Te Rūnanganui o Ngāti Hikairo

Kāwhia Moana
Kāwhia Kai
Kāwhia Tāngata

PAE ORA FUTURES BILL SELECT COMMITTEE SUBMISSION

1 Introduction

1.1 Ngāti Hikairo ki Kāwhia is an independent iwi of Tainui Waka origin. We maintain our mana motuhake and tino rangatiratanga in Kāwhia, Ōpārau and Waipā in the King Country and Waikato regions.

1.2 Ngāti Hikairo is a confederation of hapū which includes Te Whānau Pani, Ngāti Te Mihinga, Ngāti Horotakere, Ngāti Pare, Ngāti Rāhui, Ngāti Purapura, Ngāti Wai, Te Matewai, Ngāti Parehinga, Ngāti Whatitiri, Ngāti Puhiawe, Ngāti Hineue, Ngāti Te Uru, Ngāti Pōkaia, Ngāti Taiuru, Ngāti Waikaha, Ngāti Huritake, Ngāti Wai, Ngāti Paretaikō, Ngāti Te Rahopupuwai. Our whānau membership is over 5,000 and Te Rūnanganui o Ngāti Hikairo is the governance rūnanga entity representing all hapū, marae and whānau in our rohe.

1,3 Our key aspiration as an iwi is that our whānau, marae and hapū flourish both in the Māori and Pakeha worlds and that we are able to co-exist in both. A key component of this aspiration is the health and wellbeing of our people. Our whānau represent the very core for the transformation of our health system through the Pae Ora Futures Bill. As a Rūnanga we considered it was imperative that we had a voice and represent an iwi's perspective on this Bill.

2 Submission Overview

2.1 Te Rūnanganui o Ngāti Hikairo have reviewed the proposed legislation Pae Ora Futures in detail and the key areas we wish to provide feedback on are:

a) Te Tiriti o Waitangi
b) Māori Health Authority Legal Structure
c) Māori Health Authority – Scope
d) Iwi-Māori Partnership Boards
e) Health Systems Structure
f) Health Systems Transition

2.2 Pae Ora Futures Bill is a substantial attempt to realign the parity and equity of Māori within the Health System. This Bill has to take a courageous step in realising Māori aspirations and the Crown's commitment to Te Tiriti o Waitangi. This is a once in a generation opportunity to achieve systemic change that will finally empower Māori to put Māori Health into Māori Hands. This opportunity must future proof the health system by enshrining in legislation the Māori Health System in relation to Te Tiriti and within the context of the New Zealand Health System.

2.3 Māori Health is integral to the New Zealand health system, first and foremost as the first nations people of Aotearoa that differentiates our relationship with the Crown, through Te Tiriti o Waitangi. The Treaty of Waitangi is a binding agreement with the Crown recognised through the Treaty of Waitangi Act (1975) and is composite to our constitutional law within Aotearoa.

2.4 The other imperative is that through over 181 years of colonisation, Māori experience substantial deprivation across the range of wellbeing indicators that has arisen through displacement and intergenerational trauma and colonisation. Of which many non-Māori New Zealanders perceive us as an ethnic population unwilling or unable to help ourselves and this exists because they too view through the very same lens of colonisation that had caused this deprivation in the first place. Government's own data describe a health system for Māori where we experience the poorest health outcomes and more likely not to access or receive the appropriate healthcare because of institutionalised racism when compared to any other population group.

2.5 Te Rūnanganui o Ngāti Hikairo acknowledge under Te Tiriti o Waitangi the role as Kawanatanga of the Crown and their obligations to consider the interests of all New Zealanders as they develop the new Bill. As we seek to provide our feedback, we are mindful of the duality of these obligations and that any future changes must create synergy and mutuality.

2.6 Aotearoa and its people must be courageous and move beyond the singular systems thinking where one size fits all because this has failed, and it has created inequity and injustice. The proposed Bill must move beyond tweaking at the system edges with half-hearted change that ultimately disempowers Māori and creates new bureaucracies in the long term. We consider that this Bill is merely shifting deck chairs, we need a disruptive innovation of systemic change.

3 Te Tiriti o Waitangi (Treaty of Waitangi) - Section 6

3.1 The proposed legislation recognises the principles of the Treaty of Waitangi and then proceeds to specify obligations for both Health New Zealand and the Māori Health Authority in meeting these principles. The Treaty of Waitangi Principles are further referred to as informing the health system principles set out in section 7 of the proposed legislation. The key obligations can be summarised as:

a) Guided by the health principles to improve health system for Māori and raising Hauora Māori outcomes
b) Established Māori Health Authority
c) Ministerial Hauora Māori advisory committee and advice must be sought prior to any decision making
d) Recognition to iwi- Māori partnership boards
e) Māori Health Authority and Health New Zealand must engage with iwi- Māori partnership Boards
f) Joint implementation of New Zealand Health Plan by Health entities and work together in the performance of specified functions of Health New Zealand
g) Health New Zealand and Māori Health Authority Boards to have expertise to give effect to Treaty of Waitangi and tikanga Māori
h) Māori Health Authority to have systems in place to engage and enable Māori to inform the performance of its functions and

i) Māori Health Authority to report back to Māori

3.2 These obligations do not fully embrace the principles of Te Tiriti o Waitangi as we discuss further in this section of our submission.

3.3 Te Tiriti o Waitangi principles are mentioned throughout many Crown legislations, but the Crown has never explicitly stated what these principles are. As a result of the lack of clarity the definition of these principles has relied on the Waitangi Tribunal and Courts to determine the meaning of legislation in this regard.

3.4 The Waitangi Tribunal into the Hauora Kaupapa hearings determined that the interpretation of these principles by the Crown were inadequate. By not specifying the treaty of Waitangi principles to guide the principles, obligations, objectives, and functions of the health system at the outset will continue the ambiguity of meaning by the Crown and the continued risks of the health system focused on the stated obligations rather than the broader strategic health system intent through the lens of the principles.

3.5 The obligations are clearly articulated through-out the proposed legislation in terms of health system principles, entities and their functions and obligations. This section is imperative to state the Crown and the Health Systems intent in relation to Te Tiriti o Waitangi as a legislative and strategic driver of our health system.

3.6 The Crown have equally stated the health system principles as set out in section 7 of the proposed Act. It is assumed that these principles are there to guide the intent of the Crown's health system. Yet on the very same issue, the Crown only expresses its mere commitment to Māori through a series of constrained obligations that do not quantify the intent of a treaty based relationship with Māori.

3.7 To clarify the concerns that we have with the proposed legislation, the fundamental issues are the lack of clarity of intent because of the fundamental principles not being included. The following must be applied as starting points when considering the design of the legislation and the structure of the Māori Health Authority. Firstly, the accepted Principles of the Treaty of Waitangi should be applied:

a) The Principle of Partnership
b) The Principle of Active Protection
c) The Principle of Redress

3.8 As Justice McKay noted in the Broadcasting case (1992):

"It is the principles of the Treaty which are to be applied, not the literal words. The English and Māori texts in the schedule of the Treaty of Waitangi Act 1975 are not translations the one of the other, and the differences between the texts and shades of meaning are less important than the spirit"

Recommendation: The principles of the treaty should be hard wired into the legislation by explicitly including them as a part of the preamble of the act and requiring their application by all parties covered by the Pae Ora Act

3.9 We then believe that the areas of recommendation from the Tribunal Hauora Report should be overtly included in any legislation. Clarifying where the requirements were sourced from, and the actual text of the Tribunals Recommendations are important indications of partnership and holding agencies to account. The recommendations of the Tribunal were:

1. Standalone Māori health authority
2. Agree a methodology for assessing underfunding for MPHO and Providers
3. Redesign current partnership arrangements across all levels of Primary Health Sector

3.10 The Tribunal also added a fourth recommendation as a part of their final report in October 2021 which effectively reiterated their initial recommendations 1 and 3:

4. Continue working on Stand Alone Authority and Iwi Boards including core functions and final budgets to ensure a tino rangatiratanga compliant structure.

Recommendation: That the recommendations from the Hauora Report be explicitly included in the legislation and encompass the activities of all agencies covered by the legislation where they pertain to services and decisions that impact on Māori and their wellbeing.

3.11 Finally, in the Hauora Report the Tribunal suggested that the following principles be adopted for the Primary Health Care system. These principles need not be limited to only the Primary Health Care arena but apply across our health system:

Recommended Principles

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 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 the 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.

Recommendation: The guidelines outlined by the Tribunal should be included as a schedule to the Act with required application to the design, development, implementation, and assessment of success for any programme or activity that impacts on the health and wellbeing of Māori.

4 Māori Health Authority Legal Structure - Section 25 to 26

4.1 The draft legislation sets out the establishment of the Māori Health Authority and other structures. What is clear from the proposed draft is that unlike Health New Zealand, the Māori Health Authority will not be considered a Crown Entity.

4.2 This is a matter of interest, and after some discussion we have concerns about this possible oversight.

4.3 We are again seeing the Authority, which is expected to collaborate, discuss, agree, negotiate, and recommend, is being reduced to a secondary or support role to Health New Zealand.

4.4 As has been outlined in other parts of our submission, it is time that Māori have control over the decision making around what successful health outcomes are for Māori. We should be the final decision maker on determining:

a) What the successful health outcomes for Māori.
b) What successful or unsuccessful performance from health providers in relation to Māori.
c) The measures that drive performance and innovation.
d) The direction of funding to those agencies and organisations that are performing from those that are not.
e) What a fully-fledged funding relationship with Māori organisations or those organisations delivering to Māori should be within the health system continuum.

4.5 In order to undertake all these roles, the Māori Health Authority will have to be a mature resourced organisation with capability that will require years to build. Our concern is the organisation that is outlined in the draft legislation will not have the opportunity to emerge into this type of an effective organisation while constrained in its scope and mandate.

4.6 Our fear is that the Authority will be reduced to an advisory committee, if not in design, in practice. This is clear to us because a mature organisation will have much more about its structure and authorities included in the legislation. It will have a Minister, accountability documents set out in clear language, and it would be identified as an organisation subject to the Crown entities Act. We see none of these characteristics.

4.7 If these characteristics did exist then this would signal an independent and fully structured body capable of driving the improvement necessary for Māori Health and Wellbeing so that the outcomes for Māori stop languishing amongst those of the citizens in third world countries.

4.8 While the authority is proposed to be the solution to many of the ills that besiege Māori health, a cynical review would tell you that nothing has changed and Health New Zealand, the deliverer of services to non-Māori NZ remains the powerful partner in this structure, with all the authority and none of the weakness.

4.9 Often it is argued that giving greater authority to organisations like the one proposed in the legislation puts a disproportionate amount of power in the Māori organisation. This is seen by some as an inequitable share of power for Māori over the rest of the health system, which is almost 8 times the size of the footprint for Māori Health Services.

4.10 There is much concern within New Zealand that the Māori Health Authority is perceived as a separatist system. There are many international examples of indigenous health systems with the mandated authority to operate independent but also interdependent of the mainstream health system that derives substantial benefits to their nations. We are not just interested in a separatist Māori Health System but a health system that is responsive to the needs of its indigenous and non-indigenous peoples. These international examples demonstrate the effectiveness of indigenous led accountability that has synergy with the mainstream health system. However, to achieve this arrangement, the authority must be the senior partner i.e., Māori Health Authority where this pertains to Māori across the health continuum.

4.11 For that to happen, the Māori Authority must be seen as an equal partner to Health New Zealand, and more importantly, the senior authority when it comes to services for or to Māori.

Recommendation: Establish an organisation that is fully fledged in structure and authority, able to give independent advice and make decisions separate from Health NZ.

5 Māori Health Authority Scope – Subpart 3 - Māori Health Authority

5.1 The Māori Authority has an ambitious agenda and the way that the Bill is structured only empowers the Authority with the ability to influence and collaborate. Given that Health New Zealand has complete operational control within the health system then there is a duality of accountability where the substantive structural accountability rests with Health New Zealand not with the Māori Health Authority.

5.2 The proposed legislation fails to deliver clarity around who has authority and responsibility. It should be clear that for outcomes that affect Māori, or where the wellbeing of Māori is impacted that these areas fall under the auspices of the Māori Health Authority.

5.3 Clarity is important – it simplifies relationships and confirms that Māori have authority over themselves. Further, if you have authority to act, ensuring improved outcomes and wellbeing then becomes the responsibility of the Māori Health Authority.

5.4 Our experience is that unless this authority and responsibility is spelled out in legislation then erosions immediately occur on the ability to achieve any outcomes.

5.5 There are comparative examples that exists in current legislation where lack of clarity has resulted in ambiguous and ineffective actions by agencies. These examples are:

a) We would refer the members to the Public Health Acute Services Contract between the Ministry of Health and ACC. This was supposed to be a temporary solution to how the cost of accident-related injuries in Acute Services would be funded. A more appropriate contract was expected to be agreed between ACC and the Ministry of Health that would be a more accurate assessment of Acute services costs for Health and allow ACC to be able to seek rehabilitation aligned treatment from Acute Services in the Health Sector. Since 1992 ACC and Health have been unable to agree on a replacement contract and so the temporary solution PHAS is still in place.

b) These very same shared and joint governance arrangements currently exist within the health system through the District Health Boards with similarly constructed Māori advisory committees, and directorates of Māori Health that have the same directives to improve Māori health. This has clearly not worked and based on the current bill where there are exactly the same arrangements of iwi Māori partnership boards and working collaboratively within the health system is not going to enable the health system to work towards improved health outcomes for Māori. We contend that these arrangements will only deliver the same result we have today.

5.6 The Māori Health Authority must be the health systems lead with full autonomy to lead innovation and change to achieve the health outcome improvement for Māori. We consider that the Māori Health Authority should set the health targets for improvement and through its monitoring function manage the performance of the health system according to these targets; and have the authority through its partnership with Health New Zealand to direct improvements as well as the supportive infrastructure to carry out these functions.

Recommendation: Be clear as to what you want the Māori Health Authority to achieve, and the authorities to empower the entity to fulfil these responsibilities.

Recommendation: Empower the Māori Health Authority to the same levels as Health NZ where the Health and Wellbeing of Māori is concerned.

Recommendation: Make it clear which organisation is Primary and under what circumstances. Partners need to be equal in areas of common decision making but be endowed with clear delegation of authority where it is appropriate for one agency to have oversight and control.

Recommendation: The principle of equal partnership needs to be inherent in the legislation that empowers the Māori Health Authority. To succeed it needs to be the final arbiter of the wellbeing of Māori.

Recommendation: The Māori Health Authority must be the body that decides if partners or contracted organisations have met their agreed performance, and be able to issue sanctions if required

6 Iwi-Māori Partnership Boards - Section 21 and Schedule 3

6.1 We refer section 21 (a) of the Pae Ora Bill that sets out the role of the Māori Authority in their obligations to the Iwi-Māori Partnership Boards. This subsection only refers to section 92 which relates to the provision of accountability documents. Section 21 (a) should also refer to section 87 which sets out the role of the Iwi-Māori Partnership Board. The intent of this section is to specify the support that is to be provided to the iwi-Māori Partnership Board by the Māori Health Authority which does not only relate to the provision of accountability documents but also the support required to meet the functions of the board.

6.2 We also note that in Schedule 3, the iwi-Māori Boards have been specified as the representative District Council iwi Groups. Te Rūnanganui o Ngāti Hikairo are highly engaged with local council and is not aware of the Waikato District Council Iwi Representative Group. It will be important to establish a robust process of representation across the wider iwi network within the localities that incorporates both the larger and smaller iwi.

Recommendation: We propose that section 21 (a) includes the support for iwi-Māori partnership boards to include the appropriate support of these networks to meet their obligations set out in sections 87 and 92 of the proposed legislation.

Recommendation: We propose that a robust consultation is undertaken to form the iwi-Māori partnership Boards so that it includes both small and larger iwi as practicably as possible.

7 Health Systems Structure

7.1 The structure of the Māori Health Authority proposed under the Bill refers to the Māori Health Authority as a singular entity and there will be local iwi- Māori Partnership Boards with some commissioning arrangements through Hauora Providers. This is the extent of the structure within the Māori Health Authority. The Health System is more than just delivery through Hauora providers and extends across the health continuum through tertiary, secondary, primary and the wider community. It is further evident that the health system will predominately be delivered through the structure of localities which are in essence controlled from an operational perspective by Health New Zealand.

7.2 It effectively reverts the Māori Health Authority to an advisory capacity with some commissioning of Hauora providers. There has to be capacity and capability to undertake the objectives and functions set out in the legislation as equally as has been specified for Health New Zealand.

7.3 Iwi Māori already have a number of existing structures through rūnanga and particularly with the emergence of the iwi Māori partnership boards. There are also the whanau ora commissioning agencies that could be levied upon and expanded. In order to fulfil the obligations by the Māori Authority, as set out in the Bill, there has to be a comparative infrastructure to that of Health New Zealand. Therefore, the localities must incorporate this level of support to create this infrastructure.

7.4 There are comparative examples of this as proposed by the WAI 1315 Claimants regarding Nuka, and Te Runanganui o Ngati Hikairo Chair has personally led Queensland State Indigenous Health Services. These international examples indicate there must be infrastructure to empower the indigenous health system to improve health outcomes.

Recommendation: There is a comparative infrastructure within the legislation that commits the Crown to equally support the capacity and capability of the Māori Health Authority to achieve its obligations under the proposed legislation. This infrastructure should be comparative to that of Health New Zealand.

8 Health Systems Transition – Schedule 1

8.1 The Bill also sets out the transition arrangements under schedule 1, which is effectively that all the assets, which includes buildings, employees and so forth that currently rests with the District Health Boards will be transferred to Health New Zealand. An integral component of these assets relates to Māori Health.

8.2 We would seek that any assets that pertains to Māori Health should be transferred to the Māori Health Authority. We further seek that a review is undertaken within 6 months of the establishment of the Māori Health Authority to identify where resources or assets or devolved services are attributable to Māori Health across the health continuum within the Health System are then transferred to the Māori Health Authority.

Recommendation: The Māori Health Authority are equally regarded through the transition requirements of the current health system in terms of resources, assets, and funding where these refer to Hauora Māori. We further recommend that this is included in the legislation under the transition schedule with commitments to review and identify these assets to then transfer to the Māori Health Authority.

9 Summary

Te Rūnanganui o Ngāti Hikairo thank the Pae Ora Futures Select Committee for the opportunity to present our views through this submission.

We seek the opportunity to present in person when this Bill is heard by the Pae Ora Select Committee.

Prepared on behalf of Te Rūnanganui o Ngāti Hikairo

Susan Turner	Kurutia Seymour
Chair	**Secretary**

Te Rūnanganui o Ngāti Hikairo

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PAE ORA FUTURES BILL RECOMMENDATIONS

Section 6 Te Tiriti o Waitangi (Treaty of Waitangi)

Recommendation 1

The principles of the treaty should be hard wired into the legislation by explicitly including them as a part of the preamble of the act and requiring their application by all parties covered by the Pae Ora Act

Recommendation 2

That the recommendations from the Hauora Report be explicitly included in the legislation and encompass the activities of all agencies covered by the legislation where they pertain to services and decisions that impact on Māori and their wellbeing.

Recommendation 3

The guidelines outlined by the Tribunal should be included as a schedule to the Act with required application to the design, development, implementation, and assessment of success for any programme or activity that impacts on the health and wellbeing of Māori.

Section 25-26 Māori Health Authority Legal Structure

Recommendation 1

Establish an organisation that is fully fledged in structure and authority, able to give independent advice and make decisions separate from Health NZ.

Subpart 3 Māori Health Authority

Recommendation 1

Be clear as to what you want the Māori Health Authority to achieve, and the authorities that you intend to give it in order for it to fulfil these responsibilities.

Recommendation 2

Empower the Māori Health Authority to the same levels as Health NZ where the Health and Wellbeing of Māori is concerned.

Recommendation 3

Make it clear which organisation is Primary and under what circumstances. Partners need to be equal in areas of common decision making but be endowed with clear delegation of authority where it is appropriate for one agency to have oversight and control.

Recommendation 4

The principle of equal partnership needs to be inherent in the legislation that empowers the Māori Health Authority. To succeed it needs to be the final arbiter of the wellbeing of Māori.

Recommendation 5

The Māori Health Authority must be the body that decides if partners or contracted organisations have met their agreed performance, and be able to issue sanctions if required

Section 21 and Schedule 3 Iwi-Māori Partnership Boards

Recommendation 1

We propose that section 21 (a) includes the support for iwi-Māori partnership boards to include the appropriate support of these networks to meet their obligations set out in sections 87 and 92 of the proposed legislation.

Recommendation 2

We propose that a robust consultation is undertaken to form the iwi-Māori partnership Boards so that it includes both small and larger iwi as practicably as possible.

Section 48 and 49 Māori Health Authority Structure

Recommendation 1

There is a comparative infrastructure within the legislation that commits the Crown to equally support the capacity and capability of the Māori Health Authority to achieve its obligations under the proposed legislation. This infrastructure should be comparative to that of Health New Zealand.

Schedule 1 Transition

Recommendation 1

The Māori Health Authority are equally regarded through the transition requirements of the current health system in terms of resources, assets and funding where these refer to Hauora Māori. We further recommend that this is included in the legislation under the transition schedule with commitments to review and identify these assets to then transfer to the Māori Health Authority.