IN THE WAITANGI TRIBUNAL

WAI 2575
WAI 2687

IN THE MATTER The Treaty of Waitangi Act 1975

AND

IN THE MATTER of Wai 2687, being a claim to the Waitangi Tribunal by Henare Mason and Simon Royal on behalf of the National Hauora Coalition, in respect of New Zealand Government Health strategy, policy and practice pertaining to the Primary Healthcare system

---

BRIEF OF EVIDENCE OF
SIMON GEORGE TIWAI ROYAL CONCERNING REMEDIES
DATED 30 November 2018

Instructing Solicitor:
Atkins Holm Majurey
Barristers & Solicitors
Auckland
Solicitor acting: Paul Majurey
Telephone: (09) 304-0294
paul.majurey@ahmlaw.co.nz

Counsel:
Karen Feint, Barrister
Thorndon Chambers
PO Box 1530
Wellington 6140
(04) 460-0748
karen.feint@chambers.co.nz

I, **SIMON GEORGE TIWAI ROYAL**, Chief Executive, of Auckland, say as follows:

INTRODUCTION

I am providing this further brief of evidence to outline the National Hauora Coalition's proposals on the recommendations sought from the Waitangi Tribunal concerning the reform of the primary health care system. The evidence reflects the development of our thinking throughout the course of the hearings at Turangawaewae Marae and in internal workshops we have held since then.

I need to make clear at the outset that this evidence represents only the views of the National Hauora Coalition at this stage. Due to the time constraints, we have not yet had an opportunity to consult more widely on the proposals contained within this evidence, and we acknowledge that that needs to happen. Even so, we think it is helpful to outline our thinking at the December hearing week in order to give the Crown, the claimants, the interested parties, and the Tribunal the opportunity to comment on the remedies we are seeking.

Our proposals rest on some fundamental assumptions which have underpinned our approach to this hearing to date:

- Māori health inequities are so serious and persistent, and the Crown's response so pitifully inadequate, that there can be no doubt that the Crown has breached its Treaty obligations to Māori;
- The structure and operation of the current primary health care system is failing Māori, and is blighted by institutional racism (i.e. inaction in the face of need);
- There is an urgent need to act now. We do not support giving the Crown more time to try and fix this;
- Tinkering with the current system will not be sufficient – radical reform is required.
- The proposals are presented at the level of principle, rather than detailed design. It is obviously beyond the scope of this inquiry for the Tribunal to

try to redesign the health sector. Therefore, we have taken the approach that the objective is to articulate the relevance of the principles of the Treaty of Waitangi, and how they can practically be recognised and given effect to in the primary health care system. In other words, I will explain **why** we think a Hauora Authority is required, and provide only a broad brush illustration of what its functions would be and how it would work. There clearly needs to be more detailed design work to give effect to the principles. We expect that the Tribunal's recommendations will inform the health system review being undertaken by the Government currently.

I set out below the principles that we consider need to be embedded in the Tribunal's recommendations. The Treaty partnership and principles are fundamental to all of our thinking on the future of primary health care in Aotearoa. The guarantee of tino rangatiratanga (mana motuhake), equity, options and partnership are the lens through which all other principles must be viewed.

PRINCIPLES ON WHICH RECOMMENDATIONS ARE SOUGHT

1. Māori must have mana motuhake in the primary health care system

1.1. Our governing principle is that of mana motuhake – in accordance with our constitutional right to self-determination, Māori seek separate authority to lead the Māori primary health care sector within a kaupapa Māori framework. The right to exercise separate authority includes the development of Māori health policy, the governance of the Māori health care sector, and the provision of hauora services for iwi, hapū, and whānau according to kaupapa Māori models of care. We are talking about exercising real power in the design, governance, and delivery of Māori primary health care, and extending over time to the health system as a whole.

1.2. For the reasons explained by Sir Edward Taihakurei Durie in presenting his evidence,[1] we prefer the term 'mana motuhake' to that

[1] Summary of evidence of Sir Edward Taihakurei Durie, #A55(b), paragraph [16].

of 'tino rangatiratanga', as 'mana' is the guiding principle in Māori culture. However, we recognise that tino rangatiratanga is the language used in the Treaty. We consider that the concepts are broadly compatible. The right to tino rangatiratanga/ mana motuhake/ self-determination also aligns with and is supported by the UN Declaration of the Rights of Indigenous People (Articles 3, 4, 5, 23 and 24).

1.3. I support too Sir Taihakurei's view that "health policy will work best if it sits within a mana motuhake framework that is community focused, that puts Māori in charge of the programme, and that is negotiated directly with the Crown".[2] .

1.4. An important aspect of mana motuhake is respecting and supporting the mana of iwi and hapū to act for and on behalf of their own people. A national agency that is founded on mana motuhake ought to support self-determination at an iwi and hapū level. We also see a role to ensure whānau and individuals are part of a new authority's expression of mana motuhake. For example, the approach taken in the Southcentral Foundation's Nuka model to "customer owners" having a say in health priorities and spending is one mechanism to further explore**.**

1.5. The same would apply to Māori health providers – a Hauora Authority would not usurp the independence of health providers, but rather support them to operate within a kaupapa Māori framework.

2. The overarching objective is to achieve equity for Māori health

2.1. The Crown has an obligation to achieve **equity** in both the provision of health care services and ensuring equitable health outcomes for Māori. There is no justification for avoidable or remediable health differences between Māori and non-Māori. Therefore, a commitment to achieving equity is central to any future approach to

[2] Summary of evidence of Sir Edward Taihakurei Durie, #A55(b), paragraph [14].

primary health care and must be a core value in any relationship between Māori and the Crown when it comes to primary health care.

2.2. The concept of equity - as opposed to equality - presupposes that where inequity exists a differential allocation of resources and services is likely to be required in order to achieve equitable outcomes. We consider that "proportionate universalism" is required – this means that there is a universal level of service that all people in New Zealand can count on, but with a scale or intensity that is proportionate to the level of need. Using this approach means that you move away from the "one size fits all" approach that has demonstrably failed for Māori to date.

3. The health system must recognise and provide for the Treaty of Waitangi and its principles. The framework provided by Treaty principles must guide all aspects of design.

Our view is that the primary health care system designed for Māori would:

3.1. ***Guarantee tino rangatiratanga / mana motuhake in accordance with Article II*** – as above.

3.2. ***Achieve equity in accordance with the Article III guarantee*** – as above;

3.3. ***Embed the Crown's duty to actively protect the health of Māori to the fullest extent practicable,*** which requires especially vigorous action given that Māori health is in a vulnerable state. The establishment of a Hauora Authority would be part of this response, but to fully respond to this duty there must be a way to hold the Crown responsible across the entire health system (i.e. not just primary health care) and in relation to the "wider determinants of health" - the things that make good health and wellbeing more or less likely (like education and housing).

3.4. ***Provide kaupapa Māori options*** – in accordance with the right of Māori to choose our own social and cultural path in accordance with

tikanga Māori. This includes the right to access health services that are provided in a manner that is centred around tikanga Māori — addressing the impact of colonisation on tikanga and embracing concepts like mana, manaakitanga and whanaungatanga. While it should include the provision of traditional rongoā, we see mātauranga Māori as dynamic and extending to the adoption and development of new technologies and innovation.

3.5. ***Ensure that Crown and Māori work in partnership*** – the principle of partnership needs to replace the "principle of participation" that the Ministry of Health has relied upon as a Treaty principle. Merely having a seat or two at a table designed by the Crown is not what was envisaged by the Treaty and is far too low a bar for us to accept.

3.6. I agree with Sir Taihakurei's view that from a tikanga Māori perspective, "unity comes from respecting our separate spheres of influence, then finding what is common".[3] This approach should inform our partnership with the Crown so that it is a true partnership, and not merely providing Māori with the right to be consulted about the Crown's plans.

3.7. It follows that the Crown cannot be the designer of the solution; the necessary structural reforms must be Māori led and negotiated directly with the Crown at a Ministerial level. True partnership needs to be integrated into the governance and delivery of health services as well.

4. The concept of hauora (wellbeing) is intrinsic to the Māori health system

4.1. The Māori primary health system will be organised around the holistic concept of ***hauora***, which focuses on maintaining the well-being of people - whānau, hapū, and iwi - and not merely the treatment of disease and rehabilitation of injury. A hauora system

[3] Summary of evidence of Sir Edward Taihakurei Durie, #A55(b), paragraph [9].

will be designed around the Māori world view and be informed by principles of tikanga Māori.

4.2. Getting the principles right is a crucial part of construction, and we need to think about the mana motuhake framework very carefully and be guided by those steeped in mātauranga Māori so that we build a solid and enduring foundation. The cornerstone of the system would be mana – where mana resides, how mana protects and enhances wellbeing, and what mana means in terms of social responsibility.

4.3. A hauora focused approach is an integral part of kaupapa Māori models of care that enable mana whānau and whānau ora. If we are taking a truly whānau centred approach, we must look across generations, we must think about the conditions in which whānau live, and we must empower Māori to achieve their own wellbeing goals. This means that there cannot be hard and fast rules about what is and is not "health care". While for practical reasons a new Hauora Authority may have to start with boundaries agreed with the Crown, and these may look similar to what we see as primary health care today, over time the agency's role will need to develop and accord greater recognition of the wider determinants of health.

4.4. The boundaries of what we call primary health care today need rethinking for the long term. The current system makes false distinctions based on health care professional boundaries, not the health needs of people. Oral health, for example, is an essential part of our wellbeing and should be seen as part of the primary health care system. As Professors Braughton and Crampton said in evidence, there is no logical reason for dental care to be a separate system from primary health care. Poor oral health is a major problem for Māori, and the cost of dental care is a significant financial barrier for a significant proportion of the population. Other examples of issues that have a real impact on health but are not considered part

of the health system include domestic violence and early childhood education.

4.5. Although we express hauora as a Māori concept, over time it could manaaki all New Zealanders. We often hear that if something works for Māori it will work for everyone, and we think this is true of an approach that looks beyond just health services and targets the determinants of health within families. We believe this will be a hallmark of the hauora system that will over time influence mainstream approaches to health services.

5. Radical structural reform is required to give effect to these principles

5.1. We are convinced that radical structural reform is required in order to achieve Māori health equity. The current system is not working for Māori, and piecemeal reform will not fix it. As Professor Peter Crampton said in his evidence, we need to hit the reset button on the primary health care system. And for this "reset" to be enduring, Māori leadership needs to be driving these reforms.

5.2. I refer the Tribunal back to our opening legal submissions that identified the structural flaws within the current health system that have stymied our ability to operate successfully, and the consequential marginalisation of Māori consumers and Māori health providers. We contend that Māori health providers are forced to operate within a colonised framework.

5.3. It is not just a matter of providing more money. More money might help in the first instance, but it will not get to the heart of the issues, which are really centred around mana motuhake/self-determination, and holding the system to account in achieving better health outcomes for Māori.

5.4. Our fear is that (well-meaning) Crown officials will try and effect change, but in doing so will follow the path of least resistance, which will leave us without the meaningful transformation we are seeking.

For instance, the current statutory regime would enable the Minister of Health to enter into a Crown Funding Agreement with the National Hauora Coalition to roll out our kaupapa Māori programmes nationally. However, that would not be reform of the system. Such an agreement would be constrained in terms of function and purpose to the existing primary health care policy framework, and therefore wouldn't be delivering social services to address the wider social determinants, which is what is ultimately required. It would also mean that Māori health providers remain locked in the master – servant relationship, and cannot be influential in policy development and partners in holding the health system to account for Māori health equity.

6. Remove financial barriers to access primary health care

6.1. To ensure equitable access to primary health care services, the primary health care system should be completely free for consumers, i.e. as Prof Crampton said, the cash register should be removed from the front door of the health system.

6.2. While staying healthy and well requires the whole environment to work for Māori, there is no denying the valuable role of primary health care services. As the Tribunal has heard, however, there remains unmet need for primary health care services in the community. And disproportionately, the cost of visiting a GP is a barrier for Māori in getting the services we need - which contributes to the humanitarian crisis we see in Māori health outcomes.

6.3. There is no compelling reason for the cash register at the front door of our health system. It is a construct fought for by some health professionals since the 1930s, but is not in the interests of patients generally, and is certainly not in the interests of Māori. While there may be some exceptions, as a general principle we believe that primary care should be free for everyone. While this comes with an up-front cost, it is likely to lead over time to better use of the most expensive part of our healthcare system — hospitals — and will have

a positive impact on the quality of people's lives as they stay well for longer without the need for more serious health intervention.

6.4. We acknowledge that there is a debate over whether primary health care should be completely free, or whether free services should be targeted to particular parts of the population. We prefer it to be completely free, but acknowledge that proportionate universalism is an intermediate solution. What does not work is the current system. As we saw in Professor Crampton's evidence, the current system has had the effect of increasing inequity, since reducing fees benefits the "worried well" (for whom cost was never a barrier), but does not do enough to reduce the financial barriers faced by the poorest in the community.

7. Establish an independent statutory Hauora Authority

7.1. The National Hauora Coalition is advocating for a recommendation from the Tribunal that an independent statutory authority for Māori hauora be established (**Hauora Authority**). We seek an explicit recommendation to underscore the need for an enduring solution that will give effect to mana motuhake. We do not support more general recommendations promoting tino rangatiratanga, as our concern is that they may be open for misinterpretation by the Crown, and will not result in meaningful change.

7.2. To be clear, we are **not** advocating that the National Hauora Coalition become the Hauora Authority. We are proposing that an entirely new authority be established by legislation.

7.3. ***Why a Hauora Authority is required:*** We seek a statutory authority for the following principal reasons:

7.3.1. To ensure that it is Māori led and independent, i.e. it would not be a government department.

7.3.2. To enshrine the Treaty of Waitangi into its operations.

7.3.3. To ensure that the authority has the necessary functions and powers to enable it to play a role in influencing and evaluating the performance of other sectors of the health system in improving Māori health outcomes.

7.3.4. As we seek an enduring solution, legislation will mean that it cannot be as easily disestablished on a political whim.

7.4. We do not think that it is feasible or appropriate to flesh out the formal structure of the Hauora Authority at this stage. First, form needs to follow function and the options for function are varied. Second, form and accountability need to be discussed with the appropriate whānau, hapū, iwi and Māori health providers. Third, while a "straw person" structure could be proposed to align with the current health and disability structure, that status quo is itself currently under review. Structural changes are highly likely to emerge from the Health and Disability System Review that is due to report in 2020. Accordingly, the suggestions that follow should be treated as initial thinking that is subject to further refinement and will require negotiation with the Crown.

7.5. ***Features of a Hauora Authority:***

7.5.1. *The Hauora Authority would be responsible for Māori health care and be integrated across the entire health system* – the Hauora Authority would be directly responsible for Māori primary health care, but would also play a role in the provision of healthcare to Māori in the secondary and tertiary sectors. Accordingly, the agency would need to be integrated across the sectors of the health system, and have an influential role in the mechanisms that will incentivise the health system to achieve Māori health equity, as well as holding the health system to account for its performance in improving Māori health outcomes. For instance, the Hauora Authority could be involved in the development of Ministry of Health annual planning

processes, key policy development (e.g. around health sector funding priorities) and setting expectations of the relevant health authorities (e.g. through annual planning guidance to DHBs and negotiating Crown Funding Agreements).

7.5.2. *Relationship with the Crown*: in order to give effect to the Treaty partnership, the Hauora Authority must have a direct relationship with the Crown, i.e. the Minister of Health, as well as relationships with district and/ or regional health authorities that have a role in the provision of secondary and tertiary services.

7.5.3. *Resourcing*: the Hauora Authority must be properly resourced for the purpose of achieving Māori health equity. It is likely that a hybrid funding model (i.e. a mixture between capitation funding and fee for service) would be the optimum model. It is important to appreciate that primary health care is not just limited to primary care (i.e. general practice), but would require community and ancillary services to be delivered to Māori whānau.

7.6. ***Functions of Hauora Authority:*** in the exercise of mana motuhake, the Hauora Authority's functions should include:

7.6.1. *Receiving Crown funding for the provision of services*: negotiate with the Minister for Health the outcomes it is required to achieve, and the total pot of funding from within Vote: Health that the Crown will pay the Agency to commission services to achieve the agreed outcomes.

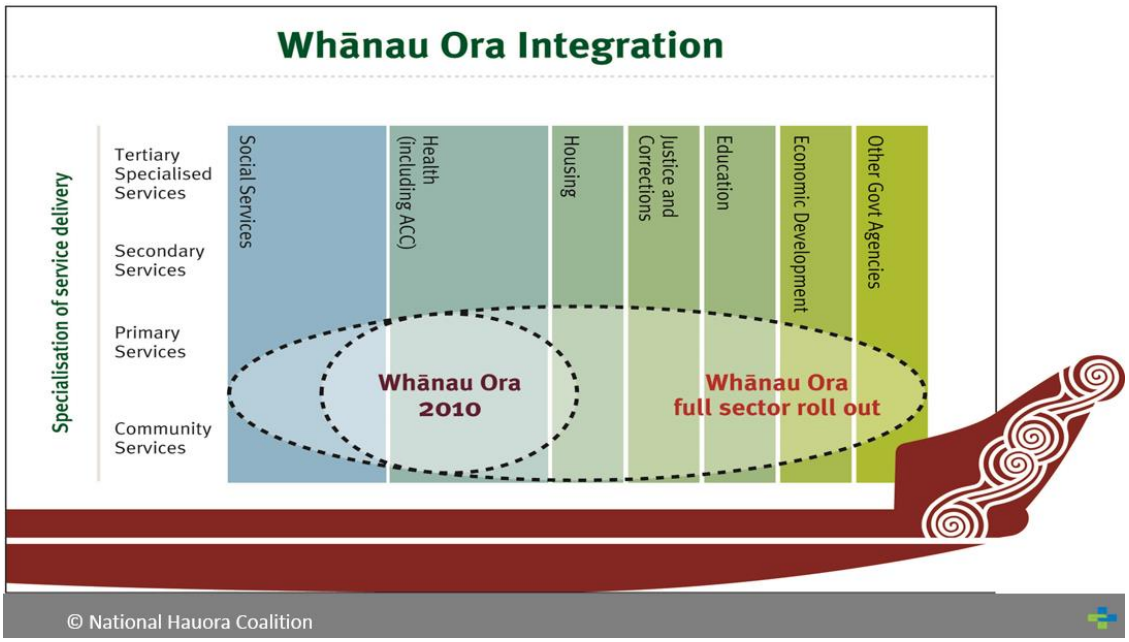
7.6.2. *Commissioning for outcomes*: develop tools and frameworks that will permit commissioning for outcomes to deliver better Māori health outcomes for whānau.

7.6.3. We consider, based on the work that the National Hauora Coalition has done on our Mana Whānau approach, that the best (and fastest) way to achieve outcomes will be to invest in a commissioning model that measures health outcomes, invests in frontline activity on the ground, and provides wraparound services for whānau by mobilising the supply chain.

7.6.4. This is a transformative approach, because the current system pays for services provided, without measuring whether those services achieve effective outcomes. Accordingly, it is entirely coincidental whether those programmes achieve any discernible impact. Commissioning for outcomes measures what the outcomes are so that you know what you are getting for your investment. It is a consistent approach to problems, and provides a range of tools to help tackle the problem. It enables agile decision-making about what is and is not effective in improving health outcomes, and to therefore determine the best use of public funding for keeping people well.

7.6.5. Commissioning for outcomes is the holy grail of public administration. There is a lot of complexity in getting it right, but if you do then you should achieve better outcomes and save money.

7.6.6. There would need to be a transitional approach because it would take time to build up a network of supply services that is integrated at the provider model. If you think about the levels of integration, in our 'waka' model it occurs at all levels of system - at central government, regional and district levels, and at provider level, and recipients of services receive them as integrated services.



7.6.7. *Procure services from providers to Māori populations*: purchase services from providers who deliver to Māori populations. Ideally this would include:

- Māori Providers; and
- other providers of health services to Māori.

In other words, although Māori consumers will have a choice as to which provider they use, the 'Māori health dollar' will be spent at the direction of the Hauora Authority. As the objective is to achieve Māori health equity, in determining the level of resourcing required, you would need to take into account the burden of disease, and not just simply apply funding according to the proportion of Māori as a population. The health sector has more sophisticated data than ever before, so the outdated approaches of other funding formulae (e.g. in primary health care) are now effectively redundant.

7.6.8. *Policy advice*: this function would include the provision of advice on Māori health to the Minister of Health on all matters directly impacting the Hauora Authority and its objectives. It would also mean a role in working with the Ministry of Health in the development of policy advice and proposals affecting Māori health outcomes across sectors.

7.6.9. *Research, evaluation, monitoring, and public debate*: using validated, outcome-driven data to:

- Evaluate and monitor the services it directly funds from Māori and other providers;
- Contribute to the Ministry's monitoring and evaluation of the performance of DHBs and other providers, and holding them to account for their performance in improving Māori health outcomes;
- Evaluate the performance of the Ministry of Health and hold the Ministry to account for its performance in improving Māori health outcomes. This could include some of the functions currently the responsibility of the Health Quality and Safety Commission (which, like District Health Boards, was established under the New Zealand Public Health and Disability Act 2000);
- Promote Māori health approaches and foster public debate on health equity. This could also include a health promotion function as currently the responsibility for the Health Promotion Agency (also established under the New Zealand Public Health and Disability Act 2000).

7.6.10. *Capability building, workforce development*: we know that in order for the health system to work for Māori it must be filled with a workforce that is competent to operate in a way

that is culturally safe for our whānau. And we know that it needs to reflect the communities we serve, so we must act to address the worryingly low number of Māori in the health and disability workforce. We consider that workforce development will require many years of focused investment including in education.

CONCLUSION

To conclude, we are asking the Tribunal to find that the Crown has breached the principles of the Treaty of Waitangi for its abject failure to achieve equity in Māori health. In terms of what is to be done about the state of Māori health, the remedies recommended by the Tribunal are crucially important. We are calling for urgent action and radical structural reform of the primary health care sector. The timing of Stage One of this inquiry provides the Tribunal with a unique opportunity to influence the recommendations of the Health and Disability System Review, and we urge the Tribunal to take a strong and principled stand. Accordingly, we seek specific recommendations in terms of the seven principles that I have outlined above. There may also need to be recommendations that cover the process to be developed to progress this kaupapa (for instance, the process will need to be adequately resourced). Those details will be covered more fully in closing submissions.

We call on the Crown to hear and act upon the wishes of the claimants, who are speaking with one voice in calling for mana motuhake in Māori health.

Mauri ora

Date: 30 November 2018

Simon George Tiwai Royal