HAUORA

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

Chapter 10

Pre-publication Version

WAI 2575

WAITANGI TRIBUNAL REPORT 2021

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PREFACE

This is a pre-publication version of chapter 10 of the Waitangi Tribunal's *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. The final version will be issued when the Tribunal releases a second edition of the entire *Hauora* report, which will incorporate this new chapter. In the final report, the Tribunal reserves the right to make certain amendments to the pre-publication version of this chapter: headings and formatting may be adjusted, typographical errors rectified, and footnotes checked and corrected where necessary. However, its recommendations will not change.

CONTENTS

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

The Honourable Willie Jackson
Minister for Māori Development

The Honourable Andrew Little
Minister of Health

The Honourable Peeni Henare
Associate Minister of Health

The Honourable Ayesha Verrall
Associate Minister of Health

The Honourable Kelvin Davis
Minister for Māori Crown Relations

The Honourable David Parker
Attorney-General

The Honourable Grant Robertson
Minister of Finance

Parliament Buildings
WELLINGTON

18 October 2021

E ngā Minita tēnā koutou

We enclose the final chapter of *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*, which contains our final recommendations and brings the first stage of this inquiry to an end.

When we initially released *Hauora* in June 2019, it included three interim recommendations calling for structural reforms of the primary health care system and more work to quantify the underfunding of Māori

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MINISTRY OF JUSTICE
Tāhū o te Ture

health services since 2000. We directed the Crown and the claimants to work together on both matters and to report back to us on progress. We undertook to review and finalise our interim recommendations on the basis of this feedback and in light of our earlier findings. We do so in the enclosed chapter.

The earlier chapters of *Hauora* identify multiple Treaty breaches in the Crown's legislation for, and administration, funding, and monitoring of, the primary health care system since 2000, when the watershed New Zealand Public Health and Disability Act was introduced. Crucially, we found that the primary health care framework has failed to recognise and properly provide for tino rangatiratanga and mana motuhake of hauora Māori. This failure has manifestly contributed to the inequitable health status of Māori, who, on average, continue to have the poorest health status of any ethnic group in New Zealand – despite the Crown investing some $220 billion in the health system since 2000. Our recommendations therefore urged the Crown to amend the Act and its associated policies and strategies to give proper effect to Treaty principles. We called for a primary health care sector that genuinely empowers tino rangatiratanga – which, we emphasised, means nothing less than Māori having decision-making power over their affairs, including hauora Māori.

The first of our time-bound interim recommendations called on the Crown to commit to exploring the concept of a standalone Māori primary health authority and, with the stage one claimants, develop its terms of reference. In addition, we recommended that the Crown review its current partnership arrangements across all levels of the primary health care sector, with the aim of redesigning them in conjunction with Māori health experts (including claimant representatives). This recommendation was also interim as we wanted to consider the progress made on our time-bound recommendation.

Having now reviewed progress on both matters, we have reached mixed conclusions. As we note here, the Government's decision to establish a Māori Health Authority in April 2021 was a welcome development and, in fact, goes further than our interim recommendation envisaged. However, it remains unclear which Treaty partner will actually wield the Authority's mandate: tino rangatiratanga demands it must be Māori who control it and to whom it is accountable. Nor are we sure if the Government's reforms will empower Māori to reshape the fundamental paradigm of health care itself, another key theme in our report. The answers will lie in the detailed legislative and policy arrangements that give effect to the reforms. For this reason, in finalising our interim recommendation, we call on the Crown to keep working with Māori to ensure a tino rangatiratanga-compliant health care system is realised in practice.

Our second time-bound interim recommendation was that the Crown and claimant representatives jointly agree on a methodology for assessing the underfunding of Māori primary health organisations and providers since 2000. Some promising work has been undertaken, but there is clearly much more to be done. After more than two years, we are disappointed that no agreement has yet been reached and especially disappointed that this is largely due to the Crown not engaging with the claimants on this issue. The longer this crucial work is delayed, the more the prejudice Māori have already suffered as a result of ongoing health inequities is exacerbated. Thus, in finalising this interim recommendation, we repeat it here with even greater urgency – an underfunding methodology must be agreed upon as a first step towards developing the funding regime a Treaty-compliant primary health system will require. The claimants and their advisers have already made a good start: it is now incumbent on the Crown to match their commitment and also to fully reimburse the claimants for their costs to date. Once the methodology has been agreed, we further recommend that the Crown compensate for the underfunding.

It is with sadness that I advise that this final chapter of *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* has been completed without the invaluable input of former panel member Dr Angela Ballara, who passed away in September 2021. Her contribution to this inquiry, and the expert knowledge she brought to the wider work of the Tribunal for more than 17 years, is evident in our work. On behalf of the panel, I also wish to acknowledge the contribution to the stage one inquiry of my predecessor as presiding officer, Judge Stephen Clark, who presided over this kaupapa inquiry up to the release of *Hauora* in 2019 and continued in this role until he was appointed to the District Court in 2020.

Nāku noa, nā

Judge Damian Stone
Presiding Officer

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!

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.

Taukuri e!
Koutū whenua e kore e taea te parepare;
Koutū tangata nā mate i papare.
He whānautanga mai i te Āo Pākehā,
he whakapuakitanga ake ki te Āo Māori, e Ruhi e.
Kua roa nei te ngau o tēnei mate i a koe, tē taea ai e te tangata tōna kino te karo. Haere, whakangaro atu ki a Papatūānuku, ki te huihuinga o Te Kahurangi, oti atu ai.
Ka kore rā e warewaretia te hōhonu o ngō whakawhiriwhiringa kaupapa, o ngō whakawhitiwhitinga whakaaro taea noatia ngā tautuhituhinga he taunaki i ā tātou whakataunga ki tā tātou Ripoata Hauora.
E te Ruahine o te Āo Rangahau, moe mai i roto i te rangimarie me te aroha.

Prominent landmarks may prove to be unconquerable;
Prominent personalities, death overtakes.
Born into the Pākehā World, expressive in, of, and with, the Māori World.
Long have you fought this terrible illness, for which we as mere humans have as yet no answer.
Farewell, you will become lost to us within the bosom of Earth Mother, amongst those precious to us there.
We will not forget your willing sharing of your considerable expertise and depth of thought, which were essential in our deliberations with our Health Report.
Revered elder and expert of the research world, rest in peace and with love.

The Tribunal wishes to acknowledge the recent passing of Dr Angela Ballara. Dr Ballara was one of Aotearoa's foremost scholars on Māori customary history and authored a number of authoritative texts on this topic. Dr Ballara was first appointed to the Tribunal in 2003 and made significant contributions over many years to a number of Tribunal reports, including the stage one *Hauora* report. This Tribunal benefited significantly from her wisdom and expert knowledge and we are thankful for her contribution to this inquiry. Our thoughts are with her whānau and loved ones at this time.

Me rere te kupu karamihi ki te kaiwhakaihuwaka o tēnei rīpoata i tōna wā, Judge Clark, kei te Kōti ā-Rohe e hautū ana i ngā whakawātanga o reira. 'Tēnei te nīnī; Tēnei te nānā; Tēnei te hana a te kaupapa hautupua, kaupapa hauora – mauri ora ki a koe!

We wish to acknowledge Judge Stephen Clark's exemplary leadership in the hearing and preparation of this report, with his now performing other duties as a Judge of the District Court. 'Here there is a growing realisation of the potential in this Health Kaupapa – which is so alive and owes so much to you!'

ABBREVIATIONS

CA	Court of Appeal
ch	chapter
cl	clause
doc	document
ed	edition, editor
ltd	limited
memo	memorandum
n	note
no	number
p, pp	page, pages
para	paragraph
PHO	primary health organisation
pt	part
ROI	record of inquiry
s, ss	section, sections (of an Act of Parliament)
SC	Supreme Court
tbl	table
v	and
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. A copy of the index is available on request from the Waitangi Tribunal.

CHAPTER 10

FINAL RECOMMENDATIONS (2021)

10.1 Introduction

In the *Hauora* report, released in July 2019, we found that Māori suffer significant prejudice arising from Treaty breaches in the primary health care system. We subsequently made three interim recommendations about structural and funding aspects of that system. We made two time-bound interim recommendations:

- [that] 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.

. . . . .

- [that] 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.

We also made the following interim recommendation that was not time-bound:

- 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.

We directed the claimants and the Crown to provide updates – preferably jointly – on our time-bound recommendations and we reserved the right to review them depending on their progress. Parties met our first deadline for an update on 20 January 2020, and we have granted several extensions to these updates over the past two years at their request. We now consider it appropriate to review the progress made and to issue our final recommendations.

At the outset of the inquiry, we expressed some doubt about the Crown's recognition of, and adherence to, Tribunal recommendations.[1] As we read and heard evidence, we were also keenly aware of the previous breakdown of discussions between the Ministry of Health and one of the claimant groups a decade ago. But as the stage one inquiry progressed, we were impressed by the apparent willingness of all parties, including the Crown, to remain constructive and conciliatory in their engagement with one another.

Further, the backdrop to the stage one inquiry suggested there was a real appetite for change. The launch of Te Arawhiti, the Ministry for Māori Crown Relations, occurred during our hearings, signalling the Crown's commitment to a more future-focused engagement with its Treaty partners. The Government's first Wellbeing Budget, which aimed to reframe the standards against which this country designs and implements policy and invests public funds, was announced in May 2019, a month before we released our first report. The Government's establishment of the Health and Disability System Review, too, indicated a willingness on the Crown's part to genuinely search for solutions, a willingness we also saw expressed by Crown witnesses during our inquiry.

As we conducted the stage one inquiry and prepared our report, parties urged us to remain cognisant of the broader context within which our work was unfolding. Given the positive signs described above, we considered that asking claimants and the Crown to collaborate on implementing some of the recommendations set out in our report held significant promise, even though we were well aware that many potential roadblocks to change lay ahead.

10.1.1 The Crown's reforms of the health system

What has unfolded since the release of our stage one report has confirmed a national consensus for structural change. The final report from the Health and Disability System Review was released in March 2020, during the first COVID-19 lockdown. The Crown had commissioned the Review in 2018 after formally recognising the need to confront existing inequities with the health system.[2] This was a significant step towards addressing systemic failures, and the Review panel was tasked with identifying those failures and making recommendations to create a system which would deliver health outcomes efficiently and equitably. The report presented a detailed analysis of the existing health system, and outlined the critical need for legislative, governance, and structural changes to create a cohesive and equitable health system for the future.[3]

The Government soon issued its initial response to the Review report, agreeing there was a need to address existing inequities by reducing fragmentation,

1. Transcript 4.1.1, p 171
2. Hon David Clark, 'Major Review of Health System Launched' (29 May 2018), https://www.beehive.govt.nz/release/major-review-health-system-launched
3. 'Health and Disability System Review – Final Report – Pūrongo Whakamutunga', Health and Disability System Review (March 2020), p 245

strengthening central leadership, and focusing on population health.[4] It noted that while the COVID-19 pandemic had exposed existing systemic fractures, it had also highlighted the resilience of the health sector and its ability to adopt new practices and embrace fundamental change.[5] The Ministry of Health also released two action plans in 2020 – the Initial COVID-19 Māori Response Action Plan and the Whakamaua Māori Health Action Plan 2020–2025. Both emphasised that it was crucial for the Crown to meet its te Tiriti obligations if the persistent health inequities experienced by Māori were to be addressed.[6]

On 21 April 2021, the Government formally announced its decision to commence reforms and build a 'truly national New Zealand health service'.[7] This would involve significant reform to the health and disability system, including:

- replacing all district health boards and primary health organisations with Health New Zealand (Health NZ), a single entity with four regional arms;
- establishing an autonomous Māori Health Authority;
- changing the Ministry of Health's focus to stewardship, policy, and strategy. Its commissioning role would be devolved to Health NZ and the Māori Health Authority;
- centralising public health advice and planning by setting up a Public Health Agency within the Ministry of Health; and
- tailoring services to meet the needs of particular communities and geographic regions through a 'locality approach'. These would comprise networks of primary health and community service providers such as general practitioners, primary health nurses, maternity carers, and optometrists.[8]

4. Cabinet Office, 'Minute of Decision: Response to the Health and Disability System Review/Hauora Manaaki ki Aotearoa Whānui' (8 June 2020), CAB-MIN-20–0269, paras 4–8, https://dpmc.govt.nz/sites/default/files/2021–03/cabinet-material-health-disability-system-review-mar21.pdf

5. Cabinet Office, 'Response to the Health and Disability System Review/Hauora Manaaki ki Aotearoa Whānui', CAB-SUB-20–0269, para 10

6. 'Initial COVID-19 Māori Response Action Plan', Ministry of Health (2020), pp 4–10; 'Whakamaua Māori Health Action Plan 2020–2025', Ministry of Health (July 2020), pp 13–15, 62

7. Hon Andrew Little and Hon Peeni Henare, 'Building a New Zealand Health Service that Works for All New Zealanders' (21 April 2021), https://www.beehive.govt.nz/speech/building-new-zealand-health-service-works-all-new-zealanders, last updated 21 April 2021

8. 'Our Health and Disability System: Building a Stronger Health and Disability System that Delivers for All New Zealanders', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet (April 2021), pp 6–8. The Review's report envisioned localities as geographically defined areas with populations of between 20,000 and 100,000 people. Each locality would have a mix of primary health services (including Māori health providers) that reflected the community's characteristics and needs, were culturally safe, and improved access for those needing care. They suggested each network would have an indicative budget based on age, ethnicity, and socio-economic deprivation, and it would be guided by five-year strategic plans: 'Health and Disability System Review – Final Report – Pūrongo Whakamutunga', Health and Disability System Review, pp 100–101.

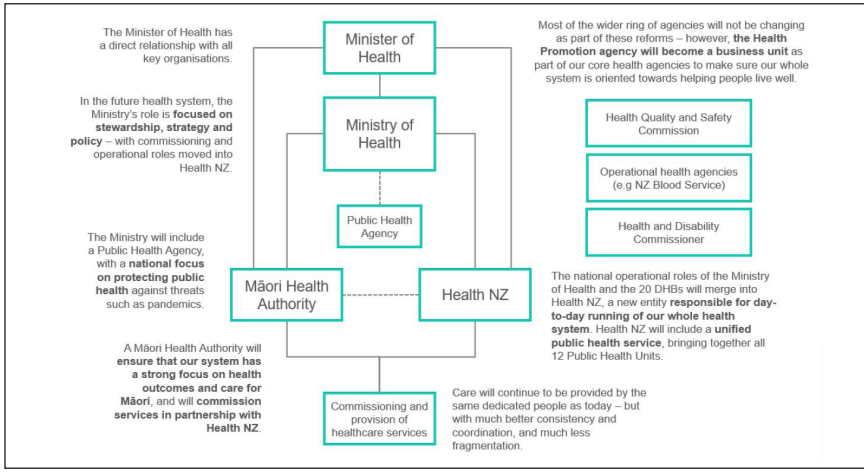

Figure 3: Outline of the proposed new national health system, as at April 2021

Source: 'Our Health and Disability System: Building a Stronger Health and Disability System that Delivers for All New Zealanders', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet (April 2021), p 6

The Hon Andrew Little, Minister of Health, stated that '[t]he system must work in true partnership with Māori to improve services and achieve equitable health outcomes.'[9]

10.1.2 The work of the stage one inquiry parties to date

Since the release of our stage one report over two years ago and alongside these broader moves towards health sector reform, the parties in this inquiry have also been working to address our interim recommendations. They have reported to us on their progress via a series of submissions. The latest submissions we have received, detailed below, convince us that progress on reform is now far enough advanced for us to finalise our interim recommendations.

We have received regular updates from the parties since January 2020. Initially the updates focused on the work to design and establish a Māori health authority. We were cautiously encouraged by these updates, as they indicated that the Crown and the claimants were moving well beyond the terms of our interim recommendation to 'explore the possibility of a stand-alone Māori primary health authority'. Instead, the updates confirmed to us that the possibility was fast becoming a reality. This was one of the primary reasons why we were prepared to extend the

9. Hon Andrew Little and Hon Peeni Henare, 'Building a New Zealand Health Service that Works for All New Zealanders', https://www.beehive.govt.nz/speech/building-new-zealand-health-service-works-all-new-zealanders, last updated 21 April 2021; 'Our Health and Disability System: Building a Stronger Health and Disability System that Delivers for All New Zealanders', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, p 6

reporting timeframes beyond 20 January 2020. While we acknowledge the claimants' expectations of the design process with the Crown were not always met, we focus here on a pathway forward for the Authority as its details are finalised.[10]

Less progress was made on our interim recommendation to agree an underfunding methodology. On 9 August 2021, we received a joint submission from the stage one claimants advising that the Sapere Research Group, which they had commissioned independently to develop a methodology for assessing underfunding, had completed its report: *Methodology for Estimating the Underfunding of Māori Primary Health Care* (referred to here as the Sapere report).[11] In response, the Crown provided a preliminary view of the report on 27 September 2021, but advised it would comment on it more fully 'in due course.'[12] We also received three affidavits and a submission on behalf of Raukura Hauora o Tainui Trust. Raukura Hauora was originally a party represented by the Māori Primary Health Organisations and Providers claim (Wai 1315), but asked to file separately.[13]

On 6 October 2021, we received a submission from the stage one claimants requesting that a two-day hearing be held to test the reliability of the Sapere report they had commissioned, so that the Tribunal could make recommendations on the methodology itself.[14] We decided this was not necessary.[15] Our caveat in chapter 9 remains relevant: we are experts in the Treaty relationship, and we think the parties themselves are more capable of interrogating in-depth the merits of any methodology.

Informed by these latest submissions and the others received from parties since 2019, we now proceed to finalise our stage one interim recommendations. We do so under the following headings:

- 'Giving Effect to the Treaty Partnership and Empowering Tino Rangatiratanga'; and
- 'Funding a Treaty-Compliant Health System'.

10.2 Giving Effect to the Treaty Partnership and Empowering Tino Rangatiratanga

10.2.1 Our interim recommendations

As set out at the start of this chapter, our first time-bound interim recommendation was that the Crown and representatives of the stage one claimants design draft terms of reference to explore the possibility of a stand-alone Māori health authority.

We also made a related interim recommendation that the Crown review, with a view to redesigning, its current partnership arrangements across all levels of the primary health care sector. This recommendation was interim also because

10. Submission 3.2.293, para 4; submission 3.2.331, paras 14–18
11. Submission 3.2.331, para 9
12. Submission 3.2.333, paras 5, 17
13. Submission 3.2.343; docs B36–B38
14. Submission 3.2.352, paras 3(b), 13
15. Memorandum 2.6.62

we wanted the opportunity to review it in light of the progress being made (or otherwise) towards our time-bound interim recommendation. If necessary, we wanted to be able to make more detailed partnership recommendations about the legislative and policy framework.

10.2.2 The Crown's proposals for the Māori Health Authority and Iwi / Māori Partnership Boards

Since we released our report, the Crown has committed to establishing a Māori Health Authority. In April 2021, it set out at a high level how it is intended to function.[16]

The Crown's initial outline of its reforms to the health system (depicted in Figure 3) emphasises that every element of the health system is responsible for achieving equitable health outcomes for Māori, and that the Māori Health Authority will be an important driver and monitor of this central standard.[17] According to Associate Health Minister Peeni Henare, the Māori Health Authority 'will have joint decision-making rights to agree national strategies, policies and plans that affect Māori, at all levels of the system.'[18]

The Authority will have two main responsibilities:

> it will support the Ministry in shaping system policy and strategy to ensure performance for Māori, and will work in partnership with Health NZ to commission care across New Zealand, ensuring that the needs and expectations of Māori communities are also centred in design and delivery.[19]

In effect, the Māori Health Authority will work with the Ministry of Health to make sure the health system is performing in a way that will ensure equitable health outcomes for Māori are a firm priority. The Authority will partner with the Ministry on providing ministerial advice and monitoring the health system's performance.[20]

16. The papers detailing the Government's April 2021 reform announcement can be found here: 'The New Health System', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, https://dpmc.govt.nz/our-business-units/transition-unit/response-health-and-disability-system-review/information, last updated 27 August 2021.

17. 'Our Health and Disability System: Building a Stronger Health and Disability System that Delivers for All New Zealanders', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, p 7

18. Hon Andrew Little and Hon Peeni Henare, 'Building a New Zealand Health Service that Works for All New Zealanders', https://www.beehive.govt.nz/speech/building-new-zealand-health-service-works-all-new-zealanders, last updated 21 April 2021

19. 'Our Health and Disability System: Building a Stronger Health and Disability System that Delivers for All New Zealanders', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, p 6

20. 'Our Health and Disability System: Hauora Māori', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet (April 2021), p 1; 'Our Health and Disability System: Stewardship', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet (April 2021), p 1

The Authority will also partner with Health NZ (which will replace all district health boards and be responsible for planning, commissioning, and day-to-day management of the health system) to 'design, commission and deliver health services'.[21] In addition, it 'will hold a direct commissioning budget for kaupapa Māori services [and] be a co-commissioner of primary care services with Health NZ'.[22] The two agencies will jointly develop the New Zealand Health Plan.[23] The Health Promotion Agency, which will be incorporated into Health NZ, will share its services with both Health NZ and the Māori Health Authority.[24] This includes retaining the agency's core functions of providing advice and recommendations to inform health policy and practices in pursuit of well-being outcomes.[25]

In addition to these joint functions, the Māori Health Authority will have the power to independently commission health services.[26] The Crown said it intends for the Māori Health Authority to use its joint and independent powers to 'intervene' where health services are underperforming for Māori.[27]

The Māori Health Authority will report to the Minister of Health and will be funded through the Ministry of Health. The process for appointing the board that will run the Authority has not been finalised, but a steering committee headed by Tā Mason Durie appointed an interim board on 23 September 2021, to be chaired by Sharon Shea and Tipa Mahuta.[28]

21. 'Our Health and Disability System: Stewardship', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, p 2. 'Commissioning' is defined as funding a service for a particular outcome; this can be done either by funding a service internally, or through an external or third-party provider. The current health commissioning framework pays for services but does not measure their outcomes. In 2014, the Government introduced 'commissioning for outcomes' – a framework which measures outcomes to identify whether public funding has been used effectively: doc A75, para 7.6. In relation to Whānau Ora, this approach has been pivotal to the success with which non-governmental commissioning agencies have acted as brokers to fulfil the needs of whānau through a more flexible, whānau-centred model: submission 3.2.18(a), p 38. The Hon Peeni Henare confirmed that research indicates 'a whānau-centred approach will lead to better health outcomes for Māori and Pacific Peoples if the Ministry of Health introduces a commissioning for outcomes model'. Commissioning for outcomes has also informed the Government's Wellbeing policy framework, along with the Whakamaua Māori Health action plan: Hon Peeni Henare, 'New Approach Affirms Whānau-Centred Approach to Primary Health Care' (3 September 2020), https://www.beehive.govt.nz/release/new-research-affirms-wh%C4%81nau-centred-approach-primary-health-care.

22. Submission 3.2.344, para 16

23. 'Our Health and Disability System: Hauora Māori', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, p 2

24. 'Our Health and Disability System: Building a Stronger Health and Disability System that Delivers for All New Zealanders', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, p 6

25. Ibid, p 10

26. 'Our Health and Disability System: Hauora Māori', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, p 1

27. Ibid, p 2

28. Hon Andrew Little and Hon Peeni Henare, 'Expert Group Appointed to Lead New Zealand's Future Health System', https://www.beehive.govt.nz/release/expert-group-appointed-lead-new-zealand%E2%80%99s-future-health-system, last updated 23 September 2021

At present, the Crown intends for the Māori Health Authority and Health NZ to take permanent form under legislation that will come into force in July 2022.[29]

In the April 2021 announcement, Associate Minister Henare also said that at a local level, 'Māori will have a clear voice in decision-making through the evolved iwi/Māori partnership boards that will approve priorities and service plans for localities.'[30] These boards appear to be envisioned as expansions of the Iwi/Māori Partnership Boards that currently exist in each District Health Board catchment. The Crown is yet to provide much further detail on how these new entities will operate, as this will be partly decided by the interim board of the Māori Health Authority.[31]

10.2.3 Our view on the Crown's proposals

The Crown's April 2021 reform announcement, including the establishment of a Māori Health Authority, is a significant, positive development towards both the provision of equitable health care and the realisation of the Treaty partnership and its obligations. It also more than satisfies the terms of our time-bound interim recommendation, which stipulated only that the parties should 'explore the possibility of' a Māori health authority. We have not inquired into the development of the Māori Health Authority to date, either in terms of process or substantive outcomes. Therefore we do not consider that further discussion of the quality of the engagement between parties leading to these reforms is needed here.

In this section, we instead consider the health reforms against our recommendations, applying the standards we established through our discussion of Treaty principles in the stage one report (see chapter 3) and our analysis and findings (see chapters 5–8).

In our view, the agency's proposed form and functions, and its intended role as an agent of tino rangatiratanga, seem to reflect the aspirations of the stage one claimants. They appear to address our findings and recommendations, especially our concern that the existing health system did not reflect the Treaty partnership or properly give effect to tino rangatiratanga. To reiterate one of the core themes of our report, tino rangatiratanga means nothing less than Māori having decision-making power over their affairs, including hauora Māori.[32] Tino rangatiratanga

29. Submission 3.2.333, para 11

30. Hon Andrew Little and Hon Peeni Henare, 'Building a New Zealand Health Service that Works for All New Zealanders', https://www.beehive.govt.nz/speech/building-new-zealand-health-service-works-all-new-zealanders, last updated 21 April 2021

31. 'Information Pack, Interim Boards: The Māori Health Authority and Health New Zealand', https://www.healthreformboardexpressionofinterest.co.nz/files/Information%20Pack.pdf

32. Waitangi Tribunal, *The Ngātiwai Mandate Inquiry Report* (Wellington: Legislation Direct, 2017), p 27; Waitangi Tribunal, *The Ngāpuhi Mandate Inquiry Report* (Wellington: Legislation Direct, 2015), 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; Waitangi Tribunal, *Te Whanau o Waipareira Report* (Wellington: Legislation Direct, 1998), p 215

means autonomy in the fullest sense possible.[33] When the Crown says it is partnering with Māori and giving effect to tino rangatiratanga, the Crown is required to protect actively Māori authority in respect of their own affairs.

Achieving equity and partnering with Māori have been expressly adopted as two of the key pillars of the new health system.[34] In our findings in chapter 8, we said that achieving equity will not be possible without tino rangatiratanga of hauora Māori. Historically, the Crown, its agents, and its delegates, have given limited recognition to tino rangatiratanga in the primary health system. As we discussed in chapter 5, that reflected, at least in part, the Crown's flawed understanding of what tino rangatiratanga means in practice. But we think it was also because, in the health context, the Crown has too often treated its Treaty obligations, and those of its agencies and delegates, as negotiable or expressed them merely as 'guidance' rather than central to the way the system should operate. In chapter 8, we found that the primary healthcare framework does not recognise or properly provide for tino rangatiratanga of hauora Māori.

It is crucial that the Crown recognise that tino rangatiratanga, as guaranteed in article 2 of the Treaty, affords Māori governance functions that sustain whānau, hapū, and iwi wellbeing. The consequences of not doing so are grave. As the Tribunal commented in the recent Oranga Tamariki report, 'decades of Crown resistance and hostility to the guarantee to Māori of the right to cultural continuity – embodied in the article 2 guarantee of tino rangatiratanga' have had a direct connection with poverty and disparities in many areas, including health.[35]

Based on the information available to us, we think the formal relationships the Māori Health Authority will have with the Ministry of Health and with Health NZ offer real potential. Beyond Māori health experts simply being consulted or 'having input' into key decisions, the proposed model appears to give the Māori Health Authority a meaningful mandate over the key functions that will dictate how health care policies and services are designed, planned, and delivered, in relation to both Māori-owned and other providers of care.

Crucially, however, it remains unclear which Treaty partner will actually wield this mandate. The claimants have stressed to us consistently – not just throughout the stage one inquiry, but in their updates since our report was released – that the Māori Health Authority needs to be controlled by Māori for it to be effective. The information the Crown has released so far indicates this is an issue its officials

33. Waitangi Tribunal, *Tauranga Moana, 1886–2006: Report on the Post-Raupatu Claims*, 2 vols (Wellington: Legislation Direct, 2010), 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

34. 'Our Health and Disability System: Building a Stronger Health and Disability System that Delivers for All New Zealanders', Health and Disability Review Transition Unit, Department of the Prime Minister and Cabinet, p 3

35. Waitangi Tribunal, *He Pāharakeke, he Rito Whakakīkīnga Whāruarua – Pre-publication Version* (Wellington: Waitangi Tribunal, 2021), p 180

Recommended Principles

In our report, we recommended the following principles be adopted 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.
(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.

The Ministry of Health has since included these in their reissued Māori health action plan, which applies to the whole health sector.[1]

1. 'Whakamaua Māori Health Action Plan 2020–2025', Ministry of Health (July 2020), p 15

continue to grapple with, and as yet it is unknown what governance arrangements will be put in place to ensure the Authority's ultimate accountability is to Māori.

So long as the Māori Health Authority is ultimately accountable to and governed by Māori, its formal relationships with the Ministry of Health and Health NZ appear (on their face) to mitigate the risk of the Crown's Treaty obligations being diluted. According to the reform papers, these arrangements will require collaboration on or joint sign-off of key strategies and planning documents; ministerial advice; policy design and delivery; commissioning of health services; and monitoring.

Formalising the Māori Health Authority's inter-agency relationships and joint functions in this way is essential for realising this partnership. Moreover, it is worth noting that initiatives requiring joint responsibility and sign-off between government agencies are very common. The Department of the Prime Minister

and Cabinet regularly coordinates inter-agency working groups for specific purposes or work programmes that require a whole-of-government response. In addition, agencies are regularly charged as joint leads or collaborators on certain national strategies and policies where priorities and interests overlap. Given we know there are already established models for joint agency work, it makes sense to apply these models to the Māori Health Authority and its partnerships in the health sector. To ensure these relationships and joint sign-off arrangements are enduring, we think they should be codified in statute.

We recognise these reforms have only been outlined at a very high level, and there is still more detail to be worked out between the Treaty partners. With that in mind, we wish to highlight two matters about the Māori Health Authority's joint functions that remain unclear after the Crown's reform announcements, and that the parties have not discussed specifically in their submissions to us. First, while the Authority's role in respect of primary care services is relatively well defined, its proposed role in secondary and tertiary care is less clear. We have not yet heard claims that go beyond primary care, but were told in the course of hearings of the severe downstream effects of an inadequate primary care system on hospital care and care for people with complex, serious illnesses. We were also made aware of the severe inequities in health outcomes arising from inadequate care at all levels of the system.[36] It seems the Authority will have a role in secondary and tertiary care, given its proposed ability to jointly approve or devise strategies, plans, and reporting standards for the whole sector. While this role is not yet confirmed, it appears this will be clarified in due course.

Secondly, the Māori Health Authority's relationship with the Public Health Agency is yet to be clearly defined. Minister Little rightly declared in announcing the reforms that '[p]opulation and public health present some of the largest opportunities to address inequity, tackle the causes of health need, and manage future demand.' As the Public Health Agency will 'lead public health strategy, policy, analysis, and monitoring', we would expect to see the Crown ensure there is Treaty-consistent Māori decision-making there, too.[37]

In addition to the Māori Health Authority's joint functions with other agencies, its independent commissioning power should allow it significant leverage to achieve equity. It is unlikely that the Crown needs to be reminded of the evidence presented in our stage one inquiry that highlighted the clearly anaemic funding for the Māori Provider Development Scheme, presently run by the Māori Health Directorate. We expect the new Authority to be funded adequately and provided with the necessary powers to make sure this independent function has a meaningful impact.

The Māori Health Authority's mandate appears clear. What remains uncertain is the ability of Māori to exercise that mandate effectively and in accordance with

36. See docs B1–B20

37. Hon Andrew Little and Hon Peeni Henare, 'Building a New Zealand Health Service that Works for All New Zealanders', https://www.beehive.govt.nz/speech/building-new-zealand-health-service-works-all-new-zealanders, last updated 21 April 2021

tino rangatiratanga. Given it appears the Authority will be a Crown entity and will receive significant public money, there will need to be some form of accountability to the Crown; however, we do not think this is necessarily incompatible with tino rangatiratanga, so long as it is not at the expense of the Crown's Treaty obligations. The well-worn adage that 'the devil is in the details' is relevant here; the quality of the Authority's governance and where its ultimate accountability will lie are crucial details that go to the heart of the stage one claims, and the findings we made in our report. Through the Treaty, Māori are guaranteed tino rangatiratanga of hauora Māori, which includes Māori health organisations and their models of care. It also means that Māori must be able to access these models of care. Consistent with the principle of options, whether the health care services that Māori access are kaupapa Māori services or so-called mainstream services, Māori tino rangatiratanga rights in respect of those services remain. Māori should be able to design the governance arrangement for the Authority themselves, and then implement it so that the Authority is governed by and accountable to Māori. We are confident that a reasonable governance arrangement for this Crown entity that upholds tino rangatiratanga is attainable. If the Crown supports the establishment of the Authority but fails to fully uphold and empower tino rangatiratanga, the Crown will be acting inconsistently with its Treaty obligations.

Further, the Māori Health Authority's stated mandate and functions will require it to discharge what is arguably the hardest job of any of the central health agencies. It will be expected to advocate for the equity agenda when the other central health agencies have dropped the ball. It will be expected to intervene in the worst-performing services of the health system, and improve them, including services offered by so-called 'mainstream' providers. It will also, as an agent of tino rangatiratanga and of iwi, hapū, and whānau health needs and aspirations, feel the enormous pressure of the communities it serves. The Crown has been advised many times – both in our inquiry and previous Tribunal inquiries – that if it is going to delegate significant responsibilities to Māori-controlled bodies, it must provide them with enough resources to ensure that they do not fail, and are able to discharge those responsibilities in a way that benefits the whānau, hapū, and iwi they serve.

We also note the intention to expand the role of the Iwi/Māori Partnership Boards. They will be, the Crown has said, one of the key ways that whānau, hapū, and iwi can voice local issues and partner with central agencies through the new 'localities' structure. They will have power to sign off on local service delivery plans and specific health measures for their communities.[38] As we noted in chapter 5, under the former system, these boards suffered from a severe lack of funding; in addition, their role was advisory only and was sought inconsistently. Broadening the remit of the Iwi/Māori Partnership Boards is a positive step, especially since it appears they will be involved in supporting and giving direction to a range of

38. Hon Andrew Little and Hon Peeni Henare, 'Building a New Zealand Health Service that Works for All New Zealanders', https://www.beehive.govt.nz/speech/building-new-zealand-health-service-works-all-new-zealanders, last updated 21 April 2021

different service providers, including non-Māori providers. We expect the Crown to provide them with the adequate tools, resourcing, and support to carry out what will also be extraordinarily difficult roles.

We wish to make one final comment on the Government's proposed reforms. One of our key findings is that Māori have tino rangatiratanga of hauora Māori. As claimants stressed to us, Māori benefit from more holistic models of care, but Māori health and social service providers are not empowered to be able to provide these services adequately. We are hopeful that, with the right conditions met, these reforms will give Māori significant power to shape the design and provision of what appears, still, a resolutely medical model of care. But we are not yet convinced these reforms will give Māori the power in practice to shape the fundamental paradigm of health care itself, and fully empower more holistic models of care. The detail of the reforms – including confirming the level of funding for and decision-making power of the Authority, Iwi/Māori Partnership Boards, and Māori health providers themselves – will reveal the capacity of the new system to properly empower hauora-based models of care.

10.2.4 Our final recommendation

We consider that, given the progress to date and the Crown's commitment to continue involving the claimants and Māori more generally in the implementation of the reforms, our interim recommendations about the need to give effect to the Treaty partnership and to explore the possibility of a Māori health authority can now be made final.

Accordingly, we recommend that:

- the Crown and the stage one claimants continue working together on the operational details of the Māori Health Authority and Iwi/Māori Partnership Boards, including their core functions and final budgets, to achieve a tino rangatiratanga-compliant model.

The appointment of the Māori Health Authority's interim board means the claimants will have some input on the rollout and details of the reforms. We know from the stage one inquiry and from the work the claimant groups have since undertaken that they have contributed valuable expertise to aid the reforms. We consider their continued involvement – including their representation on the interim Māori Health Authority board, as well as through other avenues – will be valuable to the Crown and the wider sector.

10.3 Funding a Treaty-Compliant Health System

10.3.1 Our interim recommendation

Our second interim recommendation was for the parties to agree upon a methodology for assessing the extent of underfunding of Māori primary health organisations and providers. We wanted the methodology to include a means of assessing underfunding in relation to both the initial establishment of these organisations and providers, and their ongoing resourcing, since the commencement of the New Zealand Public Health and Disability Act 2000.

10.3.2 Overview of funding for the primary health care system since 2000

As we set out in chapter 4, New Zealand transitioned to capitation funding for primary health care in 2000. The Government intended to create income stability for primary health organisations and improve affordability and health care quality for patients by using a capitated (or per-enrolled patient) model. The funding model uses several capitated funding streams based on a primary health organisation's enrolled population. These are set out in brief below.

First-level services funding (otherwise known as first-contact funding) is the dominant capitated funding stream. It is adjusted for age, gender, and patients who have high-use health cards, but does not adjust for ethnicity or socio-economic deprivation. First-level services are topped up by one or, more often, a combination of:

- Co-payments from patients who pay a fee at the point of service, set by each practice.
- Very Low-Cost Access funding, which is used by practices with enrolled patients who might be impacted by high co-payments. This stream applies where at least 50 per cent of enrolled patients are Māori, are Pacific peoples, have Community Services Cards,[39] and/or live in areas with populations having a deprivation index rating of 9–10.
- Zero Fees for under 14s scheme (where co-payments that would otherwise be charged for enrolled patients under 14 are partly funded by the Ministry).

Primary health organisations are also funded by the Flexible Funding Pool. Unlike first-level services funding, the capitated funding streams included in the Flexible Funding Pool (namely, Services to Improve Access; Health Promotion; and Care Plus) are all variously adjusted for ethnicity, as well as age, gender, and socio-economic deprivation. The Flexible Funding Pool also includes a management service fee to account for administrative and management costs, which increases depending on the size of the primary health organisation's enrolled population.

In addition to these capitated funding streams, newly formed primary health organisations received funding to assist with the costs of their establishment, referred to as establishment funding. No formula or criteria existed to calculate establishment funding and therefore it varied considerably from organisation to organisation. A contestable development fund is also available to Māori health providers through the Māori Provider Development Scheme.

10.3.3 The Sapere report

Following our 2019 report, representatives from each of the stage one claimant groups, independent advisers, and Ministry of Health officials formed an expert

39. Practices that are not part of the Very Low-Cost Access scheme can separately apply for subsidised funding for Community Services Card holders: Peter Crampton, 'The Ongoing Evolution of Capitation Funding for Primary Care: The December 2018 PHO Capitation Funding Changes for Community Services Card Holders', *New Zealand Medical Journal*, vol 132, no 1498 (12 July 2019), pp 72–73.

advisory panel and commissioned the Sapere Research Group to develop an underfunding methodology.[40] However, the Crown withdrew from the advisory group shortly after its formation for reasons that are unclear to us, and the claimants ended up engaging Sapere independently to complete a methodology to estimate underfunding.[41] The claimants presented the finalised report to the Minister of Health, the Hon Andrew Little, and the Associate Minister of Health, the Hon Peeni Henare, on 5 August 2021.

The Sapere Group's report, *Methodology for Estimating the Underfunding of Māori Primary Health Care*, aims to inform future-focused discussion of compensation and investment in Māori primary health care services in New Zealand. It presents possible methods of assessing underfunding, and also provides tentative results from applying those methods to a test population.[42] While acknowledging that our specified recommendation was to provide a methodology, the research group deemed it necessary to apply that methodology too, to ensure it was 'fit for purpose.'[43]

The Sapere report identified three key areas of underfunding in the capitation funding formulas that impact Māori practices:

- insufficient Very Low-Cost Access funding;
- insufficient recognition of distribution morbidity (essentially, that capitation formulas do not adequately account for the unique age distribution of Māori); and
- insufficient recognition of socio-economic deprivation (essentially, that capitation formulas do not adequately account for the fact that Māori populations are disproportionately represented in lower deciles).[44]

It also estimated 'aspects of establishment and working capital' underfunding for primary health organisations, as well as capital lost due to clawbacks when enrolled patients travel or move and access a service by a different primary health organisation.[45]

Applying its analysis of these insufficiencies to a test population (comprising the enrolled populations of the four Māori primary health organisations we referred to in chapter 4, as well as the Hauraki PHO) the Sapere report estimated that:

- Māori primary health organisations and providers have been underfunded by between $394 million and $531 million since 2003; and
- funding primary health care in a way that adequately serves this test population's health need in a Treaty-compliant way would cost between $346

40. Submission 3.2.333, para 18; submission 3.2.331, paras 7–9
41. Submission 3.2.331, paras 8–9. The Crown did, however, express its view that the claimants' commission for the Sapere Research Group included work that went beyond our interim recommendations: submission 3.2.333, paras 18–19.
42. Submission 3.2.331(a), p vi
43. Ibid, p iv
44. Ibid, p 5
45. Ibid, p 3

million and $412 million a year. For the whole Māori population, it would cost between $891 million and $1.06 billion a year.[46]

The Sapere report also estimated the cost of not providing an equitable health service to Māori (based on the rate of hospital admission for Māori aged under 5 and between 45–64 in 2018) at $5 billion a year.[47]

10.3.4 The parties' responses to the Sapere report

10.3.4.1 *The Crown*

The Crown filed its response to the Sapere report on 27 September 2021. Counsel submitted that the Crown was 'not in a position at this stage' to provide the substantive response the Tribunal was seeking, which would have required it to 'consider its quantification of underpayment and set out decisions about compensation for past underfunding.' The Crown submitted there had been insufficient time for the 'in-depth consideration' the Sapere report required, and for the significant financial decisions that might arise from it.[48]

Instead, the submission set out the Crown's 'preliminary assessment' of the Sapere report.[49] It argued this would be of value to its ongoing discussions with claimants and the work of the Transition Unit leading the health reforms.[50] The Crown made the following specific comments about the report's findings, adding that it could provide the Tribunal with further evidence if necessary:

- the funding streams in primary health care need to change in order to better account for health needs. Greater clarity about the streams themselves, and about how they are evaluated and monitored, is essential to ensure the health and disability system meets its Treaty obligations;
- the report finds that 'prevention is an important tool in the health and disability system to minimise health loss in an equitable manner';
- the report highlights a model of a Māori primary health care service which is reflective of a 'true hauora Māori system';
- the report includes examples of 'packaged funding', which have the flexibility to give Māori health providers the opportunity to innovate and shape services to meet their populations' needs; and
- the report also highlights the potential to adopt 'a holistic approach' to the monitoring and evaluation of health services – something which is not present in the current health system. Such an approach could prove 'more statistically sound', and help Māori health providers better meet their reporting requirements and encourage new forms of reporting.[51]

Overall, the Crown considered that the principles shaping the Sapere report were consistent with those of the Health and Disability System Review. It said the Transition Unit was drawing on the report as it worked on health system reform

46. Submission 3.2.331(a), p v
47. Ibid, pp v–vi
48. Submission 3.2.344, para 5
49. Ibid, para 6
50. Ibid, para 13
51. Ibid, paras 13–15

design and budget setting for the Māori Health Authority; further, the report was informing Budget 2022 processes. The report's findings on underfunding could also be used, the Crown submitted, in 'future health entity budget setting', with the aim of ensuring Māori health providers were equitably resourced to provide 'by Māori, for Māori services'.[52]

However, the Crown also submitted that the assumptions underlying the report necessarily 'simplify the funding streams of the health and disability system'; it cautioned that this 'raise[s] concerns about the reported estimates for underfunding to Māori primary care.' Further, counsel noted that the significant transformation Māori health providers have undergone in the past 18 years (as a result of mergers, subsidiaries, and disestablishments) 'adds additional complexity to the calculations'.[53] The Crown also advised that, having now received the Sapere report, the Deputy Director-General Māori Health was reconsidering the claimants' request for additional Ministry funding to cover the costs of producing the Sapere report.[54]

10.3.4.2 *Raukura Hauora o Tainui Trust*

Raukura Hauora's submission responding to the Sapere report was accompanied by three affidavits, which we received on 27 and 29 September 2021. One was by Raukura Hauora's chief executive, Terina Aroha Moke; Raukura Hauora commissioned the others from two health experts who had already contributed valuable evidence to our inquiry:

- Dr Jacqueline Cumming, the Director of the Health Services Research Centre at Victoria University of Wellington, who appeared as a Crown-commissioned independent witness; and
- Teresa Wall, an independent health consultant and former Deputy Director-General of Māori Health, who appeared as an interested party witness.

We summarise the three affidavits only very briefly here. We are mindful that they have not been tested as evidence, and other parties have had no opportunity to cross-examine these witnesses or present their own evidence. As such, while we go on to make some very general observations about the affidavits in section 10.3.5, we make no factual findings based on them.

Dr Cumming stated that the Sapere report 'provides an excellent starting point'.[55] However, she also identified some significant issues related to capitated funding that Sapere did not consider.[56] She emphasised that the most critical work still to be done was estimating underfunding from the first-level services funding formula, as a result of it not having risk adjustments for ethnicity and socio-economic deprivation. She recommended using the ethnicity and socio-economic deprivation risk adjustments currently used for the Services to Improve Access

52. Ibid, para 14.4
53. Ibid, para 14
54. Ibid, paras 8, 10
55. Document B38, para 18
56. Ibid, paras 39–41

funding stream.[57] Among the other issues she considered that an underfunding methodology should account for were the lower Māori enrolment rates in primary health organisations;[58] indications that Māori use primary care services more often;[59] and the unmet health needs of Māori living in deciles 1–8.[60]

Teresa Wall similarly stated that 'the Sapere report is an excellent report and goes some way to meeting the interim recommendation by the Waitangi Tribunal'.[61] She agreed with Dr Cumming's affidavit, particularly her comment that 'changes in the capitation formula[s] on their own are not likely to be sufficient to improve Māori health significantly.'[62] Accordingly, Ms Wall focused on two other likely sources of underfunding she considered were not fully accounted for in the Sapere report: the notably small amount of funding for the Māori Provider Development Scheme, which has remained essentially the same since the scheme was established in 1997.[63] She also argued for an estimate of the financial impact over time on Māori primary health organisations and providers due to insufficient or lost capital.[64]

In her closing comments, Ms Wall advocated for a comprehensive, hauora-based model of care, saying it should be a feature of the current health reforms.[65] She suggested that the vision set out in the Sapere report was somewhat limited in this respect: it based its future funding calculations on the current, medical model of care, rather than calculating the funding required to work 'across sectors' to address social determinants of health, or to enable whānau to co-design the care they needed.[66]

Terina Moke's response to the Sapere report outlined the experience of Raukura Hauora, which she argued is a victim of severe underfunding. She argued that its experiences bore out the conclusions of our report, and of the Sapere report and Dr Cumming's and Ms Wall's affidavits.[67] She said that Raukura Hauora serves many high-needs patients and provides kaupapa Māori-based services, resulting in much greater expenses per patient than other practices even within their primary health organisation network.[68]

57. Document B38, para 20
58. Ibid, para 43
59. Ibid, para 44
60. Ibid, para 57
61. Document B36, para 7
62. Document B38, para 71; doc B36, para 10(a)
63. Document B36, paras 12–13. Dr Cumming also argued the need for an assessment of 'underfunding for on-going development' of primary health organisations and providers: doc B38, para 42.
64. Document B36, paras 42–66
65. Ibid, para 71
66. Ibid, para 75
67. Document B37, paras 65–66, 78–80, 86–88, 96
68. Ibid, paras 21–23, 27, 57–60

10.3.5 Our view on the Sapere report and the responses to it

Here, we offer some insights on the Sapere report and the parties' responses, informed by our knowledge gained from stage one and what we know of the progress of work carried out since our report was released. We are particularly mindful that, although we called for submissions on the Sapere report, we have not undertaken an inquiry into it and the evidence filed in response to it has not been tested.

The parties appear to agree that the Sapere report provides a useful starting point for assessing the underfunding incurred by Māori primary health organisations and providers. The affidavits provided by Dr Cumming and Ms Wall highlight some additional funding considerations not fully accounted for in the Sapere report. Dr Cumming identified other capitated funding streams that should be investigated, in particular emphasising (and echoing the evidence we heard in our inquiry) that there should be adequate adjustments for ethnicity and socioeconomic deprivation in primary care funding. Although those affidavits have not been tested, based on the evidence we heard in stage one and our findings in chapter 6, we see some merit in the proposition that the Sapere report may not cover all aspects of underfunding.

For example, we were told in stage one of our inquiry that assessing and rethinking capitation will not solve the inequitable distribution of funds, or fully account for underfunding. We heard that establishment underfunding for primary health organisations, and the flow-on effects, must be accounted for in any underfunding methodology. Although the Crown said it could not give a thorough response, its preliminary view is that the Sapere report does not consider all funding streams or all issues with them. This view is consistent with those expressed by Raukura Hauora. While we agree with the parties that the Sapere report is a good start, it is not the finished product.

In our view, the most important outcome of the Sapere report and the parties' responses is that the Crown and Māori now have some further actionable information about how to calculate underfunding that they did not have in 2019. The Sapere report and the Raukura Hauora response address all the major funding areas we heard evidence on, and their conclusions appear to align with our findings in chapter 6. Armed with this information and sharing common ground about the Sapere report's broader findings, the parties now appear even better equipped to come up with an agreed methodology than when we released our stage one report.

The Sapere report's high-level estimate of the economic cost of inequity (however speculative) should be firmly front of mind for the Crown officials and others engaged in further work on the underfunding methodology. We are disappointed that the condition we set in our interim recommendation – namely, that parties agree on a methodology – has still not been satisfied, and particularly disappointed with the Crown's apparent lack of engagement on, and commitment to, this important work. We acknowledge the disruption caused by the COVID-19

pandemic. Nonetheless, we cannot comprehend why – after more than two years, and despite the Crown having managed to design an entirely new health system in that time – it has failed to substantially progress this critical work on underfunding, with the claimants' expert input. In our view, the Crown's declarations in its closing arguments in our stage one inquiry that it is committed to reviewing the funding for primary care have not yet been borne out by its actions.[69]

Instead, it is the claimants and their Expert Advisory Group who have done the heavy lifting on the underfunding methodology, for which we congratulate them. Our interim recommendation said that parties should work together in order to ultimately agree on underfunding. We question why the Crown, required as it is to act in good faith, disengaged from the Expert Advisory Group, when it could have been involved directly in the commissioning of the Sapere report.

We do not accept the Crown's earlier view that the Sapere report went beyond our recommendations.[70] The wording of our interim recommendation stipulated what the underfunding methodology 'should include', but it was not prescriptive in scope. We stated only that it should assess 'ongoing' underfunding. It was therefore open for a methodology to be developed that took account of a wide range of matters, including estimating the cost of an equitable primary health system, as all parties are committed to achieving. As of its 27 September 2021 submission, the Crown appears to have revised its position slightly, saying the Sapere report is now being considered as part of the planning for Budget 2022. The Crown also indicated it is reconsidering the claimants' request to fund the cost of the Sapere report. Given the Crown is using the Sapere report's findings, we consider it is more than reasonable for the claimants' costs to be fully reimbursed.

For the Crown's benefit, we reiterate the seriousness of the findings we made in our report and the depth of the prejudice which we found Māori had suffered. The continued delay in agreeing on an underfunding methodology – for which we consider the Crown must accept responsibility – is unacceptable and unsustainable. The prejudice arising from the Crown's numerous Treaty breaches compounds the longer this delay lasts.

10.3.6 Our final recommendations

Although the condition in our interim recommendation has not yet been satisfied, we consider that the parties would benefit from further direction from us about what informed our interim recommendation, and what should happen next.

Consistent with our jurisdiction, we formulated our original recommendations so that they would, once actioned, set the basis for the Crown to compensate Māori for the prejudice they have suffered, remove that prejudice, and prevent other Māori from being similarly affected in the future.[71]

69. Submission 3.3.32, paras 273–279
70. Submission 3.2.333, paras 18–19
71. Treaty of Waitangi Act 1975, s 6(3)

As we outlined in chapter 9, the Crown's numerous Treaty breaches have resulted in extensive prejudice. The indisputable fact that the Crown funds the primary health care system inadequately is a key reason for the extent of inequity that Māori continue to suffer. While the health system cannot be accountable for all of the social determinants of health, it has available to it some of the strongest levers to effect change.

Our recommendation that the parties agree on an underfunding methodology was expressed as an interim one because we considered the seriousness of the Crown's Treaty breaches, and the significant prejudice they wrought, needed to be addressed fairly and accurately. We were determined that the Crown's actions to address that prejudice would account adequately for the impact of its past actions and omissions. We also wanted to ensure the Crown would not repeat its mistakes, nor sanction a system in which inequitable Māori health outcomes were likely to continue, including by funding the system inadequately.

We acknowledge that coming up with an estimate of over 20 years of underfunding in primary care is multifaceted. But so is designing a new health system. The parties have, to an extent, worked together to inform the latter. We remain confident that they can achieve the former.

Perhaps the more demanding expectation contained in our interim recommendation was that the work it prompted should be future-focused. During our hearings, we were told that a fit-for-purpose primary health system – one where general practices and other service providers successfully identify and treat problems before they become serious enough to warrant hospital treatment – required much more significant upfront costs than were then being spent. However, we were assured these costs would be far outweighed by the long-term costs of dealing with undetected or inadequately treated health conditions. The Sapere report's analysis bears this out. It clearly indicates the severe, and unsustainable, economic cost to *all* New Zealanders of an inequitable health system. It also makes it clear that coming up with a credible methodology to estimate underfunding is possible, and provides a clearer pathway forward to complete that work.

To meet its Treaty obligations, the Crown must fund a Treaty-compliant health system; one that prioritises equity and empowers tino rangatiratanga of hauora Māori. Our interim recommendation was thus intended both to allow an estimate of the amount of compensation due to Māori primary health organisations and providers to be developed, and to stimulate work that would help the parties come up with the funding regime for the new primary health system.

We reiterate our disappointment that these intentions have been only partly realised. In finalising our interim recommendation, we can therefore only reiterate it with even greater urgency. We recommend that:

- the Crown and claimants work together to 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 expect the Crown to engage with greater commitment than it appears to have done to date, and that as a result parties can complete this work urgently.

The significant work the claimants have done to date is consistent with our interim recommendation, and goes a long way to addressing our core concerns and the findings in our report. As such, we also recommend that:

- the Crown fully reimburse the claimants for the costs of producing the Sapere report.

We consider the report of the Sapere Group and the affidavits of Dr Cumming, Ms Wall, and Ms Moke together offer a roadmap for the parties to agree on an underfunding methodology. Their expertise should be drawn on in any further work the Crown and claimants progress together. Additionally, we acknowledge Raukura Hauora's submission that health providers have expertise and first-hand experience in primary care provision.[72] The Crown and claimants should make sure Māori health providers' views too are taken into account in any further work, including through a formal consultation or submission process.

We now turn to what should happen once an underfunding methodology is agreed. Our interim recommendation assumed that would happen. We had hoped that the methodology would assist us to make specific recommendations to address the impact of the Crown's breaches regarding funding for Māori primary health organisations and providers, and the prejudice arising from these breaches. In chapter 9 of our report, we acknowledged that there would be a compensatory aspect to this process.

As noted previously, our compensatory jurisdiction is to make recommendations that enable Māori to be compensated for the prejudice suffered, remove such prejudice, and prevent Māori from being similarly affected in the future.[73] These recommendations may be general in nature or more specific as to the action we consider the Crown should take.[74] We think the latter is more appropriate here.

Accordingly, we recommend that:

- once the parties have agreed on an underfunding methodology (as set out in our interim recommendation) the Crown fully compensate for the underfunding determined by that methodology. The full compensation should be calculated as the total underfunding incurred between the enactment of the New Zealand Public Health and Disability Act 2000, and the date on which parties agree on the underfunding methodology.

As part of our interim recommendation, we said our initial thinking is that the compensation could be paid first to Māori primary health organisations and providers still in existence. We remain of this view. We recommend that:

- At the very least, the full compensation should be paid to those Māori primary health organisations and providers that suffered from this underfunding and are still in existence, or to their successor entities.

72. Submission 3.2.343, paras 5–6
73. Treaty of Waitangi Act 1975, s 6(3)
74. Ibid, s 6(4)

- Once the full compensation amount has been calculated, the parties should negotiate as to how it should be paid out: whether as a lump sum, in reparative instalments, or a combination of both. If the parties agree for the compensation to be wholly or partly paid in instalments, the instalments should be regular (and thus predictable), and also reasonable in quantum and the length of time over which the Crown will pay the full amount.
- The Crown fund the process of agreeing on an underfunding methodology and negotiating how the full compensation should be paid out.

Finally, we consider that the underfunding methodology work the parties have undertaken so far, and the work we have confirmed is still needed, will be useful in alleviating future prejudice to Māori due to inadequate funding. We therefore recommend that:

- the Crown work with the stage one claimants and others involved directly in the development of the underfunding methodology to use that work to inform the way that primary health funding is calibrated in the future.

10.4 Kōrero Whakatepe

At the time of writing this supplementary chapter, preparations were underway for the first hearings of the next phase of the Health Services and Outcomes Kaupapa Inquiry. It will investigate alleged Treaty breaches that prejudice tāngata whaikaha.[75] The details of the Crown's proposed reform of the disability support system have yet to be confirmed, and Crown counsel informed us that the Ministries of Health and Social Development are progressing further work 'in partnership with the disability sector.'[76] As outlined in this chapter, progressing something in partnership is no small commitment. We look forward to seeing this partnership unfold as the next phase of our kaupapa inquiry begins.

The broader reforms of the health system present a real opportunity. We remain optimistic that the Crown is committed to acting on the claimants' concerns and to remedying the undeniably appalling Māori health statistics that still confront us in 2021. We hope that the progress made to date will give momentum to partnership processes right across the health sector, and that these reflect the Treaty partnership and the duty of good faith that should guide the conduct of the Treaty partners. But the momentum must be maintained: the Crown's responsibility to uphold its Treaty obligations in respect of our interim recommendations remains, even though we have made them final.

Having said this, the gravity of the issues before us means that we cannot be satisfied with a merely 'satisfactory' process. We are confident that the ways and

75. The term 'tāngata whaikaha' describes Māori with a disability; 'whaikaha' meaning 'to have ability' or 'to be enabled'. As Maaka Tibble states, it can also mean 'people who are determined to do well . . . and create opportunities for themselves': Maaka Tibble, *Whāia te Ao Mārama, 2018 to 2022: The Māori Disability Action Plan* (Wellington: Ministry of Health, 2018), p 4.

76. Submission 3.2.327, para 4

means can be found to give effect to a truly equitable health care system, because a truly equitable health system is the only Treaty-consistent pathway forward.

Through its reforms, the Crown has promised it will finally give effect to tino rangatiratanga and with that, the Treaty partnership. Its enduring obligation now is to live up to its promises. As Taitimu Maipi put it on our first day of hearings, the Crown and Māori must now 'breathe life into what . . . tino rangatiratanga looks like'.[77]

77. Transcript 4.1.4, p 49

Dated at Wellington this 15th day of October 2021

Judge Damian Stone, presiding officer

Associate Professor Tom Roa, member

Tania Te Rangingangana Simpson, member

Professor Linda Smith, member