expected to broaden over time to include, for example, midwives, ambulances, pharmacies, Well Child Tamariki Ora providers, and youth health services. All district alliances are required to submit an improvement plan, through the district health board, to the Ministry, showing how the alliance will implement the System Level Measures in their district. The Ministry assesses and approves the improvement plans. District health boards report quarterly on the plans as part of their quarterly reporting process.[97]

4.5.6 Managing arrangements between district health boards and primary health organisations

PHO Services Agreements govern arrangements between district health boards and primary health organisations. These agreements set out the roles, responsibilities, and accountabilities of district health boards and primary health organisations, and contracted providers, and the minimum requirements of primary health organisations for the availability, affordability, and quality of services.

Each primary health organisation submits quarterly and annual reports to its district health board on the services it provides. The quarterly reports include details on all practitioners providing services, immunisation services delivered (including ethnicity reporting), and referred services. The reports also detail the progress primary health organisations are making in developing services to

93. Document A3, para 228.
94. Ibid, para 233.
95. Amenable mortality is premature death that could potentially have been prevented, given effective and timely health care.
96. Document A3, para 234.
97. Ibid, paras 230–234.

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improve access, Māori health programmes, and health promotion programmes. These reports enable payment to be made to a primary health organisation for services provided.[98]

The annual reports provide district health boards with information on the primary health organisations' performance against the requirements in their agreements. The reports also include the primary health organisations' performance against any additional quality indicators and targets agreed between the district health board and the organisations. The annual reports also require primary health organisations to report on progress against key performance indicators with evidence of specific initiatives that have contributed to Māori health gain. Primary health organisations must make their annual reports and financial statements available to the public.[99]

District health boards may audit a primary health organisation's compliance with its agreement. The district health board can carry out two types of audits: either a routine audit, which takes place within two years of a primary health organisation being established and every three years thereafter, or an issues-based audit, if a known or suspected serious breach or non-compliance of the PHO Services Agreement occurs.

Primary health organisations are responsible for auditing the performance of their contracted providers, including carrying out clinical audits.[100]

4.5.7 Relevance to this stage one inquiry

The way the system holds health entities to account is critical to the issues in our inquiry, especially given the permissive nature of the system as described by Director-General Dr Bloomfield. The network of organisations that make up the primary health care system is complex, and there is a detailed interplay and devolution of responsibilities to district health boards and non-governmental organisations. The tension, then, becomes one of how to ensure that the primary health care system is performing effectively and moving towards the goal of health equity while also allowing for regional variability and innovation.

The claimants argued that public information on the effectiveness of Government policies and programmes is insufficient, denying Māori communities any real opportunity to monitor the Crown's performance.[101] As we signalled in chapter 3, the principles of active protection and equity dictate that, despite the complexity of the primary health care system, the Crown is still ultimately responsible for providing appropriate and adequate health care to all citizens, including Māori.

To conclude, all parties have alleged failures of the primary health care system where Māori health issues are concerned, including breaches of the Treaty of Waitangi. Having set out the primary health care framework and its functions and intentions, we now move to our assessment of the parties' positions and evidence.

98. Document A65, paras 16–18, 36–37; doc A62, paras 294–295.
99. Document A65, paras 41–42.
100. Ibid, paras 44–45.
101. Submission 3.3.3, para 14.

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CHAPTER 5

IS THE NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000 TREATY-COMPLIANT?

Ko te hau tonga ka maranga mai rā

5.1 Introduction

In chapter 2, we discussed the reasons why this inquiry is necessary. We referred to the statistical information provided by the Crown, which affirms that as a population group Māori have, on average, the poorest health status of any ethnic group in New Zealand. Apart from in a few areas, this situation has not improved since the beginning of the twenty-first century.

We also referred to the comment in the *Māori Health Chart Book* published in 2006 that the 'Government and the Ministry of Health have made it a key priority to reduce the health inequalities that affect Māori'.[1] The Crown submitted that the legislative and policy framework contains numerous commitments that broadly give effect to this aim, but it nonetheless acknowledged that its commitment to equity could be made clearer in the major strategies and planning documents relating to primary care.[2]

The Crown also submitted that the New Zealand Public Health and Disability Act 2000 and major strategies contain 'goals and objectives aimed at giving effect to the Treaty relationship between Māori and the Crown', though it acknowledged that some of these expressions could be seen as outdated.[3]

As discussed in chapter 3, the Treaty principles oblige the Crown to make sure its commitments to give effect to those principles are clearly expressed, as well as demonstrated by its actions. In this chapter, we assess both how the legislative and policy framework acknowledges and gives effect to the Treaty and its principles and whether these arrangements are Treaty-compliant. As part of that assessment, we consider how the stated commitment to improving Māori health outcomes is manifested in the legislative and policy framework itself.[4]

1. Ministry of Health, *Tatau Kahukura: Māori Health Chart Book*, Public Health Intelligence Monitoring Report 5 (Wellington: Ministry of Health, 2006), p 1.
2. Submission 3.3.32, paras 65–66.
3. Ibid, para 31; transcript 4.1.5, p 351.
4. We take into consideration and respond to the issues posed in sections 2, 3, 7, and 9 of the statement of issues (statement of issues 1.4.1).

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5.2 EQUITY AND THE NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT

Crown counsel submitted that 'equity or reducing inequities/disparities is referred to in the NZPHD Act, strategies and other documents'.[5]

Section 3(1)(b) of the New Zealand Public Health and Disability Act 2000 requires the Crown to pursue the following objective: 'to reduce health disparities by improving the health outcomes of Maori and other population groups'.[6] The Crown submitted that this objective states an expectation of equity, and that this commitment is further reflected in various high-level policies and strategies that make up the primary health care framework. The Crown contended that the tension is in the way these 'intentions are implemented' in practice, not necessarily whether these intentions 'are insufficient'.[7] Crown counsel argued that, overall, 'key policy settings for primary health care and the strategy documents they are within, are sound for primary health care objectives'.[8] Nonetheless, Crown counsel acknowledged that the Crown's commitment to equity as expressed in the primary health care framework needs strengthening, and that pursuing equity 'has been insufficiently supported by concrete actions in plans'.[9]

The National Hauora Coalition claimants rejected the Crown's assertion that 'key policy settings are sound', broadly arguing that there are significant flaws in the current framework and that there is a 'disconnect' between the best parts of key policy documents and their practical manifestation on the ground.[10]

The National Hauora Coalition claimants said that the language of 'reducing disparities' does not go far enough. They submit that 'reducing disparities' or 'reducing inequalities' cannot be considered equivalent to the goal of health equity.[11] They further echoed the Crown's acknowledgement: that the inadequate wording in the Act was reflected throughout the strategies and policies of the primary health care framework.[12]

We see that the issue of whether or how expectations of equity are expressed in the legislative and policy framework has implications for Treaty-compliance, particularly with the principles of active protection and equity. In chapter 3, we outlined what previous Tribunal reports have said about the Treaty principles of equity, active protection, and options. These principles require the Crown not only to recognise and provide for Māori to act in partnership with the Crown in designing and providing health services for Māori but also to design and provide services that actively pursue equitable Māori health outcomes. In doing so, the Crown must focus specific attention and resources on Māori where they experience inequitable outcomes, ensuring that Māori who need to use health services

5. Submission 3.3.32, para 65.
6. New Zealand Public Health and Disability Act 2000, s3(1)(b).
7. Statement of response 1.3.1, p1.
8. Submission 3.3.32, para 24.
9. Ibid, para 65.
10. Submission 3.3.35, para 3; submission 3.3.4, para 76.
11. Submission 3.3.30, paras 5.35, 5.36.2.
12. Ibid, para 5.34.

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are treated equitably and can access health services which do not discriminate against them by being inadequate, culturally incompatible, or inequitably funded.

The broad intentions behind the reforms to primary health care were to target funding and support according to need. In the same way, when applying Treaty principles to the question of health inequities, the principles do not make individual Māori the priority but rather make the inequities suffered by Māori as a whole a priority area for action.

The World Health Organization's definition of health equity, referred to often by witnesses to this inquiry, is as follows:

> *Equity* is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *Health inequities* therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health, or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. [Emphasis in original.][13]

We consider that this definition is consistent with what we see as the Treaty's provisions for equity and active protection. There is an inherent logic in the concept of health equity: as counsel for the National Hauora Coalition submitted, it recognises that, where a population group experiences inequities, further resources and attention may be needed to offset the disadvantages suffered by that group.[14]

Under an equity-focused health system, the depth of, or imminent threat posed by, health inequity should heighten the urgency of action; the Crown's Treaty obligations are heightened under similar conditions. The deeper the need, the more urgent and substantial the targeted response should be.

As such, in order to be consistent with the Treaty principles of active protection and equity, health equity needs to be an explicit aim of the health system. Overall, all parties to this inquiry were of the same mind – achieving equitable health outcomes should be the kaupapa, or central purpose, of the health system.[15] Director-General of Health Dr Ashley Bloomfield, who appeared before us as a Crown witness, stated that one of the Government's overarching goals for health care is 'to deliver improved and more equitable health outcomes'.[16] We were told that a population-based approach to health that attempted to focus on improving inequities was the broad motivation behind the primary health reforms ushered in by the passing of the new Act in 2000 and the Primary Health Care Strategy in

13. 'Equity', World Health Organization, https://www.who.int/healthsystems/topics/equity/en, accessed 27 March 2019.

14. Submission 3.3.30, para 5.1.

15. Submission 3.3.18, paras 3–4, 88; submission 3.3.23, paras 7–9; submission 3.3.30, paras 1.1–1.4, 2.7, 2.12; submission 3.3.32, paras 6, 14.

16. Document A59, paras 37.

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2001.[17] Overall, the situation today shows that this aim has not been achieved. The state of Māori health outcomes, in particular, demonstrates this failure.

Crown witness Hector Matthews, the manager for Māori Health at Canterbury District Health Board, stated:

> there was an intention for that to occur and we have lots of strategies where intentions are well put and well-articulated, but I think you can demonstrate by the fact that [in]equity is still extant within our Māori populations that intention[s] frequently, here in Aotearoa, [don't] lead to outcome.[18]

Our principal question, then, is: Why not? And is there a Treaty breach?

In the first instance, the Act does not contain any references to health equity or health inequities; instead, it refers to reducing 'health disparities'.[19] We accept that this was the language of the time, but we do not consider this statutory objective to be Treaty-compliant. Interested party witness Professor Papaarangi Reid explained the difference between inequality or disparity – terms that essentially capture a mere difference in health outcomes – and health equity. She emphasised that, while *differences* in health outcomes will always exist, *inequities* are differences in health outcomes that are 'unfair and unjust' (emphasis in original).[20] Inequity is, therefore, a structural imbalance whereby the depth of need of all people who need to use health services is inadequately recognised.

Taking Professor Reid's explanation, in our view the Act does not go far enough to be considered consistent with the Crown's Treaty obligations of equity and active protection. Aiming to simply 'reduce health disparities' does not capture the true urgency or active effort required by the Treaty principles of active protection and equity. Counsel for the National Hauora Coalition submitted that the Crown is not even meeting its statutory obligation to reduce health disparities by improving Māori health outcomes.[21] The evidence and statistics we referred to in chapter 2 bear this out. Additionally, health equity for Māori, under the terms of the Treaty, also encompasses equitable access to health and equitable experience of health care services. The depth and persistence of the health inequities experienced by Māori indicate that the health system is barely reducing Māori health disparities, let alone achieving Māori health equity.

In the *Napier Hospital and Health Services Report*, released in 2001, the Tribunal said that the Act's commitment to reduce health disparities of population groups was 'fully consistent with the Treaty principle of equity'.[22] We understand why the Tribunal came to this conclusion at that time. The Act was new: it had introduced

17. Document A59, paras 15–20; doc A9(b), pp16–19; doc A63, paras 192, 229.
18. Transcript 4.1.7, p177.
19. As Dr Rawiri Jansen pointed out in his evidence: see doc A2, para 15.
20. Transcript 4.1.5, p43. See also Professor Crampton's comments in document A9, para 20.
21. Submission 3.3.30, paras 2.60–2.61.
22. Waitangi Tribunal, *The Napier Hospital and Health Services Report* (Wellington: Legislation Direct, 2001), p64.

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specific provisions aimed at improving Māori health outcomes and allowing for greater participation in governance and input into decision-making by Māori, at least at the district health board level. The reforms, at the time, created a sense of optimism.

However, the period since then has indicated that the health sector has, overall, not lived up to what the Tribunal thought was the intent of the clause: to 'foster affirmative action on the basis of need so as to improve average Maori outcomes'.[23] Furthermore, the Crown has failed to heed the advice by the Tribunal that '[a] general equality of health outcomes for Maori as a whole is one of the expected benefits of citizenship granted by the Treaty [and] until realised, failure to set Maori health as a health gain priority would be inconsistent with the principle of equity'.[24]

The ongoing persistence of inequities since then indicates that section 3(1)(b), in fact, is not adequate to satisfy the Crown's Treaty obligations.

5.3 Equity and the Policy Framework

Equity is not a strong feature of the current version of the New Zealand Health Strategy, released in 2016. Outside of high-level goal-setting with little context or explanation, the strategy instead highlights that in principle the health system should work to improve the health outcomes of disadvantaged population groups, and it identifies Māori as a priority population group.[25] The National Hauora Coalition claimants submitted that it is concerning that the original version, released in December 2000, had specific commentary on the existence of health inequalities, whereas the current version does not include a section that specifically discusses inequality or inequity.[26] The Crown's independent witness, Professor Jacqueline Cumming, stated in her written evidence that, when the New Zealand Health Strategy was updated, 'the emphasis on Māori health and reducing inequities [was] less prominent than in the earlier Strategy'.[27] We agree that the New Zealand Health Strategy does not prioritise Māori health sufficiently with a view to achieving equity of health outcomes.

The National Hauora Coalition claimants acknowledged that the Primary Health Care Strategy has more precise wording around committing the primary care sector to addressing health inequalities.[28] One of the six key directions of the Primary Health Care Strategy is to 'identify and remove health inequalities'. The outline of this goal mentions that Māori and Pasifika health outcomes are poor

23. Ibid.
24. Ibid.
25. Ministry of Health, *New Zealand Health Strategy: Future Direction* (Wellington: Ministry of Health, 2016), pp 6, 14.
26. Submission 3.3.30, paras 4.30–4.31, 5.34.2.
27. Document A60, para 32.
28. Submission 3.3.30, paras 4.51–53, 5.35.

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compared to the rest of the population. It also specifically acknowledges that these health disparities cannot 'be explained by socioeconomic differences alone'.[29]

Crown counsel emphasised that the Primary Health Care Strategy constituted a 'strong foundation' with regards to pursuing health equity.[30] However, Professor Cumming made the point that, 'although a key goal of the [Primary Health Care Strategy] was to enhance equity, no equity analysis/programme logic was ever completed to [her] knowledge'.[31] The director-general said that he recalled at least some work to this end taking place, but he agreed that it should have been strengthened.[32]

We agree that the Primary Health Care Strategy came closer to emphasising health equity as a goal of primary care but did not set this in place as a firm direction. Indeed, it does not explicitly mention equity itself. Professor Peter Crampton, who appeared as a witness for the National Hauora Coalition, stated, '[a]s written, the Primary Health Care Strategy was in my view a strong piece of policy making'.[33] He went on to add that, notwithstanding its strengths, the Primary Health Care Strategy is a dated document and a new overarching strategy document for primary care is needed.[34]

The claimants and the Crown each highlighted that the content of the Māori health strategy, He Korowai Oranga, represents a strong – perhaps the strongest – feature of the primary health care framework when it comes to setting a direction to pursue equity.[35] One of the 'key threads' of the original 2002 strategy was 'reducing inequalities'.[36] The strategy also acknowledged that cross-social-sector initiatives to reduce inequalities were needed.[37]

In the refresh of the strategy, released in 2014, the section on reducing inequalities was reframed around 'equity'. It included a reference to the World Health Organization's definition of equity and an acknowledgement that 'more work needs to be done to achieve health equity for Māori and for all New Zealanders'.[38] In a section entitled 'Quality Improvement', the strategy states the aspiration that 'Māori should have equitable health outcomes through access to high-quality health and disability services'.[39]

29. Ministry of Health, *The Primary Health Care Strategy* (Wellington: Ministry of Health, 2001), p10.
30. Transcript 4.1.4, p600.
31. Document A60, para 38.
32. Transcript 4.1.5, p466.
33. Transcript 4.1.4, p596.
34. Ibid, pp597–598.
35. Submission 3.3.18, para 103; submission 3.3.23, para 12; submission 3.3.30, para 5.36.3; submission 3.3.32, para 32.
36. Minister of Health and Associate Minister of Health, *He Korowai Oranga: Māori Health Strategy* (Wellington: Ministry of Health, 2002), p8.
37. Ibid, p26.
38. Ministry of Health, *The Guide to He Korowai Oranga: Māori Health Strategy* (Wellington: Ministry of Health, 2014), p9; Ministry of Health, 'Equity', https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/key-threads/equity, last modified 13 October 2015.
39. Ministry of Health, *The Guide to He Korowai Oranga*, p12.

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In these and other ways, He Korowai Oranga was much more specific in its objectives relating to health inequalities. In the foreword, the responsible Ministers acknowledged that public policies should address the social and economic determinants of health, including institutional racism.[40] Indeed, the goals and discussion in He Korowai Oranga are reflective of hauora rather than a Western model of health, at least compared to the other overarching strategies. Director-General Dr Bloomfield emphasised the centrality of He Korowai Oranga in his evidence:

> I am aware of the important role of He Korowai Oranga, the Māori Health Strategy, in ensuring the vision of the health and disability system is realised. He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Implementing He Korowai Oranga is the responsibility of the whole of the health and disability sector. It has implications for other sectors as well.[41]

However, both sets of claimants argued that, overall, He Korowai Oranga is scarcely reflected in the primary health care system.[42] The Crown acknowledged that He Korowai Oranga, along with other strategies and policies, has not been fully implemented.[43]

The commitment to equity in He Korowai Oranga is admirable; however, it is rendered ineffective if the strategy amounts to mere rhetoric. The strategy is not a 'headline strategy', as the Act does not require a Māori health strategy be prepared as it does for the New Zealand Health Strategy.[44] Nor is He Korowai Oranga and its commitment to equity reflected in either the New Zealand Health Strategy or the Primary Health Care Strategy. We agree with the criticism levelled by counsel for the National Hauora Coalition that He Korowai Oranga 'has not been integrated into the primary health care framework as a whole'.[45]

Again, we note that Director-General Dr Bloomfield said that one of the overarching goals of primary care is to 'deliver improved and more equitable health outcomes'.[46] While that may be the case today, we do not think that the strategies that set the direction of primary care in this country collectively reflect this goal.

Aside from these strategies, the district health boards produce several contracts and documents that set expectations in terms of health outcomes and the purpose of the primary health system.

District health boards' statutory obligation to 'reduce health disparities by improving health outcomes for Māori and other population groups', and further to reduce disparities between population groups 'with a view to eliminating' them, is also reinforced in the district health boards' Crown Funding Agreement and

40. Minister of Health and Associate Minister of Health, *He Korowai Oranga*, p iii.
41. Document A59, para 41.
42. Submission 3.3.18, para 103–104; submission 3.3.23, para 8.
43. Submission 3.3.32, para 61–62.
44. New Zealand Public Health and Disability Act 2000, s 8(1).
45. Submission 3.3.30, para 5.36.3.
46. Document A59, para 37.

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its appended Operational Policy Framework.[47] The Operational Policy Framework is more specific in its commitment to equity, providing for the following: 'Each DHB must aim to achieve health equity between various population groups within New Zealand, including Māori, by developing and implementing services and programmes, in consultation with Māori.'[48]

The Services Agreement for primary health organisations essentially repeats the statutory requirement in the Act, with the latest version requiring primary health organisations both to identify and understand 'the reasons for inequalities' between population groups and to agree to 'reduce health inequalities for Māori, Pacific and other high need populations'.[49]

In addition to the various strategies discussed in previous sections, broad expectations of equity are also set out in the Minister's letter of expectations. The National Hauora Coalition pointed out that this year's letter, which discusses health equity at length, only mentions Māori once and is in contrast to the letters of expectation sent in previous years. They argued that these letters cannot be relied upon as an expectation of equity, as they are written by the Minister and therefore reflect 'political priorities' of the day.[50] Professor Cumming agreed that the variability of letters of expectation does not guarantee that district health boards are being directed to 'support Māori health development'.[51]

The Ministry also annually distributes a planning guidelines package to assist with the production of district health board annual plans. Counsel for the National Hauora Coalition pointed out that the latest guidelines include some requirements to report on actions they are pursuing in relation to Māori health equity but these requirements are minimal. Further, because they are renewed each year, these documents, like the Minister's letter of expectations, cannot be guaranteed to amount to consistent expectations of equity.[52] We agree that the letter of expectations and the planning guidelines package vary too much and are subject to political priorities and, as such, cannot be considered a Treaty-consistent commitment to health equity.

The System Level Measures framework, formally initiated in 2016, also sets expectations of equity for district health boards, with incentives for pursuing or achieving equitable outcomes. However, while developing plans for System Level Measures is a mandatory accountability mechanism, Professor Crampton said, 'there is very little monitoring from an equity perspective' in relation to the framework.[53] Interested party witness Amy Downs, who in 2017 published a report

47. New Zealand Public Health and Disability Act 2000, s22(1)(e), (f); submission 3.3.30, paras 4.57, 4.61.
48. Ministry of Health, *Operational Policy Framework 2018/19*, revised ed (Wellington: Ministry of Health, 2016), para 3.10.6.
49. Ministry of Health, 'PHO Services Agreement between [District Health Board] and [PHO], Version 6', Word document, 1 December 2018, pp31, 32.
50. Submission 3.3.30, paras 4.69–4.70.
51. Document A60, para 30.
52. Submission 3.3.30, paras 4.68–4.69.
53. Document A9, para 41.

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on the nature and efficacy of funding for New Zealand health care, agreed. Her concerns included the relatively small level of funding and the fact that incentive payments were, at least according to the people she interviewed, likely to be paid out regardless of performance.[54] Professor Cumming was cautiously positive about System Level Measures in her evidence but nonetheless pointed out that the measures chosen by the Ministry 'do not distinguish between Māori and other populations.'[55]

We note also that actions to address the areas highlighted by System Level Measures are formulated at district level by groups called alliances, which include a district health board, primary health organisations, and providers.[56] This approach is presumably meant to encourage locally appropriate health initiatives. We note, though, that, given district health board performance and responsiveness to equity issues is variable, we are not sure how strong these relationships in pursuit of System Level Measures might be in practice. We accept, however, that it is a relatively new framework.

Public information on the System Level Measures framework, how it operates, and particularly how it might affect Māori is limited, and this lack of visibility in and of itself concerns us. Crown witness Keriana Brooking, a senior official in the Ministry, acknowledged this information deficit and did not recognise a publicly available pamphlet prepared by the Ministry detailing the framework.[57] We found Professor Cumming's evidence persuasive: while promising, the System Level Measures framework as it is currently formulated is not pursuing health equity for Māori in a Treaty-compliant way.

5.4 Health Discourse

As our preceding discussion shows, the aim of achieving equitable health outcomes for Māori is not consistently or clearly reflected in the primary health care framework. The fact that the Act does not set a strong initial direction in this respect has undermined a clear articulation of health equity for the primary health care system. Our discussion of the definition and implications of equity as a concept is not purely semantic: the Treaty principles of active protection and equity oblige the Crown to state clearly its commitments to Māori health and, further, we consider that these express commitments must be Treaty-compliant.[58]

The conflation of terms in health discourse highlighted by the National Hauora Coalition claimants, then, is important. Indeed, this was acknowledged in the fourth volume of the Eru Pōmare Health Research Centre's *Hauora* series, released

54. Document A43, para 26.
55. Document A60, para 31.
56. Document A3, paras 230–232; doc A62, paras 278–282.
57. Transcript 4.1.7, pp322–323.
58. Waitangi Tribunal, *Tū Mai te Rangi! Report on the Crown and Disproportionate Reoffending Rates* (Wellington: Legislation Direct, 2017), p60; Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p64.

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in 2006. The first chapter, co-authored by Professor (then Dr) Papaarangi Reid and Bridget Robson, painstakingly defined equity, differentiated it from 'health inequalities', and then acknowledged:

> The word 'inequalities' in this country is widely used to mean inequities, as are the terms disparities and gaps. In this volume of *Hauora*, we have also chosen to use these terms interchangeably.[59]

Crown witness Keriana Brooking said that the 'language of equity' is a focus of the Government's 'strategic priority areas'.[60] However, the impression we get from the persistence of Māori health inequities is that the health sector does not have a clear or consistent understanding of what equity means in practice, partly because of the conflation of terms and concepts. Even in cases where equity is explicitly invoked or defined, this conflation of terms throughout the health sector serves to undermine it. This confused terminology does not reflect the clarity of commitment required by the Treaty principles.

Brooking stated that the Crown's focus on implementing the Primary Health Care Strategy seemed to have waned since around 2007 and had become 'episodic'.[61] Under cross-examination by counsel for the National Hauora Coalition, Brooking went further:

> . . . I would say that over the course of the Primary Health Care Strategy as evidenced by where we are today that the focus on Māori health has not been enough by virtue of the evidence and performance.
>
> Q. Would you agree that there has been a lack of emphasis on Māori health?
>
> A. Certainly. If you look at the Government strategic priority areas over the 18 years that the Primary Health Care Strategy has been in place, Māori health is what I would call a marquee or a headline strategy as compared to others.[62]

Our impression is that this is partly because of the absence of clear direction by the legislative and policy framework to align the sector with health equity.

We consider that, to be Treaty-compliant, the Act and policy framework needs an objective that unequivocally spells out a commitment to achieve equitable health outcomes for Māori.

National Hauora Coalition claimant Simon Royal stated that committing to reducing disparities or inequitable outcomes 'seems to imply that there is an acceptable amount of inequity', which he rejects.[63] We do too.

The National Hauora Coalition noted that, in addition to failing to say that equity is an objective of the health system, the language in the Act emphasises the

59. Bridget Robson and Ricci Harris, eds, *Hauora: Māori Standards of Health IV – A Study of the Years 2000–2005* (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 2007), p 4.
60. Transcript 4.1.7, p 321.
61. Document A62(a), p 3.
62. Transcript 4.1.7, p 285.
63. Document A23, para 7.

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pursuit of an objective to reduce health disparity 'as opposed to a requirement that equity be achieved'.[64] Conversely, the Crown argued that the statutory obligation to pursue rather than achieve objectives, as set out in section 3(1), is important because it recognises how difficult it is to fully achieve this objective, given the Ministry cannot address all determinants of Māori health status. They further state that the qualification in section 3(2) of the Act, which provides that '[t]he objectives . . . are to be pursued to the extent that they are reasonably achievable within the funding provided', is consistent with the Treaty.[65]

We consider that the Crown's obligations under the principles of equity and active protection require action on its part. There are limitations to the action required under the Treaty, which, as the Crown highlights, is reflected in the Act. Nonetheless, we agree with the claimants that the Crown's Treaty obligations include setting a clear direction for the primary health care system to commit to achieving equitable health outcomes for Māori. Thus far, the Crown has not done so.

5.5 The Treaty Clause in the New Zealand Public Health and Disability Act

The Treaty clause set out in section 4 of the New Zealand Public Health and Disability Act 2000 reads as follows:

> In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision making on, and to participate in the delivery of, health and disability services.[66]

The claimants criticised the Treaty clause for being unduly narrow and for limiting Māori to a participatory role only in the delivery of health services.[67] Counsel for the National Hauora Coalition claimants submitted that the Treaty clause is unusual 'as it does not require the Act to be interpreted and administered so as to give effect to the principles of the Treaty of Waitangi'; rather, 'it provides mechanisms that are intended to implement the principles of the Treaty in a practical way'.[68] The Crown argued that the clause eventually settled on in the Act was an early attempt to 'recognise and respect Treaty principles' and is not as 'open ended as some other Treaty clauses'.[69] In closing submissions, Crown counsel argued that the legislation broke 'new ground'.[70] Counsel further submitted that the Treaty clause, and the provisions in part 3 of the Act to which it refers, are 'meaningful

64. Submission 3.3.30, para 4.14.
65. New Zealand Public Health and Disability Act 2000, s 3(2); submission 3.3.32, para 26.
66. New Zealand Public Health and Disability Act 2000, s 4.
67. Submissions 3.3.30, paras 4.22–4.23.
68. Ibid, para 4.23.
69. Transcript 4.1.5, p 348.
70. Submission 3.3.32, para 33.

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and [assist] Māori to exercise tino rangatiratanga in relation to health services and outcomes'.[71]

However, we note the comments of the Honourable John Tamihere, who appeared as a witness for the Māori Primary Health Organisations and Providers claimants and was a member of Parliament when the Act was being formulated:

> Politics is sort of the art of the do-able and when you're in a difficult negotiation situation as we were and we've got law draftsmen, scribes and given the command and control that was asserted by the 9th floor those days which I don't pursue too much here. But I will say you've got to do the best you can in the worst possible circumstances for your people and so that's the difficulty that Māori MPs in the house [face] as a minority group.[72]

In his 2008 book *The Treaty of Waitangi in New Zealand's Law and Constitution*, Matthew Palmer, now a judge of the High Court, traversed the history of Treaty clauses in legislation.[73] He identified three areas where Parliament enacted legislation that comprehensively elaborated on the meaning of the Treaty: Māori land, Māori fisheries, and the Māori language.[74] Overall, he noted that, prior to 2000, Parliament took a case-by-case approach to the adoption of Treaty clauses. This resulted in 'a variety of legislative provisions which elaborate on the meaning of the Treaty of Waitangi'.[75]

Palmer said that by 2000 '[a] new trend in legislative statements by Parliament about the Treaty began' and that the passing of the New Zealand Public Health and Disability Act 2000 appeared to signal that this trend was gaining traction. He summarised that the Act provided several specific ways that the Treaty would be recognised, through 'the objectives, functions, composition of and training in District Health Boards' under part 3. The approach taken in the 2000 Act was also used for subsequent Acts, including the Local Government Act 2000, the Land Transport Management Act 2003, and the Public Records Act 2005.[76]

Palmer said that elaborating the meaning of the Treaty in this way is constructive, contending that it is better for Cabinet and Parliament to 'do the hard work of considering exactly how the Treaty should be reflected in legislative provisions' rather than presenting bare, unelaborated references.[77] The Honourable John Tamihere confirmed to us that this was Cabinet's motivation behind the wording of the clause but stated that, ultimately, it had not worked:

71. Submission 3.3.32, para 29.
72. Transcript 4.1.4, p156.
73. Matthew Palmer, *The Treaty of Waitangi in New Zealand's Law and Constitution* (Wellington: Victoria University Press, 2008).
74. Palmer provides the following examples: Te Ture Whenua Maori Act 1993; the Māori Fisheries Act 2004; and the Maori Language Act 1987.
75. Palmer, *The Treaty of Waitangi*, p96.
76. Ibid, pp100–101.
77. Ibid, p101.

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> [W]e would have liked to have done a lot better, but what it was was we had to evolve from a generic principal clause to trying to imbed it and the idea behind the wording that you have just expressed would work if it was supported by good will to operationalise it. We can play with words in regards to making them mandatory and the like but ultimately it falls back on the good faith and the good will of those that you're working with, engaging with to assert the intent of the law. The intent is there and I don't think you can walk away from that. The way in which you would evidence how that works, clearly that's why we're here today because it hasn't.[78]

In our view, the clause is not so much an elaboration as a reductionist effort at a Treaty clause. It opens with the words 'in order to recognise and respect' rather than words such as 'give effect to', 'not act in a manner inconsistent with', and 'recognise and provide for'. The latter examples place a positive obligation on the Crown to interpret the Act in a manner consistent with Treaty principles.

The clause then uses the words 'with a view to improving health outcomes for Māori'. Earlier in our discussion on equity, we were critical of the use of language that focuses on reducing disparities rather than achieving health equity. That same criticism equally applies in this context: improving health outcomes does not capture wholly the definition or application of health equity. Language does matter.

The clause then introduces the idea that the mechanisms that will implement the Treaty relationship will be provided for in part 3 of the Act. The problem is that part 3 does not encompass all Crown agents in the health sector: part 3 only applies to district health boards, which essentially assumes that the Minister and the Ministry need not have any Treaty-relevant functions or obligations. So part 2, for example – which sets out the provisions for ministerial committees that are intended to advise the Minister on issues such as health and disability, public health, health workforce, and ethics – does not require that Māori representatives be appointed to these committees.[79] Nor are Māori health advisory committees statutorily required; an omission that the Crown appeared to note in closing submissions.[80] The fact that a formal national body focused on Māori health does not exist and is not statutorily required at the ministerial level is in our view inconsistent with Treaty obligations.

Also, because it is focused on district health boards, part 3 does not adequately recognise that the Treaty prescribes further Crown obligations to Māori under the principle of equity: where reasonably practicable, Māori are guaranteed to have access to, and receive, the health care that they need. While the objectives set out in section 22 are partly relevant to this guarantee, reducing disparities – even with 'a view to eliminating them' – is not directly synonymous with equity. As we concluded earlier in this chapter, clarifying the objective of the health system as

78. Transcript 4.1.4, p156.
79. New Zealand Public Health and Disability Act 2000, ss11–18.
80. Submission 3.3.32, para 111.

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health equity is an important point for an Act that sets out in statute the direction of the health sector.[81]

Finally, the extent of the Treaty and its principles is further narrowed as the clause goes on to talk about the role of Māori being limited to contributing to decision-making and participating in the delivery of services at the district health board level. Such wording downgrades the principle of partnership to mere 'participation' and 'contribution'.[82] We appreciate the Crown's submission that 'the participation provided for is meaningful', but in our view it does not go far enough to adequately, as Crown counsel put it, 'assist Māori to exercise tino rangatiratanga'.[83]

We consider that the focus on and framing of 'participation' and 'contribution' departs from the text and principles of the Treaty and does not capture the true dynamic expressed in the Treaty and its principles. Crown counsel themselves, in their opening submissions, explained:

> the following Treaty principles are central to evaluating the extent to which the two claims under inquiry are well-founded:
>
> - The principle of partnership;
> - The principle of equity; and
> - The principle of active protection.[84]

Partnership is a much stronger concept than participation. Partnership under the Treaty, underpinned by recognition of tino rangatiratanga, means at least joint decision-making between Crown and Māori agencies and groups, not mere 'contributions to' or 'participation in' decision-making. This is a crucial distinction. The principle of partnership is particularly watered down through the Treaty clause in the Act.

Again, we accept that the Treaty clause in the Act was a fresh attempt at giving effect to Treaty obligations; however, it has proved ineffective in practice, much like the objective 'to reduce disparities' discussed previously in this chapter. In summary, the current Treaty clause does not provide for a wider vision that allows for Māori as Treaty partners to be fully involved in the co-design, control, or delivery of the primary health care system. It fails to recognise the principle of partnership and fails to provide for tino rangatiratanga or mana motuhake. In effect, then, section 4 applies only to part of the health sector, not the whole sector, and is a narrow, reductionist version of the Treaty principles.

Counsel for interested party Owen Lloyd, of Ngā Ariki Kaipūtahi, submitted that stronger provisions for acting consistently with the Treaty were considered before the passage of the Act. He argued that the Crown had 'a number of significant opportunities' to ensure that the Act and the new arrangements for the health system were Treaty-compliant. For example, a Cabinet paper dated 20 June 2000

81. New Zealand Public Health and Disability Act 2000, ss22(1)(e), (f).
82. Ibid, s4.
83. Submission 3.3.32, para 29.
84. Submission 3.3.2, para 44.

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reveals that a much stronger partnership model was being pondered, including the annual convening of a 'National Maori Forum' to provide policy advice at the ministerial level and another provision that would have mandated district health boards to partner with Māori in their district.[85]

Counsel highlighted that the Treaty clause originally proposed in the Bill provided for the following: 'This Act is to be interpreted in a manner that is consistent with the principles of the Treaty of Waitangi.'[86]

In a recent decision, *Ngāi Tai ki Tāmaki Tribal Trust v Minister of Conservation*, the Supreme Court considered the meaning of section 4 of the Conservation Act 1987, which reads: 'This Act shall so be interpreted and administered as to give effect to the principles of the Treaty of Waitangi.'[87]

In that case, the Supreme Court said:

> Section 4 is stated in imperative terms. The obligation on DOC in its administration of the Conservation Act is to 'give effect to' Treaty principles. This has some similarity to s 9 of the State-Owned Enterprises Act 1986, which provides: 'Nothing in this Act shall permit the Crown to act in a manner that is inconsistent with the principles of the Treaty of Waitangi.' Section 9 was recently described by this Court as a 'fundamental principle guiding the interpretation of legislation' in *New Zealand Maori Council v Attorney-General*. The requirement to 'give effect to' the principles is also a strong directive, creating a firm obligation on the part of those subject to it, as this Court noted in a different context in *Environmental Defence Society Inc v The New Zealand King Salmon Co Ltd*.[88]

Nearly two decades on, it is clear to us that more imperative wording should have been used to embed the Treaty principles into the primary health care sector.

5.6 Treaty Principles in the Primary Health Care Framework – the 'Three Ps'

The watering down of the Treaty principles, particularly partnership, in the Act's Treaty clause is reflected in the key strategies of the primary health care framework. In its closing submissions, the Crown submitted 'the New Zealand Health Strategy, and the other strategies that lie alongside it, contain many goals and objectives aimed at giving effect to the Treaty relationship between Māori and the Crown.'[89]

The Crown referred to the preferred expression in the health sector of the relevant Treaty principles during the last 20 years as 'partnership, participation and protection' or the 'three Ps'.[90] These expressions were derived from the 1988 Royal

85. Submission 3.3.14(a), paras 7–8.
86. Ibid, para 12.
87. Conservation Act 1987, s 4.
88. *Ngāi Tai ki Tāmaki Tribal Trust v Minister of Conservation* [2018] NZSC 122, para 48.
89. Submission 3.3.32, para 31.
90. Document A59, para 49; transcript 4.1.5, p351.

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Commission on Social Policy and are set out in both the 2002 and the 2014 versions of He Korowai Oranga. The Crown acknowledged that the Ministry's 'three Ps' could be regarded as a 'reductionist view of Treaty principles' but submitted that they were an attempt to create a common language for use by a large workforce, which was about to undertake a new journey of understanding about what the Treaty means.[91]

In closing submissions, the Crown acknowledged that the Ministry's interpretation of the Treaty principles 'could be updated to better reflect current understandings'.[92] Even accounting for the Royal Commission on Social Policy's relevance to the policy work undertaken in the health sector, it does surprise us that the government of the day chose a report then over a decade old as its primary reference point for the framing of Treaty principles.

The Treaty and its principles had been traversed and interpreted in court cases and Tribunal reports in the years between 1988 and the drafting of He Korowai Oranga. Indeed, by the date of the refresh of the strategy in 2014, the Treaty and its principles had been the subject of scrutiny by the courts and this Tribunal for close to three decades. In chapter 3, we set out at length the relevant principles and how they have been interpreted over that time. Contemporary thinking on Treaty principles has moved on significantly from the 'three Ps' approach favoured in the health sector.

A statement precedes the Ministry's 'three Ps' noting that '[t]he Government is committed to fulfilling the special relationship between iwi and the Crown under the Treaty of Waitangi'. 'Partnership' is then defined as: 'Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.'[93]

But 'working together' does not necessarily constitute a Crown–Māori Treaty 'partnership'. The strategy also stated that '[p]artnership with the Crown is one of the principles of the Treaty of Waitangi' and that district health boards are required to involve iwi and other Māori communities to improve Māori health'. But partnership would only 'enable [Māori] to influence the planning, purchasing, delivery and monitoring of services to build Māori health'.[94] The New Zealand Health Strategy includes similar guarantees that the sector will 'recognise and respect' the Treaty and its principles by supporting Māori 'to participate in the sector and in making decisions on services'.[95] The director-general acknowledged that participation and partnership are very disparate concepts when read against the Treaty.[96] We agree. In our view, influencing decisions or participating in making them is not the same as making decisions.

91. Transcript 4.1.5, p 351.
92. Submission 3.3.32, para 41.
93. Minister of Health and Associate Minister of Health, *He Korowai Oranga*, p 2.
94. Ibid, p 15.
95. Ministry of Health, *New Zealand Health Strategy*, p iii; submission 3.3.32, para 48.
96. Transcript 4.1.5, p 436.

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The Crown was careful to emphasise that He Korowai Oranga included the 'pursuit of rangatiratanga' as a 'key thread' in the achievement of the strategy's objectives.[97] The Crown further argued: 'The exercise of te tino rangatiratanga is a feature of the Māori health strategy. In addition, aspirations for mana motuhake and self-determination can be explored in line with the Declaration on the Rights of Indigenous Peoples.'[98]

However, the 2002 version of He Korowai Oranga highlights 'rangatiratanga' – and not, as in the Treaty, 'tino rangatiratanga' – as an aspiration for whānau, hapū, and iwi 'to have control over the direction and shape of their own institutions, communities and development as a people'.[99] The two action plans for He Korowai Oranga (now lapsed) essentially repeat this description with similar definitions and explanations for 'rangatiratanga': for example, as a Māori aspiration manifested through 'participation' or 'involvement' in health sector decision-making.[100] We note here that aspirations are not actualities but hopes for the future. Rangatiratanga, or the right to exercise authority, is not an aspiration for Māori or for Māori communities. Rather, the right of Māori to exercise their authority is at the very core of Māori society and Māori life.

The current version of He Korowai Oranga, launched in 2014, no longer frames rangatiratanga as merely an aspiration. Instead, rangatiratanga is framed as 'Enabling whānau, hapū, iwi and Māori to exercise control over their own health and wellbeing, as well as the direction and shape of their own institutions, communities and development as a people'.[101]

However, formal implementation of this 'key thread' at district health board level is still limited to participating in health governance and 'influencing the way services are designed or delivered'.[102] Again, we note, this is not the same as control of decision-making. The strategy does associate 'Māori institutions, including Māori health providers', with rangatiratanga and views them as an intrinsic part of the health system, but it makes no direction or elaboration on what the Crown's responsibilities to these organisations are in that regard.[103] This is inconsistent with the Crown's Treaty obligations.

Having said this, 'rangatiratanga' in and of itself is not strictly what is guaranteed in the Treaty. 'Tino rangatiratanga' is guaranteed active protection in the Treaty. 'Tino rangatiratanga' means indigenous autonomy and is an equivalent

97. Submission 3.3.32, para 41.

98. Submission 3.3.32(a), p 1.

99. Minister of Health and Associate Minister of Health, *He Korowai Oranga*, p 7.

100. Ministry of Health, *Whakatātaka: Maori Health Action Plan 2002–2005* (Wellington: Ministry of Health, 2002), pp iii, 3–4, 5–6, 13–15, 17–21; Ministry of Health, *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011* (Wellington: Ministry of Health, 2006), pp 2, 10, 14, 22–29.

101. 'Rangatiratanga', Ministry of Health, https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/key-threads/rangatiratanga, last modified 13 June 2014.

102. See also Ministry of Health, *The Guide to He Korowai Oranga*, pp 4, 7, 8, 10–11, 12.

103. 'Rangatiratanga', Ministry of Health, https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/key-threads/rangatiratanga, last modified 13 June 2014.

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term to 'mana motuhake'.[104] Far from being an 'aspiration' for Māori communities, 'tino rangatiratanga is the basis of Māori political and social organisation and the foundation of Māori decision-making'.[105] Tino rangatiratanga is the fullest expression of the right of Māori to exercise authority over their own communities with 'minimum Crown interference'; however, this expression is balanced against Māori obligations to act in good faith and what is reasonably practicable for the Crown in the circumstances.[106]

Only one of the major health strategies and policies contains any mention of tino rangatiratanga. The final sentence of the foreword to the 2002 version of He Korowai Oranga, by then Minister of Health Annette King and Associate Minister Tariana Turia, reads: 'The strategy supports tangata whenua-led development resulting in the achievement of tino rangatiratanga and ultimately the promise of a healthy nation.'[107]

Aside from the obvious need to scrutinise whether this vision has been achieved, the body of the strategy does not even mention tino rangatiratanga – let alone explain what it is. Therefore, the strategy does not adequately support this vision. He Korowai Oranga and the 'three Ps' cannot be the basis for a common language or common understanding of Treaty rights and obligations.

Moreover, by watering down the true meaning of the Treaty principles, the Crown has undermined its potential strength to audit district health boards for Treaty-compliance. This was the aim behind the He Ritenga Cultural Auditing Framework, initially prepared by Janet McLean and her team at the Bay of Plenty District Health Board in 2004. While the principle behind He Ritenga is a good one, it follows the expressions of the Treaty principles in He Korowai Oranga closely, which reduces its effectiveness as an auditing framework.[108]

When asked whether the vision of Minister King and Associate Minister Turia quoted above constituted a common ground for the goals and aspirations of the Crown and Māori, Māori Primary Health Organisations and Providers claimant Taitimu Maipi said:

> You can print something onto a page, but you've got to breathe life into it, and I think that was missing. You breathe life into what you believe tino rangatiratanga looks like . . . but there was no breath of life in that, there was just a lot of words in my view.[109]

104. Waitangi Tribunal, *Tauranga Moana, 1886–2006: Report on the Post-Raupatu Claims*, 2 vols (Wellington: Legislation Direct, 2010), vol 1, p18; Waitangi Tribunal, *He Maunga Rongo: Report on the Central North Island Claims*, 4 vols (Wellington: Legislation Direct, 2008), vol 1, p172; Waitangi Tribunal, *The Taranaki Report: Kaupapa Tuatahi* (Wellington: GP Publications, 1996), pp5–6, 20.

105. Waitangi Tribunal, *The Ngātiwai Mandate Inquiry Report* (Wellington: Legislation Direct, 2017), p27.

106. Waitangi Tribunal, *He Maunga Rongo*, vol 4, p1241; *New Zealand Maori Council v Attorney-General* [1994] 1 NZLR 513 (PC), p517.

107. Minister of Health and Associate Minister of Health, *He Korowai Oranga*, p iii.

108. Māori Health Planning and Funding Team, *He Ritenga: Treaty of Waitangi Principles Health Audit Framework* (Wellington: Bay of Plenty District Health Board, 2004).

109. Transcript 4.1.4, pp 49–50.

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We note that giving effect to the Treaty partnership was a 'significant concern' for Māori involved in the consultation period, begun in March of 2000, on the development of the Primary Health Care Strategy. Crown counsel noted the consultation, which included 'Māori providers and co-funders', but did not make a submission on its adequacy.[110] Crown witness Dr Frances McGrath recalled some participants saying that the documentation proposing the reforms to primary care did not, in their eyes, reflect 'a commitment to partnership or to the action required to make it a reality'.[111]

While tino rangatiratanga may have been in the minds of Minister King and Associate Minister Turia, neither He Korowai Oranga nor the other strategies and policies relevant to primary health care require the health sector to recognise the tino rangatiratanga rights that are enshrined in article 2. In our view, the Ministry's articulation and explanation of the Treaty and its application to the health sector is not Treaty-compliant.

5.7 The Act's Provisions for District Health Boards

The district health boards' interpretation of their statutory obligations and objectives, as set out in part 3 of the Act, is coloured by the Crown's lack of clarity about the Treaty principles and insufficient recognition of the principles in the health sector strategies. In particular, we are concerned that the Treaty clause's referral to part 3 effectively freezes the health sector's purported compliance with the Treaty in time and does not adequately recognise that the Treaty is a living document. The mechanisms in part 3 may have been seen to implement Treaty principles when the Act was drafted. But Treaty jurisprudence has developed since then, and these provisions, which we discuss in the following sections, may no longer be Treaty-compliant.

5.7.1 Māori representatives on the boards of district health boards

Section 29 of the Act includes the following statutory obligation in relation to district health boards:

> (4) In making appointments to a board, the Minister must endeavour to ensure that—
>
> (a) Maori membership of the board is proportional to the number of Maori in the DHB's resident population (as estimated by Statistics New Zealand); and
>
> (b) in any event, there are at least 2 Maori members of the board.[112]

The Crown argued that section 29 partly affords a reflection of rangatiratanga rights by allowing Māori membership on these boards as decision makers.[113]

110. Statement of response 1.3.1, p5.
111. Document A63, para 174.
112. New Zealand Public Health and Disability Act 2000, s29(4).
113. Submission 3.3.32, paras 32–33.

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Claimant groups broadly argued that section 29 does not actually afford decision-making power in practice, because Māori board members are always in the minority.[114] Further, claimant groups argued that the Crown has not consistently ensured that district health boards are meeting the statutory requirements under section 29.[115]

To begin with, it is worth unpacking the lack of clarity inherent in this clause. '[Endeavouring] to ensure' does not amount to a requirement, and the test of reasonable effort on the Minister's part would appear to be set by the government of the day. We did not receive evidence on the efforts Ministers past and present have made to fulfil the requirements pursuant to section 29(4); however, the Crown did file data concerning the Māori membership of district health boards.

This data shows that on only one occasion, in 2001, have all district health boards had two Māori members. At no time have all district health boards complied with the proportionality clause. As of the last elections in November 2018, 18 of the 20 district health boards have at least two Māori board members but only 11 district health boards are meeting the proportionality requirement under section 29(4)(a).[116] According to the Crown's estimation, this is the lowest compliance rate with the proportionality clause since the Act was passed.[117]

The data also reveals that Māori are more likely to be appointed rather than elected. Instances where more Māori were elected, rather than appointed, were very few.[118]

Even acknowledging the difficulty of identifying and appointing Māori representatives for boards, in our view the lack of clarity of section 29(4) has not encouraged statutory compliance. We are particularly concerned that the Minister's compliance with section 29(4), to 'endeavour to ensure' that boards have Māori representatives, appears to be assessed only by the Crown. This does not reflect the spirit of partnership, or even community ownership, which the boards are meant to reflect. Nor does it ensure that Māori are contributing to the design and delivery of health care in their district.

Professor Peter Crampton said that he was not convinced that the attempt to recognise 'an element of community governance' through the election and appointment of district health board members is particularly effective.[119] As pointed out by witnesses, Māori board members are always in the minority.[120] Counsel for Owen Lloyd, an interested party, argued that 'the aspiration of even proportionate representation in a system that produces disproportionate outcomes is inadequate'.[121]

114. Submission 3.3.18, para 76; 3.3.30, paras 5.156–5.157.
115. Submission 3.3.18, para 75; submission 3.3.30, para 5.159.
116. Memorandum 3.2.19, response to Dr Bloomfield question 6.
117. Memorandum 3.2.19(a), apps 1–2; memo 3.2.91(a), apps A–E.
118. Memorandum 3.2.19(a), apps 1–2; memo 3.2.91(a), apps A–E.
119. Transcript 4.1.4, pp 620–621.
120. Document A46, para 16.
121. Submission 3.3.14(a), para 38.

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Other evidence we received about Māori membership on other boards or decision-making bodies indicated further shortcomings with this approach. We note that, when a national agreement to determine primary care contracting was being prepared, Māori involved in that process were in the minority.[122] National Hauora Coalition witness Tereki Stewart was a member of the body preparing the agreement in 2009 and noted that the 'few Māori voices' involved were drowned out simply because they were outnumbered.[123] Dr Heather Came-Friar and Professor Tim McCreanor said that research they were in the process of producing on the experiences of Māori and Pacific peoples' involvement on advisory boards indicated that the Māori members are not only outnumbered but also flatly ignored by others present.[124]

The requirement for Māori representation on district health boards is also a relatively general one. As a result, Māori board members may not be representative of mana whenua or indeed be intimately familiar with the actual health needs and community makeup of their district.[125] In his written evidence, Owen Lloyd said:

> What is important, is that representation of Māori on the board actually reflects the interests of mana whenua of the rohe. Iwi and hapū representatives need to be at the board table to address the inequalities of the health of our people. This is not protected in the local election and Minister appointment processes as currently provided for.[126]

A specific provision directing the Minister to endeavour to ensure the appointment of Māori to district health boards was certainly an improvement on what occurred prior to 2001. Indeed, in the *Napier Hospital and Health Services Report*, the Tribunal found: 'the explicit provisions in the Public Health and Disability Act 2000 for ensuring proportional Maori representation on district health boards and standing committees are fully consistent with the principle of *partnership*' (emphasis in original).[127]

However, the Tribunal in that inquiry did not have the benefit of seeing the district health board model play out in practice. We understand why the Tribunal came to this conclusion: at first blush, the provisions do appear to afford Māori decision-making power, at a governance level, of entities that would effectively direct and resource the health system on the ground.

But, as the period since the *Napier Hospital and Health Services Report* has revealed, the district health board model overall does not afford Māori sufficient control of decision-making to be a fulfilment of the Treaty principle of partnership. Māori board representatives operate within significant limitations, including

122. Document A60, para 40; submission 3.3.32, paras 5.166–5.167.
123. Document A20, para 10.
124. Transcript 4.1.5, pp201–202.
125. Submission 3.3.14(a), para 40; transcript 4.1.4, p621.
126. Document A45, para 8.
127. Waitangi Tribunal, *Napier Hospital and Health Services Report*, p317.

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the fact that they are a minority. Board appointees are ministerial appointees, the board is the Minister's board, and thus they are ultimately 'accountable and answerable to the Minister and Government'.[128] As such, the statute itself is insufficient to reflect the Treaty's guarantee of decision-making power for Māori. Further, the Crown has not even been able to satisfy the proportionality requirement: any assumption that the proportionality provision would be consistently achieved by the Minister has been found to be incorrect. Taking these factors into consideration, the board representation model is not a full reflection of the principle of partnership.

5.7.2 Partnership arrangements with district health boards

Crown witness Hector Matthews suggested that Māori representatives on governance boards such as district health boards are often at a disadvantage:

> Māori communities often do not have sufficient resources in order to participate, for example on governance boards, at the same level as clinicians or health professionals. Furthermore, it is difficult for local Māori representatives to feel like an equal partner in these situations when they are outnumbered by clinicians, health professionals and managers for example.[129]

These difficulties were reflected in evidence relating to efforts by various Māori groups to partner with district health boards and contribute to their decision-making processes. The Act, under sections 22 and 23, establishes various requirements for district health boards to 'foster community participation in health improvement' and 'establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement'.[130] Drawing from these sections, the *Operational Policy Framework* provides for the following:

> Each DHB (in both its funder and provider functions) must establish and maintain processes to enable Māori to participate in, and contribute to, strategies designed to improve the health of Māori. These processes include the development of effective relationships with iwi and Māori, and consultation with Māori, as well as service delivery and monitoring.[131]

What have been generally referred to as the 'Māori/iwi relationship boards' are intended as advisory boards for district health boards and constitute an attempt at interpreting sections 22 and 23.[132] While the Act does not require that district health boards have a formal relationship with a Māori entity that represents or is

128. Submission 3.3.14(a), para 39.
129. Document A64, para 94.
130. New Zealand Public Health and Disability Act 2000, ss 22–23.
131. Ministry of Health, *Operational Policy Framework 2018/19*, para 3.10.4.
132. Document A65, para 52.

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linked to the mana whenua, currently all district health boards do have a form of this arrangement.[133]

The claimants argued that the oversight and decision-making power of these boards vary considerably and are often not robust enough to give effect to the Treaty principle of partnership adequately.[134] While Crown counsel argued that these boards 'can provide an opportunity for involvement in decision-making at governance, executive, strategic and operational levels', they broadly acknowledged the criticisms forwarded by the claimants and Crown witnesses.[135]

The arrangements allow for regional variability; however, the absence of a specific, legislative requirement for Māori relationship boards concerns us. We contrast this with the statutory requirement for district health boards to establish community and public health, disability support, and hospital advisory committees under sections 33 and 34 of the Act.

In his oral evidence, Hector Matthews described Canterbury District Health Board's arrangements with iwi in its district, which amount to individual memoranda of understanding with each rūnanga. He then said:

> But going back to the mid-2000s when the Ministry was instructing DHBs to have what they called Crown/Māori relationship instruments and so DHBs were individually negotiating those instruments. I can recall that one DHB, I don't think I need to name it, signed a Crown/Māori relationship instrument and that put a big taihoa on all the other DHBs because the Minister felt that the DHB was overcommitting in terms of its Treaty responsibilities so that paused for a period of a couple of years. And then we ended up going back to our local iwi and negotiating memoranda of understanding which enabled iwi to participate in the planning of services within the DHB region.[136]

In terms of those arrangements that exist today, the Crown acknowledged the criticisms many witnesses, including its own, made in relation to Māori relationship boards.[137] Janet McLean described them as a tokenistic arrangement 'for DHBs to be able to tick a box . . . [Māori] aren't always involved in the decision making at a governance level'. She broadly concluded that the relationship boards 'do not have the same mana as a statutory board on a DHB.'[138]

Dr Nick Chamberlain, the chief executive of the Northland District Health Board, agreed under questioning that these boards 'do not typically have a governance role, a financial delegation, or an effective way to hold DHBs to account'.[139] Dr Chamberlain specifically related his observations of the difficulties experienced by

133. Document A3, para 242.
134. Submission 3.3.30, paras 5.160–5.163.
135. Submission 3.3.32, paras 217, 307–310.
136. Transcript 4.1.7, p 204.
137. Submission 3.3.32, para 308.
138. Transcript 4.1.4, p 289.
139. Submission 3.3.32, para 309.

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the Northland District Health Board's own Māori relationship board, Te Kahu o Taonui. He said that many of the members of that body do not have expertise in health, limiting their capacity to contribute meaningfully.[140] Oral evidence from Hector Matthews and Dr Chamberlain showed that the members of these boards, as iwi and hapū representatives, often have multiple responsibilities competing for their time; for example, at the last meeting of Te Kahu o Taonui, only two of the nine iwi leaders were present.[141]

Matthews also related his sense of the 'power and resources imbalance' between these advisory boards and their district health boards:

> equal partnership or even partnership is another one of those terms that we use a lot but I've found in practice [it's] very, very difficult. I look at my mana whenua group and I feel real aroha for them when they're working in partnership with our DHBs and that's not because there aren't good people sitting around the table wanting to work in partnership but you know our mana whenua is in monetary terms a $50,000 organisation if they're lucky versus – because we give them 50 some odd K a year just to run you know their administration they might get a bit more from other places – versus a $1.4 billion organisation so it's really, really challenging to be in partnership with that. That doesn't mean people aren't genuinely trying to do that but equal partnership is interesting rhetoric that is hard to put into practice.[142]

Matthews also believed that the relationship between the advisory boards and district health boards was affected by district health board members, in general, not having a grounded, thorough understanding of mātauranga Māori. Counsel for Te Ohu Rata o Aotearoa drew the analogy that, while there may be a similar power and resource imbalance between Te Rūnanga o Ngāi Tahu and individual rūnanga, there is not an imbalance in terms of their facility to engage with and work within te ao Māori.[143] Matthews agreed:

> I think there's a lot of well meaning, well intentioned people but that doesn't always translate because you're right it comes down to those values. You know if you and I are sitting down having a kōrero and you know, manuhiri turn up at the gate we know instinctively what to do and we make decisions based on those value sets that we've been raised in.
>
> Q. Yes.
>
> A. And I met a lot of really good people who have been raised differently and they make decisions based on different sets of values and so therefore we end up with that rubbing of knuckles at the point of implementation.[144]

140. Transcript 4.1.6, pp 32–33.
141. Transcript 4.1.6, p 35; transcript 4.1.7, p 213.
142. Transcript 4.1.7, p 165.
143. Ibid, p 185.
144. Ibid, p 186.

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District health board members are statutorily required to take cultural competency training.[145] The Crown provided information collected from district health boards on the type of training offered, and this information indicated that the training varies broadly and is not always undertaken by every board member. A concerning number of district health boards were vague, or provided no information at all, on the type or extent of training provided. The Capital & Coast District Health Board provided no response at all.[146] Some district health boards do not keep a training register of their board members as is statutorily required.[147]

Māori primary health organisations and providers similarly found it difficult to engage with district health boards. Claimant Janice Kuka described her and her contemporaries' attempts to partner with the Bay of Plenty District Health Board:

> The lack of resources limited our ability to participate in important decision making committees organised by the BOP DHB [Bay of Plenty District Health Board]. There was an expectation from BOP DHB that all four PHOs at the time provided representation on various committees. We only had one staff member who could sit on committees . . . Obviously it was near impossible for us to be represented on the committees given we had limited capacity with only one person. Our ability to fully engage and participate disadvantaged us at times as funding and contracting decisions were often made without us being present.[148]

Moreover, the director-general said that not all district health boards involve Māori health stakeholders in their district in their planning and delivery processes and decision-making.[149]

Counsel for Kuka and Lady Moxon summarised her clients' views on these partnership and consultation processes as follows:

> simply making provision for Māori involvement, or inviting a Māori member onto a board does not change Māori health outcomes. In almost all of the examples given Māori are a minority on boards and committees, and in many cases are the only Māori representative. The experience of Māori PHOs and Providers has been that their voices are often either not heard, or are lost to the vote of the majority.[150]

The evidence of Janet McLean indicates that this was certainly the experience of Māori providers under the Bay of Plenty District Health Board, after it decided in

145. New Zealand Public Health and Disability Act 2000, sch 3, cl 5(1).

146. Memorandum 3.2.94(a), app 2. Similarly, in appendix 1, the Crown collected information from district health boards on the ways in which primary health organisations' cultural competency is audited. We have similar concerns about these responses. Of particular concern to us is that some district health boards simply do not conduct cultural competency assessments.

147. Memorandum 3.2.94(a), app 5.

148. Document A12, para 36.

149. Document A65, para 9.

150. Submission 3.3.18, para 76.

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2017 to restructure its Māori Health Planning and Funding Team by terminating some roles and dispersing others across mainstream teams (as the Ministry had done with its own Māori health business unit, Te Kete Hauora, the year before). The Bay of Plenty District Health Board engaged in a consultation and submission process in June and August of that year, and Māori providers were reportedly clear on their rejection of the proposed restructure.[151] However, McLean noted:

> It was the view of the Māori provider sector that a decision had already been made and the DHB was merely going through the motions of consultation as evidenced by a Māori consultation Hui in June 2018. In response to the grave concerns expressed by Māori Providers at that hui regarding the review, the BOPDHB CEO stated she believed strongly in the proposed approach and she would makes these changes with or without Māori support.[152]

The proposed restructure went ahead, despite strong opposition from Māori providers.[153]

District health boards are also required to provide relevant information to Māori to enable Māori to participate in, and contribute to, strategies for Maori health improvement.[154] The *Operational Policy Framework* requires that district health boards 'must provide relevant information, including ethnicity data, to Māori to enable Māori to participate in, and contribute to, strategies for Māori health improvement'.[155]

We did not receive detailed evidence on how district health boards are currently fulfilling this requirement. In its review of the Bay of Plenty District Health Board in 2004, Te Puni Kōkiri found that the terms of reference for its Māori relationship board, the Māori Health Rūnanga, afforded oversight 'at the governance, rather than operational, level', despite the District Strategic Plan assuring operational oversight. Te Puni Kōkiri's review said that the rūnanga monitored some funding allocated for Māori health and that the general manager Māori health, Janet McLean, provided 'monthly reports to the Rūnanga' detailing the progress made against the goals in the district health board's strategic and annual plans. The review makes no mention of the nature or quality of these reports. It did, however, recommend that the terms of reference for the rūnanga be amended.[156]

Teresa Wall, who appeared as an interested party witness and has held various senior positions at the Ministry and elsewhere in the health sector, specifically noted that Māori groups who partnered with district health boards used their Māori health plans to have a 'more informed discussion' about actions and

151. Document A15, para 37.
152. Ibid, para 38.
153. Ibid, para 39.
154. New Zealand Public Health and Disability Act 2000, s23(f).
155. Ministry of Health, *Operational Policy Framework 2018/19*, para 3.10.3.
156. Document A76(a), app 4, pp 191–192, 195.

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initiatives in their communities.[157] We agree that they were likely useful in this regard, and as such the Ministry's decision to rescind the requirement that they be produced would have affected Māori groups' ability to participate in these discussions meaningfully.

Crown witnesses, including the director-general, broadly acknowledged that these partnership and consultation arrangements are not always effective, especially at implementation level.[158] Dr Chamberlain said that the depth and quality of these partnerships vary from district to district.[159] This degree of variability is not Treaty-consistent, and we consider that this is partly due to the insufficient clarity of the major strategies and other documents in relation to the sector's Treaty obligations.

In our view, Māori relationship boards, and indeed any Māori stakeholder group intending to partner with a district health board, face considerable challenges in effectively engaging in that process. The way the legislative and policy framework has organised and loosely regulated the sector is partly responsible. We agree with Janet McLean that the fact that Māori relationship boards are often only advisory boards and are not statutorily required is a significant weakness in the framework. Also, district health boards appear reluctant or nervous, or simply lack the knowledge, to partner with Māori and afford them a real stake in governance decisions.

While district health boards are Crown agents and individually have responsibilities to uphold the Treaty, the Ministry has an overarching responsibility as the steward of the health sector to ensure compliance and a form of consistency when it comes to the cultural competency of both its agents and the sector more generally.

To us, the responses from the district health boards relating to their training for board members confirm that some boards do not prioritise cultural competency as a skillset intrinsic to their governance processes and responsibilities.

We accept that, broadly, district health boards are cognisant of their need to reflect the populations that they serve, including Māori, but we are unconvinced that they actually manifest this to the extent needed.[160] This was certainly our impression from claimant and interested party evidence, but it was also confirmed by Crown witnesses. Dr Chamberlain accepted that the Northland District Health Board needed to do more to achieve this aim.[161] Hector Matthews, too, agreed under cross-examination that the Canterbury District Health Board does not reflect the values imbued in te ao Māori and that this is unacceptable.[162] We agree. As the Tribunal broadly stated in *Ko Aotearoa Tēnei*:

157. Transcript 4.1.5, p108.
158. Ibid, p414.
159. Document A66, para 10.
160. Ibid, para 22.
161. Transcript 4.1.6, p102.
162. Transcript 4.1.7, p174.

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> Fundamentally, there is a need for a mindset shift away from the pervasive assumption that the Crown is Pākehā, English-speaking, and distinct from Māori rather than representative of them. Increasingly, in the twenty-first century, the Crown is also Māori. If the nation is to move forward, this reality must be grasped.[163]

Understanding that the Crown also represents Māori is an essential step in making sure district health boards, and indeed all organisations in the health sector, engage correctly with their Treaty partner.

However, the Treaty obligations of district health boards and other Crown agents go beyond becoming more competent and comfortable with mātauranga Māori on an institutional level, as steep a learning curve as that may be for many. Crown agents need to be wholly conversant with the process and manner in which their partner wants, and needs, to engage with them. They need to have a deeper understanding of the motivations behind their partner's engagement with the Crown. Again, we draw from *Ko Aotearoa Tēnei*:

> On the Crown's part there must be a willingness to share a substantial measure of responsibility and control with its Treaty partner. In essence, the Crown must share enough control so that Māori own the vision, while at the same time ensuring its own logistical and financial support, and also research expertise, remain central to the effort.[164]

Co-governance between the Crown and Māori, as ensured under the Treaty, is not facilitated by the current arrangement of the district health board model.

As part of the Treaty settlement process, the Crown and Māori have in recent years explored and utilised the concept of co-governance in the return of natural assets to Māori. Several innovative examples have occurred that are intended to assist in the re-establishment of Māori relationships with natural resources. Co-governance and co-management arrangements have been utilised concerning the return of mountains, rivers, and national parks.[165]

In the local government sphere, the Auckland City Council has an Independent Māori Statutory Board, which was highlighted by interested party witness Patricia Tuhimata as an example of a broadly effective co-governance arrangement.[166] That board has specific powers under the Local Government (Auckland Council)

163. Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims concerning New Zealand Law and Policy Affecting Māori Culture and Identity: Te Taumata Tuarua*, 2 vols (Wellington: Legislation Direct, 2011), vol 2, p 451.

164. Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims concerning New Zealand Law and Policy Affecting Māori Culture and Identity: Te Taumata Tuatahi* (Wellington: Legislation Direct, 2011), pp161–162.

165. Examples of which are: the Mauao Historic Reserve Vesting Act 2008 and Ngā Mana Whenua o Tāmaki Makaurau Collective Redress Act 2014 (mountains); the Waikato-Tainui Raupatu Claims (Waikato River) Settlement Act 2010, Nga Wai o Maniapoto (Waipa River) Act 2012, and Te Awa Tupua (Whanganui River Claims Settlement) Act 2017 (rivers); and Te Urewera Act 2014 (a national park).

166. Document A48, para 81–83.

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Amendment Act 2010, which enables two board members to sit, with voting rights, on a number of council committees. The board provides direction and guidance to the council on issues affecting Māori. Every three years, the board conducts a Te Tiriti o Waitangi audit to assess the council's performance in acting in accordance with statutory references to the Treaty and statutory responsibilities to Māori in Auckland.[167] The Office of the Auditor-General has published a report highlighting co-governance models for natural resources around the country and suggesting principles for co-governance generally.[168] Such models already exist and go some way towards a recognition of Treaty rights and obligations. They are examples of what can happen in practice.

5.8 Treaty Obligations in Lower-level Accountability Documents

As foregrounded earlier, flowing down from the major strategies that set the direction of the health system are further accountability documents, such as policies, action plans, and contracts. These tie the vast, complex network of the primary health care system together and intend to put higher-level aims and obligations into practice. Most of these accountability documents are features of the district health boards' relationships with the primary care sector organisations in their area, though the Ministry also does direct contracting. For our purposes, we will borrow terminology from Crown counsel and refer to these as 'lower-level' accountability documents in this section.[169]

On 15 December 2006, in a letter from Acting Director-General Māori Health Teresa Wall, the Ministry directed all district health boards to 'no longer make any direct reference to the Treaty of Waitangi or its principles in any new policy, actions, plans or contracts'. Instead, the 'way forward' would be to rely on the provisions provided for in section 4 of the Act, which would 'still guide action and be a focus for DHBs'.[170]

Lady Moxon noted in her evidence that she and some of her contemporaries involved with Māori non-governmental organisations, including the Waikato District Health Board's Māori partnership entity, the Iwi Māori Council, strongly protested this change. The Iwi Māori Council stated in its correspondence that the move amounted to a downgrading of the Treaty and of the importance of Māori health.[171]

The Deputy Director-General Public Health Don Matheson and Minister of Health Pete Hodgson responded to these concerns by letters dated 4 April and 24 July 2007 respectively. They essentially repeated the explanation in Wall's December 2006 letter: because section 4 of the Act remained, as well as

167. 'About Us – Introduction', Independent Māori Statutory Board, https://www.imsb.maori.nz/about-us/introduction/, accessed on 16 May 2019.

168. Controller and Auditor-General, *Principles for Effectively Co-governing Natural Resources* (Wellington: Office of the Auditor-General, 2016).

169. Transcript 4.1.4, pp 353, 355, 359.

170. Document A11(a), app U, p 477.

171. Document A11, para 76.1, 77–81; doc A11(a), app W, pp 481–482.

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commitments expressed in He Korowai Oranga and other strategies, the Crown was still committed to the Treaty and to Māori health. The Deputy Director-General Public Health stated that the Ministry was operating under instructions 'not to downgrade the Treaty' and that the specific operationalisation of these commitments in lower-level documents, such as contracts, was more important; putting these commitments into practice would not be assisted, as the Minister said in his letter, 'by restating high-level wording around the Treaty of Waitangi'.[172] Crown counsel, in his cross-examination of Lady Moxon, emphasised that the focus appeared to be the '"what to do" and "how to do"' in relation to the sector's responsibilities to the Treaty and to improving Māori health outcomes.[173]

We have already concluded that the high-level wording in the Act and the various strategies do not give full effect to the Treaty or its principles, so the Crown's responses to Lady Moxon and others' concerns were insufficient in that regard. Having said this, it is worth examining why such references were removed, why the failure to mention the Treaty in lower-level policies and documents was of concern to many Māori, and what the practical impacts of the Treaty's inclusion in such accountability documents might be.

Wall wrote the letter dated 15 December 2006, which gave a clear directive to remove references to the Treaty and its principles from lower-level policies, plans, and contracts. When asked in our inquiry about the factors driving the removal of Treaty references, she highlighted the political context of the day, including the 2004 Orewa speech, the seabed and foreshore hikoi, and the government of the day's fear of a backlash from the New Zealand public.[174]

As for why the removal of references to the Treaty is an important issue, for many witnesses this appeared to centre on a loss of the Treaty's visibility. We agree with the Crown that the clear focus of these lower-level documents is the practical implementation of actions that are intended to give effect to the aims of the framework. It is appropriate, from a Treaty perspective, that this same focus be applied to Treaty responsibilities and obligations in these lower-level documents. As Crown counsel pointed out, one practical use of mentioning the Treaty in these documents is, at the most basic level, to 'orient' these documents and the relationships or actions to which they give effect in a manner that reflects the Treaty and its principles.[175] Indeed, in its letter to the Minister, the Iwi Māori Council stated that removing Treaty references from operational documents and contracts would render it 'invisible'.[176]

This Treaty visibility issue was highlighted by other witnesses, too. Hector Matthews stated that the fact that the Canterbury District Health Board does not have a clear statement relating to that organisation's Treaty obligations was a problem:

172. Document A11(a), app x, p 483; see also doc A11(a), app v, p 478.
173. Transcript 4.1.4, p 353–354.
174. Transcript 4.1.5, p 122.
175. Transcript 4.1.4, p 360.
176. Document A11(a), app w, p 481.

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> that lack of explicit statement I think pervades through lots of our systems in health and in social services and that adds to the vagary. Again, it's a reflection of what happens in New Zealand society because most New Zealanders have little or no knowledge. Lots of people have opinions about the Treaty, very few have read it.[177]

It strikes us that having explicit references to key concepts that are intended to underpin the health sector – like Treaty principles and obligations, but also concepts as central as health equity – would relieve some of the tensions inherent in the complexity, size, and devolved nature of the primary health care system. Dr Rawiri Jansen, for example, noted how constructive ideas and attitudes do not always permeate through the system:

> The most difficult place that we have to operate in is tier 2 and tier 3 of those Crown agencies. We often get really inspiring rhetoric from boards and chairs and CEOs and it turns to dust when you get busy trying to run a programme with the bureaucratic tier 3 managers of a programme.[178]

In this respect, explicitly articulating the Treaty and other key concepts at every level of the system would be a positive thing in our view – especially given resistance to, and misunderstandings of, the Treaty and what it means for this country.

Beyond simply ensuring the visibility of the Treaty and its meaning, having the Treaty as a part of all the so-called lower-level documents provides an imperative to give effect to the Treaty at every level of the sector. As acknowledged by Crown counsel, district health boards are Crown agents and, as such, have Treaty obligations. Dr Frances McGrath noted in her evidence for the Crown that the consultation period at the outset of the primary care reforms revealed that 'nearly two thirds' of Māori consulted said that the Treaty partnership 'should be reflected in the service agreements between DHBs and primary health care service providers'.[179] Insofar as primary health organisations and providers are concerned, Treaty principles should be expressly stated and clearly so as to be firmly in the minds of such organisations. Higher-level documents cannot be relied on in this respect. We are not convinced that the staff of every primary health organisation or provider will be familiar with He Korowai Oranga, for example, but they will certainly be intimately familiar with their own organisation's contracts and the deliverables associated with them.

The Crown is responsible ultimately for the primary health care framework and the provision of quality health care. It is therefore the Crown's responsibility that all organisations involved in the health sector are aware of its stated objectives and obligations. That should include unequivocal commitments both to achieving equity of health outcomes for Māori and to Treaty-compliance, and lower-level

177. Transcript 4.1.7, p206.
178. Transcript 4.1.4, p552.
179. Document A63, para 173.

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documents are key to embedding these goals throughout the system. Ensuring that the Treaty is visible to, and understood and abided by, all actors in the health sector is a Treaty responsibility of the Crown.

5.9 TRIBUNAL FINDINGS

In the 2001 *Napier Hospital and Health Services Report*, the Tribunal broadly concluded that the New Zealand Public Health and Disability Act 2000 contained provisions that 'committed the Crown and its health agencies to a number of particular obligations consistent . . . with the principles of *partnership* and *equity*' (emphasis in original).[180]

Since that Tribunal report, the persistence of Māori health inequities confirms that the provisions in the Act and the broad direction set for primary care, while promising, were not imperative or clear enough to manifest the urgency required of the primary health care sector to pursue health equity for Māori. The Crown is responsible ultimately for the performance of the health sector, and this includes ensuring that it, and its agents, comply with Treaty obligations. To do so, it should set clear expectations and requirements, and ensure that those expectations and requirements accurately reflect its Treaty obligations. Neither the Act nor the framework's interpretation of the Act and the Treaty meet this standard.

The complexity of health determinants, which all parties in this inquiry have acknowledged, is a significant enough prevailing factor to warrant some qualifications. While the Treaty principles mean that the Crown should be held to account for working to the fullest extent possible towards achieving equity of socio-economic status for Māori, no single Crown entity or social sector agency can be strictly held to account in isolation for achieving equity. Treaty jurisprudence on the principle of equity, and the way this principle is heightened by active protection and the other Treaty principles, is clear about this tempering of the Crown's obligations to equity for Māori.

Nonetheless, we are of the mind that the Crown needs to start somewhere. An insufficient commitment to equity of health outcomes for Māori is inconsistent with the Crown's Treaty obligations. In our view, it should not be controversial to include an express stand-alone commitment to achieving equity of health outcomes for Māori; after all, that is what the ultimate purpose of a just health system in New Zealand should be. The current expectations and goals expressed in the framework do not, in our view, reflect the sense of urgency that is demanded by the circumstances. The Ministry has a responsibility, as the steward of the health system, to understand and maintain this sense of urgency in the way that it directs the health sector.

It is not sufficient to aspire only to reduce Māori health disparities along with other sections of the New Zealand population when the Crown is fully aware that, overall, Māori suffer from the worst health status of any population group in New Zealand. Accordingly, we find, when viewed as a whole, that:

180. Waitangi Tribunal, *The Napier Hospital and Health Services Report*, p xxxiii.

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- the New Zealand Public Health and Disability Act 2000 and the primary health care framework fails to consistently state a commitment to achieving equity of health outcomes for Māori;
- notwithstanding the fact that the Treaty clause in the Act reflected the politics of the time, section 4 does not go far enough in ensuring that the whole health sector complies with Treaty principles;
- those provisions outlined in part 3 do not give full or proper effect to Treaty principles;
- He Korowai Oranga and its articulation of 'partnership, participation and protection' does not adequately give effect to the Treaty principles; and
- both individually and when taken together, these omissions by the Crown constitute breaches of the Treaty principles of partnership, active protection, and equity and the duty of good governance.

Further, we find that:

- the arrangements providing for Māori representation on district health boards in particular do not afford Māori Treaty-consistent control of decision-making in relation to health care design and delivery;
- similarly, the ways in which district health boards have variously interpreted their obligations under sections 22 and 23 do not work consistently to afford Māori Treaty-compliant control of decision-making in relation to health care design and delivery. In particular, the lack of specific provision for Māori relationship boards and the variable effectiveness and oversight powers of those boards are not Treaty-consistent;
- the removal of specific Treaty references from lower-level documents amounts to a concerning omission in the health sector's Treaty obligations; and
- when taken together, these failures by the Crown constitute breaches of the Treaty duty of good faith and the principle of partnership.

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CHAPTER 6

ARE THE FUNDING ARRANGEMENTS FOR THE PRIMARY HEALTH CARE SYSTEM TREATY-COMPLIANT?

Toki tā wahie te toki nui

6.1 Introduction

In chapter 3, we noted that adequate resourcing and funding is a Crown obligation under the Treaty principles of partnership, active protection, and equity. In particular, where persistent inequities are clear and urgent, a requirement to provide additional adequate resourcing can be an essential part of acting consistently with these principles. In chapter 4, we outlined the types and amounts of funding relevant to primary care. In this chapter, we assess whether the funding arrangements for primary health care are compliant with the Treaty principles and the broad objectives of the system.[1]

6.2 The Funding for Primary Health Care

Vote Health, the health funding administered by the Ministry of Health, totalled $15.910 billion in 2017–18. The Ministry retained $3.228 billion, with $12.684 billion being allocated to district health boards.

Various capitation-based funding sources for primary health organisations and providers, administered both by the Ministry and through district health boards, totalled $907 million.[2] Of this capitated funding:

- based on the recorded number of Māori enrolees in all primary health organisations, $167 million was allocated for Māori patients;
- based on the total number of enrolees, Māori and non-Māori, in Māori primary health organisations, $28.7 million of capitation funding went to Māori primary health organisations; and
- based on the number of Māori enrolees of Māori primary health organisations, $10.17 million of this funding was allocated for Māori patients enrolled in those organisations.[3]

We accept that the primary health care reforms and the introduction of capitation was intended to shift the health care system to focus on equity, and

1. We take into consideration and respond to the issues posed at sections 4.3, 5, 7.2.3, 7.2.5, and 9 of the statement of issues (statement of issues 1.4.1).
2. Memorandum 3.2.95, pp1, 3.
3. Ibid, pp3–4.

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the evidence before us indicates that capitation-based funding for primary health care could, in theory, facilitate this.[4] Professor Peter Crampton stated that these formulas could potentially be 'a very strong equity tool'.[5]

We also note that the introduction of the current primary health care framework involved a large investment of new funding for the health sector:

> As a significant lever for change, additional funding was needed to enable the change in approach and focus, improve universal access and reduce equity gaps. The amount of funding was a significant investment in primary care, one of the largest in recent history – over $620 million between 2004/05 and 2007/08.[6]

Director-General Dr Bloomfield emphasised that, aside from the question of whether the capitation formulas are adequate, the investment in primary health care under the new framework was significant.[7]

Notwithstanding these points, the Crown acknowledged that 'there is pressure on the funding model' for primary health care and that the capitated funding arrangements for primary care 'have not been thoroughly updated'.[8] Crown counsel noted that Crown witnesses acknowledged the claimants' criticisms of the funding for primary care: broadly, that the arrangements currently in place do not funnel funding to those most in need, including Māori and, further, that they underfund those organisations serving high-needs patients.[9] Crown counsel said '[t]he Crown agrees that it is time for the funding formula[s] for primary health care to be reviewed again'.[10]

We recognise that these are significant acknowledgements by the Crown, and we are pleased with the attention that the Crown gave to this issue in its closing submissions. Notwithstanding the Crown's acknowledgements, in this chapter we show how these acknowledged limitations to the primary health care funding regime impacted Māori organisations, as demonstrated in the evidence before us. We think this is necessary not only in order to decide whether there are breaches of the Treaty but also as context for the other issues analysed in this report and for our recommendations.

Interested party witness Amy Downs, who conducted research on funding for primary care in New Zealand, noted in her evidence that this shift in the type of funding allowed primary health organisations some freedom to create 'new and innovative models to address issues of access'.[11]

4. Submission 3.3.32, paras 259–262; doc A60, para 44; doc A62, para 102; transcript 4.1.4, pp 164, 578, 581; transcript 4.1.5, p 97; transcript 4.1.7, p 267.
5. Transcript 4.1.4, p 581.
6. Document A62, para 102.
7. Transcript 4.1.5, p 406.
8. Submission 3.3.32, para 37.
9. Ibid, paras 273–278.
10. Ibid, para 279.
11. Document A43, para 47.

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However, we also heard evidence suggesting that in practice, and because of the specific formulas used, the shift to capitation for primary health care did not refocus the system on equity. Section 3 of the New Zealand Public Health and Disability Act 2000 conditions the Act's objectives against funding for health care, such that the objective of reducing disparities should be pursued 'to the extent that they are reasonably achievable within the funding provided'.[12] Downs cautioned that funding models such as the one put in place under the current primary health care framework need 'rigorous risk adjustment' to ensure that the capitated funding accurately reflects the population accessing the health care.[13] Testing whether the funding arrangements for primary health care have these risk adjustments is important to our assessment of the Treaty-compliance of these arrangements.

6.3 Were Māori Primary Health Organisations Adequately Funded at the Point of Establishment?

The claimant groups referred to their optimism for community-driven primary care, which appeared to be firmly endorsed under the new framework. However, they said that, ultimately, they were not sufficiently funded for start-up costs associated with establishing primary health organisations. The Māori Primary Health Organisations and Providers claimants alleged that it was difficult to secure adequate establishment funding and claimed that they felt intense pressure right from the outset of the framework. Tureiti Lady Moxon, for example, pointed out that the $50,000 allocated by the Waikato District Health Board and the Ministry to assist the establishment of the now-closed Toiora PHO Coalition could not realistically cover a full-time salary for one employee, let alone set up the infrastructure necessary to get the organisation off the ground.[14]

Hakopa Paul, a trustee of the now-closed primary health organisation Te Kupenga a Kahu, reported similar difficulties with the establishment funding allocated by the Lakes District Health Board, which eventually gave Te Kupenga a Kahu $38,500, up from its initial offer of $18,500, after 'furious negotiations'.[15] Janice Kuka, too, cited resourcing difficulties with the establishment of Ngā Mataapuna Oranga and said that the establishment funding provided by the Ministry barely covered the costs associated with running the organisation.[16]

The Crown acknowledged that the way the Ministry determined funding at the point of establishment for primary health organisations was inadequate. The Ministry did not develop a national formula or set of criteria for the establishment funding, and therefore the establishment funding that primary

12. New Zealand Public Health and Disability Act 2000, s 3(2).
13. Document A43, para 8.
14. Document A11, paras 20–21.
15. Document A30, para 10.
16. Document A12, para 35.

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health organisations received varied.[17] For example, Independent Practitioner Associations, collectives of general practitioners formed under the arrangement of the health system prior to 2000, already had infrastructure in place, capital, and experience running primary health services before reforming as primary health organisations under the primary health care reforms. Independent Practitioner Associations rapidly reconfigured into primary health organisations. At the same time, many people and community groups that sought to establish primary health organisations, including Māori, struggled to establish the required infrastructure and governance and additionally struggled to compete with former Independent Practitioner Associations for enrolees and funding.[18] The Crown conceded that the primary health care framework 'did not differentiate between IPAs and Māori PHOs in terms of existing capital or the enrolled population IPAs already had'.[19] According to Crown witness Keriana Brooking: 'the Ministry of Health had no objective or transparent process for establishing PHOs and did not take into consideration or target establishment funding according [to] the different financial position of the organisations forming new PHOs'.[20]

At hearings, she elaborated:

> In terms of the kind of generic term of means testing, when people were raising their hands in order to become a Primary Health Organisation, the establishment of those Primary Health Organisations and the support we may want to give them including financial support, it didn't take into account what the resources were that were already available to those organisations nor did it take into account to a definitive degree the type of populations they'd be serving.[21]

This failure by the Crown afforded significant advantages to Independent Practitioner Association-based primary health organisations. During a consultation period begun in March of 2000 on the proposed content of the Primary Health Care Strategy, Māori respondents were concerned about 'the potential for primary care organisations to be dominated by large general practice groups'.[22] It appears that ultimately the Ministry did not heed their concerns. Instead, the Primary Health Care Strategy's implementation and funding 'made no acknowledgment of the different starting points of developing PHOs while holding them all accountable in the same way'.[23] As such, the advantages afforded to Independent Practitioner Association-based primary health organisations have compounded over time, while at the same time disadvantaging Māori primary health organisations.

17. Document A62, paras 59, 117, 122.
18. Document A28, para 10.
19. Statement of response 1.3.1, p 4.
20. Document A62, para 59.
21. Transcript 4.1.7, p 286.
22. Document A63, para 172.
23. Document A62, para 117.

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6.4 Are the Funding Arrangements for the Primary Health Care System Adequate to Pursue Equity of Health Outcomes for Māori Meaningfully?

6.4.1 Funding for district health boards

Two specific issues were raised about the population-based funding for district health boards.

As we detailed in chapter 4, the population-based funding formula is calculated using statistics from the national census. Crown witness Dr Nick Chamberlain, the chief executive of the Northland District Health Board, highlighted that, in relation to the capitated distribution of Vote Health to district health boards, problems with census completion mean that the population-based funding formulas do not accurately account for a district health board's population catchment. In Northland, for example, Māori and rural populations in particular have been significantly undercounted, despite increased participation in the census. Dr Chamberlain detailed his district health board's work in 2013 that revealed that 'at least five or six thousand' patients had not been recorded by the census and, as such, were not funded by the population-based funding formula.[24]

The underfunding that occurred due to census undercounting was compounded by the impact of a funding cap imposed by the Ministry after the Global Financial Crisis. Despite proving significant undercounting in the census for Northland, the district health board was unsuccessful in lobbying the Ministry to lift its funding cap to reflect the recorded change to the population. This underfunding continued for three years, and Dr Chamberlain said the total shortfall was $30 million. That money could not be recouped by the district health board. As Dr Chamberlain pointed out, this funding shortfall had acute impacts on Northland, whose high-needs population is among the largest in the country.[25]

Research undertaken by Professor Tahu Kukutai and Dr Donna Cormack indicates that the underfunding of district health boards due to census undercounting is not a problem that is restricted to Northland. Further, the census is more likely to undercount high-needs populations, with Māori more likely than any other population group to be missed. 'In 2013, the Māori net undercount was 6.1 per cent compared with just 1.9 per cent for Europeans', although further research suggests that the undercount of Māori has probably been underestimated.[26] The population-based funding formula does not satisfy its very definition in every case, to the specific detriment of people who need the funding the most, especially Māori. This population-based underfunding inevitably has flow-on effects for primary health care funding. Dr Chamberlain described the situation in Northland as 'outrageous'.[27] We found his evidence persuasive. The fact that it seems to be a problem on a national scale concerns us.

24. Transcript 4.1.6, p 96.
25. Ibid, p 16.
26. Tahu Kukutai and Donna Cormack, 'Census 2018 and Implications for Māori', *New Zealand Population Review*, no 44 (2018), p 137.
27. Transcript 4.1.6, pp 96–97.

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The second issue we heard was that, while the population-based funding for district health boards uses Māori ethnicity as a factor to direct funding, district health boards are not obliged to spend that money on Māori health initiatives.[28] This is inconsistent with the Crown's obligations under the Treaty principles of active protection and equity.

6.4.2 Capitation and other funding

The first level services funding formula is based on a national average of general practice utilisation rates organised by age and sex only, taken from a relatively small sample in 1998–99. A small sample of general practice expenditure data was also used.[29] While first level services funding is calculated using demographic information from the census, the limited data set from 1998–99 has not been changed since the funding formula was introduced.[30] No other factors, including ethnicity, were used to determine first level services funding. Plainly, the data used for first level services funding is neither complete nor reliable. It is not fit for the purpose of adequately addressing the health needs of Māori, let alone accounting for such complexities as dispersed or rural populations or populations living in economically deprived areas.

Downs said that the samples used to calculate the first level services funding formula were too small to give an accurate picture of Māori health needs.[31] Further, since the data set that the formula is based on is over two decades old, it does not reflect the make-up or health needs of today's population. The Crown broadly conceded on these points, saying '[t]he data does not directly take into account access issues and differential health needs for Māori.'[32]

These omissions from the first level services funding formula were intended to be offset by other types of capitated funding, which variously take ethnicity and differential health needs into account. However, the distinct impression from the evidence before us is that this supplementary funding is not enough to meet Māori health needs.[33] Brooking said that the Ministry concedes that, 'on reflection', the funding for the primary care sector was insufficient – further, the funding streams intended to supplement capitation that did have ethnicity and deprivation as factors were not enough to make up for the insufficiency of first contact funding.[34] This was broadly confirmed by other Crown witnesses, including Director-General Dr Bloomfield.[35]

28. Document A60, para 29; transcript 4.1.5, p 477; see also doc A43, para 19.
29. Document A62, para 108.
30. Statement of response 1.3.1, p 5.
31. Document A43, para 11(b).
32. Statement of response 1.3.1, p 4.
33. Transcript 4.1.4, pp 600–602; transcript 4.1.4, p 564; doc A19, para 33; doc A11, para 185.
34. Document A62, para 119. See also paras 116–120 for a fuller explanation of Brooking's appraisal of capitation.
35. Transcript 4.1.5, pp 463–464, 483–484.

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The Crown acknowledged that a review of the base formula for capitation has not been carried out since its inception 'to see whether changes in levels are required to meet the needs of more vulnerable groups including Māori', despite several internal reports since 2013 recommending that this should occur.[36]

In fact, Crown and claimant witnesses pointed out that the Ministry had been made aware of this problem before 2013, for example by the Māori Primary Health Organisations and Providers claimants (Wai 1315) when they engaged in negotiations with the Ministry in 2005.

Further, in 2006 the Ministry appointed an expert advisory group to review the funding formulas. When reporting back, the group made several findings, including the following:

- the formulas needed refining and the Ministry should consider whether to include ethnicity and other variables in the first level services formula;
- an analysis of unmet need showed that both ethnicity and deprivation were significant factors in explaining variations in unmet need; and
- the preferred socio-economic or demographic predictors of health need were age, gender, ethnicity, and deprivation.[37]

The Minister at the time did not agree to proceed with a recommendation to review the funding formula by applying, amongst other matters, a factor for ethnicity to the first level services formula.[38]

Under cross-examination, Brooking remarked that, from the very beginning of the development of the framework, questions were being raised about how 'the PHC [Primary Health Care] Strategy in its execution was going to adequately cover high needs populations'.[39] Dr Frances McGrath, a chief adviser at the Ministry who appeared as a Crown witness, detailed some of these concerns, which were raised during a consultation period begun in March of 2000 on the proposed content of the Primary Health Care Strategy. The concerns included: 'that funding formulae might disadvantage some providers and population groups, and about the level of funding made available to support the implementation of the PHC Strategy'.[40]

Respondents also outlined that:

- Māori providers should be closely involved in the development of any funding formulae;
- the funding formulae should take into account the wider, holistic, health needs of Māori;
- capitation should include workforce development; and
- development of capitation for primary care organisations' practices should not negatively affect Māori provider services.[41]

36. Statement of response 1.3.1, p 5; transcript 4.1.5, p 465.
37. Document A62, paras 202–213; transcript 4.1.7, p 67; transcript 4.1.5, p 465; doc A19(b), para 56.
38. Document A62, para 210.
39. Transcript 4.1.7, p 289.
40. Document A63, para 172.
41. Ibid, paras 176.1–176.4.

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Counsel for Janice Kuka and Lady Moxon pointed out that these concerns, articulated at the beginning of the primary care reforms, were central allegations outlined by the claimants in this inquiry, nearly two decades later.[42]

The evidence brought before us appears to confirm these early concerns. Professor Jacqueline Cumming concluded that primary health care funding arrangements are likely inadequate to meet high-needs patients, including Māori.[43] We heard evidence from Neil Woodhams, a claimant witness who works as a health consultant, to this effect:

> I am satisfied that Māori providers and other providers to very high needs populations have been underfunded by many millions of dollars every year since the capitation was first introduced in 2002. While there has been some tinkering at the edges, the fundamental flaws that have been pointed out by many commentators and consultants have not been addressed and remain in existence today.[44]

Professor Cumming similarly noted that it is unclear whether the weighting in the capitation formulas for primary health organisations provides sufficient reimbursement for the higher needs of Māori.[45] She pointed out: 'This makes it difficult for PHOs with higher proportions of higher needs patients (including Māori) to meet the needs of their enrolees and it puts them at a higher financial risk than practices with a healthier population.'[46]

Director-General Dr Bloomfield also confirmed that, as with the population-based funding for district health boards, primary health organisations are not required to spend on Māori the capitated funding they receive to address differential Māori health needs.[47] Again, we find this to be unacceptable. At hearings, Director-General Dr Bloomfield said that today 'there is a pretty universal appetite' for a review of the first level services funding formula.[48] It is easy to see why. Amy Downs said that, when she conducted her research into primary care funding in 2017, she discovered that very few people in the health care sector or at Treasury fully understood how the capitation formulas operated.[49] This in and of itself is of grave concern to us.

In turn, these inadequate funding arrangements impact on patients. Data shows that, by the 1990s, various groups, including Māori, were accessing primary care less than they needed because of the high costs involved. We accept the evidence provided by Crown witness John Hazeldine, a chief adviser at the Ministry, who maintained that '[a]s GP [general practice] user charges increased, people opted

42. Transcript 4.1.6, pp 212–213.
43. Document A60, para 13.4.
44. Transcript 4.1.4, p 169.
45. Document A60, para 51.
46. Ibid.
47. Transcript 4.1.5, p 478.
48. Ibid, p 463.
49. Ibid, p 165.

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to use the free public hospital system for primary care'.[50] In other words, the costs of the primary health care system are forcing economically deprived population groups to access treatment through the free, secondary system, creating pressure on that system. Māori are represented disproportionately in economically deprived population groups.[51]

The evidence before us suggested that the shift to capitation-based funding was in part aimed at reducing the cost of co-payments, thereby encouraging patients to engage with the primary health care system. However, the evidence indicates that this has not happened, with Professor Cumming providing evidence that, while co-payment fees decreased slightly for Māori children and seniors, co-payment fees actually increased for Māori between the ages of 18 and 64 compared with what they paid under the previous system.[52] The failure to decrease co-payment fees appears to affect high-needs patients the most, including Māori. Professor Crampton's evidence showed that:

> A significant percentage of the population routinely report service access barriers and avoid associated services because of an inability to pay. For example, the 2016/17 New Zealand Health Survey revealed 28 percent of all adult respondents reporting unmet need for primary health care. This figure was even higher for Māori, with 37.5 percent of Māori respondents experiencing unmet need for primary health care and 22.2 percent of those living in the most socioeconomically deprived areas indicating cost as a reason.[53]

Professor Crampton's evidence also noted a Commonwealth Fund International health policy survey, published in 2016, showing that, internationally, New Zealand has the third-highest rate of respondents who said that cost is a barrier to their health care.[54] At hearings, Professor Crampton said: 'We need a system which guarantees, essentially, universal access. We need to take the cash register off the front door.'[55]

Professor Crampton clarified further under Tribunal questioning that co-payments should be 'either absent or calibrated in such a way that they do not present barriers to those most in need. Usually, that means those fees being absent.'[56]

6.4.3 The impact on Māori primary health organisations and health providers

The evidence before us clearly indicates that inadequate funding for high-needs patients creates sustainability issues for, and disproportionately affects, Māori

50. Document A3(a), app 1, p 6.
51. Memorandum 3.1.175(a), para 2.
52. Document A60, para 53.9.
53. Document A69, para 7.
54. Ibid, para 8.
55. Transcript 4.1.4, p 593.
56. Ibid, p 618.

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primary health organisations and providers, compounding the effects from inadequate establishment funding. The Crown has acknowledged this.[57]

As explained by the evidence of Neil Woodhams, primary health organisations were expected to have a mix of patients. Those requiring frequent visits were expected to be subsidised by healthier patients not needing as much care. However, as Lady Moxon pointed out, the environment favoured larger primary health organisations that had 'much more start-up capital, healthier patients needing less care and the ability to significantly supplement their income with co-payments from those patients'.[58]

This was certainly reflected in the evidence presented by claimants who work with Māori primary health organisations. For example, Janice Kuka, the managing director of Ngā Mataapuna Oranga in Tauranga, told us that organisations such as hers 'care for Māori with the highest need and poorest health' and that capitation funding does not recognise the 'level of complexity and social deprivation' of these patients. These patients make up 83 per cent of enrolees in Ngā Mataapuna Oranga. Despite significant challenges, Kuka said, 'the expectation is that we will care for them within the limited resources we receive'.[59]

Essentially, the expectation was that a co-payment would be as much as 50 per cent of the income of a clinic. As Woodhams noted, high-needs providers do not get this level of income from patients. He noted that the funding received from co-payments for these clinics is about 10 to 15 per cent.[60] The result is a significant shortfall for these clinics, as the capitation payment is not sufficient to meet the costs of adequately caring for high-needs patients.

Beyond funding arrangements not recognising the differences in care needed for high-needs populations, we heard that these funding arrangements broadly do not cater for Māori primary health organisations and providers offering kaupapa Māori approaches to care. Philip Hikairo provided evidence that a kaupapa Māori approach to primary care requires 'time and energy' that a mainstream provider may not have. As he put it, '[w]e take into consideration the complex chronic high needs that is required for some of our Māori clients. This takes a lot more time.'[61] Professor John Broughton discussed with the Tribunal the importance of taking time to establish a connection with those he is providing dental treatment for:

> a whānau brought their 90 year old grandmother to see me . . . and talking to her she wanted her main teeth extracted. Like just talking to her I said it was going to take me 10 seconds to remove these teeth but it took me 30 minutes and 10 seconds because we had to have a kōrero. She wanted to know who I was, where I was from—
>
> Q. Right.

57. Submission 3.3.32, para 290.
58. Transcript 4.1.4, p 341.
59. Ibid, pp 301, 303.
60. Ibid, p 190.
61. Document A14, para 32.

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A. —and then she told me about her and her whakapapa and she put them together and she had known my grandmother from many previous years ago. But that took half an hour of this kōrero to get that far and then for her to allow me to extract these remaining teeth. But that's all part and parcel of a kaupapa Māori service . . .[62]

The Crown acknowledged these issues in principle, conceding that inadequacies with 'funding streams' could undermine the ability for Māori to apply their own solutions.[63] In the case of the claimants in this inquiry, we heard that this was certainly one of the many effects of inadequate funding.

Issues of establishment costs and ongoing resourcing for Māori primary health organisations were a catalyst for the Māori Primary Health Organisations and Providers claimants (Wai 1315) lodging their claim with the Waitangi Tribunal in 2005. Neil Woodhams gave evidence about the so-called Sustainability Project, the response of the Ministry to the claimants' allegations of underfunding. The purpose of the project was to quantify the 'financial, clinical and cultural issues which the claimants allege negatively impact on the sustainability of' primary health organisations and providers serving predominately Māori populations.[64]

The Ministry engaged management consulting company Deloitte in 2007 to attempt to quantify the additional costs that primary health organisations serving predominantly Māori populations incurred, compared with other primary health organisations.[65] Deloitte produced a high-level report, which estimated that, based on the organisations involved in the study and the information provided for 2007, Māori primary health organisations were under-funded by approximately $21.77 million a year as they faced higher costs for a range of reasons, including 'higher presentation rates of Māori at clinics, longer consultation times due to the . . . complexity of [the health needs of] those patients, [and] additional costs for providing a culturally appropriate service'.[66]

We note that the figure of $21.77 million a year was a provisional, high-level estimate of underfunding and was intended to act as a marker for Ministry budget purposes while a second phase of the project was undertaken. The scope of the second stage was widened to include non-Māori primary health organisations and providers who serviced predominantly high-needs communities, such as Pacific Islanders.[67] This culminated in a further report by Deloitte, delivered in draft to the Ministry in 2010.[68] This report was never released because, according to Brooking, some of the report's statements were 'regarded as subjective by the Ministry'.[69]

Woodhams summarised the 2010 draft report as follows:

62. Transcript 4.1.4, p 218.
63. Statement of response 1.3.1, p 3.
64. Document A62, para 234.
65. Document A19, para 8.
66. Transcript 4.1.4, p 166.
67. Document A62, para 238.
68. Document A77, pp 3566–3595.
69. Document A62, para 239.

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> high needs providers have a significantly different patient mix in terms of both age and ethnicity, much higher than average fee for service deductions, much higher than average patient turnover, and a smaller percentage of their income generated by patient co-payments. They also had more patients with chronic and long-term illness.[70]

Woodhams noted that the estimation of underfunding by Deloitte in its original report did not consider other impacts these providers may be facing, such as having to offer a lower salary to staff and to rely on unpaid volunteers' contributions, and the unmet needs of eligible patients who were not accessing the services. He said a report he prepared in 2011, in response to Deloitte's work, confirmed that providers who serve largely high-needs patients were seriously disadvantaged by the inadequacy of the capitated funding formulas.[71]

Lady Moxon and Kuka seek payment of $348 million, extrapolated from the annual underfunding estimated by Deloitte in the 2007 report, for the historical underfunding of Māori primary health organisations and providers. They say this payment is reparative and should be given to the existing Māori primary health organisations and providers today.[72] We agree with Crown counsel's submission that the 2007 Deloitte report referred to by Woodhams is too high-level either to extrapolate to the entire sector or to accurately estimate funding shortfalls in previous or subsequent years and that it was limited by its small sample size.[73]

We note, nonetheless, that the 2007 report was only ever meant to be an initial assessment of underfunding as part of a longer project. For us, the crucial point is that the sustainability issues identified in both the 2007 and the 2010 Deloitte reports about small primary health organisations and providers serving predominantly high-needs populations, including Māori, were repeated during this inquiry. We are concerned that the project was never completed by the Ministry for reasons which were not explained to us.

What is clear to us is an acceptance by all concerned, including Crown witnesses, that primary health organisations and providers serving predominantly high-needs communities were underfunded at the point of establishment and throughout their operation.[74] What we are unclear about is to what extent. As the evidence discussed in this chapter shows, Māori organisations and the patients they serve are particularly affected by the shortcomings of the current arrangements for capitated funding.

Professor Peter Crampton pointed out that non-Māori primary health organisations that had grown out of the original Independent Practitioner Associations were 'inexperienced in designing and delivering services for Māori'.[75] Dr

70. Transcript 4.1.4, p166.
71. Ibid, p167.
72. Submission 3.3.18, para 153.3.
73. Submission 3.3.32, para 291.
74. Ibid, para 290.
75. Document A9, para 32.

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Chamberlain said that this tension was recognised by the Northland board when primary health organisations began to be established in that district:

> Northland DHB was particularly explicit with PHO establishment groups (six at the time) that they needed to demonstrate a high level of Māori engagement and Treaty-based ownership and governance to form a PHO . . . Northland DHB would not allow a PHO to form if Māori interests were not seen to be a priority. For example, Manaia PHO, an Independent Practitioner Association-based PHO, experienced delays in establishment as it needed to demonstrate a shift away from Independent Practitioner Association-based working arrangements towards an approach that enabled high levels of Māori engagement, ownership and governance.[76]

The director-general accepted that the Crown's response to the inadequacy of the formulas has been insufficient, 'in that there are still obviously quite significant barriers to access to primary care and . . . some PHOs and practices serving high needs populations have continued to really struggle'.[77] However, he pointed out that, while some districts underfunded Māori non-governmental organisations in primary care, other district health boards have recognised the inefficacy of the base funding provided under the primary health care framework and have reprioritised their discretionary funding accordingly.[78] In his written evidence, Dr Chamberlain detailed how the Northland District Health Board uses discretionary funding to resource and support Māori organisations outside of the regular funding arrangements provided for under the primary health care framework.[79] He said:

> It is important to note that Northland DHB's policy is not to 'apply resources equally to Māori and non-Māori' but to invest more in services that will improve equity. All programmes, initiatives and funding are designed to explicitly target Māori and our prioritisation tools have heavy weightings for equity and Māori health.[80]

The Northland District Health Board's focus on equity has allowed it to realign the priorities of its discretionary funding accordingly, and its efforts in this area are to be acknowledged. However, the evidence suggests that this board's actions do not constitute a representative case. We heard in fact that discretionary funding is, like supplementary capitation funding, very small in the scheme of things. Brooking estimated that it was about 5 per cent of the funding for each district health board.[81] When asked about district health boards reprioritising funding to primary health organisations with large high-needs populations (as the Northland District Health Board appears to have done), Hector Matthews stated:

76. Document A66, paras 48–49.
77. Transcript 4.1.5, p 465.
78. Ibid, p 464.
79. Document A66, paras 53–59.
80. Ibid, para 60.
81. Transcript 4.1.7, p 272.

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6.4.3

> It happens but it only happens on the fringes. In my experience DHBs actually have very limited latitude, very little discretionary funding. I think there's this view that the Ministry gives us 1.4 billion dollars and we can allocate that 1.4 billion out in our case but actually the reality is that we have to pay all the doctors in the hospital, we have to pay all the nurses in the hospital, we have to pay all . . . the 10 and a half thousand staff and then we've got to fund the PHOs and the Primary Health Care . . . [A]t the end of it . . . there's less than 5% discretionary funding and then everyone is scrapping over that five. [S]o we've done that on limited occasions . . . [T]o get to our immunisation target we did that but it would be fair to say that it's a very rare event and it's pocket change in that 1.4 [billion] dollar spend that we have in Canterbury.[82]

Director-General Dr Bloomfield also made the point that the Global Financial Crisis seriously affected the way that district health boards used their discretionary funding. Crown counsel summarised his comments as follows:

> Prior to the GFC [Global Financial Crisis], the health sector as a whole received annual increases in funding of around 7 to 8 per cent per annum. These increases diminished after the GFC to around 2 to 3 per cent per annum. This confined funding growth affected the ability for the health system generally to invest in primary health in light of the growing health need[s] of an aging population and an increased prevalence of chronic diseases.[83]

Crown counsel quoted the director-general's comments on the effects of the reduced funding:

> the challenge for District Health Boards was two-fold. First of all, they had sort of built a system that was based on seven to eight percent increases each year and then those dried up somewhat. So there [were] a lot of costs locked into the system and so you will see from about 2009/10 onwards the District Health Boards increasingly had to try and find ways to, as it were, balance the budget while delivering on the Minister and the Government's expectations. At that time there was more discretion, what one might call, discretionary expenditure by District Health Boards including in primary care but also in other NGO providers including Māori and Pacific providers. And so that discretionary expenditure was scrutinised and in some cases and increasingly it became harder for District Health Boards to sustain that expenditure . . .[84]

Crown counsel were also careful to emphasise that many district health boards operate under a 'level of financial deficit'.[85] The director-general said that, after the Global Financial Crisis, district health boards were 'not so much looking after

82. Transcript 4.1.7, p 164.
83. Submission 3.3.32, para 267.
84. Transcript 4.1.5, p 382.
85. Submission 3.3.32, para 268.

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themselves but doing their best to juggle resources in a very resource constrained environment.'[86]

We accept that these pressures are acute for district health boards and that this has likely impacted on the ways that they invest discretionary funding. Nonetheless, we note the evidence of Hector Matthews, who remarked: 'often these Māori health contracts have terminal dates, hit their expiry date and it is easier to deal with cutting [them than] it is for example to say, "Let's stop five procedures in the hospital," or something like that.'[87]

In this way, discretionary funding from district health boards, whether invested into primary care organisations or other health initiatives, is tied to systemic bias arising from the fact that district health boards are both funders and providers of secondary care. Amy Downs pointed out that this arrangement creates an 'inherent conflict of interest', whereby district health boards are naturally more likely to preserve funding for their secondary care provider arm than they are to preserve funding for externally provided discretionary spending, such as on primary health organisations and providers.[88] Professor Cumming agreed, noting that public health research identified a concern that district health boards' 'joint planning, funding and delivery roles would lead them to prioritise their own services.'[89] She speculated that this may have been partly because it appeared district health boards had been hamstrung during the implementation of the Primary Health Care Strategy:

> A key problem, however, was that DHBs were then not adequately supported in developing a role with respect to primary care, and when funding then began to flow through them, they were not provided with funding to support a key role in primary care: neither in terms of their own staffing (in contrast to PHOs which receive management support funding) nor in terms of service development funding. It is still my understanding that the main contract for primary care is a national one, agreed through a national Primary Health Organisation Service Agreement (PSAAP) process. I believe that this has hampered the role of DHBs in developing primary care services over time; we lament the strong focus that DHBs have on hospitals as opposed to primary care, but it is not clear to me that DHBs have been given a sufficient mandate in primary care to overcome their perceived hospital focus.[90]

Whatever the pressure on district health boards, the loss of direct contracts was highlighted as a significant issue by both sets of claimants. Lady Moxon highlighted the loss of smoking cessation contracts by Māori providers working with the Waikato District Health Board as a situation that demonstrates the tough

86. Transcript 4.1.5, p 383.
87. Transcript 4.1.7, p 224.
88. Transcript 4.1.5, p 179.
89. Document A60, para 27.
90. Ibid, para 40.

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contracting environment for Māori primary health organisations. She stated that, 'in terms of disinvestment, this reflects a disinvestment in Māori health services for Māori by Māori of $1,045,269.96' since 2010.[91]

Dr Rawiri Jansen presented two National Hauora Coalition-developed Māori health initiatives that showed proven positive outcomes: Mana Kidz and the Auckland Wide Healthy Homes Initiative. He said that, despite their proven results and endorsement from the Ministry, the National Hauora Coalition struggles to contract with district health boards to provide these services.[92]

Director-General Dr Bloomfield discussed these allegations of a pattern of rejection and loss of contracts, emphasising that 'this is by no means unique to these programmes or Māori driven innovation'.[93] In light of the incomplete picture given by the evidence before us, we accept this point. District health boards are coping with a myriad of factors, not least of which is the impact of financial restraints.

Nonetheless, this issue is concerning to us because it was indicated that, since establishment funding and funding through capitation and other channels is insufficient, Māori organisations need to access other funding in order to make up for that shortfall.[94] Some of this funding, presumably, comes out of district health board discretionary funding, which Crown witness Hector Matthews accepted does not allow much flexibility in practice and often is not a reliable form of revenue for Māori organisations.[95]

We also heard evidence on the Māori Provider Development Scheme, which was established in 1997 and run by the Health Funding Authority to provide grants and support to Māori health and disability support service providers. Since the reforms in 2000, the scheme has been managed by the Ministry.[96] The scheme is designed to provide organisational development support to Māori providers and to improve the Māori health and disability workforce by offering scholarships. We heard that, since its initiation, the scheme has funded an average of 130 health providers and 550 Māori health students per annum.[97] We also heard that funding for the scheme, approximately $9 million annually, has remained virtually unchanged since its establishment more than two decades ago.[98] As well as being a relatively small amount of money, the fact that it is used to fund scholarships and develop the Māori health workforce means that it is not, in reality, solely for provider development, as its title suggests. Workforce development initiatives should not be developed using funding that is, in principle, set aside for a different purpose. These issues concern us. The evidence before us shows that the scheme needs to be

91. Document A11, paras 83–84.
92. Document A21, paras 25, 32.
93. Transcript 4.1.5, pp 457–459.
94. Transcript 4.1.8, pp 37–38.
95. Transcript 4.1.7, pp 164, 224.
96. Document A63, para 98.
97. Document A62, para 181.
98. Ibid, para 176.

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reviewed and properly directed, funded, and administered to support and develop Māori providers.

The Crown acknowledged that ongoing resourcing and development for providers has varied from district to district and is insufficient for those providers serving high-needs populations, as is the case for many Māori providers.[99] In her written evidence, Professor Cumming further critiqued the severe underfunding of Māori providers:

> One useful piece of information is spending by the Ministry of Health and DHBs on Māori health providers, including in relation to other spends in health care. This shows, however, how small the proportion of funding going to Māori health providers is (1.86%) and that increases in health spending each year are not always matched by increases in spending on Māori health providers. Although Māori receive services from a wide range of providers, this tiny proportion clearly demonstrates that few Māori have opportunities to receive services from Māori-led organisations.[100]

Janet McLean was aware of this tension when she was general manager planning and funding Māori health at the Bay of Plenty District Health Board, and she made sure that the board invested in Māori organisations to help them remain economically viable.[101] McLean said:

> There are three PHOs in the region, Western Bay PHO, Eastern Bay Alliance and Ngā Mataapuna Oranga, the Māori PHO. There are only four GPs clinics under Ngā Mataapuna Oranga, but the two mainstream PHOs have around forty GPs clinics between them. Their Māori members were not making a 'choice' as such to be with them, in most cases it would simply be . . . that they have chosen the closest clinic. If we did not invest in Māori GP clinics and other Māori Providers, there would never be the opportunity for them to grow and give Māori more choice for their health care needs.[102]

We agree with the evidence of Professor Cumming and Janet McLean, which essentially concludes that the underfunding of Māori providers is a failure of the Crown to act consistently with the principle of options.

6.5 Tribunal Findings

The Crown devolved significant responsibilities to primary health organisations and providers to deliver primary health care. As such, the Crown has a Treaty obligation to support and fund Māori primary health organisations and providers so that they can carry out these responsibilities. The funding arrangements for

99. Document A66, para 55; submission 3.3.32, para 290.
100. Document A60, para 34.
101. Document A15, paras 16, 18.
102. Ibid, para 19.

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primary health care did not facilitate this and, in some cases, actively undermined the Crown's Treaty partner.

The Crown accepted much of the claimants' allegations regarding the insufficiency of primary health care funding arrangements. We note the Crown's acknowledgements, and the evidence of Crown witnesses, detailing that establishment funding was unequally distributed and that this negatively impacted on Māori primary health organisations.[103]

Accordingly, we find that:

- the Crown broadly allowed variability of establishment funding for primary health organisations, with no consistent recognition of the existing capital they may have had or the needs of the populations they would serve. This disadvantaged many Māori organisations seeking to become Māori primary health organisations and, as a result, Māori patients with high needs who enrolled with these organisations. The failure to implement a system to allocate equitably establishment funding is a breach of the Treaty principles of partnership, options, active protection, and equity.

The shift to capitation funding for primary care was intended to be equity-enhancing, but Professor Peter Crampton stated that the current funding arrangements for primary care 'run the risk' of being anti-equity.[104] The evidence before us indicates that they are, in fact, anti-equity in practice.

From the evidence before us, we conclude that the funding arrangements for primary care are barely sufficient to pursue the stated goals in the New Zealand Public Health and Disability Act, let alone ensure that the primary health care system is consistent with the principles of active protection and equity. Changes to funding that have been introduced have tended to be ad hoc and have not sufficiently focused on the goal of achieving equity. And yet the sector has not been held to account for failing to deliver on this fundamental component of the health reforms. The necessary 'rigorous risk adjustments' highlighted by Amy Downs as crucial to a successful capitation-based system were not put in place, either when the reforms were first introduced or subsequently.

Accordingly, we find that:

- both the population-based funding formula for district health boards and the funding arrangements for the primary health care system have not worked to address Māori health needs;
- the funding arrangements for the primary health care system particularly disadvantage primary health organisations and providers that predominantly service high-needs populations and particularly impact on Māori-led primary health organisations and providers in that category;
- the funding arrangements for the primary health care system do not adequately provide for kaupapa Māori models of care; and

103. Statement of response 1.3.1, p 4; transcript 4.1.7, pp286–287.
104. Document A9, para 46.

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- both individually and when taken together, these Crown failures constitute a breach of the Treaty principles of partnership, active protection, equity, and options.

In discussing the merit of the Crown's various responses to funding and access issues with Crown counsel, Professor Crampton said:

> What I see is a recognition of financial barriers to access for those most in need . . . [T]he incremental funding changes are a partial response to those barriers, and I welcome them on that basis. I would still class them as ad hoc incremental changes in the context of a set of issues around access barriers which are not being systematically addressed. The net result, if we waited 100 years, might be the systematic addressing of those access barriers. I, from where I'm sitting, do not see a natural end point to this process of incremental changes.[105]

The Crown was more than well-informed about the problems with the funding arrangements in primary health care. Given the persistence of inequitable Māori health outcomes, its failure to address these issues properly is a serious failure. Accordingly, we find that:

- the Crown's failure adequately to amend or replace these funding arrangements for over a decade, in the face of both consistent advice to do so and persisting Māori health inequity, is inconsistent with the duty of good faith and is a breach of the Treaty principles of partnership, options, active protection, and equity.

The funding regimes for primary care are a crucial component to the success of the system. The cumulative effect of these breaches partly explains why only four Māori primary health organisations remain.[106] Further, the funding arrangements for primary health care have hampered – and at times, it appears, outright undermined – the ability of the primary care sector to improve inequitable Māori health outcomes. The Crown understands this is the case and, from what we have seen in this inquiry, is open to making the substantial assessment of, and changes to, funding arrangements that appear to be required.

105. Transcript 4.1.4, p 602.
106. Claimant counsel said that at the height there were 14: submission 3.3.3, para 34.

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CHAPTER 7

IS THE WAY HEALTH ENTITIES ARE HELD TO ACCOUNT TREATY-COMPLIANT?

Toki tā wahie te toki roa

7.1 Introduction

The Tribunal has already established in previous reports that the Crown is ultimately responsible for the provision of health care and the performance of the health system.[1] As such, we were broadly interested in the ways that the sector is held to account. In chapter 4, we outlined the planning and accountability documents established in the primary health care sector.

We have already concluded that the primary health sector's statutory objective 'to reduce disparities' is not Treaty-compliant. As we alluded to in previous chapters, the current state of Māori health outcomes confirms that the sector is not meeting its statutory requirement and indicates that it is not pursuing health equity in a way consistent with the Treaty principles of active protection and equity. Accordingly, in this chapter, we look at the effectiveness of this system for holding the health sector to account for reducing inequities in a Treaty-compliant way.[2]

7.2 Accountability Mechanisms for Primary Health Care

Broadly, health entities are held to account through three, often overlapping, processes: planning, measuring, and reporting. *Planning* sets the expectations of what health entities need to deliver. For district health boards, which distribute most of the funding for primary care, planning documents include annual plans and regional service plans and, for those that still prepare them, Māori health plans.

Health entities are *measured* against the expectations set in their planning documents to assess their performance. The health measures set at a high level include the national health targets and the System Level Measures framework, as well as the Minister's annual letter of expectations to district health boards. Some can be set at a more local level, for example through contracting documents like the Crown Funding Agreements for district health boards, PHO Services Agreements

1. Waitangi Tribunal, *The Napier Hospital and Health Services Report* (Wellington: Legislation Direct, 2001), p xxiv; Waitangi Tribunal, *Tū Mai te Rangi! Report on the Crown and Disproportionate Reoffending Rates* (Wellington: Legislation Direct, 2017), p 22.

2. We take into consideration and respond to the issues posed at sections 7.1, 7.2.4, 7.2.6, and 9 of the statement of issues (statement of issues 1.4.1).

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for primary health organisations, and contracts between primary health organisations and health providers.

Reporting against these expectations, which is generally done through annual reports, is how health entities are intended to be held to account by Parliament and the public.

Broadly, the claimant groups argued that existing accountability measures and mechanisms are not used often enough to hold health entities to account for improving Māori health outcomes. They further argued that the current raft of accountability measures is insufficient and could afford to be expanded.[3]

The Crown agreed that holding health entities to account for their performance is critical to the successful operation of the system, including how it is performing for Māori and whether it is fulfilling its Treaty obligations.[4] Crown witness Keriana Brooking acknowledged that the complexity of the devolved system means it is difficult to orientate the sector towards some health priorities, including Māori health equity.[5] Again, while the Crown broadly argued that the deficiencies of the system were due to insufficient implementation rather than significant problems with the levers themselves, we note that it broadly acknowledged many of the claimants' allegations in this area and has committed to strengthening accountability arrangements.[6] Nonetheless, we are required to traverse and analyse these issues to assess whether there has been a breach of Treaty principles.

7.3 Holding District Health Boards to Account

The evidence before us showed that, when it comes to addressing Māori health outcomes, the performance of district health boards across the country varies, and that the Ministry has been aware of this.[7] The claimants firmly argued that the state of Māori health inequity indicates that district health boards have clearly not been held to account for their statutory responsibility to reduce Māori health disparities.[8]

The Crown submitted that the existing accountability mechanisms for district health boards provide 'a potentially adequate basis' for the Crown to monitor their performance.[9] The Crown nonetheless acknowledged that the current accountability measures need strengthening. The director-general accepted that, in spite of some isolated successes in improving outcomes, the overall performance of district health boards to date was 'largely not good enough'.[10] He also acknowledged that accountability for district health boards, in particular, needed strengthening.[11]

3. Submission 3.3.18, para 114; submission 3.3.30, para 5.171.
4. Submission 3.3.32, para 177.
5. Document A62, paras 18.1–18.2.
6. Submission 3.3.32, paras 24, 182.
7. Document A62, paras 26, 34; transcript 4.1.5, pp20–21; transcript 4.1.7, p148.
8. Document A23, para 91.
9. Submission 3.3.32, para 211.
10. Transcript 4.1.5, p396.
11. Document A59, paras 39, 44.

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The director-general said that he plans to 'introduce more systemic accountability for ensuring that the health system is meeting the needs of Māori.'[12]

Crown witness Professor Jacqueline Cumming similarly stated that there is a lack of accountability for Māori health under the current framework.[13] Part of the problem, she said, was that 'there is inconsistency over time in whether or not Māori health has been a key priority' of district health boards. She asserted that '[g]overnments could and should do more consistently in ensuring that key organisations are better held to account for achievements in Māori health and in reducing inequities'.[14]

In their oral opening submissions, Crown counsel acknowledged that key mechanisms in place that could be used to hold district health boards to account are often not or have not been exercised in relation to Māori health.[15] For example, under Crown funding agreements, funding can be withheld for poor performance, but the director-general could not provide an example of this mechanism being exercised in relation to non-performance or under-performance on Māori health issues.[16]

Similarly, the Minister can appoint Crown monitors in response to an extreme circumstance or severe under-performance, but the director-general confirmed that, despite the well-known and on-going existence of Māori health inequities, the Crown had never appointed a Crown monitor to audit a district health board's actions in relation to Māori health.[17] The same appears to be true of the mechanism provided for under section 31, whereby the Minister can opt to dismiss a board and replace it with a commissioner if it is seriously underperforming. Non-performance or under-performance in relation to Māori health has never been specified as the reason for sacking a board.[18]

Crown witness Dr Nick Chamberlain, the chief executive of the Northland District Health Board, noted that senior executives have key performance indicators in their employment contracts that relate to Māori health outcomes, and he specifically highlighted as an example that his contract includes a key performance indicator for improving Māori mortality rates.[19] He said that the Ministry does not have prescribed ordering or weighting to the key performance indicators in his contract, but he did note the following: 'at the end of the day, what I'm probably going to lose my job about is financial – lack of financial performance and

12. Document A59, para 39.
13. Transcript 4.1.7, p 65.
14. Document A60, para 35.
15. Transcript 4.1.5, p 359.
16. Ibid, p 419.
17. Ibid, pp 493–494.
18. 'Sacked Hawke's Bay DHB Members Reinstated', *Stuff*, http://www.stuff.co.nz/national/health/757786/Sacked-Hawkes-Bay-DHB-members-reinstated, 31 January 2009; 'Southern District Health Board Dismissed by Health Minister over Deficits', *Stuff*, https://www.stuff.co.nz/national/politics/69465196/null, 17 June 2015; 'Health Minister David Clark Sacks Waikato DHB Board', *Stuff*, https://www.stuff.co.nz/national/health/112512137/health-minister-makes-decision-on-future-of-waikato-dhb, 7 May 2019.
19. Transcript 4.1.6, p 119.

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significant issues around staff or patient safety. I'm not sure if I would lose my job over not achieving my KPIs [key performance indicators].'[20]

While we discuss district health board annual plans in the next section, we note here Keriana Brooking's evidence that, while Ministers must personally sign annual plans and have the power to refuse to approve them and ask them to be reviewed, this has only ever been done for financial reasons. No annual plan has ever been rejected because of issues in their reporting or planning relating to reducing Māori health disparities.[21]

7.4 The Importance of Effective Measures and Reporting

The evidence before us indicates that appropriate measuring of, and reporting on, Māori health inequities needs to be a key accountability mechanism in the health sector. Indeed, the claimants cite Tribunal jurisprudence indicating that a lack of public information on the effectiveness of Government policies and programmes breaches the partnership principle of the Treaty in that it denies Māori communities any real opportunity to monitor the Crown's performance.[22] Dr Heather Came-Friar and Professor Tim McCreanor, who appeared as interested party witnesses, highlighted research commissioned by the Ministry in 2014 that stressed the importance of 'setting targets and monitoring progress and the normalisation of equity analysis'.[23] In their closing submissions, counsel for Tureiti Lady Moxon and Janice Kuka submitted that 'there are few measures in place' that can be used to hold district health boards to account effectively for the persistence of Māori health inequity.[24]

Keriana Brooking, giving evidence for the Crown, similarly noted the importance of effective measuring and reporting multiple times in her oral evidence when asked about Māori health plans, at one point stating:

> So certainly, there needs to be agreement across parties about what the measures are that we consider to be important and who [is] the 'we' [that] needs to be described and developed. So, the Māori health plans were a set of constructs that happened within ourselves, so Māori Health Managers and Planning and Funding staff within the Ministry of Health sought to determine what the measures were. So, from my perspective that means that people were absent in the developing of what appropriate measures could be. So, if I started back there, what would be the appropriate measures that we would all consider, then certainly how would we work on those measures to improve them and publish those measures in order for people to see the progress that is being made.[25]

20. Transcript 4.1.5, pp 120–121.
21. Transcript 4.1.7, p 316.
22. Submission 3.3.3, para 14.
23. Document A46, para 39.
24. Submission 3.3.18, para 114.
25. Transcript 4.1.7, p 294; see also pp 319–320.

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Māori health plans were often referred to as an example of a planning document that specifically referred to Māori health outcomes in particular districts and then outlined what the district health board was planning to do to reduce Māori health disparities. The Ministry implemented a requirement for Māori health plans in response to a review of district health boards conducted in 2008–09 by the Office of the Auditor-General.[26] The Auditor-General's report found that district health boards 'did not provide detailed information on the level of disparity in their district and did not report consistently on Maori health disparities in their annual reports'.[27] Māori health plans were not required to be public – they were seen by district health boards, which could choose to make them public if they wished.[28] In 2010–11, in response to a further review by the Office of the Auditor-General, the Ministry required all district health boards to describe in their Māori health plan how Māori health would be improved and how health disparities would be reduced.[29]

The Ministry rescinded the requirement for district health boards to prepare Māori health plans in 2016.[30] In the last year that the boards had to produce plans, the Ministry emphasised their intrinsic role in assisting boards with their responsibilities for Māori health:

> MHPs are fundamental planning, reporting and monitoring documents, that underpin the DHB's efforts to achieve health equity and improve health outcomes for Maori. As key planning and monitoring documents, it is important that these plans are comprehensive, complete and robust.
>
> The MHP provides a summary of a DHB's Maori population and their health needs. The plan then documents and details the interventions and actions the DHB plans to undertake to address health issues to achieve indicator targets set nationally and locally.[31]

Interested party witness Teresa Wall, who was closely involved with the formulation of Māori health plans when she was the head of Te Kete Hauora and the Deputy Director-General Māori Health, spoke generally of the practical usefulness of Māori health plans in principle for district health board planning. She particularly emphasised their usefulness to Te Kete Hauora's activities as the

26. Document A2, para 36; doc A15, para 21.3.

27. Document A15, para 21.3. Teresa Wall, then-head of Te Kete Hauora, noted that some early work pursued by her team in 2008 similarly found that district health boards were not adequately monitored against their performance on reducing Māori health disparities. In response, Te Kete Hauora worked on a set of indicators for Māori health intended for district health board reporting. This work was then picked up by the Auditor-General's report in 2011 (see transcript 4.1.5, pp84–85).

28. Transcript 4.1.7, pp293–294.

29. Document A15, para 21.3; submission 3.3.32, para 170.

30. Document A2, para 38; doc A3, para 216; doc A62, para 50.

31. Document A50, para 24; 'Māori Health Plan Guidance 2016/2017', Ministry of Health, https://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package-and-review-plans/mhp-guidance, last modified 4 March 2016.

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Ministry's Māori health unit. Many witnesses, including Crown witnesses, broadly agreed with her assessment.[32]

Māori health plans themselves were by no means perfect. Witnesses acknowledged, for example, that the indicators that were selected for inclusion in the plans were likely inadequate.[33] Further, Keriana Brooking said that, while some Māori health officials in the Ministry and in district health boards were involved in the creation of Māori health plans, the wider health sector and Māori communities were not.[34] Her view was that Māori health plans were plainly not developed in partnership with the Māori communities.[35]

We were told that, from 2017, the information included in Māori health plans was to be incorporated into district health board annual plans.[36] Nevertheless, the claimants stated that the plans' disestablishment (along with the disestablishment of Te Kete Hauora at the same time) contributed to a perception that the Ministry did not consider Māori health a priority and further risked detracting focus from Māori health inequity.[37]

We note Brooking's evidence that, when the Ministry announced in 2016 that they were discontinuing Māori health plans, 'some' district health boards expressed their disapproval of the move; however, it appears that Te Tumu Whakarae, a national collective of Māori managers from district health boards, offered more significant resistance.[38] The Ministry ultimately ignored their recommendation not to remove the requirement for Māori health plans, and it did not heed their specific advice on how to include improving equity as a priority in annual plans.[39]

The Ministry's explanation for the removal of the requirement for Māori health plans was summarised in evidence before us as follows:

> The Ministry of Health's rationale for amalgamating the Māori health plans with DHB annual plans was to improve Māori health outcomes by strengthening the accountability, focus and profile on Māori health not only to the Minister of Health but also to DHB Chairs and Boards.
>
> While the amalgamation of the Māori health plans has meant a reduction in visibility for Māori health, there are certain DHBs who continue to develop a stand-alone Māori health plan. The amalgamated plan aims to ensure all priorities of the

32. Transcript 4.1.5, pp 87–88; transcript 4.1.7, pp 179–180, 293. The Office of the Auditor-General has also endorsed their usefulness: doc A12, para 54; Controller and Auditor-General, *Health Sector: Results of the 2010/11 Audits* (Wellington: Office of the Auditor-General, 2012), p 37; Controller and Auditor-General, *Health Sector: Results of the 2012/13 Audits* (Wellington: Office of the Auditor-General, 2014), p 55.

33. Document A50, para 26; doc A70, para 17; transcript 4.1.5, pp 39–40, 84; transcript 4.1.6, pp 23–24; transcript 4.1.7, pp 149–150.

34. Transcript 4.1.7, pp 309, 319.

35. Ibid, p 309. Professor Cumming also made a similar point about community consultation on their development: p 141.

36. Document A2, para 38; doc A3, para 216; doc A62, para 50.

37. Document A20, paras 20–20.1; transcript 4.1.4, p 301; transcript 4.1.5, p 40.

38. Document A62, para 51.

39. Document A64, paras 21–22; transcript 4.1.7, p 216.

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> government and DHB are given equal status. The amalgamated Annual Plans are formally approved by the Minister of Health, while Māori health plans were not.[40]

Hector Matthews stated that this incorporation did not result in any information being 'lost', but he made the point that explicit data about Māori health outcomes is harder to find in annual plans.[41] Referring to the latest examples of the Canterbury District Health Board annual plan and Māori health plan, Matthews also agreed that the actions that district health boards will undertake to address inequitable Māori health outcomes – detail that was required in Māori health plans – are difficult to find in the Canterbury District Health Board's annual plan.[42] He further stated that the new equity action guidelines for annual plans are not sufficient.[43]

When asked about Māori health plans, the director-general essentially repeated the Ministry's explanation quoted above: that the idea was that amalgamation would broaden accountability for Māori health.[44] In our view, and in practice, amalgamation has achieved the opposite.

Having discussed the circumstances of their removal, in our view Māori health plans themselves are not the central issue: the key point is that appropriate measures for Māori health inequities need to be developed in consultation with the rest of the sector, as well as Māori. These measures need to be visible and easily understood both by the sector and by the wider public. Further, health entities such as district health boards need to report against these measures.

Crown witnesses agreed that district health boards should revert to measuring and reporting separately against Māori health outcomes more effectively to hold them accountable for addressing Māori health inequities in their districts. Dr Nick Chamberlain and Professor Cumming indicated that work would need to be undertaken to make sure that this did not end up simply being a box-ticking exercise, as this had been a criticism of Māori health plans when they were required.[45] Witnesses considered the visibility of health measures for Māori an important internal accountability tool in and of itself. Hector Matthews highlighted that, at a minimum, clear visibility of data detailing inequitable health outcomes was an important way to inform and motivate health professionals:

> It is much easier for me to say, 'Look, look at these 15 indicators that we haven't hit.' Now I've got to hunt through a 100-page document to find it . . . but you see I'm motivated to do that. The specialist sitting in Ward 24 at Christchurch Hospital isn't

40. Document A62, paras 52–53; see also doc A64, para 14.
41. Transcript 4.1.7, p 209.
42. Ibid, pp 220–222. We note that the Auditor-General's report on the health audit results from 2010 to 2011 expressed similar concerns about district health board annual plans: Controller and Auditor-General, *Health Sector: Results of the 2010/11 Audits* (Wellington: Office of the Auditor-General, 2012), pp 35–36, 38.
43. Transcript 4.1.7, pp 156, 161.
44. Transcript 4.1.5, pp 526–527.
45. Transcript 4.1.6, pp 23–24; transcript 4.1.7, pp 140–141.

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necessarily motivated. He needs something easily visible to go to see how the system that he's working in is going for him. So, visibility of our accountability is a really important tool to make change within the system at an operational level.[46]

Matthews provided a specific recent example:

last year we had 30% of Māori kids enrolled in our dental health service so 70% weren't and our board, literally, pointed a big finger at the clinical director of our community dental services and said, 'Sort that out.' Now, they didn't have an answer for that but they've started to sort that out. They haven't nailed it yet, they haven't even cracked 50% but we are getting there, so what I find is data is very compelling, despite people's belief. If you show them that actually, this is the requirement and you have a difference between non–Māori and Māori what are you going to do about it, what I find with clinicians is they don't like looking at data which makes them look bad.[47]

We accept the evidence we received indicating that the information previously contained in Māori health plans is now included in annual plans. However, we agree with Matthews that this results in a lack of clear visibility (at least in the annual plans provided and shown to us in this inquiry).[48] Further, as the Tribunal's exchange with Matthews about the Canterbury District Health Board's planning documents indicates, the new annual plans lack specificity, or at least clarity, about the action points or the 'how' of addressing inequities.

We are not convinced that the current iteration of annual plans is as useful for separately identifying and setting out what actions district health boards are taking to address Māori health inequities. Our impression is that this information is very difficult to glean from annual plans. Indeed, Professor Cumming said that district health board annual plans are, on the whole, difficult to interpret.[49]

This lack of measuring and reporting inequitable health outcomes is a feature of other mechanisms, too. Professor Cumming highlighted that the measures in the new System Level Measures framework do not break down information by population groups.[50] Further, she made the point that the annual *Health and Independence Report*, which is prepared by the director-general and is one of the central mechanisms that holds the Ministry accountable to Parliament, 'does not always report on key issues consistently over time, or report on trends, it does not break information down by DHB, and does not always report on inequities'. She, too, emphasised the importance of reporting on the sector's progress on reducing health inequities, 'including on Māori health'.[51]

46. Transcript 4.1.7, p 181.
47. Ibid, p 169.
48. Counsel for Kuka and Lady Moxon made a similar comment in their closing submissions: submission 3.3.18, para 118.
49. Transcript 4.1.7, p 140.
50. Document A60, para 31.
51. Ibid, para 30.

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While some district health boards and other organisations in the primary health care sector still practise separate measuring and reporting, the Ministry's failure to require this amounts to a weakening of the statutory obligation to focus on reducing Māori health disparities. It follows that this weakening constitutes a breach of the Crown's obligations to the Treaty principles of equity and active protection.

7.5 Holding Primary Health Organisations and Providers to Account

As with district health boards, the performance of primary health organisations and their commitment to Māori health vary across the country. The Crown accepted that, broadly, the framework has not, in its implementation, ensured 'sufficient accountability from PHOs to DHBs'.[52] Lady Moxon said that the commitment of primary health organisations to improving Māori health outcomes varies from organisation to organisation.[53] The fact that the accountability arrangements in primary care appear to allow this variability concerns us too.

Representatives and witnesses from all parties acknowledged that accountability for primary health organisations and providers is severely lacking. The Crown's independent witness, Professor Cumming, confirmed that accountability measures for primary health organisations 'have kind of been set aside'.[54] Director-General Dr Bloomfield also agreed, acknowledging that existing levers available to district health boards are difficult to utilise in practice. The director-general also said that 'no agreed performance framework' exists between district health boards and primary health organisations and providers.[55] Broadly, it appears to us that health entities face few negative consequences if they fail to provide sufficient care for the citizens they are responsible for.[56] The lack of consequences acknowledges not only that the levers in place are not utilised to their full extent but also that important accountability mechanisms are arguably missing from the system.

We heard that primary health organisations essentially self-audit, as Amy Downs – an American scholar who completed a study of funding flows in the New Zealand primary care system in 2017 – emphasised in her evidence:

> PHOs conduct self-audits of their performance. I would not consider that this activity introduces accountability into the system. My perception is that DHBs are so concerned with the challenges of serving as a provider of hospital services that they have minimal capacity to pursue accountability in their role as a funder of primary healthcare services. According to the chief executives of PHOs who I interviewed,

52. Submission 3.3.32, para 185.
53. Document A11, paras 107, 110.
54. Transcript 4.1.7, p 88.
55. Document A65, para 51; see also transcript 4.1.5, p 385.
56. For examples, see submission 3.3.18, paras 117–118, 178; submission 3.3.30, paras 5.185–5.188; doc A65, paras 50–51.

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> DHBs pass on the primary care funding to PHOs with minimal follow-up regarding how those funds are spent. Some reporting does occur but is generally not scrutinised in a meaningful way.[57]

Downs also said that, throughout the interviews she conducted for her research, staff of primary health organisations told her that accountability for funding under the System Level Measures framework and the Flexible Funding Pool was weak, with 'little to no follow-up' from district health boards.[58] Her impression was that health providers similarly are given funding by primary health organisations without scrutiny of their practices or their responses to Māori inequities.[59]

Despite this alleged loose accountability for primary health organisations and providers, counsel for Lady Moxon and Janice Kuka argued that Māori primary health organisations and providers 'experience high levels of compliance monitoring and auditing' in comparison to non-Māori organisations. She cited research co-authored by interested party witnesses Dr Came-Friar and Professor McCreanor, comprising a nationwide survey of 150 providers, which similarly indicated difference in district health board and Ministry treatment of Māori organisations and non-Māori organisations.[60] The research indicated that Māori organisations in the survey were more likely than non-Māori organisations to perceive the monitoring of their organisations as 'burdensome'. Further, the research established that the Māori health providers surveyed were audited more frequently than their non-Māori counterparts and that audits were more often perceived by Māori providers to be unnecessarily harsh and taxing on their time and resources.[61]

One specific example in evidence before us related to Te Kupenga a Kahu, a Māori primary health organisation, which used funds allocated under the Services to Improve Access framework to pay for general administration costs instead, a practice known as 'top-slicing'. Te Kupenga a Kahu was pursued by its district health board and directed to repay the money it had top-sliced. The evidence before us appears to show that the practice of top-slicing was more widespread than just in Te Kupenga a Kahu but was not uniformly policed. Te Kupenga a Kahu later closed because it could not repay the money it owed to its district health board, though the district health board did eventually stop pursuing Hakopa Paul and others formerly involved with Te Kupenga a Kahu for the repayment.[62]

The broad indications are that the high-level of scrutiny experienced by most Māori organisations contrasts with the auditing and monitoring environment that

57. Document A43, para 22; see also transcript 4.1.5, p 168.

58. Document A43, paras 25–27. Dr Rawiri Jansen appeared to agree with Downs's assessment: transcript 4.1.4, pp 554–555.

59. Document A43, para 30.

60. Submissions 3.3.18, para 72.

61. Document A46, para 36; Heather Came, Claire Doole, Brian Mckenna, and Tim McCreanor, 'Institutional Racism in Public Health Contracting: Findings of a Nationwide Survey from New Zealand', *Social Science & Medicine*, vol 199 (2017), doi 10.1016/j.socscimed.2017.06.002, pp 135–136.

62. Document A30, para 9; doc A13, paras 22–24; doc A11, para 35; transcript 4.1.5, p 90; doc A13(a).

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other, non-Māori, organisations experience. The Crown accepted that the experience of Te Kupenga a Kahu exemplified a weakness in the permissive approach to accountability inherent in the primary health care framework.[63]

Like district health boards, primary health organisations also used to produce Māori health plans. Hector Matthews noted that as early as 2007 some primary health organisations were resistant to producing stand-alone Māori health plans. He attributed this resistance to the fact that primary health organisations were essentially uncomfortable with publishing any data that revealed persisting Māori health inequities in their enrolled population.[64]

The Ministry rescinded the requirement for primary health organisation Māori health plans in 2013. The organisations were instead required to contribute to the district health boards' Māori health plans.[65] Matthews was of the view that primary health organisations' resistance to producing these plans may have been part of the pressure to lift the requirement.[66] As noted in the previous section, the Ministry has not required district health boards to produce Māori health plans since 2016. Again, we think that separately publishing measures on Māori health outcomes and then reporting against those measures is an equity-enhancing approach.

7.6 The Detail of Data and Information Collected from Primary Health Organisations and Providers

Many witnesses stressed that robust public reporting is a key form of accountability. They broadly emphasised that data on health inequities and the actions being taken to address them is useful not only for those working within the system but also for academics, researchers, and entities that are involved or adjacent to the health sector, such as Māori relationship boards, and the public more generally. Director-General Dr Bloomfield agreed that the health sector needs to be 'providing much more data publicly on system performance including on Māori health and key Māori health indicators and outcomes'.[67]

We heard that most of the data relating to primary care is collected by health providers and primary health organisations but that they are not required to provide much of this data to district health boards or to the Ministry.[68] Amy Downs's research found that primary health organisations only submit a quarterly report detailing the number of visits by enrolled patients but that even this data is incomplete as it records only the last visit in any given quarter: '[i]f a member had four visits in one quarter, only the last date is recorded'.[69] Her overall impression was that the data provided to the Ministry was extremely limited, to the extent that,

63. Submission 3.3.32, para 240.
64. Document A64, para 39; transcript 4.1.7, p 217.
65. Document A20, para 20.3; doc A64, para 40.
66. Document A64, para 39.
67. Transcript 4.1.5, p 466.
68. Document A43, para 28; doc A44, para 21; transcript 4.1.5, pp 147–148, 153, 167–168.
69. Document A43, para 28.

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in her view, '[t]here are no policy incentives or requirements to ensure that New Zealand learns the outcomes of its investment in primary care'.[70]

Public health academics and researchers who appeared before us consistently stated that, while ample evidence of Māori health inequities existed, more detailed Māori health data – and especially performance data for health entities – is not readily available. Dr Suzanne Crengle, for example, said that limited data was published relating to the performance of district health boards, primary health organisations, and health providers:

> The paucity of publicly available data limits opportunities to monitor and evaluate the performance of the health sector. Furthermore, in my view if the Crown had a comprehensive commitment to Māori health it would also have a comprehensive range of outcomes and indicators . . . that it was monitoring. This does not appear to be the case.[71]

Dr Crengle also said that ethnic-specific health data had been more readily available in the past than it is today.[72] Under cross-examination, she said that, while the *Māori Health Chart Book* (the latest edition of which was published in 2015) was useful, it was not as detailed as some previous reports. She confirmed that the last published report that, in her view, thoroughly assessed Māori health standards was released in 2007.[73]

'Trendly', a Government website that publishes measures of, and reporting on, health outcomes across the health sector, was set up about the time that Māori health plans were developed. Dr Crengle praised the principle of public reporting on district health board performance that was behind 'Trendly' and noted that it was a positive national approach to hold district health boards to account for addressing inequitable health outcomes.[74] However, she noted that only three primary care-related indicators are published on 'Trendly': breast cancer screening, cervical cancer screening, and immunisation rates.[75] She noted that outcomes reported for all of these indicators show inequities for Māori.[76]

We heard that Te Kete Hauora, previously the Ministry's Māori health business unit, provided useful information and data on Māori health by producing or commissioning the *Hauora* series of reports and research, the last occurring in 2007. The unit then went on to produce three editions of the *Māori Health Chart Book*, the last of which was in 2015. According to Dr Crengle, the range of information and data provided and the depth of analysis in the last one were more limited than the previous two.[77] Dr Crengle's evidence was that this knowledge base had

70. Document A43, para 30.
71. Transcript 4.1.5, pp21–22; see also doc A52, para 12.
72. Document A52, para 28.
73. Transcript 4.1.5, p27.
74. Ibid, p89.
75. Document A52, paras 17–21.
76. Transcript 4.1.5, p21.
77. Transcript 4.1.4, p312; transcript 4.1.5, pp28, 36, 37, 119.

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progressively lessened since 2007.[78] We also received evidence that Te Kete Hauora had prepared information concerning levels of funding to Māori health providers for the years 2011–12 to 2015–16. We heard that a further such report has not been provided since Te Kete Hauora was disestablished by the Ministry in 2016.[79]

As well as the amount of data no longer available to researchers, other witnesses said that some data that could prove useful as evaluative tools for the performance of the system was not even being collected. Professor Papaarangi Reid noted that, because data was often quantitatively focused rather than qualitative, 'we can see when something clicked or went through a system, but we don't know how was that process, was it a good engagement, was it timely, all those sorts of other types of data that we need to reinforce and to do better'.[80]

After noting that, even the quantitative data that primary health organisations provide to the Ministry is essentially incomplete, Amy Downs echoed Dr Crengle and Professor Reid: 'the data submitted is so limited that it does not provide meaningful or actionable intelligence to address primary healthcare utilisation needs, quality or coordination with secondary care'.[81]

This failure to collect meaningful and actionable information appears to have been an issue even when the framework was being designed and introduced. We refer to Professor Cumming's appraisal of the Primary Health Care Strategy, partially quoted in chapter 5, in full:

> It is worth noting that although a key goal of the PHCS [Primary Health Care Strategy] was to enhance equity, no equity analysis / programme logic was ever completed to my knowledge. This would have provided clarity about the various features of the PHCS and careful thinking and documenting of how those features would likely affect equity. It might also have identified the need for additional policies and programmes to support Māori health. Future policies, programmes and plans aiming to improve equity should include a clear programme logic relating to how equity is to be improved. There should be regular monitoring about achievements against such plans.[82]

Professor Cumming also highlighted the lack of information about primary health organisations' governance arrangements or how primary health organisations are held to account:

> It is unclear how today's PHOs meet these requirements, and research is urgently needed to identify how PHOs are governed and how they work with local communities, including Māori. It would be of concern if Māori are not involved in local PHO governance where there are many Māori patients enrolled.[83]

78. Transcript 4.1.5, pp 27–28.
79. Document A67(a), pp1–2; transcript 4.1.5, p 476.
80. Transcript 4.1.5, p 62. Amy Downs agreed: doc A43(a), pp 5–6.
81. Document A43, para 28.
82. Document A60, para 38.
83. Ibid, para 41.

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Professor Cumming also stated: 'It is difficult to know how the Ministry of Health and DHBs work to hold PHOs to account, including in relation to Māori health, as such research does not, to my knowledge, currently exist.'[84]

It appears, then, that the type of data and information that is collected, and how it is utilised, and what is made publicly available, is significantly deficient. We are particularly concerned that the Crown has not robustly assessed how the primary health care framework is operating or provided the means to conduct research in this area.

We noted earlier that public reporting, as well as being key to academic research (which may assist in improving the responsiveness of the health system), also allows for the general public to see how health entities are performing and hold them to account. We heard evidence indicating that public reporting of performance, and the associated reputational risk, were key means of holding health entities to account. The director-general, for one, said that, in his experience, public reporting was an effective way of motivating district health boards and primary health organisations to focus on particular areas.[85]

In 2009, the Government renewed its national health targets, which slimmed down the targets reported on and clarified their focus.[86] Matthews summarised this change as follows:

> The government introduced public reporting of health targets as a way of using reputational concerns as a lever for improving performance against health targets. At the same time, the new government also removed differential targets for different ethnic groups, reinforcing the expectation that all New Zealanders should receive the same level of care and service regardless of ethnicity. The government continued to require reporting by ethnicity (not publicly) to ensure visibility of results and monitored DHB performance by ethnicity.[87]

To emphasise, district health boards have not been required to report publicly on Māori health outcomes, or indeed the specific outcomes of any population group by ethnicity, since 2009. Matthews indicated in his written evidence that the 'robust ethnicity data' shared internally by district health boards has been key to improving the district health boards' responsiveness to Māori health inequity since 2009, and he used improved Māori outcomes achieved in his organisation's district as an example.[88]

However, this does not discount the evidence supplied by the Crown and others in relation to reporting that shows district health board performance varies considerably and is poor overall. It is perplexing to us that the Crown would at

84. Document A60, para 43.
85. Transcript 4.1.5, p 385. Hector Matthews agreed: doc A64, para 11; transcript 4.1.7, pp 181–183.
86. Document A62, paras 249–250.
87. Document A64, para 47.
88. Ibid, para 49.

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once recognise the power of public reporting while at the same time not use that mechanism to its fullest extent.

As noted by Dr Crengle and Professor Reid, among others, the open availability of quality data would ideally lead to improvements to the ways the system addresses Māori health inequities. Despite the *Operational Policy Framework* contractually requiring that district health boards 'provide relevant information, including ethnicity data, to Māori', it appears that district health boards are not consistently complying with the obligations in their contracts.[89] The onus for this responsibility is mostly on district health boards but is also on the Ministry for not holding them accountable for insufficient action.

A discussion of the health sector's use of data demonstrated the importance of visibility to the public. Dr Rawiri Jansen said that the National Hauora Coalition publishes data on the health outcomes of its enrolees, and he emphasised how important it was to publish data. He acknowledged that publishing data showing insufficient progress was uncomfortable but necessary, saying 'we have to use data to tell uncomfortable truths'.[90]

The Office of the Auditor-General's report on its 2010–11 audit of the health sector suggested that the improvement in immunisation rates for Māori and Pacific peoples was expressly due to setting specific targets for these groups and then publishing the results for public view.[91] At hearings, Matthews clarified his written evidence and said he personally disagreed with the Ministry's and with some of his colleagues' justification for limited public accountability, and he made the point that 'visibility within the system' is not enough.[92] He further remarked under cross-examination:

> clinicians who work within the health system are quite proud of the efforts they make and you know when they see that some of those efforts aren't actually leading to results people generally respond in two ways. They either you know pull their socks up and go to change that or they get quite defensive about it and generally our system gets quite defensive about inequitable results.
>
> Q. But isn't that the point of an accountability?
>
> A. Indeed.[93]

We agree. It is not solely for the Crown to determine what will be measured and how it will be reported. We emphasise that the Crown cannot be the sole auditor of its own performance – the Treaty obliges Crown agents to ensure that the health system is accountable to their Treaty partner.

89. Ministry of Health, *Operational Policy Framework 2018/19*, revised ed (Wellington: Ministry of Health, 2016), para 3.10.3.

90. Transcript 4.1.4, pp 540, 546–547.

91. Controller and Auditor-General, *Health Sector: Results of the 2010/11 Audits* (Wellington: Office of the Auditor-General, 2012), p 38.

92. Transcript 4.1.7, p 183.

93. Ibid, pp 182–183.

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7.7 External Monitoring of the Ministry of Health

In addition to the director-general's *Health and Independence Report*, referred to in section 7.4, the Ministry of Health makes two presentations to Parliament's Health Select Committee each year. The first is to address appropriation estimates and funding. The second is where the Minister is statutorily required to report on 'progress in implementing the New Zealand health strategy'.[94] The Ministry's financial and non-financial outputs are also audited and reported to Parliament each year by the Office of the Auditor-General.[95]

Te Puni Kōkiri also has a statutory responsibility to monitor the health sector, and we heard that such monitoring was an important mechanism for holding the health sector to account.

Section 5 of the Ministry of Māori Development Act 1991 states:

> **5 Particular responsibilities of Ministry of Maori Development**
> (1) The responsibilities of the Ministry of Maori Development include—
> (a) Promoting increases in the level of achievement attained by Maori with respect to—
> (i) education;
> (ii) training and development;
> (iii) health;
> (iv) economic resource development;
> (b) monitoring, and liaising with, each department and agency that provides or has a responsibility to provide services to or for Maori for the purpose of ensuring the adequacy of those services.
> (2) The responsibilities of the Ministry of Maori Development under subsection (1) are in addition to the other responsibilities conferred on that Ministry from time to time.
> (3) Nothing in this section limits the provisions of the Treaty of Waitangi Act 1975 or of any other Act.[96]

Teresa Wall, a former Deputy Director-General of Health, was critical of the failure by Te Puni Kōkiri to deliver on its monitoring function under the Act. She characterised Te Puni Kōkiri's responsibility as: 'A critical monitoring and accountability opportunity to improve performance in Māori primary health services which has been lost because it has simply not been implemented.'[97]

Lisa Davies, a deputy chief executive at Te Puni Kōkiri, was called as a Crown witness and confirmed that Te Puni Kōkiri completed four agency reviews in the health sector between 1993 and 2004. Only one, a 2004 review of the Bay of Plenty District Health Board, was conducted after the establishment of the current

94. New Zealand Public Health and Disability Act 2000, s 8(4); submission 3.3.32, para 168.
95. In sections 7.3 and 7.5, we referred to some criticisms made by the Office of the Auditor-General in its 2008–09, 2010–11, and 2012–13 audits.
96. Ministry of Māori Development Act 1991, s 5.
97. Document A50, para 28.

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primary health care framework.[98] She stated that, with regard to Te Puni Kōkiri's responsibility to monitor other agencies:

> The Act gives no specific guidance as to the method Te Puni Kōkiri should use to monitor and liaise with agencies, or promote increases in levels of achievement attained by Maori with respect to health and other outcomes. Te Puni Kōkiri's approaches to addressing its section 5 responsibilities have been refined over time to accord with Government priorities of the day and the prevailing public sector management environment. The approaches used have varied and included monitoring, evaluation, research, policy, relationships, capability building and investments.[99]

Davies' evidence asserted that, from 2004, the leadership of Te Puni Kōkiri underwent a 'distinct shift' in direction, which resulted in the 'discontinuation of agency reviews and effectiveness audits, and an increased focus on policy and programme development'. As a result, as expressed in its 2006 annual report, Te Puni Kōkiri is now 'more involved at the front-end of policy development' rather than monitoring the outcomes or results of policy initiatives.[100] She explained during our hearings that Te Puni Kōkiri saw itself as fulfilling its monitoring responsibility by 'monitoring' policy development and 'trying to influence' that process. She did, however, acknowledge that a shift away from monitoring 'in a formal sense' had occurred and, further, that since 2004 'there hasn't been a huge deliberate focus on monitoring the health sector along with other sectors'.[101]

Under cross-examination, Davies further agreed that Te Puni Kōkiri had departed from the original philosophy underpinning its formation. Counsel for Patricia Tuhimata and David Ratu, who appeared as an interested party, submitted that, prior to Te Puni Kōkiri being established, the Government had intended to devolve significant public sector responsibilities, largely handled by what was then known as the Department of Māori Affairs, to iwi groups. When the new Government was voted in at the turn of the 1990s, it abandoned this approach and instead resolved to transfer those responsibilities to 'mainstream' agencies, including social sector agencies such as the Ministry of Health.[102]

Counsel for Tuhimata and Ratu stated in closing submissions:

> [because] Te Puni Kokiri no longer carries out agency reviews of this kind, it is submitted that Te Puni Kokiri is in breach of section 5(1)(b) of the Ministry of

98. Document A76, para 18.
99. Ibid, para 15.
100. Document A76, paras 38–39.
101. Transcript 4.1.7, pp 240, 247.
102. Ibid, pp 245–247; see also Richard Hill, *Maori and the State: Crown–Maori Relations in New Zealand/Aotearoa, 1950–2000* (Wellington: Victoria University Press, 2009), pp 233–237, 241–252; Aroha Harris and Melissa Matutina Williams, 'Rights and Revitalisation, 1970–1990', in *Tangata Whenua: An Illustrated History*, ed Atholl Anderson, Judith Binney, and Aroha Harris (Wellington: Bridget Williams Books, 2014), pp 449–450.

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Māori Development Act 1991. As a consequence, the Crown is in breach of its Treaty obligations.[103]

Counsel for the Māori Nurses stated that Te Puni Kōkiri's relinquishing of its monitoring responsibility was 'alarming' given the poor state of Māori health.[104]

We agree with both counsel. Te Puni Kōkiri operates under an express statutory function to monitor and liaise with certain public sector agencies, including the Ministry of Health, to ensure that the design and delivery of services is adequate for Māori.

That responsibility has not changed since Te Puni Kōkiri was established. What has changed is the type and scope of monitoring undertaken by Te Puni Kōkiri. Notwithstanding the lack of specific guidance in the Ministry of Māori Development Act, we know that Te Puni Kōkiri has not:

- monitored or reviewed whether the implementation of the Primary Health Strategy or He Korowai Oranga has improved Māori health outcomes;
- monitored or reviewed whether the Ministry and district health boards have adequately ensured the sustainability of Māori primary health organisations and providers;
- assessed the effectiveness of governance structures that exist between district health boards and Māori; and
- monitored or reviewed the effectiveness of the capitated funding formula for its impact on improving Māori health outcomes.

Beyond the provision of some policy advice and a sole, discrete review of the Bay of Plenty District Health Board in 2004, Te Puni Kōkiri has not undertaken any formal monitoring of the health sector since the commencement of the New Zealand Public Health and Disability Act 2000. In light of the well-known Māori health statistics, we consider that this is wholly inadequate. In our view, section 5 of the Ministry of Māori Development Act 1991 places a firm responsibility on Te Puni Kōkiri to monitor the health sector in its delivery of achievement of improved Māori health outcomes, which it has failed to do.

7.8 Accountability in a Permissive System

Much of the hearings and evidence focused on the 'permissive' policy environment for primary health care described by the director-general.[105] The claimants have alleged that this 'permissive', semi-devolved system is problematic, in part because, as district health boards operate semi-autonomously, it is difficult to roll out programmes nationally that are beneficial to Māori.[106] We accept the Crown's position that the permissiveness of the system was intended not to abrogate the Crown's responsibilities to Māori health but rather to foster local solutions and

103. Submission 3.3.15, para 174.
104. Submission 3.3.20, para 300.
105. Document A59, para 20.
106. Submission 3.3.4, paras 74–75.

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community ownership of health care design and delivery.[107] However, we find Dr Peter Jansen's appraisal of the Crown's permissive approach compelling:

> the [Primary Health Care Strategy] of 2001 was aspirational but wonderfully naïve . . . to think that you can have a permissive system that will achieve everything by allowing different ways to flourish without direction . . . without strong monitoring, without refocussing people and continual improvement imbedded in the system is flawed. If you allow people to develop their own ideas but not strengthen them, repoint them in the right direction and strongly monitor them it won't succeed, you'll get increasing disparity.[108]

Professor Peter Crampton was similarly critical:

> That promise has not been realised, systematically not realised over the intervening 17 plus years. The risks associated with its implementation were identified, and written about, and noted, and commented on from earlier on but there was inadequate monitoring and the necessary adjustments and strengthening of implementation, those steps were not taken. As a result, we're confronted with this situation now in 2018 whereby Primary Health Care in our system fails in its core functions of meeting the basic health care needs of those who are most in need, as evidenced by huge amounts of data which convey the human reality of the system which is not meeting the needs of those most in need.[109]

This arguably reflects a broader failing of leadership on the part of the Ministry. We agree with the claimants that, good intentions notwithstanding, the consistent signals sent by the Ministry and district health boards since the beginning of the primary health care framework indicate that achieving equitable Māori health outcomes has not been a high priority.

The permissive nature of the primary health care framework, with its considerable devolution of responsibilities, permits actors in the health sector to downplay their responsibilities to improve inequitable health outcomes for Māori and to abide by Treaty obligations. If the Ministry is to fulfil its role as the steward of the health system, it must demonstrate strong leadership. This includes strengthening accountability mechanisms throughout the sector to ensure the sector is performing well but also extends to leading by example and expressing core concepts and directions for the sector thoroughly and clearly. The language of leadership the Ministry uses as the steward of the health system is important.

The central point we are making is that a permissive approach to health that allows for local control and delivery of primary care should not preclude strong accountability mechanisms and measures.

107. Submission 3.3.32, paras 43, 238.
108. Transcript 4.1.4, p 240.
109. Ibid, p 582.

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7.9 TRIBUNAL FINDINGS

We agree with the parties that not only are accountability measures not always used to hold the Ministry and district health boards to account for insufficient action to address Māori health inequity but the current raft of accountability measures appears to be insufficient. In our view, the accountability arrangements set out in the primary health care framework barely work to achieve the statutory aim of reducing Māori health disparities, let alone pursuing or achieving Māori health equity. As with the funding arrangements for primary health care, the Crown was more than well-informed that its permissive approach to primary health care had significant drawbacks and resulted in grave impacts both on Māori organisations and on Māori as patients.

These serious weaknesses in the Crown's permissive approach are compounded by the fact that, as we concluded in chapter 5, there are few actual expectations of equitable outcomes, either in general or specifically for Māori health, in the primary health care framework at a high level. While the 'language of equity' may be in common usage in the health sector, aiming to 'reduce disparities' is the language expressed in the Act and is the language that permeates all levels of the health system, from high-level strategies down to practical implementation through lower-level accountability documents. It follows, then, that 'reducing disparities' is the firm reference point for the primary health care sector in understanding how to address Māori health issues, not the concept of health equity. 'Reducing disparities' is what the sector is held accountable to, when it is held accountable at all.

The extent and persistence of Māori health inequity dictates that the failures of the accountability mechanisms put in place and governed by the Crown are unacceptable.

We find that:

- The ways health entities are held to account does not support the pursuit of equitable Māori health outcomes and this is a breach of the Treaty principles of active protection and equity.
- The Crown does not collect sufficient qualitative or quantitative data to fully inform itself how the primary health care sector is performing in relation to Māori health and this is a breach of the Treaty principles of active protection and equity.
- The Crown also does not use the data it does collect effectively, including by making it accessible to, and understandable by, the public. This failure, similarly, has acute repercussions for Māori health, which is not systematically separately measured and reported on. The ineffective use of data, particularly the failure to measure and report separately on Māori health outcomes, is a breach of the Treaty principles of active protection, equity, and partnership.
- Te Puni Kōkiri's failure to carry out its statutory duty to monitor the health sector through conducting agency reviews, under section 5 of the Ministry of Māori Development Act 1991, is a breach of the Treaty principle of active protection and the duty of good governance.

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CHAPTER 8

IS PARTNERSHIP FOR MĀORI IN THE PRIMARY HEALTH CARE FRAMEWORK TREATY-COMPLIANT?

Toki tā wahie te toki matarau;
Ka whanatu au ka hahau i te takapū o Rangi e tū nei

8.1 Introduction

In chapter 5, we concluded that the New Zealand Public Health and Disability Act 2000 is not Treaty-compliant and that the primary health care framework does not properly articulate, or give effect to, Treaty principles, particularly the principle of partnership. We analysed the partnership arrangements for district health boards provided for in the Act, and we discussed how these arrangements attempt to give effect to the Treaty partnership but broadly fall short.

Our focus in this chapter is to expand on our discussion in chapter 5 to discuss more broadly the ways in which the Māori voice, or Māori influence, is afforded the centrality guaranteed by the Treaty partnership. We were concerned with the experiences of Māori working with and within Crown entities and their relative decision-making power. In this way, we were interested in how these entities account for, and then implement, Māori perspectives on health issues; and, more broadly, whether the framework adequately ensures that Crown entities, and the health sector generally, are focused on addressing Māori health inequity.

The Crown agreed that ensuring Māori influence decision-making on health policy is a Treaty guarantee.[1] Crown counsel submitted that there were various expressions in the legislative and policy framework recognising this, and they highlighted several areas where it said Māori are afforded decision-making responsibilities.[2] However, as shown in the discussion throughout this chapter, they also importantly acknowledged weaknesses with these arrangements.

We were also specifically concerned with how tino rangatiratanga is provided for under the framework. Again, the Crown broadly submitted that the framework recognises these rights and that the permissive approach to the primary health care system is partly intended to foster community control and to balance that local control against national interests and priorities.[3] Again, however, as shown in this chapter, Crown witnesses broadly acknowledged weaknesses in the ways that the framework ensures recognition of and support for tino rangatiratanga.

1. Submission 3.3.32, para 48.
2. Ibid, paras 32–34, 48–49.
3. Ibid, paras 22, 32, 249–257.

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The Crown said it was particularly interested in the Tribunal's guidance on how to practically implement the Treaty partnership.[4] Crown counsel said:

> Serious and persistent health inequities that exist at a population level cannot be overcome by short term emergency-style actions. The Crown cannot affect real and long lasting change without acting across a range of domains – not just the health sector – with its Treaty partners. Similarly, there is no sense or cause in Māori being left to tackle this alone.[5]

In this chapter, we look at how the principle of partnership is reflected in the current implementation of the primary health care framework.[6]

8.2 Designing the Primary Health Care Framework

Both the claimant groups said that a proper, equitable partnership between the Treaty partners is central to the successful implementation of the aspirations of the primary health care framework.[7] During our inquiry, Director-General Dr Bloomfield related his personal understanding of the Treaty principle of partnership as follows:

> my understanding of the principle of partnership is that there should be a sense of equality in a partnership. It's a two-way relationship and I talked yesterday about the alliancing framework which is characterised by high trust, high shared accountability, so that's how I would think about partnership. It's in a sense a contract between the two parties to behave in a certain way and to work together not just on some aspects of the work but on all aspects of the work.[8]

We acknowledge the director-general's recognition of the importance of a Treaty partnership in primary care and his openness to co-design arrangements. In our view, his understanding aligns with the spirit of the Treaty partnership.

However, the claimants allege that their experience of partnership does not match with Director-General Dr Bloomfield's understanding. For example, the National Hauora Coalition claimants argued that the Crown did not adequately consult Māori when it designed the primary health care framework.[9] In 2000, the Crown undertook consultation on the development of what would become the Primary Health Care Strategy, releasing a discussion document, entitled *The Future Shape of Primary Health Care*, and inviting feedback on its contents. Crown

4. Submission 3.3.32, paras 6.
5. Ibid, para 21.
6. In this chapter, we take into consideration and respond to the issues posed at sections 4.1, 4.2, 6.1, 7.2.1, 7.2.2, and 9 of the statement of issues (statement of issues 1.4.1).
7. Submission 3.3.18, paras 150, 152; submission 3.3.30, para 6.12; submission 3.3.32, para 48.
8. Transcript 4.1.5, p 436.
9. Submission 3.3.30, para 6.11.1.

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counsel noted the consultation, which included 'Māori providers and co-funders', but did not make a submission on its adequacy.[10]

Crown witness Dr Frances McGrath recorded that Treaty partnership was a 'significant concern' raised in Māori responses to the discussion document:

> [Māori respondents] did not believe the discussion document showed a commitment to partnership or to the action required to make it a reality. Several Māori respondents stated that the partnership implicit in the Treaty of Waitangi meant Māori should have a significant and equal voice in deciding their own services. They felt they had not been consulted sufficiently in the early development of the PHC Strategy and that the discussion document would have looked different if they had.[11]

Sir Edward Taihākurei Durie, who appeared as an interested party witness, observed what 'co-design' arrangements with public sector agencies looked like in practice:

> We do have a bit of a feeling . . . that co-design means they design and we comment. It's inevitable with Government departments that their people will have a lot of thoughts, they will get excited about their thoughts, and so it comes still back to consultation where they have the initiative and we are commenting on their thoughts.[12]

As pointed out by these respondents and affirmed by Sir Edward Taihākurei Durie in front of us at hearings, this process in and of itself is a key failing by the Crown with regards to its recognition of the principle of partnership. National Hauora Coalition claimant Simon Royal said:

> Māori were not involved in policy development nor in the implementation design for the strategy. It was only once decisions were made that Māori providers and organisations were let in to execute the policy. Māori advice, input and structures were not considered. In this way, Māori were treated as a marginal part of the health sector, rather than central to government success.[13]

Dr McGrath said that these responses to the discussion document were then considered in the development of the final Primary Health Care Strategy, 'with the assistance of a primary health care reference group'.[14] She was not able to confirm how many Māori were members of this reference group, but it appears that they were in the minority.[15]

10. Statement of response 1.3.1, p 5.
11. Document A63, para 174.
12. Transcript 4.1.5, p 567.
13. Document A70, para 24.
14. Document A63, para 177.
15. Transcript 4.1.6, pp 264–265.

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We agree that 'co-design' as a concept and Government process runs the risk of, in practice, meaning something lesser than the actual partnership arrangements guaranteed by the Treaty. We agree with the parties that a correct balance of partnership, with recognition of tino rangatiratanga and mana motuhake, is important to get right in social services, including primary health care.

Based on the evidence presented to us, we conclude that neither the development of the Primary Health Care Strategy nor the development of the framework itself involved a robust co-design process.

As demonstrated by our discussion in chapter 5 and by the evidence before us, the health sector does not have a clear and consistent understanding of, or commitment to, the principle of partnership. In our view, this lacking is symptomatic of a failure to give sufficient emphasis to, and expression of, the principles of the Treaty. Participants told us of a lack of understanding of, or even an absence of recognition of, for example, tino rangatiratanga.

Some Crown witnesses also acknowledged that institutional racism exists in the health system.[16] This, along with personal racism and stereotyping, is a significant barrier to giving effect to the meaning of the Treaty and its principles. We discuss these issues further in this chapter.

8.3 Māori Experiences of Working in the Primary Health Care Sector

We received a broad range of evidence on the small proportion of, and relatively limited influence of, Māori working in the health sector. We note that statistics filed by the Crown indicate that Māori are significantly under-represented across all health professions. Māori general practitioners, for example, are significantly under-represented, making up just 3.6 per cent of the total general practitioner workforce in 2017.[17] Statistics from the Medical Council of New Zealand covering doctors more generally (including general practitioners but also other senior doctors and doctors employed in hospitals, for example) show that just 3.3 per cent of doctors identify as Māori.[18] The latest statistics for the following professions show the following:

- nurses (7.4 per cent in 2018);
- midwives (9.4 per cent in 2016);
- oral health professionals (4.2 per cent in 2017);
- physiotherapists (4.9 per cent in 2018);
- psychologists (5.3 per cent in 2018);
- radiology (5.4 per cent in 2010);
- dietitians (3.6 per cent in 2010);

16. Submission 3.3.32, para 42.
17. Medical Council of New Zealand, *The New Zealand Medical Workforce in 2017* (Wellington: Medical Council of New Zealand, 2019), pp30–31.
18. Document B4, p11.

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- laboratory scientists (1.7 per cent in 2010);
- laboratory technicians (4.7 per cent in 2010);
- pharmacists (2.5 per cent in 2018);
- optometrists (1.8 per cent in 2010);
- dispensing opticians (1.9 per cent in 2010);
- podiatrists (6.9 per cent in 2010);
- osteopaths (7 per cent in 2010); and
- chiropractors (12 per cent in 2010).[19]

Further, official statistics reveal that Māori are under-represented within the Ministry itself: as of June 2018, Māori make up just 8.2 per cent of the Ministry's total employed staff.[20] We see that the proportion and relative seniority of Māori staff within Crown agents has a significant impact on the way those agents then shape their priorities and make investment decisions. We traverse some of the relevant evidence relating to health workforce issues in the following sections.

8.3.1 Te Kete Hauora

Te Kete Hauora, a unit in the Ministry that was focused specifically on Māori health, was highlighted as a practically positive component of the Ministry's Māori health policy process. One of Te Kete Hauora's functions was to advise on, and assist with, the formulation of specific policies to address Māori health inequities and, additionally, to provide advice on consultation with Māori communities and contract management.[21] Te Kete Hauora, then, brought an important focus on Māori health to the Ministry and to the health sector more broadly.[22] The claimants suggested that the disestablishment of Te Kete Hauora in 2016 brought about a lack of focus on Māori issues, including health inequities.[23] The Crown did not explicitly submit a position on Te Kete Hauora or its disestablishment in its closing submissions, but the issue was mentioned by Crown witnesses. Director-General Dr Bloomfield made it clear that he understood and agreed with the claimants' concerns regarding the disestablishment of Te Kete Hauora and that he disagreed with the previous director-general's decision to disestablish the unit. Indeed, he cited his decision to establish a new Māori health directorate within the Ministry as evidence of this.[24]

Witnesses, however, acknowledged that, because Te Kete Hauora was primarily an advisory unit, its influence was not totally effective. Teresa Wall remarked that the Ministry did not always take up the unit's policy advice and policy development about health equity.[25] We note that Dr McGrath's evidence indicated that at

19. Document B4, pp8–10, 12–37.
20. State Services Comission, *Our People: Public Service Workforce Data 2018* (Wellington: State Services Comission, 2018), p 35.
21. Transcript 4.1.5, p78; doc A63, para 47.
22. Transcript 4.1.5, p28.
23. Submission 3.3.4, para 87.4.
24. Transcript 4.1.5, p526; doc A59, para 48.
25. Transcript 4.1.5, pp78–79.

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least one previous iteration of a Māori health-focused unit in the Ministry disbanded in 1993 after all of its staff resigned.[26]

Other witnesses related broader discussions around whether the fact that these Māori-focused and -staffed teams operate within what is ultimately the Crown's Ministry makes them particularly effective. These witnesses emphasised that having Māori control was preferable to that situation, but they nonetheless acknowledged that having teams within Crown agencies that were focused on Māori health was better than not having them.[27]

The Ministry explained that the disestablishment of Te Kete Hauora in 2016, and the spreading of its functions across other units, was intended to improve 'the whole Ministry's capacity to address Māori health inequities'.[28] Many claimant and interested party witnesses rejected this explanation and instead cited Te Kete Hauora's demise and the dispersal of its functions as signalling a significant watering down of the Ministry's focus on Māori health. Māori Primary Health Organisations and Providers claimant Janice Kuka stated that in her view the change 'weakened the voice of Māori decision making and advocacy for primary health'. She further noted that she had seen district health boards take Te Kete Hauora's disestablishment as a signal that specific units focused on Māori health were not necessary.[29] National Hauora Coalition witness Tereki Stewart said that he saw Te Kete Hauora's disestablishment as an indication that the Crown was not wholly committed to Māori health.[30] Stewart remarked that his sense of the impact of the action to disperse Māori policy work across the other units was the creation of 'a policy advice vacuum': 'One [Māori] person in a room, for example, full of 20 other people that have different agendas . . . it becomes hard to kind of leverage Māori health perspectives and outcomes in that kind of context.'[31]

On this point, the director-general observed that focusing policy development for Māori health with a specific team carries a risk that other units and teams across the organisation will not take any responsibility for Māori health.[32] Professor Papaarangi Reid and Dr Peter Jansen both stated that Māori-specific issues can be the focus of a particular team as well as the responsibility of more than just that particular team. Director-General Dr Bloomfield expressed an openness to this idea.[33] Conversely, Keriana Brooking, another Crown witness, stated that 'from the evidence and in my experience . . . the more you share something across a group the easier it is for it to get lost'.[34]

26. Document A63, para 46.
27. Transcript 4.1.4, pp 312–313, 389.
28. 'Māori Health', Ministry of Health, https://www.health.govt.nz/our-work/populations/maori-health, last modified 8 December 2018.
29. Document A12, paras 58–59; transcript 4.1.4, p 321.
30. Document A20, paras 20, 20.2; transcript 4.1.4, pp 651–652.
31. Transcript 4.1.4, p 651.
32. Transcript 4.1.5, pp 526–527.
33. Transcript 4.1.4, pp 266–267; transcript 4.1.5, pp 53, 527.
34. Transcript 4.1.7, p 320.

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In our view, the Ministry should have a specific team that is expert in, and focused on, issues relevant to Māori health, while also requiring its entire organisation to take responsibility for Māori health issues. Indeed, as suggested by Teresa Wall, we consider that the existence and proper support of a specific Māori health directorate, as has just been established, would likely strengthen the whole Ministry's compliance with its responsibilities to address Māori health inequity.[35]

In addition to the repercussions for Māori health policy-making, the prevailing impression from the evidence is that the disestablishment of Te Kete Hauora also broadly sent the signal that Māori health was not a priority. The rescinding of the requirement for district health boards to prepare Māori health plans the same year and the cumulative signals sent in years prior by actions such as the removal of the Treaty from lower-level documents amplify this impression. Claimant witness Janet McLean's evidence alleging that the Bay of Plenty District Health Board restructured its Māori teams and roles after the Ministry disestablished Te Kete Hauora, which we discuss in the following section, is an example of this.[36] McLean said the board used the same rationale as the Ministry: that improving mainstream responsiveness would provide better results for Māori.[37]

8.3.2 District health boards

The Crown submitted information confirming that, currently, every district health board has at least one role in the top or second tier of their organisation that has responsibility for Māori health in their district. Most, though not all, report directly to the chief executive. The information provided does not give a full picture of the responsibilities of these roles: some appear to have direct reports and control of certain portfolios, while others operate in an advisory capacity.[38] In its closing submissions, the Crown argued this was another important way Māori are afforded decision-making responsibility, but it broadly accepted that there is variability in the remit, oversight, and budget holding of these roles.[39] Crown counsel highlighted the evidence of claimant witness Janet McLean, who worked as general manager planning and funding Māori health for the Bay of Plenty District Health Board, as evidence of how these roles can be effective, while acknowledging Crown witness Hector Matthews' evidence on the limitations he experiences in his current role.[40]

McLean worked for the Bay of Plenty District Health Board from 2001 to 2016.[41] Her position was on the executive team, with joint responsibilities and oversight

35. Transcript 4.1.5, pp106–107.
36. Document A15, para 33.
37. Ibid, para 36.
38. Memorandum 3.2.94(a), app 5.
39. Submission 3.3.32, paras 300–301.
40. Ibid, paras 303–305.
41. Document A15, para 4. Prior to that period, she held senior roles at the Hutt Valley District Health Board and in the Ministry, from 1991 onwards: doc A15, para 2.

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with the general manager planning and funding of the district health board's budget process.[42] In her written evidence, McLean stated:

> What is important to understand about this joint overall responsibility is that the structure put the Māori Health General Manager in direct control of funding for Maori providers. This is in stark comparison to other DHBs where this responsibility resides principally with the General Manager Planning and Funding. It meant that the Māori health team had equivalent staffing such as service development and contract management positions directly managing the Maori providers contracts. Another key difference was the mainstream planning and funding team managed contracts based on a portfolio focus eg aged care, mental health, primary health and population health under more of a siloed approach. The Maori health team focused on the provider relationship noting many Maori providers delivered a range of social and health services and therefore this required a more generalist approach.[43]

The seniority, responsibilities, budget holding, and team of reporting staff that were afforded under McLean's role, then, were significant. The remit of the role, which included control of funding for Māori providers, facilitated significant investment in Māori providers in the Bay of Plenty, such that the Bay of Plenty District Health Board invested more money in those organisations than any other district health board.[44] No other board gave equivalent roles this kind of budgetary oversight. The team helped ensure that the district health board also invested in non-Māori providers that were engaging in equity-focused or Māori-targeted initiatives.

McLean's evidence indicates that these efforts were specifically targeted to enhance equity and were calibrated to fund Māori and non-Māori providers and primary health organisations in a way that would mean high-needs patients, including Māori, would get the services they needed.[45] The team also worked with Tumu Whakarae (the national collective of Māori general managers of district health boards) to implement a number of other initiatives, including tools to help district health boards monitor Māori health outcomes and training on Māori health care provision.[46] McLean said unequivocally that 'effective Māori leadership' was a critical factor in the number and success of equity- and Māori-focused initiatives at the Bay of Plenty District Health Board.[47]

McLean said that these successes in the Bay of Plenty were secured in spite of resistance external to the team, who found themselves 'constantly fighting for and justifying the funding to Māori health'. Further, she said that the team often had to

42. Document A15, para 10.
43. Ibid.
44. Ibid, paras 13, 15.
45. Ibid, paras 15–19.
46. Ibid, para 21.
47. Transcript 4.1.4, pp 277–278.

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justify the existence of Māori providers.[48] In answer to Tribunal questioning about the attitudes of other senior personnel to Māori health issues, McLean said:

> It would be fair to say that Māori inequalities have been normalised in DHBs . . . it was very clear that they didn't want to have a conversation about institutionalised racism, it was never explicitly said but you could read the body language, you could understand when a conversation was not ready to be heard, it became a struggle because often part of the challenge of many Māori working in a DHB in the Ministry is having to frame the conversations in a way that are palatable so that they can be heard, so that they can be [understood], that wears you down. It wears you down.[49]

McLean said that about a year before she resigned in 2016 she became aware that the district health board was planning to restructure her role and team to focus on so-called mainstream responsiveness, which was the same approach taken with the disestablishment of Te Kete Hauora at the Ministry that same year. It was clear to us that she did not make the decision to resign lightly. The threat of neutering a team that could point to its successes in directly supporting and promoting kaupapa Māori models of care affected her deeply.[50]

The year after McLean resigned, the Bay of Plenty District Health Board restructured the Māori Health Planning and Funding Team, disestablishing her former role and dispersing most of the team's responsibilities across other units. She said that an ongoing restructure since then has 'created a culture of mistrust and grave concern for the state and future of Māori health in the Bay of Plenty'. This mistrust now extends, she said, to Māori providers' relationships with the district health board; Janice Kuka, the managing director of Ngā Mataapuna Oranga and the chair of several Māori providers in the Bay of Plenty, confirmed these relationships had deteriorated.[51] We agree with McLean's conclusion that 'The greatest concern is observing how the hard-fought gains achieved in Māori health over so many years by so many people can be so easily eroded.'[52]

Hector Matthews, who gave evidence for the Crown, confirmed that much of McLean's general experiences from working for a district health board reflected his own. He similarly confirmed that he has had to fight hard to progress Māori-specific health issues.[53] We were struck by his answers under our questioning:

> Q. . . . how much power do you actually have to say, 'This action is really important and must be in our plan?' I mean are you simply just advising or do you have the mana to insist that things are included?
> A. Yes, gee, that's a confronting question.

48. Ibid, p 274.
49. Ibid, p 287.
50. Document A15, para 35; transcript 4.1.4, p 288.
51. Transcript 4.1.4, pp 275–276; doc A12, para 40.
52. Transcript 4.1.4, p 276.
53. Transcript 4.1.7, p 175.

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Q. I mean if you were a finance specialist and you said, 'This is what it is,' everyone would fall over and go, 'Well yes, because money people know what they're talking about.' Well, does that happen for a Māori expert that Māori people know what they're talking about?

A. The short answer is no.[54]

He elaborated, saying that he felt that the chief executive of the Canterbury District Health Board does listen to his advice but that even small amounts of funding for minor initiatives can be difficult to push for in the context of the board's other priorities and pressures.[55] The annual budget holding for his role is $80,000, which he confirmed was likely similar for his equivalent roles across all district health boards, at least since McLean's former role was disestablished in 2016. He said that the money allocated to them essentially allows for them to 'work with iwi and hapū and run hui and provide kai.'[56]

The variability of the remit of these roles, as described in the Crown's submissions and in evidence, concerns us. The framework does not guarantee these roles consistently have effective oversight or decision-making when it comes to Māori health, including primary health care. Indeed, they are open to the kind of restructuring undertaken by the Bay of Plenty District Health Board, which in our view was a step backwards in terms of Treaty-compliance. We note Matthews' agreement under questioning that overall the mechanisms provided for under the primary health care framework do not consistently ensure good performance when it comes to Māori health inequity; instead, the system is often only as good as the people who work within it.[57]

Matthews' view was that the struggles of himself, McLean, and other Māori managers in district health boards are reflected amongst lower management and employment tiers of those organisations too. He said this was partly because, in spite of progressive gains made in New Zealand society, on the whole district health boards do not reflect Māori values.[58]

Crown witness Dr Nick Chamberlain confirmed that this tension was a specific focus of the Northland District Health Board, which has pursued several targeted initiatives to employ more Māori staff, develop the Māori nursing workforce in the district, and encourage more Māori secondary school students to pursue health as a career.[59]

The Northland District Health Board increased the proportion of Māori staff under its employ from 13.1 per cent in 2012 to 16.15 per cent in 2017.[60] Dr Chamberlain confirmed, however, that this increase was largely in lower-paid

54. Transcript 4.1.7, pp 209–210.
55. Ibid, p 210.
56. Ibid, p 211.
57. Ibid, p 178.
58. Ibid, p 174.
59. Document A66, paras 22–25; transcript 4.1.6, pp 103–104.
60. Document A66, para 23.

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roles.[61] Information subsequently provided by the Crown showed that an increase in the number of staff employed at all levels of the institution had occurred, but not in an even spread. The roles that have seen the largest proportional increase of employed Māori are made up of 'Healthcare Assistants, Orderlies, Cleaners and occupations that are considered non-regulated'. This group remained 'the highest employed occupation group for Maori' during the period where the Northland District Health Board was attempting to increase its number of Māori staff.[62]

This is plainly not a fulfilment of the spirit of the Northland District Health Board's recruitment drive. Given one of the reported barriers to access to health care is an objection to engaging with institutions that do not provide for the socio-cultural paradigm of Māori, this ideally needs to be reflected by the makeup of employed health practitioners, as well as senior staff.

8.3.3 Māori primary health organisations and providers

While the Crown did not make submissions on workforce retention in primary health organisations and providers, this issue was a significant one for the Māori Primary Health Organisations and Providers claimants. Janice Kuka spoke of how, in a primary care environment with scarce resources and not enough Māori health professionals, non-Māori organisations' efforts to develop their own Māori workforce sometimes came at a cost for Māori organisations:

> Many of our Māori GPs and senior Māori Nurses have chosen to move to BOP DHB [the Bay of Plenty District Health Board] and other less demanding general practices with the lure of better pay and less stressful working conditions. The poaching of Māori staff by BOP DHB from Hauora has been deliberate. DHBs and mainstream providers use the Māori person to make mainstream services appear more Māori friendly. It is very hard to accept after we have invested considerable time and resource on professional development, particularly in Kaupapa Māori ways of working. An example of this is an attempt by BOP DHB to lure a third Dietitian away from us at Te Manu Toroa.
>
> Our resulting workforce turnover is always consistently high and we are constantly understaffed adding to the pressure in managing both our clinics and primary care services. The staff often liken this pressure to working in a 'pressure cooker' all day. This situation can go on for months until we can fill vacancies. Our reputation as a PHO and employing organisation has suffered as a result.[63]

Piripi Hikairo similarly spoke of the same problems with workforce retention, particularly of skilled Māori clinicians, between Te Manu Toroa and the Bay of Plenty District Health Board.[64]

61. Transcript 4.1.6, p102.
62. Memorandum 3.2.19(a), app 3.
63. Document A12, paras 42–43.
64. Document A14, paras 43, 45.

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8.3.3

Pay parity is another issue and was a key concern of the Māori Nurses, who appeared as an interested party. Their counsel pointed out that, while nursing was recognised as intrinsic to the success of the reforms to primary health care, research indicates that 'significant pay disparities of up to approximately 25% exist for kaimahi who work in Māori and Iwi providers compared to their counterparts employed by the DHBs.'[65]

As such, this is as much an issue of the discrimination against nurses working for Māori providers as it is relevant to staff retention issues faced by those providers. Professor Tim McCreanor also agreed that funding pressures on Māori providers had acute impacts on their workforce: 'the funding structures that apply to Māori health providers are part of the structure of institutional racism that effectively drives down the pay of the workers in those places and contributes to disparity between different groups of nurses.'[66]

Kerri Nuku, for example, related that this amounts to a difference of 'up to $600 in a fortnight'. She further related the difficult working arrangements that many nurses are forced to enter into as a result:

> They go to work and work an eight-hour day and they go and pack the supermarket shelves at night to make up for their wages that they don't have enough of. With the increasing cost of living they're unable to meet those needs. For nurses that voluntarily now are sleeping in the backs of cars it's because they can't afford the rent; that's a reality.[67]

We heard that these pay discrepancies occur even between nurses with the same qualifications.[68] Further, we heard evidence on a bachelor of nursing degree offered at Whitireia Polytechnic, called the bachelor of nursing Māori, which appeared to be an effort in nursing workforce development. Nuku said that graduates with this degree are broadly seen as less qualified than those with a bachelor of nursing, despite the degree having the same status as a professional qualification as the bachelor of nursing and despite graduates having to pass the same standards and exam requirements.[69] Given the obvious need to develop the health workforce's overall competency in relation to culturally appropriate care for Māori, this evidence is particularly concerning to us.

Māori nurse Tracey Morgan, for example, highlighted how the Crown's insufficient resourcing of Māori providers translates into significant extra work for their staff.[70] Further, as pointed out by counsel for the Māori Nurses, Māori health professionals working in institutions that do not reflect Māori values, such as some district health boards, are asked to do work beyond their job description,

65. Submission 3.3.20, paras 144–145.
66. Transcript 4.1.5, p 253; doc A57, para 37.
67. Transcript 4.1.5, pp 253–254.
68. Submission 3.3.20, para 145.
69. Transcript 4.1.5, p 258; submission 3.3.20, para 122.
70. Document A39, paras 5–11.

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such as leading pōwhiri, but are still paid the same as their colleagues who do not have this expertise.[71]

Counsel for the Māori Nurses stated: 'Many Māori Nurses enter this career because they want to make a difference for their whānau, they want to care, but then when the system doesn't care for them, that becomes incredibly challenging.'[72]

It is unacceptable that Māori nurses are financially penalised if they choose to work for Māori providers, which are under significant strain from the way the Crown has legislated and organised primary health care. Māori nurses should not be paid less or have to tolerate adverse working conditions simply to work for an employer that reflects their values or to work for health providers that service their communities.

8.4 Inaction in the Face of Need

All parties variously agreed that the severity and persistence of health inequity Māori continue to experience indicates that the health system is institutionally racist and that this, including the personal racism and stereotyping that occur in the primary care sector, particularly impacts on Māori. We accept that institutional racism is a determinant of health and wellbeing.[73] The director-general acknowledged this at hearings:

> Q. Would you agree that racism is also a determinant of health?
> A. Yes, I would and this is one that we have learnt a lot more about over recent years and continuing to learn. I think we have now some quite good evidence that racism at a range of levels does determine access to experience of and outcomes in the health care system.[74]

We heard that institutional racism manifests in a variety of different ways in primary care. We saw these terms as essentially two sides of the same coin: as ways of identifying, and ideally explaining, unconscious bias or conscious indifference, or indeed the prevalence and cumulative effects of both. Whatever the form of racism, it ultimately results in discrimination, indicating Treaty non-compliance. It is the Crown's obligation to ensure that the health system is upholding the Treaty and its principles, including the guarantee of freedom from discrimination for Māori citizens. Māori should not experience disadvantage based on the mere fact of their identity.[75]

The history of Treaty breaches, then, is part and parcel of the explanations for the social determinants of Māori health. Evidence and submissions from all parties, including the Crown, acknowledged that the legacy of colonisation

71. Submission 3.3.20, para 128.
72. Ibid, para 149.
73. Document A51, para 17.
74. Transcript 4.1.5, p 421.
75. Document A46, para 5.

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manifests itself in the lived experience of Māori as a population group today.[76] Māori experience a wide range of socio-economic inequities that the Tribunal in previous reports has linked to colonisation and breaches of the Treaty compact. In these ways, and more, the colonisation of New Zealand and its ongoing impacts are as much a determinant of Māori health outcomes as any other, and continue to manifest as institutional racism.

The definition of institutional racism the claimants and interested parties broadly used was 'inaction in the face of need'.[77] This echoes the definition of health equity discussed in chapter 5: that population groups with the highest levels of need should receive attention and resources proportionate to that need. If a system is not doing this, it is not an equitable system. When tested against this definition, much of the evidence we have traversed and made findings upon in preceding chapters indicates that the framework is institutionally racist.

For example, funding arrangements for primary care disadvantage Māori as a population group, particularly Māori with high health needs or co-morbidities or both. Because the collective fallout from inadequately directing funding to a large extent follows racial lines, whether intentionally or not, funding arrangements for primary care are institutionally racist.

We further note that both systems and individuals can perpetuate unconscious bias and conscious indifference. The primary health care system exhibits some biases because of its framework and how that framework's various mechanisms operate in practice. Dr Heather Came-Friar stated:

> I think that institutional racism doesn't have to be deliberate. It can be the unintended you know outcome of well-intentioned people. I am sure that the people that wrote the Primary Health Care Strategy weren't trying to write a document that was going to produce institutional racism. But I think what we have is definitely a gap between policy and practice and we've got problematic policy. But I think it's a failure in imagination, it's a failure in monitoring, it's a failure in reporting and it's a failure for consequences for poor performance.[78]

Again, the Crown is responsible for identifying institutional racism, in partnership with Māori, and for implementing solutions to mitigate its impact. The Crown's failure to adequately identify or address problems with primary care funding is another manifestation of institutional racism. Similarly, the Crown's failure to institute mechanisms that ensure that Māori health outcomes are measured and reported on in a robust way undermines the ability of the system to improve the design and delivery of Māori health care. This, in turn, impacts on the way that Māori experience and receive care. We accept the evidence of claimant Simon Royal, which stated that ineffective accountability and monitoring of

76. Document A57, paras 8–9; doc A46, para 6; submission 3.3.4, para 13; submission 3.3.30, para 2.8.1; transcript 4.1.5, pp153–155, 432; transcript 4.1.6, p259; transcript 4.1.7, pp160, 167.
77. Transcript 4.1.5, p53.
78. Ibid, p211.

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health entities fosters the prevalence of institutional bias and racism in the health system.[79]

Other manifestations of institutional racism include common terms and language used in the health system to describe Māori health outcomes. Director-General Dr Bloomfield agreed that the deficit-oriented language commonly used by health professionals contributes to negative stereotypes of Māori. He said that the use of the term 'hard to reach' in primary care settings to describe Māori and other non-Pākehā population groups, for example, was not constructive, and he agreed that it diminishes Māori. He clarified that the language should be reoriented to capture that it was a failure to deliver health care, rather than a failure on the part of individual Māori.[80]

Crown witness Hector Matthews agreed, saying that this attitude does not account for the myriad complexities that arise from social determinants of health, remarking as an example that, if one is struggling to feed one's family, the cost of a visit to a doctor may not be a priority.[81]

As such, Crown witnesses agreed that the onus is on the health sector to improve its service delivery with a view to seeing every citizen receive the care that they need but that the subtlety of language can undermine this effort. This is reflected in Ministry-funded research by the Eru Pōmare Health Research Centre, which describes that, through the use of deficit-oriented language, 'Māori move from being normal to being 'different' from Pākehā . . . norms'. This thinking normalises the idea that the 'problem' lies with Māori: thus, they receive 'lower levels of health services and poorer quality of service'. Over time, even some Māori are pressured into believing the problem lies with themselves.[82] Piripi Hikairo said:

> In my experience a number of doctors and the Bay of Plenty District Health Board ('DHB') consistently state that Maori are not 'compliant' meaning that they do not take their medicine or listen to their doctor. However, most doctors work on the basis of seeing a set number of clients per hour, and are frustrated by the pathology of Maori who have multiple ailments and therefore require more time.
>
> I firmly believe that for Maori to appropriately understand their health requirements and to be 'compliant', it is necessary for health providers to understand the cultural and holistic view of Maori rather than treating them exactly the same as non-Maori.[83]

Again, while some of these manifestations of racism are unconscious, conscious biases still impact on the way that Māori experience primary health care. All parties accepted that personal racism of individuals towards Māori is still a feature of

79. Document A23, para 8.
80. Transcript 4.1.5, pp 402–403.
81. Transcript 4.1.7, pp 162–163.
82. Bridget Robson and Ricci Harris, eds, *Hauora: Māori Standards of Health IV – A Study of the Years 2000–2005* (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 2007), pp 4–5.
83. Document A29, paras 8–9.

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the primary health care system.[84] The claimants broadly said that, as professionals and clinicians involved with Māori primary health organisations and providers, they were not taken seriously by non-Māori in the same sector. Matthews said that people in the primary health care system still do not believe that Māori health clinicians and professionals are competent when it comes to policy and strategy design, even when it is specific to Māori health.[85] Other witnesses, such as the Māori nurses who appeared before us, related similar experiences.

Matthews related his own personal experience:

> I'm a 53-year-old Māori male and I have confronted racism my entire life, and it ebbs and flows, and it chops and changes, and once I got a bit more educated and a bit more articulate, some of those racists shut themselves down a wee bit and wouldn't argue with me because I can argue the toss with them, sometimes, some are clever[er] than me and I can't. But, you know, racism in its covert and overt forms exists everywhere and we see examples of that, not just in health, all over New Zealand society.[86]

Matthews made the point that institutional racism and individual biases around Māori capacity mean that, even when the data plainly points to inequities or an area that needs focus, sometimes that advice is still ignored by clinicians.[87]

Clearer and freer accountability to the public, then, could assist in shifting or at least overriding these biases.

Indeed, as Matthews described, it is about not the individual culpability of specific general practitioners who are making conscious or unconsciously biased decisions about treatment but rather the cumulative effects of these actions.[88] He elaborated:

> individuals cumulatively are making biased decisions and we're not confronting that issue, what we are saying is that the system needs to improve access, that is good, the system does but what we find in Canterbury is Māori access Primary care at the same rate as Pākehā so access isn't the issue and yet we still have more Māori diagnosed in ED with Cancer than they do at the GP. Despite the fact that they have gone to the GP, so what that means is individuals cumulatively are making biased decisions and we're not confronting that as a society. That is the big mammoth in the room.[89]

Professor Jacqueline Cumming confirmed that this is true nationally: on average, Māori children see general practitioners and primary care nurses at the same rate as non-Māori. Māori adults are in fact seeing general practitioners and primary care nurses at a rate higher than non-Māori. Despite this, Māori have on

84. Submission 3.3.32, para 42; transcript 4.1.5, pp 22, 45–46, 154–155, 198.
85. Transcript 4.1.7, p 165.
86. Ibid, p 167.
87. Ibid, p 160. Teresa Wall made similar comments in relation to the kind of action that should, in her view, be prompted by data showing lung cancer rates for Māori women: transcript 4.1.5, p 115.
88. Transcript 4.1.7, p 167.
89. Ibid, p 168.

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average the highest levels of unmet need of any population group.[90] If the system was truly equity-focused and was focusing resources and attention adequately on population groups with the highest need, this would not be the outcome of an average of higher visitation rates. Notwithstanding the complexity of health determinants, the primary health care system itself is not calibrated to address Māori needs.

Actions that contribute to experience of personal and institutional racism, especially on the scale indicated by the evidence before us, are breaches of the Treaty principles.

8.5 Providing Culturally Appropriate Services

The way in which health services are delivered, and the nature of the institutions that deliver them, impacts the pursuit of health equity for Māori; as such, the Crown is required to inform itself of these access issues, and address them. It is worth repeating again this passage from the Tribunal's *Te Urewera* report, which we included in chapter 3:

> A 'one-size-fits-all' model tends in practice to suit the needs of the majority, who are rarely the group in most need of help. Even when they can access mainstream aid and services, minority groups such as Māori have often found that what is being provided simply does not work for them, or is so alienating that they prefer to disengage.[91]

Over the course of the hearings for stage one of this inquiry, we were consistently reminded that one of the central goals of the primary health care reforms was the provision of accessible, community-led primary health care as a framework for coordinating care around defined population groups and reducing health inequities.[92] The Crown has a Treaty obligation to ensure that health services are culturally appropriate. This is important because, as the passage from the *Te Urewera* report illustrates, providing care in a way that respects and understands Māori sociocultural paradigms is a care access issue, and impacts on the quality of health care received or, indeed, dictates whether care is received at all. Māori occupy the most deprived deciles of the population when compared to other ethnic groups. However, compounding that is the fact that Māori cultural needs, spiritual beliefs, and social attitudes and priorities may differ from those of other population groups that live in those same areas. As such, ensuring care is culturally appropriate ensures equitable access to care.

This link between access to and quality of health care and the recognition of sociocultural difference is broadly captured by the concept of cultural safety, developed as a training programme for nurses in New Zealand in the 1980s and

90. Document A60, para 56.
91. Waitangi Tribunal, *Te Urewera*, 8 vols (Wellington: Legislation Direct, 2015), vol 8, pp3776–3777.
92. Ministry of Health, *Minimum Requirements for Primary Health Organisations* (Wellington: Ministry of Health, 2001), p 3.

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1990s. Cultural safety intends to recognise that sociocultural difference manifests, in part, as a power imbalance between different ethnicities. It recognises the dynamics of institutional racism: that tikanga and mātauranga Māori, while centrally important to many Māori, are not recognised as 'ordinary' in the nation as a whole and, as a result, are not often properly provided for by institutions.[93] In this way, cultural safety recognises not just that services need to be *culturally appropriate* but that, if services are delivered inadequately, then the delivery method of those services *can become a negative determinant of health outcomes.*

Adequate support of Māori organisations who design and deliver kaupapa Māori models of care is central to providing culturally safe and appropriate care. The reforms to primary care were accompanied by optimism from Māori involved in primary care. Repeatedly, we heard that Māori saw a fresh opportunity to design and deliver better health care to their own people and to narrow the inequity between the Māori and non-Māori health outcomes.

This optimism was reflected in the Māori primary health organisations that were eventually established. Counsel for Janice Kuka and Lady Moxon said that, at the peak, there were 14 Māori primary health organisations; today, only four of these organisations remain.[94] We have already established not only that the funding and accountability arrangements for primary care are insufficient to address Māori health inequity but that they also actively disadvantage Māori primary health organisations and providers. The sustainability issues these organisations experience largely reflect the cost of Crown inaction. Keriana Brooking acknowledged that the Crown has not adequately supported Māori primary health organisations and that as a result some have had to close.[95]

Crown witnesses nonetheless agreed with the claimants that Māori primary health organisations and providers are innovative and have achieved impressive improvements in Māori health outcomes despite the limitations of the primary health care system. They broadly agreed that these organisations should be considered benchmarks for the approaches and performance of the rest of the sector.[96] The work of Māori primary health organisations and providers presented to us in this hearing demonstrates that they are faithful to the spirit of the reforms to primary care. As Professor Cumming acknowledged, much can be learnt from these organisations' approaches to care and their many successes in relation to addressing health inequities.[97]

Claimant counsel broadly agreed with Professor Cumming, arguing that Māori primary health organisations were truer to the original intent of the Primary Health Care Strategy than the bulk of the primary health sector.[98]

It appears to us that Māori organisations provide culturally safe care in ways that other parts of the primary care sector should emulate, where appropriate. To

93. Submission 3.3.20, para 191–192.
94. Transcript 4.1.4, p 27.
95. Document A62, para 345; submission 3.3.32, para 47.
96. Transcript 4.1.5, pp 482–483; transcript 4.1.6, p 62; transcript 4.1.7, pp 159, 275.
97. Transcript 4.1.7, p 74.
98. Submission 3.3.18, para 85; submission 3.3.30, para 5.101.

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do so, Māori organisations require adequate financial and logistical support. Piripi Hikairo described the approach forwarded at Te Manu Toroa, a Māori provider in the Bay of Plenty:

> Our clinics are culturally safe in a complex environment as we provide cultural training with a difference. It is unique [insofar] that staff, Māori or non-Māori, can recite karakia, partake in waiata, greet in Māori and understand and provide services within our values. Annexed and marked 'B' is an *Introduction to Kaupapa Māori* programme document which is the basis of the training that we provide to all new Te Manu Toroa staff. We adapt the programme as is appropriate, but Kaupapa Māori training is a very important part of working with us, and I believe something that mainstream providers cannot and do not give all of their staff.[99]

Such organisations are rooted in te ao Māori. We heard repeatedly that the broader primary care sector generally fails to recognise and provide for the particular cultural, as well as health, needs of Māori.

In this regard, we heard that the optimism expressed by Māori for primary health organisations and providers after the primary care reforms stemmed from their view that these structures could provide for tino rangatiratanga and mana motuhake.[100] Counsel for Taitimu Maipi and Hakopa Paul stated that the claimants felt that 'the recognition of their tino rangatiratanga and mana motuhake are the overriding considerations in the area of primary health care'.[101] The claimants broadly related that, in relation to health, tino rangatiratanga extended both to the control of these organisations and the kaupapa Māori systems and models of care that they wanted to entrench and also to their right to sustain and develop the health and wellbeing of their communities. Lady Moxon said:

> The reason we established Toiora PHO was a matter of survival. We were three small Māori Health Providers and at the time of establishing the PHO had a combined population of 6,000. The exciting thing about PHOs was that they were promoted as being community owned, governed and led. PHOs were an opportunity for community groups to exert our own Mana Motuhake and Tino Rangatiratanga in our own communities.[102]

Janice Kuka, recalling the outset of the primary care reforms, outlined the motivations behind applying to have a Māori primary health organisation in the Bay of Plenty:

> Driving this request was the desire for Ngā Mataapuna Oranga and Hauora to build on the gains we had made and move us closer to tino rangatiratanga over our own

99. Document A14, para 29.
100. Document A13, para 16.
101. Submission 3.3.23, para 32.
102. Document A11, para 19.

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> health business . . . because PHOs were designed to be purchasers of health services. That means that instead of just seeing people who come in sick every day and being reactive, we could look at a health problem across a population and be strategic about how to front foot dealing with it. And we could do it in line with Kaupapa Māori values. This approach requires working in partnership with Iwi and Hauora to develop Māori designed solutions and cultural approaches rather than continuing to attempt to get Māori to fit within western systems that more often than not fail.[103]

Henare Mason said:

> I believe there was an exciting opportunity in the introduction of the PHO concept, particularly in that [it] promoted an opportunity for Māori Providers to exercise our own Mana and Tino Rangatiratanga within their own communities, by being community owned, governed and led. With the assumption that this would allow Māori PHOs to coordinate the services of their networks, implement sustainable options by delivering services to Māori and keeping intact their commitment to Kaupapa Māori philosophy – empowering Māori communities to come together to control their own Primary Health Care futures.

To the claimants, then, tino rangatiratanga provides for a truly holistic definition of hauora Māori, one that encompasses both the Māori structures and models that provide for hauora and the people that those structures and models are for.

We consider that tino rangatiratanga over hauora Māori should be an intrinsic facet of a Treaty-compliant primary health system. Māori-led primary health organisations and providers must have the capacity, and space, to exert their tino rangatiratanga in the primary health care system.

As counsel for Lady Moxon and Kuka said in her opening submissions, Māori primary health organisations have 'never had the opportunity to take control of looking after the health of their member population in a proactive holistic way'.[104] This has taken a deep personal toll on Māori health professionals and clinicians, as Kuka highlighted in her evidence:

> [Ngā Mataapuna Oranga faces] additional difficulty in recruiting the relevant qualified Māori and general practice workforce. Often our clinics were understaffed and placed under extreme pressure due to the complexity and acute illness of our presenting patients. Many of our Māori staff have found working in our clinics and Hauora overwhelming. Not only are they required to care for the physical needs of the Whānau and patients but they are also having to deal with the social situations that these same Whānau are confronted with every day. Staff and patients are often living in the same communities. This eventually takes its toll on staff and they leave.[105]

103. Document A12, para 21.
104. Transcript 4.1.4, p 27.
105. Document A12, para 41.

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Piripi Hikairo said the same of Te Manu Toroa:

> When we first started, the passion was huge and the community was beside us. But it has been a struggle after that because people need to earn enough to live and we can't afford to pay staff to meet their cost of living. The dedication from when people initially came to see us is fading, because we have difficulty providing the long term care our sick people need under today's financial constraints and increased demand.[106]

We saw this, too, in the evidence of Janet McLean and her difficult decision to resign from the Bay of Plenty District Health Board. We saw it in the passion Dr Rawiri Jansen had for the National Hauora Coalition's kaupapa Māori programmes.[107] It was also clear in the evidence of Taitimu Maipi, who highlighted the importance of whānau ora and who said plainly and forcefully that the persistence of Māori inequities is unacceptable and must be addressed.[108]

We agree that it is unacceptable that the health of the most vulnerable whānau is under threat because of the way that the primary health system is organised and monitored. The Treaty partnership envisioned in *Ko Aotearoa Tēnei*, where the Crown provides financial and logistical support but otherwise gives effect to tino rangatiratanga, has not yet been achieved in primary care.[109] As the Tribunal stated in *Turanga Tangata, Turanga Whenua*, giving effect to tino rangatiratanga is 'the single most important building block upon which to re-establish positive relations between the Crown and Maori'.[110]

8.6 Tribunal Findings

In this chapter, we have covered a relatively broad range of evidence, from the recognition and incorporation of mātauranga Māori by so-called 'mainstream' entities to the broader experiences of Māori clinicians, health professionals, and patients under the primary health care system. The Crown's legislative and policy arrangements for primary care do not, either in the ways they are designed or in the ways they are implemented, afford Māori the central role they are guaranteed under the Treaty. Being given the opportunity to merely add commentary to the margins is not consistent with the principle of partnership and certainly does not recognise mana motuhake and tino rangatiratanga rights in the primary care sector.

106. Document A14, para 46.
107. Transcript 4.1.4, pp533–541.
108. Ibid, p43.
109. Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims concerning New Zealand Law and Policy Affecting Māori Culture and Identity: Te Taumata Tuatahi* (Wellington: Legislation Direct, 2011), pp161–162; Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims concerning New Zealand Law and Policy Affecting Māori Culture and Identity, Te Taumata Tuarua* 2 vols (Wellington: Legislation Direct, 2011), vol 2, p559.
110. Waitangi Tribunal, *Turanga Tangata, Turanga Whenua: The Report on the Turanganui a Kiwa Claims*, 2 vols (Wellington: Legislation Direct, 2004), vol 2, p739.

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The flawed process that the Crown followed when designing the reforms to primary care and the demise of Te Kete Hauora is emblematic of this inadequate support. Similarly, we are concerned that Māori are significantly under-represented in the health sector, both in the Ministry and in every medical profession. What we saw as the essence of the claimants' allegations – that the primary health sector is fundamentally based on and designed for a community that is already in good health – is borne out by these statistics. Māori are scarcely reflected throughout the system itself, whether in its upper echelons or in medical professions directly responsible for delivery of care. We are concerned that this is evidence of further Crown omissions in relation to workforce development.

Nonetheless, for now, we find that:

- the Crown did not design the primary health care framework in partnership with Māori; and
- the disestablishment of Te Kete Hauora, and the failure to replace it at the time, is a breach of the Treaty principles of equity and active protection.

We are pleased that the Ministry has decided to establish a Māori health directorate, seemingly confirming that a unit focused on Māori health is an intrinsic part of designing and providing health care to Māori.[111] The role, oversight, and support given to a Māori-focused team, unit, or agency should be given careful thought going forward.

As we concluded in section 8.5, Māori are guaranteed tino rangatiratanga rights over hauora Māori, which encompasses Māori organisations and their models of care, and Māori people who need to access these models of care. In the present system, hauora Māori is considered lesser in value or priority, even though hauora Māori is in greater need of active support. This dynamic is inconsistent with the Treaty.

Further, in order to have a Treaty-compliant primary health care system, the Crown needs to support models of health care that are culturally appropriate for Māori. Māori primary health organisations and providers are central to the development of these models of care. The Crown has failed to properly recognise through its actions that the work of these organisations, and the people that work for them, is intrinsic to pursuing Māori health equity. Tino rangatiratanga of hauora Māori is necessary to pursue health equity. Tino rangatiratanga of hauora Māori will not be possible without more active support from the Crown.

We have already found Treaty breaches regarding the inadequate funding of primary care and the impact this has, both on Māori who need to use health services and on Māori organisations. Given these breaches, and taking into account the matters discussed in this chapter, we find that:

- the primary health care framework does not recognise and properly provide for tino rangatiratanga and mana motuhake of hauora Māori. This is a breach of the Treaty's active protection of tino rangatiratanga, as well as a breach of the principles of partnership, active protection, equity, and options.

111. Document A59, para 48.

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CHAPTER 9

PREJUDICE AND RECOMMENDATIONS

Whakataka te hau ki te muri;
Whakataka te hau ki te tonga kia mākinakina ki uta;
Kia mātaratara ki tai kia hiia ake te ātākura, he tio, he huka, he hau-hūnga

9.1 Prejudice

Our task in stage one was to focus on the legislative and policy framework of New Zealand's primary health care system and its alleged flaws, when assessed against the principles of the Treaty of Waitangi. We focused on four specific areas: the Treaty-compliance of the Act and framework; funding; accountability; and the nature of Treaty partnership arrangements in the primary health care sector. In each of these areas, we found that the Crown acted inconsistently with the principles of the Treaty. Thus, we find that the claims of the Māori Primary Health Organisations and Providers (Wai 1315) and the National Hauora Coalition (Wai 2687) are well founded.

We accept that the primary health care legislative and policy framework broadly cannot address all the determinants of health. We also are aware that this report is the result of stage one of a continuing inquiry process that will investigate the design and provision of health care beyond the scope of what we have covered here. Even when taking these factors into account, the legislative and policy framework of the primary health care system fails to address adequately the severe health inequities experienced by Māori. Further, the Crown failed to lead and direct the primary health care system in a way that adequately supported and resourced Māori to design and provide for their own wellbeing through designing and delivering primary health care to Māori. The Crown's failures prejudicially affect the ability of Māori to sustain their health and wellbeing.

The prejudice suffered by Māori because of these Crown failures is extensive. The legislative and policy framework is insufficient in and of itself, and the Crown's renewed, specific commitments to improve Māori health are not enough to negate this insufficiency on their own. However, we are particularly concerned that the evidence before us indicates that some of the framework's provisions, intended to improve Māori health outcomes and give Māori input into how primary health care is designed and delivered, were not fully implemented or in some cases ceased to operate entirely. This is unacceptable. We reiterate that the depth of inequity suffered by Māori, and particularly the fact that it has not measurably improved in the two decades since the framework was put in place, mean that the Crown's failures are very serious.

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9.2 RECOMMENDATIONS

Our analysis and findings in this report into the Māori Primary Health Organisations and Providers and National Hauora Coalition claims are final, and this is reflected in our recommendations. However, we have also made several interim recommendations where we have asked the stage one claimants and the Crown to report back to us on certain matters by 20 January 2020. Where the recommendations are interim, we have clearly indicated so. Some of the interim recommendations reflect the fact that a wider discussion is needed involving other Māori stakeholders in the health sector.

In making our recommendations, we are conscious that there are other primary health-related claims that have yet to be heard. Previously, we signalled that we will hear from those other claimants on whether the Health Services and Outcomes Kaupapa Inquiry process we have pursued to date needs to be redesigned to allow for broader inquiry into other primary health-related claims. This will be an agenda item at yet to be held forthcoming judicial conferences, which will address the future planning of the overall inquiry.

Given the scope of stage one of this inquiry, we have exercised caution in making our recommendations. Our expertise is the Crown–Māori Treaty relationship. In this inquiry, that requires an assessment of the Crown's performance as it relates to the primary health care legislative and policy framework. This report outlines the Treaty standards that in our view will make the framework Treaty-compliant. With this in mind, we begin with two overarching recommendations.

9.3 OVERARCHING RECOMMENDATIONS

9.3.1 The Treaty of Waitangi and its principles

In chapter 5, we found that the New Zealand Public Health and Disability Act 2000 does not give proper and full effect to the Treaty or its principles and is not Treaty-compliant. We found that He Korowai Oranga and its articulation of '"partnership, participation and protection"' does not adequately reflect the Treaty or its principles. We considered that the removal of specific Treaty references from lower-level documents amounted to a concerning omission of the health sector's Treaty obligations. When viewed collectively or individually, these omissions by the Crown constitute breaches of the Treaty principles of partnership, active protection, and equity. As such, we are of the view that the relationship between the Crown and Māori in primary health needs in future to provide for an enhanced commitment to the Treaty of Waitangi and its principles.

We recommend that the Crown ensure that the legislative and policy framework of the New Zealand primary health care system recognise and provide for the Treaty of Waitangi and its principles.

Such a commitment starts with the relevant legislation, currently section 4 of the New Zealand Public Health and Disability Act 2000. We recommend that section 4 be amended to read as follows:

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4 **Treaty of Waitangi and its principles**
This Act shall be interpreted and administered so as to give effect to the principles of the Treaty of Waitangi.

In this inquiry, we found that the Crown has failed to ensure that everyone who works in the primary health care system is aware of their Treaty obligations. The Crown's failure to abide by its Treaty obligations and ensure that its agents and the health sector as a whole are doing the same has contributed to the dire state of Māori health outcomes. It cannot continue to evade its obligations. We say this because the health inequities experienced by Māori compel an urgent, and thorough, intervention. The commitment to recognise and provide for the Treaty of Waitangi and its principles must be embedded at all levels of the primary health system and in all the relevant documents that make up the framework.

To this end, we found that the Crown's 'three Ps' articulation of Treaty principles is outdated and needs to be reformed. While the Crown accepts that is the case, it has submitted that updated principles for the health sector should be developed and articulated as part of a draft Māori health action plan.[1] We consider that proposal unnecessary.

We recommend that the commitment to recognise and provide for the Treaty of Waitangi and its principles should not be limited to a Māori health strategy and any Māori health action plan. The commitment should be stated expressly in all documents that make up the policy framework of the primary health system: the strategies, the plans, and the so-called lower-level documentation.

We recommend that the following are adopted as the Treaty principles for the primary health care system:

(a) The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of primary health care.
(b) The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
(c) The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well-informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
(d) The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

1. Submission 3.3.32, para 58.

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(e) The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

9.3.2 Equity

We found that the dominant language in the legislation and policy framework is 'reducing disparities' or 'reducing inequality', rather than a commitment to achieving equity of health outcomes for Māori. We reiterate that including an expressly stated, stand-alone commitment to achieving health equity should not be controversial. Achieving health equity should be among the ultimate purposes of any just health system.

We recognise that complexities are at play. All parties to this inquiry, including the Crown, are aware of the impact of the social determinants of health and the ongoing impact of colonisation and institutional racism. While the commitment to achieve equitable health outcomes for Māori must be enduring, the contemporary circumstances heighten, under the principles of active protection and equity, the Crown's obligations to act to address these inequities.

We recommend that the Crown commit itself and the health sector to achieve equitable health outcomes for Māori.

That commitment starts with the legislation. We recommend that:

(a) section 3(1)(b) of the New Zealand Public Health and Disability Act 2000 be amended to read as follows: 'to achieve equitable health outcomes for Māori and other population groups'; and

(b) section 3(2) remain as is, to account for prevailing factors.

We recommend that the commitment to achieve equitable health outcomes for Māori is expressly stated in all documents that make up the policy framework of the primary health system: the strategies, the plans, and the so-called lower-level documentation.

9.4 Structural Reform – an Independent Māori Health Authority

Both claimant groups have said that the Crown has led and controlled the design, structure, and resourcing of the primary health system. This system has not addressed Māori health inequities in a Treaty-compliant way, and this failure is in part why Māori health inequities have persisted. In response, the claimants seek recommendations from the Tribunal that an independent Māori health authority be established.

The Māori Primary Health Organisations and Providers claimants led evidence on and sought recommendations that New Zealand adopt a model of health similar to an Alaskan model of indigenous health – the NUKA model. The National Hauora Coalition claimants sought a recommendation that the Crown establish an independent statutory Hauora Authority. Further, they said that this authority should have similar legal status to an autonomous or independent Crown entity under the Crown Entities Act 2004, such as the Accident Compensation

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Corporation or Pharmac, and should carry out a variety of functions, including providing services, procuring services from providers, commissioning for outcomes, and developing and providing policy advice.

The recommendations sought in this respect reflect the evidence we heard for recognition of tino rangatiratanga and mana motuhake in the design, delivery, resourcing, and control of Māori primary health.

We observe that the demand for structures and services that are 'by Māori, for Māori' across all sectors of social service design and delivery is a current and future reality that successive governments of the day will face. That demand will not diminish; it will only increase in the years to come. The Tribunal has made clear in its previous reports that co-governance, particularly in social service design and delivery, is not only an essential part of upholding the Treaty relationship but also essential to the improvement of Māori socio-economic status. The Crown should be making policy decisions with a view to fulfilling this Treaty obligation under the principle of partnership and to recognise tino rangatiratanga.

In responding to a call from one claimant counsel that it 'should work in partnership with Māori' to come up with and implement reforms to the primary health care framework, the Crown submitted that 'the Health and Disability Review is supported by a Māori Advisory Group' and that its recommendations will be 'discussed between the Treaty partners'.[2] This is certainly part of a partnership process but is not on its own a reflection of the joint obligations under the principle of partnership. Co-design must be manifested through a more robust engagement between Treaty partners.

We recognise that the Ministry is the steward of the New Zealand health system. It has responsibilities to deliver health services across all levels of the health system, not just primary health and not just for Māori. We understand that the health system is complex and resource hungry, but the Crown must do better in meeting its obligations to Māori arising out of the Treaty relationship.

We make an interim recommendation that the Crown commit to exploring the concept of a stand-alone Māori primary health authority.

This recommendation is an interim one for several reasons. We are conscious that we heard evidence from only two out of the four Māori primary health organisations. We also heard evidence from some Māori providers, but not all. The positions of non-Māori primary health organisations and providers, which deliver most primary health services to Māori, should also be considered. The claimant groups intend this new authority to be involved not just in primary health care but in all types and levels of health care. We have not heard from all Māori stakeholders in the primary care sector, and we certainly have not heard from any stakeholders beyond primary care.

We are also conscious that both claimant groups sought a recommendation that either a NUKA-based model or an independent Māori health authority has a much wider ambit than primary health and covers both secondary and tertiary health care. We have not gone as far as that yet because the claims before us are focused

2. Submission 3.3.32(a), p 1.

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on the legislative and policy framework of the New Zealand primary health care health system, not the entire health system.

We make further interim recommendations that:

(a) Within the next seven months, the Crown and representatives of the Wai 1315 and Wai 2687 claimants design a draft term of reference to explore the possibility of a stand-alone Māori health authority. We direct that the Crown and the Wai 1315 and Wai 2687 claimants file a joint memorandum by 20 January 2020 updating the Tribunal on progress. If the parties are unable to agree on filing a joint memorandum, they may file separate memoranda.

(b) The Crown fund the process and provide the necessary secretariat support.

We reserve the right to review these interim recommendations and make further recommendations depending on the outcome of this process.

Our recommendation only mentions the representatives of the Māori Primary Health Organisations and Providers and the National Hauroa Coalition for the initial seven-month period. This is because they are the groups that undertook the responsibility for the prosecution of these claims. Our reasoning is also pragmatic. The process must start with someone, somewhere. We would not like to see the first step delayed by a failure to agree upon who should be involved in that process.

If a draft term of reference is agreed upon, it should then go out for consultation and discussions with the wider Māori primary health sector. Obvious entities to involve would be the two Māori primary health organisations and other Māori providers that we have not heard from, and mainstream primary health organisations that have a significant number of Māori enrolled patients. Groups that appeared before us as interested parties, such as the Māori Medical Practitioners Association, the Māori Nurses, and the New Zealand Māori Council, would no doubt wish to be involved. Representative iwi entities may also wish to participate.

To reiterate, we have specified only that the terms of reference should explore the possibility of a stand-alone Māori health authority. As experts in primary health care design and delivery, we are confident that the parties are best placed to formulate the rest of the terms of reference between them.

9.5 Specific Recommendations

What follows are a series of specific recommendations to the existing framework. We make these recommendations based on the assumption that the recommendations outlined earlier may take some time to be fully implemented.

9.5.1 Funding

In chapter 6, we discussed the initial funding of Māori primary health organisations. In broad terms, we found that the funding at the time of the establishment of primary health organisations was variable and, as such, disadvantaged Māori organisations and Māori patients with high needs. For some Māori primary health organisations, that resulted in severe underfunding.

We make interim recommendations that:

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(a) Within the next seven months, the Crown and representatives of the Wai 1315 and Wai 2687 claimants agree upon a methodology for the assessment of the extent of underfunding of Māori primary health organisations and providers. The methodology should include a means of assessing initial establishment and ongoing resource underfunding since the commencement of the New Zealand Public Health and Disability Act 2000. We direct that the Crown and the Wai 1315 and Wai 2687 claimants file a joint memorandum by 20 January 2020 updating the Tribunal on progress. If the parties are unable to agree on filing a joint memorandum, they may file separate memoranda.

(b) The Crown fund the process and provide the necessary secretariat support.

We reserve the right to review these interim recommendations and make further recommendations depending on the outcome of this process.

We recognise that there is a compensatory aspect to this process, in that it responds to acknowledged historical underfunding. However, we make no recommendations at this stage as to the final destination of any such compensation. Compensation is a matter that is complicated by the fact that many of the initial Māori primary health organisations and providers no longer exist. Our initial thinking is that, if a final sum can be agreed upon, first, it could be used in part to compensate those Māori primary health organisations and providers still in existence and, secondly, it could be future-focused, perhaps with a view to supporting the development of additional Māori primary health organisations and providers. We think these matters should form part of the development of the methodology we recommend.

In relation to the capitated funding formulas, we have found that the formulas disadvantage primary health organisations and providers that predominantly service high-needs populations and particularly impact on Māori-led primary health organisations and providers that predominantly serve these populations. Further, kaupapa Māori models of care are not adequately recognised or resourced by these funding arrangements. The Crown failed to amend adequately or to replace those funding formulas, despite being well-informed that they were insufficient and that its attempts to fix them were not working to the nature and extent required by the health needs of Māori.

We recommend that the Crown conduct an urgent and thorough review of the funding for primary health care, to better align it with the aim of achieving equitable health outcomes for Māori.

9.5.2 Accountability

In chapter 7, we discussed how the health sector is held to account for pursuing Māori health equity. We discussed the standards and processes used in the planning, measuring, and monitoring undertaken by the numerous entities in the primary health sector. The evidence confirmed to us that the existing accountability mechanisms are not being used effectively to hold entities to account for insufficient, or no, action in relation to improving Māori health outcomes.

Moreover, we found that the Crown is neither undertaking sufficiently robust

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assessments of whether the primary health system is performing well for Māori nor collecting or publishing enough quantitative and qualitative information to make any assessment useful. Further, we concluded that external monitoring of the Ministry appears severely lacking, as exemplified by the minimal monitoring conducted by Te Puni Kōkiri since 2000, particularly its failure to conduct agency reviews.

Strong accountability mechanisms and robust, public measuring and reporting are key to the Treaty-compliance of the legislation and policy of the primary health care sector. We find the lack of these mechanisms and measures are inconsistent with the principles of partnership, active protection, and equity.

We make a general recommendation that the Crown commit to reviewing and strengthening accountability mechanisms and processes in the primary health sector, which impact on Māori.

We recommend that He Korowai Oranga is reviewed considering the content of this report. It, the New Zealand Health Strategy, and the Primary Health Care Strategy, and their relevant action plans, need to state expressly how our overarching recommendations are to be integrated across the primary health care sector. Given the importance of achieving equitable health outcomes for Māori, we recommend that section 8(4) of the New Zealand Public Health and Disability Act 2000 be amended to include a Māori health strategy.

We endorse the Crown's commitment to develop and maintain at all times an action plan for the Māori health strategy. We recommend that this action plan is co-designed with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants.

Further, we make the following recommendations:

(a) The Crown, in conjunction with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants, co-design a primary health research agenda.

(b) The Ministry collect robust quantitative and qualitative primary care data and information relevant to Māori health outcomes. This data and information should be made public and be easily understandable and accessible. To this end, the Crown should, in conjunction with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants, co-design measures specific to Māori as a population group.

(c) The Crown ensure that measures relevant to Māori health outcomes are reported on separately. These measures and the reporting against them should be made public and be easily understandable and accessible.

(d) District health boards and primary health organisations prepare, and make publicly available, an annual Māori health plan. The nature and content of these plans should have national minimum requirements that are set and monitored by the Ministry but should also be co-designed with Māori who are associated with the particular organisation.

(e) All health sector contracting documents should have a reference to the Treaty of Waitangi and its principles, as we have outlined in our

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overarching recommendations. Health sector contracts should also include a commitment to achieving equitable health outcomes for Māori.

(f) The Crown review, with a view to redesigning, the current arrangements for the monitoring of the Ministry by external agencies, which are intended to ensure the sufficiency of the design and delivery of health services to Māori. Further, any agency or agencies tasked with these monitoring responsibilities should have particular regard to those matters we mention at section 7.7 of this report.

9.5.3 A Treaty-compliant primary health care framework

In chapter 5, we highlighted several concerns we have about how the primary health care framework fails to recognise and provide for Māori expertise and viewpoints as guaranteed by the Treaty. For example, we noted that in part 2 of the New Zealand Public Health and Disability Act 2000 none of the Ministerial advisory committees were specifically focused on Māori health, nor was there a requirement for Māori membership on those committees.

In chapter 8, we concluded that the development of neither the Primary Health Care Strategy nor the framework involved a robust co-design process. We also noted that Māori are significantly under-represented across a range of health professions and in the Ministry itself. We were particularly concerned at the disestablishment of Te Kete Hauora and the impact that this may have had on the efficacy of Māori-specific policy-making and advice at the Ministry level. Similarly, we discussed the fact that those managers responsible for Māori health within district health boards felt hamstrung by the ambit of their role and had very minimal budget holding functions. The fact that the extent of these roles varies considerably and is effectively at the whim of individual district health boards is particularly concerning to us.

In the governance sphere, we found that Māori members of district health boards are always in the minority and do not necessarily reflect mana whenua interests or the Māori population of the district they serve and that the board members are ultimately appointed by the Minister of Health and are thus ultimately answerable to the Minister. Accordingly, we found that the district health board model does not reflect a true partnership relationship.

We further noted that Māori relationship boards do not have the statutory recognition and status that the committees referred to in sections 34 to 36 of the Act have. Further, the actual extent of their role in the governance and operation of district health boards varies considerably throughout the country. We found scant evidence of an accurate reflection of the principle of partnership as required by the Treaty.

We make an interim recommendation that, after considering our findings in chapters 5 and 8, the Crown review, with a view to redesigning, its current partnership arrangements across all levels of the primary health care sector. This process should be co-designed with Māori health experts, including representatives from the Wai 1315 and Wai 2687 claimants.

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This recommendation is an interim one because we wish to see what progress is made in the co-design of a stand-alone Māori primary health authority, as outlined earlier in this chapter. Depending on progress or otherwise in that respect, we reserve to ourselves the right to review these interim recommendations and to make more detailed partnership recommendations to the current legislative and policy framework if needed.

9.5.4 Acknowledgement

We recommend that the Crown acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health system to improve Māori health outcomes since the commencement of the New Zealand Public Health and Disability Act 2000.

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Dated at Wellington this 28th day of June 2019

Judge Stephen Clark, presiding officer

Dr Angela Ballara, member

Associate Professor Tom Roa, member

Tania Te Rangingangana Simpson, member

Professor Linda Smith, member

THE SEAL OF THE WAITANGI TRIBUNAL

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APPENDIX I

STATEMENT OF ISSUES

1.0 Introduction

1.1 The following statement of issues is intended for use in stage one of the Waitangi Tribunal Inquiry into Māori Health – Wai 2575. During stage one, the Tribunal will be enquiring into the claims of the Māori Primary Health Organisations ('PHO') and Providers (Wai 1315) and the National Hauora Coalition (Mason and Royal) (Wai 2687) claims. The focus of stage one is the legislative and policy framework of New Zealand's primary healthcare system as a whole and its alleged flaws when assessed against the principles of the Treaty of Waitangi.[1]

1.2 The statement of issues has been developed taking into account the following:

- **1.2.1** The statements of claim filed on behalf of the Wai 1315 claimants;[2]
- **1.2.2** The statement of claim filed on behalf of the Wai 2687 claimants;[3]
- **1.2.3** The proposed statement of issues filed on behalf of the Wai 1315 and Wai 2687 claimants on 17 May 2018;[4]
- **1.2.4** The proposed statement of issues and statement of facts filed on behalf of the Crown on 25 May 2018;[5]
- **1.2.5** A joint memorandum of counsel received on behalf of the Wai 1315 and Wai 2687 claimants on 31 May 2018.[6]

1.3 The statement of issues is intended to provide a guideline to the stage one claimants, the Crown and any interested party for whom leave may be granted, during the preparation of their respective cases and submissions. They are not intended to straightjacket the parties however they provide a clear indication of the issues which the Tribunal would like to be addressed during stage one of this Inquiry.

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1. Wai 2575, #2.5.25, para 80. The primary healthcare framework means the legislation, regulation, policy, and practice which determines the delivery of primary healthcare. It includes the New Zealand Public Health and Disability Act 2000, the Crown Funding Agreement, the Operating Policy Framework, the New Zealand Health Strategy, the New Zealand Primary Health Care Strategy, the PHO Minimum Requirements, the PHO Services Agreement, Additional Services Contracts, the New Zealand Disability Strategy, and He Korowai Oranga: Māori Health Strategy.
2. Wai 2575, #1.1.1 and #1.1.1(a).
3. Wai 2575, #1.1.2.
4. Wai 2575, #3.1.177.
5. Wai 2575, Schedule 1: Statement of Facts, #3.1.175(a) and Schedule 2: Proposed Statement of Issues, #3.1.175(b).
6. Wai 2575, #3.1.178.

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2.0 EQUITY

2.1 What health disparities do the Māori population experience compared to the non-Māori population?

2.2 What are the nature and extent of any inequities between Māori and non-Māori health status?

2.3 Does the Crown set expectations of equity between Māori and non-Māori in the primary healthcare framework?

2.4 If so, where are those expectations located?

2.5 Are the expectations of equity between Māori and non-Māori in the primary healthcare framework sufficient?

2.6 Is the Crown addressing inequity in health outcomes for Māori compared to non-Māori in relation to the primary healthcare framework? If so, how?

2.7 Is the primary healthcare framework prejudicial to achieving equitable Māori health outcomes?

2.8 Is the primary healthcare framework prejudicial to the ongoing development of Māori PHOs and Māori health providers?

3.0 THE PRIMARY HEALTHCARE FRAMEWORK

3.1 Does the primary healthcare framework:

- 3.1.1 Adequately recognise the extent and nature of existing inequity between Māori and non-Māori health status?
- 3.1.2 Remove barriers to Māori accessing and using primary healthcare services?
- 3.1.3 Do enough to address consistent under-utilisation of health services by Māori?
- 3.1.4 Do enough to address multiple conditions which Māori often present with when health services are utilised?
- 3.1.5 Operate on a model that is able to address the particular health needs of Māori?

4.0 MĀORI SOLUTIONS

4.1 Does the primary healthcare framework allow sufficient scope for Māori to determine and apply their own solutions to improve Māori health?

4.2 To what extent does the primary healthcare framework support the development and use of Māori-designed solutions for Māori centred health issues? Is that support sufficient?

4.3 Does the primary healthcare framework adequately resource Māori PHOs and Māori providers in the following respects:

- 4.3.1 By addressing the disparity in resources at the point of establishment between Māori PHOs and PHOs developed from established primary care providers (eg independent practitioner associations)?
- 4.3.2 By taking into account the dispersed nature of the Māori population?
- 4.3.3 By ensuring a constant funding stream for services provided?
- 4.3.4 By ensuring that equitable and adequate resourcing of providers is not compromised by competition?

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5.0 FUNDING

5.1 On what data is the current capitation formula based?

5.2 Is that data complete and/or reliable?

5.3 Does the data take into account access issues and differential health needs for Māori?

5.4 Is the current capitation formula adequate to meet Māori health needs?

6.0 POLICY AND STRATEGY

6.1 Does the primary healthcare framework provide Māori with a real and meaningful role in the development and implementation of primary healthcare policy and strategies, in particular:

- **6.1.1** By adequately addressing concerns raised by Māori PHOs and providers and Māori communities (whānau, hapū, iwi, other groups and individuals) in submissions prior to the development of the primary healthcare strategy?
- **6.1.2** By adequately consulting with Māori PHOs and providers and Māori communities (whānau, hapū, iwi, other groups and individuals) in the implementation of the primary healthcare strategy?
- **6.1.3** By ensuring Māori PHOs and providers have a role in the development of contractual arrangements to implement the primary healthcare strategy?

7.0 ACCOUNTABILITY

7.1 Does the primary healthcare framework provide sufficient accountability:

- **7.1.1** From PHOs to DHBs; and
- **7.1.2** From DHBs to the Ministry of Health and to the Minister of Health; and
- **7.1.3** From all parties to whānau, hapū, iwi and Māori communities to ensure that any of the services provided within it achieve equitable outcomes for Māori compared to non-Māori?

7.2 What accountability measures are there to demonstrate how the primary healthcare framework in practice:

- **7.2.1** Meets the requirements set out in legislation and policy derived from the Treaty of Waitangi and its principles?
- **7.2.2** Requires PHOs to be controlled by their communities, including Māori?
- **7.2.3** Ensures that DHBs are providing sufficient resources to eliminate or reduce inequity in Māori health outcomes?
- **7.2.4** Ensures that DHBs are taking sufficient actions to eliminate or reduce inequity in Māori health outcomes?
- **7.2.5** Ensures that PHOs and providers are accountable for how they spend funding to reduce Māori health inequality?
- **7.2.6** Ensures that PHOs and providers are accountable for how they achieve positive outcomes for Māori health?

8.0 SOCIAL POLICY

8.1 Does the primary healthcare framework:

- **8.1.2** Adequately address the relationship between Māori health and services and all its determinants (such as poverty, housing, education, income)?
- **8.1.3** Address or provide for hauora as a holistic concept?

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9.0 TREATY PRINCIPLES

9.1 Are any acts or legislative instruments that relate to the primary healthcare framework in breach of the principles of the Treaty of Waitangi?

9.2 Are any policies, practices, acts or omissions of the Crown, or those acting on behalf of the Crown that relate to the primary healthcare framework in breach of the principles of the Treaty of Waitangi?

9.3 Are any policies, practices, acts or omissions of the Crown or those acting on behalf of the Crown, that relate to the primary healthcare framework, in breach of the Crown's Treaty-based obligation to address Māori health inequality?

10.0 PREJUDICE

10.1 Are Māori prejudicially affected by any breach of Treaty principles that relate to the primary healthcare framework?

10.2 If so, has the breach of Treaty principles resulted in prejudice in relation to:

- **10.2.1** The development and implementation of primary healthcare policy and strategy?
- **10.2.2** The funding of Māori primary healthcare?
- **10.2.3** Achieving equitable outcomes for Māori health?
- **10.2.4** Enabling Māori PHOs and Māori health providers to close the inequalities between Māori and non-Māori health status?

11.0 RECOMMENDATIONS

11.1 What steps, if any should the Crown take to:

- **11.1.1** Remedy any breach of the principles of the Treaty of Waitangi?
- **11.1.2** Remove any prejudice as a result of any breaches of the principles of the Treaty of Waitangi?

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APPENDIX II

INTERESTED PARTIES GRANTED LEAVE TO PARTICIPATE IN STAGE ONE OF THE WAI 2575 HEALTH SERVICES AND OUTCOMES INQUIRY

Granted Leave to Participate on a Watching Brief Basis

Claim: Wai 144
Counsel: Zwaan Legal
Party: Vernon Winitana on behalf of himself and Ngāti Ruapani

Claim: Wai 682
Counsel: Tukau Law
Parties: Reweti Pomare Kingi Pita Paraone, Johnson Erima Henare, Samuel Kevin Prime, Pita Tipene, and Waihoroi Shortland on behalf of Ngāti Hine

Claim: Wai 2003
Counsel: Dixon and Co
Parties: Cheryl Turner, John Klaricich, Harerei Toia, Ellen Naera, Fred Toi, Warren Moetara, and Hone Taimona on behalf of Ngati Korokoro, Ngati Wharara, and Te Pouka Hapu
Cross-examination: Leave granted to cross-examine Dr Nick Chamberlain

Claims: Wai 2634, Wai 2643, Wai 2647, Wai 2650, Wai 2688
Counsel: Oranganui Legal
Parties: Maraea Katene (Wai 2634); Rosaria Hotere and Jane Hotere (Wai 2643); Teresa Goza on behalf of Ngā Amo Titoki (Wai 2647); Wiremu Bayliss (Wai 2650); Glennis Rawiri (Wai 2688)
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, Dr Heather Came-Friar, Professor Jacqueline Cumming, Amy Downs, and Dr Frances McGrath on behalf of Wai 2647 claimants.

Claim: Wai 2655
Counsel: Lyall and Thornton
Party: Ngā Kairauhii Nannies Against P

Claims: Wai 2719, Wai 2723
Counsel: Te Mata Law Ltd
Parties: Beverly Te Huia (Wai 2719) and Maria Baker (Wai 2723)

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Granted Leave to File Submissions

Claim: Wai 179
Counsel: Phoenix Law
Parties: Colin Malcom, Anne Davies, Huhana Seve, and Ruiha Collier
Leave granted to file: Closing submissions on Tribunal statement of issues 2–7

Claim: Wai 996
Counsel: Phoenix Law
Parties: David Potter, Andre Paterson, and Cletus Maanu Paul on behalf of the hapū of Ngāti Rangitihi
Leave granted to file: Closing submissions on Tribunal statement of issues 2–7

Claims: Wai 1670, Wai 2619
Counsel: Morrison Kent
Parties: Rickey Houghton on behalf of his whānau (Wai 1670); Dr Huhana Kickey on behalf of disabled Māori (Wai 2619)
Leave granted to file: Closing submissions
Cross-examination: Leave granted to cross-examine Hector Matthews

Claim: Wai 1732
Counsel: Ranfurly Chambers
Parties: Mate Pihema, Cyril Chapman, and Oneroa Pihema on behalf of the Kohatutaka hapū and Ngāti Kiore of Mangataipa
Leave granted to file: Closing submissions on Tribunal statement of issues 4.1, 4.2, 9.1–9.3, 11

Claim: Wai 1813
Counsel: Wackrow Williams
Parties: Tania Wolfgramm and Dr Rachel Maunganui Wolfgramm
Leave granted to file: Closing submissions on Tribunal statement of issues 2–5

Claim: Wai 2623
Counsel: Phoenix Law
Party: Cletus Maanu Paul, chairperson of the Mataatua District Maori Council
Leave granted to file: Closing submissions on Tribunal statement of issues 2–4, 6–10

Claim: Wai 2720
Counsel: Phoenix Law
Parties: John Tamihere on behalf of Te Whānau o Waipareira Trust, the Manukau Urban Māori Authority, the National Urban Māori Authority, Te Roopu Awhina ki Porirua, and the Kirikiriroa Marae
Leave granted to file: Closing submissions on Tribunal statement of issues

Granted Leave to File Evidence and Submissions

Claim: Wai 507
Counsel: Bennion Law
Party: Owen Lloyd on behalf of Ngā Ariki Kaipūtahi

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Leave granted to file: Opening and closing submissions
Witnesses: Owen Lloyd (did not attend hearings)
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, Professor Jacqueline Cumming, Dr Frances McGrath, and Hector Matthews

Claims: Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2165, Wai 2382
Counsel: Tamaki Legal
Parties: Evelyn Kereopa on behalf of Te Ihingarangi (Wai 762); Merle Ormsby, Daniel Ormsby, Tiaho Pillot, and Manu Patena on behalf of Ngāti Tamakopiri, Ngāti Hikairo, and Ngāti Hotu (Wai 1196); Te Enga Harris and Lee Harris on behalf of the Harris whānau (Wai 1531); Wiremu Reihana on behalf of his whānau and Ngāti Tautahi ki te Iringa (Wai 1957); Jasmine Cotter-Williams on behalf of her whānau and Ngāti Taimanawaiti (Wai 2063); Joseph Naden on behalf of Ngāti Porou ki Tamaki Makaura (Wai 2165); Nuki Aldridge on behalf of his whānau (Wai 2382)
Leave granted to file: Opening and closing submissions
Witnesses: Amy Downs and Mana Hape
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, Professor Jacqueline Cumming, John Hazeldine, and Hector Matthews

Claims: Wai 827, Wai 1622, Wai 1804, Wai 1832, Wai 1959, Wai 2046, Wai 2051, Wai 2053, Wai 2121, Wai 2145, Wai 2173, Wai 2183, Wai 2240, Wai 2599, Wai 2624, Wai 2626, Wai 2627, Wai 2633, Wai 2635, Wai 2638, Wai 2641, Wai 2642, Wai 2645, Wai 2654, Wai 2672, Wai 2673, Wai 2683, Wai 2684, Wai 2686, Wai 2689, Wai 2695, Wai 2697, Wai 2701, Wai 2703, Wai 2714, Wai 2719, Wai 2723, Wai 2725
Counsel: Te Mata Law Ltd
Leave granted to file: Opening and closing submissions
Witnesses: Dr Heather Came-Friar and Professor Tim McCreanor
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, and Hector Matthews

Claim: Wai 2499
Counsel: Kahui Legal
Parties: Dr David Jansen and others on behalf of Te Ohu Rata o Aotearoa and all Māori generally
Leave granted to file: Opening and closing submissions
Witnesses: Teresa Wall, Dr Suzanne Crengle, and Professor Papaarangi Reid
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, Professor Jacqueline Cumming, Dr Frances McGrath, and Hector Matthews

Claim: Wai 2644
Counsel: Woodward Law
Party: Edward Taihākurei Durie on behalf of the New Zealand Māori Council
Leave granted to file: Opening and closing submissions
Witnesses: Sir Edward Taihākurei Durie and Teresa Wall

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Claim: Wai 2702
Counsel: Te Mata Law
Parties: David Ratu and Patricia Tuhimata
Leave granted to file: Opening and closing submissions
Witnesses: Patricia Tuhimata (did not attend hearings)
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, Professor Jacqueline Cumming, John Hazeldine, Dr Frances McGrath, and Hector Matthews

Claim: Wai 2713
Counsel: Annette Sykes and Co
Party: Hineraumoa Te Apatu and Kerri Nuku on behalf of Te Rūnanga o Aotearoa Tōpūtanga Tapuhi Kaitiaki o Aotearoa
Leave granted to file: Opening and closing submissions
Witnesses: Bay of Plenty and Tairawhiti Nurses, Kelly McDonald Beckett, Maria Briggs, Dr Heather Came-Friar, Margaret Hand, Professor Tim McCreanor, Leanne Manson, Tracey Morgan, Kerri Nuku, Keelan Ransfield, Nola Tanner, and Waiharakeke Winiata
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, Professor Jacqueline Cumming, Dr Frances McGrath, and Hector Matthews

Claim: Wai 2738
Counsel: Afeaki Chambers
Party: Kahurangi Fergusson-Tibble on behalf of Māori mental health and addictions workers
Leave granted to file: Opening and closing submissions on Tribunal statement of issues 4.2
Witnesses: Kahurangi Fergusson-Tibble
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, Dr Heather Came-Friar, Dr Nick Chamberlain, Professor Jacqueline Cumming, Francis McGrath, Taitimu Maipi, Hector Matthews, and Tureiti Lady Moxon

Subsequent Requests to Cross-examine Only

Claim: Wai 2727
Counsel: Watkins Law
Party: Tanya Filia
Cross-examination: Leave granted to cross-examine Director-General of Health Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, John Hazeldine, and Dr Frances McGrath

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APPENDIX III

WITNESSES WHO GAVE EVIDENCE AT HEARINGS FOR STAGE ONE

Kimikimi Whare, Tūrangawaewae Marae

Monday 15 October 2018
Taitimu Maipi
Dr Katherine Gottlieb
Hakopa Paul

Tuesday 16 October 2018
Honourable John Henry Tamihere
Neil Bernard Woodhams
Professor John Renata Broughton
Dr Peter Martin Jansen

Wednesday 17 October 2018
Janet McLean
Janice Kuka
Piripi Hikairo
Tureiti Haromi Lady Moxon

Thursday 18 October 2018
Simon George Tiwai Royal
Dr Rawiri Jansen

Friday 19 October 2018
Professor Peter Crampton
Tereki Ross Stewart
Henare Parks Mason

Tuesday 23 October 2018
Dr Suzanne Crengle
Professor Papaarangi Reid
Teresa Wall

Wednesday 24 October 2018
Mana Hape
Amy Downs
Dr Heather Came-Friar

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Wednesday 24 October 2018—*continued*
Professor Tim McCreanor
Leanne Manson
Kerri Nuku
Keelan Ransfield
Tracey Morgan

Thursday 25 October 2018
Waiharakeke Winiata
Mairi Lucas
Jessica Tamihana
Nichola Awatere
Nola Tanner
Kelly McDonald-Beckett
Director-General of Health Dr Ashley Robin Bloomfield

Friday 26 October 2018
Director-General of Health Dr Ashley Robin Bloomfield
Margaret Hand
Kahurangi Fergusson Tibble
Sir Edward Taihākurei Durie

Thursday 1 November 2018
Dr Nick Chamberlain
John Hazeldine

Friday 2 November 2018
John Hazeldine
Dr Frances McGrath

WAITANGI TRIBUNAL UNIT OFFICES, WELLINGTON
Monday 17 December 2018
Professor Jacqueline Margaret Cumming
Hector John Rarawa Matthews

Tuesday 18 December 2018
Hector John Rarawa Matthews
Lisa Davies
Keriana Louise Brooking

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APPENDIX IV

WAI 1315 SELECT RECORD OF PROCEEDINGS

1. Statements

1.1 Statements of claim

1.1.1 Taitimu Maipi, Tureiti Moxon, Elaine Tapsell, and Hakopa Paul on behalf of Te Kupenga o Hoturoa (including Raukura Hauora, Turiki Healthcare, and Papakura Marae), Primary Health Organisation Māori coalition (including Taumaranui Kokiri Trust, Te Rohe Potae o Rereahu Trust, Te Kohao Health Limited, and Tom Ellis), Te Kupenga a Kahu, and Ngā Mataapuna Oranga (including Te Manu Toroa), Wai 1315 statement of claim concerning objectives, funding, and administration of primary health organisations, 11 November 2005 (received 14 November 2005)

(a) Taitimu Maipi, Tureiti Moxon, Elaine Tapsell, and Hakopa Paul, amended statement of claim, 1 February 2018 (received 1 February 2018)

2. Tribunal Memoranda, Directions, and Decisions

2.1 Registering new claims

No data found

2.2 Amending statements of claim

2.2.1 Chief Judge Joseph Williams, memorandum registering amended statement of claim, 7 February 2018

2.3 Waitangi Tribunal research commissions

No data found

2.4 Section 8D applications

No data found

2.5 Pre-hearing stage

2.5.1 Chief Judge Joseph Williams, memorandum adjourning judicial conference, 24 January 2006

2.5.2 Chief Judge Joseph Williams, memorandum convening judicial conference, 14 August 2006

2.5.3 Chief Judge Joseph Williams, memorandum granting leave to file evidence, 6 October 2006

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2.5.4 Chief Judge Joseph Williams, memorandum convening judicial conference, 12 January 2007

2.5.5 Chief Judge Joseph Williams, memorandum granting adjournment of judicial conference, 3 April 2007

2.5.6 Chief Judge Joseph Williams, memorandum granting further adjournment of judicial conference, 14 October 2007

2.5.7 Chief Judge Joseph Williams, memorandum granting further adjournment of judicial conference, 22 August 2008

2.5.8 Chief Judge Joseph Williams, memorandum delegating Judge Craig Coxhead to determine urgency application, 22 August 2008

2.5.9 Judge Craig Coxhead, memorandum requesting Crown response to urgency application, 21 October 2008

2.5.10 Judge Craig Coxhead, memorandum adjourning urgency application *sine die*, 5 November 2008

2.5.11 Judge Craig Coxhead, memorandum concerning claimant submissions on adjournment of urgency application, 24 November 2008

2.5.12 Judge Craig Coxhead, memorandum concerning *sine die* adjournment of urgency application, 24 November 2009

3. Submissions and Memoranda of Parties

3.1 Pre-hearing represented

3.1.1 Grant Powell (Wai 1315), memorandum supporting urgency application, 11 November 2006

3.1.2 Craig Linkhorn (Crown), memorandum requesting adjournment of judicial conference, 11 January 2006

3.1.3 Grant Powell (Wai 1315), memorandum responding to Crown request for adjournment, 19 January 2006

3.1.4 Christina Inglis (Crown), memorandum requesting adjournment of judicial conference, 27 February 2006

3.1.5 Craig Linkhorn (Crown) and Sarah Eyre (Wai 1315), joint memorandum requesting further adjournment of judicial conference, 8 June 2006

3.1.6 Grant Powell (Wai 1315) and Craig Linkhorn (Crown), joint memorandum concerning adjournment, 20 July 2006

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3.1.7 Grant Powell (Wai 1315) and Craig Linkhorn (Crown), joint memorandum seeking adjournment of judicial conference, 16 January 2007

3.1.8 Sarah Eyre (Wai 1315) and Christina Inglis (Crown), joint memorandum seeking futher adjournment of judicial conference, 30 March 2007

3.1.9 Sarah Eyre (Wai 1315) and Craig Linkhorn (Crown), joint memorandum seeking further adjournment of judicial conference, 1 October 2007

3.1.10 Craig Linkhorn (Crown) and Grant Powell (Wai 1315), joint memorandum seeking further adjournment of judicial conference, 1 April 2008

3.1.11 Sarah Eyre (Wai 1315), memorandum concerning application for urgency, 14 August 2008

3.1.12 Donna Llewell and Merran Cooke (Crown), synopsis of Crown submissions opposing renewed urgency application, 3 November 2008

3.1.13 Grant Powell (Wai 1315), memorandum seeking recall of urgency decision, 12 November 2008

3.1.14 Sarah Eyre (Wai 1315), memorandum concerning reply submissions, 16 December 2008

3.1.15 Sarah Eyre (Wai 1315), memorandum concerning Crown submissions, 25 February 2009

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APPENDIX V

WAI 2575 SELECT RECORD OF INQUIRY

RECORD OF HEARINGS

Panel Members

The panel members were Judge Stephen Clark (presiding), Dr Angela Ballara, Associate Professor Tom Roa, Tania Simpson, and Professor Linda Tuhiwai Smith.

Hearings

Week one of the hearings was held at Turangawaewae Marae from Monday 15 October 2018 to Friday 19 October 2018.

Week two of the hearings was held at Turangawaewae Marae from Tuesday 22 October 2018 to Friday 26 October 2018.

Week three of the hearings was held at Turangawaewae Marae from Thursday 1 November to Friday 2 November 2018.

Week four of the hearings was held at the Waitangi Tribunal's offices on Monday 17 December 2018 and Tuesday 18 December 2018.

The closing submissions were held at the Waitangi Tribunal's offices on Tuesday 12 March 2019 and Wednesday 13 March 2019.

RECORD OF PROCEEDINGS

1. Statements

1.1 Statements of claim

1.1.1 Taitimu Maipi, Tureiti Moxon, Elaine Tapsell, and Hakopa Paul on behalf of Te Kupenga o Hoturoa (including Raukura Hauora, Turiki Healthcare, and Papakura Marae), Primary Health Organisation Māori coalition (including Taumaranui Kokiri Trust, Te Rohe Potae o Rereahu Trust, Te Kohao Health Limited, and Tom Ellis), Te Kupenga a Kahu, and Ngā Mataapuna Oranga (including Te Manu Toroa), Wai 1315 statement of claim concerning objectives, funding, and administration of primary health organisations, 11 November 2005

(a) Taitimu Maipi, Tureiti Moxon, Elaine Tapsell, and Hakopa Paul, amended statement of claim, 1 February 2018

1.1.2 Henare Mason and Simon Royal on behalf of the National Hauora Coalition, Wai 2687 statement of claim concerning Government health strategy, policy, and practice pertaining to primary health care strategy, 11 October 2017

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1.2 Final statements of claim
No data found

1.3 Statements of response
1.3.1 Crown, statement of response to statement of issues 1.4.1, no date
(a) Crown, statement of response to statement of issues 1.4.1, no date

1.4 Statements of issues
1.4.1 Waitangi Tribunal, statement of issues for stage one of inquiry, 1 June 2018

2. TRIBUNAL MEMORANDA, DIRECTIONS, AND DECISIONS

2.1 Registering new claims
2.1.1 Wai 1315 (claim 2.1) 22 December 2005

2.1.2 Wai 2687 (claim 2.1) 5 December 2017

2.2 Amending statements of claim
2.2.1 Wai 1315 (claim 2.2) 7 February 2018

2.3 Waitangi Tribunal research commissions
No data found

2.4 Section 8D applications
No data found

2.5 Pre-hearing stage
2.5.1 Chief Judge Wilson Isaac, memorandum commencing kaupapa inquiry into health services and outcomes, 30 November 2016

2.5.2 Judge Stephen Clark, memorandum concerning next steps in inquiry, 21 December 2016

2.5.03 Judge Stephen Clark, memorandum concerning extension requests for claimant submissions, 14 March 2017

2.5.04 Chief Judge Wilson Isaac, memorandum appointing panel for Health Services and Outcomes Kaupapa Inquiry, 15 March 2017

2.5.05 Judge Stephen Clark, memorandum concerning extension requests for Crown submissions, 24 March 2017

2.5.06 Judge Stephen Clark, memorandum concerning first judicial conference, 13 April 2017

2.5.07 Second Judge Stephen Clark, memorandum concerning first judicial conference, 2 May 2017
(a) Timetable for first judicial conference, 2 May 2017

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(b) List of claimants and counsel to be heard at first judicial conference, 2 May 2017

2.5.08 Judge Stephen Clark, memorandum following first judicial conference, 26 May 2017

2.5.09 Judge Stephen Clark, memorandum concerning extension requests for claimant bibliographies, 5 July 2017

2.5.10 Judge Stephen Clark, memorandum concerning extension requests for post-roundtable submissions and health timeline, 31 August 2017

2.5.11 Judge Stephen Clark, memorandum concerning post-roundtable submissions and chronology, 13 September 2017

2.5.12 Chief Judge Wilson Isaac, memorandum appointing panel member, 14 September 2017

2.5.13 Judge Stephen Clark, memorandum concerning extension requests for further information on proposed research, 18 October 2017
(a) Table of upcoming filing dates, 18 October 2017

2.5.14 Judge Stephen Clark, memorandum concerning further background research, 2 November 2017

2.5.15 Judge Stephen Clark, memorandum concerning extension requests for further information on proposed research, 15 November 2017

2.5.16 Judge Stephen Clark, memorandum concerning extension request for filing of supplementary evidence, 22 November 2017

2.5.17 Judge Stephen Clark, memorandum confirming next steps in inquiry, 8 December 2017

2.5.18 Judge Stephen Clark, memorandum concerning release of preliminary bibliography, 18 December 2017

2.5.19 Judge Stephen Clark, memorandum concerning extension requests, 22 December 2017

2.5.20 Judge Stephen Clark, memorandum concerning pre-casebook review and other matters, 19 January 2018

2.5.22 Judge Stephen Clark, memorandum concerning inquiry planning and related procedural matters, 28 February 2018
(a) Confirmed forthcoming inquiry stage one filing dates, 28 February 2018
(b) Filing dates for wider inquiry programme, 28 February 2018

2.5.23 Judge Stephen Clark, memorandum concerning participation of parties at forthcoming teleconference on stage one inquiry matters, 6 March 2018

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2.5.24 Judge Stephen Clark, memorandum concerning participation in stage one and confirming details of judicial conference, 8 March 2018

2.5.25 Judge Stephen Clark, memorandum concerning approach to be taken to stage one, 29 March 2018

2.5.26 Judge Stephen Clark, memorandum concerning progression of inquiry, 7 May 2018
(a) Confirmed forthcoming inquiry stage one filing dates, 7 May 2018
(b) Filing dates for wider inquiry programme, 7 May 2018

2.5.27 Judge Stephen Clark, memorandum confirming Tribunal stage one statement of issues, addressing extension requests and late filing of claimant counsel memoranda, confirming venue for stage one hearings, and confirming agenda for 11 June 2018 judicial conference, 1 June 2018
(a) Agenda for 11 June 2018 judicial conference, 1 June 2018

2.5.28 Judge Stephen Clark, memorandum confirming oral directions given at 11 June 2018 judicial conference and providing amended stage one timetable, 20 June 2018
(a) Confirmed forthcoming inquiry stage one filing dates, 20 June 2018

2.5.29 Judge Stephen Clark, memorandum concerning priorities for stage two and research, 29 June 2018
(a) Filing dates for wider inquiry programme, 29 June 2018

2.5.30 Judge Stephen Clark, memorandum concerning stage one interested party requests, 5 July 2018
(a) Confirmed forthcoming stage one filing dates, 5 July 2018
(b) Filing dates for wider inquiry programme, 5 July 2018

2.5.31 Judge Stephen Clark, memorandum concerning participation of stage one interested parties, 10 August 2018
(a) Confirmed forthcoming stage one filing dates
(b) Filing dates for wider inquiry programme, 10 August 2018
(c) Interested parties granted leave to participate in stage one, 10 August 2018

2.5.32 Judge Stephen Clark, memorandum responding to requests for reconsideration of stage two priorities and possibility of further Tribunal-commissioned research, 30 August 2018

2.5.33 Judge Stephen Clark, memorandum responding to Crown request for extension of time for filing evidence, 6 September 2018
(a) Amended stage one filing dates, 6 September 2018

2.5.34 Judge Stephen Clark, memorandum concerning removal of material from record of inquiry, 10 September 2018

2.5.36 Judge Stephen Clark, memorandum concerning interested party cross-examination requests and hearing timetable, 28 September 2018

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(a) List of interested parties granted leave to participate in stage one, 28 September 2018

2.5.37 Judge Stephen Clark, memorandum concerning forthcoming stage one hearing weeks, 10 October 2018
(a) Interested parties granted leave to participate in stage one, 10 October 2018
(b) Confirmed forthcoming stage one filing dates, 10 October 2018

2.5.38 Judge Stephen Clark, memorandum confirming hearing week one timetable, 11 October 2018
(a) Finalised hearing week one timetable, 11 October 2018

2.6 Hearing stage

2.6.1 Judge Stephen Clark, memorandum concerning hearing weeks one and two, 31 October 2018
(a) Interested parties granted leave to participate in stage one, 31 October 2018
(b) Confirmed forthcoming inquiry stage one filing dates, 31 October 2018

2.6.2 Judge Stephen Clark, memorandum concerning hearing week three, 8 November 2018
(a) Confirmed forthcoming inquiry stage one filing dates, 8 November 2018

2.6.3 Judge Stephen Clark, memorandum inviting parties to review hearing week one transcript and submit corrections, 26 November 2018

2.6.4 Judge Stephen Clark, memorandum inviting parties to review hearing week two transcript and submit corrections, 29 November 2018

2.6.5 Judge Stephen Clark, memorandum inviting parties to review hearing week three transcript and submit corrections, 30 November 2018

2.6.6 Judge Stephen Clark, memorandum concerning hearing week four, 10 December 2018

2.6.7 Judge Stephen Clark, memorandum concerning hearing week four timetable, 14 December 2018
(a) Finalised hearing hearing week four timetable, 14 December 2018

2.6.8 Judge Stephen Clark, memorandum concerning hearing week four, 20 December 2018
(a) Confirmed forthcoming inquiry stage one filing dates, 20 December 2018

2.6.9 Judge Stephen Clark, memorandum concerning hearing week four transcript and recent Crown extension request, 22 January 2019

2.6.10 Judge Stephen Clark, memorandum concerning closing submissions, 26 February 2019

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2.6.11 Judge Stephen Clark, memorandum concerning closing submissions hearing timetable, 11 March 2019
(a) Closing submissions hearing timetable, 11 March 2019

2.6.12 Judge Stephen Clark, memorandum concerning hearing of stage one closing submissions, 18 March 2019

2.6.13 Judge Stephen Clark, memorandum concerning stage one closing submissions transcript, 12 April 2019

2.7 Post-hearing stage

No data found

2.8 Other matters

2.8.1 Waitangi Tribunal, 'Pre-judicial Conference Discussion Paper on Matters of Participation, Process and Evidential Basis for this Inquiry', discussion paper, 21 April 2017

3. Submissions and Memoranda of Parties

3.1 Pre-hearing represented

3.1.1 Bryce Lyall and Linda Thornton (Wai 874, Wai 1247, Wai 421, Wai 593, Wai 869, Wai 1383, Wai 1890, Wai 1666), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.2 Eve Rongo (Rosaria Hotere and Jane Hotere), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.3 Eve Rongo (Wiremu Bayliss), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.4 Eve Rongo (Teresa Goza), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.5 Eve Rongo (Maraea Katene), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.7 Robyn Zwaan (Wai 1758, Wai 1787), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.9 Bryan Gilling and Sophie Dawe (Huhana Hickey, Wai 1341, Wai 1670, Wai 605, Wai 246, Wai 972, Wai 1940, Wai 1843), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.10 Te Kani Williams, Coral Linstead-Panoho, and Chloe Manga (Wai 1813), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.11 Gerald Sharrock (Wai 121, Wai 1450, Wai 2108, Wai 884, Wai 1841, Wai 2179), memorandum responding to memorandum 2.5.2, 13 March 2017

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3.1.12 Mark McGhie (Wai 1072), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.13 Chris Beaumont (Wai 88, Wai 89, Wai 966, Wai 2257), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.14 Donna Hall and Jordan Hamel (Wanda Brljevich), memorandum accompanying statement of claim of Wanda Brljevich and responding to memorandum 2.5.2, 13 March 2017

3.1.15 Donna Hall and Jordan Hamel (Taipari Munro), memorandum accompanying statement of claim of Taipari Munro and responding to memorandum 2.5.2, 13 March 2017

3.1.16 Aidan Warren (Wai 1589, Jack Rifle), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.17 Annette Sykes and Jordan Bartlett (Wai 1835), memorandum responding to memorandum 2.5.2, 13 March 2017

3.1.18 Kelly-Maree Dixon and Alisha Castle (Wai 2003, Wai 745, Wai 1308), memorandum responding to memorandum 2.5.2, 13 March 2017

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3.1.191 Donna Hall (New Zealand Māori Council), memorandum seeking leave to participate in stage one as an interested party, 26 June 2018

3.1.192 Janet Mason (Wai 2623, Wai 996, Wai 179), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.193 Janet Mason (Wai 2720), memorandum seeking leave to participate in stage one as an interested party, 27 June 2018

3.1.194 Bryan Gilling and Sarah Dysart (Wai 2679, Wai 1670), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.195 Bryce Lyall (Wai 2655), memorandum seeking leave to participate in stage one as an interested party, 27 June 2018

3.1.196 David Stone (Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2683, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 2228, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, Wai 1823), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.197 David Stone (Wai 2702), memorandum seeking leave to participate in stage one as an interested party, 27 June 2018

3.1.198 David Stone (Wai 2719), memorandum seeking leave to participate in stage one as an interested party, 27 June 2018

3.1.199 David Stone (Wai 2723), memorandum seeking leave to participate in stage one as an interested party, 27 June 2018

3.1.200 Peter Johnston and Daniel Hunt (Wai 2109), memorandum declining to seek leave to participate as an interested party in stage one, 27 June 2018

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3.1.201 Tu'inukutavake Afeaki, Neuton Lambert, and Siaosi Tofi (Wai 619, Wai 1309, Wai 1455, Wai 1479, Wai 2059), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.202 Darrell Naden and Nancy Dhaliwal (Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2165, Wai 2382), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.203 Roslyn Park and Daniel Watkins (Wai 2727), memorandum seeking leave to participate in stage one as an interested party, 27 June 2018

3.1.204 Eve Rongo (Wai 2634, Wai 2643, Wai 2647, Wai 2650, Wai 2688), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.205 Kelly-Maree Dixon and Alisha Castle (Wai 2003), memorandum seeking leave to participate in stage one as an interested party, 27 June 2018

3.1.206 Robyn Zwaan (Wai 144, Wai 375, Wai 1758, Wai 1787), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.207 Tom Bennion and Emma Whiley (Wai 507, Wai 52), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.208 Charl Hirschfeld, Tony Sinclair, and Barney Tupara (Wai 2685, Wai 2681, Wai 1732, Wai 2006, Wai 2682, Wai 2380, Wai 2072), memorandum seeking leave to participate in stage one as interested parties, 27 June 2018

3.1.209 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum seeking leave to participate in stage one as an interested party, 7 June 2018

3.1.210 Geoffrey Melvin (Crown), memorandum accompanying statement of response to stage one statement of issues, 2 July 2018

3.1.211 Geoffrey Melvin (Crown), memorandum responding to applications for interested party status in stage one, 3 July 2018

3.1.212 Roimata Smail (Wai 1315), memorandum responding to applications for interested party status in stage one, 3 July 2018

3.1.214 Karen Feint (Wai 2687), memorandum responding to applications for interested party status in stage one, 4 July 2018

3.1.215 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum responding to memoranda 3.1.211, 3.1.212, and 3.1.214, 4 July 2018

3.1.216 Paranihia Walker (Wai 2499), memorandum responding to memoranda 3.1.211, 3.1.212, and 3.1.214, 5 July 2018

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3.1.218 Janet Mason (Wai 2720, Wai 2623, Wai 996, Wai 179), memorandum responding to memoranda 3.1.211, 3.1.212, and 3.1.214, 5 July 2018

3.1.219 Darrell Naden, memorandum accompanying fifth amended statement of claim for Wai 762, 27 June 2018

3.1.220 Darrell Naden and Nancy Dhaliwal (Wai 433, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2005, Wai 2165, Wai 2382, Wai 2671, Wai 2729), submissions concerning proposed research project timeframes, 20 July 2018

3.1.221 Geoffrey Melvin (Crown), memorandum responding to memorandum 2.5.30, 20 July 2018

3.1.222 Bryce Lyall (Wai 2655), memorandum amending request for leave to participate as interested party to that of watching brief, 23 July 2018

3.1.223 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum accompanying affidavits and advising of filing of further affidavits, 26 July 2018

3.1.224 Roslyn Park (Wai 2727), memorandum seeking leave to cross-examine technical and Crown witnesses, 27 July 2018

3.1.225 Charl Hirschfeld, Tony Sinclair, and Barney Tupara (Wai 1732), memorandum seeking leave to participate in stage one as interested party, 27 July 2018

3.1.226 Janet Mason (Wai 2720), memorandum seeking leave to file evidence and submissions, 27 July 2018

3.1.227 Darrell Naden and Nancy Dhaliwal (Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2165, Wai 2382), memorandum seeking leave to cross-examine, present submissions, and file written briefs of evidence, 27 July 2018

3.1.228 Te Kani Williams and Coral Linstead-Panoho (Wai 1813), memorandum seeking leave to participate in stage one by way of watching brief, 27 July 2018

3.1.229 Janet Mason (Wai 2623), memorandum seeking leave to file evidence, make submissions, and cross-examine Crown witnesses, 27 July 2018

3.1.230 Tom Bennion and Emma Whiley (Wai 507, Wai 52), memorandum seeking leave to participate in stage one as interested parties, 27 July 2018

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3.1.234 David Stone and Grant Hewison (Wai 2702), memorandum seeking leave to file brief of evidence, 27 July 2018

3.1.235 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum seeking leave to file evidence, make submissions, and be heard *viva voce* with witnesses available for cross-examination, 27 July 2018

3.1.237 Paranihia Walker (Wai 2499), memorandum seeking leave to participate in stage one as an interested party, 27 July 2018

3.1.238 Kelly-Maree Dixon and Alisha Castle (Wai 2003), memorandum seeking leave to participate in stage one by way of watching brief only, 27 July 2018

3.1.239 Donna Hall (New Zealand Māori Council), memorandum seeking leave to file evidence and make submissions, 28 July 2018

3.1.240 Eve Rongo (Wai 2634, Wai 2643, Wai 2647, Wai 2650, Wai 2688), memorandum seeking leave to participate in stage one by way of a watching brief only, 30 July 2018

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3.1.242 Matanuku Mahuika (Wai 2499), memorandum seeking reconsideration of Tribunal's approach for stage two, 10 August 2018
(a) 'Select Chronology of Relevant Procedural History of Wai 2575 Health Services and Outcomes Inquiry', typescript, no date

3.1.243 Geoffrey Melvin (Crown), memorandum updating the Tribunal and claimants on Government's health and disability system review, 14 August 2018
(a) New Zealand Health and Disability System Review, 'Final Terms of Reference– Review of New Zealand Health and Disability System', typescript, no date

3.1.244 Season-Mary Downs and Josey Lang (Wai 682), memorandum seeking urgent clarification as to whether Ngati Hine's claims will be heard in later stages, 19 July 2018

3.1.245 Season-Mary Downs and Josey Lang (Wai 682), memorandum seeking clarification from Tribunal concerning hearing of Ngati Hine claims, 17 August 2018

3.1.246 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum supporting memorandum 3.1.242, 28 August 2018

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3.1.247 Geoffrey Melvin (Crown), memorandum seeking brief extension for filing of briefs of evidence for stage one, 5 September 2018

3.1.248 Geoffrey Melvin (Crown), Roimata Smail (Wai 1315), and Karen Feint and Erin James (Wai 2687), joint memorandum filing final statistics for stage one, 6 September 2018

3.1.249 Geoffrey Melvin (Crown), memorandum accompanying tranche one of evidence for stage one, 7 September 2018

3.1.251 Eve Rongo (Wai 2674), memorandum seeking leave to cross-examine witnesses, 14 September 2018

3.1.252 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum seeking further particularisation of hearing programme, 14 September 2018

3.1.253 Tom Bennion and Emma Whiley (Wai 507, Wai 52), memorandum seeking leave to cross-examine witnesses, 14 September 2018

3.1.255 Darrell Naden, Nancy Dhaliwal, and Karuna Deobhakta (Wai 1196, Wai 1957, Wai 2165, Wai 762, Wai 1531, Wai 2063, Wai 2382), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.256 Bryan Gilling and Sarah Dysart (Wai 2619), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.257 Roslyn Park (Wai 2727), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.258 David Stone and Catherine Leauga (Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2638, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 2228, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, Wai 1823), memorandum seeking leave to cross-examine Crown witnesses, 19 September 2018

3.1.259 David Stone and Grant Hewison (Wai 2702), memorandum seeking leave to cross-examine Crown witnesses, 19 September 2018

3.1.260 Matanuku Mahuika, Lana Underhill-Sem, and Tara Hauraki (Wai 2499), memorandum seeking leave to cross-examine Crown witnesses, 19 September 2018

3.1.261 Janet Mason (Wai 2720, Wai 2704, Wai 2623, Wai 1384, Wai 996, Wai 179), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.262 Geoffrey Melvin (Crown), memorandum indicating time required for witness cross-examination and accompanying updated statement of response to Tribunal's stage one statement of issues, 19 September 2018

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3.1.263 Karen Feint (Wai 2687), memorandum indicating time required for witness cross-examination, 19 September 2018

3.1.266 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.267 Darrell Naden and Nancy Dhaliwal (Wai 1196, Wai 1957, Wai 2165, Wai 762, Wai 1531, Wai 2063, Wai 2382), memorandum concerning proposed expert witness travel and attendance at stage one hearing, 20 September 2018

3.1.268 Roimata Smail (Wai 1315), memorandum indicating time required for witness cross-examination, 19 September 2018

3.1.269 Gerald Sharrock (Wai 884, Wai 1460, Wai 1941, Wai 2179), memorandum seeking leave to cross-examine witnesses, 20 September 2018

3.1.270 Geoffrey Melvin (Crown), Roimata Smail (Wai 1315), and Karen Feint (Wai 2687), joint memorandum updating Tribunal about stage one hearing timetable, 27 September 2018

3.1.271 Matanuku Mahuika, Lana Underhill-Sem, and Tara Hauraki (Wai 2499), memorandum responding to joint memorandum 3.1.270, 28 September 2018

3.1.274 Geoffrey Melvin (Crown), memorandum concerning evidence of Professor Jacqueline Cumming, 5 October 2018

3.1.275 David Stone and Grant Hewison (Wai 2702), memorandum requesting evidence of Patricia Tuhimata be taken as read, 5 October 2018

3.1.277 Roimata Smail (Wai 1315), Karen Feint (Wai 2687), and Geoffrey Melvin (Crown), joint memorandum concerning hearing timetable, 5 October 2018
(a) Draft hearing timetables weeks 1–4, no date

3.1.278 Season-Mary Downs and Josey Lang (Wai 682), memorandum seeking leave to participate in stage one as interested parties, 8 October 2018

3.1.279 Gerald Sharrock, memorandum requesting inclusion of documents on record of inquiry, 5 October 2018

3.1.281 Tom Bennion and Emma Whiley (Wai 507), memorandum requesting evidence of Owen Lloyd be taken as read, 9 October 2018

3.1.282 'Hearing Timetable – Week 1 –15 to 19 October 2018 – Claimant Evidence', table, no date

3.1.283 Gerald Sharrock (Wai 884, Wai 1460, Wai 1941, Wai 2179), memorandum seeking leave to file documents and to attend hearing week one as interested party, 11 October 2018

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3.1.286 Donna Hall (New Zealand Māori Council), memorandum concerning order of appearances for stage one hearings, 11 October 2018

3.2 Hearing stage

3.2.1 Matanuku Mahuika, Lana Underhill-Sem, and Tara Hauraki (Wai 2499), memorandum concerning appearances for stage one, 14 October 2018

3.2.2 Sally McKechnie (Counties Manukau District Health Board), memorandum concerning memorandum 3.1.275 and document A48, 17 October 2018

3.2.3 'Draft Hearing Timetable – Week 2: 23 to 26 October 2018 – Interested Party and Crown Evidence', table, no date

3.2.4 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum concerning Legal Aid Service's decision on funding interested parties, 18 October 2018

3.2.5 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum concerning availability of witnesses to appear, 18 October 2018

3.2.6 Janet Mason (Wai 2720, Wai 2704, Wai 2623, Wai 1384, Wai 996, Wai 179), memorandum supporting memorandum 3.2.4, 18 October 2018

3.2.7 'Hearing Timetable – Week 2: 23 to 26 October 2018 – Interested Party and Crown Evidence', table, no date

3.2.8 Tom Bennion and Emma Whiley (Wai 507, Wai 52), memorandum seeking leave to cross-examine witnesses and for Wai 52 to participate in stage one as an interested party, 24 October 2018

3.2.9 Roimata Smail (Wai 1315), memorandum providing background information on Nuka system of care, 24 October 2018

3.2.10 Tom Bennion and Emma Whiley (Wai 507, Wai 52), memorandum concerning cross-examination of Frances McGrath, 1 November 2018

3.2.11 Geoffrey Melvin (Crown), memorandum updating Tribunal on information requested of Dr Bloomfield during cross-examination, 31 October 2018

3.2.12 Karen Feint and Erin James (Wai 2678), Roimata Smail (Wai 1315), and Geoffrey Melvin (Crown), joint memorandum seeking leave to file supplementary evidence, 2 November 2018

3.2.13 Geoffrey Melvin (Crown), memorandum concerning written questions for stage one, 15 November 2018

3.2.14 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum accompanying written questions, 15 November 2018
(a) 'Written Questions for Mr Simon Royal', typescript, no date

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(b) 'Written Questions for Dr Katherine Gottlieb', typescript, no date

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(a) 'Wai 2575 Stage One Common Bundle of Documents: Volume 3: Exhibits and Relevant Materials – Part 1', table, no date

3.2.17 Taitimu Maipi (Wai 1315), memorandum concerning legal representation of Taitimu Maipi and Hakopa Paul, 28 November 2018

3.2.18 Roimata Smail (Wai 1315), memorandum concerning legal representation of Taitimu Maipi and Hakopa Paul and seeking leave to file evidence, 30 November 2018
(a) Amohia Boulton, Heather Gifford, Haze White, and Tanya Allport, *Commissioning for Outcomes Report* (commissioned research report, Auckland: Te Pou Matakana Board, 2017)
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3.2.19 Geoffrey Melvin (Crown), memorandum responding to information requests of Crown witnesses and providing update on Government inquiry into mental health and addiction, 4 December 2018
(a) 'DHB Board Māori Members – as at December 2016', table, no date
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3.2.20 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum seeking leave to cross-examine Lisa Davies, 5 December 2018

3.2.21 Bryan Gilling and Sarah Dysart (Wai 2619), memorandum seeking leave to file written questions, 5 December 2018

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3.2.23 Matanuku Mahuika, Lana Underhill-Sem, and Tara Hauraki (Wai 2499), memorandum seeking leave to cross-examine witnesses, 5 December 2018

3.2.24 Darrell Naden and Nancy Dhaliwal (Wai 1196, Wai 1957, Wai 2165, Wai 762, Wai 1531, Wai 2063, Wai 2382), memorandum seeking leave to cross-examine Lisa Davies, 5 December 2018

3.2.25 Tom Bennion and Emma Whiley (Wai 507), memorandum seeking leave to cross-examine Lisa Davies, 6 December 2018

3.2.26 Karen Feint (Wai 2687), memorandum seeking leave to cross examine Tureiti Lady Moxon, 13 December 2018, 12 December 2018
(a) Vacated

3.2.27 Roimata Smail (Wai 1315), memorandum accompanying answers to written questions by Dr Katherine Gottlieb, 13 December 2018
(a) Vacated
(a) Vacated

3.2.28 'Draft Hearing Timetable – Week 4: 17 and 18 December 2018 – Crown Evidence', table, no date

3.2.29 Roimata Smail (Wai 1315), memorandum concerning legal representation of Taitimu Maipi and Hakopa Paul, 13 December 2018
(a) Joyce Maipi to Roimata Smail, email concerning legal representation of Taitimu Maipi and Hakopa Paul, 27 November 2018
(b) Roimata Smail to Janice Kuka, Taitimu Maipi, and Tureiti Lady Moxon, covering email, 27 November 2018
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(c) Joyce Maipi to Tureiti Lady Moxon, email concerning legal representation of Taitimu Maipi and Hakopa Paul, 28 November 2018

3.2.30 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), memorandum accompanying documents to assist with cross-examination of Professor Jacqueline Cumming, 14 December 2018
(a) Bridget Robson and Ricci Harris, eds, *Hauora: Māori Standards of Health IV – A Study of the Years 2000–2005* (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 2007), p 17
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3.2.38 Karen Feint (Wai 2687), memorandum accompanying answers to written questions, and seeking leave for late filing, 14 December 2018

3.2.39 James Ferguson (Wai 1315), memorandum concerning legal representation of Taitimu Maipi and Hakopa Paul, 17 December 2018

3.2.42 Geoffrey Melvin (Crown), memorandum accompanying corrections to stage one transcript of weeks one to three and seeking leave for late filing, 11 January 2019

3.2.46 Geoffrey Melvin (Crown), memorandum accompanying final scoping report for Wai 2575 background historical research, 28 January 2019
(a) Melissa Matutina Williams, Fiona Cram, Beverly Te Huia, and Tracee Te Huia, 'Wai 2575 Background History: Scoping Report' (commissioned scoping report, Wellington: Ministry of Health, 2018)

3.2.47 Bryan Gilling and Sarah Dysart (Wai 1670, Wai 1619), memorandum concerning stage one closing submissions, 31 January 2019

3.2.48 Geoffrey Melvin (Crown), memorandum concerning expected filing date of historical background report, 13 February 2019

3.2.49 Te Kani Williams, Coral Linstead-Panoho, and Taria Ngawhika (Wai 1813), memorandum declining to file closing submissions at this stage, 15 February 2019

3.2.57 Karen Feint (Wai 2687), memorandum accompanying recommendations sought by Wai 2687 claimants in stage one and advising of filing of closing submissions, 18 February 2019
(a) Karen Feint (Wai 2687), memorandum listing recommendations sought by Wai 2687 claimants in stage one, 18 February 2019

3.2.58 Karen Feint (Wai 2687), James Ferguson (Wai 1315), Matanuku Mahuika (Wai 2499), and Annette Sykes and Rebekah Jordan (Wai 2713), joint memorandum seeking urgent judicial conference, 18 February 2019

3.2.94 Craig Linkhorn and Abbey Lawson (Crown), memorandum accompanying final documents filed in response to information requests of Crown witnesses, 29 March 2019

3.2.95 Craig Linkhorn and Geoffrey Melvin (Crown), memorandum detailing funding information requested by Tribunal, 29 March 2019

3.3 Opening, closing, and in reply

3.3.1 Tu'inukutavake Afeaki, Moana Tuwhare, and Siaosi Tofi (Wai 2738), opening submissions, 9 October 2018

3.3.2 Geoffrey Melvin (Crown), opening submissions, 9 October 2018
(a) Crown Law, 'Crown Opening Submissions', PDF of Powerpoint presentation, 25 October 2018

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3.3.4 Karen Feint (Wai 2687), opening submissions, 9 October 2018
(a) 'Structure of the Primary Health Care System', flowchart, no date
(b) Table of claim issues relating to legislative and policy framework, no date
(c) Karen Feint, 'National Hauora Coalition Wai 2687: Opening Submissions', PDF of Powerpoint presentation, no date

3.3.5 Darrell Naden and Nancy Dhaliwal (Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2165, Wai 2382), opening submissions, 11 October 2018

3.3.6 Matanuku Mahuika, Lana Underhill-Sem, and Tara Hauraki (Wai 2499), opening submissions, 11 October 2018

3.3.7 David Stone and Grant Hewison (Wai 2702), opening submissions, 11 October 2018
(a) New Zealand Public Health and Disability Act 2000, ss3, 4, 22(1)(e), 23(1)(d)–(f), 29(4), 34, 35, 36, 77, sch 3 cl5, sch 3 cl38(2)

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3.3.9 Annette Sykes, Rebekah Jordan, and Jordan Bartlett (Wai 2713), opening submissions, 11 October 2018
(a) Annette Sykes, Rebekah Jordan, and Jordan Bartlett, 'The Māori Nurses' Claim: Wai 2713', PDF Powerpoint presentation, no date

3.3.10 Tom Bennion and Emma Whiley (Wai 507), opening submissions, 11 October 2018

3.3.11 Donna Hall (New Zealand Māori Council) opening submissions, 10 October 2018

3.3.12 Darrell Naden, Nancy Dhaliwal, Stephanie Roughton, Nephi Pukepuke, Margo Duhamel (Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2165), stage one closing submissions, 18 February 2019

3.3.13 Darrell Naden, Nancy Dhaliwal, Stephanie Roughton, Nephi Pukepuke, Margo Duhamel (Wai 2382), stage one closing submissions, 19 February 2019

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3.3.30 Karen Feint and Erin James (Wai 2687), stage one closing submissions, 25 February 2019
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4. Transcripts and Translations

4.1 Transcripts

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A1 John Hazeldine, brief of evidence, 3 July 2017
(a) John Hazeldine, 'Summary of Evidence', PDF of Powerpoint presentation, 1 November 2018

A2 Dr Rawiri Jansen, brief of evidence, 22 December 2017
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A40 Maria Briggs, affidavit, 26 July 2018

A41 Nola Tanner, affidavit, 26 July 2018

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(a) 'Breastfeeding Māori / Non-Māori Infants', Excel spreadsheets, 6 March 2017
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(b) 'Health Status Indicators – All Unintentional Injury Mortality, Māori vs Non-Māori', Excel spreadsheets, 6 March 2017

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(a) 'Chronic Conditions – Māori / Non-Māori Adults Aged 15+ Years', Excel spreadsheets, 6 March 2017

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(a) 'Infectious Diseases', Excel spreadsheets, 6 December 2018
(b) 'Infectious Disease: Māori and Non-Māori Non-Pacific', Excel spreadsheets, 23 January 2019
(c) Craig Linkhorn and Geoffrey Melvin, comps, 'Māori Health Trends 1990–2015: Infectious Diseases Module Supplement Appendices – Rheumatic Fever, Non-Māori Non-Pacific', assorted documents, 26 March 2019
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B18 Craig Linkhorn and Geoffrey Melvin, comps, 'Māori Health Trends 1990–2015 Project: Respiratory Disease Module Appendices', assorted documents, 5 March 2019
(a) 'Diagnosed Asthma – Māori / Non-Māori Adults Aged 15–44 Years', Excel spreadsheets, 6 March 2017
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(d) 'Health Status Indicators – Respiratory Disease Mortality, Māori vs Non-Māori', Excel spreadsheets, 6 March 2017
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B19 Craig Linkhorn and Geoffrey Melvin, comps, 'Māori Health Trends 1990–2015 Project: Disability Module Appendices', assorted documents, 5 March 2019
(a) 'Disability Statistics', Unmet Need for Special Equipment, Excel spreadsheet, 1 November 2018
(b) 'Disability Statistics, Prevalence Data', Excel spreadsheet, 31 October 2018
(c) 'Disability Statistics, Single Multiple Impairment', Excel spreadsheet, 1 November 2018

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B19—*continued*
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B20 Craig Linkhorn and Geoffrey Melvin, comps, 'Māori Health Trends 1990–2015 Project: Risk and Protective Factors Module Appendices', assorted documents, 5 March 2019
(a) 'Body Size – Māori / Non-Māori Adults Aged 15+ Years', Excel spreadsheets, 6 March 2017
(b) 'Body Size – Māori / Non-Māori Non-Pacific Adults Aged 15+ Years', Excel spreadsheets, 6 March 2017
(c) 'Alcohol and Drug Use – Māori / Non-Māori Adults Aged 15+ Years', Excel spreadsheets, 6 March 2017
(d) 'Body Size – Māori / Non-Māori Children Aged 2–14 Years', Excel spreadsheets, 6 March 2017
(e) 'Body Size – Māori / Non-Māori Non-Pacific Children Aged 2–14 Years', Excel spreadsheets, 6 March 2017
(f) 'Gambling – Māori / Non-Māori Adults Aged 15+ Years', Excel spreadsheets, 6 March 2017
(g) 'Nutrition – Māori / Non-Māori Adults Aged 15+ Years', Excel spreadsheets, 6 March 2017
(h) 'Physical Activity – Māori / Non-Māori Adults Aged 15+ Years', Excel spreadsheets, 6 March 2017
(i) 'Percentage of Māori and Non-Māori Year 10 Students Who Were Daily Smokers, 1999–2015', Excel spreadsheets, 6 March 2017

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(e) 'Non-Maori Deaths from Malignant Neoplasm by Age, Sex and Year', Excel spreadsheets, 19 December 1997
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(g) 'Māori Deaths from Malignant Neoplasms of the Trachea, Bronchus, and Lung by Age, Sex and Year', Excel spreadsheets, 19 December 1997
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(m) 'NZ Mortality, Maori Deaths', Excel spreadsheets, 1 April 2010
(n) 'NZ Mortality, Non-Maori Deaths', Excel spreadsheets, 1 April 2010
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