



Public Board meeting

Meeting:	Thursday, 01 August 2019
Start time:	9.00 am
Venue:	Board room Pilmuir House Hutt Valley DHB

Hutt Valley District Health Board

Whanau Ora ki te Awakairangi

Healthy People, Health Families, Healthy Communities

Our Values

Always caring – respectful, kind and helpful

Can-do – positive, learning and growing and appreciative

In Partnership – welcoming, listens, communicates and involves

Being our Best – innovating, professional and safe.

Hutt Valley DHB Strategic directions and enablers


Support living well	Adaptable workforce
Shift care closer to home	Smart Infrastructure
Deliver shorter, safer, smoother care	Effective commissioning

Central Region Strategic Objectives 2018/19

Cancer Services	Regional care arrangements
Cardiac Services	Mental Health and Addictions
Ensuring a digitally enabled health system	An enabled and capable workforce
A clinically and financially sustainable health system	

Government priorities 2018/19

Primary Care Access	Mental Health
Public Delivery of Health Services	Child Health
School-based health services	Healthy Ageing
Disability Support Services	Pharmacy Action Plan
Improving Quality	Climate Change
Waste Disposal	Budget 18 initiatives
Health Targets	Cross-Government targets
Delivering the Regional Services Plan	

		AGENDA Held on Thursday, 1 August 2019 Boardroom, Pilmuir House, Hutt Hospital Commencing at 9.00 am				
BOARD		PUBLIC SESSION				
	Item	Action	Presenter	Min	Time	Pg
1.	PROCEDURAL BUSINESS			25	9.00 am	
1.1	Karakia					5
1.2	Apologies	ACCEPT	A Blair			
1.3	Continuous Disclosure - Interest Register - Conflict of Interest	ACCEPT CONFIRM	A Blair			6
1.4	Minutes of Previous Meeting 27 June 2019	ACCEPT	A Blair			10
1.5	Matters Arising from Previous Meeting	NOTE	F Dougan			16
1.6	Draft 2019 HVDHB Board Work Plan	NOTE	F Dougan			17
1.7	Chair's Report	VERBAL	A Blair			
1.8	Chief Executive's Report	NOTE	F Dougan			18
2.	FOR DECISION					
2.1	CPHAC Membership	APPROVE	Y Grace	5	9.25 am	35
3.	FOR DISCUSSION					
3.1	Strategy, Planning and Outcomes Update	NOTE	H Carbonatto	10	9.30 am	37
3.2	Māori Health Update	NOTE	K Dougall	10	9.40 am	45
3.3	Quality & Safety Update	NOTE	D Gell	10	9.50 am	53
3.4	Health Roundtable Performance Report 1 April 2018 – 31 March 2019	NOTE	M Brown	15	10.00 am	64
4.	COMMITTEE REPORTING					
4.1	HVDHB Clinical Council Board Report 4 July 2019	NOTE	C Kerr	10	10.15 am	67
4.2	HVDHB CPHAC Minutes 14 June 2019	NOTE	Y Grace	5	10.25 am	69
4.3	Draft HVDHB Consumer Council Minutes 10 July 2019	NOTE	P Ravi	5	10.30 am	74
5.	OTHER					
5.1	General Business			5	10.35 am	
5.2	Resolution to Exclude the Public	AGREE	A Blair	5	10.40 am	78
DATE OF NEXT MEETING 26 September 2019						

APPENDICES		
1.7	Chair's report	
1.7.1	Letter from Sarah Turner, Ministry of Health regarding board decision-making and communications in the district health board election period	79
1.7.2	Letter from the Minister of Health regarding an update to the Minister's 2019/20 expectations	110
1.8	Chief Executive's Report	
1.8.1	Operational Action Plan – ACC Partnership Audit 2019	121
1.8.2	May 2019 Finance Report	124
1.8.3	Fuseworks Media Report	150
2.1	CPHAC Membership	
2.1.1	Biography – Dougal Thorburn	154
2.1.2	CPHAC Terms of Reference	155
3.2	Māori Health Update	
3.2.1a	Te Pae Amorangi – Draft Focus Area One Māori Workforce 29th May 2019	157
3.2.1b	Te Pae Amorangi – Draft Focus Area Two 29th May 2019	160
3.2.1c	Te Pae Amorangi – Draft Focus Area Three Commissioning 12th June 2019	164
3.2.2	Feedback from Matariki Awards	167
3.2.3	Hauora Pre-PubW	169
3.4	Health Roundtable Performance Report 1 April 2018 – 31 March 2019	
3.4.1	HRT Report	425
4.1	HVDHB Clinical Council Board Report 4 July 2019	
4.1.1	Enhancing Quality Improvement Capacity and Capability Update	436
4.1.2	Mental Health Primary and Secondary Integration Update	440
4.1.2a	Hutt South Caseload	442
4.1.3	Quality and Safety Report to Clinical Council June 2019	444
4.1.4	Infection Prevention and Control Annual Report – Hutt Valley DHB 2019	459
4.1.5	Clinical Council Minutes 04 July 2019	477

Karakia – Whakataka te hau

Whakataka te hau ki te uru

(Cease the winds from the west)

Whakataka te hau ki te tonga

(Cease the winds from the south)

Kia mākinakina ki uta

(Let the breeze blow over the land)

Kia mātaratara ki tai

(Let the breeze blow over the ocean)

E hī ake ana te atakura

(Let the red-tipped dawn come with a sharpened air)

He tio, he huka, he hau hū

(A touch of frost, a promise of the glorious day)

Tīhei mauri ora!



Hutt Valley Board INTEREST REGISTER

Name	Interest
Graeme Andrew Blair <i>Chair</i>	<ul style="list-style-type: none"> • Chair, Capital & Coast DHB • Chair, Hutt Valley DHB • Chair, Hutt Valley DHB Hospital Advisory Committee • Member, Hutt Valley DHB Finance, Risk and Audit Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley DHB Community and Public Health Advisory Committee • Member, Capital & Coast DHB Finance, Risk and Audit Committee • Member, Capital & Coast DHB Health Systems Committee • Owner and Director of Andrew Blair Consulting Ltd • Former member of the Hawke's Bay DHB (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO, Acurity Health Group Limited • Advisor to Southern Cross Hospitals Ltd and Central Lakes Trust in relation to establish an independent surgical hospital facility in the Queenstown Lakes region • Chair, Queenstown Lakes Community Housing Trust • Member of the State Services Commission Advisory Group on Crown Entity Chief Executive Remuneration • Member of the Governing Board for the Health Finance, Procurement & Information Management System business Case • Advisor to the Board of Breastscreen Auckland Ltd • Advisor to the Board of St Marks Women's Health (Remuera) Ltd
Wayne Guppy <i>Deputy Chair</i>	<ul style="list-style-type: none"> • Upper Hutt City Council Mayor • Deputy Chair, Hutt Valley District Health Board • Deputy Chair, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Wife employed by various community pharmacies in the Hutt Valley • Trustee - Orongomai Marae • Director MedicAlert • Chair – Wellington Regional Mayoral Forum • Chair – Wellington Regional Strategy Committee
Lisa Bridson <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Hutt City Councillor • Chair, Kete Foodshare
Ken Laban <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Trustee, Hutt Mana Charitable Trust • Member, Ulalei Wellington • Chairman, Hutt Valley Sports Awards • Member, Greater Wellington Regional Council • Commentator, Sky Television • Broadcaster, Numerous Radio Stations • Member, Christmas in the Hutt Committee • Trustee, Te Awakairangi Trust • Member, Computers in Homes

David Ogden <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Regional Councillor • Principal, Oak Chartered Accountants Limited • Accountant, affiliated, with Simple Accounting Services Limited, which has various clients involved in the Health Sector • Daughter is a Doctor in Clinical Psychology and working within a District Health Board outside of the Central Region • Former Mayor and Councillor, Hutt City Council.
John Terris <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • National President of Media Matters in NZ – a viewer advocacy group work in the area of TV and the internet, and incorporating Children’s Media Watch • Patron – Hutt Multicultural Council Inc
Prue Lamason <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, 3DHB combined Disability Support Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • Deputy Chair, Hutt Mana Charitable Trust • Councillor, Greater Wellington Regional Council • Chair, Greater Wellington Regional Council Holdings Company • Trustee, She Trust • Daughter is a Lead Maternity Carer in the Hutt
Yvette Grace <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Hospital Advisory Committee • Deputy Chair, 3DHB combined Disability Support Advisory Committee • Chair, Hutt Valley District Health Board Community and Public Health Advisory Committee • General Manager, Rangitane Tu Mai Ra Treaty Settlement Trust • Husband, Family Violence Intervention Coordinator Wairarapa DHB • Sister in law, Nurse at Hutt Hospital • Sister in Law, Private Physiotherapist in Upper Hutt
Tim Ngan Kee <i>Member</i>	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • Member, Hutt Valley District Health Board Finance, Risk and Audit Committee • Member, Hutt Valley District Health Board Hospital Advisory Committee • Member, Hutt Valley District Health Board Community and Public Health Advisory Committee • General Practitioner, Churton Park Medical Care • Partner, Churton Park Medical Care
Kim von Lanthen	<ul style="list-style-type: none"> • Member, Hutt Valley District Health Board • One third shareholding Kim von Lanthen and Associates Ltd • One half shareholding Commodity Markets (NZ) Ltd • Nephew seconded as a cardiology registrar • One third shareholding NZ Bio Forestry Ltd




Hutt Valley DHB Executive Leadership Team

Interest Register

Name	Interest
Fionnagh Dougan <i>Chief Executive</i> <i>Hutt Valley & Capital and Coast DHB</i>	<ul style="list-style-type: none"> Board member, Queensland Children's Hospital foundation Adjunct Professor University of Queensland
Nigel Fairley <i>General Manager, 3DHB Mental Health Addictions & Intellectual Disability Service</i>	<ul style="list-style-type: none"> Fellow, NZ College of Clinical Psychologists President, Australian and NZ Association of Psychiatry, Psychology and Law Trustee, Porirua Hospital Museum Director and Shareholder, Gerney Limited
Melissa Brown <i>Acting Chief Operating Officer</i>	<ul style="list-style-type: none"> Member of the Australian College of Midwives
Tofa Suafole Gush <i>Director Pacific Peoples Health</i>	<ul style="list-style-type: none"> Member of the Te Awakairangi Health Board Pacific Member, Board of Compass Health Husband is an employee of Hutt Valley DHB
Dr Sisira Jayathissa <i>Chief Medical Officer</i>	<ul style="list-style-type: none"> Member of the Medicine Adverse Reaction Committee MedSafe (MOH) Member Standing committee on Clinical trials (HRC) Member Editorial Advisory Board NZ formulary Member Internal medicine Society of Australia and NZ Australian and New Zealand Society for Geriatric Medicine Writer NZ internal Medicine Research Review Clinical Senior Lecturer and Module convenor Clinical Skills module (HUTT campus), University of Otago
Judith Parkinson <i>General Manager, Finance and Corporate Services</i>	<ul style="list-style-type: none"> Director of Allied Laundry
Bridget Allan <i>Chief Executive, Te Awakairangi Health Network (PHO)</i>	<ul style="list-style-type: none"> Chief Executive, Te Awakairangi Health Network (PHO) Board member of Vibe Healthy Families Lower Hutt Leadership Group member
Fiona Mayo <i>Communications Manager</i>	<ul style="list-style-type: none"> No interests declared
Helene Carbonatto <i>General Manager Strategy Planning & Outcomes</i>	<ul style="list-style-type: none"> Sister is a GP in CCDHB Husband is a general manager at the Health Promotion Agency
Fiona Allen <i>General Manager Human Resources & Organisational Development</i>	<ul style="list-style-type: none"> No interests declared

Kerry Dougall <i>Director of Māori Health</i>	<ul style="list-style-type: none"> • Board Chair, Kokiri Marae Māori Women's Refuge • Board member, Ta Kirimai te Ata Whanau Collective
Chris Kerr <i>Director of Nursing</i>	<ul style="list-style-type: none"> • Member and secretary of Nurse Executives New Zealand (NENZ) • Relative is HVDHB Human resources team leader • Relative is a senior registered nurse in SCBU • Relative is HVDHB Bowel Screening Programme Manager
Debbie Gell <i>General Manager Quality, Service Improvement and Innovation</i>	<ul style="list-style-type: none"> • Member of consumer council for Healthy Homes Naenae
Christine King <i>Director of Allied Health, Scientific and Technical</i>	<ul style="list-style-type: none"> • Brother works for Medical Assurance Society (MAS) • Sister is a Nurse for Southern Cross
Kristine McGregor <i>Executive Officer</i>	<ul style="list-style-type: none"> • Husband works in 3DHB ICT

BOARD**PUBLIC**

	MINUTES Held on Thursday, 27 June 2019 Boardroom, Pilmuir House, Hutt Hospital, Lower Hutt Commencing at 9.00 am
BOARD	PUBLIC SECTION

PRESENT

Andrew Blair	Chair
Wayne Guppy	Deputy Chair
Kim von Lanthén	Member
Tim Ngan Kee	Member
Lisa Bridson	Member
Ken Laban	Member
David Ogden	Member
Prue Lamason	Member
John Terris	Member

APOLOGIES

Yvette Grace	Member
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IN ATTENDANCE

Dale Oliff	Acting Chief Executive
Christine Rabone	Committee Secretary
Kristine McGregor	Executive Officer
Judith Parkinson	General Manager, Finance and Corporate Services
Melissa Brown	Interim Chief Operating Officer
Rod Bartling	Service Improvement Director, Mental Health and Addiction
Kerry Dougall	Director of Maori Health
Chris Kerr	Director of Nursing
Fiona Mayo	Communications Manager
Debbie Gell	General Manager – Quality, Service Improvement and Innovation
Christine King	Director of Allied Health, Scientific and Technical

GUESTS

Vida Rye (Member of the public)	9.00am – 12.20pm
Alison Grant (Member of the public)	9.00am – 12.20pm

BOARD**PUBLIC****1. PROCEDURAL BUSINESS**

1.1 KARAKIA

The meeting opened with a karakia.

1.2 APOLOGIES

The Board **NOTED** apologies from Ms Y Grace

1.3 CONTINUOUS DISCLOSURE

The Board **CONFIRMED** that it was not aware of any matters (including matters reported to, and decisions made by the Board at this meeting) that required disclosure.

1.3.1 INTEREST REGISTER

The Board **NOTED** that no changes to the interest register were declared in the meeting

1.3.2 CONFLICT OF INTEREST

The Board **CONFIRMED** that it was not aware of any matters (including matters reported to, and decisions made, by the Board at this meeting) that require disclosure and that there would be an opportunity to declare any conflicts prior to discussion on each item of the agenda.

1.4 PRIMARY BIRTHING

Ms Vida Rye (member of the public) presented short videos on the benefits of primary birthing (compared to secondary birthing) and new mothers' experiences to the Board, and requested that the Board consider funding primary birthing facilities.

The Board thanked Ms Rye for her presentation and strong messaging, and confirmed that the Maternity Refurbishment update had been deferred to the 1 August 2019 board meeting.

1.5 MINUTES OF PREVIOUS MEETING

The Board **RESOLVED** to approve the minutes of the Members' (Public) meeting held on 30 May 2019 as a true and accurate record of the meeting.

MOVED: Ken Laban

SECONDED: Wayne Guppy

CARRIED

1.6 ACTION LIST AND MATTERS ARISING

The Board **RECEIVED** the matters arising from the previous meeting, and **NOTED:**

- Items BP2019-9, CP2019-8, and CBP2019-7 are scheduled for delivery at the Board Meeting on 29 August 2019;
- Item CBP2019-6 has been completed;
- Item B2019-2 has been scheduled for today and will be marked completed.

1.7 DRAFT 2019 BOARD WORK PLAN

The Board noted the 2019 Work Plan and the deferral of the Maternity Refurbishment update to the July 2019 Board Meeting.

1.8 CHAIR'S REPORT

The Board Chair provided a verbal report to the Board noting no meetings had been attended since the last meeting, aside from regular contact with the incoming Chief Executive, Fionnagh Dougan.

BOARD**PUBLIC**

The Board Chair noted the upcoming Mihi whakatau for Fionnagh (which would also be attended by the Maori Partnership Board) on 2 July and extended his appreciation to Arawhetu Gray, Kerry Dougal and their teams for organising. The majority of Board members signaled they would be attending.

The Board **NOTED** the contents of the verbal report.

1.8 CHIEF EXECUTIVE'S REPORT

The report was taken as **READ**.

The Board:

- a) **NOTED** that HVDHB underwent a full on-site certification audit during 4 – 7 June and that Management is awaiting the full draft report to consider findings and put measures in place for any corrective actions;
- b) **NOTED** that management is currently finalising the economic and financial case for the Te Whare Ahuru reconfiguration project, and that Management is working to complete the business case whilst it awaits advice from the Ministry of Health on whether the project has been prioritised as part of the new national capital process;
- c) **NOTED** the April 2019 DHB financial performance showed a favourable variance of \$925K that was \$3,091K favourable year-to-date (YTD).
- d) **REQUESTED** that the Health and Disability Commissions Report be added to the Board Members Resource Centre in Board Books once received, noting that this will also be reported on at the 1 August Meeting.

Action: Management to investigate and report back as to whether there were specific reasons for the decline in survey response rates in quarter one 2018/19.

Management verified that there is a project currently underway between Ambulance, Police and HVDHB; which is looking to develop a patient management model that will work towards decreasing demand and risk of unstable mental health patients attending ED.

2. PATIENT STORY**2.1 PATIENT EXPERIENCE STORY**

Ms D Gell introduced a video called "Pat's Story", which recounted her experience being admitted to the hospital through ED following a fall. Whilst she was positive about the care received from staff, Pat noted that improvements could be made around communication, and waiting times - from presentation to being seen by a doctor in ED, and the from being seen by a doctor to admission to a ward.

Ms D Gell noted that ED have reflected on Pat's feedback and are piloting a project (Smooth Sailing) that aims to provide a faster and more streamlined approach to admission to the medical ward from ED. The Chief Medical Officer is also leading an "across the system" Frailty Programme that has been running for 8 – 9 months.

The Board thanked Ms D Gell for sharing Pat's story.

3. DECISION ITEMS**3.1 INTERNAL AUDIT PLAN 2019/20**

The paper was taken as **READ**.

The Board noted that the paper had been considered at the FRAC meeting the previous day, which recommended the Board approve the paper.

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The Board:

- a) **APPROVED** the proposed 2019/20 Internal Audit Plan to be completed by Central Region Technical Advisory Service.

MOVED: Andrew Blair

SECONDED: Lisa Bridson

CARRIED

3.2 JOINT CCDHB AND HVDHB FRAC TERMS OF REFERENCE

The paper was taken as **READ**.

The Board noted that the paper had been considered at the FRAC meeting the previous day, however, they were not approved as further work is required to these.

The Board:

- a) **NOTED** the Terms of Reference for the joint FRAC have been updated as requested at the May FRAC meeting;
- b) **NOTED** there are separate terms of reference for HVDHB and CCDHB however, they are now the same;

4. DISCUSSION ITEMS

4.1 HEALTH, SAFETY AND WELLBEING REPORT

The paper was taken as **READ**.

The Board:

- a) **NOTED** that during the period 1 March to 31 May 2019 there were no notifiable events;
- b) **NOTED** that there were 149 SQuARE reported 'Staff and Other Health and Safety' events with workplace health and safety implications reported for the period 1 March to 31 May 2019
- c) **NOTED** that there were 740 SQuARE reported 'Staff and Other Health and Safety' events with workplace health and safety implications reported for the 12 month period to 11 March 2019;
- d) **NOTED** the Health and Safety events logged on SQuARE are consistent with what would be expected through common cause variation;
- e) **NOTED** the annual usage and statistics provided for EAP Services for the period 1 May 2018 to 30 April 2019.
- f) **NOTED** the ACC on-site audit took place during 11 to 13 June 2019;
- g) **NOTED** the DHB's joint funding submission to the ACC "Workplace Injury Prevention Grant" with Hawkes' Bay and Auckland DHBs;
- h) **NOTED** the overview of the operations of the WHS Team including Occupational Health Services, as well an update on the 2019 flu campaign and other vaccination activities

Action: The Board requested management provide keys to graphs and narrative to these so that members are able to interpret the data.

4.2 HOSPITAL AND HEALTH SERVICES REPORT

The paper was taken as **READ**.

The Board:

- a) **NOTED** that for the month of May and year to date, Hutt Valley DHB achieved 90 percent against the *Shorter Stays in ED* health target
- b) **NOTED** that Hutt Valley DHB's performance against the *Faster Cancer Treatment* target for May was 83.3 percent, with a year to date achievement of 92.2 percent for the 60 day target;

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- c) **NOTED** that Hutt Valley DHB's performance against the *Improved Access to Elective Surgery* health target as at May 2019 was 96 percent for discharges and 86 percent for case weighted discharges;
- d) **NOTED** the impact of the four RDA strikes on cancellation of surgery and outpatients clinics and ESPI2 and ESPI5 compliance;
- e) **NOTED** the impact of the overall lower length of stay on bed requirement

5. COMMITTEE REPORTING**5.1 DRAFT CONSUMER COUNCIL MINUTES – 12 JUNE 2019**

The Board **NOTED** the draft minutes of the Consumer Council meeting on 12 June 2019.

Action: The Board requested that management (on behalf of the Board) issue a standing invite to Board meetings to the Consumer Council's Establishment Chair

Action: The Board requested management invite Consumer Council Members to join a number of other DHB consumer representative groups that align with their interest areas.

5.2 CLINICAL COUNCIL REPORT – 6 JUNE 2019

The paper was taken as **READ**

The Board:

- a) **NOTED** the report and request that the minutes be appended to the report going forward.

Action: The Board requested draft minutes from Clinical Council meetings be appended to the Clinical Council board report.

6. OTHER**6.1 GENERAL BUSINESS**

The Board Chair acknowledged the work Ms D Oliff has undertaken during her time as the acting Chief Executive over the past 18 months and wished her all the very best for her new endeavors as CE at Wairarapa DHB.

Ms D Oliff thanked the Board for their well wishes.

6.2 RESOLUTION TO EXCLUDE THE PUBLIC

The Board **RESOLVED** to **AGREE** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the 30 May 2019 Board agendas	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in the 30 May 2019 Board agendas	
Chief Executive's report	Information contained in the paper may be subject to change as the information has not yet been reviewed by the FRAC Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(f)(iv) Section 9(2)(j)
Clinical Council report		

BOARD**PUBLIC**

Sub-committee draft minutes	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations.	Section 9(2)(i)(j)
Final 2019/20 Operating and Capital budgets		
NZHP FPIM impairment		
Collective insurance renewal		
AoG contract for the supply of electricity and associated services		
MRI lease extension		
Register of Board Chair Executed documents		
Facilities and Infrastructure report		
Health and Safety Case study	<p>Paper contains information that is likely to prejudice the privacy of natural persons, including that of deceased natural persons.</p> <p>Paper contains information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations.</p>	<p>Section 9(2)(a)</p> <p>Section 9(2)(i)(j)</p>
Final 2019/20 Annual Plan	Subject to Ministerial and/or Cabinet approval	Section 9(2)(f)(iv)

MOVED: Andrew Blair **SECONDED:** Ken Laban **CARRIED**

7. DATE OF NEXT MEETING

The next meeting will be held on Thursday, 1 August 2019, in the Boardroom, Pilmuir House, Hutt Valley DHB, commencing at 9.00 am.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting.

DATED this day of 2019

ANDREW BLAIR
CHAIR
HUTT VALLEY DISTRICT HEALTH BOARD

BOARD

PUBLIC

MATTERS ARISING FROM PREVIOUS MEETINGS

Original Meeting Date	Ref	Topic	Action	Resp	How Dealt with	Delivery date	Completed Date
27 June 2019	BP2019-14	Clinical Council report	The Board requested draft minutes from Clinical Council meetings be appended to the Clinical council board report	Committee Secretary	Information included in next report	1 August 2019 and ongoing	August 2019
	BP2019-13	Consumer Council minutes	The Board requested management invite Consumer Council Members to join a number of other DHB consumer representative groups that align with their interest areas.	General Manager Quality, Service Improvement & Innovation	Invitation to Consumer Council Members extended as opportunities arise and highlighted at their August meeting	14 August 2019 and ongoing	August 2019
	BP2019-12	Consumer Council minutes	The Board requested that management (on behalf of the Board) issue a standing invite to Board Meetings to the Consumer Council's Establishment Chair	Committee Secretary	Invitation extended to Establishment Chair of the Consumer Council	5 July 2019	July 2019
	BP2019-11	Health, Safety and Wellbeing Report	The Board requested management provide keys to graphs and narrative to these so that members are able to interpret the data	General Manager Human Resources & Organisational Development	Reminder sent for graphs to be updated going forward	1 August and ongoing	August 2019
	BP2019-10	Chief Executive's Report	Management to investigate and report back as to whether there were specific reasons for the decline in survey response rates in quarter one 2018/19	General Manager Quality, Service Improvement & Innovation	Investigation undertaken and report back included in July's Chief Executive report	1 August 2019	August 2019
30 May 2019	BP2019-9	Population Health report	The Board requested data be provided in subsequent reports regarding the follow up of patients following abnormal cervical and breast screening results	Interim COO, HVDHB	Information included in next report	29 August 2019	
	CPB2019-8	Population Health report	The Board requested management investigate what work can be done to improve access to warm water in schools (as a means of reducing skin infections)	Interim COO, HVDHB	Investigation undertaken and report back included in next report	29 August 2019	
	CPB2019-7	Population Health report	The Board requested further information be provided in subsequent reports regarding access rates to community dental services	Interim COO, HVDHB	Information included in monthly balanced scorecards	29 August and ongoing	

Hutt Valley DHB Board work plan 2019

Regular monthly items:							Strategy, Planning and Outcomes updates to include:					
Public	Chair's report	CEO's report	Resolution to exclude the public				• ALT update		• Palliative Care update		• Obesity prevention	
Public Excluded	Chair's report	CEO's report	FRAC report back	FRAC minutes			• Primary Care update		• Child & Youth health		• Smoking cessation services	

	January	February	March	April	May	June	July	August	September	October	November	December
Decision	Combined Boards workshop		First draft 2019/20 Annual Plan	2019/20 Funder Commitments		Internal audit plan 2019/20	Unified telephony and pager business case 1*		Allied Laundry AGM	HVDHB 2018/19 Draft Annual report		
			Lead DHB model for MHAIDS			Final 2019/20 Operating and Capital budgets	IT backup system replacement		Hospital dental system replacement business case*	Final 2019/20 Annual Plan		
						Insurance renewal	Concerto Transition Phase 1 Business Case		Radiology Equipment Upgrades and Refurbishment business case	Final 2019/20 RSP		
						AoG contract for the supply of electricity and associated services	Final Draft Annual Plan			Electronic order of and signoff of other diagnostics *		
										Theatre Capacity		
										IT backup system replacement		
										Concerto Transition Phase 1 Business Case		
			Hospital & Health Services report	Strategy, Planning & Outcomes update		Hospital & Health Services report	Strategy, Planning & Outcomes update		Hospital & Health Services report	Strategy, Planning & Outcomes update		Hospital & Health Services report
			Health & Safety report	Maori Health update		Health & Safety report	Maori Health update		Health & Safety report	Maori Health update		Health & Safety report
			Q2 performance	Quality and Safety report		Facilities & Infrastructure	Quality and Safety report		People & Capability update	Quality and Safety report		RSP progress update
			Progress update 2018/19 Annual Plan actions	Staff turnover		Clinical Council report/minutes	Facilities & Infrastructure		Clinical Council report	Facilities & Infrastructure		
			Update on Phases 1 and 2 – ICT Resilience Programme	Maternity refurbishment update		Consumer Council report/minutes	Clinical Council report		Consumer Council report/minutes	External Audit report		
			Recognition of long serving staff	Clinical Council report/minutes		Maternity refurbishment update	Consumer Council report/minutes			Clinical Council report		
			Clinical Council report	Consumer Council report/minutes		Health Roundtable performance				Consumer Council report/minutes		
			Consumer Council report/minutes									
Presentation			Closer to home	Clinical Services Plan		Iwi Relationship Board			Iwi Relationship Board	NZ Police – Whangaia Nga Pa Harakeke: reducing and preventing family harm and its impact on families/whanau		Iwi Relationship Board
Visits			OPRS	Te Whare Ahuru		Visit to Te Omanga Hospice			IHI Patient Safety Congress Conference Feedback (Sisira) 20 mins			


Commented [CR1]: Removed from Board Workplan as within CE's level of delegation

Commented [CR2]: Paper rescheduled to October due to hold within procurement process which requires completion

Commented [CR3]: Paper rescheduled to October as Regional CIOs & CUG/Clinical Council approval required prior

Commented [KM(4)]: * Timing subject to Hutt Valley and Wairarapa business cases being progressed concurrently

Commented [CR5]: Added as per email from Maranda on 8/7. Can be pushed out if required.

		BOARD UPDATE
		Date: 1 August 2019
Author	Fionnagh Dougan, Chief Executive	
Subject	Chief Executive’s report July 2019	
RECOMMENDATIONS		
It is recommended that the Board:		
<ul style="list-style-type: none">a) NOTES that HVDHB achieved 89.2 percent against the <i>Shorter Stays in ED</i> target in June 2019, with an overall year-to-date result of 92 percent;b) NOTES that for the month of June 2019, HVDHB achieved 92.9 percent against the <i>Faster Cancer Treatment</i> target, with a year-to-date result of 92.6 percent;c) NOTES that for 2018/19, HVDHB achieved 96.5 percent against the <i>Improved Access to Elective Surgery</i> target;d) NOTES that the DHB has secured a potential contractor for the Manager Workplace Health and Safety position. The DHB has also recently made an offer of employment for the Senior Health and Safety Advisor position. These positions are critical to the DHB implementing its Health, Safety and Wellbeing Strategy, addressing a number of existing workplace health and safety risks and issues, and increasing worker participation and engagement;e) NOTES that the rollout of TrendCare across the Mental Health, Addictions and Intellectual Disability Service 3DHB is progressing wellf) NOTES that the Minister of Health visited Hutt Hospital on 2 July, and as part of this visit was taken on a tour of Te Whare Ahuru;g) NOTES the May 2019 DHB financial performance showed an unfavourable variance of (\$1,286K) that was \$1805K favourable year-to-date (YTD).		
APPENDICES		
<ul style="list-style-type: none">1. Operational action plan – ACC partnership audit 20192. May 2019 finance report3. Fuseworks media report		

1. PURPOSE

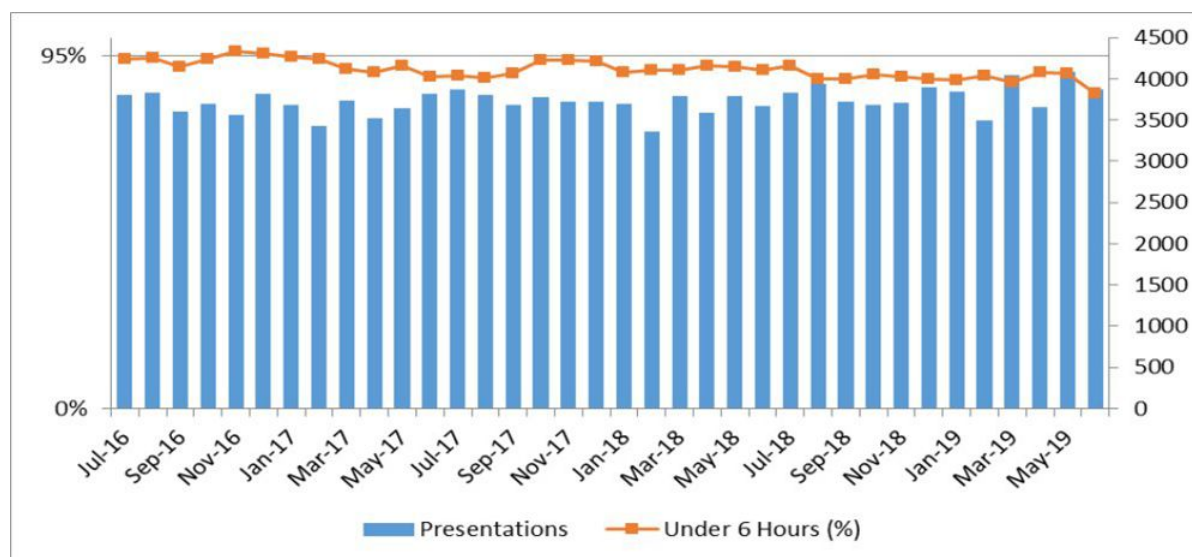
The purpose of this paper is to provide the Board with an overview of key areas of performance and updates from across the hospital and wider Hutt Valley health system. It highlights work that is occurring at the DHB that relates to the Government's priorities:

- workforce (through the focus on health, and safety);
- sustainability (through various Choosing Wisely initiatives including "PJ Paralysis");
- Equity (Hauora Maori workforce work);
- public health (through the monitoring of health targets, and various pieces of internal and external communications regarding health and wellbeing).

2. GOVERNMENT PRIORITIES AND HEALTH TARGETS

2.1 Shorter Stays in ED

During June 2019, HVDHB achieved 89.2 percent against the *Shorter Stays in ED* health target (compared to 92 percent in June 2018).



During June, 69 percent of presentations were admitted, and 93 percent were seen and discharged. Of note:

- There were 4 percent more presentations to ED than for the same period last year;
- The largest increase were in triages two (6.9 percent), four (5.5 percent) and five (8.5 percent) presentations;

2.1.1 Patients presenting to ED with ILI (influenza-like-illness)

Compared to 2017/18, there has been a 27 percent increase in the number of patients who have presented to ED with ILI. Whilst most have been in triages four and five (low acuity – GP type patients), the number of patients admitted has almost doubled (with most of these patients being in triages two and three).

Diagnosis Primary	Discharge MOH	Triage	2016/2017	2017/2018	2018/2019
Flu Viral Illness NOS	Admitted	1	1	2	7
		2	70	57	123
		3	150	108	212
		4	27	32	50
		5			2
	Admitted Total		248	199	394
	Treated & Discharged	1			1
		2	83	114	135
		3	626	662	779
		4	444	465	644
		5	36	70	109
	Treated & Discharged Total		1189	1311	1668
	Did Not Wait	3			1
		5		1	2
	Did Not Wait Total			1	3
Flu Viral Illness NOS Total			1437	1511	2065

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This year, point of care testing is now undertaken routinely for those patients who are presenting to ED with flu symptoms. This is reducing the need for unnecessary treatment and isolation. Also, more work has been done in the community and hospital to offer the flu vaccination, including:

- Supporting Te Awakairangi Health Network and Kokiri Marae to deliver over 40 flu vaccinations to Kaumātua;
- Regional Public Health providing vaccination to all Kokiri Marae and wide Takiri Mai Te Ata Whanau Ora collective kaimahi (these were done as part of a wholistic approach where wider health education was provided at the same time).

2.1.2 Hospital Average Length of Stay

The table below presents the Average Length of Stay (ALOS) for all admission groups for the 2018/19 year, compared to the previous two years.

Admission Type	Data	2016/2017	2017/2018	2018/2019	Var Bet 17/18 and 18/19
Acutes/Arranged Admissions	Discharges	22350	22053	22199	1%
	Avg Caseweights	0.90	0.92	0.93	
	Avg LOS	3.30	3.38	3.31	
	Day Case (%)	28%	28%	28%	
Elective Admissions	Discharges	10557	10927	11544	6%
	Avg Caseweights	0.80	0.80	0.78	
	Avg LOS	0.80	0.73	0.72	
	Day Case (%)	77%	77%	80%	
Total Discharges		32907	32980	33743	2%
Total Avg Caseweights		0.87	0.88	0.88	NC
Total Avg LOS		2.50	2.50	2.43	-0.08
Total Day Case (%)		43%	44%	46%	2%
Bed Required Per Day		225	226	224	NC

Of note:

- There has been a 1 percent increase in volume in acute and arrange admissions compared to 2017/18
- Elective admissions have increased by 6 percent but the case weight had dropped. This is primarily driven by the higher proportion of day cases undertaken (46 percent) as a result of the need to select lower acuity cases during the RMO strikes;
- The overall lower length of stay (2.43 days) has seen an increase in discharges, however the daily requirement was almost the same as 2017/18.

There are a number of initiatives underway to improve performance in this area, including:

- Completion of the abdominal pathway for general surgery and gynaecology (this is the group of patients who experience long waits in ED);
- 'Smooth Sailing' – this is a patient flow improvement project being undertaken within the medicine service teams aimed at minimising delays and delivering timely patient care. Each team is 'awarded' points for being proactive and 'pulling' patients to medical services, sometimes even before they are referred;
- Red2Green – this was implemented in the Medical Ward with the engagement from the wider multidisciplinary team, looking at barriers to a patient's journey and to refocus on 'valuing a patient's time'. The multidisciplinary team has a daily board to evaluate what is holding the patient back from returning home. These are indicated in the electronic whiteboard, which allows

regular reports and evaluation to occur. The project has already seen improvement in the length of stay;

- Criteria Led Discharges (CLD) has also been implemented in the Medical ward. CLD empowers nurses in the team to assess the patient against the criteria, and if these are met, patients are discharged.

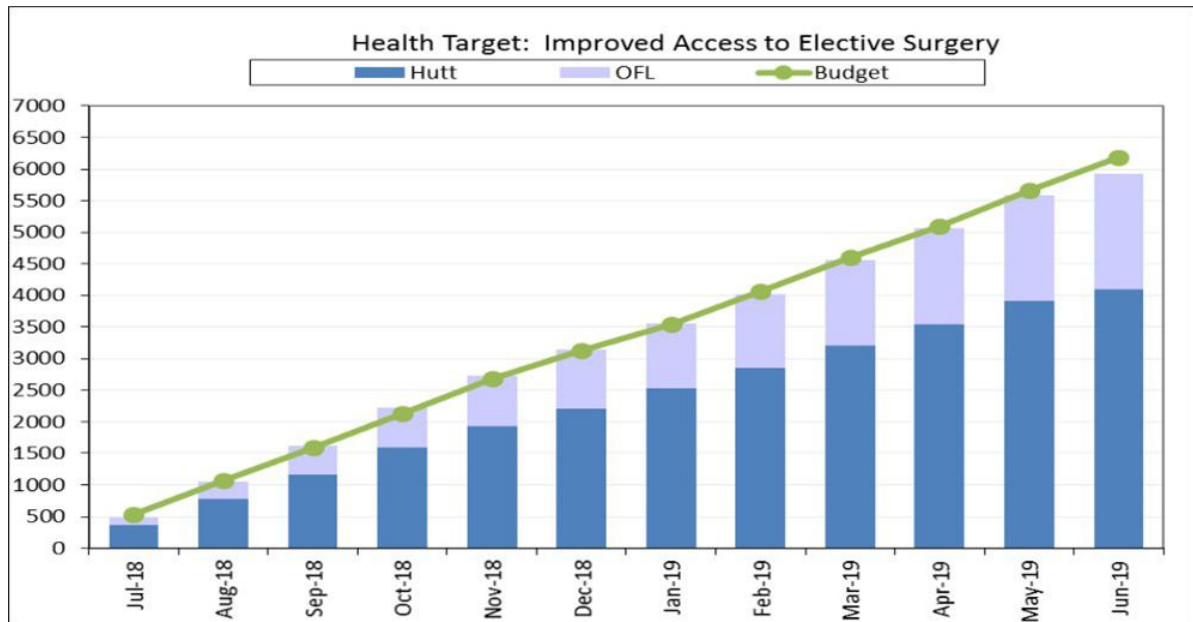
2.2 Faster Cancer Treatment

For June, HVDHB achieved 92.9 percent against this target, with a year-to-date result of 92.6 percent.

FinYear	FinYear Quarter	Month	62 Day Target (%)
2018/2019	Quarter 4	Jun 19	92.9%
		May 19	90.0%
		Apr 19	100.0%
	Quarter 4 Total		94.6%
	Quarter 3	Mar 19	87.5%
		Feb 19	100.0%
		Jan 19	91.7%
	Quarter 3 Total		92.0%
	Quarter 2	Dec 18	87.5%
		Nov 18	100.0%
		Oct 18	92.3%
	Quarter 2 Total		92.7%
	Quarter 1	Sep 18	77.8%
		Aug 18	100.0%
		Jul 18	90.9%
	Quarter 1 Total		90.9%
2018/2019 Total			92.6%
2017/2018	Quarter 4	Jun 18	100.0%
		May 18	88.9%
		Apr 18	100.0%
	Quarter 4 Total		97.6%
	Quarter 3	Mar 18	92.9%
		Feb 18	100.0%
		Jan 18	86.7%
	Quarter 3 Total		92.7%
	Quarter 2	Dec 17	93.3%
		Nov 17	81.8%
		Oct 17	85.7%
	Quarter 2 Total		87.5%
	Quarter 1	Sep 17	90.9%
		Aug 17	92.9%
		Jul 17	90.0%
	Quarter 1 Total		91.4%
2017/2018 Total			92.4%

2.3 Elective Surgery

As at the end of June, HVDHB was at 96.6 percent of the *Improved Access to Elective Surgery* target. This was made up of 96.5 percent of procedures delivered at HVDHB, and 96.8 percent IDFs (mostly CCDHB). The decrease in discharges in 2018/19 (209 out of a target of 6,192) was primarily in general surgery, gynaecology, paediatric surgery, urology, ENT and vascular (some of which are delivered as part of IDF).



2.3.1 ESPI compliance

Since January 2019, HVDHB has been non-compliant for both ESPI2 (first specialist appointment greater than four months) and ESPI5 (patients given commitment to treatment but not treated within four months). HVDHB was the last DHB to “go red”. This non-compliance has driven by this year’s RDA strikes.

	March	April	May	June
ESPI-2--FSAs				
ESPI-5--surgery				

Currently there are 345 patients who have waited longer than 120 days for a First Specialist Assessment (FSA). All services are struggling to meet compliance for ESPI5. Management recently submitted a recovery plan to Ministry of Health. Actions include on the recovery plan include:

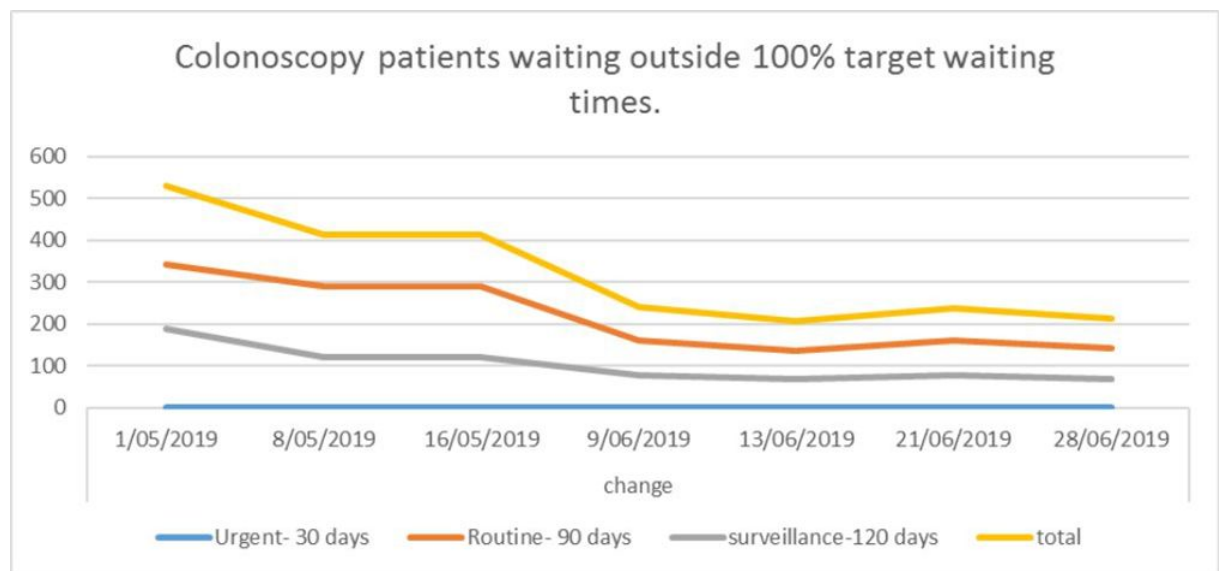
- Weekly meetings to monitor performance against plan;
- Utilising all available capacity on site;
- Outsourcing to private providers for ophthalmology, gynaecology, plastics and ENT;
- Extra clinics and theatre lists for gynaecology, general surgery, dentals and plastics;
- Gynaecology are reviewing their acceptance criteria for FSAs and are looking at alternate patient pathways eg, physiotherapy/incontinence nurse as well as nurse-led follow-ups.

The outsourcing, locums and additional sessions will affect the DHB financially and this will be monitored and balanced against ESPIs compliance. Management are seeking for the DHB to be compliant by September.

2.4 Colonoscopy

Details of the colonoscopy waiting times target are outlined below, comparing HVDHB's performance against the Ministry target.

Descriptor	Ministry target	HVDHB performance
Urgent colonoscopies – 30 days	100	100
Semi-urgent colonoscopies – 84 days	70	68
Surveillance colonoscopies – 120 day	70	82



3. PROFESSIONAL LEADERS' UPDATES

3.1 Director of Nursing (DoN)

3.1.1 Nursing – a year in review

Another year has flown by in the Director of Nursing role and so much has been achieved. I am extremely proud of my team and all the nursing staff here at Hutt Valley DHB. They are resilient in times of challenge, yet positive and forward thinking, and provide great patient care to all those that touch health services across the Hutt Valley.

As our nursing strategy reflects '*Whāia te iti kahurangi ke to tūohu koe me he maunga teitei*' – seek the treasure you value most dearly: if you bow your head, let it be to a lofty mountain.

The best achievements over the last twelve months have come from:

- Maintaining visibility across the nursing workforce – at least weekly visits to all areas connecting with the nurses on the floor;
- Participating in patient care when the nurses are so stretched – it was an absolute privilege to be able to assist with the bed bath of a patient in the last days of their life – the gratitude passed on by the family said it all;
- Always asking '*Why, why, why, why and why?*' This allows me to get to the heart of the issue and to problem solve from the roots up;
- Delivering on what we promise. Providing support and resource where needed to gain the respect and trust of the nurses;

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- Striving to make sure the nursing voice is present at every point that relates to patient care; and most importantly;
- Asking the nurses for solutions, empowering them to be in charge and guide what happens next.

Key highlights include:

- Establishment of the Nursing Recruitment Pool with ongoing advertisements running and suitable applicants moved onto a hotlist. CNMs then pull from the hotlist as vacancies arise
- First DHB to submit a plan and gain Ministry of Health approval for additional funding as per the nursing accord, with quick implementation of additional FTE as per the plan;
- Expansion of the CCDM team with permanent fulltime CCDM Nurse Coordinator, TrendCare Nurse Coordinator and Project Support Nurse. In addition, a CCDM Data Analyst 0.5FTE fixed term was added to the team. This was made possible with the additional Ministry of Health funding for CCDM implementation as part of the MECA settlement;
- Successfully negotiated an ACC contract to support recruitment of a Pressure Injury Prevention and Management Nurse for two years;
- The January 2019 intake of New Graduates was 14 with 50 percent of Maori and/or Pacific descent;
- Launch of the HVDHB Nursing Strategy 2018 to 2023 – *Tepanikiri pai o ngaa neehi* on 30 January 2019;
- Integrated Operations Centre (IOC) management moved under the responsibility of the DoN in line with CCDM standards. This has brought more of a clinical focus to the IOC, being the hub of the hospital for patient flow, bed management and safe staffing;
- “Whanau as Partners in Care” pilot in Older Person’s Rehab Service (OPRS) – enabling family/whanau to stay and care for their loved ones while in hospital. The success of the programme is evident in the feedback from family/whanau, patients and staff, and the programme will be extended to other areas of the hospital;
- Community Health Nurses went electronic with patient progress notes;
- Capacity Planner forecasting tool went live in May providing a greater depth of information than was previously available to match capacity with demand tomorrow, next week, next month etc;
- Coming through a Certification Audit with positive feedback around nursing leadership and great implementation of the CCDM Programme.

Key challenges:

- Finding the right workforce to fill vacancies;
- Increasing demand for one to one care for patients;
- Workforce strikes – both Nurses and Doctors;
- Ongoing outsourced nursing costs.

Regardless of the challenges presented, the nursing workforce at Hutt is resilient when things get tough, the nurses are open to being challenged on their thinking and making changes when they make sense, and they live the DHB Values through and through with the patients always at the forefront. I am extremely privileged and proud to be their Director of Nursing.

3.1.2 Certification Audit

Nursing overall received some awesome feedback from the auditors who undertook the recent certification audit during the week of 4 – 7 June 2019. Comments received included “great leadership” and “implementation and visibility of CCDM was evident and the programme of work was well understood by those at the front line of services”.

3.1.3 Surgical teams profile Surgical Briefing Awareness

A nationwide initiative called ‘Spend five to save lives’ was run by the Health Quality & Safety Commission (HQSC) on 27 June. This ‘start of list briefing’ was a five-minute discussion held with the whole surgical team to create greater understanding about what needs to happen for each operation that day.

As a result, Hutt Valley DHB’s surgical teams have started holding the ‘start-of-list’ briefing sessions before commencing their lists each day. The teams review each patient case, identify what equipment is needed and what the staffing requirements are, and thus any potential risks can be identified. This five-minute briefing also provides an opportunity for team members to ask any questions prior to surgery, which is having a positive impact on patient safety by improving communication and teamwork and reducing delays.

3.1.4 Working at Hutt Hospital and promoting the Choosing Wisely campaign



Cathy Whiteside, (Associate Director of Nursing (ADoN) for Acute Services and the Integrated Operations Centre (IOC)) provided an overview of why she enjoys working at Hutt Hospital in a ‘Know your staff’ video clip recently posted on our intranet and Facebook pages. Cathy talked about her role and a typical day as an ADoN for Acute Services and IOC. She also profiled what it means to be a Choosing Wisely Champion for HVDHB. Choosing Wisely is a global campaign to promote conversations between clinicians and

patients by helping patients choose care that is supported by evidence, not a duplication of tests or procedures already received, free from harm and truly necessary. Cathy explained how she has used the Choosing Wisely initiative for *#PJ paralysis* where patients are encouraged to get up and wear their own clothes, rather than being in PJs. This initiative has numerous benefits including faster recovery times, less risk of infection, improved mobility and less muscle weakening.

3.1.5 Orthopaedics ward achieve 100 percent in Care Planning

A senior registered nurse (Jaeleen) from Orthopaedics recently undertook a quality initiative for her PDRP (professional development and recognition programme) portfolio. In April 2019, an audit revealed that care planning completion rates were relatively low. Since then she has been championing the way with motivating and encouraging staff individually and collectively with better care plan completion. The improvement in audit results has been outstanding due to her work within the team. As a result of her work (alongside Clinical Nurse Manager, Anne Taylor, and the rest of the nursing team), Orthopaedics achieved a 100 percent completion rate in the June care planning audit. Well done Orthopaedics.

3.1.6 Cardiac Society of Australia and NZ (CSANZ) Annual Scientific Meeting

Six nursing and allied health staff from the Coronary Care Unit/Cardiology Services attended the annual CSANZ Scientific Meeting that was held at the TSB Arena in Wellington from 13 - 15 June.

Clinical Nurse Managers Jennie Dean and Jane Clarke, along with the DHB’s four Cardiologists; Kathy Ferrier, Tim O’Meeghan, Russell Anscombe and Susan Plunkett, had all been involved with organising the conference and provided an excellent representation from Hutt Valley DHB. The Hutt team organised national and international speakers and chaired many of the sessions.

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One of the key themes that was apparent at the meeting was how forward thinking and innovative Hutt Valley DHB is. Presentations from large DHBs were given addressing areas where they are struggling to meet recommended targets and timeframes for patient follow-up, including initiating medication titrations that are used to improve cardiac function. Hutt Valley DHB already has existing systems in place to allow for early follow-up and identification of patients requiring ongoing support and medication adjustments.

CSANZ meetings provide our staff with valuable opportunities to network with other health professionals from across New Zealand and Australia. Ongoing challenges and innovative practices can be shared, discussed and adapted to meet the clinical needs of cardiac patients within the Hutt Valley.

During the nursing stream of the conference, Jennie Dean (*pictured below left*) delivered an excellent presentation addressing the priorities in nursing patients with Atrial Fibrillation. Naila Rahman (*pictured below right*) delivered her first presentation providing a case study of a young man with Methamphetamine associated Cardiomyopathy. Naila's case study highlighted how optimum heart failure medication and abstinence of methamphetamine can significantly improve heart function from severe heart failure to near normal heart function.



3.2 Director of Allied Health, Scientific and Technical (DAHST)

3.2.1 Local HVDHB Allied Health Scientific and Technical updates

Community Integration and Community DHB 'One Team' project

Staff forums are scheduled for 23 and 24 July to engage with Allied Health staff (Community, Outpatients and Hospital based) and wider staff within the DHB's Community Older Persons and Rehabilitation service. These forums will - focus on developing our shared vision, and discussing opportunities for Allied Health and community DHB services to support the future health and disability needs in the Hutt Valley that are congruent with the Community Integration programme.

We will share with staff the focus of moving toward increasingly integrated teams and ways of working, with a focus initially on community services, and progression towards supporting staff with greater integration in the way we work, within the hospital setting as well.

Early Supported Discharge (ESD)

Work continues on developing a model for the ACC non-acute rehabilitation (NAR) contract, with funding moving towards supporting an ESD model. This will support staff to discharge people home sooner with the appropriate level and intensity of rehabilitation required.

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Alongside this, the National Stroke Rehabilitation Guideline is being launched across New Zealand and this has a number of KPIs that DHBs are expected to audit themselves against to establish gaps and the level of service provision being provided. The guideline also recommends the provision of an ESD service for stroke patients, of which Hutt Valley DHB does not currently have.

Get Up Get Dressed, Get Moving Campaign

This campaign has been launched (in the first week of July) across HVDHB's ED and inpatient wards as part of the #EndPJparalysis campaign.

Throughout the month of July, the DHB's inpatient wards are competing to see who can achieve the highest percentage of their patients up and dressed in their own clothes, as this is strongly linked to shorter stays, decreased complications in hospital, and higher levels of independence for our patients. Occupational Therapists, Physiotherapist Nurses and Assistants will work together to provide patients, whānau, and staff with education about simple ways to get up and moving, and why it is so important for the health of patients.

3.2.2 Celebrations**New fluoroscopy machine**

In June we celebrated the opening of our newly-renovated fluoroscopy suite, complete with state of the art hardware for reviewing studies. The fluoroscopy room is a unit that can do static x-rays and also moving (video) x-rays; this means 3D-real-time imaging.

As this equipment is digital it will be more efficient, give faster workflows and most importantly reduce the radiation required for imaging.

Sonographer wins National Sonographer of the Year award

Congratulations to Liz Hunt, our Charge Sonographer who has won the national Sonographer of the Year award.

The ASA (Australasian Sonographers Association) Awards of Excellence recognise one sonographer per geographical area, who, by their personal efforts and desire for excellence, advances the profession of sonography.

Liz's expertise is particularly in obstetrics where she works closely with the Obstetrics and Gynaecology (O&G) Department at Hutt Hospital. Liz is generous with her expertise and confidently leads teaching sessions for Doctors, Registrars, Midwives and the Radiology staff. Examples of her input in the last two years include:

- Improving scanning protocols regarding complications of multiple pregnancies;
- Producing guidelines to assist with the appropriate use of Doppler (blood flow assessment) in pregnancy;
- Assisting with scanning experience for radiologist registrars and O&G doctors.

3.3 Chief Medical Officer**3.3.1 Electronic handover**

The second version of the electronic handover tool was launched in the medical service in late June. Further improvements will be done incrementally and it will be rolled out to cardiology and older persons service in the coming months with further improvements.

While nurses and other staff at various DHBs also share information using digital platforms such as excel spreadsheets, NZ is the first in the country where the tool will be based in the Concerto clinical portal.

3.3.2 Launch of Peer Support programme for doctors

With support from Karen Kyne, senior clinical psychologist and Ross Kelly, senior social worker, HVDHB has developed a Peer Support Programme to support its medical staff. The DHB has trained 15 senior medical staff as peer support workers. This is based on the doctor Peer Support Programme developed by Dr Jo Shapiro from Harvard University. The programme will be launched in mid-July.

Work related stress after an adverse event can be devastating for front line staff. In the health care industry, adverse outcomes occur and this is mainly related to system issues, complexity of patients and human factors. Often such occurrences is devastating to staff. HVDHB's Peer Support Programme is consistent with the organisation's values, staff wellbeing and principles of a just culture. This programme is the first of its kind for medical staff in a New Zealand DHB.

3.3.3 Hutt Valley sustainability group

HVDHB's sustainability group is getting stronger with new members coming together on a regular basis. The group has been working on a new logo and initiatives to promote the use of bicycles. The group continues to work closely with #Mauri Ora (the DHB's staff wellbeing programme), Regional Public Health, Greater Wellington Regional Council and Capital & Coast DHB teams to implement a programme that makes bikes, e-bikes and e-scooters more accessible to staff, in the hope that they will get out of their cars and into more active modes of transport.

3.3.4 Choosing Wisely update

Staff have recently been told 'to think before ordering a scan' after a project revealed numerous times when neuroimaging did not add any value to patient treatment plans. Dr Rachel Matthews (OPRS registrar) and Dr Perminder Kaur (Geriatrician, OPRS) at Hutt Valley DHB have completed a project titled 'Neuroimaging in Cognitive Impairment/ Dementia'. This was presented at the recent Choosing Wisely Forum 2019 in Wellington, where it was well received. Dr Kaur, a Choosing Wisely champion, says, "We should think before we order a scan". As part of the project an audit was conducted at the Older Persons Rehabilitation Service (OPRS) outpatient clinic with 60 patients. Concerto clinic letters, referral letters and radiology appointment were reviewed to assess neuroimaging practices and outcomes.

3.3.5 Service accreditations by medical colleges

HVDHB has received several accreditation reports from professional colleges. Overall, there has been significant support from the colleges acknowledging the quality of training opportunities at Hutt Valley DHB.

4. MHAIDS UPDATE

4.1 TrendCare update - Mental Health Addictions and Intellectual Disability Service (MHAIDS 3DHB)

The roll-out of TrendCare across MHAIDS inpatient services, is progressing well with Rangatahi, Tane Mahuta, Tāwhirimātea, Rangipapa and Purehurehu all up and running with the programme.

Overall, teams have been very responsive to training and implementation and most areas are making great progress with predicting and actualising, and using the 'allocate' and 'inpatient' data screens effectively. There have been recent challenges due to the level of acuity in some areas, and we are working with those teams to ensure that data continues to be entered accurately.

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This now means that there are only four remaining areas to implement the programme in—Haumietiketike, including the ID step-down cottages, Hikitia and Te Whare Ra Uta. Training begins for Haumietiketike and the step-down cottages over the next few weeks, followed by Te Whare Ra Uta and Hikitia at the start of August.

It is expected that TrendCare will be operational across all inpatient units by the end of September.

4.2 Te Whare Ahuru acute mental health inpatient unit

4.2.1 Minister's visit

The Minister of Health, Hon Dr David Clark, visited Te Whare Ahuru on 2 July as part of an official visit to Hutt Valley DHB.

The Minister and his delegation met with Nigel Fairley, Rod Bartling, Andy Horrigan (lead clinician) and David Taylor (clinical nurse manager), where he was taken on a brief tour of the unit to learn about the challenges of the current environment, including overall layout, configuration and impediments to a person's recovery journey. He also received background about the TWA reconfiguration project, and the current status of the bid for Capital Investment Committee funding.

4.2.2 Te Whare Ahuru admissions

During May 2019, Te Whare Ahuru May had 59 admissions, and 56 discharges. The average length of stay was 12 days, and the readmission rate was four percent. These statistics are a real achievement for the team and our clients, and demonstrates a high level of commitment to outcomes for our population.

5. HEALTH AND SAFETY UPDATE

5.1 Reportable events

There were no notifiable events for June and early July 2019. The numbers of reported staff health and safety events continues to be monitored by the DHB's Health and Safety team and follow up action taken as needed.

5.2 Health and Safety staffing

Discussions have progressed positively with a potential contractor for the Manager Workplace Health and Safety position. If successful, the DHB will have the contractor in position by mid-August. Further, an offer of employment has been made for the Senior Health and Safety Adviser position and if accepted the successful candidate will commence in late August 2019.

Having both these positions filled has become critical to the DHB being able to move forward with implementing its Health, Safety and Wellbeing Strategy, address a number of existing workplace health and safety risks and issues, and increase worker participation and engagement.

5.3 ACC/DHB preventative harm project

Management are currently working with Auckland and Hawkes' Bay DHBs, ACC and Safe365 on a bid to secure a funding grant under the ACC's injury prevention scheme. The funding grant scheme was established by ACC in February 2019 and aims to support small to medium sized businesses to invest in new technologies, research and innovation to improve workplace health and safety.

Working with Safe365, the proposal submitted by the DHBs in March has passed the initial evaluation stage. Work is now underway with ACC to confirm an implementation plan, costs and governance arrangements. If successful, the grant will enable the DHBs to work more closely with their small to medium sized suppliers to enhance workplace health and safety capability across these supply chains.

5.4 ACC Approved Accredited Employer Programme audit

Following receipt of the ACC Approved Employer Audit report in late June, an action plan of corrective actions (refer appendix one) has been agreed with ACC and is now being implemented. There are seven critical areas that need to be addressed, with most corrective actions to be completed by 5 August 2019. The DHB is currently on track to meeting these timeframes.

6. NATIONAL INPATIENT EXPERIENCE SURVEY QUARTER ON 2018/19 RESPONSE RATES

Each quarter, DHBs undertake patient experience surveys. The results of the most recent survey (quarter one 2018/19) were presented to the Board in June, where there was a slight decline in response rates. Management has looked into this, and the 'drop' in responses for quarter one is not statistically significant; the number of responses received were within the normal range of responses expected back (each quarter, 400 surveys are sent out, and there is usually around a 25 percent response rate). The difference between the previous quarter (quarter four 2017/18) and the current quarter (quarter on 2018/19) was eight people. At this stage, there is no trend that would indicate HVDHB's response rates are below normal variation.

7. FINANCIAL OVERVIEW – MAY 2019

The draft May 2019 financial report is attached as appendix two. The month of May showed an unfavourable variance to budget of (\$1,286K), and a favourable variance of \$1,805K year-to-date (YTD).

The key results were:

- Funder favourable by \$8,105K;
- Governance unfavourable by (\$268K);
- Provider unfavourable (\$6,032K).

The draft full year forecast is a deficit of (\$8,150K) against a budget deficit of (\$8,049K).

Material YTD variances:

- Total revenue favourable \$5,074K:
 - Devolved Ministry of Health Revenue \$3,055K;
 - Non-devolved revenue was unfavourable by (\$442K);
 - ACC revenue was \$918K favourable, mainly in plastic and orthopaedics;
 - Other revenue was \$270K favourable
 - IDF Inflows were \$1,033K favourable, predominantly in acute and electives (plastic surgery).
- Total personnel including outsourced was unfavourable by (\$7,473K):
 - Medical personnel was (\$1,954K) unfavourable. Outsourced was (\$1,043K), internal staff were (\$912K) unfavourable including (\$697K) strike costs
 - Nursing was (\$4,521K) unfavourable due to continued increased workload YTD and continued high use of minders;
 - Allied Health was (\$467K) unfavourable, driven by the recent MECA pay out which was greater than originally budgeted and additional funding;
 - Management and administration was \$152K favourable, driven by favourable employee variance of \$703K, partly offset by Outsourced (\$551K) that includes savings targets;
 - Annual leave liability increased by \$1,609K since May 2018, and there are approximately 39,577 outstanding leave days;

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- The sickness level for the month was 3.2 percent; this is higher than last month and lower than time last year.
- Outsourced other expenses was unfavourable by (\$1,519K) with overspends in clinical services (\$1,375K), mainly driven by Radiology Outsourced (\$991K), Breast surgery (\$77K) to manage volumes and vacancies, and Ophthalmology (\$590K), offset by other savings.
- Treatment related costs were favourable by \$223K – pharmaceuticals \$1,754K including PHARMAC rebates, Leased Radiology equipment \$471K, offset by Implants and Prostheses (\$543K), Treatment Disposables (\$927K), and other unfavourable variances;
- Non-treatment related costs were unfavourable by (\$368K) – favourable variances in Consultants \$624K, partly offset by ICT repairs and maintenance (\$112K), printing (\$172K), general repairs and maintenance (\$67K), software license fees (\$211K), conference costs (\$70K), bad debts (\$33K), transport and travel (\$39K), crockery and Hardware (\$54K), and postal and courier (\$106K);
- IDF outflows were \$3,831K favourable – this includes favourable inpatients of \$1,995K mainly from under delivery of volumes by CCDHB;
- Other External Provider Costs were \$2,013K favourable; mainly related to Surgical inpatients \$2,321K, offset by capitation (\$1,372K);

Hospital activity – for the month of May, Medical inpatient discharges continued to be above budget and above last year. Discharges for Surgical were lower than budget for the month and May 2018. YTD, case weights for Surgical were 5 percent higher than budget. YTD case weights for Medical services were 4 percent higher than last year and 13 percent higher than budget. ED volumes for May were 16 percent higher than budget and YTD 5 percent higher than budget. The proportion of patients admitted (22 percent) for May was lower than the same time last year (25 percent). Theatre visits for the year to date were 7 percent higher than budget and higher than this time last year.

The cash position averaged \$23.7M for the month, compared to \$10.1 for April, and was \$2.7M at the end of May. The cash flow forecast is becoming tight and the DHB is expecting to go into overdraft in June.

8. COMMUNICATIONS ACTIVITY – JUNE 2019

8.1 Media enquiries and releases

There were 11 media enquiries in June. Key matters for media enquiries were:

- How the DHB is managing the issue of patients assaulting staff;
- Any harm from wait times for cancer treatment.

HVDHB was in 13 media articles in June. The Fuseworks media report for March 2019 is attached as appendix three.

8.2 OIA requests

HVDHB received 16 OIA requests in June, and 118 historical requests were responded to.

8.3 Website traffic



8.4 Social media highlights

HVDHB's social media engagement is among the highest of all DHBs. On average, the DHB's Facebook page remained in the top three most engaged pages for June, alongside Northland DHB and Waitemata DHB.

Most popular post: Measles contact tracing – check if you may have been exposed	Reached: 16,516	182 reactions, comments and shares	Number who like HVDHB Facebook page: 4307
Most popular post: Introducing one of our junior doctors, Helen.	Reached: 324		Number who follow Instagram: 323
Most popular Tweet: Thank you to everyone who nominated in the 2019 Hutt Valley Matariki Achieving Excellence in Maori Health Awards	Impressions: 387		Number who follow our Twitter: 1000

8.5 All staff communication (in addition to weekly CEO update emails)

- Email farewelling acting Hutt Valley DHB chief executive Dale Oliff;
- Email welcoming joint Hutt Valley DHB and CCDHB chief executive Fionnagh Dougan;
- Fish for Compliments (staff wellbeing initiative);
- Staff updates during two-day access issue at Hutt Hospital.

9. RECENT MEDIA STORIES AND INTERNAL COMMUNICATIONS

9.1 Congratulations to the Children's Ward

Well done to the Children's Ward (including outpatients), where 100 percent of staff have been vaccinated.



9.2 Equity and Choosing Wisely



Associate Professor Sue Crengle was the keynote speaker at the Choosing Wisely forum held in Wellington on 10 May. She spoke about the need for deliberate consideration of equity across all Choosing Wisely activities and focused on how equity could be embedded into the programme.

During her address, she had a number of recommendations on how equity can be embedded into Choosing Wisely programmes, including:

- strengthening capacity and capability of Choosing Wisely governance and operational groups to consider and address issues of equity;
- expanding the focus of programmes from reducing and avoiding low value and inappropriate interventions to include promoting high value and appropriate interventions being provided to groups that are currently under represented;
- eliminating instances where people are giving high value treatment or investigations inappropriately (where patients might not meet the criteria for these investigations or treatments but they receive them anyway);

- considering whether a low-value investigation or treatment is low value for all populations.

Associate Professor Crengle's full presentation can be viewed at:
<https://docs.google.com/presentation/d/1OdjfM43tZvvSVxWLVHe90YaszFo-PsEs8kLixVEUpb4/edit#slide=id.p1>

9.3 Hauora Maori Workforce funding

Do you have Maori whakapapa? Are you planning to study towards a NZQA accredited course (levels 2 – 6) in trimesters three or four of 2019, or in 2020? If so we may be able to assist you with funding.

Hauora Maori Workforce funding is available for enrolment in NZQA accredited courses (levels 2 - 6, excluding degree level).

People who are eligible for this funding will:

- have Maori whakapapa;
- be a New Zealand citizen or a permanent resident;
- have the support of their employer;
- enroll in a course that meets HVDHB Maori health/disability workforce priorities.



Funding is not available for people who:

- are studying in a programme not accredited by the New Zealand Qualifications Authority (NZQA) or an Industry Training Organisation (ITO);
- already enrolled in a sponsored study programme under the Maori Provider Development Scheme (MPDS);
- have a current Ministry of Health Hauora Scholarship or who are participating in another Hauora Maori Workforce-funded programme.

Hauora Maori Workforce funding covers reimbursements for:

- tuition fees;
- cultural supervision or support;
- travel subsidies for people who are required to travel further than 100km by road one way from their usual place of work to the agreed training programme location;
- accommodation subsidies (maximum of \$100 per night) for people who have to travel to their course;
- course-related resources (maximum of \$300 per person on a pro-rata basis).

For further information, contact Carrie Maniapoto, Māori Workforce Development Coordinator.

9.4 New car for the paediatric community team



The Lower Hutt Countdown branches have been fundraising, and earlier this week presented a new car for our Paediatric Community Team to use. We would like to extend a big thank you to the Countdown branches, their managers, staff and all the community who helped make this possible.

9.5 Where to go to get the right help when you're sick

Sometimes people in our community may not need to come to hospital. If you, or someone in your whanau, feels unwell this new guide will help you choose the right place to go to get the healthcare you need at the right time.

We've recently published advice on our [website](#) and on Facebook about where people can go to get help.

A colour wheel (pictured) shows where to go for easy identification:

- Call a help line for free confidential advice. For free advice from a registered nurse 24/7, call Health Line (0800 611 116). Call the free Plunket parent helpline (0800 933 922) Or visit the Health Navigator website (<https://www.healthnavigator.org.nz>);
- Your local pharmacy can give advice on medication and minor health concerns;
- Call your local GP. The team at your GP clinic might be able to see you quicker and are experts in your care. Check out the [General Practice Directory](#) for local GPs;
- Afterhours – if you are unable to get an appointment with your GP visit one of the afterhours clinics in the Hutt Valley;
- Hospital ED – if it's for a life threatening illness.



9.6 From the Hutt to the Hague



Shenal Senanayake from Hutt Hospital's Central Sterile Sciences Department is off to the Hague.

The New Zealand Sterile Sciences Association has awarded him a scholarship to attend the [World Sterilization Congress](#) at The Hague in the Netherlands in October.

Shenal said the scholarship was in recognition of his work this year.

"As an initiative by our manager, Shelagh Thomas, the CSSD department is moving forward with many quality improvement programmes.

"As a strong believer in quality, I was involved with a few projects which assist our technicians to step up their service skills."


His goal is to see the department step-up its services for the safety of patients.

"I value the support and encouragement I receive from my manager and the whole team at CSSD.

"I attribute my success to the whole team I work with. This was a result of a good team work.

"I thank New Zealand Sterile Sciences Association for the ongoing support they give to us in learning and developing in the field of Sterile Sciences."

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		BOARD DECISION PAPER
		Date: 1 August 2019
Author	Christine Rabone, Committee Secretary	
Endorsed by	Helene Carbonatto, General Manager Strategy, Planning and Outcomes Yvette Grace, Community Public Health Advisory Committee Chair	
Reviewed/approved by	The Executive Leadership Team (reviewed on 19 July 2019)	
Subject	Community Public Health Advisory Committee Membership Recommendation	
RECOMMENDATIONS		
The Community Public Health Advisory Committee (CPHAC) recommends the Board:		
a) APPROVES the addition of one co-opted member to the CPHAC who holds additional expertise in the area of population health to further support the CPHAC 2019/20 workplan, as per the CPHAC Terms of Reference;		
b) NOTES payment for this expert advisor’s attendance at CPHAC’s quarterly meetings will be required at the rate of \$80.00 per hour, which equates to \$640.00 over the 12 month nomination period;		
c) APPROVES the recommendation to appoint Dr Dougal Thorburn as a co-opted member to the CPHAC for a 12 month period.		
APPENDUMS:		
1) Bio of Dougal Thorburn – Clinical Director Population Health, Te Awakairangi Health Network		
2) Terms of Reference, Hutt Valley District Health Board, Community And Public Health Advisory Committee		

1. PURPOSE

The purpose of this paper is to seek approval from the Board to approve the appointment of an additional expert advisor to the CPHAC.

2. BACKGROUND

Under the Terms of Reference of CPHAC, there is the opportunity to co-opt expert members to the Committee to help assist and support the work of the committee. There are already two co-opted members on the committee with Māori health and Pacific health expertise. Following discussions at CPHAC, it was agreed that CPHAC would benefit from an expert with a population health perspective and requested that management consider options on possible candidates.


The Hutt Valley DHB leadership team's recommended that we approach Dr Dougal Thorburn, who is currently the Clinical Director, Population Health at Te Awakairangi Health Network and a practicing GP to be co-opted onto the committee for a period of one year. A short bio for Dougal Thorburn is attached as appendix one. CPHAC endorsed his nomination for approval to the Board.

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3. FUNDING

As per the Hutt Valley DHB Recognising Community Participation Policy, financial recognition is given to those who are specifically invited by the DHB to contribute their expertise and advice. This honorarium for their time and advice is paid at \$80.00 (tax exclusive) per hour, up to a maximum of \$160.00 (tax exclusive) per meeting.

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		BOARD DISCUSSION PAPER
		Date: 1 August 2019
Author	Helene Carbonatto, General Manager – Strategy, Planning and Outcomes	
Endorsed by	Fionnagh Dougan, Chief Executive	
Reviewed/approved by	The Executive Leadership Team (reviewed 19 July 2019)	
Subject	Strategy, Planning and Outcomes report	
RECOMMENDATIONS		
It is recommended that the Board:		
<ul style="list-style-type: none">a) NOTES good progress is being made through the joint hospital network planning process, with one successful workshop identifying the approach the DHBs will utilise to better understand future configuration opportunity and an upcoming workshop planned with key stakeholders;b) NOTES progress is well underway in driving the key workstreams identified in the clinical services plan and in particular, the first 1,000 days of life and community integration work.c) NOTES the progress being made in defining the investment gaps in our adult mental health acute care continuum, as well as the investment proposal for Te Whare Ahuru.		

1. PURPOSE

The purpose of this paper is to provide an update to the Board on the work being progressed through the Strategy, Planning and Outcomes group (SPO).

2. STRATEGIC WORK PROGRAMME

2.1 Joint Hospital Network Planning

The joint Long Term Investment Plan (LTIP) work programme includes service planning across the greater Wellington region's network of hospitals, and a long-term plan for the services needed at Wellington Regional Hospital, Kenepuru Hospital, and Hutt Hospital. The Leadership teams across Hutt Valley and Capital & Coast DHBs are seeking the optimal configuration and placement of services across the hospital network to meet future demands.

Improving equity of service access and outcomes for priority populations and high-need communities is a key consideration in this work. Hutt Valley and Capital & Coast DHBs (2DHBs) also need to maximise co-location opportunities, consolidate highly specialised services, and avoid unnecessary service duplication. For example, some complex procedures require highly specialised teams and equipment. Highly specialised services require a critical mass of staff, and a minimum throughput of patients, to be safe, financially viable, and sustainable. In short, the DHBs are wanting to provide services that are as local as possible and as specialised as necessary.

The first of two Joint Hospital Network strategic planning workshops with senior managers and clinicians from both DHBs was held on 6 June 2019 to begin establishing a shared strategic view of the opportunities across the hospital sites. The workshop group considered learnings from past attempts and approaches to joint service development, and considered criteria for assessing different service configuration/service placement options. The workshop participants also discussed the importance of

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establishing a core underlying framework – in terms of enabling systems, infrastructure, relationships and leadership – to support an aligned hospital network and whole-of-system approach.

Preparation is now underway for a second workshop that will progress the thinking around a number of high-level service configuration/service placement options for discussion and consideration. In the meantime, the hospital network approach is being put into action through the sub-regional planning work for Breast, Oncology, Renal Dialysis Services, Cardiology, gastroenterology/colonoscopy, ENT and Ophthalmology services.

2.2 Long Term Investment Plan

The 2DHBs are working collaboratively on the development of Capital & Coast DHB's Long Term Investment Plan (LTIP), which is due with Treasury in August 2019, followed by the development of a joint 2DHB LTIP in 2020.

The long term investment planning will identify the investments needed to ensure the greater Wellington region's hospitals have the facilities and assets needed in the future to manage growing demand and achieve the 2DHBs' strategic objectives – as set out in Capital & Coast DHB's *Health System Plan 2030* and Hutt Valley DHB's *Vision for Change* and *Clinical Services Plan*.

A joint governance structure and work programme is in place, supported by the Programme Director Long-term and Joint Planning (2DHB), and the Programme Director Clinical Services Planning & Project Management Office at Hutt Valley DHB. To enable a joint LTIP to be delivered in 2020, both DHBs have been working on single methodologies and frameworks for asset planning, workforce planning, and financial modelling. All work streams contributing to the LTIP (finance, asset management, workforce, future specialty service configuration) are in the process of coming together for the final draft being presented to the Capital & Coast DHB Board on 31 July. The main storyline and assumptions are being discussed with key stakeholder groups from 5 July onward.

2.3 Clinical Services Plan

The work programme for 2019/20 has been finalised with an agreed mechanism for raising new projects and re-prioritising resource as necessary.

Key projects continue in dental radiology, theatre optimisation, paediatric outpatients, Radiology, community integration, and the Medicine Service Improvement project.

2.4 Wellbeing Plan

The key priority areas for implementation of the Wellbeing Plan over the last four months are outlined in the following paragraphs:

2.4.1 Promoting Wellbeing at Work

Ongoing support has been provided to the Human Resources and Organisational Development team on the development of activities to support the implementation of the staff wellbeing programme 'Mauri Ora', such as development of walking tracks for staff. The three priority areas in the programme are: mental health and wellbeing, healthy eating, and physical activity.

2.4.2 Tamariki and Whānau with Complex Social Needs

Please refer to section 3.3 – Maternal and Child Health.

2.4.3 Tobacco

A two year Tobacco Control Action Plan is now in place, developed with key providers and community partners, focussing on target populations, cessation, and strengthening smokefree environments. In line with the Plan, the DHB has recently appointed a part-time Smokefree Coordinator to provide ongoing training of staff in the delivery of the ABC approach to smoking cessation as well as to work on improving coding and referral processes. This role will work closely with two staff from the Regional Stop Smoking Service provider, Takiri Mai te Ata, who come into the hospital to help Māori and Pacific patients (and their whānau) who smoke to consider quitting and to support them in their cessation journey. Takiri Mai te Ata staff are also available to talk to staff that smoke (and this was promoted on World Smokefree Day).

Another action in the Tobacco Control Action Plan is the development of a social media campaign, where the DHB asked the Hutt Valley community to share their quit smoking stories. The campaign went live at the end of June, focusing on the stories and engaging quizzes. After eight weeks, on Facebook alone, the DHB has reached around 60,000 people within its priority populations. Work is currently underway to develop a Hutt Valley Vaping Position Statement.

2.4.4 Enabling Healthy Eating and Active Lifestyles

Planning is underway with Regional Public Health, Healthy Families Lower Hutt and the Ministry of Education to ensure collaborative work on the water in schools project, with maximum impact. This renewed focus includes a strong focus on equity and a place based approach to implementation. It is intended that this work will then develop into healthy food environment work with schools also.

2.4.5 Embedding the Wellbeing Plan

The focus has been to continue to build relationships and understand perspectives of key partners in health and other sectors as well as clarifying the role of the DHB in each of the Wellbeing Plan's seven focus areas (whether to lead, coordinate or support). The DHB was also part of a Healthy Families Lower Hutt-led workshop with Lower and Upper Hutt Councillors on the health of our population with a 'what it is like to grow up in the Hutt Valley' focus. The health and wellbeing data and statistics presented at this workshop will be used to inform implementation and measurement of the Wellbeing Plan.

3. INTEGRATION WORK PROGRAMME

3.1 Health Care Home (HCH)

The Health Care Home (HCH) programme continues to progress well with all five tranche one HCH practices going 'live'. These are:

- Ropata Medical Centre and Hutt City Health Centre – July 2018;
- Silverstream – October 2018;
- Naenae Medical Centre and Waiwhetu Medical Centre – January 2019.

Change management continues to progress well with the four tranche two practices and all are on track for the 'go live' date of 1 July 2019. The practices are:

- Muritai;
- Petone;
- Queen Street;
- Upper Hutt Health Centre.

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When all nine practices are live, more than 50 percent of the total enrolled population and more than 50 percent of Hutt Valley's high needs population will be under a HCH.

Early HCH activity data has begun to be reported for the early tranche one practices. There has been encouraging data around the GP triage activity as practices become familiar and confident with processes – 29 percent of GP triage calls resulted in a resolution on the phone in December 2018. Patient portal activity is also promising with three practices having more than 50 percent of their enrolled patients 'activated'.

3.2 Community Networks – Neighbourhood Approach

Phase one of the Community Networks work stream continues with the DHB's Community Team consulting on how to build a new model of 'one-team' including central referrals and transdisciplinary working. Progress has been slow with numerous changes to DHB management and sponsors for the project, and the next six months will be core to getting traction on the model.

At the same time, work has commenced on designing the community health networks or 'Neighbourhood' approach to be piloted in 2019. The Neighbourhood approach is wrapping the DHB's district nursing and allied health teams around general practice clusters as a first step to developing extended primary care teams. In February, the DHB, PHO and Primary Care in the Upper Hutt Neighbourhood came together to initiate the design phase.

3.3 Maternal and Child Health

Maternal and child health continues to be a focus for the team. The *First 1,000 Days Partnership Project* is nearing completion. The whānau engagement portion of the project will be completed shortly. The project's write-up has commenced and a draft report will be given to the DHB's Child Health Network and Maternal and Child Health Provider (MECH) Group in August. Additionally, the *Data Matching Project Phase II* is nearing completion. This project is focused on tracking a cohort of children born in the Hutt Valley in 2013 through to their Before School Check at age four. The project aims to understand utilisation patterns of children across the health services provided in the Hutt Valley. Final data is being collated presently and a draft project report will be provided to the Child Health Network and the MECH Group in August. Both of these projects will inform next steps as the DHB works to strengthen its provision of care provided to children and their families.

In addition to the above, the following are other key pieces of work happening across the maternal and child health portfolio:

3.3.1 Children's Outpatient Project

The Children's Outpatient Project is progressing well with the majority of 'first tranche' work nearing completion. The team is considering the next work streams to progress. The project is working to drive efficiency within the Children's Outpatient Service and building ways of working across secondary services and with primary/community providers.

3.3.2 Community Paediatrics

The DHB is fortunate to have Dr Pat Tuohy working part-time on a fixed term contract as a community paediatrician in the paediatrics team. Dr Tuohy is supporting the service as it explores opportunities for better integration with primary and community services.

3.3.3 Newborn Enrolment

The DHB has identified a number of system issues with its newborn enrolment process (the process by which a baby is registered with a general practice, Well Child Tamariki Ora, National Immunisation Register and Community Dental). A project has been initiated to address these concerns and ensure appropriate handover of the child from midwifery care.

4. MENTAL HEALTH WORK PROGRAMME

4.1 Living Life Well, the Government Response to the MHA Inquiry Report and Budget

In February 2019, the Hutt Valley and Capital & Coast DHB Boards approved the 3DHB Mental Health & Addictions Strategy *Living Life Well (2019 – 2025)*. On 30 May 2019, the Boards approved the implementation approach and 2019/20 action plan.

Living Life Well was produced with the 2018 Government Inquiry into Mental Health and Addiction in mind and its strategic direction and focus areas were reviewed to ensure that they were in line with the Inquiry recommendations.

On 29 May 2019, the Government released their response to the Inquiry recommendations which saw 38 of the 40 recommendations either accepted, accepted in principle, or subject to further consideration. This gave further assurance that the direction set out in *Living Life Well* remained strongly aligned with the Governments future direction for mental health and addiction services and provides us with a strong platform to respond to new national priorities.

The release of The Wellbeing Budget on 30 May 2019 saw the Government respond to the mental health Inquiry with a \$1.9 billion package over five years across a range of portfolios including health, education, corrections, justice and housing. At the centre of the package is \$455.1 million to expand access to primary mental health and addiction support for those with mild to moderate mental health needs.

Significant funding has also been allocated to suicide prevention, increased access to addiction treatment, strengthening specialist and crisis services, expanding the nurses in schools programme, tackling chronic homelessness, and increasing access to services for offenders.

DHBs are currently waiting to hear how and when the new funding will be disbursed. What is known is that the Ministry of Health is running a national co-design process to determine the new primary mental health and addiction model; and that local services will be developed in consultation with local communities, which aligns with *Living Life Well's* co-design and partnership approach. The Ministry of Health has been asked to prioritise suicide prevention, reform of the Mental Health Act, and the establishment of the new Mental Health Commission.

Management expect more information to be available soon and will then be able to consider how the national approach supports and strengthens the DHB's local work programme and investment planning.

4.2 Mental Health Acute Care Continuum

The Mental Health Acute Care Continuum Project is a 3DHB project led out of Hutt Valley DHB. The design of the Acute Care Continuum has now been completed and each DHB has advanced implementation planning, including what activity is needed to improve the coordination of existing services, and what additional services need to be introduced over time in each locality. It is planned that the proposed Continuum of Care and enabling options will be presented at the next joint boards meeting on 30 August 2019, and funding for rolling out year one services is part of Hutt Valley DHB's 2019/20 budget.

4.3 Alcohol and Other Drugs

Work is progressing on the development of a 3DHB Alcohol and Other Drug Model of Care led out of Capital & Coast DHB. Interviews with providers and stakeholders have been completed, and mapping of existing services across the 3DHBs is complete. Themes and options to address critical service gaps have been developed for steering group consideration. These options will feed into the mental health investment pipeline work underway for each DHB.

4.4 Te Whare Ahuru Reconfiguration

Phase two of the Te Whare Ahuru (TWA) reconfiguration project is well advanced with several user group workshops now completed with architects to inform a preferred building option. This option is nearing completion and is informed by what model of care and enabling building design features will maximise optimal outcomes for our tangata whaiora.

Meanwhile, the DHB is still waiting to hear from the Ministry of Health and National Capital Investment Committee as to whether it has approval to submit a Business Case for capital funding. The Minister of Health toured TWA on Tuesday, 2 July with the DHB's Board Chair and Chief Executive.

4.5 Mental Health Improvement Programme

The Mental Health Improvement Programme continues to advance and oversee several key initiatives. Amongst these are phase one of the MHAIDS Review and independent review of the acute response and triage services. Each initiative will be reported back to the Board at a future date.

4.6 Maternal Mental Health

The DHB is committed to strengthen its response to maternal mental health concerns by increasing services available for women with mild to moderate postnatal depressions. Funding for service expansion will come from the DHB's 2019/20 commitments or from Budget 19 resource. At present, the team continues to develop options for service design.

4.7 Palliative Care Project and Embedding Advanced Care Planning

This work is advancing well and a new model of integrated specialist nursing is currently being rolled out across the Hutt Valley. This involves new Palliative Care Facilitators being designated to a neighbourhood (Upper Hutt, Central Hutt and Lower Hutt) to work with clusters of general practice teams. These specialist nurses will work with practices to develop a palliative care registers at their practice (based on the Gold Standards Framework, UK) that clearly identifies patients in their last year of life, and where they are on this trajectory. The facilitator will work closely with the practice to ensure adequate assessments, planning of care and regular and timely reviews are undertaken for this group of patients and their family/whanau.

Other work continues alongside this work including training for staff, funding for GP teams, support for residential care as well as other projects to better integrate services.

5. SPO OPERATIONAL PROGRAMME

5.1 2019/20 Annual Plan

On 5 April 2019, the DHB provided the first draft 2019/20 Annual Plan to the Ministry of Health. On 11 June the Ministry provided feedback stating the DHB's "plan appropriately reflects the Minister's priorities." There were a number of technical issues to address and management are continuing to work with the Ministry to address all of these. In their feedback the Ministry advised all DHBs of the need to ensure the equity actions identified reflect a change agenda to support improved equity outcomes, rather than business as usual approaches. The Ministry also reminded DHBs that many of the budgets submitted in the first round of the 2019/20 annual plans were not acceptable to the Minister, and all DHBs should be considering ways to contain expenditure.

On 28 June 2019, the Ministry provided DHBs with the final update to the planning guidance. It included additional requirements for mental health, planned care, screening activities in the annual plans. In the update, the Ministry asked for final draft plans to be submitted to the Ministry on 26 July. The final draft 2019/20 Annual Plan is being presented to the Board for approval in the public excluded of the meeting. Once the Ministry confirms that the final draft plan is acceptable, it will then be presented to the Board Chair and Chief Executive for signature. Following this, it will be provided to the Minister of Health.

5.2 Statement of Intent 2019-2023, Incorporating the Statement of Performance Expectations 2019/20

On 5 April 2019, the DHB provided its draft Statement of Intent 2019 – 2023, incorporating the Statement of Performance Expectations 2019/20 (the SOI/SPE) to the Ministry of Health. Following Budget 2019, the Ministry provided DHBs with updated funding advice. Management updated the financial tables included in its SOI/SPE based on this advice. At the Ministry's request, the DHB provided them an updated draft version of our SOI/SPE on 21 June. The final SOI/SPE was signed by the Board and Deputy Chairs and then posted on the DHB's website on 28 June 2019.

5.3 Primary Care

High Street Health Hub is a new medical practice that has opened in the Hutt Valley. The practice is a member of Te Awakairangi Health Network and is currently enrolling new patients. The practice is participating in the under 14/Community Services Card (CSC) Programme, meaning that children under 14 will be seen at no cost and the CSC rate will apply to those patients who are eligible for a community services card (see below).

Changes to the National PHO Agreement came into effect from 1 July 2019. The table below outlines the increase in capitation rates agreed under the new PHO Agreement.

Funding stream	To increase by
First Contact	2.91%
Health Promotion	1.78%
Services to Improve Access	1.78%
Care Plus	1.78%
Very Low Cost Access	2.91%
Zero Fees for Under 6s	2.91%
Zero Fees for Under 13s	2.91%
Management Services	1.78%

The adult co-payments for Community Services Card and Very Low Cost Access have increased to \$19.00 and co-payments for 14 – 17 year olds will be \$13.00. Children under the age of 14 remain free of charge.

5.3.1 Co Payments Increases

The 2019/20 Annual Statement of Reasonable Fee Increase¹ has been set at 2.91 percent. This is the amount that practices can increase the co-payments charged to patients in 2019/20.

5.4 Home and Community Support Services

The first stakeholder meeting for the new bulk funded Home & Community Support Services Contract took place in June. Both DHBs, Access and Nurse Maude Managers updated the stakeholders as to the first three months of operating. The stakeholder group includes consumers, representation from NGOs who advocate and provide a range of support across the 2DHB region to older people. Nurse Maude is new to the North Island and presented its history and organisational highlights. The overwhelming stakeholders' feedback was that despite the complexities of the transition, generally, from a community perspective, it has gone well.

¹ On behalf of the sector, Sapere Research Group produces the *Annual Statement of Reasonable GP Fee increases* (the Annual Statement) each year as part of the annual rate increase process.

5.5 Hutt Valley Dementia Framework Stakeholder Group

For eighteen months there has been a multi-agency group led by the DHB with a focus on increasing the activities and knowledge of the Hutt Community to enable a wider range of activities accessible to people living with dementia. The group has evolved to a quarterly meeting, increasing its clinical membership to oversee the development of a Hutt Valley-wide response to the national dementia framework. The DHB has been tasked with providing a stocktake of current activities across all sections of the framework. The group is in a strong position to contribute to the plan and support the agreed actions that will arise from the stocktake.

5.6 Māori Health

5.6.1 Kokiri Marae Hauora

Kokiri Marae Hauora have been working with the DHB to complete a service specification reconfiguration of their Whānau Ora contract. Similar to the reconfiguration of the Runanga's Whānau Ora contract, the aim with Kokiri is to:

- Create the contractual mechanisms for the DHB's primary and community providers to work seamlessly to target care and support those most in need;
- Provide clarity on what the components of the Whānau Ora agreements should be;
- Provide clarity on Access, quality, workforce capabilities, and reporting requirements within Whānau Ora agreements;
- Allow return of investment in health outcomes and achieving equity to be measured.


The reconfigured Whānau Ora Contract will be in operation from 1 October 2019.

The Strategy, Planning and Outcomes Team is hosting Kokiri Marae Hauora this month to continue sharing the work that is being done across both organisations to improve Māori health outcomes, and build on the strong working relationships we have with them.

5.6.2 Māori Mental Health

Work is also well advanced in re-establishing a Māori mental health team within MHAIDS. This team was disestablished in 2009, and management has been working with MHAIDS to re-establish such a team with a strong kaupapa model of care for Hutt clients. Work is well underway in defining the model of service we would like implemented, with a likely start date of 1 July 2020.

As part of the Adult Acute Continuum of Care Programme of work underway, the DHB is also considering how it can expand service offerings with kaupapa mental health providers. Investment options along the continuum are currently being scoped, with the strengthening of Māori kaupapa options a core component of that work.

		BOARD DISCUSSION PAPER
		Date: 1 August 2019
Authors	Kerry Dougall, Director Māori Health Carrie Maniapoto, Māori Workforce Development Coordinator	
Endorsed by	Fionnagh Dougan, Chief Executive	
Reviewed/approved by	The Executive Leadership Team (reviewed on 19 July 2019)	
Subject	Māori Health update	
RECOMMENDATIONS It is recommended that the Board: <ul style="list-style-type: none"> a) NOTES the launching of Te Pae Amorangi Hutt Valley DHB Māori Health Strategy on Wednesday, 17 July 2019; b) NOTES the work underway in the following areas of Te Pae Amorangi Hutt Valley DHB Māori Health Strategy: <ul style="list-style-type: none"> • Te Pae Aronga Tuatahi – Increasing Māori workforce across the system; • Te Pae Aronga Tuarua – Organisational Development and Cultural Safety; • Te Pae Aronga Tuatoru – Commissioning; • Te Pae Aronga Tuawhā – Mental Health and Addictions; • Te Pae Aronga Tuarima – First 1,000 Days. c) NOTES the updates following the 31 May 2019 Mana Whenua Relationship Board meeting; d) NOTES the work underway in defining terminology to refine the rules of engagement around equity and co-design; e) NOTES the update on the re-establishment of a Hutt Valley DHB Kaupapa Māori Mental Health Services; f) NOTES the WAI 2575 Hauora Report and Tribunal Highlights. 		
APPENDICES <ol style="list-style-type: none"> 1. Draft final Implementation Plans <ul style="list-style-type: none"> a) Te Pae Amorangi – Focus Area One (draft) b) Te Pae Amorangi – Focus Area Two (draft) c) Te Pae Amorangi – Focus Area Three (draft) 2. Feedback from Matariki Awards 3. Wai 2575 Report 		

1. PURPOSE

The purpose of this paper is to provide the Board with an update on the activities of the Māori Health Directorate.

*Ko te Amorangi ki mua, ko te hāpai ō ki muri
The leaders in the front, the workers behind*

2. STRATEGIC WORK PROGRAMME

This paper links through to *Our Vision for Change*, Te Pae Amorangi HVDHB Māori Health Strategy, and Hutt Valley DHB's Wellbeing Plan, and also aligns with government priorities, including:

- Māori Health;
- Equity;
- Mental Health.

2.1 Te Pae Amorangi Hutt Valley DHB Māori Health Strategy

Te Pae Amorangi, Hutt Valley DHB's Māori Health Strategy was launched on Wednesday, 17 July 2019. Dr Ashley Bloomfield attended the launch and spoke. Dr Bloomfield was part of the original journey to development. Wayne Guppy HVDHB Board Deputy Chair also spoke about the Board's aspirations and commitments to achieving Māori health equity. Mr Guppy has volunteered to Champion Te Pae Amorangi at governance level.

The aim of the Strategy is to achieve equity for Māori health across the system within nine years. In order to achieve this aim, the Strategy has been themed to be focused on collaboration and partnerships. We need everyone in every part of the system to take action and implement.

Implementation plans have been developed for each of the Strategy's five key focus areas;

- Increasing our Māori Workforce across the system;
- Organisational Development and Cultural Safety;
- Commissioning;
- Mental Health and Addictions;
- First Thousand days.

These draft plans have been consulted on with the previous acting HVDHB Chief Executive, the DHB's Mana Whenua Partnership Board, Māori providers, and each of the Executive leaders within which accountability sits.

The accountability for each focus area intentionally sits within the designated executive leadership directorate. The general manager from each directorate will cascade the actions through their respective teams, and by working in collaboration and partnership, the work will be actioned.

The Māori Health Team will work in partnership and alongside each directorate to support the delivery on the actions.

2.1.1 Te Pae Aronga Tuatahi – Increasing Our Māori Workforce across the System

2.1.1.1 Capital & Coast DHB work exposure day

On 20 May 2019, college students from throughout the Wellington and Hutt Valley regions took part in a Work Exposure Day at Wellington Regional Hospital, a programme that aims to show students what it is like to have a career in health.

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The day is a collaboration between the DHB and Kia Ora Hauora, a Māori health workforce programme. Hutt Valley DHB's Māori Workforce Development Coordinator attended and took along a group of rangatahi from Te Ara Whanui Kura Kaupapa.

The invitation was extended to secondary school Māori classes with 85 students in years 9, 10 and 11 taking part. The students rotated around different workshops designed to show them what life as a health professional would be like. They ranged from midwifery to physiotherapy, through to a simulated surgery where students took the roles of nurses and an anaesthesiologist.

The day was hugely successful and HVDHB's Māori Workforce Development Coordinator plans to hold something very similar at Hutt DHB annually from 2020.

2.1.1.2 Increasing our Māori Workforce through Policy

Māori and Pacific workforce development and recruitment is a high priority for Hutt Valley DHB as well as nationally.

Evidence based research confirms that health outcomes improve significantly for patients and their whānau when they are treated with a higher level of cultural understanding, awareness and sensitivity. A highly skilled, capable and confident workforce reflective of our communities will contribute to and strengthen our ability to deliver equitable health outcomes for Māori and Pacific.

The DHB will develop specific strategies to attract, recruit and retain more Māori and Pacific people to its workforce. The immediate opportunity starts with the way in which we recruit.

Our Māori Workforce Development Coordinator has drafted the following policies, which are currently being consulted on:

- Māori Workforce Recruitment Policy;
- Progression of Eligible Māori and Pacific Applicants to Interview Policy.

The Māori Workforce Recruitment Policy seeks to improve the way the DHB recruits by making the process more culturally adept. The policy will ensure that all Hutt Valley DHB advertisements are designed to attract Māori applicants and will include an organisation diversity statement, a Māori welcome, a whakatauki and a DHB kowhaiwhai.

The Progression of Eligible Māori and Pacific Applicants to Interview Policy will see all Māori and Pacific candidates who meet the core criteria for the role applied for automatically shortlisted for an interview along with any other candidates who meet the position criteria.

2.1.2 Te Pae Aronga Tuarua – Organisational Development and Cultural Safety

2.1.2.1 Pou Tikanga appointment

Daniel Kawana has been in the role since April 2019, coming to the DHB from the Wairarapa. He has spent some time orientating himself within the Hospital, DHB environment and with local providers.

The organisational development and cultural safety aspects of the role are forming, with a fervent buzz of excitement around the role and initial requests from all over the DHB for Daniel's support in a practical sense around tikanga, kawa, and te reo Māori, with some requests focused specifically on the design of cultural training for staff.

2.1.2.2 Development of Internal Cultural Safety Training

Some initial pieces of work from the Pou Tikanga will be brought through to the Board and Mana Whenua Board. The DHB is currently developing its Treaty of Waitangi Policy and later this year a final outline of the training programme Te Kawa Whakaruruhau, which is intended for implementation across the DHB covering all DHB employees.

Te Kawa Whakaruruhau will concentrate on two key aspects of learning – Te Tiriti o Waitangi and Ko Aotearoa Tenei. The Treaty of Waitangi training will place specific emphasis on the local experience within Wellington and the Hutt Valley; Ko Aotearoa Tenei is an exploration of NZ history as seen through an indigenous lens.

Another important aspect of the training programme will be the return to two day marae based training Ngā Kanohi Marae and ongoing informal question and answer sessions, Kōrero Mai Kōrero Atu.

2.1.2.3 Cultural Intelligence Application

The Maori Health team have been investigating the range of options available to build the DHB's knowledge and responsiveness in Te Ao Māori. The team has been working with IT staff and Kiwa Digital to develop an online tool that will enhance staff capability to understand and apply Māori values, practises and knowledge in their work and when engaging with Māori.

A business case has been developed that requests capital funding. This is an exciting and modern way of providing information and learning opportunities that are immersive, interactive, and provide individual positive experiences.

2.1.2.4 Hutt Valley Matariki Achieving Excellence in Māori Health Awards

In celebration of the Māori New Year and rising of Matariki, Hutt Valley DHB took the opportunity to recognize the exceptional work at the first Matariki Achieving Excellence in Māori Health Awards 2019. With over 45 nominations, 12 finalists were selected and announced at Fraser Park on Thursday, 4 July, led by the Māori Health team.

The awards were timed to coincide with the rising of the Matariki (star cluster), marking the Māori New Year. Rich in tradition, these stars were important to our ancestors as they represented a signal for harvest and planting of crops. Traditionally, family would gather together to celebrate and reflect on whakapapa (genealogy). The Māori Health Team saw this as an opportunity to share the stories and reflect on the significant contributions Māori providers, Māori communities, individuals and other providers make to achieve equity and excellence in Māori health.

On the night, there were five categories that were named after the stars of Matariki. Two people in each category were presented an award. In addition to the five categories, there

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were two supreme awards that were announced and presented on the night. The Matariki – Te Mana Whakahaere recognizes the recipient's ability to demonstrate excellence across Te Ao Māori and Te Ao Hurihuri. Each of the finalists across the six categories demonstrated a high caliber of Māori success and accomplishment in making positive outcomes in the lives of whānau and our community.

These awards are part of Hutt Valley DHB's plan to achieve equity for Māori health within nine years. The awards are part of the bigger picture; aimed at highlighting and celebrating the outstanding commitment and contribution of those working within the community, DHB and wider health networks. The night was a huge success and the DHB look forward to continuing these annual awards as it is important to build on and acknowledge the tremendous work that is being done.



2.1.3 Te Pae Aronga Tuatoru – Commissioning

2.1.3.1 Advancing Treaty relationships

Advancing Treaty relationships is a theme across all five key focus areas. The DHB is building on the relationships it has with existing Māori health providers and identifying ways to develop relationships across the expansive range of marae and Māori communities. Some explicit actions as part of our implementation plans have been identified to meet our obligations for Māori participation in decision making at all levels and will continue to build these throughout the system.

2.1.3.2 Ethnicity Data Collection and Reporting

The Maori Health team are working alongside the DHB's data analyst to develop consistencies with ethnicity data collection, data reporting and narrative in order to present meaningful and robust reports, which translates into action to shift inequity and the status quo.

2.1.3.3 Māori Provider Development Scheme (MPDS)

This annual fund, administered through the Ministry of Health, gives Māori providers the opportunity to apply for funding to build their capability and capacity. This year, the Māori

Health Team worked alongside providers to support their application process through application peer review, letters of support, as well as being advocates for their individual applications. Following on from this, the team is planning to work with providers to identify synergies and gaps from unfunded areas and work to develop a plan to share resources where applicable to continue to support their aspirations, capacity and capabilities.

2.1.4 Te Pae Aronga Tuawhā – Mental Health and Addictions

2.1.4.1 Hutt Valley DHB Kaupapa Māori Mental Health Services

In 2007, 10.8 full time employees (FTE) within the Hutt Valley DHB Mental Health Service were allocated to Māori specific roles and integrated into the Mental Health Community Teams.

Over time however, 6.8 of the FTE has been absorbed into other vacancies and have not been replaced with Māori Clinicians. Currently there are two Māori FTE roles in the Community Team and it is not clear that these roles are delivering culturally appropriate services. The remaining 2FTE sit within the Hutt Valley DHB Māori Health Unit.

The proposal is to re-establish a Kaupapa Māori Mental Health and Addictions Service at Hutt Valley DHB, which has been endorsed by MHAIDS Kaunihera, MHAIDS Executive Leadership Team, Hutt Valley DHB, and Mana Whenua Relationship Board.

The next steps in this project are to:

- Develop a change management plan;
- Identify and allocate project resource support;
- Employ a Project Manager using existing resource;
- Identify iwi, Māori and stakeholders to develop a communications and engagement plan regarding the change;
- Focus on the service development;
- Develop a Governance and Steering group;
- Implement this new Kaupapa Māori service, with all vacancies filled by June 2020.

2.1.5 Te Pae Aronga Tuarima – First 1,000 Days

2.1.5.1 First Thousand Days Maternal project

This joint project between HVDHB (Strategy, Planning and Outcomes (SPO) and Māori Health) and Naku Enei Tamariki, is working with Māori mums to listen to their stories about their experience of maternal care received. The DHB is seeking to understand what was done well, what could be done better and their experiences of any Te Ao Māori practices during their pregnancy. There have been two face-to-face interviews and three group sessions (eight Mums in each). Te Whare Tapa Whā has been the model utilised during the structured sessions. Emerging themes have come through and a detailed report will be developed. The intention is to utilise this information to co-design a way forward with a key focus on equity.

2.1.5.2 Kaupapa Māori Maternal Team development

A small steering group has met with two researchers from Victoria University to have initial conversations about the intention of developing a specific Kaupapa Māori Maternal Team. Next steps are to secure specialist project resource support to further develop this service.

2.1.5.3 Maternity Support

In addition to the above, we support the Maternity Clinical Governance Group and other sub-groups that are branches off this work (eg, supporting healthy weight gain in pregnancy group and Sudden Unexplained Death in Infants (SUDI) work).

3. MANA WHENUA RELATIONSHIP BOARD (MWRB)

Meeting bi-monthly, work is being done to develop a relevant work plan as well as understanding the wide range of planning processes our DHB undertakes. Wayne Guppy, Yvette Grace and Ken Laban attend as the HVDHB Board representatives, along with our CEO and Director Māori Health.

3.1 31 May 2019 MWRB meeting

The MWRB approved the draft implementation plans for the Workforce, Organisational Development and Cultural Safety, and Commissioning focus areas of Te Pae Amorangi Hutt Valley DHB Māori Health Strategy.

Discussion took place around the need for Māori Health KPIs for the Executive Leadership Team and their direct reports. The Director Māori Health was tasked with developing draft KPIs for the MWRB's review.

The MWRB also noted the need for the Director Māori Health to work with Mana Whenua Relationship Board to develop a Māori Health Strategy Investment Plan.

3.2 Mana Whenua Relationship Board work plan and focus areas

3.2.1 Defining Terminology to Refine the Rules of Engagement around Equity and Co-design

"Co-design" and "Equity" are both words that are being used more frequently within the wider health sector and Hutt Valley DHB. It is essential DHB employees have a shared understanding of what these terms mean, a common process or processes for using or implementing them, and know the impact this has on Māori health. The current definitions that the DHB is working with are detailed below and currently do not have any specific associated strategies for implementation. This has been highlighted as a risk, which we propose can be proactively minimised.

The use of the terms co-design and equity are integral to our work in Māori health, the Hutt Valley DHB's focus on reducing inequities, and our aspiration to work in partnership with Iwi Māori to improve Māori health outcomes. These terms are currently seen throughout the major strategies underpinning the work of Hutt Valley DHB eg, (Te Pae Amorangi – Māori Health Strategy, the Clinical Services Plan, Our Vision for Change, and the Wellbeing Plan). Aside from Te Pae Amorangi, these documents do not use these terms with an explicit Māori focus, which outlines an opportunity to support a shared understanding of these definitions.

The Director of Māori Health will work alongside the Mana Whenua Relationship Board to:

- define EQUITY for general use within the HVDHB environment;
- define CO-DESIGN for general use within the HVDHB environment;
- establish a process or processes for implementing equity and co-design.

4. NATIONAL DEVELOPMENTS


4.1 WAI 2575 – Waitangi Tribunal report and recommendations

The Waitangi Tribunal released its report to WAI 2575 on 1 July 2019. Hauora lays out the serious distortions of our health system, and is very clear how urgent it is for the government to take actions.

The Tribunal highlights:

- the need to reset the health systems overarching framework;
- DHB's do not afford Māori Treaty consistent control of decision making in relation to health care design and delivery;
- Lack of Māori staff in senior level positions also breach the Treaty principles of equity and active protection;
- Primary health care funding has not addressed Māori health need and has disadvantaged Māori led services;
- Health entities aren't appropriately held to account for achieving equity;
- The Crown does not collect sufficient qualitative or quantitative data to ensure primary care is performing for Māori;
- The dominant language in the health sector of "reducing disparities or reducing inequity" rather than "commitment to achieving equity outcomes for Māori", they recommend legislation and strategy be updated to that effect;
- The Tribunal issues findings on racism, inaction in the face of need, and unconscious bias.

The complete report is attached as an appendix. A full briefing paper will be developed in the coming weeks to ensure Hutt Valley DHB is proactively working to develop and drive solutions to address the injustice and inequity for Māori.

		BOARD DISCUSSION PAPER
		Date: 1 August 2019
Author	Debbie Gell, General Manager – Quality, Service Improvement and Innovation	
Endorsed by	Fionnagh Dougan – Chief Executive	
Reviewed/approved by	The Executive Leadership Team (reviewed on 19 July 2019)	
Subject	Hutt Valley DHB Quality and Safety update	
RECOMMENDATIONS		
It is recommended that the Board:		
a) NOTES the report for June 2019;		
b) NOTES the Quality Safety Walk-Round – Plastics;		
c) NOTES the Consumer Council update.		

1. PURPOSE

The purpose of this report is to provide the Board with an update on key Service Quality and Safety activities at Hutt Valley DHB.

2. STRATEGIC ALIGNMENT

This paper links to the strategic directions and enablers in *Our Vision for Change*.

The Quality and Patient Safety dashboard information in this paper shines a light on information that contributes to developing shared goals for improving physical and mental health, wellbeing, as well as eliminating health inequalities across the health and social sector, that supporting the living well strategic direction for Hutt Valley DHB.

The strategic direction for Hutt Valley DHB is to shift care *Closer to Home*, and this is supported by the Patient Experience information shared in this report. Telling patient stories informs and supports the goal of health professionals and community providers collaborating, and working as one team to support people in their communities.

The Hutt Valley DHB's Quality, Service Improvement & Innovation (QSII) team's workplan and building quality improvement capability plan contributes to the strategic direction of delivering *Shorter, Safer and Smoother Care* and the strategic enabler of an *Adaptable Workforce* by supporting all health professionals within the system to engage and collaborate in training, leadership and quality improvement activities and opportunities.

The QSII team contributes to the strategic enablers of *Smart Infrastructure* by supporting improved care and experience for people and whānau; this is highlighted in the patient experience feedback, patient stories and information on the Quality Walkrounds shared with the Board. The QSII team uses data to identify areas for improvement and drive people-focused services; this can be seen in the Quality and Patient Safety dashboard information, and updates from the Quality and Patient Safety Committee.

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This paper contributes to the *Effective Commissioning* as a strategic enabler as evidenced through the Quality and Patient Safety dashboard, by the Quality Improvement Programme work, our patient experience and co-design work, patient experience survey reports, and work in improving outcomes by understating and measuring what matters to patients and whānau.

3. GOVERNMENT PRIORITIES

This paper addresses the Government's key priorities by supporting our organisation to identify, understand through data and patient feedback information to support achieving equity. Work will continue to highlight health equity information in the Quality and Patient Safety dashboard information. The work that the QSII team does through improvement training, improvement project support, and supporting co-design aims to enhance innovation and trial new processes with the aim of achieving equity. Further work in this area will assist in supporting child wellbeing as a priority for continuous improvement. The information in this paper supports the governance of Mental Health and Addiction Service delivery at Hutt Valley DHB through the Quality and Patient Safety Committee. This, combined with data shown in the Quality and Patient Safety dashboard and patient feedback, supports the mental health government priority.

4. CONSUMER ENGAGEMENT AND PARTICIPATION

Consumer participation and engagement is about patients and their families/whānau making decisions about their own care and taking part in the design, delivery and evaluation of the services they use.

The DHB receives consumer feedback through its complaints and compliments processes, DHB-specific patient satisfaction surveys, and consumer group forums. This information is analysed and directly informs continuous quality improvements.

4.1 Consumer Council – update

The Consumer Council met in June 2019 and continue to develop their annual work plan. In addition, the Consumer Council has provided feedback on the Clinical Service Plan and is currently gathering information to update the Consumer Council page on the DHB's website. The Council has been approached to send one to two representatives to participate in the website refresh project.

5. A COMMITMENT TO WORKING ON QUALITY AND SAFETY

A Hutt Valley DHB value is *Being Our Best*: one of the ways staff model this is by looking for and acting on opportunities for improvement and innovation. Staff aim to make sure improvements made are sustainable by making process and system-level improvements. Hutt Valley DHB is building its capability to use the Institute for Healthcare Improvement (IHI) – Model for Improvement as its key improvement methodology.

5.1 Quality and Patient Safety Committee update – June 2019

The Quality and Patient Safety Committee (QPSC) is the key committee for enabling clinical governance, ensuring the organisation has appropriate systems and processes to support patient safety, and learn from our events. The committee meets monthly; the agenda includes updates from committees reporting as part of the Clinical Governance Framework; reviewing the Quality and Patient Safety dashboard and considering any special cause variation; and confirming recommendations of reviewed severe or major adverse events.

At the June 2019 meeting, the QPSC received reports from the Falls Committee and the Hutt Valley Restraint Advisory Group. Claire Jennings, Associate Director of Nursing (ADoN) and chair of the Falls Committee presented the most recent quarters' data on the number of patients receiving falls risk assessments and care plans where Hutt Valley continues to not meet the target level. There have been

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several initiatives to try and improve this, including through putting the assessments on TrendCare. The ADoN will now closely monitor monthly audits, data made available for discussions with staff at ward level some areas will receive individual follow-up.

The restraint advisory group report was discussed, noting the ongoing need for restraint, enabler and de-escalation training for clinical and non-clinical staff in non-mental health settings. Under reporting of events is also noted. It may be appropriate for Hutt Valley to share a restraint co-ordinator position with Capital & Coast DHB; this will be discussed by the general managers of both DHBs.

One adverse event review for an always report and review event was received and the recommendations confirmed. The May 2019 Quality and Safety Dashboard was reviewed, with no special cause variation.

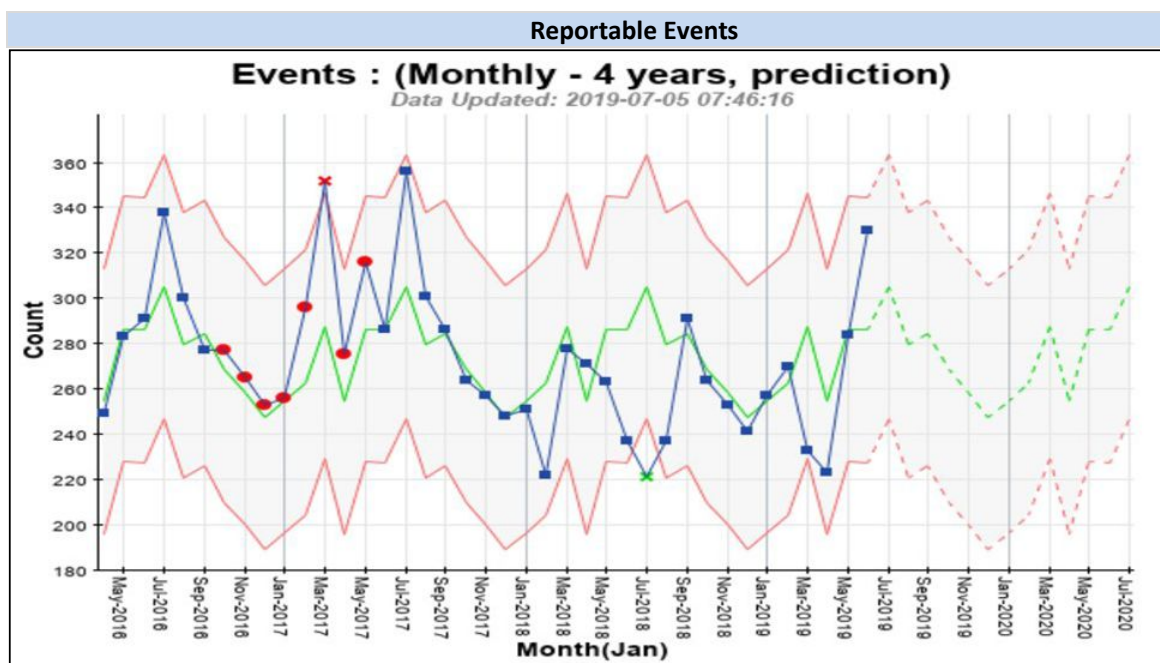
5.2 Quality and Patient Safety Dashboard – June 2019

The Hutt Valley DHB Quality and Patient Safety ‘dashboard’ has been enhanced in recent months and is now produced with the Lightfoot ‘Signal for Noise’ tool. This means that the data is now visible live for managers to view their own data at any time. The reports are easily customised to suit teams’ needs, and to encourage greater clinical engagement. This tool also enables staff to monitor and view the DHB’s quality and patient safety data with visible seasonal variation and predilections. The dashboard provides reporting at an organisational level on a small set of quality and patient safety indicators that are internationally recognised in a range of aspects of quality. The data in the dashboard is viewable in one place and includes trends over time presented, where appropriate, in Statistical Process Control (SPC) charts. The SPC charts show an Upper Control Limit (UCL), a Mean, and a Lower Control Limit (LCL). Presenting the data in this way enables staff and management to identify common cause variation (those causes inherent in the system over time that affect everyone working in the system and affect all outcomes of the system), and special cause variation (those causes not part of the system all the time or that do not affect everyone but arise because of specific circumstances).

The Hutt Valley DHB Quality and Patient Safety dashboard Indicators include:

- the number of reported events;
- reportable events by service;
- reportable events by category;
- feedback data – number of complaints;
- themes of complaints;
- complaints received by service.
- open complaints by service;
- patient falls events reported;
- medication error events reported;
- skin/tissue events reported;
- safe staffing events reported;

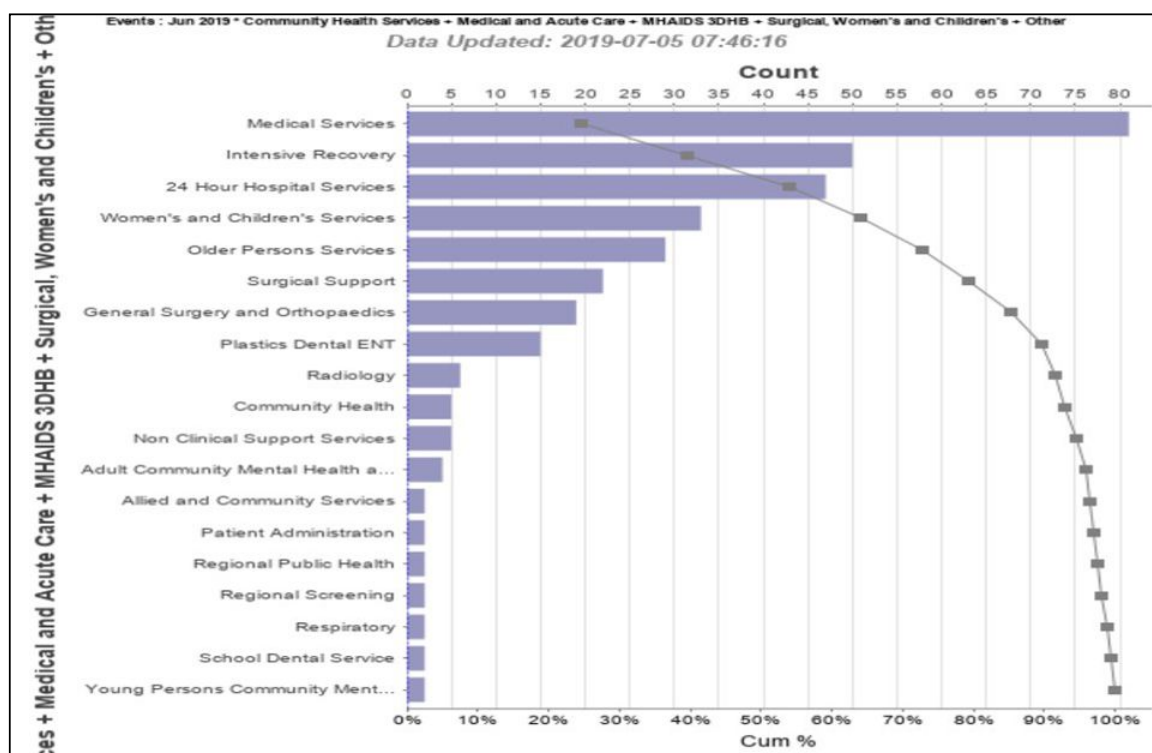
The data included in the dashboard is drawn from Hutt Valley DHB’s Safety, Quality and Reportable Events (SQuARE) database, on the first available working day of the month.

**Commentary**

While there was an increase in the number of Reportable Events received in June, it is consistent with what would be expected through common cause variation.

Suggested Action

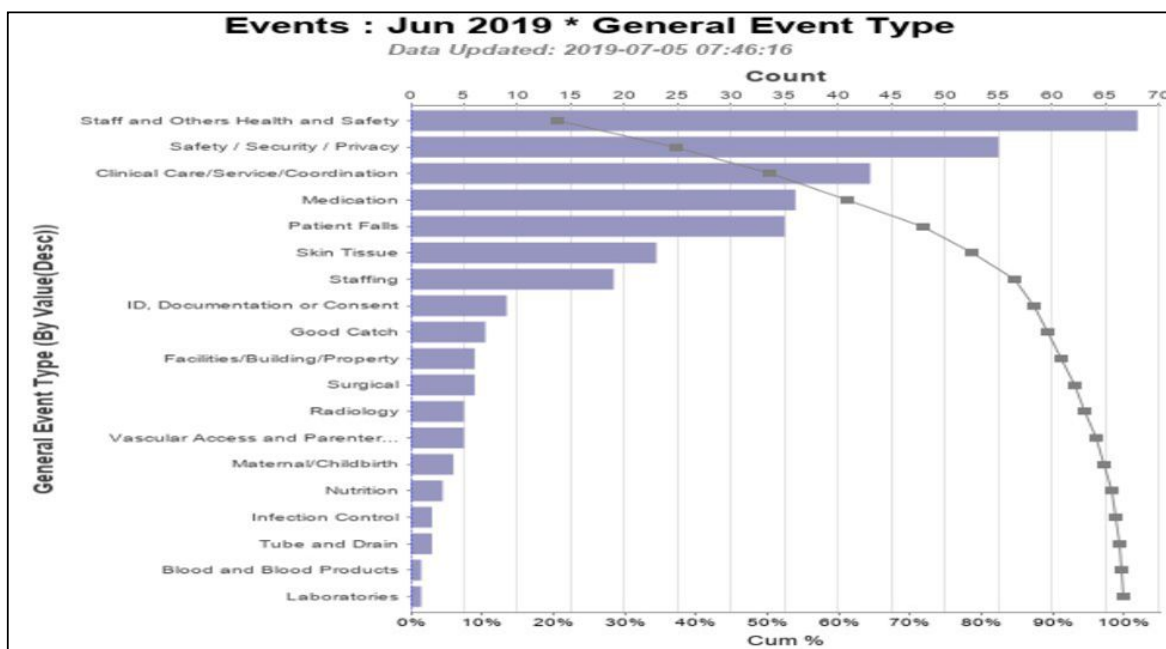
Continue monitoring.

**Commentary**

Of the events reported for June, 24.5 percent (n=81) of the total number reported originate from Medical Services, 15.1 percent (n=50) in Intensive Recovery and 14.2 percent (n=47) in 24 Hour Hospital Services. This accounts for 53.9 percent of all events reported. While numbers are higher, this pattern is similar to previous months.

Suggested Action

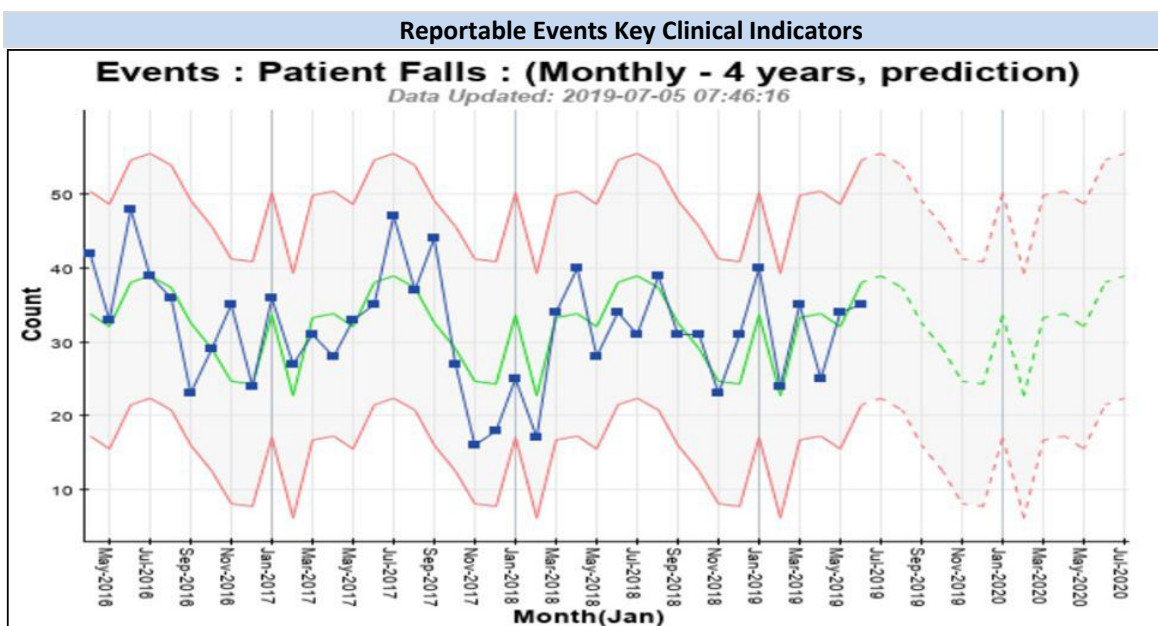
Continue monitoring and oversight by service groups.

**Commentary**

For the events reported this month, 20.6 percent (n=68) of all events occurred in Staff and Others H&S, 16.6 percent (n=55) occurred in Safety/Security/Privacy, 13.0 percent (n=50) occurred in Clinical Care/Service/Coordination, 10.9 percent (n=36) occurred in Medication, 10.6 percent (n=35) occurred in Patient Falls. These account for 71.8 percent of all reportable events logged. This pattern of categories is consistent with previous months.

Suggested Action

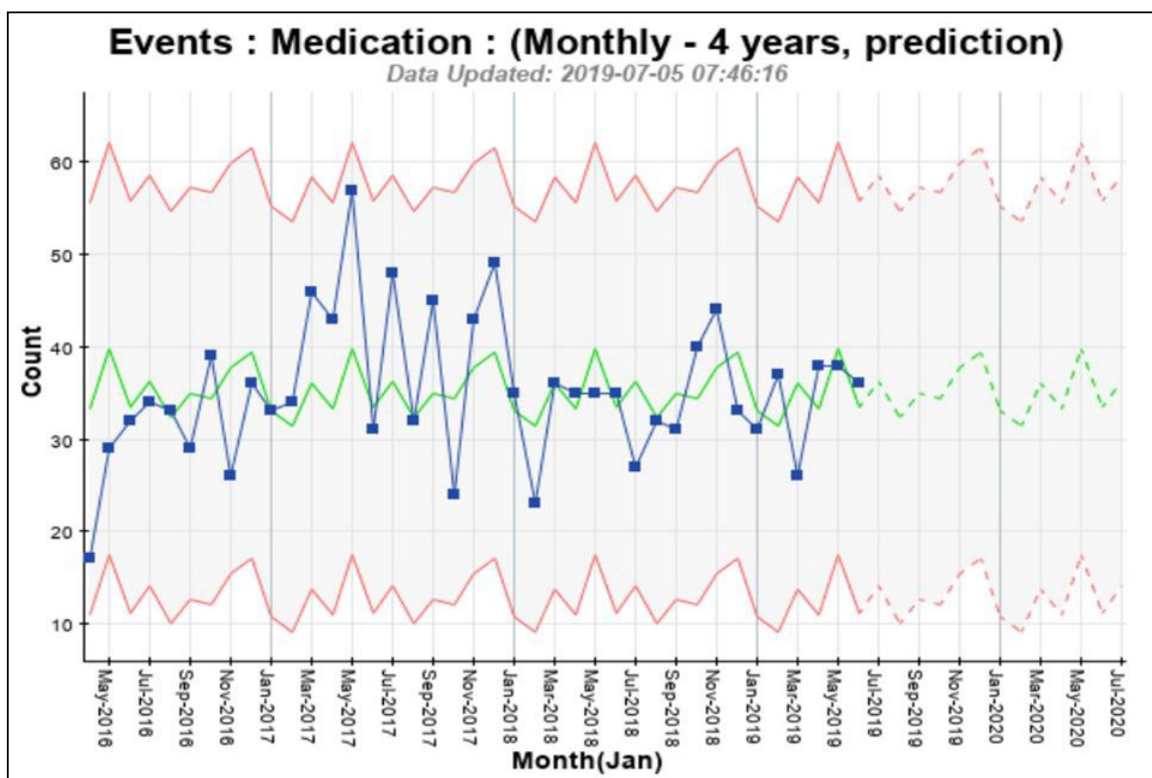
Continue monitoring and consideration by the Quality and Patient Safety Committee and Health and Safety.

**Commentary**

Number of patient fall events logged on SQuARE for June is consistent with what would be expected through normal common cause variation. No special cause variance/trend identified.

Suggested Action

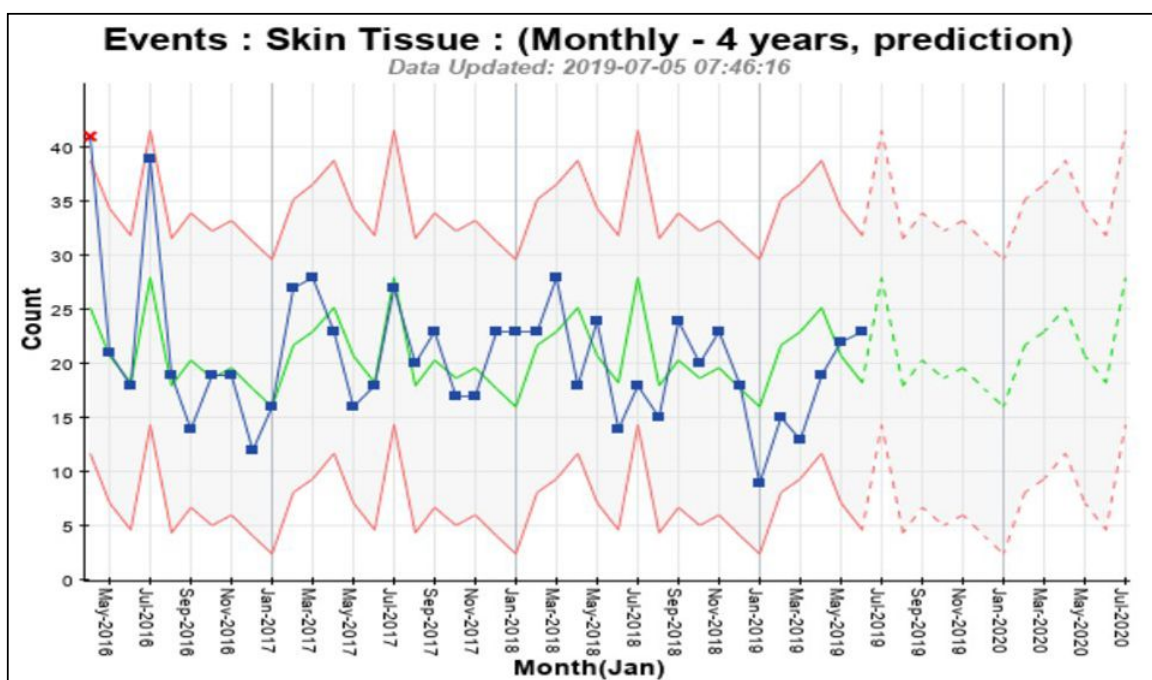
Continue monitoring by the Falls Committee with active implementation of falls minimisation strategies on wards.

**Commentary**

Number of medication events logged on SQuARE for June is consistent with what would be expected through common cause variation. No special cause variation is identified.

Suggested Action

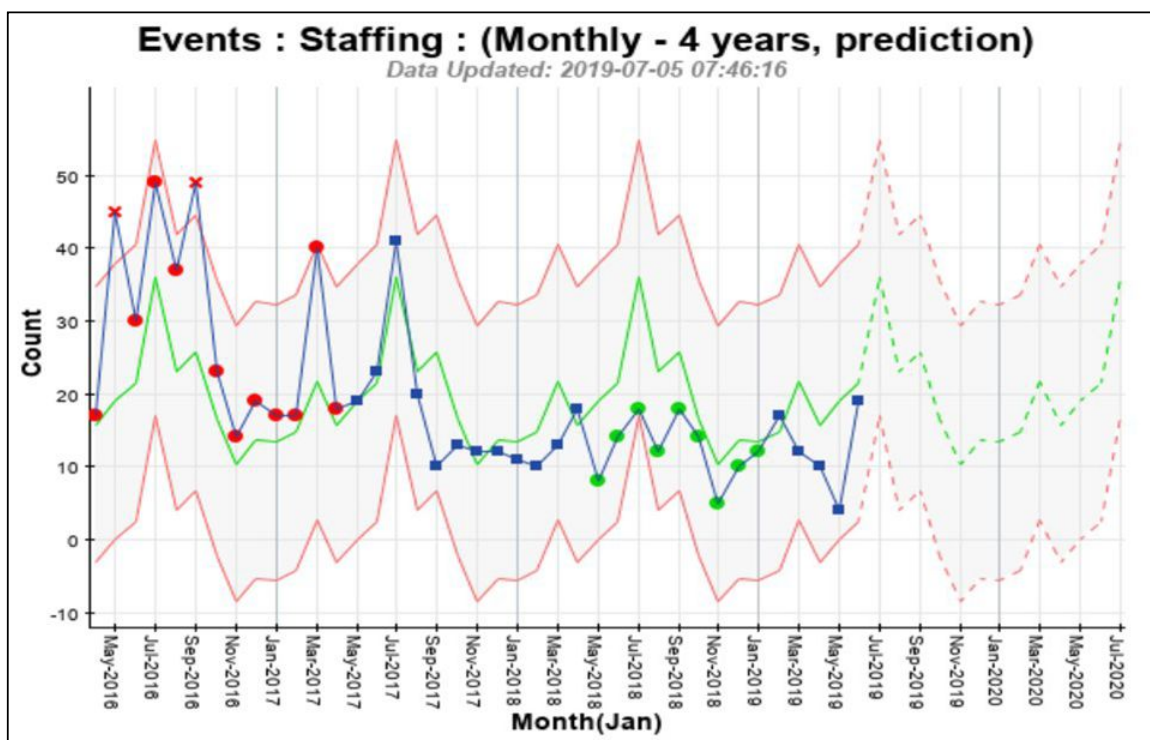
Continue monitoring and analysis by ward medication groups and the Medicines Committee.

**Commentary**

Number of skin/tissue events logged on SQuARE for June is consistent with what would be expected through common cause variation. No special cause variation is identified.

Suggested Action

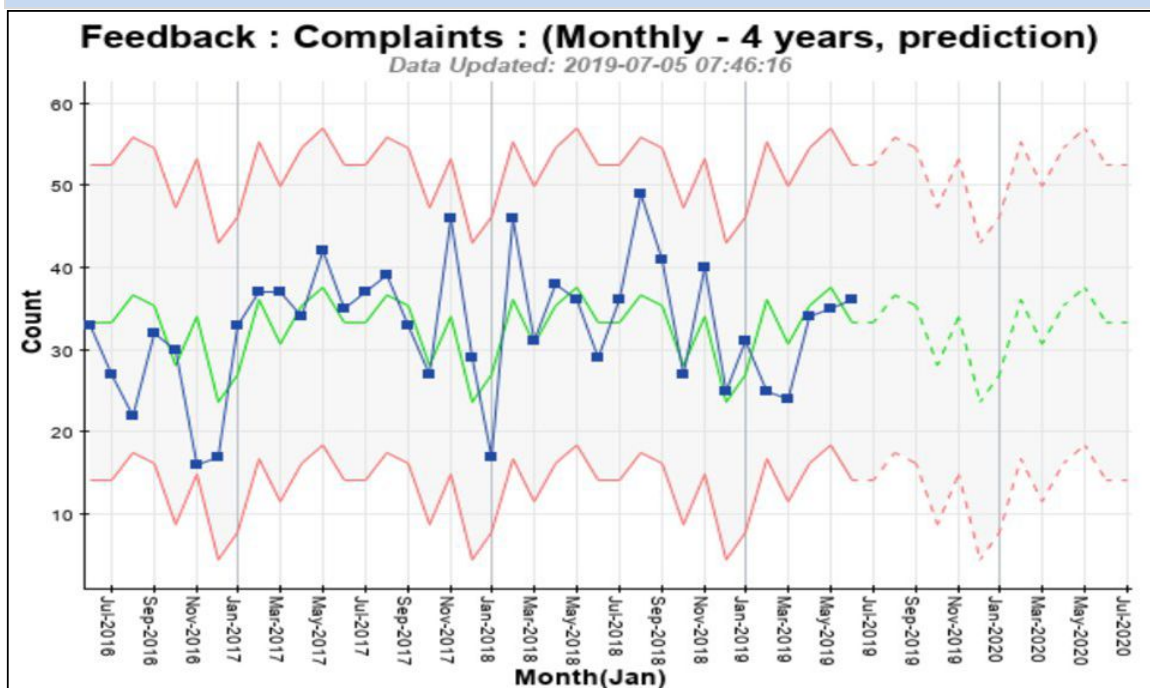
Continue monitoring and analysis by the Pressure Injury Steering Group.

**Commentary**

The number of staffing events logged on SQuARE for June is consistent with what would be expected through common cause variation.

Suggested Action

Continue monitoring within services.

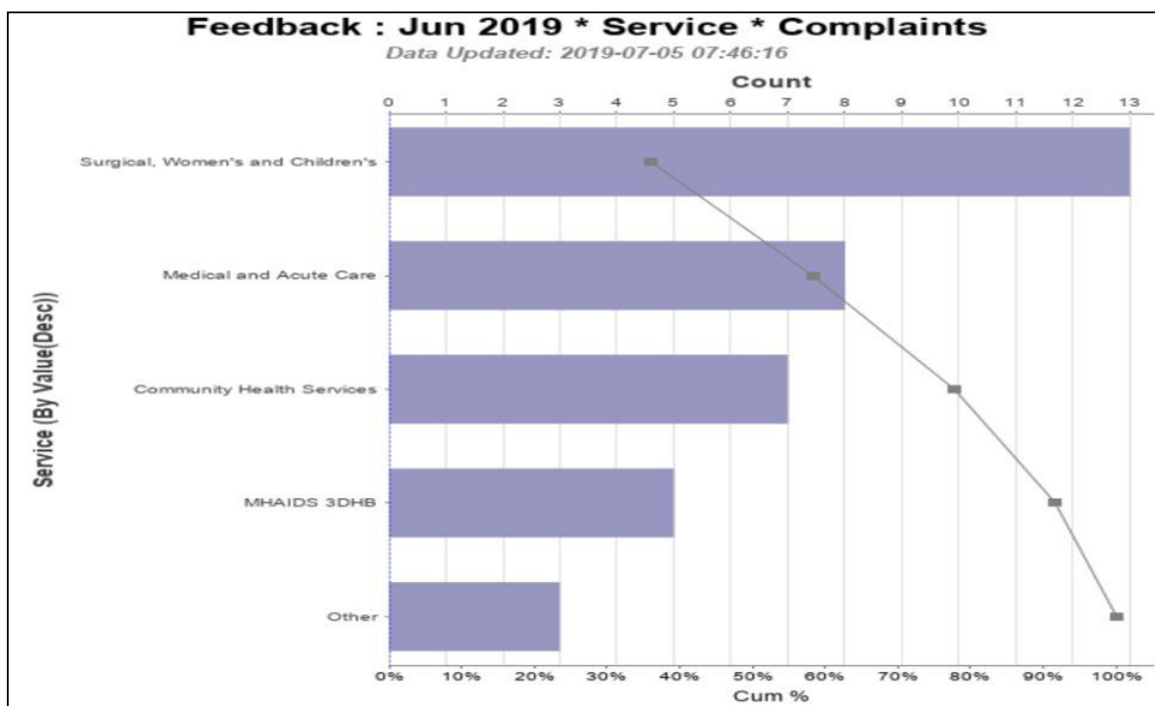
Feedback**Commentary**

The number of complaints logged on SQuARE for June (n=33) is consistent with what would be expected through common cause variation.

Suggested Action

Continue monitoring.

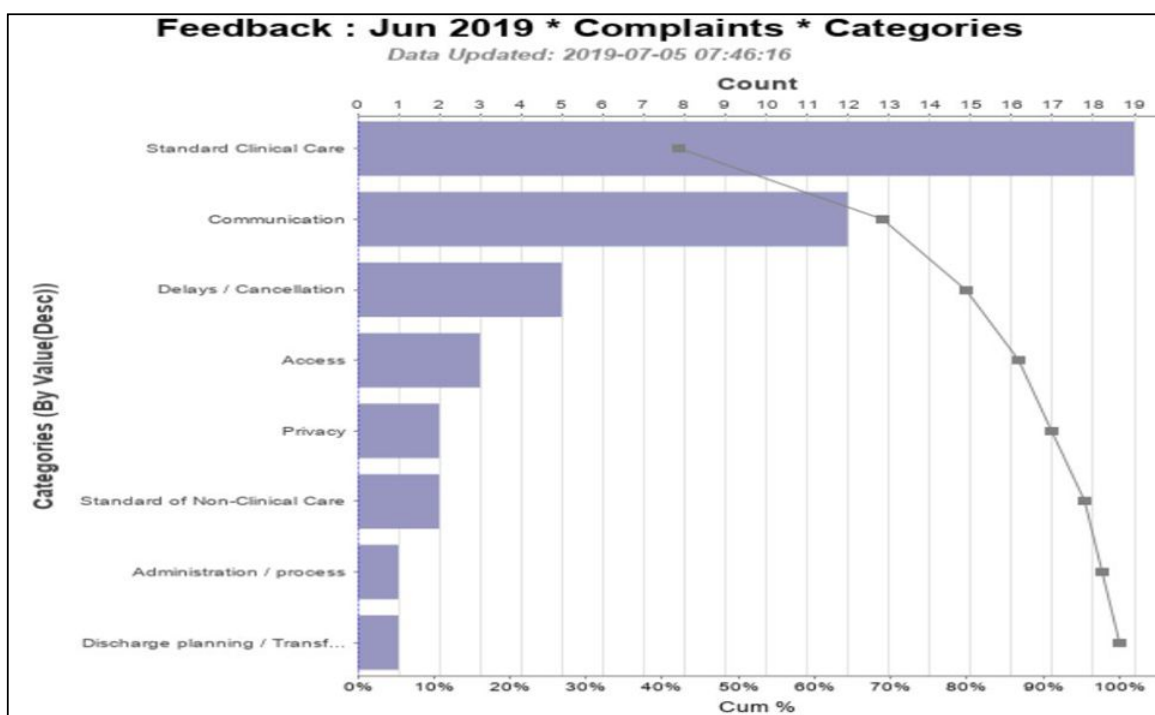
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**Commentary**

Complaints received (including HDC complaints) for this month were predominately in the Surgical, Women's and Children's Service Group (n=13) followed by Medical and Acute Care (n=8) and MHAIDS (n=5).

Suggested Action

Services continue to respond to and learn from complaints. Continue monitoring and review at the ward/department level.

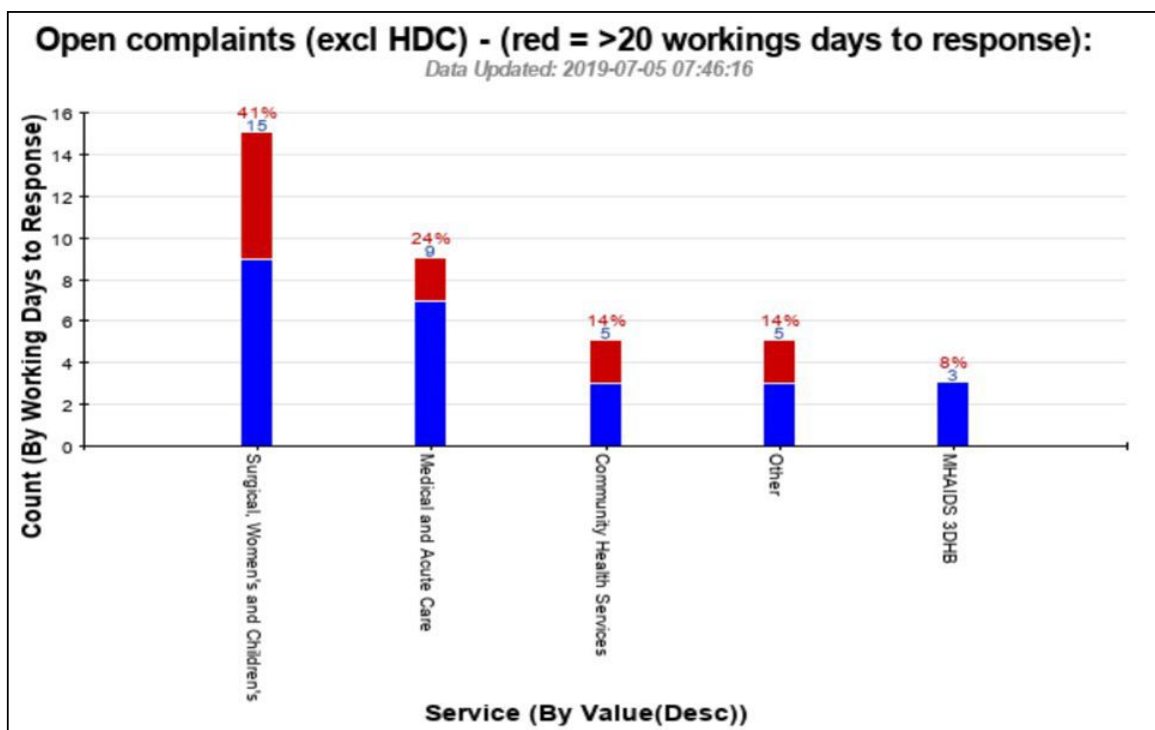
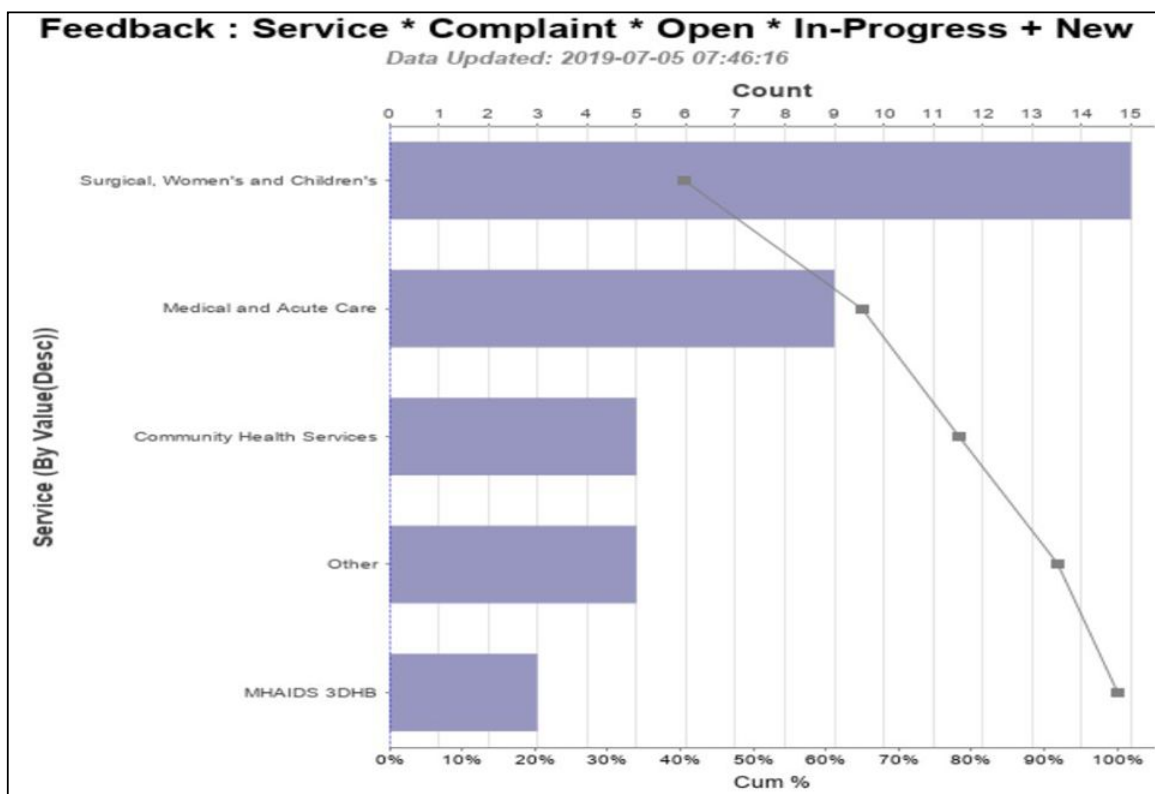
**Commentary**

42.2 percent of the identified themes from complaints received in June were in the area of 'Standard Clinical Care'; 26.6 percent involved 'Communication'. These two categories account for 68.8 percent of the themes identified in complaints received, similar to previous months.

Suggested Action

Continue monitoring.

PUBLIC



<=20 days >20 days

Commentary

There are a number of open complaints currently and of these open complaints (not including HDC) 41 percent (n=15) are in the Surgical, Women's and Children's Service Group and 24 percent (n=9) in Medical and Acute Care. These make up 65% of the open complaints. 32.4% (n=12) are outside the 20 working day response KPI (at 01/05/2019).

Suggested Action

Continue monitoring.

6. AN ENGAGED, EFFECTIVE WORKFORCE

As part of being a thriving organisation, Hutt Valley DHB wants to be: the organisation of choice for people to work in; a place where patients are at the centre of what we do; a place where staff feel valued, have development opportunities, are involved in improving the way we do things; and have a safe and supportive workplace. An engaged and effective workforce focuses on how we are growing staff members to ensure that the people who use Hutt Valley DHB services are getting the best care and the DHB is facilitating the best value health care for our population.

6.1 Quality Improvement Capability and Capacity Plan update

This month the Quality Service Improvement and Innovation team has welcomed Erin Stewart as an Improvement Advisor, who has joined the incumbent Improvement Advisor Vivian Martin. Erin has previously completed the Ko Awatea Quality Improvement Facilitator course and has an extensive background in a variety of clinical roles in both New Zealand and Australia. Her work will focus on supporting hospital teams and coaching individuals to make measurable improvements, using robust methodology – this role significantly strengthens the Quality team’s improvement capacity at the expert level.

6.2 Quality Safety Walkround – Plastics

Quality and Safety Walk Rounds (walk-round) involve members of the Executive Leadership Team (ELT) visiting an area in the DHB to meet with patients and staff. The aims include:


- demonstrating leadership’s commitment to quality and safety for patients, staff and the public;
- increasing staff engagement;
- and strengthening commitment and accountability for quality and safety.

Through structured and informal discussions issues can be raised, good practices identified, and actions agreed to improve quality and safety. The walk-rounds have been held on a monthly basis since June 2016.

During May’s walk-round the ELT visited Plastics. ELT noted the cohesive team environment where short stand-up meetings occurred daily to monitor the key activities in the unit and provided staff opportunities to seek support from others in the team. The two patients spoken to by ELT were very complimentary about the care they have received and felt that their care was well coordinated. Both patients commented that they felt free to ask questions and that their questions / concerns were taken seriously by the staff.

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		BOARD DISCUSSION PAPER
		Date: 1 August 2019
Author	Melissa Brown, Interim Chief Operating Officer	
Endorsed by	Fionnagh Dougan, Chief Executive	
Reviewed/approved by	The Executive Leadership Team (reviewed on 19 July 2019)	
Subject	Health Roundtable performance report 1 April 2018 – 31 March 2019	
RECOMMENDATIONS		
It is recommended that the Board:		
<ul style="list-style-type: none">a) NOTES the summary of Hutt Valley DHB’s performance provided by the Health Roundtable for April 2018 to March 2019;b) NOTES that Hutt Valley performs better than peer groups across some hospital acquired complication categories and not against others, but is improving overall;c) NOTES that the standardised mortality rate for Hutt Valley is not significantly different to the New Zealand average;d) NOTES that Hutt Valley emergency department performance is poorer than that of benchmarked like services across Australasia;e) NOTES that Hutt Valley emergency readmission rates are in the middle of benchmarked like services across Australasia;f) NOTES that Hutt Valley discharge performance is poorer than that of like services in our benchmarking group across Australasia.		
APPENDICES		
<ul style="list-style-type: none">1. Health Roundtable – ELT report April 2018 to March 2019		

1. PURPOSE

To update the Board on the indicators provided through the Health Roundtable benchmarking (April 2018 to March 2019), comparing Hutt Valley DHB with similar health services across Australasia.

2. BACKGROUND

The Health Roundtable (HRT) provides a benchmarking service for health services across Australasia, including reports on clinical outcomes. HRT reports also provide information on exemplar sites and peer group medians, to support collaborative improvement opportunities and create a culture where for health services aspire to continually improve performance and deliver better health outcomes.

3. KEY THEMES

3.1 Hospital acquired complications

Hutt Valley DHB's performance has improved over time in relation to hospital-acquired complications, and overall compared better than benchmarked peer group health services in the following areas:

- Pressure injuries;
- Falls;
- Surgical complications;
- Respiratory complications;
- Gastrointestinal bleeding;
- Malnutrition.

However, Hutt Valley had higher rates of acquired complications than peer groups in the following areas:

- Venous thromboembolism (15 percent greater than the peer group median);
- Perineal tears during birth (40 percent more than the peer group median);
- Neonatal birth trauma (more than double the peer group median).

3.2 Standardised mortality rate

The standardised mortality rate for Hutt Valley is not significantly different from the New Zealand average, however, there is a much higher standard deviation of the mortality ratio from the peer group for the following:

- Mental health and behavioural disorders;
- Musculoskeletal;
- Genitourinary.

3.3 Emergency department performance

Hutt Valley DHB is in:

- The middle of the benchmarked peer group for 28 day emergency readmissions (excluding short stay);
- The bottom 20 percent of the benchmarked peer group for the percentage of emergency department patients seen within clinically recommended timeframes;
- and is the bottom third performer in the benchmarked peer group for the percentage of patients seen within four hours (for admitted patients only). Just over one third of admitted patients were seen within the six-hour target.

3.4 Discharges before noon

Hutt Valley DHB was in the bottom 10 percent of the benchmarked peer group for patient discharges before noon.

4. NEXT STEPS

The Health Roundtable report and other more detailed Health Roundtable data is shared with operational managers and clinical leaders. It is acknowledged that we need to celebrate the areas where performance is positive. In areas where performance is not at the level expected, clinical directors and service managers,


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together with the multidisciplinary teams are reviewing and developing a plan for improvement. This will include:

- Reviewing best practice;
- Utilising learnings including from exemplar health services;
- Measuring and reviewing performance more regularly to identify and proactively manage any issues;
- Developing specific actions plans for improvement.

Work is also underway in the following areas to drive performance improvement:

- The Women's Health review report recommendations include changes and improvements to:
 - Service delivery models;
 - Quality and safety, including governance processes around review of adverse events.
- An emergency department rapid improvement event is planned for September 2019, where key stakeholders will review emergency department performance, identifying gaps against targets and workshopping solutions to identified issues.

		BOARD INFORMATION PAPER
		Date: 01 August 2019
Author	Christine Rabone, Committee Secretary	
Endorsed by	Chris Kerr, Director of Nursing & Clinical Council Co-Chair	
Reviewed/approved by	Fionnagh Dougan, Chief Executive	
Subject	Hutt Valley District Health Board Clinical Council Report – 03 July 2019 Meeting	
RECOMMENDATIONS		
It is recommended that the Board:		
a) NOTES that the Hutt Valley District Health Board Clinical Council met on 3 July 2019;		
b) NOTES that the Hutt Valley District Health Board Clinical Council discussed the following papers:		
<ul style="list-style-type: none">• Innovation Fund Update<ul style="list-style-type: none">– Enhancing Quality Improvement Capacity and Capability at Hutt Valley DHB;– Mental Health and Primary and Secondary Integration.• Hutt Valley District Health Board Quality and Safety Update (as tabled at the June 2019 Board Meeting);• Infection Prevention and Control Annual Report.		
APPENDICES		
<ol style="list-style-type: none">1. Enhancing Quality Improvement Capacity and Capability at Hutt Valley DHB2. Mental Health and Primary and Secondary Integration3. Hutt Valley District Health Board Quality and Safety Update4. Infection Prevention and Control Annual Report5. Clinical Council Meeting Minutes 4 July 2019 (for reference only)		

1. PURPOSE

The purpose of this report is to provide an overview for the Board on discussion points and recommendations made at the Hutt Valley Clinical Council's (the Council) 3 July meeting.

2. PAPERS PRESENTED AND DISCUSSED

2.1 Innovation Fund Update

The Council received two final reports, which summarised the final activities in 2018 and 2019 that were funded through the Innovation Fund.

The Council **NOTED**:

2.1.1 Enhancing Quality Improvement Capacity and Capability at Hutt Valley DHB (HVDHB)

Innovation Funding of \$126,600 was approved to be spent on Enhancing Quality and Improvement Capacity and Capability at HVDHB. This was allocated as follows:

Amount	Investment
\$71,600	Two three-day courses for 41 staff members held at Hutt Valley DHB and facilitated by Ko Awatea (the centre for improvement and innovation at Counties-Manukau DHB).
\$27,500	9 month Improvement Advisor training for two staff members.
\$27,500	9 month Improvement Advisor training for an additional two staff members

Following discussion, the Council **RECOMMENDED** the GM Human Resources and Organisation Development present to ELT and Clinical Council around future plans for leadership training as none has been taken in 2019 to date.

2.1.2 Mental Health and Primary and Secondary Integration

Innovation Funding of \$120,000 was approved to be spent on transitioning consumers from secondary to primary care – ensuring robust assessment of consumer readiness to transition, facilitation of transition and packages of care to support transition. To date:

- 846 clients were in the Hutt South Team in May 2019
- 687 discharges completed from July 2018 to May 2019
- 94 clients identified as stable with discharge potential. Between May and June 2019, 32 of these clients were discharged and a further 25 are being reviewed for discharge appointments in the next month
- 2 nurses have been appointed in each of the Community Teams who work alongside the GP practise to support a positive discharge process
- Currently running a HQSC Connecting Care project which assists in the transitions from Hutt Valley Adult Community Mental Health & Addiction Teams back to Primary Care, and links with the work being done by the Mental Health and Addictions Network for Hutt Valley

2.2 Hutt Valley District Health Board Quality and Safety update

The Council:

NOTED the report, which was presented at the Hutt Valley DHB Board Meeting on 27 June.

NOTED the trend reduction in event reporting over quarter one 2018/19 has not continued and response numbers are back to normal.

NOTED the draft Certification Audit results received from the DAA Group, particularly noting:

- 25 identified corrective actions have been recognized
- infection control process was commended
- complaints are well managed
- DHB is very project heavy
- lack of a centralised repository for recommendations and monitoring of areas for improvement

2.3 General

The Council:

RECOMMENDED an Action be raised to include the resignation of a Wairarapa DHB General Surgeon and the significant impact this imposes on the Hutt Valley, Wairarapa and potentially Manawatu regions on the HVDHB Risk Register.

NOTED Te Awakairangi Health Network are actively seeking a replacement for one of the Council's Co-Chairs (Hans Snoek) and will advise once an appointment has been made.

NOTED Chris Mallon has resigned as Director of Midwifery.



CPHAC Meeting Minutes

DATE:	14 June 2019	Time:	9.00am – 11.15am
VENUE:	Board Room, Pilmuir House, Hutt Hospital, Lower Hutt		
PRESENT:	Yvette Grace (Chair), Prue Lamason, Tim Ngan Kee, John Terris, Lisa Bridson, Ken Laban, Taefa Heker Roberston, Teresa Olsen (Joined meeting at 10am)		
APOLOGIES:	Andrew Blair, Dale Oliff		
IN ATTENDANCE	Christine Rabone (Minutes), Helene Carbonatto, Kerry Dougal, Peter Gush, Brian Nevin, Harley Rogers, Jazz Heer, Judi Keegan, Nathan Clark, Jared Nicoll		
PUBLIC	No members of public present		
PRESENTERS	<p>Tu Kotahi Maori Asthma and Research Trust Cheryl Davies, Manager</p> <p>Te Mauri Tira Albert, Mana Wahine</p> <p>Maori Health Plan – Progress Update Kerry Dougal, Director Maori Health, Hutt Valley DHB</p>		

	Agenda Item	Discussion	Action Required and by Whom
1	PROCEDURAL BUSINESS		
1.1	KARAKIA	Yvette Grace welcomed attendees to the Hutt Valley DHB CPHAC Meeting.	
1.2	APOLOGIES	Received from: Andrew Blair, Dale Oliff	
1.3	INTEREST REGISTER	There were no amendments made to the Conflict of Interest Register	

		<p>Taefa Heker Robertson noted no conflicts but will email Christine Rabone should any arise.</p> <p>Board Members to note any further conflicts.</p>	
1.4	CONFIRMATION OF PREVIOUS MINUTES	<p>Minutes were accepted as true and correct.</p> <p>Moved Tim Ngan Kee, seconded by Lisa Bridson</p>	
1.5	MATTERS ARISING	<ul style="list-style-type: none"> CPHAC Membership – Christine Rabone to draft a Board Decision Paper seeking approval for Dougal Thornburn to join CPHAC as their Population Health Expert. Wellbeing Plan – Item now closed. Regional Public Health – Peter Gush advised that water policy is covered in the quarterly updates presented at the joint Board Meetings. Therefore, no separate recommendation will be put forward. Item to be marked closed. RPH Service Delivery Newsletter – Members have emailed Janice Hemi-Williams to request inclusion on the distribution list for monthly updates – Item to be marked closed. General Business – Yvette Grace discussed the option of combining CPHAC and HAC Committees with Andrew Blair. This will be raised with Fionnagh Dougan upon her commencement. Item to be deferred to September. 	Christine Rabone to draft a Board Decision Paper on Yvette Grace's behalf seeking approval for D Thornburn to join CPHAC
2	PRESENTATION		
2.1	Tu Kotahi Māori Asthma and Research Trust – Māori Innovation	<p>Presentation from Cheryl Davies covering the work being undertaken by Tu Kotahi Māori Asthma and Research Trust and the Takiri Mai Te Ata Whanau Ora Collective.</p> <p>Points of note:</p> <ul style="list-style-type: none"> Tū Kotahi is part of a whānau ora collective in the Hutt Valley which comprises of 6 Māori health organisations. They specialize in delivering asthma and respiratory programmes to Māori (e.g. COPD, Bronchiolitis, Asthma, and bronchiectasis). 	

		<ul style="list-style-type: none"> • Have collaborated with other organisations to research housing conditions for vulnerable populations which has included insulation programmes, improved heating, maintenance and repairs. • Referrals come from both HVDHB, CCDHB, general practice centers, various community providers, self-referrals and government agencies. <p>There was discussion on:</p> <ul style="list-style-type: none"> • 90% of their services being provided directly into home or community settings. • The need the DHB to integrate better with external providers to offer more referrals. • Data measurement outcomes against ASH rates. <p>Yvette Grace thanked Cheryl for her presentation.</p> <p>The Committee NOTED the presentation.</p>	
2.2	Te Mauri – Mana Wahine	<p>Presentation from Tira Albert covering how Te Mauri and Mana Wahine are supporting whanau through the journey of cancer.</p> <p>Points of note:</p> <ul style="list-style-type: none"> • Te Mauri was developed in 2017 to support Māori with cancer. In 2018 it was implemented in 3 sites. • Services provided includes culturally appropriate support for the various stages of cancer and education in conjunction with other cancer care specialists. <p>There was discussion on:</p> <ul style="list-style-type: none"> • Increasing communication, knowledge and linkages across the system so people are aware of what support is available. • Sustainability due to funding constraints. <p>Kerry Dougal thanked Tira Albert for stepping in to present to the CPHAC at such short notice.</p>	

		Yvette Grace thanked Tira for her presentation.	
		The Committee NOTED the presentation.	
2.3	Maori Health Plan – Progress Update	<p>Presentation from Kerry Dougal which provided an update on the Māori Health Strategy.</p> <p>Points of note:</p> <ul style="list-style-type: none"> • Attracting Māori into health careers, recruiting more Māori health professionals, promoting and retaining Māori staff in the district, and building health sector competencies amongst staff are a priority. • A Māori workforce development role has been created and filled, and a Pou Tikanga role has been created which is focusing on staff training around NZ's history etc. • Looking to create a Marae space on the HVDHB campus. • A Kaupapa Māori Health Services for mental health and addictions will be created by July 2020. • Internal networks for support have been created as well as sector partnerships (e.g. Oranga Tamariki) • Matariki and achieving excellence in Māori Health Awards will be held on 4 July • Launch of Te Pae Amorangi, HVDHB Māori Health Strategy will be held on 17 July. <p>Points of discussion:</p> <ul style="list-style-type: none"> • Māori recruitment applications will go straight to interview stage providing set criteria is met and relevant qualifications held. • How we attract Māori into the health sector to fill skill gaps and what age groups should be targeted. • Workforce development training around cultural safety, institutional racism and sexism. <p>Yvette Grace thanked Kerry Dougal for her presentation.</p> <p>The Committee NOTED the presentation</p>	

3	OTHER		
3.1	General Business	Work Programme – To be updated as noted below: <ul style="list-style-type: none"> • Items scheduled for June 2019 have been deferred to December 2019 • Items scheduled for December 2019 have been deferred until March 2020. • Presentation from Naku Enei Tamariki to be included for September 2019. 	Christine Rabone to update work plan as noted in June 2019 minutes.

Draft



Consumer Council

Meeting Minutes

Date & time	Wednesday, 10 th July 2019, 6.05pm – 9.15pm
Venue	Board Room, Hutt Valley DHB
Chair	Prabha Ravi
Members Present	Anne Blackledge, Heather Cotter, Chris Harrington, Wendy Hill, Michelle McIntyre, Deborah Peters, Toshy Rapana, Patria Tamaka, Kamal Chandra, Paul Gruschow
In Attendance	Fionnagh Dougan, Chief Executive (until 5.20pm) Judith Parkinson, General Manager of Finance and Corporate Services Christine Rabone, Committee Secretary Jazz Heer, Service Development Manager – Long Term Conditions & Palliative Care Rod Bartling, Service Improvement Director – Mental Health & Addictions
Apologies	Saty Candasamy (absent)

1. Welcome and Introduction	
Members were welcomed to the Consumer Council Meeting.	
1.1 Introduction to New Chief Executive HVDHB & CCDHB	Fionnagh Dougan gave an overview of her background and expressed how valued feedback from Consumer Council members is to the DHB. Consumer Council members introduced themselves to Fionnagh, whom she noted had fantastic backgrounds and could add real value to DHB projects. Fionnagh Dougal left the meeting at 5.25pm
1.2 Apologies	No apologies received.
1.3 Continuous Disclosure	<ul style="list-style-type: none"> There were no amendments made to the Conflict of Interest Register. Members to advise Christine Rabone of any new conflicts which will be formally noted at the meeting following.
1.4 Confirmation of Previous Minutes	Minutes were accepted as a true and accurate record with no amendments to be made. Moved: Michelle McIntyre Seconded: Patria Tamaka Carried
1.5 Matters Arising / Action Items	<ul style="list-style-type: none"> <u>Hospital Tours</u> – Christine Rabone advised she has followed up with Quality and due to a lack of resources to work through logistics of a tour during the high peak winter illness period and lack of HOD availability, it was unfeasible to conduct tours at this time of year. Item deferred until February 2020.

- Microfiber Cloths – The Sustainability Committee advised microfiber cloths were chosen over cotton cloths due to the follow reasons:
 - Cottons cloths spread surface residue and require additional harsher chemicals being used to have the same effect as microfiber cloths.
 - Microfiber cloths are low linting and require less harsh chemicals which results in greater longevity and less wastage.
 Action item closed.
- Sentence clarification around institutional racism and bias training requiring rework was discussed during the members only session and considered and individual opinion rather than that of the Consumer Council. Item to be marked closed.
- Workplan - to be further updated following members only discussion.

2. DHB Presentations

2.1 Palliative Care Network

Jazz Heer presented the work underway on the 3DHB Palliative Care Strategy which is designed to improve the journey for Palliative care patients and their families/whanau.




Jazz Presentation to
Consumer Council L

Presentation points of note:


- Palliative refers to care for individuals who have been identified as having an illness, condition or disease that will ultimately end their life.
- There are 3 types of trajectories that benefit from high quality palliative care services. Those being:
 - Rapid progression illness (e.g. Cancer)
 - Erratic progression (e.g. COPD)
 - Slow progression (e.g. Dementia)
- The palliative care approach is relevant to carers and staff across the entire health system (community, hospital, general practice, residential care facilities, retirement villages, and hospice).
- Current system and models of care are ill equipped to cope with forecasted future demand.
- Sub-regional forums have been held to hear stories from career and families to identify required system changes, and what is most important to them.
- The strategies goal is to create greater system integration that puts the patient and their family/whanau at the core of every decision that is made.
- The strategy outlines the goal for each step of the palliative care patient journey:
 1. Self-management – it is important that people are told they have a life limiting illness and conversations begin early.
 2. Planning – Coordinated Assessment and Care Planning – a plan that follows the patients with a clear pathway to support service transitions and transfers.
 3. Integration – one integrated palliative care system with formalised ways of working with a single point of service facilitation and technology to support this.
 4. Quality – Building capability and capacity.
 5. Last Days of Life
 6. After Death Support – having a range of services to support patients/whanau as end of life approaches which continues into bereavement.

Discussion points of note:

- Information sharing and security between Oncologists, GP's etc. will be achieved by having one shared care planning platform. A 3DHB project is currently underway to develop one IT system to achieve this. Current workarounds are:
 - Staff working across various computer applications / systems

<ul style="list-style-type: none"> ○ Face to face meetings between the patient and their family / whanau, and all health care personnel involved in their palliative care planning. ○ Specific facilitator who assists in developing a coordinated approach with various providers. ○ Patients being encouraged to hold their own records at home <ul style="list-style-type: none"> • Deb Peters noted that it is important that the general public are aware of these developments. • Chris Harrington noted that the strategy needs to be written in a language that consumers can understand. • Modelling criteria for identifying patients requiring a palliative care approach is based on a UK model called Supportive and Palliative Care Indicators Tool (SPICT). More information can be found here: https://www.spict.org.uk/ <p>Prabha Ravi thanked Jazz for her presentation and noted that it is an incredibly complex area, especially in regards to data recording and ensuring cultural requirements are met.</p> <p>The Consumer Council members applauded Jazz for her presentation and look forward to her update in the new year.</p>	<p>2.3 <u>Mental Health Strategy</u></p> <p>Rod Bartling presented on the 5 year strategic direction of the Mental Health Strategy.</p>  <p>MH Presentation to Consumer Council 1</p> <p><u>Presentation points of note</u></p> <ul style="list-style-type: none"> • A detailed action plan and Population Outcomes Framework is due for development by August 2019. This will feed into the high level 5-year investment plan which is due by December 2019. • 5-6 courses on Mental Health 101 awareness have been delivered, some of which have been delivered in a Marae based setting. The Ministry of Health have been running these courses across the country and will be looking to running them again in 2020. <p><i>Action: Rod Bartling will advise Christine Rabone of dates when feedback / input will be sought from the Consumer Council members on the Mental Health Strategy.</i></p> <p><i>Action: Rod Bartling will advise Christine Rabone when these courses are available again to enable Consumer Council members the opportunity to attend.</i></p> <ul style="list-style-type: none"> • Currently waiting to see how the Mental Health budget will be rolled out and how best to utilise these funds within our community. <p><u>Discussion points of note:</u></p> <ul style="list-style-type: none"> • Toshya Rapana noted the current gap in services for intermediate and primary school aged children and how the responsibility is being left to teachers who are not always equipped to deal with the more serious issues. • Noted that Hubs are in their early stages and have the potential to be physical or virtual. This is early thinking and an initiative that is being led by the CCDHB. <p><i>Action: members to email Christine Rabone with any further questions they would like passed on to Rod Bartling for comment.</i></p> <p>Prabha thanked Rod for his highly anticipated presentation.</p>
BREAK	
<p>2.2 <u>ELT Update</u></p> <ul style="list-style-type: none"> • Nil 	<p>3. <u>Members Only Session</u></p> <ul style="list-style-type: none"> • Names of those who would like to be considered for the Mental Health 101 courses in 2020 have been passed onto Christine Rabone. • Names of those who wish to attend the Website Refresh workshop have been passed onto Christine Rabone who will inform the organiser.

Next Meeting
14 August 2019 6pm – 9pm Board Room, Hutt Valley DHB

		BOARD DECISION PAPER
		Date: 01 August 2019
Author	Andrew Blair, Board Chair	
Subject	Resolution to Exclude the Public	
RECOMMENDATIONS It is recommended that the Board: <ul style="list-style-type: none"> a) AGREES that the public be excluded from the following parts of the of the Meeting of the Board in accordance with the NZ Public Health and Disability Act 2000 ("the Act") where the Board is considering subject matter in the following table; b) NOTES that the grounds for the resolution is the Board, relying on Clause 32(a) of Schedule 3 of the Act, believes the public conduct of the meeting would be likely to result in the disclosure of information for which good reason exists under the Official Information Act 1982 (OIA), in particular: 		

SUBJECT	REASON	REFERENCE
Public Excluded Minutes	For the reasons set out in the 27 June 2019 Board agendas	
Public Excluded Matters Arising from previous Public Excluded meeting	For the reasons set out in the 27 June 2019 Board agendas	
Chief Executive's report	Information contained in the paper may be subject to change as the information has not yet been reviewed by the FRAC Paper contains information and advice that is likely to prejudice or disadvantage negotiations	Section 9(2)(f)(iv) Section 9(2)(j)
Clinical Council report	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations.	Section 9(2)(i)(j)
Sub-committee draft minutes		
Lead DHB model MHAIDS		
Radiology equipment upgrade and refurbishment tender		
Register of Board Chair executed documents		
Adverse Event HDC Coroner Update	Paper contain information that is likely to prejudice the privacy of natural persons, including that of deceased natural persons.	Section 9(2)(a)
Maternity refurbishment update		
MHAIDS operating model		
Final 2019/20 Annual Plan	Subject to Ministerial and/or Cabinet approval	Section 9(2)(f)(iv)
NZ Health Partnerships Statement of Performance Expectations	Subject to Ministerial and/or Cabinet approval	Section 9(2)(f)(iv)

* Official Information Act 1982.



133 Molesworth
Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

1 July 2019

Mr Andrew Blair
Chair
Hutt Valley DHB
Private Bag 31907
LOWER HUTT 5010

Dear Andrew

Board decision-making and communications in the district health board election period

The 2019 district health board (DHB) election period is almost upon us. The election period poses particular challenges for DHBs, boards and members, to ensure that policies which touch on election-related matters are being appropriately followed.

This letter provides general guidance around issues that often arise in the context of the elections. I would appreciate it if you could bring it to the attention of all board members.

Board decision-making

The general practice with the local body and DHB elections is to treat the three months before the elections as the 'pre-election period'. The pre-election period, and the weeks after the election before new board members take office, is a sensitive time when additional protocols are frequently required. In 2019, the pre-election period will start on 1 July, the date of the commencement of the Electoral Commission campaign, with new board members due to take office on 9 December (58 days after election day on 12 October).

The makeup of boards may change significantly once election and appointment processes are completed. Given this, binding long-term significant decisions – such as signing off new plans and making key appointments (for example, to the Chief Executive Officer position) – should be approached with additional caution during this time. However, because the pre- and post-election period is close to five months long, it would be impractical for boards to entirely restrict their decision-making to minor or non-controversial matters.

In the past, we have observed that it is helpful for new board members to be given observer status at board meetings from the time final results are announced until they take office on 9 December. While this is a decision for each individual board to make, it may allow for a smoother transition from the current membership to the new board.

Communications

The following guidance on communications is based on the Auditor-General's report, *Good Practice for Managing Public Communications by Local Authorities*, which is available on the Auditor-General's website at: <http://www.oag.govt.nz/2004/public-communications>. A copy is also attached for your reference. Although the report's main focus is on local bodies, it contains useful information that is also relevant to DHBs at election time. This includes a principles-based approach to looking at communicating with the public, which will be of interest if your DHB is planning communications around health topics such as fluoridation.

Comments from the Auditor-General's report on the 2014/15 local government audits are also useful.¹

Communications by DHB board members

All communications by board members, acting in that capacity, should be guided by relevant DHB and board policies. The Auditor-General has suggested that local authorities look out for the following risks:

- the use of publicly-funded (or in the case of DHBs, board-funded) events as a platform for incumbent members to promote their achievements; In the pre-election period, board members may wish to consider actively reducing the number of major events they attend
- the use of newspaper columns and other communication channels, in case they change from being a useful vehicle for communicating ordinary business to something that could be seen as a vehicle for political campaigning.

Board members should be reminded that they are often aware of matters of high sensitivity or confidence, and that these confidences must be strictly maintained. Members have a legal duty under section 57 of the Crown Entities Act 2004 not to disclose information obtained in their capacity as board members that would not otherwise be available to them. Members should also be aware of their other individual duties under sections 53 to 56 of the Crown Entities Act (that is, to comply with the Crown Entities Act and the New Zealand Public Health and Disability Act 2000; to act with honesty and integrity; to act in good faith and not at the expense of the DHB's interests; and to act with reasonable care, diligence and skill).

Communications by DHBs

DHBs should not promote, or be perceived to be promoting, the re-election prospects of a sitting board member or any other candidate. Therefore, any use of DHB resources – such as stationery, postage, internet, email or phone – by members for re-election purposes – is unacceptable and a possible breach of the principles of the Local Electoral Act 2001.

A DHB's communications policy should also recognise the risk that communications by or about members (in any capacity as spokesperson for the DHB) during the pre-election period could result in the member achieving an electoral advantage at taxpayers' expense. The DHB's Chief Executive Officer should actively manage this risk.

Established DHB communication channels (for example, websites, newsletters, and 'advertorial' content in newspapers) may also present a risk during the pre-election period. This is because they could have the effect of raising a board member's personal profile in a manner that may appear to promote their re-election. For example, a photograph of a board member launching a DHB initiative in a board magazine may not be appropriate in the pre-election period because it could have the effect of raising that member's profile in the community.

This does not mean that a DHB should cease to publish news and information that is relevant to its activities. Rather, caution should be exercised over such matters. For example, while board member profiles should be removed from a DHB's website in the pre-election period, it would be appropriate to have the candidate profile statements of all candidates on the website once these are available to be published.

The Auditor-General has also cautioned local authorities about ensuring that their annual reports and annual report summaries do not have the effect of promoting or favouring existing members who are candidates for re-election. DHBs are asked to monitor any accountability documents that may be published in the pre-election period to ensure that they also meet these expectations.

¹ <http://www.oag.govt.nz/2016/local-govt/part5.htm> – see Part 5, 'Local body elections'.

Communications from DHB staff

Chief Executives are advised to brief staff about the risks of inappropriate communications that may be perceived as a staff member contributing directly to the political debate and supporting a particular side. DHBs may wish to introduce special or temporary procedures in the pre-election period that cover such matters, and also set out protocols for dealing with media enquiries very clearly.

Another issue to manage is the contact between staff and those who are working on election campaigns. Candidates and their staff may ask for information about current activities, policies and costs. It is important that election candidates are treated equally in these circumstances and that the information they receive is neutral and factual. Protocols to ensure the equal treatment of requests from current members and candidates can provide important protection.

I trust that you find this information useful. Should you require clarification around any of the matters raised in this letter, Lisa McPhail, Chief Advisor, DHB Appointments Project, would be happy to assist. You can contact Lisa on 021 719 865 or lisa.mcphail@health.govt.nz.

Yours sincerely



Sarah Turner
Deputy Director-General
Office of the Director-General

cc Dale Oliff, Acting CEO, Hutt Valley DHB, dale.oliff@huttvalleydhb.org.nz
Bruce Hodgins, bruce.hodgins@huttcity.govt.nz

Encl.



**The Controller and
Auditor-General**
Tumuaki o te Mana Arotake

**Good Practice
for Managing
Public Communications
by
Local Authorities**

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Foreword

We first published our *Suggested Guidelines for Advertising and Publicity by Local Authorities* in 1996. We published a revised version of those *Guidelines* in 1999.

Since 1999, a number of factors have contributed to significant change in the environment in which local authorities are involved in “advertising and publicity”. Probably the two major factors are the advances in communications technology and the rate of adoption of the new technology, and (more recently) the enhanced requirements for communication in the Local Government Act 2002.

We saw as a consequence of that significant change the clear need to revisit the *Guidelines* to reassess their validity and determine what changes might be needed to preserve their usefulness. This publication reflects the fresh approach we have taken to the subject – still principles-based, but with an emphasis on the wider concept of “communication” rather than “advertising and publicity”.

As previously, this update represents what we believe is a code of good practice. The guidance it contains is no more authoritative than that. Further, the guidance is intended neither to be an operating manual nor to cover every conceivable situation.

Local authorities will have to determine what practical application they make of our good practice guidance in particular situations. To do so, and to reflect the more open approach to disclosing how local government manages itself, we recommend that the adoption and application of the guidance in this publication be incorporated in a formal communications policy.

A handwritten signature in black ink, consisting of a series of loops and a long horizontal stroke, identifying K B Brady.

K B Brady
Controller and Auditor-General

14 April 2004

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1 Introduction

The importance of Council communications

- 1.1 Communication with the public is a major part of any Council's activities. It can consume large amounts of ratepayers' money.
- 1.2 Some types of public communications are mandatory – for example, notifying Council meetings, or issuing a statutory plan for consultation. Others are discretionary – for example, a Council-funded newsletter, a media release explaining a recent decision, or a pamphlet about disposal of household waste.
- 1.3 Councils communicate with the public by many different means. For any communication, a Council has a broad range of choices – both as to the medium to be used (e.g. whether to pay for newspaper advertising or use the Council's web site) and the degree of sophistication involved.
- 1.4 Choice introduces judgment and subjectivity. The dilemma of the communicator is in reconciling the potentially conflicting criteria of:
 - making the communication attractive so that the audience will give it their attention, absorb it, understand it, and (if that is what is expected) act on it;
 - meeting acceptable standards of probity; and
 - presenting accurate, complete, and fairly expressed information.
- 1.5 The skill required of the communicator is to observe the relevant principles and apply the highest possible standards, and, importantly, to learn from experience.

Why this guide?

- 1.6 Communication of information at public expense or in an official capacity always carries the risk of criticism. The commonest complaints (except for statutory notifications) are that a communication is unnecessary, unbalanced, or politically biased. The best defence to any complaint is that the communication meets acceptable standards.
- 1.7 The Auditor-General is often asked to express a view on whether a particular communication is acceptable. Some requests come from the Council, before publication. Others come from members of the public afterwards, complaining about what has been done.

- 1.8 Until 1996, there was no authoritative guidance as to what standards were acceptable in Council communications. Our suggested guidelines – first published in that year, and now updated for the second time – have aimed to fill that vacuum. Just as we bring an independent perspective to our job as the auditor of local authorities, we try to describe good practice that reflects not only the theory and practice of communications but also the expectations of the public.
- 1.9 We derive our guidance from:
- our knowledge of the kinds of official communications that may cause concern in both the central and the local government sectors;
 - our experience, not only in giving help to communicators but also in dealing with complaints from the public; and
 - our consultations with a range of Council communications staff and advisers and with Local Government New Zealand.
- 1.10 The feedback we received from our consultations was that independent guidance is a valuable and necessary aid, not only for Council Members but also for communications staff and advisers. Guidance can:
- provide a general framework for the conduct of a Council's communications activities;
 - help with clarifying roles and responsibilities – especially as between Members and communications staff and advisers; and
 - set benchmarks for particular types of communications – especially as to what is acceptable in the political context and at critical times such as during a pre-election period.

The objects and scope of the guide

- 1.11 The statements of good practice in this guide are designed to meet three objectives in relation to a Council's communications practices:
- to ensure that Council communications resources are applied effectively and efficiently, and in a manner that produces good value for money;
 - to ensure that those who are permitted to use Council communications facilities do so for legitimate purposes; and
 - to promote appropriate standards of conduct by those who consume Council communications resources, or use Council facilities, or otherwise communicate on behalf of the Council.

- 1.12 This wide scope is consistent with our role as the auditor of local authorities, which includes examining the extent to which they, and their members and staff:
- carry out activities effectively and efficiently, consistent with Council's own policies;
 - comply with statutory obligations;
 - avoid wasteful use of resources; and
 - act with probity and financial prudence.¹
- 1.13 The guide itself is produced under the authority of section 21 of the Public Audit Act, as a report on matters arising out of the performance and exercise of those functions.

What is the status of the guide?

- 1.14 Our guidance is not binding on Councils. Each Council is free to adopt its own standards – which must of course be consistent with the relevant principles of the Local Government Act 2002 (LGA).²
- 1.15 We recommend that every Council consider adopting a formal communications policy framed to suit its particular needs. The policy should:
- embrace these guidelines – or a variation of them (stricter or otherwise) that the Council considers appropriate to its circumstances; and
 - clearly direct Members and communications staff and advisers³ on how the policy is to be applied in particular cases.
- 1.16 Although this guide is not binding on Councils, they and the public should be aware that it establishes the criteria that we will use in future in order to form a view on the appropriateness of a Council's public communications.

¹ Public Audit Act 2001, section 16.

² Section 14 of the LGA.

³ Including those engaged as consultants.

2 Scope – What are “Communications”?

2.1 Our guidance applies to any communication by a Council, or a Member or employee or office holder of a Council, or a Member of a Community Board, where:

- the Council meets the cost (wholly or in part); or
- the person making the communication does so in an official capacity on behalf of the Council or a Community Board.

2.2 We make no distinction between:

- mandatory and discretionary communications;
- communications in the Council’s own publications and the news media generally;
- Council-funded advertisements and other forms of publicity; or
- electronic (including web site or e-mail) and hard copy publication.

The underlying principles are the same in each case.

2.3 Common examples of communications by Councils include:

- statutory documents – such as draft, final, and summary versions of the Long Term Council Community Plan or an Annual Report under the LGA;
- information on a web site, or in a poster or pamphlet, about Council services available to the public, or the rights, entitlements, and responsibilities of people affected by a Council activity;
- newspapers and newsletters reporting Council news and activities;
- material explaining a particular proposal, decision, policy, or bylaw of the Council;
- marketing material promoting the Council, its communities, or a regional brand;
- Council-funded advertising about a particular event, proposal, or Council policy;
- educational material about issues affecting the community; and
- media releases initiating or responding to public comment about matters affecting the Council or its communities.

- 2.4 In a different category are communications by Members using Council resources or facilities. We address this type of communication in paragraphs 4.33-4.40 on pages 19-20.
- 2.5 The guide does not apply to:
- normal day-to-day correspondence between Members and their constituents on appropriate matters, *except* during a pre-election period when the content of the correspondence should not be inconsistent with Principle 12 on page 22; and
 - communications by Members using their own resources.

3 Communications – Whose Responsibility?

- 3.1 Corporate governance principles stress the different roles of the governing body and the management of an organisation. For local authorities, section 39 of the LGA reflects these principles.
- 3.2 Members (i.e. the governing body) and management of a Council share different elements of the communications function. In essence:
- Members are accountable to the community for the Council’s decisions and actions. What the Council says in its communications is, therefore, ultimately the Members’ responsibility.
 - The mechanics of communications are operational activities, which form part of the everyday business of the Council. Moreover, effective communication often requires professional input. Most Councils employ (or engage on contract) professional advice and assistance for some or all of their communications activities. The chief executive is responsible for the effective and efficient management of those people and their activities.
 - Communications is also an area of risk. Those who are authorised to communicate on behalf of a Council, and those who exercise editorial or quality control, need to have access to sources of professional advice when necessary (including legal and strategic communications advice). Obtaining that advice is also a management responsibility.
- 3.3 The communications function thus straddles the divide between governance and management in the Council organisation. Each Council should allocate the respective roles and responsibilities according to its own size and needs. For example, in a small Council the Mayor might be the primary spokesperson on all issues, whereas in a larger Council the role might be shared between the Mayor and a communications manager.
- 3.4 The governance/management divide also affects the crucial elements of policy development, quality control, and editorial supervision. We think these elements are best regarded as management functions, for which the chief executive is responsible.
- 3.5 The respective roles and responsibilities need to be well understood by all concerned and put into practice effectively.⁴ This is especially important when the Council employs professional communications staff – who could, for example, feel undermined by Members intervening in editorial decisions.

⁴ See section 39(e) of the LGA. The local governance statement required by section 40 of the LGA could be the appropriate place to record particulars of the division of roles and responsibilities.

- 3.6 A useful approach is to regard the roles of Members and management as complementary, and to encourage everyone to work together in partnership for the good of the Council and the community.

4 Principles and Practice

- 4.1 In this section we set out 13 principles that we believe should underpin a Council's policy and practice on communications. We supplement each of the principles with commentary.
- 4.2 We stress that the principles are intended as general statements, which are to be applied in a flexible and common sense manner. Likewise, the commentary cannot expect to foresee all possible situations that might arise.

Legitimacy and justification

Principle 1 –

A Council can lawfully, and should, spend money on communications to meet a community's (or a section of a community's) justifiable need for information about the Council's role⁵ and activities.

- 4.3 Communications are a necessary and legitimate Council expense. Councils are also justified in employing, or otherwise engaging, professional advice and assistance for their communications activities.
- 4.4 However, no communication should be undertaken without justification or regard for the cost.
- 4.5 The main elements of justification are:
- establishment of an identifiable need for information on the part of a particular audience;
 - the chosen method of communication should be one that is effective in reaching those who have the need; and
 - once the method has been identified, the communication should be made in the most cost-efficient manner.
- 4.6 Consideration should also be given to evaluating the effectiveness of the communication. What is known to have been an effective communication supports the justification for that communication and can be a benchmark to support future communications.

⁵ *The role of a local authority is to—*
 (a) *give effect, in relation to its district or region, to the purpose of local government ...;*
and
 (b) *perform the duties, and exercise the rights, conferred on it by or under this Act and any other enactment.*
 (LGA, section 11)

- 4.7 A communication will be lawful when it:
- is authorised by a Council resolution or under a delegation; and
 - complies with any specific legal requirements as to form, content⁶, timing, or method of publication⁷.
- 4.8 A Council can also exercise significant power over individuals and groups in the community. Consequently, a Council has an obligation to ensure those people know how they are being affected by the Council's actions, and what their rights and responsibilities are in relation to those actions.
- 4.9 Council communications are all the more important in the environment of the LGA. Consultation with the community is fundamental to the working of the Act, and effective communication is vital to effective consultation.

Principle 2 –

Communications should be consistent with the purpose of local government⁸ and in the collective interests of the communities the Council serves.

- 4.10 A Council is a corporate entity, with statutory role and purpose. The role and purpose include promoting the well-being of communities in its district or region. A Council may serve many communities, both in the geographical sense and in the sense of communities of interest. It should always act within the scope of its role and purpose, and in the collective interests of its communities.
- 4.11 Sometimes, a Council will need to communicate with only some of its communities about a particular issue, or with part of a community. But it should always be able to justify any communication as being in the collective interests of them all.

⁶ Including the avoidance of defamatory comment, or misleading or deceptive conduct under the Fair Trading Act 1986.

⁷ E.g. use of the special consultative procedure under the LGA.

⁸ *The purpose of local government is—*

(a) to enable democratic local decision-making and action by, and on behalf of, communities; and

(b) to promote the social, economic, environmental, and cultural well-being of communities, in the present and for the future.

(LGA, section 10)

Principle 3 –

Communications should comply with any applicable Council policies and guidelines as to process (including authorisation) and content.

- 4.12 We encourage all Councils to adopt a policy on communications: see paragraph 1.15 on page 9.

Collective position

Principle 4 –

Communications on Council policies and decisions should reflect the collective position of the Council.

- 4.13 Wherever possible, the Council should “speak with one voice”, and its communications should represent the corporate or collective position.
- 4.14 A communication by an authorised spokesperson appointed by the Council (whether that person is a Member or an employee) should identify that person in his or her official capacity (for example, as a Committee chairperson). The purpose of the communication should always be to meet the Council’s, not the spokesperson’s, communications objectives. The person responsible should be careful to ensure that what is being said is portrayed as the Council’s position, not the personal views of the spokesperson.
- 4.15 Some Councils allow the Mayor to produce a regular “column” in a Council-funded or other local publication, or to make regular broadcasts on local radio or television. The purpose of such communications should be to give voice to the Council’s corporate position on its activities, through the elected leader.
- 4.16 Communication of a Member’s personal perspective, views or opinions (including in a regular “column”, broadcast, etc) should be the exception rather than the rule, and should be subject to Principles 9 to 11 (see pages 19-21).

Principle 5 –

Communications on Council business should always be clearly attributed to the Council as the publisher.

- 4.17 A communication might, for example, identify the Council by reference to the name of the Council or by use of its corporate logo. A communication designed to meet the Council’s statutory obligations (such as a draft annual plan) should not only say who authorised its publication (usually the chief executive officer) but also identify the statutory provision under which it is being published.

- 4.18 For commentary about the identification of sponsors, see paragraphs 5.3-5.7 on pages 25-26.

Standards of communication

Principle 6 –

Factual and explanatory information should be presented in a way that is accurate, complete, fairly expressed, and politically neutral.

- 4.19 **Accurate** means what it says. That which is held out to be true should be founded on ascertainable facts, and be carefully and precisely expressed consistently with those facts. No claim or statement should be made that cannot be substantiated.
- 4.20 A communication will be **complete** when it consists of all the information necessary for the audience to make a full and proper assessment of the subject matter.
- 4.21 Information will be **fairly expressed** when it is presented in an objective, unbiased, and equitable way. In particular:
- the audience should always be able to distinguish facts from analysis, comment, or opinion; and
 - when making a comparison, information should state fully and accurately the nature of what is being compared, and inform the audience of the comparison in a way that does not mislead or exaggerate.
- 4.22 Information will be **politically neutral** when it presents the Council's collective position, or, where there is no collective position, sets out the issues in a manner that does not refer to the positions taken by any individual Member or political party or group of Members.

Consultation and public debate

Principle 7 –

Communications about matters that are under consideration by the Council, or are otherwise a matter of public debate, should present the issues in an even-handed and non-partisan way.

- 4.23 Communications about matters that will be the subject of a future decision by the Council should be distinctly different from those that follow a decision.

- 4.24 In the “before” phase, all relevant facts and other considerations should be taken into account, and all significant points of view should be aired. The aim is to enable the Council to make itself aware of, and then to have regard to, the views of all its communities in relation to a particular decision⁹, while also meeting all its statutory obligations in respect of consultation¹⁰.
- 4.25 In particular, a “before” phase communication should:
- avoid the appearance and reality of bias or pre-determination – especially when summarising facts or arguments;
 - present the issues in an objective manner, avoiding subjective opinion or comment; and
 - mention both the advantages and the disadvantages of particular options.
- 4.26 Mention of individual Members’ or political parties’ positions should always be avoided.
- 4.27 In the “after” phase, the emphasis should be on what has been decided and its implications for the Council and its communities.
- 4.28 This principle applies whether the purpose of the communication is to satisfy LGA requirements, or otherwise.

Principle 8 –

If engaging in public debate with an interest group or a section of the community, a Council should use the news media (rather than a Council funded publication) and designated spokespersons (rather than professional communications advisers) unless there is a particular justification for not doing so.

- 4.29 A Council may be justified in responding to publicity that is unfair, unbalanced, or inaccurate. The object should be to put the record straight, including a measure of rebuttal.
- 4.30 But it is important to keep a balance and perspective. Council resources should not be used merely to engage in a public argument.
- 4.31 The preferred approach in such cases should be to make use of the news media, through release and publication of a written statement or making an authorised spokesperson available for interview. Use of Council-funded publications or professional advisers to engage in debate with interest groups could create the perception that Council resources are being used for the benefit of one section of the community against another, or in a way that results in an unequal public relations contest.

⁹ LGA, sections 14(1)(b) and 78.

¹⁰ LGA, sections 82-90.

- 4.32 An example of where a Council-funded publication to engage with an interest group could be justified is when the group has issued public statements encouraging citizens to commit acts of civil disobedience or to actively break the law.

Communications by Members

Principle 9 –

If the Council's Communications Policy permits them, communications by Members of their personal perspective, views or opinions (as opposed to communication of Council matters in an official capacity) should:

- be clearly identified as such; and
- be confined to matters that are relevant to the role of local authorities¹¹.

- 4.33 Members are collectively responsible for Council decisions. Communication of Council business to the community often falls to a designated spokesperson. See Principle 4 and paragraphs 4.13-4.15 on page 16.
- 4.34 But Members are also individually responsible to the communities that elected them. It is for the Council to decide whether and, if so, on what terms to make resources available to Members to communicate with constituents or the wider community in their capacity as individual Members.
- 4.35 An example of a communication that could involve a Member expressing personal views is a "Members' column" in a Council-funded newspaper or on a Council web site.
- 4.36 It is important that the Communications Policy, and the relevant part of the communications budget, also sets out clearly the limits in relation to such communications. The policy should say:
- What types of communications are permitted and in what circumstances, and the range of permitted subject matter.
 - Whether the material can or should be subject to editing and, if so, by whom.
 - What procedures apply in respect of authorisation, attribution, and editorial and quality control. These are for the Council to determine. However, whether or not material is edited, the Member must formally subscribe to what is being published.

¹¹ Under sections 10 and 11 of the LGA – see footnotes 5 (page 14) and 8 (page 15).

- 4.37 Note, however, that a Member's freedom to talk about Council business is subject to confidentiality requirements (such as under Standing Orders) and the Council's Code of Conduct – especially as regards Members' conduct towards each other and their disclosure of Council information.¹²
- 4.38 Here are our views on some other examples of a Member communicating personally:
- It is not appropriate for a Member to use a Council newsletter or web site to express views on a matter of central government responsibility (such as defence and foreign relations) that has no direct bearing on the Council's activities.
 - It may be appropriate (but only when the Council is undertaking no formal consultation process) for a Member to use Council facilities to consult with the public on an issue under consideration by the Council, or to explain his or her position on a contentious decision, but not to seek political support on an issue that the Council has not considered. References to, or the use of a logo or slogan of, a political party or grouping are unacceptable.
 - Members should not be permitted to use Council communications facilities for political or re-election purposes. (See Principles 12 and 13 on pages 22-24 for more information on communications in the pre-election period.)
 - Staff protocols on the use of the Internet, e-mail, and other communications facilities for personal purposes should also apply to Members. The minimal cost of allowing use of such facilities can easily be outweighed by the perception that public resources are being misused.

Principle 10 –

Politically motivated criticism of another Member is unacceptable in any Council-funded communication by a Member.

- 4.39 Neither the inherently adversarial nature of much Council politics nor the right of free speech can justify Council communications resources being used to enable one Member to engage in political debate with, or to criticise, another Member. Preventing such misuse should be an objective of the Council's policy on where editorial control and the power to authorise communications should lie.
- 4.40 Members are, of course, free to use their own resources for such purposes.

¹² LGA, Schedule 7, clause 15.

Members' personal profile

Principle 11 –

Care should be exercised in the use of Council resources for communications that are presented in such a way that they raise, or could have the effect of raising, a Member's personal profile in the community (or a section of the community). In permitting the use of its resources for such communications, the Council should consider equitable treatment among all Members.

- 4.41 Two related objectives underlie this principle:
- It is important that the public know who their Councillors are. Councils are justified in using, or in some circumstances permitting Members to use, Council facilities for communications that have the objective of raising a Member's personal profile.
 - Giving a "human face" to a piece of information can be an effective communications strategy to attract attention and make the information relevant and understandable to its audience.
- 4.42 It is acceptable for Councils to use photographs of Members, personal quotes/attributions, and other standard journalistic techniques provided they are consistent with these objectives. However, Councils need to bear in mind the inherent risks of favouritism and unequal treatment of members.
- 4.43 For example, a "photo opportunity" shot, in a Council-funded publication, of a Mayor or Committee Chairperson announcing a Council decision helps to draw the reader's attention to the decision, and thereby improve the effectiveness of its communication, but could also have an unintended and beneficial spin-off effect for the Member's personal or political profile in the community.
- 4.44 Allowing Members representing a particular Ward to issue their own newsletter to constituents could have a similar effect. There is nothing wrong with such an idea in principle. However, the principle of equitable treatment makes it important that the same communications opportunity is available to Members representing other Wards. Matters such as editorial and quality control and attribution should also rest with the Council's communications staff in accordance with Council policy.

Communications in a pre-election period¹³

Principle 12 –

A local authority must not promote, nor be perceived to promote, the re-election prospects of a sitting member. Therefore, the use of Council resources for re-election purposes is unacceptable and possibly unlawful.

- 4.45 Promoting the re-election prospects of a sitting Member, directly or indirectly, wittingly or unwittingly, is not part of the proper role of a local authority.
- 4.46 A Council would be directly promoting a Member's re-election prospects if it allowed the member to use Council communications facilities (such as stationery, postage, internet, e-mail, or telephones) explicitly for campaign purposes.
- 4.47 Other uses of Council communications facilities during a pre-election period may also be unacceptable. For example, allowing Members access to Council resources to communicate with constituents, even in their official capacities as members, could create a perception that the Council is helping sitting Members to promote their re-election prospects over other candidates.
- 4.48 For this reason, we recommend that mass communications facilities such as –
- Council-funded newsletters to constituents; and
 - Mayoral or Members' columns in Council publications –
- be suspended during a pre-election period.
- 4.49 Promoting the re-election prospects of a sitting Member could also raise issues under the Local Electoral Act 2001. For example:
- Local elections must be conducted in accordance with the principles set out in section 4 of the Local Electoral Act – see Appendix 1 on page 27. The principles apply to any decision made by a Council under that Act or any other Act, subject only to the limits of practicality. A breach of the principles can give rise to an “irregularity” which could result in an election result being overturned.¹⁴

¹³ By “pre-election period” we mean the three months before the close of polling day for the purposes of calculating “electoral expenses”: see Local Electoral Act 2001, section 104. However, a Council may decide to apply restrictions over a longer period.

¹⁴ See *Aukuso v Hutt City Council* (District Court, Lower Hutt, MA 88/03, 17 December 2003).

- The publication, issue, or distribution of information, and the use of electronic communications (including web site and e-mail communication), by a candidate are “electoral activities” to which the rules concerning disclosure of electoral expenses apply.

4.50 “Electoral expenses”¹⁵ include:

- the reasonable market value of any materials applied in respect of any electoral activity that are given to the candidate or that are provided to the candidate free of charge or below reasonable market value; and
- the cost of any printing or postage in respect of any electoral activity.

4.51 A Member’s use of Council resources for electoral purposes could therefore be an “electoral expense” which the Member would have to declare – unless it could be shown that the communication also related to Council business and was made in the candidate’s capacity as a Member.

Principle 13 –

A Council’s communications policy should also recognise the risk that communications by or about Members, in their capacities as spokespersons for Council, during a pre-election period could result in the Member achieving electoral advantage at ratepayers’ expense. The chief executive officer (or his or her delegate) should actively manage the risk in accordance with the relevant electoral law.

4.52 Curtailing all Council communications during a pre-election period is neither practicable nor (as far as mandatory communications, such as those required under the LGA, are concerned) possible. Routine Council business must continue. In particular:

- Some Councils publish their annual reports during the months leading up to an October election, which would include information (including photographs) about sitting Members.
- Council leaders and spokespersons need to continue to communicate matters of Council business to the public.

¹⁵ Also defined in section 104.

- 4.53 However, care must be taken to avoid the perception, and the consequent risk of electoral irregularity, referred to in the commentary to principle 12. Two examples are:
- journalistic use of photographic material or information (see paragraph 4.42 on page 21) that may raise the profile of a Member in the electorate should be discontinued during the pre-election period; and
 - access to Council resources for Members to issue media releases, in their capacities as official spokespersons, should be limited to what is strictly necessary to communicate Council business.
- 4.54 Even if the Council's Communications Policy does not vest the power to authorise Council communications solely in management at normal times, it should do so exclusively during the pre-election period.

5 Other Commonly Arising Issues

Use of surveys and market research

- 5.1 Councils should target their communications resources to best effect. In appropriate cases, professional advice should be sought, and soundly obtained survey and market research information may be used.
- 5.2 Councils should meet acceptable standards in survey and market research information. To assist Councils to meet those standards:
- we reproduce in Appendix 2 on page 28 the ten principles identified by Statistics New Zealand underpinning its *Protocols for Official Statistics*; and
 - they can find useful guidance in the Statistics New Zealand publication *A Guide to good survey design*¹⁶.

Joint ventures and sponsorship

- 5.3 Many Councils seek to be involved with their communities, and may engage in collaborative ventures with other public agencies and business and community groups.¹⁷ Communication (for example, to promote public education or changes in people's behaviour) may be a feature of such ventures.
- 5.4 There is no reason in principle why a Council should not join with another agency or group to publish information for the benefit of the community – provided the activity is consistent with the Council's role and purpose. The use of private or community sponsorship for a Council communication may be a feature of such co-operation.
- 5.5 Examples of joint communication could include:
- a joint venture with the Police to issue information about individual and community safety in the Council's district; and
 - the use of business sponsorship for a Council advertisement of a community event.

¹⁶ ISBN 0-477-06492-2; revised July 1995. Copies can be ordered through the Statistics New Zealand web site at:
[www.stats.govt.nz/domino/external/web/prod_serv.nsf/htmldocs/A+Guide+to+Good+Survey+Design+\(2nd+edition\)](http://www.stats.govt.nz/domino/external/web/prod_serv.nsf/htmldocs/A+Guide+to+Good+Survey+Design+(2nd+edition))

¹⁷ Section 14(1)(e), LGA.

5.6 The Council's Communications Policy should, if the Council wishes to involve a partner, address:

- the types of communications for which joint ventures or sponsorship are appropriate; and
- the controls and procedures designed to manage the associated risks – such as perception of Council “capture” by a business or community group, actual or potential conflict of interest, and community attitude to the nature of the problem.

5.7 As a minimum, the Communications Policy should:

- require all mandatory communications to be funded solely by Council;
- require every communication joint venture or sponsorship proposal to be supported by a sound business case that is approved at an appropriate level within the Council organisation;
- set out the criteria for selecting a communication joint venture partner or sponsor, in order to avoid conflict of interest and prevent a partner or sponsor from gaining (or being perceived to gain) inappropriate commercial or political advantage;
- require both the Council and the joint venture partner or sponsor to adhere to the principles (including those in respect of editorial control) that it has adopted in the Communications Policy; and
- contain clear guidance as to the placement of logos, slogans, and other sponsorship references.

Appendix 1

Principles of the Local Electoral Act 2001

4 Principles

- (1) The principles that this Act is designed to implement are the following:
 - (a) fair and effective representation for individuals and communities:
 - (b) all qualified persons have a reasonable and equal opportunity to—
 - (i) cast an informed vote:
 - (ii) nominate 1 or more candidates:
 - (iii) accept nomination as a candidate:
 - (c) public confidence in, and public understanding of, local electoral processes through—
 - (i) the provision of a regular election cycle:
 - (ii) the provision of elections that are managed independently from the elected body:
 - (iii) protection of the freedom of choice of voters and the secrecy of the vote:
 - (iv) the provision of transparent electoral systems and voting methods and the adoption of procedures that produce certainty in electoral outcomes:
 - (v) the provision of impartial mechanisms for resolving disputed elections and polls.
- (2) Local authorities, electoral officers, and other electoral officials must, in making decisions under this Act or any other enactment, take into account those principles specified in subsection (1) that are applicable (if any), so far as is practicable in the circumstances.
- (3) This section does not override any other provision in this Act or any other enactment.

Appendix 2

Statistics New Zealand Principles Applicable to the Production of Official Statistics

- 1 The need for a survey must be justified and outweigh the costs and respondent load for collecting the data.
- 2 A clear set of survey objectives and associated quality standards should be developed, along with a plan for conducting the many stages of a survey to a timetable, budget and quality standards.
- 3 Legislative obligations governing the collection of data, confidentiality, privacy and its release must be followed.
- 4 Sound statistical methodology should underpin the design of a survey.
- 5 Standard frameworks, questions and classifications should be used to allow integration of the data with data from other sources and to minimise development costs.
- 6 Forms should be designed so that they are easy for respondents to complete accurately and are efficient to process.
- 7 The reporting load on respondents should be kept to the minimum practicable.
- 8 In analysing and reporting the results of a collection, objectivity and professionalism must be maintained and the data impartially presented in ways which are easy to understand.
- 9 The main results of a collection should be easily accessible and equal opportunity of access is enjoyed by all users.
- 10 Be open about methods used; documentation of methods and quality measures should be easily available to users to allow them to determine if the data is fit for their use.

A full copy of *Protocols for Official Statistics* can be obtained by contacting Statistics New Zealand through its web site www.stats.govt.nz .

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance



Mr Andrew Blair
Hutt Valley District Health Board
Private Bag 31 907
Lower Hutt 5040

12 JUL 2019

andrew@blairconsulting.co.nz

Tēnā koe Andrew

UPDATE: Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out an update to the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20. This builds on my December 2018 letter, attached for your reference. I want to emphasise that my strong focus remains on the expectations set out in that letter.

I also want to acknowledge your engagement with the important conversations we have been having on improving financial sustainability and clinical performance.

While I recognise there are a number of challenges, it is my expectation that DHBs ensure their local communities can access high quality sustainable services that deliver equitable outcomes.

Wellbeing Budget

Budget 2019 is about delivering better wellbeing for all New Zealanders and driving intergenerational change. There are five key priorities – taking mental health seriously, improving child poverty, supporting Māori and Pasifika aspirations, building a productive nation, and transforming the economy.

Budget 2019 builds on last year's Vote Health investment. A record \$19.871 billion is being invested for 2019/20 to support a stronger, more sustainable health and disability system.

Our Government has signalled a willingness not just to invest, but also to make the fundamental changes needed to deliver long term and sustainable change. Budget initiatives are also based around evidence on what will make the greatest contribution to the long term improvement of living standards and wellbeing.

Monitoring improved performance

High performing DHBs are needed to support the delivery of the Government's priorities. I am concerned about the sector's overall financial position, and some areas of service performance.

As you are aware I have worked with the Ministry of Health (Ministry) to ensure DHB performance is supported through a stronger performance programme. This will help DHBs to be more sustainable, and to improve financial and clinical performance to ensure better and more equitable outcomes for New Zealanders. I have made it clear that you have a responsibility to address the range of performance challenges in partnership with the Ministry.

Your DHB's performance will be reported to me regularly, and I support the use of data and benchmarking to identify variation as well as opportunities for improvement. This will also support collaboration across DHBs regionally and nationally to make the most of our collective capability. I expect all DHBs to contribute to, and participate in, such work to help ensure the system is safe, equitable, efficient, and maximises the resource use across the whole system.

Fiscal responsibility

I have made my expectations on improving financial performance very clear, and DHBs need to have a plan to return to financial sustainability.

You have been provided with your confirmed budget allocations for 2019/20 and I expect you to be considering ways to contain expenditure, including maximising available capability and resources in the system, tightly managing recruitment and staff leave, and improving consistency of clinical pathways and decision-making.

Continuing to do things in the same way as we are now is not sustainable operationally, clinically or financially. There will be a dedicated focus in 2019/20 on strengthening sustainability planning and establishing an on-going sustainability programme.

You will be aware that Budget 2019 invests an extra \$94.7 million over four years to help improve DHB financial sustainability. This new funding will enable DHBs to work more collaboratively across your regions, to share and build on best practice, to implement new service models that transform the way we use workforce and facilities, and to make the best use of the available funding and capacity in your region.

Capital investment

Budget 2019 invests \$1.7 billion over two years for capital investment projects, building on last year's investment to restore our hospitals and health facilities. This funding will be prioritised for mental health projects, high growth areas with increased demand, and health facilities that are no longer fit for purpose. I urge that in all investment, environmental sustainability be a significant consideration.

Some business cases for new infrastructure projects are already well advanced and have been indicatively prioritised for consideration. I expect this process to be completed with DHBs being advised of the outcomes in July/August 2019.

The Ministry of Business, Innovation and Employment is developing a new framework which will focus on skills development and training as a requirement of construction projects. New construction procurement guidelines will also be applied across government. I expect you to apply the changes to the procurement of new construction projects.

National Asset Management Plan

In the long term, we need to better map out future infrastructure requirements. This will enable the Government to make more informed decisions, and better prioritise remediation work and plan for new facilities.

I am pleased that you are actively supporting the National Asset Management Plan programme of work. I expect that any requests for information from the project team are responded to in a timely manner.

It is also my expectation that you will update your DHB's Asset Management Plans. These are a requirement of the Ministry, and will assist in the formulation of the capital investment pipeline, and the ongoing work on the National Asset Management Plan.

The Budget also provides some funding to lift capacity and capability within the Ministry, notably to establish a new health infrastructure unit that will provide better support to DHBs.

Update on my priority areas

Improving child wellbeing

As you know, child wellbeing is a key priority for this Government. I expect your annual plans to reflect how you are actively working to improve childhood immunisation coverage and eliminate inequity, especially for Māori.

As I have said in my earlier letter of expectations, I expect you to support the reduction of family violence and sexual violence through addressing abuse as a fundamental healthcare responsibility.

Improving mental wellbeing

Mental health and addiction is a top priority in the Wellbeing Budget with \$1.9 billion over four years being invested into a range of mental wellbeing initiatives and mental health and addiction facilities. These strongly align with the Government's response to He Ara Oranga, the report of the independent inquiry into mental health and addiction.

We have a unique opportunity to improve the mental health and wellbeing of all New Zealanders. We need to embed a focus on wellbeing and equity at all points of the system. We also need to focus more on mental health promotion, prevention, identification, and early intervention.

It is my expectation that you will work closely with the Ministry and key partners in your region to help drive this transformation; your leadership is essential.

Improving wellbeing through prevention

Our Government's vision is for a welfare system that ensures people have an adequate income and standard of living, are treated with respect, can live in dignity and are able to participate meaningfully in their communities. DHBs have an important and ongoing role working alongside social sector partners to improve the welfare and health system outcomes for their population.

I have introduced a new priority section in DHB annual plans, given the considerable overlaps between people engaging with the welfare system as well as the health and disability support system. Over half the proportion of working age people receiving a main benefit have a health condition or a disability, or care for someone with a health condition or disability.

Better population health outcomes supported by a strong and equitable public health and disability system

Planned Care

I am confident that the changes to how planned care is planned, funded and monitored will remove the current disincentives to developing better ways of delivering services.

The new planned care approach will enable DHBs to deliver more appropriate, timely, high quality services to support the health and wellbeing of New Zealanders. DHBs will be able to provide care in the most appropriate setting, with the right workforce.

There will also be a greater focus on equity, quality, and people's experience of our services. I expect DHBs to create robust plans for these services and to consistently meet volume, waiting time, and other quality expectations.

Cancer Action Plan

I have asked the Ministry to work with you and other stakeholders to develop a Cancer Action Plan. I expect you to support and drive the development of this important work, and to deliver on the local actions within your Plan.

Health Research Strategy Implementation

Research, evidence and innovation is critical to addressing inequities and in continuously improving the quality and outcomes of services provided.

I am aware that the Ministry is working with DHBs and other government agencies to develop a work programme to implement the Health Research Strategy. I encourage you to continue to work closely with the Ministry to progress this important work.

Workforce

DHBs have a key role in training our health and disability workforce. I expect that all DHBs continue to maintain a strong focus on this area to build capacity and capability, and to implement an equitable approach to funding professional development.

In your current annual plan I expect you to develop a sustainable approach to nursing career pathways, including actions to support equitable funding for professional development for nurse practitioners.

Care Capacity Demand Management

At the end of last year I outlined my expectation that DHBs are to implement Care Capacity Demand Management (CCDM) in line with the process and timetable set out in the 2018-2020 MECA.

I expect to see significant progress on CCDM implementation this year, as well as detailed planning to ensure full implementation by June 2021.

I expect you to confirm that you have met my expectation to include implementing CCDM in the performance expectations of your Chief Executive and that you are updating these expectations to include implementation in midwifery services.

Devolution of the pay equity appropriation

I have supported the devolution of the pay equity appropriation. I expect you to work with the Ministry to ensure a seamless transition of responsibilities.

The Ministry has an ongoing stewardship responsibility to ensure that Care and Support Workers (Pay Equity) Settlement Act obligations are met.

The Government's agenda to improve the health and wellbeing of New Zealanders is significant, as evidenced by the sizable investments being made. I am confident that DHBs will present strong plans to support delivery of our priorities and I am looking forward to seeing progress against both measures and activities during the year.

I have appreciated the willingness shown by DHB teams to focus on equity and outcomes, and have confidence that you will all embrace the direction and implement plans to deliver it.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

A handwritten signature in blue ink, appearing to be 'David Clark', with a stylized flourish at the end.

Hon Dr David Clark
Minister of Health

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance



Dear Chair

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

Fiscal responsibility

Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure

My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over \$10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan

I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution

I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce

I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening

The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care

I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability

Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures

As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health

The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery

High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025

I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment*Environmental sustainability*

I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight

As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy. This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water

You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration

Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

A handwritten signature in blue ink, consisting of a stylized 'D' and 'C' intertwined, enclosed within a circle.

Hon Dr David Clark
Minister of Health

REMEDIAL ACTION PLAN FOLLOWING ACC PARTNERSHIP AUDIT 2019

AUDIT ELEMENT PRIMARY	AUDIT ITEM	ACTION PROPOSED	RESPONSIBILITY	TIMEFRAME AND REVIEW
Element Two: Planning, review and evaluation	2.4.1 - No procedure to undertake self-assessments against the AEP Audit standard every twelve months.	Establish a process for Managers, Health & Safety Reps and Employee Representatives to engage in the Self-Assessment process.	Health & Safety.	By 5 August 2019.
	2.4.2 - A self-assessment (involving employee representatives) was not carried out against the audit standards for at least the last twelve months.	Carry out a full self-assessment.		By 5 August 2019.
		Carry out a further full self-assessment before scheduled AEP Audit in April 2020.		By 31 March 2020.
Element Four: Information, training and supervision	4.9.1 - Inability to demonstrate that current Emergency Wardens and Building Wardens have received specific training for their role.	(Note that at HVDHB the role of Fire Warden currently includes the role of Building Wardens). A full list of Fire Wardens will be updated and will identify those that have received training and those that require training.	Building & Facilities Manager	By 5 August 2019
Element Six: Employee participation in health and safety management	6.2.1 - Evidence was unable to be provided to support health and safety forums between health and safety representatives and management representatives, occurring at least quarterly over the last twelve months.	Health and Safety to schedule and diary monthly meetings with each of the 12 HSR Hubs and 3 monthly meeting of all 12 Hubs. Evidence of Meetings / Minutes to be provided.	HVDHB Health & Safety Advisor	By 5 August 2019
Element Seven: Emergency planning and readiness	7.2.2 - The organisation does not currently have an up to date list of all Area and Building Wardens and does not know if all Warden positions are currently filled.	(Note that at HVDHB the role of Fire Warden currently includes the role of Building Wardens). A full list of Fire Wardens will be updated and published to staff via internal Newsletter Daily Dose.	Building & Facilities Manager.	By 31 July 2019

AUDIT ELEMENT PRIMARY	AUDIT ITEM	ACTION PROPOSED	RESPONSIBILITY	TIMEFRAME AND REVIEW
	7.3.1 - Trial emergency evacuation drills have not occurred at least six monthly over the past twelve months. (nine-month gap between the last two trial evacuations)	A full evacuation was held on 23 May 2019. A further full evacuation will be held by 23 November 2019.	Building & Facilities Manager	By 23 November 2019.
Element Fourteen: Complaint and review management	14.1.2 – No register of complaints/concerns being maintained regarding the management of work-related injuries.	HVDHB to: Establish a Complaints Register and record any complaints received since last audit. Update the Injury Management section of the Intranet including posting of the Resolving Issues fact sheet and notify all staff through internal newsletter Daily Dose.	HVDHB Workplace Health & Safety	By 5 August 2019.
Element Sixteen: Assessment, planning and implementation of rehabilitation	16.3.4 - Rehabilitation plans reviewed identified gaps of over a month between the expiry date of the rehabilitation plan and the development of a new rehabilitation plan. This indicates that individual rehabilitation plans are not consistently updated to reflect the status of rehabilitation.	A copy of the Contract For Service engaging WellNZ to manage all claims management to be provided to ACC. WellNZ will ensure all claims requiring a rehabilitation plan have a task in their claims management system, Zephyr, for two weeks prior to the rehabilitation plan expiry date. This will also ensure that if the covering Case Manager is on leave, other staff are able to access the task list and complete any necessary action, i.e. update the rehabilitation plan.	HVDHB WellNZ Case Manager, overseen by Team Leader and Branch Manager	By 5 August 2019.

AUDIT ELEMENT PRIMARY	AUDIT ITEM	ACTION PROPOSED	RESPONSIBILITY	TIMEFRAME AND REVIEW
		The rehabilitation plan expiry date will also be detailed in the "comments" field on the front screen of each claim in Zephyr.		
Element eighteen: File reviews and case studies, confirmation of inquiry management procedures in action:	18.5.4 - Two of the three rehabilitation plans reviewed at audit did not contain evidence of being consistently updated to reflect the status of rehabilitation.	Evidence that the claims selected for audit have up to date IRP's. Each open claim will be reviewed at the monthly review of rehab meeting, with a specific focus on those claims with rehabilitation plans to consider the ongoing rehabilitation needs and ensure the rehabilitation plan has been updated to reflect these.	Wellnz Case Manager and HVDHB Health and Safety	By 5 August 2019



Finance Report

May 2019

Strategic enabler;  *Effective Commissioning*

Dale Oliff
Acting Chief Executive

Judith Parkinson
General Manager Finance & Corporate Service

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Financial Performance Overview

The month of May has a total unfavourable variance to budget of (\$1,286k) and favourable variance of \$1,805 year to date.

Key results YTD were:

Funder favourable by \$8,105, Governance unfavourable by (\$268k), Provider unfavourable by (\$6,032K)

The full year forecast is a deficit of (\$8,150) against a Budget deficit of (\$8,049k).

Material variances year to date

Total Revenue favourable \$5,074: Devolved MoH Revenue favourable \$3,055k, Non-Devolved MoH Revenue unfavourable (\$442k), ACC Revenue \$918k favourable mainly Plastic and Orthopaedics; Other Revenue \$270k favourable, IDF Inflows \$1,033k favourable, predominantly in acute and plastic surgery electives.

Personnel and outsourced Personnel unfavourable (\$7,473):

Medical unfavourable (\$1,954k); Outsourced medical is (\$1,043k) unfavourable, Internal staff (\$912k) unfavourable including (\$697k) strike costs.

Nursing unfavourable (\$4,521k); continued increased workload year to date and continued high use of minders.

Allied Health unfavourable (\$467k); driven by the recent MECA pay out which was greater than originally budgeted and additional funding.

Management and Admin; favourable \$152k, driven by favourable employee variance of \$703k, partly offset by Outsourced (\$551k) which includes savings targets.

Annual leave Liability cost has increased \$1,609k since May 2018, and there are approx. 39,577 outstanding leave days.

Sickness level for the month is 3.2%; this is higher than last month and lower than this time last year.

Outsourced other expenses unfavourable (\$1,519k) with overspends in clinical services of (\$1,375k), mainly driven by Radiology Outsourced (\$991k) and Breast surgery (\$77k) to manage volumes and vacancies, Ophthalmology (\$590k), offset by other savings.

Treatment related Costs favourable \$223k; Pharmaceuticals \$1,754k including Pharmac rebates, Leased Radiology equipment \$471k, offset by Implants and Prostheses (\$543k) and Treatment Disposables (\$927k) and other unfavourable variances.

Non Treatment Related Costs unfavourable (\$368k); Favourable variances on Consultants \$624k, offset by ITC Repairs and Maintenance (\$112k), Printing (\$172k), General Repairs and Maintenance (\$67k) Software License Fees (\$211k), Conference costs (\$70k), Bad Debts (\$33k), Transport & Travel (\$39k), Crockery & Hardware (\$54k) and Postal and Courier (\$106k).

IDF Outflow favourable \$3,831k; this includes favourable inpatients of \$1,995k mainly from under delivery of volumes by CCDHB.

Other External Provider Costs \$2,013k favourable; mainly related to Surgical inpatients \$2,321k, offset by Capitation (\$1,372k).

Hospital activity;

For the month of May Medical inpatient discharges continue to be above budget and above last year. Discharges for Surgical were lower than budget for the month and May last year. Year to date, case weights for Surgical are 5% higher than budget. Year to date case weights for Medical services are 4% higher than last year and 13% higher than budget. ED volumes for May were 16% higher than budget and year to date 5% higher than budget. The proportion of patients admitted (22%) for the month was lower than May last year (25%). Theatre visits for the year to date are 7% higher than budget and higher than this time last year.

Cash position averaged \$23.7m for May and \$10.1m for April and was \$2.7m at the end of May. The cash flow forecast is becoming tight and the DHB is expecting to go into overdraft in June.



Operating Results

Summary of the financial performance of the DHB for May 2019

Month					Hutt Valley DHB Operating Report for the month of May 2019	Year end Result					Annual	Annual			
Actual	Budget	Variance	Last Year	Variance	\$000s	Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
					<u>Revenue</u>										
35,953	35,828	124	34,585	1,368	Devolved MoH Revenue	397,169	394,113	3,055	376,268	20,901	433,147	429,942	3,205	410,594	22,552
1,551	1,646	(95)	1,595	(44)	Non Devolved MoH Revenue	17,591	18,033	(442)	17,051	540	19,355	19,828	(473)	18,746	609
594	554	40	612	(17)	ACC Revenue	6,985	6,067	918	5,628	1,356	7,587	6,620	968	6,221	1,366
828	488	340	1,052	(224)	Other Revenue	5,681	5,411	270	7,501	(1,820)	6,169	5,899	270	8,980	(2,811)
8,640	8,445	194	8,281	359	IDF Inflow	93,932	92,899	1,033	92,926	1,006	102,366	101,344	1,022	100,951	1,415
295	320	(26)	394	(100)	Inter DHB Provider Revenue	3,763	3,522	241	4,322	(560)	4,083	3,843	241	4,953	(870)
47,860	47,282	578	46,518	1,342	Total Revenue	525,119	520,045	5,074	503,696	21,423	572,707	567,475	5,232	550,445	22,262
					<u>Expenditure</u>										
					<u>Employee Expenses</u>										
5,750	4,948	(802)	4,487	(1,263)	Medical Employees	51,750	50,838	(912)	47,918	(3,832)	56,188	55,156	(1,031)	52,044	(4,143)
6,881	5,793	(1,087)	5,521	(1,359)	Nursing Employees	63,935	60,578	(3,357)	57,652	(6,283)	69,751	65,617	(4,134)	62,889	(6,861)
2,680	2,640	(39)	2,545	(135)	Allied Health Employees	27,497	27,211	(286)	25,381	(2,116)	30,048	29,514	(533)	27,819	(2,229)
761	615	(146)	600	(161)	Support Employees	6,915	6,413	(502)	6,411	(504)	7,505	6,947	(558)	6,995	(510)
2,404	2,511	107	2,358	(47)	Management and Admin Employees	24,965	25,668	703	23,488	(1,477)	27,199	27,852	653	25,578	(1,621)
18,475	16,508	(1,968)	15,511	(2,965)	Total Employee Expenses	175,061	170,707	(4,354)	160,849	(14,212)	190,689	185,086	(5,603)	175,325	(15,364)
					<u>Outsourced Personnel Expenses</u>										
356	188	(168)	478	122	Medical Personnel	3,113	2,071	(1,043)	4,366	1,252	3,447	2,259	(1,188)	4,558	1,111
191	74	(117)	116	(75)	Nursing Personnel	1,980	817	(1,164)	1,538	(442)	2,148	891	(1,257)	1,612	(536)
72	24	(48)	37	(35)	Allied Health Personnel	443	262	(180)	414	(28)	527	286	(240)	480	(47)
31	10	(21)	15	(16)	Support Personnel	292	111	(181)	152	(140)	302	121	(181)	196	(106)
(1)	59	60	4	5	Management and Admin Personnel	1,001	450	(551)	787	(214)	1,072	509	(563)	891	(180)
650	355	(294)	650	0	Total Outsourced Personnel Expenses	6,829	3,710	(3,119)	7,257	428	7,495	4,066	(3,429)	7,737	242
					Outsourced Other Expenses	8,361	6,842	(1,519)	8,855	493	9,151	7,490	(1,660)	9,265	115
2,882	2,292	(590)	2,531	(351)	Treatment Related Costs	23,670	23,893	223	25,123	1,453	25,497	25,736	239	27,876	2,380
1,594	1,531	(63)	1,639	46	Non Treatment Related Costs	17,204	16,836	(368)	15,783	(1,421)	19,013	18,434	(579)	17,894	(1,119)
7,994	8,136	143	7,889	(105)	IDF Outflow	85,666	89,497	3,831	84,392	(1,273)	93,802	97,633	3,831	93,040	(761)
17,297	18,102	806	16,986	(311)	Other External Provider Costs	190,979	192,992	2,013	185,367	(5,612)	208,937	210,801	1,864	202,382	(6,556)
2,144	2,183	39	1,957	(187)	Interest, Depreciation & Capital Charge	24,060	24,083	23	21,625	(2,435)	26,274	26,278	3	23,816	(2,458)
51,624	49,760	(1,864)	47,874	(3,749)	Total Expenditure	531,830	528,561	(3,269)	509,251	(22,579)	580,858	575,524	(5,334)	557,336	(23,522)
(3,764)	(2,478)	(1,286)	(1,356)	(2,407)	Net Result	(6,711)	(8,516)	1,805	(5,555)	(1,156)	(8,150)	(8,049)	(102)	(6,891)	(1,259)
Result by Output Class															
144	(548)	693	247	(103)	Funder	8,201	96	8,105	5,266	2,935	7,940	(159)	8,099	4,224	3,715
(65)	(8)	(57)	(5)	(60)	Governance	(277)	(9)	(268)	154	(430)	(264)	4	(268)	282	(546)
(3,843)	(1,921)	(1,922)	(1,599)	(2,244)	Provider	(14,635)	(8,603)	(6,032)	(10,974)	(3,661)	(15,826)	(7,893)	(7,932)	(11,398)	(4,428)
(3,764)	(2,478)	(1,286)	(1,356)	(2,407)	Net Result	(6,711)	(8,516)	1,805	(5,555)	(1,156)	(8,150)	(8,049)	(102)	(6,891)	(1,259)

There may be rounding differences in this report



May Month Results:

Unfavourable variance to budget of (\$1,286k) for the month; the main variances are detailed below:

1. **Revenue:** Total revenue favourable \$578k for the month.
 - Devolved MoH revenue \$124k favourable for May driven by PHO Capitation \$258k offset by other variances.
 - Non Devolved revenue (\$95k) unfavourable, driven by HWNZ Training revenue.
 - ACC Revenue \$40k favourable this month, driven by Community Health \$67k offset by other variances.
 - Other revenue \$340k favourable driven by rebates for Community Pharmacy.
 - IDF inflows favourable \$194k for the month predominately driven by Personal Health \$394k, partly offset by Mental Health (\$297k); and other small variances.
2. **Total Personnel** including outsourced unfavourable (\$2,262k) for the month.
 - Medical personnel incl. outsourced is unfavourable (\$970k) for the month. Outsourced costs are (\$168k) unfavourable for month Medical Staff Internal are (\$802k) unfavourable driven by strike costs (\$280k) and Statutory Leave (including time in Lieu) (\$246k).
 - Nursing incl. outsourced (\$1,204k) unfavourable for the month. Employee costs are (\$1,087k) unfavourable for the month, driven by Senior Nurses (\$164k), Registered Nurses (\$276k) Internal Bureau Nurses (\$201k) and Health Service Assistants (\$178k). Included in the Registered Nurses variance was the MECA impact of (\$150k). For all Nursing Employees the impact of Easter and ANZAC was recorded in May resulting in an unfavourable variance of (\$890k), including Statutory Leave (Including time in Lieu) (\$248k). Outsourced was unfavourable (\$117k), mostly driven by Nurses TWA (\$51k) and CATT (\$33k) with other minor variances.
 - Allied Health incl. outsourced (\$88k) unfavourable for the month, driven largely by the impact of MECA changes. The rate change compared to budget is estimated to be (\$106k) for May and (\$907k) YTD. Statutory Leave (including time in Lieu) had an unfavourable variance of (\$192k)
 - Support incl. outsourced unfavourable (\$168k) for the month, tradesmen and sterile supply.
 - Management & Admin incl. outsourced is favourable \$167k for the month internal staff favourable \$107k. Outsourced favourable \$60k. This includes savings targets.
3. **Outsourced other** favourable \$64k for the month, driven by Outsource Inpatient care \$52k.
4. **Treatment related costs** unfavourable (\$590k), driven by Treatment disposables (\$285k) and Pharmaceuticals (\$167k).
5. **Non Treatment Related costs** are unfavourable (\$63k) including ICT fees and Maintenance Costs.
6. **IDF Outflows** \$143k favourable for the month, mostly due to lower than expected activity at Capital and Coast DHB.
7. **Other External Provider** costs favourable \$806k driven by Pharmaceuticals \$273k, Mental Health providers \$164k, Health Promotion \$160k and Adolescent Dental Health \$100k.
8. **Interest, Depreciation & Capital Charge** favourable \$39k, driven largely by Depreciation \$34k.



Funder Financial Statement of Performance

DHB Funder (Hutt Valley DHB)
Financial Summary for the month of May 2019

Month					\$000s	Year to Date					Annual				
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Forecast	Budget	Variance	Last Year	Variance
Revenue															
33,092	33,092	0	32,073	1,019	Base Funding	364,016	364,016	0	351,344	12,672	397,109	397,109	0	383,574	13,535
2,860	2,736	124	2,512	348	Other MOH Revenue	33,152	30,097	3,055	24,924	8,228	36,038	32,833	3,205	27,021	9,017
62	47	15	104	(42)	Other Revenue	614	517	97	554	60	661	564	97	599	62
8,640	8,445	194	8,281	359	IDF Inflows	93,932	92,899	1,033	92,926	1,006	102,366	101,344	1,022	100,951	1,415
44,655	44,321	334	42,970	1,685	Total Revenue	491,714	487,529	4,185	469,747	21,967	536,174	531,850	4,323	512,144	24,030
Expenditure															
291	291	0	285	(6)	DHB Governance & Administration	3,176	3,176	0	3,150	(26)	3,467	3,467	0	3,428	(39)
18,929	18,339	(589)	17,563	(1,366)	DHB Provider Arm	203,690	201,768	(1,922)	191,572	(12,118)	222,025	220,108	(1,917)	209,069	(12,956)
External Provider Payments															
2,684	2,966	282	2,849	164	Pharmaceuticals	32,987	33,716	728	32,883	(105)	36,210	36,938	728	36,297	87
4,291	4,273	(19)	4,479	187	Laboratory	46,973	47,001	28	46,632	(341)	51,246	51,274	28	50,898	(348)
2,358	2,096	(262)	2,103	(254)	Capitation	24,473	23,051	(1,421)	23,043	(1,430)	26,718	25,147	(1,571)	25,062	(1,656)
946	1,014	68	932	(14)	ARC-Rest Home Level	10,576	10,978	402	10,326	(249)	11,537	11,939	402	11,360	(177)
1,592	1,596	4	1,393	(199)	ARC-Hospital Level	16,787	17,270	483	16,276	(511)	18,300	18,783	483	17,715	(585)
2,170	2,271	102	2,014	(156)	Other HoP	21,367	21,411	44	20,673	(694)	23,413	23,457	44	22,404	(1,010)
718	689	(29)	805	86	Pay Equity	8,174	7,532	(642)	7,017	(1,157)	8,849	8,207	(642)	7,862	(987)
593	757	164	566	(27)	Mental Health	7,958	8,176	218	9,619	1,662	8,714	8,933	218	10,081	1,366
734	737	3	724	(10)	Palliative Care / Fertility / Comm Radiology	8,074	8,104	30	8,015	(58)	8,810	8,840	30	8,740	(71)
1,210	1,503	293	1,121	(88)	Other External Provider Payments	13,598	13,542	(56)	10,881	(2,717)	14,926	14,870	(56)	11,964	(2,963)
7,994	8,136	143	7,889	(105)	IDF Outflows	85,666	89,497	3,831	84,392	(1,273)	93,802	97,633	3,831	93,040	(761)
0	201	201	0	0	Provision for IDF Wash-ups	15	2,212	2,197	0	(15)	216	2,413	2,197	0	(216)
44,510	44,869	359	42,723	(1,788)	Total Expenditure	483,513	487,433	3,920	464,482	(19,032)	528,234	532,009	3,775	507,919	(20,315)
144	(548)	693	247	(103)	Net Result	8,201	96	8,105	5,266	2,935	7,940	(159)	8,099	4,224	3,715

There may be rounding differences in this report

The May result for the funder was \$693k favourable.

Revenue

- Base Funding is on budget for the month and year to date.
- Other MoH revenue is favourable \$3,055 YTD compared to \$2,931k YTD for April 2019. This change is a result of favourable variance of \$273k for Capitation Funding.
- Other revenue is favourable \$97k YTD due to timing.
- IDF inflows are \$1,033k favourable YTD. Mostly due to Wash-ups for Prior Year & Current Year inpatients favourable \$1,795k YTD.



Expenditure

- Governance and Administration is on budget.
- Provider Arm payments are (\$589k) unfavourable for the month, (\$1,922k) year to date, related to; IDF inflows and unbudgeted funding for additional air ambulance costs and other wash-up variances.

Funder Changes to Provider Arm Funding May 2019 (\$000s)			
Description	Funding Source	Variance to budget	
		Month	YTD
Activity Based Wash-up			
Inpatient IDF Inflows wash-up	IDF Inflows	(376)	(1,499)
WAI - Mental Health Acute Beds	IDF Inflows	4	(2)
Air Ambulance Costs	PBF	(170)	(365)
Funding Changes			
Disability coordinator	PBF	(6)	(29)
WAI - Reduction in tobacco funding	IDF Inflows	(11)	(65)
DSS ASD Coordinator	PBF	(30)	(30)
Prior Year Wash-up			
Inpatients	IDF Inflows	-	-
Non-Inpatient	IDF Inflows	-	(14)
Assessment, Treatment & Rehabilitation	IDF Inflows	-	61
Rounding	IDF Inflows	-	22
Provider Arm Funding Variance		(589)	(1,922)

External Provider Payments:

- Pharmaceutical costs are favourable \$282k to budget for the month and year to date \$728k.
- Laboratory costs are adverse to budget by (\$19k) for the month and favourable to budget \$28k year to date.
- Capitation expenses (\$1,421k) unfavourable year to date offset by revenue.
- Aged residential care costs are \$72k favourable for the month, and favourable \$885k YTD; rest home & hospital level combined. The residential care loan adjustment (reported within other HOP) is favourable by \$355k YTD.



- Other HOP costs are favourable by \$102k for the month and \$44k year to date.
- Pay Equity costs are (\$29k) unfavourable to budget for the month, and unfavourable (\$642k) YTD, offset by revenue.

Pay Equity Summary May 2019			
(\$000s)	Variance to budget		
	Month	YTD	Forecast
Revenue			
HOP and ARC	74	945	993
Mental Health	(39)	(208)	(190)
Variance on Revenue	35	737	803
Expenditure			
HOP and ARC	(68)	(850)	(977)
Mental Health	39	208	197
Variance on Expenditure	(29)	(642)	(780)
Net Variance	6	95	24

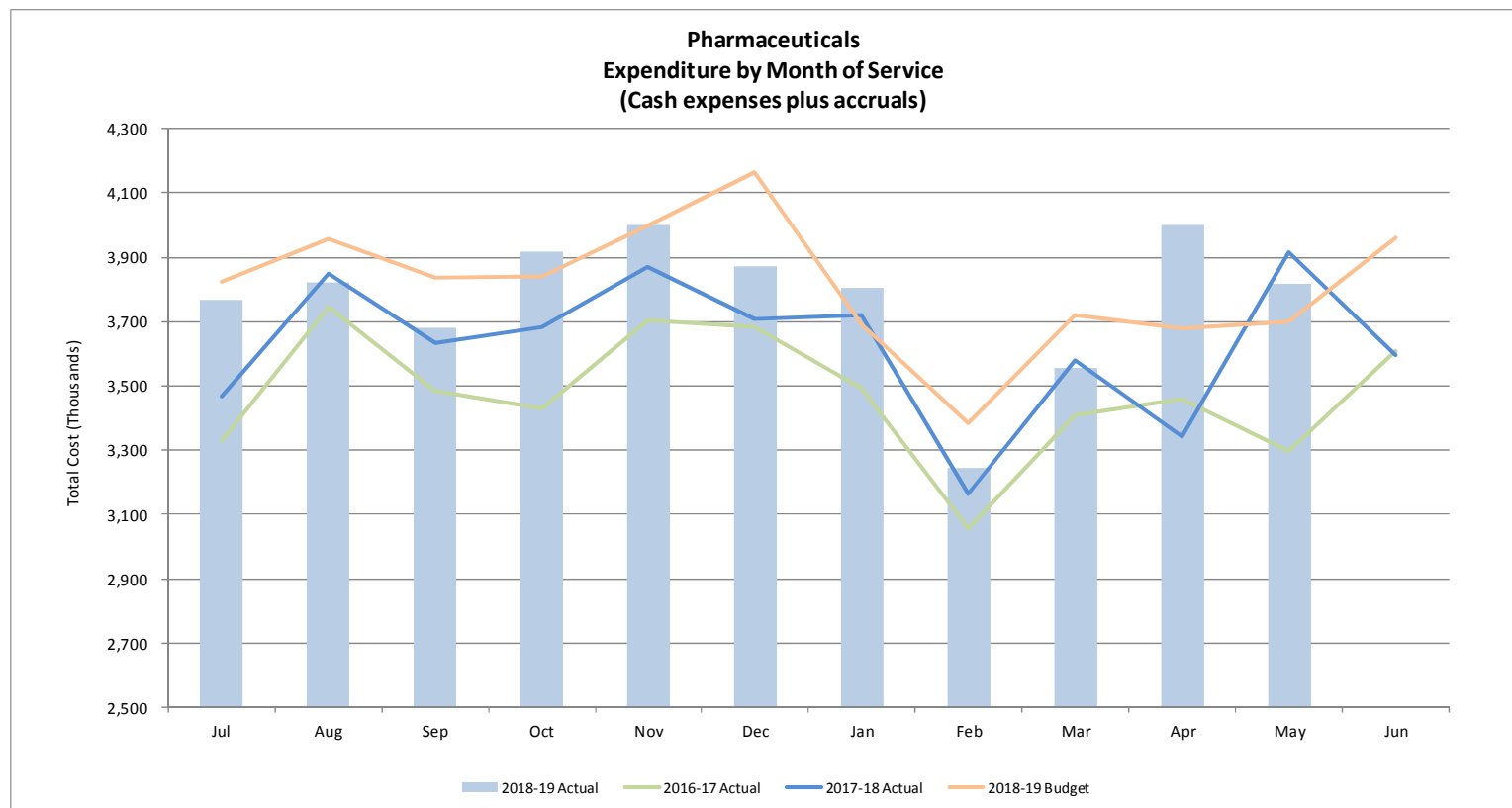
- Mental Health costs are favourable \$164k for the month, and \$218k favourable year to date, reflecting increased certainty on contract commitments and timing.
- Palliative Care, Fertility and Community Radiology costs are on budget, with a small favourable variance of \$30k year to date.
- Other external provider costs are favourable \$293k for the month, bringing the year to date to adverse (\$56k). This includes timing differences and some smaller contracts not yet in place.

- IDF Outflows are favourable \$143k for the month, favourable \$3,831k year to date. This result includes current year in-patient wash-up estimated as favourable by \$1995k (mainly due to under delivery by CCDHB – see IDF section for more detail)

IDF Wash-ups and Service Changes May 2019			
IDF Outflows \$000s	Variance to budget		
	Month	YTD	Forecast
National Services	-	-	-
Emergency Dental	(0)	(2)	2
Expected increase in immunisations	-	-	(2)
MH various service changes	268	979	-
PH various service changes	22	507	-
Wash-ups	-	-	-
Current Year Inpatients	(44)	1,995	631
PHO and FFS washup	(103)	(257)	154
Prior Year	-	-	-
Community Pharmacy	-	12	(12)
PCT Wash-up	-	(28)	28
Inpatients	-	314	(314)
Non-Inpatient	-	(31)	31
Assessment, Treatment & Rehabilitation	-	342	(342)
Rounding (timing) differences	-	-	-
IDF Outflow variance	143	3,831	176

Pharmaceutical Costs

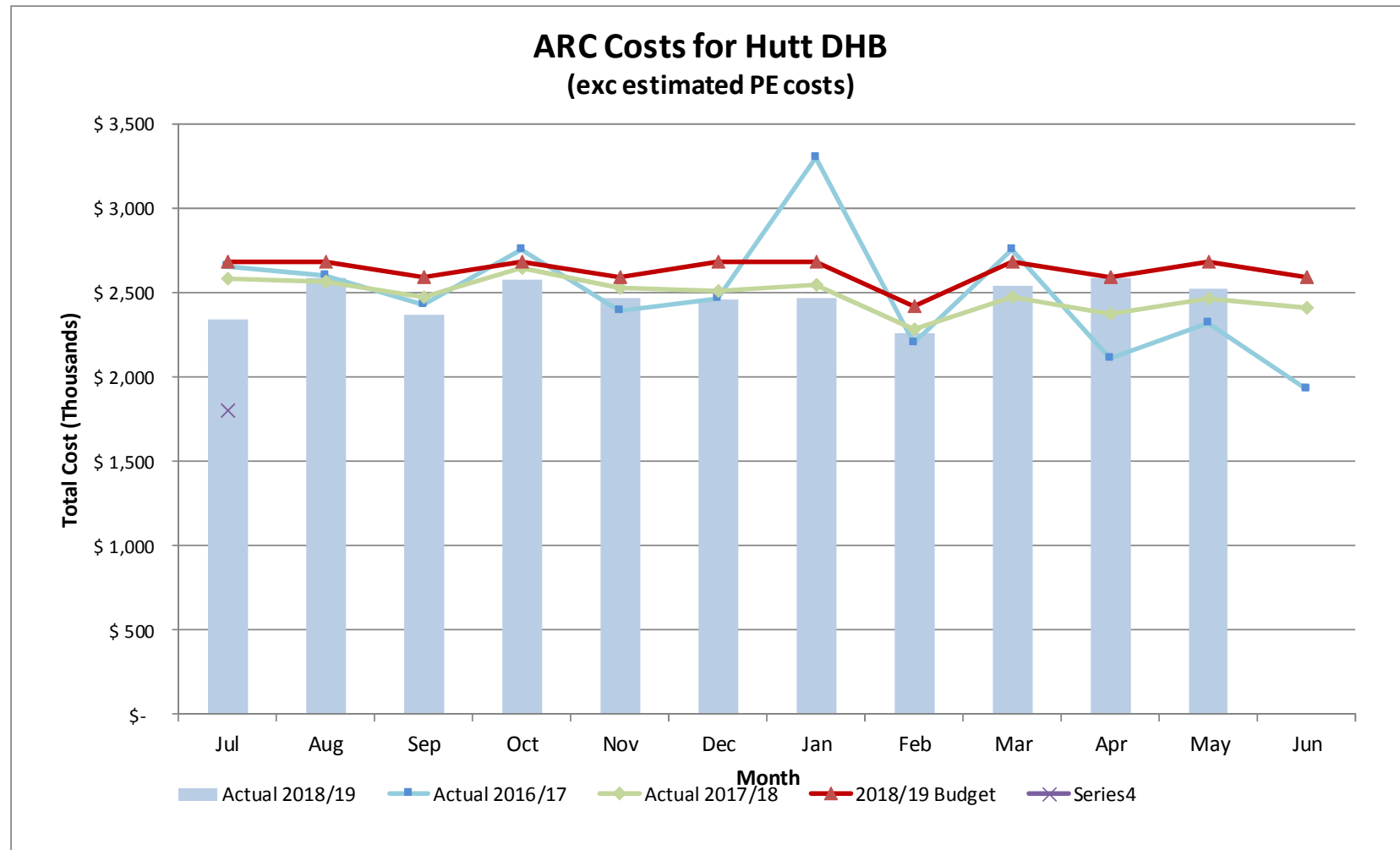
Community Pharmaceuticals accruals are calculated on a consistent methodology, which takes into account the seasonality of the expenditure, and timing delays between the month of service and the month of payment. In the 2017/18 financial year, on average, 31.5% of the costs were paid in the month of service, 66.3% in the month following, and the remaining 2.2% spread across the following months.



The graph above shows the expenditure on community pharmaceutical costs including the actuals for 2016/17 to 2018/19 together with the budget for 2018/19. The budget for 2018/19 has been phased based on trends of expenditure in previous years. The net amount reported as pharmaceutical costs in the accounts includes community pharmaceutical costs, Pharmac rebates, payments for National Haemophilia services and any transactions relating to the Discretionary Pharmaceutical Fund (DPF).

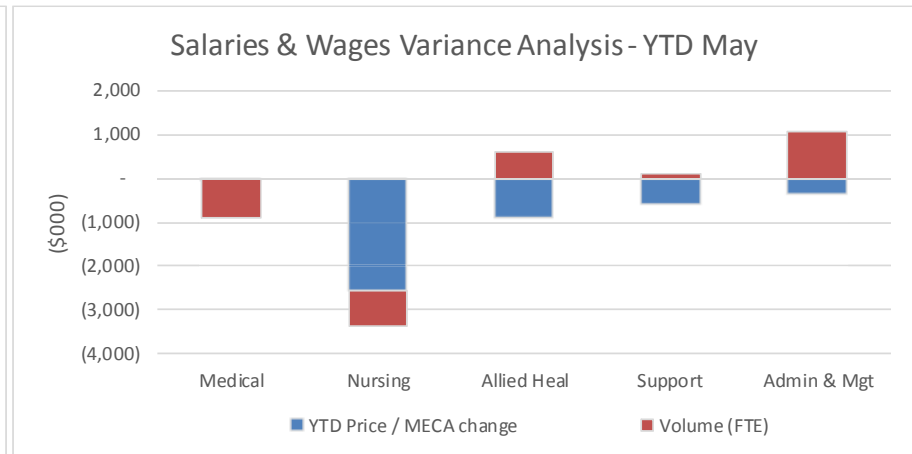
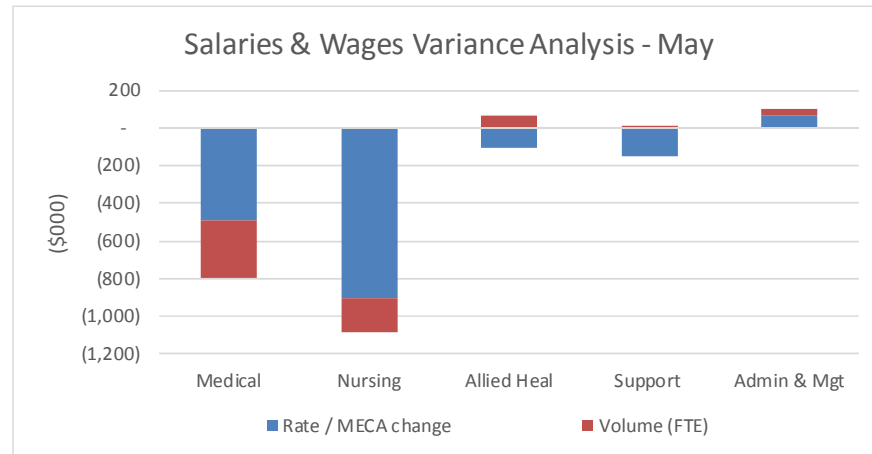
Aged Residential Care

The following graph shows the expenditure for aged residential care. Note that estimated costs of Pay Equity are excluded.



Personnel & FTE

Month					FTE Report May-19	Year To Date					Annual	
Actual	Budget	Variance	Last Year	Variance		Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
286	269	(17)	272	(14)	FTE	273	268	(5)	265	(8)	268	266
788	764	(24)	771	(17)	Medical	775	765	(10)	763	(12)	765	763
391	401	10	389	(2)	Nursing	386	395	9	377	(9)	396	379
135	137	2	135	0	Allied Health	135	137	2	134	(1)	137	134
361	367	5	365	4	Support	352	367	15	357	5	367	355
					Management & Administration							
1,961	1,937	(24)	1,932	(29)	Total FTE	1,920	1,932	12	1,896	(24)	1,932	1,897
					\$ per FTE							
20,110	18,405	(1,706)	16,512	(3,598)	Medical	189,695	189,610	(85)	180,979	(8,716)	209,451	207,444
8,732	7,582	(1,150)	7,164	(1,568)	Nursing	82,545	79,220	(3,324)	75,585	(6,959)	91,222	85,986
6,850	6,579	(271)	6,536	(314)	Allied Health	71,166	68,818	(2,348)	67,325	(3,840)	75,881	77,957
5,634	4,499	(1,135)	4,436	(1,198)	Support	51,400	46,939	(4,461)	47,891	(3,509)	54,933	51,816
6,654	6,851	197	6,452	(202)	Management & Administration	70,974	69,941	(1,033)	65,756	(5,218)	74,120	78,473
9,419	8,520	(899)	8,026	(1,393)	Average Cost per FTE all Staff	91,177	88,366	(2,811)	84,856	(6,321)	98,678	97,589

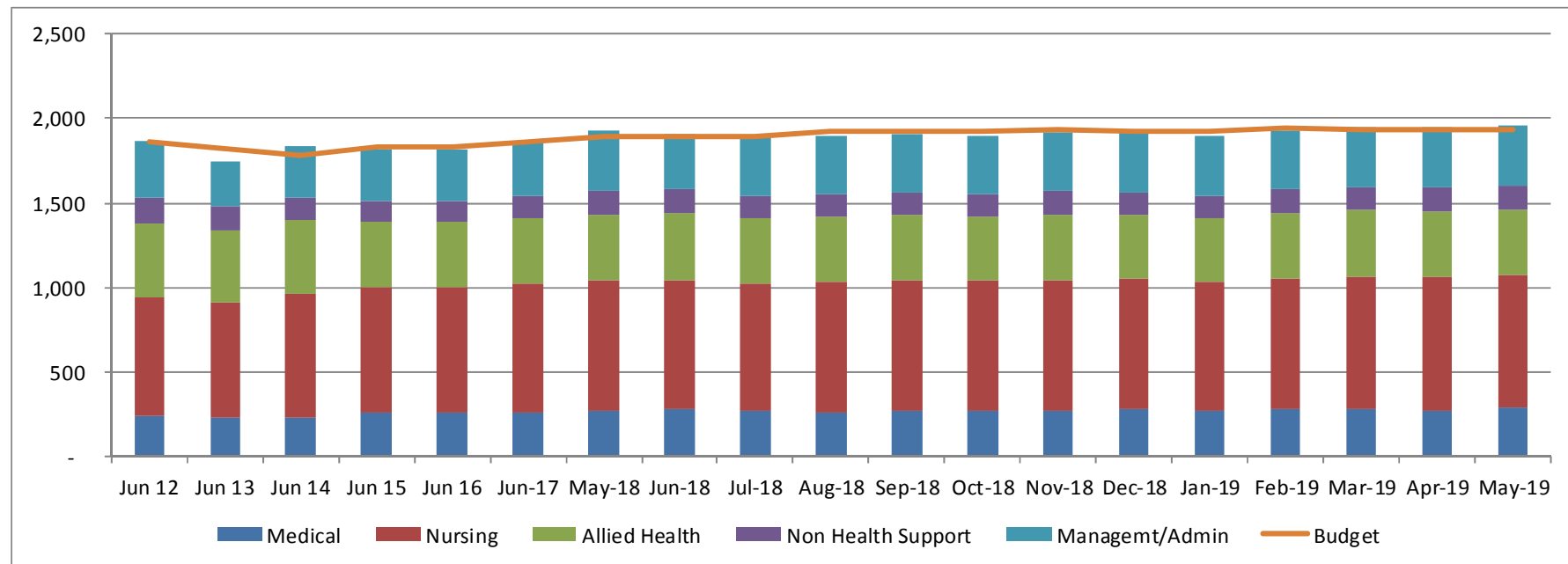


Personnel & FTE Commentary

- **Medical** 17 FTE over budget for the month; **SMOs** over FTE budget by (12) FTE, with an unfavourable Leave variance of (59) FTE partly offset by Ordinary Time variance of 38 FTE. **RMOs** over FTE budget by 2 FTE, with an unfavourable variance of (27) FTE related to Leave, partly offset by 34 FTE Ordinary Time. This reflects the impact of the Easter & ANZAC holiday period been recognised in the May result. **House Officers** are over FTE Budget by 2 FTE.
- **Nursing** over by (24) FTEs for the month. **Senior Nurses, Registered Nurses** and Midwives are under budget by 13 FTE, which includes an unfavourable Leave variance of (136) FTE offset by an unfavourable ordinary time variance of 149 FTE. This reflects the impact of the Easter & ANZAC holiday period been recognised in the May result. **Nurse Practitioners** are over budget (2) FTE. **Internal Bureau Nurses** are over by (19). **Health Care Assistants** are (11) FTE over. Personnel cost variance for May (\$1,087k) is predominately driven by a price variance of (\$906k) reflecting impact of MECA step change (\$150k) and penal rates over the Easter / ANZAC holiday period. The YTD variance (\$3,357k) is predominantly driven by the impact of price variance (\$2,575k), driven in part by MECA changes, penal rates and other allowances.
- **Allied** FTEs are under by 10 FTEs for the month due in the main to; Favourable variances in **Dental Therapists 3, Occupational Therapists 3, Community support workers 5, Child therapists 1, Phycologists 6**. YTD unfavourable variance (\$180k) is driven by the MECA and other price variances (\$907k) mostly offset by ongoing vacancy savings.
- **Support** FTEs are under budget by 2 FTEs mainly orderlies.
- **Management & Admin** are under budget by 5 FTEs. Driven by ongoing acting arrangements and administrative support staff vacancies.

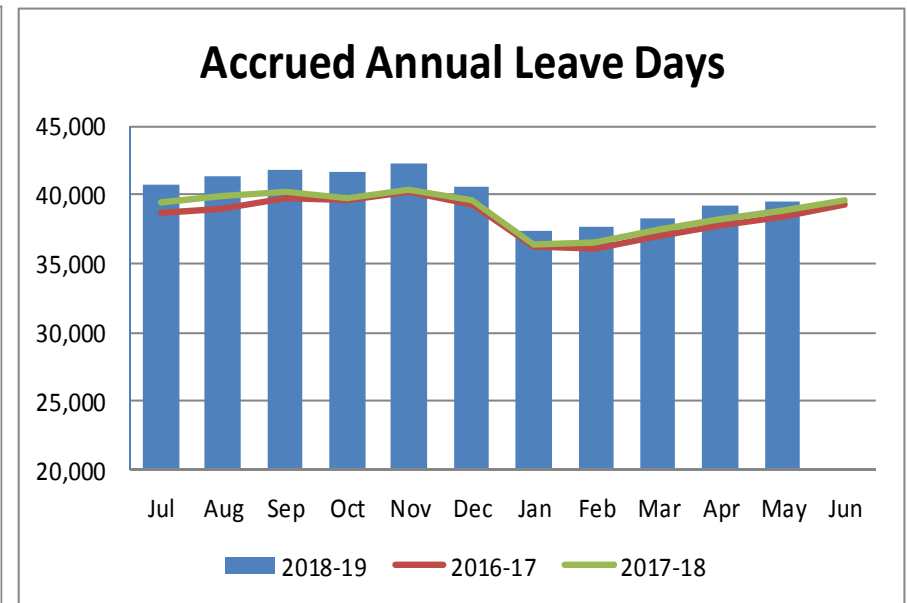
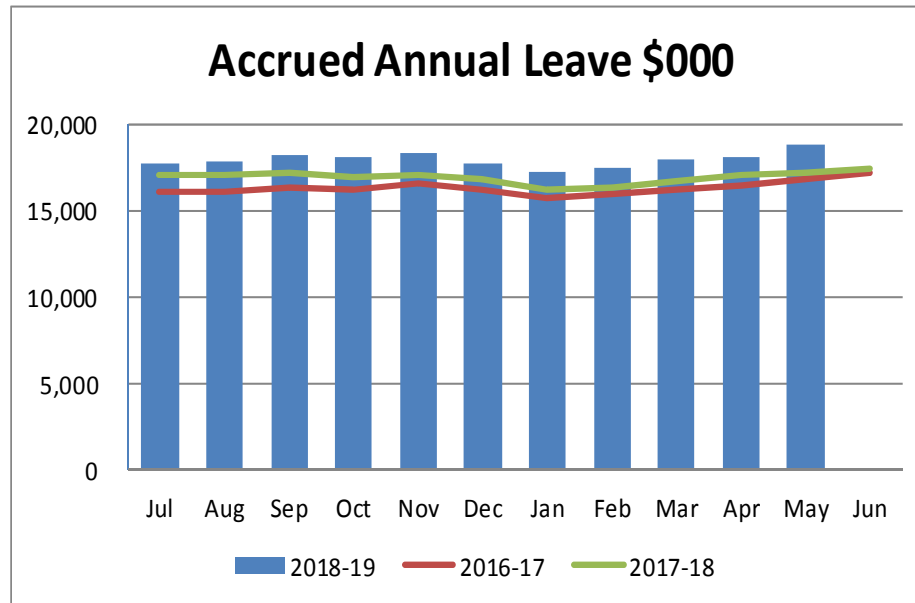
The following Table and Graph reflect the FTE Trend.

		Jun 12	Jun 13	Jun 14	Jun 15	Jun 16	Jun 17	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Actual	Medical	238	224	228	257	257	263	272	278	266	264	271	268	272	279	272	277	277	269	286
	Nursing	707	690	733	744	744	759	771	767	752	772	770	773	772	770	761	781	790	791	788
	Allied Health	437	428	435	385	385	385	389	396	388	384	387	381	389	383	380	387	389	392	391
	Non Health Support	145	133	135	129	129	131	135	137	135	134	135	132	136	133	132	136	136	136	135
	Managemt/Admin	342	272	305	302	302	330	365	330	351	344	343	346	349	352	354	352	358	359	361
Total	Actual FTE	1,869	1,748	1,836	1,817	1,817	1,869	1,932	1,908	1,892	1,898	1,905	1,900	1,918	1,916	1,899	1,932	1,950	1,948	1,961
	Budget	1,862	1,824	1,785	1,835	1,835	1,862	1,890	1,890	1,891	1,923	1,924	1,921	1,934	1,926	1,926	1,938	1,937	1,937	1,937



Annual Leave

The following graphs show the historical trends in annual leave for the last two years. The cost of annual leave increased compared to last month \$385k.

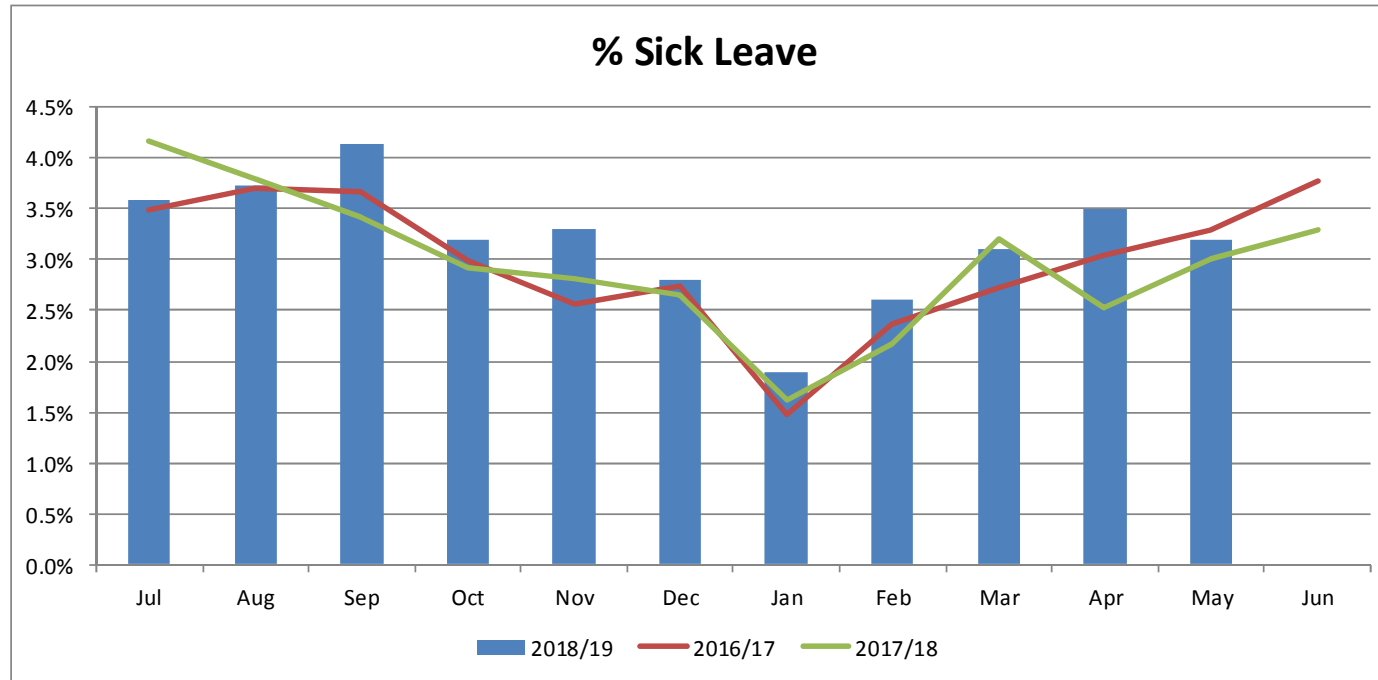


Category	Total staff with Annual leave days						Total Leave Less LSL \$
	Less than 20	20-30	30-40	Greater than 40	% of staff >40		
Medical - Senior	71	29	23	36	23%	159	5,028,293
Medical - Junior	112	24	6	10	7%	152	1,253,968
Nursing	536	188	75	105	12%	904	8,243,981
Allied Health	367	61	29	12	3%	469	1,913,024
Support	70	26	20	13	10%	129	835,724
Mgmt/Admin	287	63	28	13	3%	391	1,596,790
Total*	1,443	391	181	189	9%	2,204	18,871,779



Sick Leave

The following graph shows the historical trends in sick leave for the last two years.



	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Medical	2.1%	1.8%	2.6%	2.1%	2.2%	1.7%	1.6%	1.3%	0.9%	1.5%	1.7%	1.5%	1.4%
Nursing	3.9%	3.6%	4.3%	4.5%	4.7%	3.6%	3.6%	3.6%	2.6%	3.6%	3.6%	4.0%	3.3%
Allied Health	2.8%	4.2%	3.4%	3.7%	4.4%	2.8%	3.8%	2.4%	1.7%	2.4%	3.0%	3.0%	3.1%
Support	0.6%	2.4%	5.4%	3.5%	4.0%	3.1%	4.6%	3.5%	2.4%	3.9%	3.2%	3.8%	3.9%
Admin	2.3%	3.1%	3.2%	3.9%	4.1%	3.6%	2.8%	3.0%	1.3%	2.4%	3.0%	4.3%	3.8%
Total	3.0%	3.3%	3.6%	3.7%	4.1%	3.2%	3.3%	2.8%	1.9%	2.6%	3.1%	3.5%	3.2%

IDF Analysis

Month					Inter District Flows (IDF) - \$'000s	Year to Date					Annual	
Actual	Budget	Variance	Last Year	Variance	YTD May-19	Actual	Budget	Variance	Last Year	Variance	Budget	Last Year
1,109	998	111	913	196	<i>IDF Inflows</i>	12,114	10,982	1,132	10,707	1,406	11,981	11,639
1,014	890	124	976	38	Acute	10,241	9,790	450	8,903	1,338	10,680	9,710
3,020	3,020	0	2,991	28	Elective	33,215	33,215	0	32,906	309	36,235	35,898
(66)	0	(66)		(66)	Laboratory	(66)	0	(66)		(66)	0	0
3,563	3,537	25	3,400	162	Prior year wash-up	38,428	38,911	(483)	40,410	(1,982)	42,449	40,219
					Other Services							
8,640	8,445	194	8,281	359	Total IDF inflows	93,932	92,899	1,033	92,926	1,006	101,344	97,466
2,271	2,644	373	2,825	554	<i>IDF Outflows</i>	27,139	29,080	1,941	27,025	(114)	30,969	30,204
1,083	1,194	111	1,099	16	Acute	12,128	13,134	1,006	12,567	440	14,328	13,388
1,878	1,878	0	1,794	(84)	Elective	20,662	20,662	0	19,734	(928)	22,540	21,527
346	346	0	289	(57)	Outpatient	3,808	3,808	0	3,737	(72)	4,155	4,079
(609)	0	609		609	Pharmaceutical Cancer Treatment	(609)	0	609		609	0	0
3,025	2,074	(951)	1,883	(1,142)	Prior year wash-up	22,538	22,812	275	21,330	(1,207)	25,641	21,108
					Other Services							
7,994	8,136	143	7,889	(105)	Total IDF Outflows	85,666	89,497	3,831	84,392	(1,273)	97,633	90,306
	201	201			Funder IDF provision		2,212	2,212			2,413	1,280
7,994	8,337	344	7,889	(105)	Total IDF Net of provision	85,666	91,709	6,043	84,392	(1,273)	100,046	91,586

Note: Timing differences when reporting on IDFs will have a bearing on year to date figures reported above

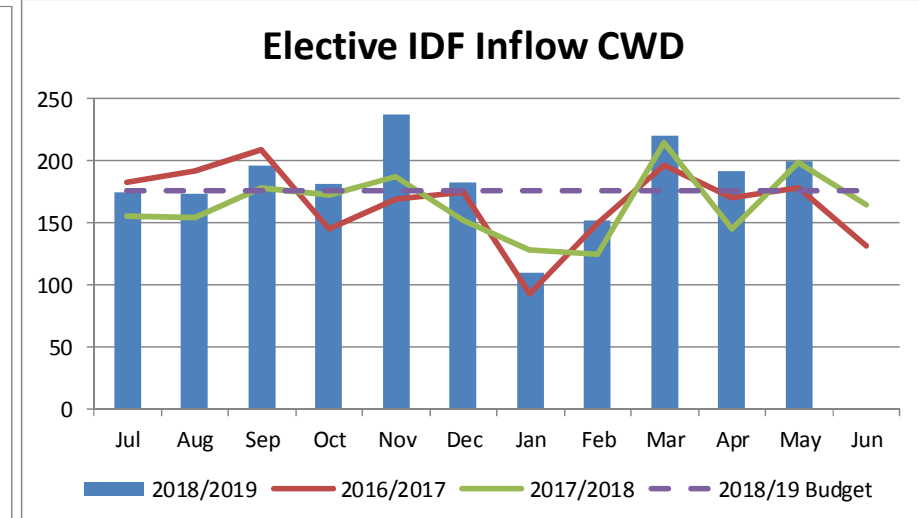
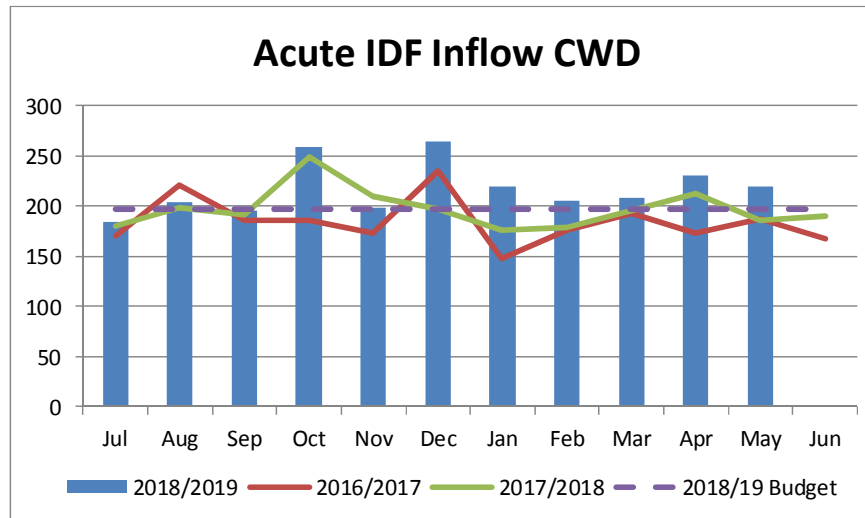
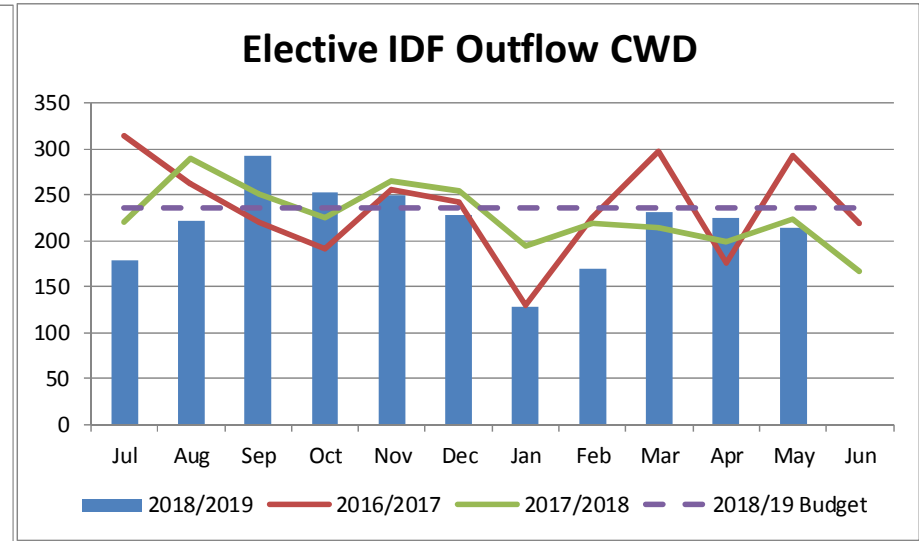
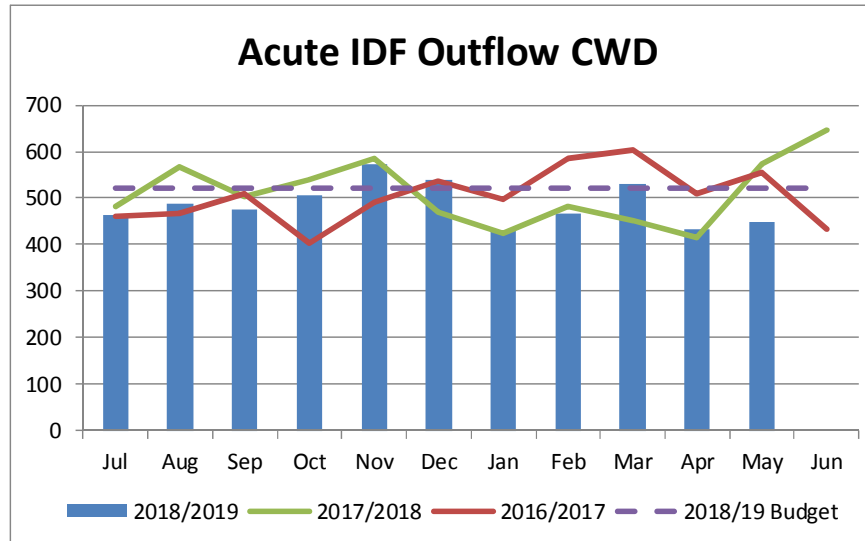
Note: Other Services Inflow includes: Outpatients, Mental Health, PHO, Older people services (incl ARC) and NGO (e.g. Fertility). Other Services Outflow is the same with the addition of laboratory

IDF inflow (revenue):

Overall IDF inflows are above budget YTD by \$1,033k, mainly due to inpatient inflows being \$1,582k over budget. There were higher acute inflows than budget in April and May as well as high inflows in October and December particularly in Plastic surgery. Elective inflows have also been above budget in the last 3 months. Total Inflows for Plastic surgery are \$1,358k (9%) over budget year to date.

IDF Outflow (expense):

Overall IDF outflows are below budget by \$3,831k and include a favourable washup for the prior year. Inpatient outflows are below budget year to date based on 11 months data from CCDHB and 10 months from other DHBs. Acute outflows are significantly below budget especially for Neurosurgery, Cardiothoracic, and Neonatal, but this is offset by Haematology being significantly above budget. Elective outflows are also below budget after low volumes in July and August particularly for Capital & Coast and volumes have been just below budget in recent months. Outflows for other services are below budget by \$275k. The Funder IDF provision was partly for a sick child in Starship part of whose cost may impact in June, but the first part of their stay has been paid by MoH through national services.



Hospital throughput

Month					Hutt Valley DHB Hospital Throughput YTD May-19	Year to Date					Annual	
Actual	Budget	Variance	Last year	Variance		Actual	Budget	Variance	Last year	Variance	Annual Budget	Last year
		Actual vs Budget		Actual vs Last year				Actual vs Budget		Actual vs Last year		
					<i>Discharges</i>							
1,138	1,179	41	1,194	56	Surgical	12,041	11,451	(590)	11,984	(57)	12,437	12,797
1,982	1,718	(264)	1,878	(104)	Medical	20,463	17,595	(2,868)	19,075	(1,388)	19,238	19,506
415	447	32	428	13	Other	4,677	4,936	259	4,970	293	5,360	5,474
3,535	3,344	(191)	3,500	(35)	Total	37,181	33,982	(3,199)	36,029	(1,152)	37,035	37,777
					<i>CWD</i>							
1,132	1,206	75	1,197	66	Surgical	12,653	12,102	(551)	12,302	(351)	13,123	12,852
1,144	1,014	(130)	1,101	(43)	Medical	11,886	10,519	(1,367)	11,404	(483)	11,501	11,991
363	404	41	377	14	Other	4,434	4,464	29	4,487	53	4,840	4,698
2,639	2,624	(15)	2,676	37	Total	28,973	27,085	(1,889)	28,193	(781)	29,465	29,540
					<i>Other</i>							
4,518	3,889	(629)	4,023	(495)	Total ED Attendances	45,557	43,284	(2,273)	44,071	(1,486)	47,337	47,491
999	978	(21)	987	(12)	ED Admissions	10,987	10,586	(401)	10,478	(509)	11,601	11,847
825	839	14	849	24	Theatre Visits	8,843	8,245	(598)	8,627	(216)	8,945	9,271
176	147	(29)	149	(27)	Non- theatre Proc	1,420	1,325	(95)	1,390	(30)	1,425	1,891
6,275	6,498	223	6,802	527	Bed Days	76,385	73,795	(2,590)	78,263	1,879	80,599	85,515
4.23	4.29	0.06	4.14	(0.08)	ALOS Inpatient	4.30	4.29	(0.02)	4.37	0.07	4.29	4.29
1.89	2.20	0.31	1.96	0.07	ALOS Total	2.04	2.20	0.16	2.14	0.10	2.20	2.20
7.20%	7.58%	0.38%	7.20%	0.00%	Acute Readmission	7.92%	7.58%	-0.34%	7.59%	-0.34%	7.31%	7.36%

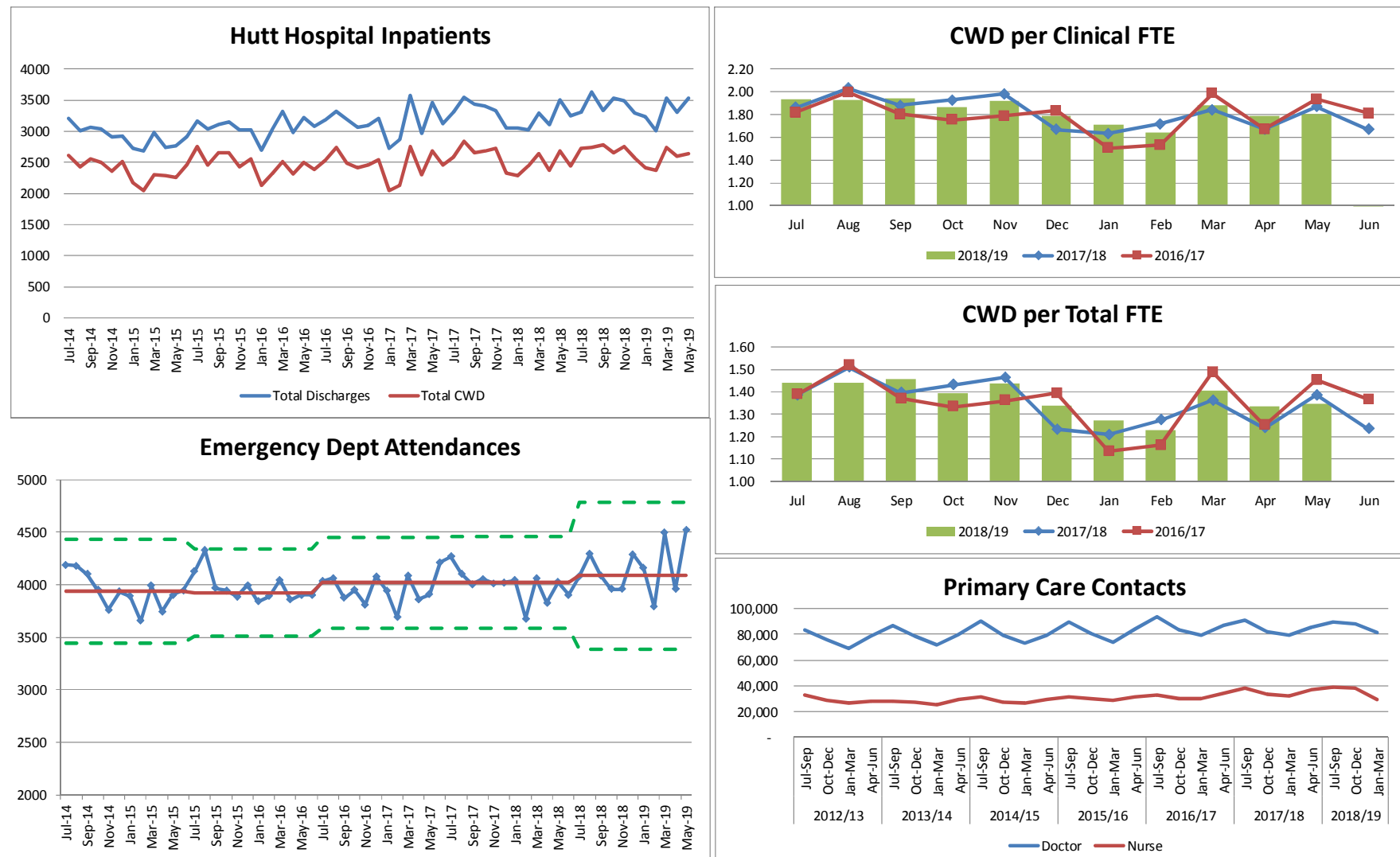
Note: Other inpatient includes mental health and maternity. Activity in this report includes ACC, overseas cases and privately funded cases.

For the month of May Medical inpatient discharges continue to be above budget and above last year. Discharges for Surgical were lower than budget for the month and May last year. Year to date, case weights for Surgical are 5% higher than budget. Year to date case weights for Medical services are 4% higher than last year and 13% higher than budget because a low budget was set with the expectation that acute demand projects would reduce demand.

ED volumes for May were 16% higher than budget and year to date 5% higher than budget. The proportion of patients admitted (22%) for the month was lower than May last year (25%). Theatre visits for the year to date are 7% higher than budget and higher than this time last year. Non-Theatre procedures were also higher than budget for the month and year to date. Bed days Year to date were 4% lower than the same time last year.



ALOS for Inpatients was lower than expected for May and the same time last year. The acute readmission rate was lower than budget and the same time last year. The last ministry report shows our standardised readmission rate is the same as the national rate.



Statement of Financial Position and Cash Flows

Financial Position as at 30 May 2019

\$000s	Actual	Budget	Variance	Jun 18	Variance	Explanation of Variances Between Actual and Budget
Assets						
Current Assets						
Bank	2,689	(4,792)	7,481	5,885	(3,196)	Average bank balance in May-19 was \$23.7m
Bank - Non DHB Funds *	7,134	9,557	(2,424)	9,557	(2,424)	Payments from NHMG to DHB's paid earlier than budgeted
Accounts Receivable	27,985	17,661	10,323	17,422	10,562	Higher than budgeted accrued revenue figure.
Stock	1,477	1,415	62	1,387	90	
Prepayments	868	671	196	671	196	
Total Current Assets	40,153	24,513	15,640	34,923	5,229	
Fixed Assets						
Fixed Assets	220,396	226,788	(6,392)	227,121	(6,725)	
Work in Progress	18,548	16,632	1,916	16,632	1,916	
Total Fixed Assets	238,944	243,420	(4,476)	243,753	(4,809)	
Investments						
Investments in Associates	1,150	1,150	0	850	300	Allied Laundry
Trust Funds Invested	1,426	1,389	37	1,389	37	Restricted trusts in high interest savings account
Total Investments	2,576	2,539	37	2,239	337	
Total Assets	281,672	270,472	11,200	280,915	757	
Liabilities						
Current Liabilities						
Accounts Payable and Accruals	41,118	38,066	(3,053)	37,026	(4,093)	Higher than budgeted accrued expenses
Crown Loans and Other Loans	23	509	486	509	486	
Capital Charge Payable	5,029	0	(5,029)	0	(5,029)	
Current Employee Provisions	24,193	22,986	(1,207)	22,986	(1,207)	
Total Current Liabilities	70,363	61,560	(8,803)	60,520	(9,843)	
Non Current Liabilities						
Other Loans	221	221	0	221	0	Finance leases
Long Term Employee Provisions	7,617	7,769	152	7,617	0	
Non DHB Liabilities	7,136	9,557	2,421	9,557	2,421	Payments from NHMG to DHB's paid earlier than budgeted
Trust Funds	1,442	1,395	(47)	1,395	(47)	
Total Non Current Liabilities	16,416	18,942	2,527	18,790	2,375	
Total Liabilities	86,779	80,503	(6,276)	79,311	(7,468)	
Net Assets	194,893	189,969	4,924	201,605	(6,711)	
Equity						
Crown Equity	124,330	124,330	0	124,330	0	
Revaluation Reserve	133,597	133,597	0	133,597	0	
Opening Retained Earnings	(56,323)	(59,443)	3,120	(49,432)	(6,891)	
Net Surplus / (Deficit)	(6,711)	(8,516)	1,805	(6,891)	180	
Total Equity	194,893	189,969	4,924	201,605	(6,711)	

* NHMG - National Haemophilia Management Group

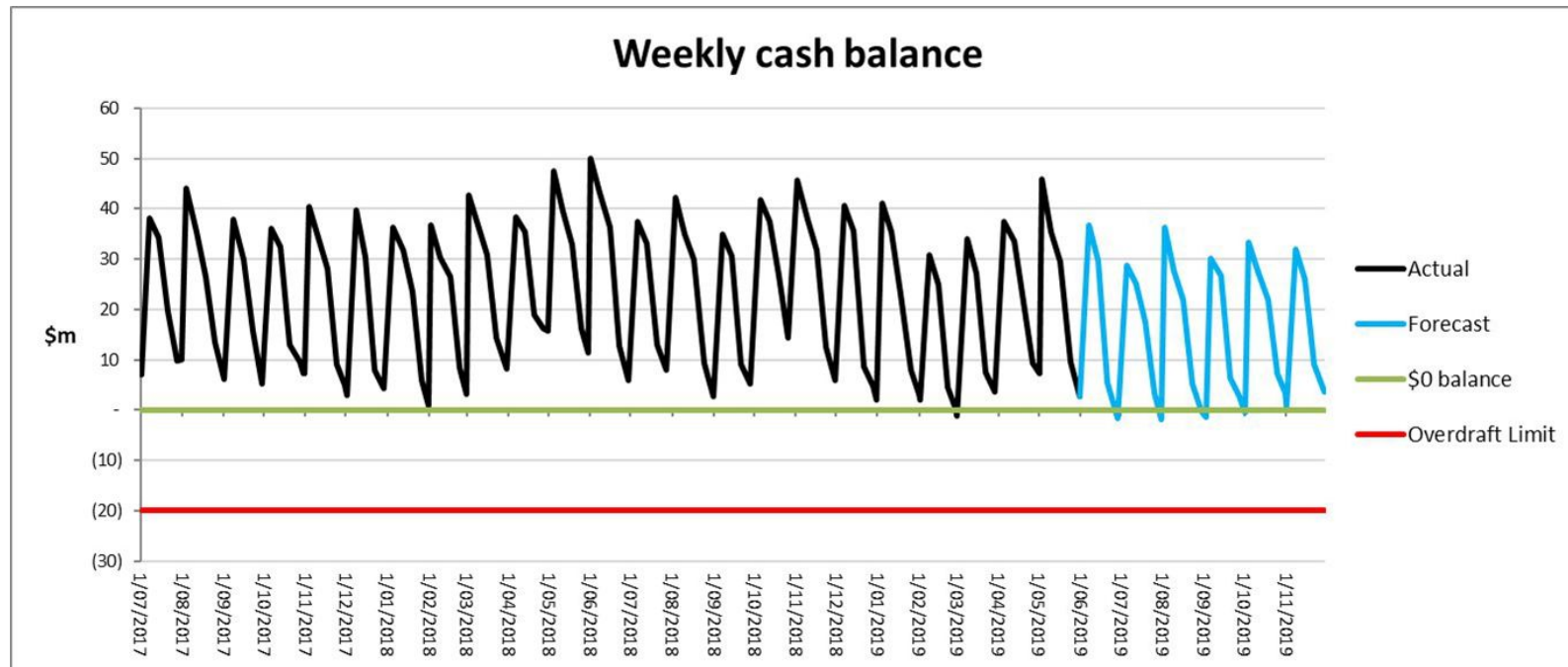


Statement of Cash Flows to 30 May 2019

\$000s	Jul Actual	Aug Actual	Sep Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	Jun Forecast
Operating Activities												
Government & Crown Agency Revenue	36,824	38,151	38,715	37,712	38,421	38,629	37,158	35,952	39,387	38,120	37,352	37,743
Receipts from Other DHBs (Including IDF)	3,481	7,352	5,025	10,181	8,853	8,496	6,993	8,559	9,628	7,926	8,215	8,755
Receipts from Other Government Sources	619	782	1,050	639	751	704	575	635	793	632	602	669
Other Revenue	287	(1,608)	(265)	2,684	(358)	(2,100)	4,038	826	(1,649)	2,140	1,223	376
Total Receipts	41,211	44,676	44,526	51,217	47,668	45,729	48,764	45,972	48,158	48,818	47,391	47,543
Payments for Personnel	(14,079)	(18,382)	(15,710)	(17,094)	(15,325)	(17,989)	(15,441)	(17,030)	(15,602)	(15,194)	(18,645)	(16,294)
Payments for Supplies (Excluding Capital Expenditure)	(4,462)	(4,252)	(2,172)	(5,382)	(5,012)	(3,493)	(730)	(7,065)	(2,867)	(2,338)	(7,741)	(2,653)
Capital Charge Paid	0	0	0	0	0	(6,035)	0	0	0	0	0	(6,048)
GST Movement	459	(704)	568	374	(1,029)	3,124	(3,240)	545	540	(116)	(657)	0
Payments to Other DHBs (Including IDF)	(8,078)	(7,648)	(8,447)	(8,399)	(8,247)	(7,160)	(6,339)	(7,733)	(8,414)	(7,206)	(7,994)	(8,136)
Payments to Providers	(12,994)	(17,795)	(15,445)	(15,277)	(20,672)	(17,462)	(20,938)	(16,820)	(17,682)	(16,669)	(19,007)	(17,959)
Total Payments	(39,154)	(48,781)	(41,206)	(45,779)	(50,285)	(49,015)	(46,687)	(48,103)	(44,025)	(41,522)	(54,043)	(51,089)
Net Cashflow from Operating Activities	2,057	(4,104)	3,320	5,438	(2,617)	(3,286)	2,076	(2,131)	4,133	7,295	(6,652)	(3,547)
Investing Activities												
Interest Receipts	38	39	34	46	50	40	36	29	30	43	39	46
Dividends	0	8	0	0	0	0	0	0	33	0	0	0
Sale of Fixed Assets	0	(1)	0	0	0	0	(341)	(309)	0	0	0	0
Total Receipts	38	46	34	46	50	40	(305)	(280)	62	43	39	46
Capital Expenditure	(362)	(647)	(719)	(1,391)	(921)	(740)	(376)	(476)	(791)	(931)	(828)	(612)
Increase in Investments and Restricted & Trust Funds Assets	(200)	(21)	(10)	24	24	(22)	(161)	12	(15)	5	25	0
Total Payments	(562)	(667)	(728)	(1,367)	(897)	(763)	(536)	(463)	(805)	(926)	(804)	(612)
Net Cashflow from Investing Activities	(525)	(621)	(695)	(1,321)	(847)	(723)	(842)	(743)	(743)	(883)	(764)	(566)
Financing Activities												
Interest Paid on Finance Leases	(3)	(4)	(4)	(2)	(0)	(2)	(2)	(2)	(2)	(2)	(0)	(5)
Other Equity Movement	0	0	0	0	0	0	0	0	0	0	0	(207)
Total Payments	(3)	(4)	(4)	(2)	(0)	(2)	(2)	(2)	(2)	(2)	(0)	(212)
Net Cashflow from Financing Activities	(3)	(4)	(4)	(2)	(0)	(2)	(2)	(2)	(2)	(2)	(0)	(212)
Total Cash In	41,248	44,722	44,560	51,263	47,718	45,768	48,458	45,693	48,221	48,860	47,431	47,588
Total Cash Out	(39,719)	(49,452)	(41,938)	(47,148)	(51,182)	(49,779)	(47,225)	(48,568)	(44,832)	(42,450)	(54,847)	(51,914)
Net Cashflow												
Opening Cash	5,885	7,415	2,685	5,307	9,421	5,957	1,946	3,179	304	3,692	10,102	2,686
Net Cash Movements	1,529	(4,729)	2,621	4,115	(3,464)	(4,011)	1,233	(2,875)	3,388	6,410	(7,416)	(4,325)
Closing Cash	7,415	2,685	5,307	9,421	5,957	1,946	3,179	304	3,692	10,102	2,686	(1,639)
Non DHB Funds - NHMG												
Opening Balance	9,557	6,158	5,655	8,491	7,025	6,486	5,466	6,340	7,145	7,245	8,007	
Net Movement	(3,399)	(503)	2,835	(1,466)	(540)	(1,019)	874	805	100	762	(873)	
Closing Balance	6,158	5,655	8,491	7,025	6,486	5,466	6,340	7,145	7,245	8,007	7,134	



Weekly Cash Flow – Actual to 30 May 2019



Note

- the overdraft facility shown in red is set at \$21 million
- the lowest bank balance for the month of May was \$2,667k

Capital Expenditure – Actual to 30 May 2019

Project description	Budget rolled over from 2017/18	New budget for 2018/19	Prior year approved projects and roll over budget	Prior year approved projects spend	Balance of prior year approved projects budget	Funds available in 2018/19	2018/19 spend	Remaining funds available in 2018/19	Prior year costs	Estimated Costs in 2018/19	Estimated Costs in future years	Forecast Lifetime Project Costs at Completion	Forecast Budget Surplus
	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)	(\$000)
Baseline													
Buildings and Plant	1,007	3,435	9,305	5,158	4,147	7,582	2,363	5,219	5,158	2,480	1,545	9,183	3,557
Clinical Equipment	-	3,300	2,411	1,986	425	3,725	1,223	2,502	1,986	1,000	1,012	3,998	1,713
Vehicles - Dental Van	-	250	-	-	-	250	249	1	-	250	-	250	-
Office Equipment	-	-	-	-	-	-	-	-	-	-	-	-	-
Information Technology (Hardware)	548	1,150	3,465	2,522	943	2,093	1,195	898	2,522	2,163	165	4,850	(235)
Intangible Assets (Software)	855	1,395	2,136	923	1,213	2,608	462	2,146	923	2,055	260	3,238	293
Baseline Total	2,410	9,530	17,317	10,589	6,728	16,258	5,492	10,766	10,589	7,948	2,982	21,519	5,328
Strategic													
RHIP - Regional RIS Migration	400	30	430	-	430	460	7	453	-	130	330	460	-
Regional Clinical Portal (CTAS)	826	-	951	76	875	875	1	874	76	375	500	951	-
Patient Experience Survey	100	-	100	-	100	100	-	100	-	-	100	100	-
e-Medicines Management	250	100	250	-	250	350	-	350	-	40	310	350	-
Electronic Nursing Observation	280	-	280	-	280	280	-	280	-	30	250	280	-
Mental Health Shared Electronic Record	150	100	150	-	150	250	-	250	-	100	150	250	-
Shared Cared - Record and Planning	-	100	-	-	-	100	13	87	-	-	100	100	-
Electronic In Patient Meal Ordering	-	50	-	-	-	50	-	50	-	-	-	-	50
Referrals, Bookings & Scheduling	-	250	-	-	-	250	28	222	-	-	250	250	-
Replacement Dental Imaging and Care system	-	50	-	-	-	50	17	33	-	25	25	50	-
Community Health Integration Platform	-	180	-	-	-	180	-	180	-	25	155	180	-
Whiteboard & Patient Dashboards	-	200	-	-	-	200	60	140	-	25	175	200	-
Volpara Mamography Density Assessment	-	35	-	-	-	35	-	35	-	(25)	60	35	-
Integrated HRIS	-	150	-	-	-	150	-	150	-	140	10	150	-
NZ Post Letter Automation	-	50	-	-	-	50	16	34	-	50	-	50	-
Software Automation (Robots) Development	-	150	-	-	-	150	40	110	-	-	150	150	-
webPAS Enhancements for ACC Claiming & Flo	-	50	-	-	-	50	-	50	-	50	-	50	-
Pager Replacement	-	150	-	-	-	150	-	150	-	50	100	150	-
Mobile Application Development	-	200	-	-	-	200	96	104	-	75	125	200	-
Digital Workplace	-	25	-	-	-	25	16	9	-	25	-	25	-
Kitchen Relocation (incl fitout & equipment)	985	-	985	-	985	985	516	469	-	400	585	985	-
Old Ward 6 Repurpose	200	400	200	-	200	600	-	600	-	-	600	600	-
C Vision IVS100 - Fluoroscopy fixed unit	-	600	-	-	-	600	78	522	-	600	-	600	-
Digital Mamography	-	-	841	654	187	187	10	177	654	166	-	820	21
General room 1, Toshiba X Ray Unit	-	300	-	-	-	300	-	300	-	-	300	300	-
Mobile breast screening Trailer Unit Strategic	-	600	-	-	-	600	-	600	-	-	600	600	-
VOIP Upgrade	-	-	-	-	-	-	-	-	-	-	-	-	-
PACS Version Upgrade	-	-	294	256	38	38	24	14	256	39	-	295	(1)
Strategic Total	3,191	3,770	4,481	986	3,495	7,265	922	6,343	986	2,320	4,875	8,181	70
Total Capital (excluding Trust Funds & GRNI)	5,601	13,300	21,798	11,575	10,223	23,523	6,414	17,109	11,575	10,268	7,857	29,700	5,398
Plus Goods Received Not Invoiced (GRNI)													
IT Tangibles - GL 9379							55						
IT Intangibles - GL 9382							573						
Building Services - GL 9332							23						
Clinical - GL 9362 Plus 9367							126						
Total GRNI							777						
Total Capital Spend Including GRNI							7,191						
Donated from Trust Funds													
IT - Trust							3						
Building Services - Trust							72						
Clinical - Trust							217						
Total Donated from Trust Funds							292						
Total Capital							7,483						



Summary of Leases – as at 30 May 2019

		Original Cost	Monthly Amount	Annual Amount	Total Lease Cost	Start Date	End Date	Lease type
Rental Property Leases								
	Occupants							
Wainuiomata Health Centre	District Nurses	-	1,149	13,787		1/11/2014	31/10/2020	Operating
Public Trust House (Lower Hutt)	Community Mental Health	-	21,887	262,643		1/09/2017	1/09/2020	Operating
CREDS - Johnsonville	Eating Disorders	-	5,370	64,435		1/01/2015	Rolling lease	Operating
RPH - Porirua Public Health	RPH School Health - Promotional Health	-	9,088	109,055		1/03/2013	15/03/2021	Operating
Criterion Lane Upper Hutt	Lagans Pharmacy - Physiotherapy	-	2,204	26,449		5/01/2017	4/01/2021	Operating
CBDI Towers Upper Hutt	Community Mental Health	-	9,854	118,247		1/02/2015	30/01/2021	Operating
Upper Hutt Health Centre	District Nurses	-	671	8,056		24/01/2015	1/02/2022	Operating
		-	50,223	602,672				
Car Park Leases								
CBD Towers Upper Hutt		-	542	6,500		1/02/2015	30/01/2021	Operating
St Peters (SPO)		-	270	3,240		Ongoing	Ongoing	Operating
		-	812	9,740				
Motor Vehicle Leases								
Motor Vehicle Lease plus Management Fees (135 Vehicles)		-	32,171	386,049		Ongoing	Ongoing	Operating
		-	32,171	386,049				
Equipment Leases								
	Supplier							
MRI ingenia 1.5T		-	38,934	467,203	2,336,015	29/06/2016	26/09/2019	Operating
Theatre Equipment (FAR0135107)	All Leasing	710,858	21,009	252,103	756,309	1/04/2017	1/01/2020	Finance
Theatre Equipment (FAR0135105)	All Leasing	330,881	6,039	72,468	217,404	1/07/2017	1/04/2020	Finance
Anaesthetic Machines		1,092,000	22,237	266,839	1,334,195	1/06/2014	31/05/2020	Finance
Stryker Tools		-	9,024	108,292	758,044	1/09/2016	31/08/2023	Operating
3 x Ultrasounds (Equigroup)	GE Healthcare Limited	-	7,315	87,782	438,910	28/06/2017	28/06/2022	Operating
1 x Ultrasound (Equigroup)	Philips NZ Commercial Ltd	-	1,761	21,129	105,645	28/08/2017	28/07/2022	Operating
CT Scanner (Equigroup)	Toshiba Medical Systems	-	25,076	300,911	1,504,555	28/05/2017	28/05/2022	Operating
		2,133,739	131,395	1,609,654	7,484,004			
Total Leases		2,133,739	214,601	2,608,115				



Treasury - as at 30 May 2019

1) Short term funds / investment (\$000)

NZHP banking activities for the month	Current month (\$000)	Last month (\$000)
Average balance for the month	\$23,657	\$23,293
Lowest balance for the month	\$2,667	\$945
Average interest rate	1.96%	2.08%
Net interest earned for the month	\$39	\$40

2) Hedges

No hedging contracts have been entered into for the year to date.

3) Foreign exchange transactions for the month (\$)

No. of transactions involving foreign currency 8
 Total value of transactions \$51,467 NZD
 Largest transaction \$29,290 NZD

	No. of transactions	Equivalent NZD
AUD	5	\$13,637
GBP	1	\$5,263
USD	2	\$32,566
Total	8	\$51,467

4) Debtors (\$000)

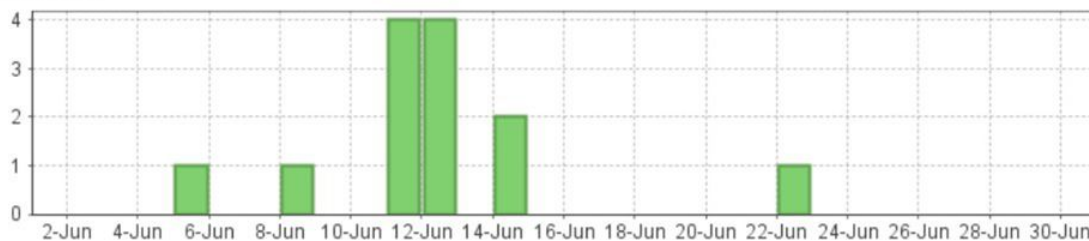
Top 10 Debtors	Outstanding	Current	1-30 Days	31-60 Days	61-90 Days	91-120 Days	121-180 Days	181+ Days
Capital & Coast District Health Board	\$1,516	\$102	\$24	\$112	\$0	\$46	\$287	\$944
Ministry of Health	\$922	\$406	\$206	\$2	\$0	(\$12)	\$63	\$258
Accident Compensation Corporation	\$501	\$606	(\$166)	\$2	\$62	(\$50)	\$57	(\$10)
Wairarapa District Health Board	\$496	\$79	\$0	\$178	\$5	\$0	\$93	\$142
Ministry for Vulnerable Children, Oranga	\$55	\$0	\$42	\$0	\$0	\$0	\$0	\$13
Non Resident	\$46	\$0	\$0	\$0	\$0	\$0	\$0	\$45
ESR Limited	\$37	\$40	\$0	\$0	\$0	(\$4)	\$0	\$0
Hawkes Bay District Health Board	\$30	\$16	\$0	\$0	\$0	\$0	\$14	\$0
Midcentral District Health Board	\$22	\$22	\$0	\$0	\$0	\$0	\$0	\$0
Te Awakairangi Health Network Trust	\$22	\$22	\$0	\$0	\$0	\$0	\$0	\$0
Total Top 10 Debtors	\$3,647	\$1,292	\$106	\$294	\$67	(\$19)	\$514	\$1,392



Fuseworks media report June 2019

Hutt Valley DHB

Volume



The folder contains 13 within the date range 01/06/2019 - 30/06/2019.

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Sources



Stuff.co.nz: 4
NZ Doctor: 2
The Press: 1

New Zealand Herald: 3
Newstalk ZB: 2
Waikato Times: 1

Content Types



Online: 11

Digest: 2

Helping our 'invisible girls' be all that they can be

From Stuff.co.nz

Published 08:10 22/06/2019

Heather Drysdale is the developmental services co-ordinator at the Child Development Service at *Hutt Valley DHB*

Prognosis good for Southern Cross' remote-access medical records app

From NZ Doctor

Published 15:19 14/06/2019

The chief information officer for Capital & Coast, *Hutt Valley*, and Wairarapa *DHBs*, Rommel Anthony, says staff are welcome to use their own devices provided they meet security standards.

'We can do this better': Government departments look to review OIA processes

From Stuff.co.nz

Published 14:10 14/06/2019

The Environmental Protection Authority (EPA) and *Hutt Valley DHB* have confirmed they're working to better their processes around the OIA. ... In a statement a spokesperson for *Hutt Valley DHB* said that "We acknowledge there is room for improvement in our process for managing OIAs and that's why we are reviewing how we do this". ... - Where appropriate, *Hutt valley DHB* will publish additional information alongside responses to support the material released, provide proper context, and mitigate any potential risk of misinterpretation of the information by the general public.

Homelessness in Lower Hutt an invisible crisis affecting everyone and increasing by the day

From New Zealand Herald

Published 12:44 12/06/2019

The *Hutt Valley District Health Board* said it was seeing a steady increase in patients presenting as homeless.

Newstalk ZB Wellington 8am - Item 2

From Newstalk ZB

Published 08:23 12/06/2019

The Capital and Coast DHB has reported three cases from guests of the party and the *Hutt Valley DHB* has reported five.

Lower Hutt party proves to be hotbed for measles after eight people infected

From New Zealand Herald

Published 05:29 12/06/2019

Also from [New Zealand Herald](#)

The Capital and Coast District Health Board has reported three cases from guests at the party and the *Hutt Valley DHB* has reported five.

Mental health crisis spills into hospital wards

From Stuff.co.nz

Published 16:10 11/06/2019

Since the incident, *Hutt Valley District Health Board* (DHB) has confirmed another assault occurred in January, also involving a patient with mental health issues.

Newstalk ZB Wellington midday - Item 1

From Newstalk ZB

Published 12:49 11/06/2019

Patient homelessness is increasing the pressure on *Hutt Valley District Health Board* staff.

NZ measles outbreak: Confirmed cases in 12 of 20 health boards across the country

From Waikato Times

Published 12:10 11/06/2019

There have also been cases in Northland, Lakes (Rotorua), Midcentral (Palmerston North), *Hutt Valley*, Capital and Coast (Wellington), Canterbury and Southern *DHB* areas.

Bashed nurses fed up with inaction following Hutt Hospital assaults

From Stuff.co.nz

Published 05:10 11/06/2019

Hutt Valley District Health Board (DHB) declined an interview request and to answer questions. ... The DHB declined an interview request on Monday, but provided a statement attributed to acting chief executive *Dale Oliff* saying safety of staff and patients was the DHB's highest priority. ... The *Hutt Valley DHB* recorded 50 instances of physical assault in 2017, 55 in 2017, and 34 in 2018.

Investigation into Ministry of Health contracts reveals 'shortcomings'

From The Press

Published 05:11 08/06/2019

He was appointed to the role by Chai Chuah, the former director-general of health who had previously worked with Hundleby at the Canterbury and *Hutt Valley district health boards*.

Prognosis good for Southern Cross' remote-access medical records app

From NZ Doctor

Published 11:52 05/06/2019

The chief information officer for Capital & Coast, **Hutt Valley**, and Wairarapa **DHBs**, Rommel Anthony, says staff are welcome to use their own devices provided they meet security standards.

Dougal Thorburn

Dougal Thorburn is a General Practitioner with a strong interest in Population Health and Māori Health.

Of Waikato descent, he graduated MBChB in 2005, working in mostly provincial areas as a junior doctor before completing his DPH and MPH with distinction in Otago.

After working in Māori Health Education and the local Public Health Unit, he moved to Whanganui-a-Tara with his whānau, trained in General Practice, and obtained his FRNZCGP in 2016.

He has spent 6 years working as a GP in Porirua East for Ora Toa Health Services.

Now, when not riding his bike, running, reading, or spending time with his whanau, he works as the Clinical Director Population Health at Te Awakairangi Health Network and as a GP at Hutt Union Community Health Services.



TERMS OF REFERENCE

HUTT VALLEY DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE

2 MARCH 2018

Compliance	<p>In accordance with Section 35 of the New Zealand Public Health and Disability Act 2000, the Board shall establish a Community and Public Health Advisory Committee (hereinafter called "The Committee") whose members and chairperson shall be as determined by the Board from time to time.</p> <p>The Committee shall comply with the New Zealand Public Health and Disability Act 2000. The terms of reference of the Committee shall be to do the following in a manner not inconsistent with the New Zealand Health Strategy.</p> <p>The Committee shall comply with the Hutt Valley District Health Board's (the Board) Standing Orders for Statutory Committees.</p> <p>These Terms of Reference:</p> <ul style="list-style-type: none"> • are supplementary to the provisions of the Act and Schedule 4 to the Act; • supersede the previous Capital & Coast, Hutt Valley and Wairarapa District Health Board Community and Public Health Advisory Committee and Disability support Advisory Committee's Terms of Reference dated 1 March 2017; • are effective from 1 March 2018.
Functions of the Committee	<p>The functions of this Committee are to give advice to the Board on:</p> <ul style="list-style-type: none"> • the needs, and the factors that may affect the health and disability status, of the residents of the DHB; • priorities for use of health and disability support funding. <p>The aim of the Committee's advice is to ensure that the DHB maximizes the overall health gain for the population and promotes the inclusion and participation in society within the DHB's resident population through:</p> <ul style="list-style-type: none"> • the service interventions the DHB has provided or funded or could provide or fund for the population; • the policies the DHB has adopted or could adopt for those people. <p>The Committee's advice will be consistent with the New Zealand Health Strategy.</p> <p>The Committee shall present its findings and recommendations to the Board for its consideration.</p>
Objectives and Accountability	<p>The Committee shall:</p> <ul style="list-style-type: none"> • monitor the health and disability status of the DHB's resident population; • provide advice to the Board on the implications of health and disability need and status for planning and funding of nation-wide, sector-wide and local health and disability goals;

	<ul style="list-style-type: none"> • provide advice to the Board on policies, strategies and commissioning (planning and funding) to support improved health and disability outcomes in the district; • provide advice to the Board on priorities for health improvement and independence as part of the strategic and annual planning process to improve health gain and independence within the district; • provide advice to the Board on strategies to achieve equity in modifiable health and disability status amongst the population of the DHB including but not limited to Māori, Pacific, people living in high deprivation, people with mental health and addiction conditions, and people with disabilities; • monitor and advise the Board on the impact of health and disability support services being provided for the resident population of the DHB; • identify issues and opportunities in relation to the provision of health services that the Committee considers may warrant further investigation and advise the Board accordingly; • report regularly to the Board on the Committee's findings (generally the minutes of the meeting will be placed on the agenda of the next Board meeting); • collaborate as required with Committees of other District Health Boards in the interests of providing optimum, economical and efficient services; • perform any other functions as directed by the respective DHB Boards.
Authorities and Access	<p>The following authorities are delegated to the Committee:</p> <ul style="list-style-type: none"> • to require the Chief Executive Officer and/or delegated staff to attend its meetings, provide advice, provide information and prepare reports upon request; • to interface with any other Committee(s) that may be formed from time to time.
Meetings	<p>The Committee shall hold no less than four meetings per annum, but may determine to meet more often if considered necessary by the Committee or upon instruction from the Board.</p>
Quorum	<p>A quorum is a majority of Committee members, and must include at least one member from the Board.</p>
Membership	<p>Membership of the Committee shall be as directed by the Board. The Committee has the ability to co-opt expert advisors as required.</p>
Procedure	<p>Schedule 4 of the New Zealand Public Health and Disability Act will apply to the business and procedure of the Committee.</p>

*Te Pae Amorangi*Te Pae Aronga Tuatahi – Focus area one***Māori Workforce***

We will dramatically increase the number of Māori staff employed by our DHB over the next nine years to reflect our Māori population

Outcome One – HVDHB has clearly defined and transparent recruitment and retention policies and procedures to pro-actively recruit Māori across all positions			
Specific Action	Measure	When	Who
Develop a Māori workforce coordinator role, advertise, interview and appoint	Workforce Coordinator appointed	1 st year	DHM
Develop and adopted recruitment policy to shortlist to interview all Māori job applications across all roles within the HVDHB	Policy developed Increase in Māori appointments	1 st year	GMHR DMH
Review and strengthen current recruitment practices <ul style="list-style-type: none"> • Develop specific and relevant training for hiring managers • Review and strengthen interview processes and interview panels • Review and revise all position descriptions and performance documents to ensure Māori health equity is embedded 	Training attended by hiring managers Increase in Māori appointments	1 st year 1 - 2 years	GMHR DMH
Māori are proactively recruited in positions of Senior Leadership with a commitment to have an equal portion of Executive and Senior Leaders	Increase in Māori leadership across the organisation	3 years	CEO
Review and strengthen current workforce data systems to ensure consistency and accuracy of ethnicity data collection	Data review completed Actions identified and implemented	1 st year	GMHR
Provide regular reporting to HVDHB Board, HVDHB Mana Whenua Relationship Board and ELT of workforce data by ethnicity and position	Dashboard Developed	1 st year	GMHR DHM
Develop a Māori specific workforce strategy to support HVDHB workforce strategy (In development)	Māori strategy developed	1 – 2 years	DMH GMHR

Outcome 2 – HVDHB is the preferred employer for Māori Health Professionals			
Develop a specific Māori marketing profile and plan to attract and retain Māori into our workforce <ul style="list-style-type: none"> • Advertise on Māori specific employment forums • Develop relationships with external stakeholders across the community • Create a safe and supportive values based culture across the organisation 	Profile completed Ongoing relationships developed	2 – 3 years	COMMs GMHR DMH
Complete a pay equity review for Māori vs. non-Māori <ul style="list-style-type: none"> • developed actions to address inequities 	Review completed Actions developed	1 – 2 years	GMHR CFO DMH
Develop a Māori workforce survey to identify areas of focus and growth for HVDHB	Survey developed	1 st year	DMH
Outcome Three – HVDHB will be a supportive environment for further growth and development of our Māori workforce			
Develop a proactive Māori mentoring programme across all professions to enhance and strengthen opportunities for growth	Programme Developed	2 – 3 years	DMH
Develop career pathway opportunities for Māori leadership across positions	Career pathways identified	1 – 2 years	DMH GMHR
Māori staff issues (including experiences of bullying or other complaints) are referred to the Director Māori Health and are mediated jointly by HR to ensure a pro-equity, anti-racism approach is taken	Number of complaints reported through Mediated jointly	1- 2 years	DMH GMHR
Training rates are reported by Māori/non-Māori and inequities are identified and eliminated	Data is collected and plans are developed	1-3 years	GMHR COO
All HVDHB training programmes and opportunities are shared with Māori community providers and health professionals	Pathway for shared training is developed and up and running	1 – 3 years	GMHR DoN DMH CMO
Develop graduate nursing and midwifery cultural support and mentoring programme	Programme developed	1 – 3 years	DMH DoN
Outcome Four – HVDHB are supporting and developing Māori into Health workforce careers			
Invest in, grow and coordinate workforce development programmes run through the Māori health team including	Increased Māori engagement Increased cultural support	1-3 years	CEO DMH

<ul style="list-style-type: none"> • Kia ora Hauora • Hauora Māori Scholarship fund • Puna Waiora 			
Develop an annual hands on career expo on site for Rangatahi	Expo is held annually	1 st year	DHM GMHR DAHST GMQI
Build and further strengthen No Te Rangatira youth leadership programme to include: <ul style="list-style-type: none"> • Place based practical internships • Scholarships attached • Career pathways developed and supported • Mentoring and support 	No Te Rangatira is implemented	1-2 years	DMH
Create a board level governance seat for Māori rangatahi to be exposed to and participate in governance	Rangatahi position is created Increased Māori engagement	1 st year	Board
Outcome Five - HVDHB will advance our Treaty of Waitangi relationships with Iwi, Mana whenua, Māori and our communities			
Develop, build and strengthen relationships to further build HVDHB profile within the Māori communities	Increased DHB engagement across Māori communities	1 st year	Board CEO ELT
Develop an agreed co-design methodology for patient and whānau experience	Co-design methodology developed and agreed	1 st year	GMQI
Strengthen, make relevant and adapt HVDHB commitment and understanding to the articles of the Treaty of Waitangi	HVDHB has agreed adopted statement to effect articles	1 st year	Board CEO ELT
Develop and build strong relationships across the region to strength Māori participation and engagement in health	Regional relationships are developed	1 – 2 years	Board CEO DHM

Action Plan

Te Pae Aronga Tuarua – Focus area two

Organisational Development and Cultural Safety

Everyone who works with and for us will be culturally safe, highly skilled and knowledgeable on Māori health, equity and our local community needs.

All DHB staff are responsive to Māori and understand the ongoing impacts of colonisation, structural and institutional racism, bias and privilege

Outcome One – HVDHB will develop Māori cultural safety workforce training, supports and resources			
Specific Action	Measure	When	Who
Develop a Pou Tikanga role, advertise, interview and appoint	Pou Tikanga appointed	1 st year	DMH
Design Cultural Safety and Health Equity Training and begin implementation across the organisation <ul style="list-style-type: none"> Develop data collection for training attendance across professions and departments Develop dashboard to report to Board and ELT 	Training developed Implementation plan developed All ELT and Senior Leaders completing the training first Dashboard completed	1 st year 1-2 years	DMH GMHR
Contract and deliver racism and bias training across senior professional and leadership groups to understand the impacts on Māori health	Allocation of resources to deliver the training Training being delivered	1 st year	DMH CMO GMHR

Redevelop our physical and natural environments to reflect our dual heritage <ul style="list-style-type: none"> • Create a marae space within the hospital • Our DHB will develop and implement a bi-lingual Māori language and signage plan • All interior and exterior spaces will be reflective of our dual cultural heritage 	Patient experience surveys	1-3 years	CFO DMH
Develop a suite of resources to support ongoing organisational development <ul style="list-style-type: none"> • Treaty of Waitangi Training as it refers to health • Online tools and apps • Te Reo Māori training • Te Ao Māori practices <ul style="list-style-type: none"> ○ Waiata ○ Karakia ○ Kawa ○ Whakawhānaungatanga ○ Rongoa 	Resources developed Staff accessing training Staff more confident when working with Māori Staff satisfaction survey	1-3 years	DMH GMHROD
Outcome 2 – HVDHB will support its workforce to build their knowledge on Māori health and equity			
Develop an equity think piece specific to our population and community to advance equity actions across our DHB; <ul style="list-style-type: none"> • Set a clear equity goal and direction • Agree a set of equity principle's • Operationalise our Equity think piece 	Equity think piece developed Organisational equity understanding and statement developed Explicit inclusion of equity outcomes embedded across the whole organisation	1 – 3 years	GMSP0 DMH GMQSI
Develop a Kaumatua role for the DHB and appoint	Kaumatua appointed	1 st year	DHM

Outcome Three – HVDHB will embed health equity and Māori health as part of all quality and safety improvements			
Develop a quality improvement framework which includes setting goals and metrics related to health equity and cultural safety	Framework developed	1-2 years	GMQSI DMH
Health Equity improvement tools will be developed and used across all quality improvement projects	Data collected and reported on quality improvements	1 st year	GMQSI
We will proactively eliminate inequities and be proactive in achieving Māori Health outcomes We will address racism and cultural bias <ul style="list-style-type: none"> • We will name racism • We will support our workforce to understand the impacts of racism • We will invest in developing our organisations capacity and capability in understanding racism in health 	All leaders and managers across the organisation have Māori health equity KPI's	1 – 2 years	ELT members direct reports
All quality improvement actions and projects will have Māori health equity assessments for prioritisation	Quality Improvement reporting against actions and projects	1-2 years	GMQSI GMSP0
Adopt health equity for Māori as a strategic priority for HVDHB and develop KPI's for all ELT, leaders and managers	All ELT, leaders and managers have KPI's for Māori health equity	1 st year	HVDHB Board CE
Māori inequities are measured by every service and action plans are developed to address inequity	Transparent reporting across whole organisation Action plans to address inequities	1-2 years	CE ELT SLG
All service plans have relevant action points for Māori health equity and outcomes	Service plans are focused on achieving Māori health equity	1 st year	Board CE ELT

Outcome Four - HVDHB will advance our Treaty of Waitangi relationships with Iwi, Mana whenua, Māori and our communities			
We will develop Matariki Achieving Excellence in Māori health annual awards to celebrate and acknowledge Māori health	Awards held annually	1 st year	DMH CEO DQSI
Support the ongoing development and advancement of Nga Hau e Wha Hapori Ora (Māori community provider network)	Increased Māori relationships and engagement	1-2 years	DMH
We will further develop our relationship with Mana Whenua Relationship Board (MWRB) by holding bi-monthly board to board meetings to further develop the achievement of health equity and outcomes for Māori	Board to Board meetings at least 5 per year	1 st year	HVDHB Board CE
We will engage with our communities by shifting DHB meetings to marae and community settings including <ul style="list-style-type: none"> • Board meetings • Senior leader meetings • Executive leadership meetings 	Meetings held in community Increased Māori engagement	1-2 years	HVDHB Board ALL ELT
We will develop a process and policy to ensure annual planning processes include Mana Whenua Relationship Board, Māori providers and community	Policy is in place Mana Whenua Relationship Board and Māori providers are included in planning processes	1-3 years	GMSP0 All ELT

Te Pae Amorangi

Te Pae Aronga Tuarua – Focus area three

Commissioning

Commissioning refers to the services our DHB purchases to meet the health needs of our populations. HVDHB will ensure we get excellent value from our investments; and that where and how we invest contributes to equitable outcomes for Māori in our district

Outcome One – HVDHB Māori Health providers are funded equitably from our investments in community based services as a direct commitment to thriving Māori providers			
Specific Action	Measure	When	Who
Work with Māori health providers annually to identify areas for support and ongoing strengthening and enhancement of relationships	Strong relationships with Māori providers	1 st year	GMSP0 DHM
Develop a plan to sustainably increase funding to Māori health providers (as a proportion of total funding)	Report Māori Health funding to ELT and Board	1-3 years	GMSP0
Prioritise commissioning for Māori health providers, where inequity in Māori Health is persistent	Increase in kaupapa Māori funded services	1-3 years	GMSP0
Develop a co-design methodology for all contracts and agreements with Māori health providers to ensure balance of outcomes and focused on what matters to Māori	Increased engagement with Māori Co-design methodology agreed Contracts are balanced and focus on what matters to Māori 360 feedback from Māori providers	1-3 years	GMSP0 DMH

Outcome 2 – HVDHB is proactive in supporting Māori Health providers capacity and capability			
Develop a plan to actively support Māori providers seeking to expand and strengthen <ul style="list-style-type: none"> Actively support Māori Provider Development Scheme (MPDS) Actively encourage and support Māori providers to develop and apply to Te Ao Auahatanga Hauora Māori (MoH Innovation fund) Support health workforce New Zealand (HWNZ) applications Promote development opportunities Support funding applications 	MPDS funding allocated Innovation fund allocated HWNZ funding is allocated Increase in funding applications	1-2 years	DMH
Investigate secondment opportunities to grow and develop workforces across health professions	Secondment agreement developed and implemented	1-3 years	All ELT
Investigate and support placement of clinical staff to Māori providers to support and enhance reach of services for whānau	Clinical placements in Māori providers	1-3 years	CMO DoN DAHST
Outcome Three – HVDHB commissioning practices have Māori health equity as a foundational priority across all services			
Develop a consistent approach to reporting on ethnicity	Data reporting dashboard developed Reporting Māori vs Non-Māori	1 st year	GFO
Review current HVDHB framework to ensure Māori health equity outcomes are embedded	Framework reviewed and implemented	1 st year	GMSP0
Develop Māori health commissioning KPI's for all managers and leaders	KPI's developed	1 st year	All ELT
Develop a mechanism to engage Māori in the process of commissioning and decision making	Framework designed	1 st year	DMH GMSP0

All services understand the complexity of Māori Health achievement <ul style="list-style-type: none"> all services have actions to address inequity all services report transparently around actions and performance Māori equity outcomes 	Deliverables are clear and accountable in the planning process	1 st year	All ELT
Strength based language is the preferred method for the development of all plans and reporting	Strength based narrative is being reported through at every level	1 st year	All ELT
Standardized all contracting tools to make explicit a clear and measurable focus on achieving Māori health outcomes	Contracting tools developed	1 st year	GMSP0
Develop and implement health equity training for Board, ELT, SPO portfolio managers, annual plan leads and their teams	Training developed and implemented	1-3 years	DMH GMHROD
Outcome Four - HVDHB will advance our Treaty of Waitangi relationships with Iwi, Mana whenua, Māori and our communities			
Develop policies to strengthen and embed the Treaty of Waitangi as it relates to health	Policies developed and Implemented	1-3 years	DMH
Identify opportunities to integrate community services with Māori providers, mana whenua and whānau to shift care closer to home	Services are integrated	1-3 years	
Promote and share the work of Māori providers across the DHB and community	Communication plan developed	1-3 years	CM DMH SPO
Regular reporting to the Mana Whenua Relationship Board to update progress against actions	Reporting 6 monthly	1 st year	SPO

<p>Kia ora whanau o te HV DHB Maori Health Team,</p> <p>Many thanks for the invitation for Kokiri Marae Maori Women's Refuge to attend the inaugural Matariki Awards on Thursday 4 July 2019.</p> <p>The evening was absolutely fantastic. Your team were outstanding hosts. We'd like to give a special shout out to Carrie who organised the evening. And to the MC - what a guy! And actually to your entire team. We are very aware that not much happens in isolation. So from our hearts to yours, we thank you for a fabulous evening where so much aroha, manaaki and tautoko was at mass capacity.</p> <p>Arohatinonui, From the team at Kokiri Marae Maori Women's Refuge</p>
<p>Hi Carrie,</p> <p>Congratulations on organising such an incredible event last night. You should be feeling very proud of yourself, (by comparison I've seen the photos from the Wellington Airport Regional Awards, Upper Hutt evening - my work was runner up in a category, and your evening smashed it!).</p> <p>Sarah Hamilton, Photographer</p>
<p>Kia ora koutou</p> <p>I was very blessed and humbled to receive our Matarki Award on behalf of the Regional Screening Services, Cervical team, to be honest we are just coming back down to earth.</p> <p>I would like personally to express my sincere appreciation for organising such a fantastic evening. It was so awesome to be in the presence of such talented and dedicated Māori Professional's. Māori Health in Te Awa Kairangi is in good hands with you Kerry and your team at the helm.</p> <p>On a final note Carrie you must be Super Woman to have pulled this off in such a short-time. Ka mau te wehi! Thank you for all your hard work.</p> <p>He huarahi whakamaru mō te wharetangata, mō te iwi, atawhaitia te Wharetangata. Cervical Screening is a way of protection for the womb, and for the future.</p> <p>Nga mihi Robyn Fox, Team Leader, Cervical Screening , Regional Screening Services, Hutt Valley DHB</p>
<p>An outstanding night recognizing the work of so many who tirelessly work for their people. Congratulations to Kerry and Carrie Maniapoto and the team for making it a memorable night.</p> <p>Keri Brown, Hutt City Councillor</p>
<p>Kia Ora Kerry and Carrie</p> <p>I just want to give you both and the rest of the team a huge congrats as the Matariki awards were amazing. They were really uplifting and a great event.</p> <p>Chris King, Director Allied Health, Scientific and Technical, HVDHB</p>
<p>Thank you for an amazing and very humbling evening. It was such a fantastic turnout. I am so proud of everyone who was nominated</p> <p>Nga mihi to you and your amazing team, please thank them for me. Cheryl Davies, Tu Kotahi Asthma Research Trust</p>

Congratulations to all those involved with the establishment of these awards. It is amazing to see people acknowledged in our community for the work they do in very vulnerable and high risk areas.

Ken Laban, HVDHB Board Member

Congratulations to all the nominees and winners at the DHB Matariki Awards. You are all amazing. Also to the organisers, Kerry and Carrie, for giving us a way of recognising all of the outstanding work happening in Maori Health, thank you.

Lisa Bridson, HVDHB Board Member

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HAUORA

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

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Waitangi Tribunal

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

The Honourable Dr David Clark
Minister of Health

The Honourable Nanaia Mahuta
Minister for Māori Development

The Honourable David Parker
Attorney-General

Parliament Buildings
WELLINGTON

28 June 2019

E ngā Minitia tēnā koutou

Introduction

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

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

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

- ▶ priority themes that demonstrate system issues (stage one);
- ▶ nationally significant issues and themes that emerged (stage two);
- and

Level 7, 141 The Terrace, Wellington, New Zealand. Postal: DX SX11237
Fujitsu Tower, 141 The Terrace, Te Whanganui-ā-Tara, Aotearoa. Pouaka Poutāpeta: DX SX11237
Phone/Waea: 04 914 3000 Fax/Waea Whakaahua: 04 914 3001
Email/E-mēra: information@waitangitribunal.govt.nz Web/Ipurangi: www.waitangitribunal.govt.nz



- remaining themes of national significance, including eligible historical claims (stage three).

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

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

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

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

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

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

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

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

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

Our Findings

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

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

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

organisations, \$167 million was allocated for Māori patients with \$28.7 million of funding going to Māori primary health organisations.

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

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

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

recognition, and the extent of their role and influence upon the operation of district health boards varies considerably throughout the country.

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

Recommendations

We have made two overarching recommendations:

- (a) That the legislative and policy framework of the New Zealand primary health care system recognises and provides for the Treaty of Waitangi and its principles. To that end, we recommend an amendment to the New Zealand Health and Public Disability Act 2000 to include a new Treaty of Waitangi clause. We have also gone on to recommend several principles for adoption and use in the primary health care sector.
- (b) That the Crown commit itself and the health sector to achieve equitable health outcomes for Māori. To that end, we recommend an amendment to section 3(1)(b) of the New Zealand Public Health and Disability Act 2000.

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

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

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

In relation to accountability arrangements, we recommend that the Crown commit to reviewing and strengthening accountability mechanisms and processes in the primary health care sector which impact upon Māori. We go on to make a number of specific recommendations concerning: He Korowai Oranga (the New Zealand Māori health strategy); the New Zealand Health Strategy; the Primary Health Care Strategy; and their relevant action plans. We also recommend that the Crown, in conjunction with Māori health experts, co-design a primary health research agenda.

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

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

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

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

Acknowledgements

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

cooperation, particularly on the part of counsel. I thank all persons for the part they played in making that happen. It was only with that cooperation that we have been able to hear and report back within the timeframe requested by parties.

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

Tēna koutou, tēna tātou katoa



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

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 hīia 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.

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PREFACE

This is a pre-publication version of the Waitangi Tribunal's *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry*. As such, all parties should expect that in the published version, headings and formatting may be adjusted, typographical errors rectified, and footnotes checked and corrected where necessary. However, the Tribunal's findings will not change.

GLOSSARY

<i>hapū</i>	sub-tribe
<i>hauora</i>	holistic health and wellbeing
<i>iwi</i>	tribal grouping
<i>kaupapa</i>	central purpose, initiative, issue
<i>kāwanatanga</i>	government, governorship
<i>mana motuhake</i>	autonomy, self-determination, sovereignty, self-government
<i>mātauranga Māori</i>	the Māori worldview, Māori knowledge, traditional knowledge
<i>rangatiratanga</i>	chieftainship, authority, right to exercise authority, chiefly autonomy, chiefly authority
<i>rongoā</i>	indigenous medicine and treatment
<i>rūnanga</i>	a council or board to discuss community issues
<i>take</i>	cause, subject
<i>tangata whenua</i>	people of the land, local people
<i>tikanga</i>	correct procedure/protocol, a system of values and practices
<i>tino rangatiratanga</i>	the fullest expression of rangatiratanga, autonomy, self-determination, sovereignty, self-government
<i>wairuatanga</i>	spirituality
<i>whānau</i>	family
<i>whānau ora</i>	family wellbeing

ABBREVIATIONS

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

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ABBREVIATIONS

v	and
VLCA	Very Low Cost Access
vol	volume
Wai	Waitangi Tribunal claim

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

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CHAPTER 1

INTRODUCTION

*Pūnganangana ki tawhito-o-te-rangi e tū nei***1.1 THE HEALTH SERVICES AND OUTCOMES KAUPAPA INQUIRY – STAGE ONE****1.1.1 Introduction**

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

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

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

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

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

1.1.2 The inquiry process to date**1.1.2.1 The initial claim for urgency**

A statement of claim concerning health issues on a national scale was received on 11 November 2005 from Taitimu Maipi, Tureiti Moxon (now Tureiti Lady Moxon), Elaine Tapsell and Hakopa Paul on behalf of a coalition of Māori Primary Health Organisations and Providers. This claim is registered as Wai 1315.² Along with their statement of claim, the claimants filed several affidavits in support of an urgent inquiry into the primary health care system on the basis that there was an imminent threat to the survival of their organisations.³

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

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

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

On 22 August, Chief Judge Williams delegated the task of determining the application for urgency to Judge Craig Coxhead.¹⁰ Judge Coxhead requested and received a Crown response to the application on 3 November 2008.¹¹

After considering the urgency application and the Crown's response, on 5 November, Judge Coxhead deferred a decision on the claimants' application for an urgent hearing to see whether Phase 11 of the Ministry's Sustainability Project would reveal potential prejudice to the claimants.¹² Judge Coxhead's decision was confirmed on 24 November in response to a request for a recall of that decision by

2. Claim 1.1.1, p 2.

3. Document A24; doc A26; doc A28; doc A29; doc A30.

4. Wai 1315 memorandum 2.1.1, p 1.

5. Wai 1315 memoranda 2.5.1- 2.5.2.

6. Wai 1315 memorandum 2.5.3.

7. Wai 1315 memoranda 2.5.4-2.5.7.

8. Wai 1315 memorandum 3.1.11, para 6.

9. Wai 1315 memorandum 2.5.8, para 1; doc A31; doc A32; doc A33; doc A34; doc A35; doc A36.

10. Wai 1315 memorandum 2.5.8, para 3.

11. Wai 1315 memorandum 2.5.9, para 4; Wai 1315 memorandum 3.1.12.

12. Wai 1315 memorandum 2.5.10, paras 15-16.

claimant counsel. Claimants were invited to file responses to Crown submissions if they wished to.¹³

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

1.1.2.2 The kaupapa inquiry programme

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

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

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

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

13. Wai 1315 memorandum 2.5.11.

14. Wai 1315 memoranda 3.1.14–3.1.15.

15. Wai 1315 memorandum 2.5.12, para 5.

16. Memorandum of the Chairperson Concerning the Kaupapa Inquiry Programme, 1 April 2015, para 11.

17. Memorandum of the Chairperson Concerning the Kaupapa Inquiry Programme, 1 April 2015, para 5.

18. Memorandum 2.5.1.

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1.1.2.3

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

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

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

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

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

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

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

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

19. Memorandum 2.5.1, para 12.

20. Memorandum 2.5.4.

21. Memorandum 2.5.12.

22. Memorandum 2.5.2, paras 15, 21; memorandum 2.5.6.

23. Memorandum 2.5.8, para 12.

24. Memorandum 2.5.8, para 13.

25. Memorandum 2.5.17, para 4.

26. Claim 1.1.2, para 17(b)(iii).

27. Memorandum 2.5.14, para 7.

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

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

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

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

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

Several other parties challenged the decision to hear these two claims at stage one and filed submissions to that effect. A judicial conference was held at the Māori Land Court, Hamilton, on 15 March 2018 to consider the matter. On 29 March 2018 we confirmed that the claims to be inquired into during stage one would be the Wai 1315 and Wai 2687 claims.³⁴ The two claims were consolidated under the Health Services and Outcomes Kaupapa Inquiry on 7 May 2018.³⁵

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

28. Memorandum 2.5.17, paras 5–7.

29. Memorandum 2.5.17, para 9.

30. Memorandum 2.5.25, para 80.

31. Memorandum 2.5.17, para 11.

32. Claim 1.1.1(a).

33. Memorandum 2.5.17, para 13.

34. Memorandum 2.5.25.

35. Memorandum 2.5.26, para 31.

36. Memorandum 2.5.27, paras 3–5.

37. Memorandum 2.5.27, para 8.

1.1.2.4

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

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

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

1.1.2.4 *The stage one hearings*

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

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

1.2 THE STAGE ONE PARTICIPANTS

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

38. Memorandum 2.5.17, para 17; memorandum 2.5.29, paras 2, 11, 18.

39. Memorandum 2.5.17, para 6.

40. Ann Parsonson, 'Herangi, Te Kirihaehae Te Puea', in *The Dictionary of New Zealand Biography*, Ministry for Culture and Heritage, <https://teara.govt.nz/en/biographies/3h17/herangi-te-kirihaehae-te-puea>, accessed 4 April 2019.

1.2.1 The claimants

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

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

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

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

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

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

Tureiti Lady Moxon is the Managing Director of Te Kōhao Health Ltd in Hamilton, a Māori provider which operates under the Hauraki Primary Health Organisation.⁴⁴ She has had a longstanding involvement on boards and in an advisory capacity to Crown health entities since the 1990s, and has been on the Waikato District Health Board Iwi Māori Council since 2002.⁴⁵ She was also the former Chief Executive Officer of Toiroa Primary Health Organisation from 2003 to 2012. Toiroa ceased to operate as a primary health organisation in 2013.⁴⁶

41. Memorandum 2.5.25, para 67.

42. Claim 1.1.1(a), para 1.

43. Document A28, para 1; doc A10, para 1.

44. Document A11, paras 3, 40.

45. Document A11, para 2.

46. Document A11, paras 6, 38.

Hakopa Paul was formerly a Trustee of Te Kupenga a Kahu, a Rotorua-based Māori primary health organisation that ceased operating in 2005.⁴⁷

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

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

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

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

Maipi and Paul similarly claim that the Crown does not adequately ‘empower or resource’ Māori primary health organisations and health providers, emphasising the inadequate recognition of tino rangatiratanga and mana motuhake as their primary concern.⁵⁴ The claimants argued that the current primary health care legislative and policy framework ‘is not sufficiently contributing to the achievement of Māori health equity.’⁵⁵ Accordingly, they claim that the Crown’s insufficient action in relation to primary health for Māori, and its inadequate support of

47. Document A13, paras 12, 15.

48. Document A12, paras 3–4.

49. Memoranda 3.2.17, 3.2.18; memo 2.6.8, para 25.

50. Memorandum 2.6.8, paras 25–27.

51. Submission 3.3.18, para 5.

52. Submission 3.3.18, para 129.

53. Submission 3.3.18, para 153.

54. Submission 3.3.23, paras 4, 32.

55. Submission 3.3.23, para 7.

Māori tino rangatiratanga in the health sector, constitute breaches of the Treaty, particularly the principles of partnership, active protection and equity.⁵⁶

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

1.2.1.2 The National Hauora Coalition claim (Wai 2687)

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

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

The National Hauora Coalition claimants sought recommendations that the Treaty principles, especially the guarantee of Māori tino rangatiratanga, should be thoroughly embedded within the primary health care framework and guide its

56. Submission 3.3.23, para 44.

57. Submission 3.3.23, para 9.

58. Submission 3.3.23, para 32.

59. Submission 3.3.23, para 48(c).

60. Claim 1.1.2, para 1.

61. Document A23, paras 2, 14; submission 3.3.30, para 5.86.

62. Submission 3.3.30, paras 1.4.

63. Submission 3.3.30, paras 2.8.8.

64. Submission 3.3.30, paras 2.5, 2.6.2.

65. Submission 3.3.30, paras 2.8.4, 2.8.5, 2.8.7, 2.8.12.

66. Submission 3.3.30, paras 2.8.9.

67. Submission 3.3.30, paras 2.8.10–2.8.13.

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1.2.2

policy-making.⁶⁸ They alleged that the Treaty clause in the New Zealand Public Health and Disability Act 2000 is not Treaty-consistent, as it emphasises participation as opposed to applying the principles of partnership and tino rangatiratanga.⁶⁹

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

1.2.2 The Crown

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

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

The Crown accepted Māori health outcomes are inequitable, amongst other acknowledgements regarding the inadequacies of the primary health care framework.⁷⁵ The Crown argued it is 'well-founded' that New Zealand's health care system is comparatively strong by international standards.⁷⁶ The Crown argued an ongoing commitment to improving the many features of primary health care defines New Zealand's internationally highly-regarded model. This commitment, they said, fundamentally contributes to greater individual and societal wellbeing. The Crown acknowledged, however, that the Māori health experience remains

68. Submission 3.3.30, paras 7.4–7.5.1.

69. Submission 3.3.30, paras 2.17–2.20.

70. Submission 3.3.30, para 7.8.

71. Submission 3.3.30, paras 7.8, 7.22–7.24.

72. Submission 3.3.30, para 7.22.

73. Submission 3.3.30, paras 7.34–7.54.

74. Document A76, para 9.

75. Submission 3.3.32, para 35.

76. Submission 3.3.32, para 1.

inequitable and, therefore, unacceptable.⁷⁷ The Crown emphasised that the intentions of the framework are good and that the fundamental aims and settings of the system are sound, but that the framework has simply not been effectively implemented.⁷⁸

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

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

1.2.3 The interested parties

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

1.2.3.1 The Ngā Ariki Kaipūtahi claim (Wai 507)

Owen Lloyd, of Ngā Ariki Kaipūtahi, supported the remedies sought by the stage one claimants in principle. However, he argued for a more specific reform of

77. Submission 3.3.32, para 35.

78. Submission 3.3.32, para 24.

79. Submission 3.3.32, paras 5–6.

80. Submission 3.3.32, para 142.

81. Submission 3.3.32, paras 15–16.

82. Submission 3.3.32, para 4.

83. Submission 3.3.32, para 16.

84. Memorandum 2.5.31, paras 2–3; memorandum 2.6.1(a). A full list of interested parties and their involvement in the inquiry appears as appendix II.

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1.2.3.2

district health board structure and governance to empower iwi and hapū authority should be the priority for stage one.⁸⁵ Accordingly, he sought a recommendation that the minimum Māori representation on district health boards be increased to 50 per cent, and that these representatives be appointed by iwi and hapū.⁸⁶

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

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

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

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

1.2.3.4 *The Māori health disparities (Te ORA) claim (Wai 2499)*

Dr David Jansen and others on behalf of themselves and Te Ohu Rata o Aotearoa (the Māori Medical Practitioners Association, or Te ORA) submitted that the Crown had failed in its responsibility to Māori as shown by persisting inequalities in Māori health outcomes, in Māori access to services, in primary health system responsiveness to Māori health issues, and in Māori experience of other social determinants of health.⁹³ They also submitted that, given the limited scope of the stage one inquiry, a broader, more thorough inquiry into primary care is required.⁹⁴ They, nonetheless, sought recommendations that aim to commit the

85. Submission 3.3.14(a), para 55.

86. Submission 3.3.14(a), para 56.

87. Submission 3.3.12–3.3.13.

88. Submission 3.3.13, paras 246–262.

89. Submission 3.3.13, paras 273–274.

90. Submission 3.3.17, para 5.

91. Submission 3.3.17, para 6.

92. Submission 3.3.17, para 9(c).

93. Submission 3.3.22, para 9.

94. Submission 3.3.22, paras 59–63.

Crown and the primary health care sector to achieving Māori health equity more robustly.⁹⁵

1.2.3.5 The District Māori Council claim (Wai 2623)

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

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

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

1.2.3.7 The New Zealand Māori Council health claim (Wai 2644)

The New Zealand Māori Council argued that 'inequitable outcomes largely define Maori experiences with the current Primary Health Care system.'¹⁰¹ They sought recommendations that health care for Māori should be provided by Māori and should more adequately recognise the particular needs of high needs patients.¹⁰² They further claimed that the Crown should be compelled by the Tribunal to acknowledge the Māori-Crown partnership in the health sector and further recognise Māori mana motuhake.¹⁰³ To this end, they sought the establishment of a 'Maori Health Care Agency' with similar responsibilities and constitution as the agency outlined by the National Hauora Coalition claimants.¹⁰⁴

95. Submission 3.3.22, para 71.

96. Submission 3.3.31, paras 18, 21. The closing submissions were supported in full by the closing submissions of the Wai 179 claimants (submission 3.3.25) and the Wai 996 claimants (submission 3.3.26).

97. Submission 3.3.31, paras 19, 21.

98. Submission 3.3.31, paras 21, 280.

99. See the Statements of Claim for Wai 2634, Wai 2643, Wai 2647 and Wai 2650.

100. Wai 2688 claim 1.1.1.

101. Submission 3.3.21, para 3.

102. Submission 3.3.21, para 5(a).

103. Submission 3.3.21, para 5(b)-(c).

104. Submission 3.3.21, para 5(d)-(h).

1.2.3.8

1.2.3.8 The Counties Manukau health claim (Wai 2702)

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

1.2.3.9 The Māori nurses claim (Wai 2713)

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

1.2.3.10 The health services (Tamihere) claim (Wai 2720)

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

1.2.3.11 The natural and indigenous health care treatments claim (Wai 2727)

Tanya Filia, of Ngāpuhi, alleged prejudice as a result of a lack of funding for, public promotion of and access to mirimiri and other indigenous health treatments.¹¹¹ Filia also argued that the primary health care system does not adequately account for 'Maori tikanga, values and practices when dealing with Maori and treating Maori patients.'¹¹²

105. Submission 3.3.15, paras 4–6, 10.

106. Submission 3.3.15, para 177.

107. Submission 3.3.20, paras 8.

108. Submission 3.3.20, paras 28, 30.

109. Submission 3.3.27, paras 18–19, 21.

110. Submission 3.3.27, paras 21, 300.

111. Wai 2727 claim 1.1.1, paras 6, 8.4.

112. Wai 2727 claim 1.1.1, paras 8.5.

1.2.3.12 The mental health and addiction (Fergusson-Tibble) claim (Wai 2738)

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

1.2.3.13 Additional claims represented by Te Mata Law Ltd

Te Mata Law's submissions on behalf of multiple interested parties¹¹⁵ focused on the alleged existence of institutional racism in the primary health care framework and system.¹¹⁶ These interested parties submitted that a 'revamping' of the primary health care framework is required to remedy Māori health inequity, including more robust clauses in legislation and policy explicitly referring to Treaty principles, a requirement that district health boards prioritise equity, and changes to accountability and funding arrangements.¹¹⁷

1.3 THE SCOPE OF THIS REPORT

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

Elsewhere, we have expressly stated that stage one was not intended to be a broad, all-purpose inquiry into primary health. We said that in stage one, we would specifically inquire into and report on the Māori Primary Health Organisations and Providers (Wai 1315) and National Hauora Coalition (Wai 2687) claims and the issues they raise as set out in the Statement of Issues.¹¹⁹ We were assisted in that process by hearing evidence and submissions from various interested parties illustrating points in response to questions posed in the Statement of Issues, which

¹¹³. Submission 3.3.29, paras 135.2, 135.3.

¹¹⁴. Submission 3.3.29, para 2.

¹¹⁵. Including: Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2638, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, and Wai 1832.

¹¹⁶. Submission 3.3.15, paras 3–5.

¹¹⁷. Submission 3.3.15, para 167.

¹¹⁸. Submission 3.3.23, para 51; submission 3.3.32(a), p 3; transcript 4.1.8, pp 45, 65, 70, 176–177.

¹¹⁹. Memorandum 2.5.25, para 90; memorandum 2.5.30, para 19; see also Statement of Issues 1.4.1.

1.4

referred to the primary health care framework as well as various issues related to its implementation in practice.

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

1.4 THE STRUCTURE OF THIS REPORT

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

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

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

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

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

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

CHAPTER 2

WHY IS THIS INQUIRY NEEDED?

*He ngana riri; he ngana tauā***2.1 INTRODUCTION**

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

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

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

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

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

and:

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

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

1. Submission 3.3.3, para 2.

2. Document A59, para 22.

3. Document A65, para 65.

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

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

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

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

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

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

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

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

4. Submission 3.3.2, para 9.

5. Document A59, para 20.

6. Document A60, para 16.

7. Document A9, para 13.

8. Document A63, para 138.

9. Document A63, para 138.

10. *Tatau Kahukura: Māori Health Chart Book*, Public Health Intelligence Monitoring Report No 5 (Wellington: Ministry of Health, 2006), pp 29–30; doc A63, para 136.

11. Document A63, para 139.

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

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

Total cardiovascular disease mortality was more than two-and-a-half times higher for Māori than for non-Māori; Māori were twice as likely to be hospitalised for cardiovascular disease than non-Māori[;]

Stroke mortality was nearly twice as high in Māori than in non-Māori, and the stroke hospitalisation rate for Māori was twice that of non-Māori[;]

The heart failure mortality rate for Māori was almost three times the rate for non-Māori. Māori were five-and-a-half times more likely to be hospitalised for heart failure than non-Māori[;]

Rheumatic heart disease mortality was more than eight-and-a-half times higher in Māori than in non-Māori[;]

Māori rates of mortality from all types of cancer were twice those of non-Māori[;]

Māori females had a breast cancer registration rate 1.3 times that of non-Māori females, but a breast cancer mortality rate twice that of non-Māori females. For cervical cancer, Māori females had a registration rate twice that of non-Māori; however the mortality rate for Māori females was disproportionately higher at four times that of non-Māori females[;]

Māori females had a lung cancer registration rate four-and-a-half times that of non-Māori females. The relative disparity was slightly higher for lung cancer mortality, with Māori females having a rate five times that of non-Māori females[;]

Māori male lung cancer registration and mortality rates were three times those of non-Māori males[;]

For Māori males, the liver cancer registration rate was five-and-a-half times that of non-Māori males[;]

Rates of stomach cancer registration and mortality were almost three times higher for Māori males than for non-Māori males[;]

For many cancers the rate ratio for Māori compared with non-Māori is higher for mortality rates than for registration rates. This suggests that Māori with cancer may be more likely to die from their cancer than non-Māori[;]

Prostate cancer registration was lower for Māori males than for non-Māori males. However, Māori males had a prostate cancer mortality rate twice that of non-Māori males[;]

Māori aged 5 to 34 were twice as likely to be hospitalised for asthma as non-Māori . . . Māori aged 15 to 45 years reported an asthma prevalence rate one-and-a-half times that of non-Māori[;]

Māori aged 45 years or more had a COPD [Chronic Obstructive Pulmonary Disease] hospitalisation rate four times that of non-Māori. The relative inequality was greatest

12. Document A63, para 144.

13. Document A9, para 14.

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

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

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

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

2.3 WHY ARE MĀORI HEALTH OUTCOMES SO BAD COMPARED WITH THOSE OF NON-MĀORI?

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

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

14. *Tatau Kahukura* (2006), p 37, pp 39–47.

15. *Tatau Kahukura* (2006), pp 50–58.

16. Document A60, para 9; doc A59, paras 21, 28. These factors include health determinants within the remit of the health sector that relate to issues outside of the scope of our stage one inquiry.

17. Submission 3.3.4, para 62.

18. Document A51, para 17.

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

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

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

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

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

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

The 1990s saw many health reforms as successive governments grappled with persisting inequities in health care. Reforms included the introduction of a Community Services Card, allocated on the basis of income, that entitled general practitioners to claim a subsidy, thus lowering the fee charged to the patient; the formation of four Regional Health Authorities that held all funding for health and disability care, only to be replaced by a national Health Funding Authority; and the rise and growth of Independent Practitioner Associations, associations that represented and negotiated on behalf of general practitioners.²⁴ The reforms also

19. Memorandum 3.1.155, para 1.11.

20. Document A57, para 10.

21. *Puao-te-ata-tu: The Report of the Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare* (Wellington: Department of Social Welfare, 1988), p 19.

22. Document A57, para 14.

23. Document A59, para 32.

24. Document A60, para 22.

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saw the growth and funding of Māori-led providers of primary and community care.²⁵

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

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

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

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

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

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

The parties particularly highlighted the formation of primary health organisations, which broadly superseded Independent Practitioner Associations, as a real opportunity for community-owned and -driven care. Claimant Janice Kuka similarly spoke of the ‘great hope’ inspired by the Act with its references to the Treaty of Waitangi. She stated that it provided hope for ‘real partnerships between us and the Crown to improve Māori health’. The Act provided an opportunity to build an alternative model to the existing private general practice: Māori organisations

25. Document A63, para 82; doc A9, para 11.

26. New Zealand Public Health and Disability Act 2000, s3(1)(b).

27. *Primary Health Care Strategy* (Wellington: Ministry of Health, 2001), pp vii, 2–3, 10–11.

28. Transcript 4.1.4, p 574.

would be able to provide, in Kuka's words, 'our kaupapa Māori based philosophy and operation from a not-for-profit paradigm'.²⁹

2.5 MĀORI HEALTH INEQUITIES PERSIST

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

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

In 2013, 23.5 percent of Māori lived in decile 10 (most deprived) areas (compared with 6.8 percent of non-Māori)[;]

In 2013/14, Māori adults were almost twice as likely as non-Māori adults to have experienced racial discrimination in their lifetime[;]

Overall the gap in life expectancy at birth between Māori and non-Māori is 7.3 years for males and 6.8 years for females[;]

Ischaemic heart disease is the leading cause of death for [the] Māori population in 2010–12, except for Māori females, for whom lung cancer is the most common cause of death[;]

While New Zealand performs well internationally in terms of cancer outcomes, Māori experience a disproportionate burden of cancer. Māori with cancer have a higher risk of dying from their cancer than non-Māori (1.7 times as likely) in 2010–12[;]

Māori adults aged 25 and over had significantly higher cancer registration rates than non-Māori adults for total cancers in 2010–12. The total-cancer mortality rate among Māori adults is more than one-and-a-half times as high as that among non-Māori adults in 2010–12[;]

There are screening programmes for both breast and cervical cancer in New Zealand. For both these programmes, coverage rates to 31 March 2015 were lower for Māori than for non-Māori[;]

In 2010–12, the total cardiovascular disease mortality rate among Māori was more than twice as high as that among non-Māori[;]

In 2010–12, Rheumatic heart disease mortality is over five times that of non-Māori, while rheumatic heart disease hospitalisation is almost six times that of non-Māori[;]

Māori aged 5–34 years were more than twice as likely as non-Māori in the same age group to have been hospitalised for asthma in 2012–14[;]

The chronic obstructive pulmonary disease (COPD) mortality rate among Māori aged 45 and over is almost three times that of non-Māori in the same age group in

29. Document A12, paras 16, 25.

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

2.5

2010–12. Māori aged 45 and over had a COPD hospitalisation rate over four times that of non-Māori in the same age group in 2012–14[;]

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

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

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

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

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

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

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

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

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

Māori children and adults were more likely than non-Māori children and adults to have reported not collecting prescriptions due to cost in 2013/14.³¹

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

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

It is striking to us that the Director-General was repeating in 2018, word for word, a statement published in 2006 in the *Māori Health Chart Book* referenced earlier in this chapter. This Crown report goes on to say: ‘This is not acceptable,

31. Document A59(a), pp 11–16.

32. Documents B1–B21.

33. Document A59, para 23; doc A63, para 138.

and the Government and the Ministry of Health have made it a key priority to reduce the health inequalities that affect Māori.³⁴

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

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

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

34. *Tatau Kahukura* (2006), p1.

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

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CHAPTER 3

TREATY PRINCIPLES

*Ue-ue 'Nuku; Ue-ue Rangi***3.1 INTRODUCTION**

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

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

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

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

3.2 PARTNERSHIP

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

1. *New Zealand Maori Council v Attorney General* [1987] 1 NZLR 641 (CA), p 667.

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

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

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

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

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

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

2. The Treaty of Waitangi Act 1975, sch 1, arts 1, 2.

3. Waitangi Tribunal, *Te Whanau o Waipareira Report* (Wellington: GP Publications, 1998), p xxvi.

4. Waitangi Tribunal, *Tū Mai te Rangi! Report on the Crown and Disproportionate Reoffending Rates* (Wellington: Legislation Direct, 2017), p 21.

5. Waitangi Tribunal, *The Napier Hospital and Health Services Report* (Wellington: Legislation Direct, 2001), p 66.

6. Waitangi Tribunal, *Te Whanau o Waipareira Report*, pp xxvi, 16, 30.

7. Waitangi Tribunal, *Te Whanau o Waipareira Report*, p 232; Waitangi Tribunal, *The Napier Hospital Report*, p 59; Waitangi Tribunal, *The Te Urewera Report*, 8 vols (Wellington: Legislation Direct, 2017), vol 8, p 3783; Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims Concerning New Zealand Law and Policy Affecting Māori Culture and Identity*, *Te Taumata Tuarua*, 2 vols (Wellington: Legislation Direct, 2011), vol 2, p 559.

8. Waitangi Tribunal, *Te Whanau o Waipareira Report*, p 25.

9. Waitangi Tribunal, *Matua Rautia: The Report on the Kōhanga Reo Claim* (Wellington: Legislation Direct, 2013), pp 64–65.

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

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

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

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

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

In other words, what might appear at the time to be a Treaty-consistent partnership arrangement may not have lived up to its promise. We emphasise this point because the Tribunal in *The Napier Hospital Report* found that the New Zealand Public Health and Disability Act 2000, in committing the Crown and its health

10. Waitangi Tribunal, *Tū Mai te Rangi!*, pp 62–63.

11. Waitangi Tribunal, *Ko Aotearoa Tēnei: Te Taumata Tuarua*, vol 2, p 559.

12. Waitangi Tribunal, *Te Urewera*, vol 8, p 3773.

13. Waitangi Tribunal, *The Napier Hospital Report*, p xxvi.

14. Waitangi Tribunal, *Ko Aotearoa Tēnei: Te Taumata Tuarua*, vol 1, p 284; vol 2, p 705.

15. Waitangi Tribunal, *Tū Mai te Rangi!*, p 64.

agencies to several specific obligations to Māori, was consistent with the principles of partnership and equity. That finding was made shortly after the advent of the then-new Act.¹⁶ We discuss these findings later in our report.

3.3 ACTIVE PROTECTION

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

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

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

16. Waitangi Tribunal, *The Napier Hospital Report*, pp 314.

17. Waitangi Tribunal, *The Whakatōhea Mandate Inquiry Report* (Wellington: Pre-publication version, 2018), p 23; Waitangi Tribunal, *Tū Mai te Rangī!*, p 21; *New Zealand Maori Council v Attorney-General* [1987] 1 NZLR 641 (CA), p 664.

18. Waitangi Tribunal, *Tauranga Moana, 1886–2006: Report on the Post-Raupatu Claims*, 2 vols (Wellington: Legislation Direct, 2010), vol 1, p 22; Waitangi Tribunal, *The Ngāpuhi Mandate Inquiry Report*, p 23; Waitangi Tribunal, *Te Whanau o Waipareira Report*, p 215.

19. Waitangi Tribunal, *The Ngātiwai Mandate Inquiry Report* (Wellington: Legislation Direct, 2017), p 27; Waitangi Tribunal, *Te Whanau o Waipareira Report*, p 215; Waitangi Tribunal, *Ngāpuhi Mandate Inquiry Report*, p 24; Waitangi Tribunal, *Turanga Tangata Turanga Whenua: The Report on the Turanganui a Kiwa Claims*, 2 vols (Wellington: Legislation Direct, 2004), vol 2, p 739.

20. Waitangi Tribunal, *The Ngāpuhi Mandate Inquiry Report*, p 23.

21. Waitangi Tribunal, *Tauranga Moana*, vol 1, p 20; Waitangi Tribunal, *He Maunga Rongo: Report on the Central North Island Claims*, 4 vols (Wellington: Legislation Direct, 2008), vol 1, p 172; Waitangi Tribunal, *The Taranaki Report: Kaupapa Tuatahi* (Wellington: Legislation Direct, 1996), pp 6, 20.

22. Waitangi Tribunal, *Te Mana Whatu Ahuru: Report on Te Rohe Pōtae Claims – Pre-publication Version Parts I and II* (Wellington: Waitangi Tribunal, 2018), p 189.

23. *New Zealand Maori Council v Attorney-General* [1994] 1 NZLR 513 (PC), p 517.

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

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

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

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

An approach to health care that assumes that the needs of all patients are largely the same not only undermines the recognition of tikanga Māori but may

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

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

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

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

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

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

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

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

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

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

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

30. Document A59(a), paras 4–5.

31. Waitangi Tribunal, *Te Urewera*, vol 8, pp 3776–3777.

32. Waitangi Tribunal, *The Napier Hospital Report*, p 362.

33. Waitangi Tribunal, *The Napier Hospital Report*, p 175.

34. Waitangi Tribunal, *The Napier Hospital Report*, pp 53–54. See also Waitangi Tribunal, *Tū Mai te Rangi!*, p 27.

35. Waitangi Tribunal, *Tū Mai te Rangi!*, p 54.

inquiry should have compelled the Crown ‘to do all it could’ to achieve Māori health equity.³⁶ The Tribunal also observed that given the Crown’s knowledge of the persistence of Māori health disparities since the mid-twentieth century, it would be reasonable in Treaty terms to expect the Crown to implement positive steps to reduce these disparities.³⁷

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

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

3.4 EQUITY

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

36. Waitangi Tribunal, *Tauranga Moana*, vol 2, p 811.

37. Waitangi Tribunal, *Tauranga Moana*, vol 2, pp 809–810.

38. Waitangi Tribunal, *The Napier Hospital Report*, p 64.

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

40. Waitangi Tribunal, *Tū Mai te Rangi!*, p 60.

41. Waitangi Tribunal, *The Napier Hospital Report*, p 64.

42. The Treaty of Waitangi Act 1975, sch 1, art 3.

43. Waitangi Tribunal, *The Napier Hospital Report*, pp 48, 62; Waitangi Tribunal, *Report on the Crown’s Foreshore and Seabed Policy* (Wellington: Legislation Direct, 2004), p 133; Waitangi Tribunal, *The Mohaka ki Ahuriri Report* (Wellington: Legislation Direct, 2004), p 27; Waitangi Tribunal, *The Te Arawa Mandate Report* (Wellington: Legislation Direct, 2004), p 94; Waitangi Tribunal, *The Offender Assessment Policies Report* (Wellington: Legislation Direct, 2005), p 13; Waitangi Tribunal, *He Maunga Rongo*, vol 2, p 428.

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

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

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

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

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

44. Waitangi Tribunal, *Te Mana Whatu Ahuru – Pre-publication Version Parts I and II*, p 185.

45. Waitangi Tribunal, *He Maunga Rongo*, vol 2, pp 428–429.

46. Waitangi Tribunal, *Te Mana Whatu Ahuru – Pre-publication Version Parts I and II*, p 189.

47. See for example Waitangi Tribunal, *The Napier Hospital Report*, p 55; Waitangi Tribunal, *Tauranga Moana*, vol 2, p 811; Waitangi Tribunal, *The Hauraki Report*, 3 vols (Wellington: Legislation Direct, 2006), vol 3, p 1182.

48. Waitangi Tribunal, *Te Urewera*, vol 8, p 3773.

49. Waitangi Tribunal, *The Napier Hospital Report*, p 64.

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

3.5 OPTIONS

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

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

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

50. Waitangi Tribunal, *The Napier Hospital Report*, p 62;

51. Waitangi Tribunal, *The Napier Hospital Report*, p 62.

52. Waitangi Tribunal, *The Napier Hospital Report*, p 65.

53. Waitangi Tribunal, *Report of the Waitangi Tribunal on the Muriwhenua Fishing Claim* (Wellington: Waitangi Tribunal, 1988), p 195; Waitangi Tribunal, *The Ngai Tahu Sea Fisheries Report 1992* (Wellington: Brooker and Friend Ltd, 1992), p 274; Waitangi Tribunal, *The Napier Hospital Report*, p 65; Waitangi Tribunal, *The Tarawera Forest Report* (Wellington: Legislation Direct, 2003), p 28.

54. Waitangi Tribunal, *Matua Rautia*, p 68.

55. Waitangi Tribunal, *Te Tau Ihu o te Waka a Maui: Preliminary Report on Customary Rights in the Northern South Island* (Wellington: Legislation Direct, 2007), p 6.

56. Waitangi Tribunal, *The Napier Hospital Report*, pp 44, 57, 65, 175.

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

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

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

57. Waitangi Tribunal, *The Napier Hospital Report*, pp 170–171.

58. Waitangi Tribunal, *Tē Mana Whatu Ahuru – Pre-publication Version Parts I and II*, p 189.

59. Waitangi Tribunal, *The Wairarapa ki Tararua Report*, vol 1, pp 345–346.

60. Waitangi Tribunal, *Tauranga Moana*, vol 2, p 811.

61. Waitangi Tribunal, *Tauranga Moana*, vol 2, p 811.

62. Waitangi Tribunal, *Matua Rautia*, p 67.

63. Waitangi Tribunal, *Matua Rautia*, p 68.

3.6 CONCLUSION

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

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

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

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

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

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

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

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

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

3.6.4

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

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

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

64. Submission 3.3.32, para 8.

CHAPTER 4

**THE PRIMARY HEALTH CARE
LEGISLATIVE AND POLICY FRAMEWORK***Tē tūngia te kawaru rā***4.1 INTRODUCTION**

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

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

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

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

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

4.2 THE STRUCTURE OF THE PRIMARY HEALTH CARE SYSTEM**4.2.1 The New Zealand Public Health and Disability Act 2000**

The New Zealand Public Health and Disability Act 2000 (the Act), came into effect on 1 January 2001.² It established a semi-devolved health system structure.³ The system of health and disability services is organised to achieve several objectives, including:

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

The Act includes a Treaty clause in section 4:

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

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

4.2.2 The role of the Minister of Health

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

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

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

2. Document A63, para 129.

3. Document A3, para 30.

4. New Zealand Public Health and Disability Act 2000, s 3.

5. New Zealand Public Health and Disability Act 2000, s 4.

6. Document A59, para 20.

7. Document A3, paras 10, 26, 46–49.

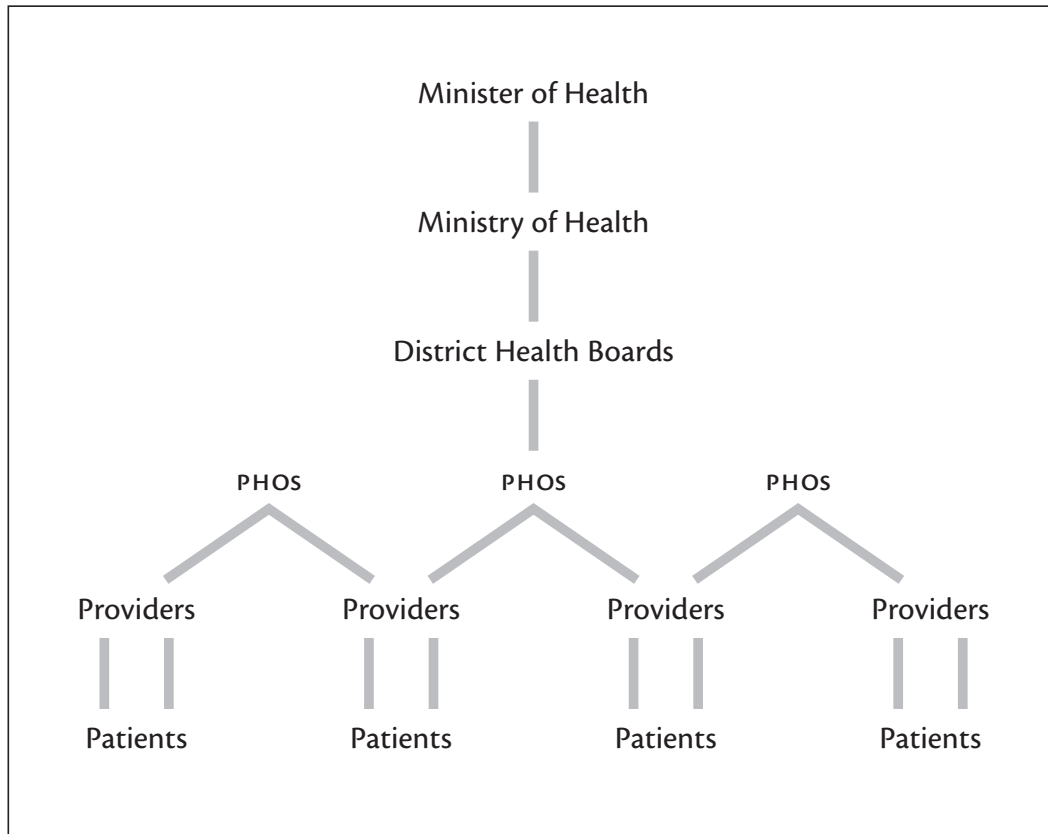


Figure 1: A basic outline of the devolved layers of the primary health care system

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

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

The Crown entity's Statement of Intent sets out the strategic objectives that the entity intends to achieve or contribute to. The Minister can require amendments or a new Statement of Intent. Entities are accountable to Parliament through these documents, which are tabled in Parliament by the Minister. The entity reports on

8. Document A3, para 50.

4.2.3

how it performed against those expectations and intentions in its annual report to Parliament.⁹

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

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

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

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

An example of this was the 2018 Mental Health and Addictions Inquiry, established under the Inquiries Act 2013.¹²

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

4.2.3 The role of the Ministry of Health

The Minister is primarily supported in these duties by the Ministry of Health. The Ministry of Health (the Ministry) is the government's primary agent for implementing health priorities and policies within the health and disability sector.¹⁴ In addition to being the principal advisor and source of support to the Minister, the Ministry has overall responsibility for the stewardship of the health and disability system.¹⁵ By statute, this includes a responsibility to work directly

9. Document A3, paras 52–53, 132, 134, 136, 198, 201–202.

10. Document A3, para 54; 'Eligibility Direction', Ministry of Health, <https://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/eligibility-direction>, last modified 15 April 2011.

11. Document A3, para 61; New Zealand Public Health and Disability Act 2000, ss 71–72.

12. Document A3, para 61; Office of the Minister of Health and Office of the Minister of Internal Affairs, 'Establishing the Government Inquiry into Mental Health and Addiction', <https://mental-health.inquiry.govt.nz/assets/Uploads/Establishing-the-Government-Inquiry-into-Mental-Health-and-Addiction.pdf>, accessed 5 February 2019.

13. Document A3, paras 56–58.

14. Document A3, para 17.

15. Document A3, para 10.

with communities, advocates and health practitioners to set a vision, goals and accountabilities for the sector.¹⁶

The Ministry's stewardship role includes a duty to keep an overview of the whole system to ensure that the capabilities and connections across organisations work together to deliver a health service that strives to improve, protect and promote the health and wellbeing of all New Zealanders. Among the ways it seeks to achieve this is by directly purchasing several national health and disability support services, and by providing health sector information and payment services for the benefit of all New Zealanders.¹⁷

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

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

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

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

- ▶ maintain the regulatory environment and national policy settings, including ensuring that legislative requirements are being met;
- ▶ fund, monitor and regulate the performance of district health boards and other health Crown entities;²³
- ▶ support the planning and accountability functions of district health boards and other health Crown entities; and

16. Document A3, paras 15, 65.

17. Document A3, paras 16, 31, 32, 65, 69.

18. Document A3, paras 15, 34.

19. Document A2, para 27; doc A63, para 47.

20. Document A2, para 28.

21. Document A3, para 38; 'Ministry of Health makes senior appointments', Ministry of Health, <https://www.health.govt.nz/news-media/media-releases/ministry-health-makes-senior-appointments>, last modified 22 April 2016.

22. Transcript 4.1.5, p 372; 'Delivering on the Ministry's Sector Leadership and Stewardship Roles: Final Decision Document on Changes to the Ministry's second-tier structure', Ministry of Health, <https://www.health.govt.nz/system/files/documents/pages/moh-structure-decision-document-1oct-2018.pdf>, last modified 1 October 2018, pp 9, 16.

23. Examples of other Crown health entities include the Health Promotion Agency, the Health Research Council of New Zealand, the New Zealand Blood Service and the Pharmaceutical Management Agency (Pharmac).

4.2.4

- ▶ work with the Accident Compensation Corporation (ACC) and the Health Quality and Safety Commission to support their respective leadership roles.²⁴

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

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

4.2.4 The roles of district health boards

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

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

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

For non-hospital services the relationship is structured differently, occurring through a cascading series of contracts. For example, district health boards buy services by contracting with primary health organisations, who in turn contract with general practitioners and other providers to deliver services to a population. Consequently, district health boards have an ownership interest in hospitals that

24. Document A3, paras 10, 18, 19, 33, 72.

25. Document A3, paras 17, 77.

26. Memorandum 3.2.95, para 2(a).

27. New Zealand Public Health and Disability Act 2000, s 22.

they do not have for other services, such as aged care services, services delivered by Māori and Pacific providers, mental health support, and medication management.

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

District health boards are Crown agents, under the Crown Entities Act 2004. This means they must give effect to a government policy that relates to the entity's functions and objectives if directed by the Minister (see the Eligibility Direction mentioned in section 4.2.2 for an example).²⁹

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

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

Each district health board has at least three advisory committees:

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

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

4.2.5 The role of primary health organisations and providers

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

28. Document A1, paras 8, 11, 12; doc A3, paras 12, 182, 183, 184; doc A63, para 130; doc A43(a), p 14.

29. Document A3, paras 127, 128.

30. New Zealand Public Health and Disability Act 2000, s 29.

31. Document A1, para 8; doc A3, table 2 in para 128, paras 192–195; doc A60, para 26.

32. Document A1, para 9.

33. Document A3, para 242.

34. Document A3, para 243.

4.2.5

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

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

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

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

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

35. Document A3, para 258; 'Primary health care providers', Ministry of Health, <https://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/primary-health-care-providers>, last modified 8 July 2014.

36. Document A63, para 185.

37. Document A63, paras 187–194.

38. Document A63, para 207

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

New Zealand now has 31 primary health organisations (South Canterbury District Health Board operates as its own primary health organisation and is sometimes referred to as the 32nd primary health organisation), which vary in size and structure, including the remaining four Māori primary health organisations. A Māori primary health organisation is defined as an organisation that is owned, governed and operated by iwi and/or a Māori organisation.⁴⁰ The four Māori primary health organisations are:

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

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

4.2.6 Relevance to this stage one inquiry

Claimants argued that the primary health care framework's intention for community owned and driven primary health care, while promising in principle, has not been fulfilled in practice and falls well short of the Treaty guarantee of tino rangatiratanga. They were critical of the Ministry's permissive approach to the system, which they alleged has allowed for health entities to ignore their responsibilities to Māori, amongst other allegations. In particular, the allowances for Māori perspectives at senior levels in Crown health entities, such as representatives on district health boards and senior staff and business units within the Ministry, are charged

39. Document A63, para 209.

40. Document A3, paras 257, 259.

41. Document A12, paras 3–4, 16–17.

42. Document A23, paras 2, 14.

43. 'About Us', Ngāti Porou Hauora Charitable Trust, <https://www.nph.org.nz/about-us>, accessed 13 February 2019.

44. 'Ora Toa PHO', Ora Toa PHO, <http://www.oratoa.co.nz/>, accessed 13 February 2019.

45. Document A63, para 196; 'Māori health providers', Ministry of Health, <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers>, last modified 14 February 2014.

4.3

as inadequate. Both claimant groups argued for far greater input into and control of the design and implementation of primary health services in ways that are not facilitated by the structure of the primary health care system as set out by the Act.

4.3 SETTING THE FRAMEWORK FOR PRIMARY HEALTH CARE

4.3.1 The New Zealand Health Strategy

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

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

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

4.3.2 The Primary Health Care Strategy

Following the introduction of the New Zealand Health Strategy, the government released the Primary Health Care Strategy in 2001, intended to provide a direction for the future development of primary health care in New Zealand. This strategy sits under, and reflects the direction of, the New Zealand Health Strategy and the New Zealand Disability Strategy 2002 (which was still being developed at that time). The Primary Health Care Strategy was prepared in response to a problem: the delivery of primary health care services was not working well for everyone.

46. Document A63, paras 216–217.

47. Document A62, paras 334–336; 'The New Zealand Health Strategy 2016', Ministry of Health, <https://www.health.govt.nz/publication/new-zealand-health-strategy-2016>, last modified 18 April 2016.

Publicly funded health services (particularly primary care services) were not reaching some population groups to the degree needed (such as Māori, Pacific peoples, youth, people with disabilities and those on low incomes), nor successfully addressing all barriers to access (including cost and opening hours).⁴⁸

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

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

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

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

The Primary Health Care Strategy introduced three major changes, by:

- ▶ providing an increase in funding to support primary health care, with the aims of reducing the fees that patients pay for services, extending eligibility for government funding of primary health care to the entire enrolled population, and expanding the services provided;
- ▶ mandating the development of primary health organisations as local non-governmental organisations to serve the primary health care needs of their enrolled patients; and

48. Document A63, paras 178–180.

49. Document A63, paras 192, 202.

50. Document A63, paras 182, 198

51. Document A60, para 36; doc A63, para 183.

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- ▶ changing the method of allocating the public share of primary health care funding from fee-for-service subsidies at the practitioner level to (largely) capitation funding of primary health organisations.⁵²

The Primary Health Care Strategy was introduced within a context of broader reforms to New Zealand's health and disability system, with several other health strategies introduced or prepared at the time. One of these was He Korowai Oranga, the Māori Health Strategy.⁵³

4.3.3 He Korowai Oranga

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

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

He Korowai Oranga sought the following outcomes for whānau:

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

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

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

It aspired to improve Māori outcomes through:

52. Document A60, para 37.

53. Document A63, para 231.

54. Document A63, paras 220–221.

55. Document A63, para 222.

56. Document A63, para 223.

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

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

4.3.4 Relevance to this stage one inquiry

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

4.4 FUNDING ARRANGEMENTS FOR PRIMARY HEALTH CARE

4.4.1 Vote Health funding

Vote Health, the government funding administered by the Ministry, totalled \$15.910 billion in 2017–18.⁶⁰ Additional significant funding for health comes from ACC, other government agencies such as the Ministry of Social Development, the Department of Corrections, the Ministry of Education, and the Ministry of Business Innovation and Employment; local government – for prevention and public services; and private sources such as insurance and user fees.⁶¹

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

57. Document A63, para 224.

58. Document A62, para 331.

59. Submission 3.3.18, paras 102–104; submission 3.3.30, paras 4.42, 5.49.3, 5.57.4.

60. Memorandum 3.2.95, para 2(a).

61. Document A1, para 5; doc A3, paras 43–44; ‘The Estimates of Appropriations 2018/19 – Health Sector’, Budget.govt, <https://www.budget.govt.nz/budget/2018/estimates/v6/index.htm>, last modified 17 May 2018.

62. Memorandum 3.2.95, para 2(e).

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size of the health system and the significant number of patients it serves (termed diseconomies of scale). As mentioned above, this approach to funding is intended to help reduce inequities by directing resources to communities with the greatest health need.⁶³

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

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

4.4.2 Capitation funding for primary health care

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

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

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

63. Document A3, paras 11, 45, 236–237. Table 3 shows an example of district health board populations and funding for 2017–18 (doc A3, para 187); doc A63, para 198.

64. Transcript 4.1.7, pp 164, 272.

65. Document A3, paras 238–239.

and the following section are summarised in Table I. This table is drawn from the evidence of Amy Downs, who completed a study of primary care funding in New Zealand in 2017.⁶⁶

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

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

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

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

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

66. Document A43(a).

67. Document A9, para 17; doc A43, paras 7, 11–12; doc A43(a), p 15; doc A60, para 44; doc A62, paras 105–107; 'Capitation funding', Ministry of Health, <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/capitation-funding>, last modified 8 July 2014.

68. Document A43, para 13; doc A43(a), pp 15–16; doc A62, paras 214–217.

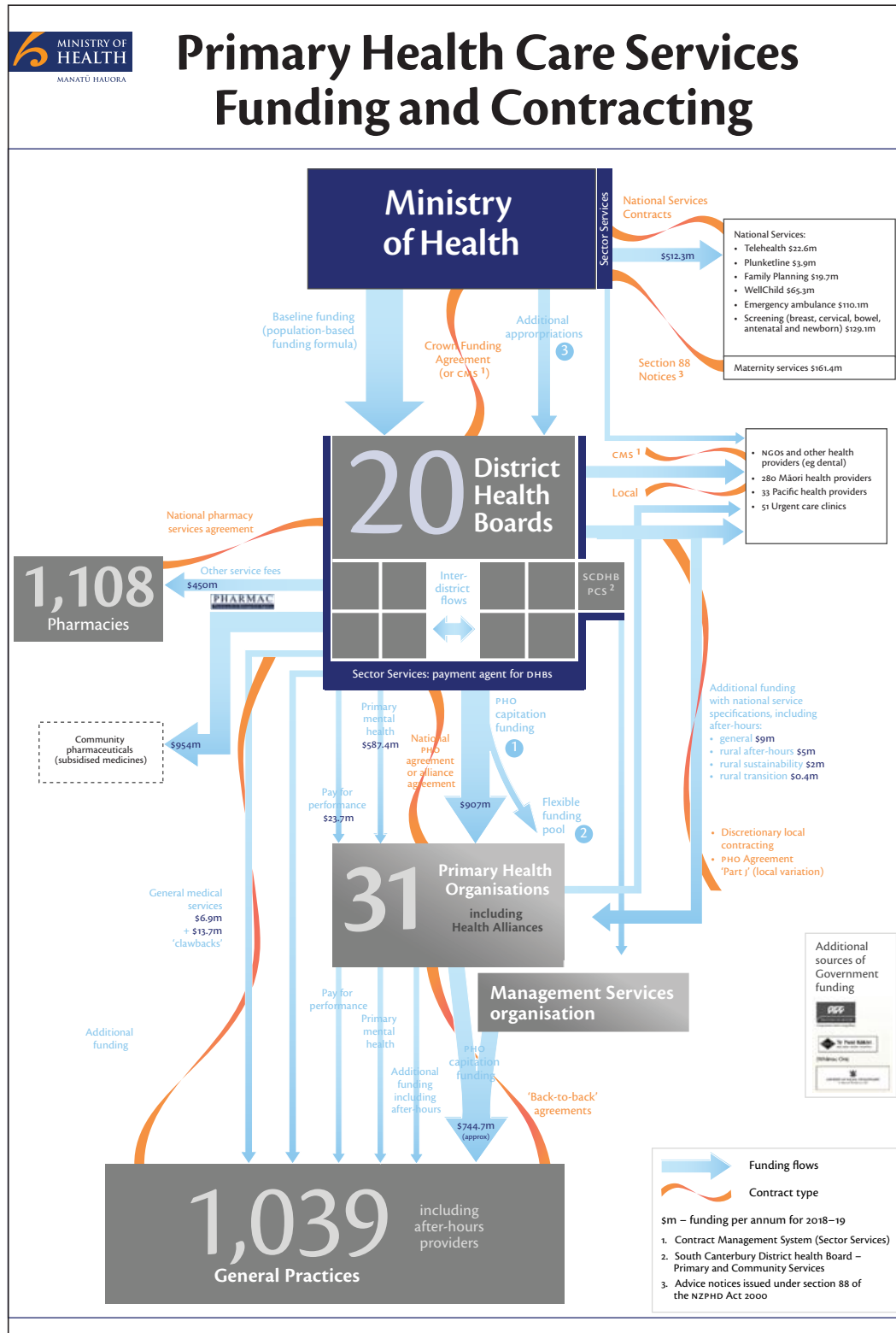


Figure 2: The relationships between funding and contracting for primary health care services

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

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

4.4.3 Other capitated funding streams

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

Services to Improve Access funding was established in 2002 to enable primary health organisations to introduce new approaches to reach people with high health needs who might be accessing the services they need because of various barriers such as language, distance and transport. Some examples of these approaches included primary care nurses and community nurses taking a key role in delivering primary care services in collaboration with schools, marae and community groups.⁷²

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

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

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

69. Document A62, paras 218–220; doc A60, paras 47–48; Pete Hodgson, ‘More support for free doc visits for under-6s’, Beehive.govt, <https://www.beehive.govt.nz/release/more-support-free-doc-visits-under-6s>, last modified 28 August 2007.

70. Document A43, para 19; doc A60, para 49; doc A62, paras 109, 130, 216.

71. Memorandum 3.2.95, para 2(c).

72. Document A9, para 26; doc A62, paras 128–129.

73. Document A62, paras 132–134.

74. Document A43, para 20; doc A62, para 140.

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

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

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

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

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

Source: Document A43(a), p 35

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

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

4.4.4 Other funding to primary health organisations

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

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

75. Document A62, paras 135–136, 283.

76. Document A43(a), p 16; doc A62, paras 269–274.

77. Memorandum 3.2.95, pp 3–4.

78. Document A62, para 121.

79. Ross Barnett and Pauline Barnett, 'Primary Health Care In New Zealand: Problems and Policy Approaches', *Social Policy Journal of New Zealand* 21 (March 2004); Pauline Barnett, Judith Smith, and Jacqueline Cumming, *The Roles and Functions of Primary Health Organisations* (Wellington: Health Services Research Centre, 2009).

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

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

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

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

The scheme currently provides for \$9 million per annum for these initiatives. This budget has not materially changed since the scheme was established in 1997.⁸¹

4.4.5 Relevance to this stage one inquiry

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

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

4.5 HOLDING ENTITIES TO ACCOUNT FOR PERFORMANCE

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

4.5.1 Government expectations and directions

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

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

81. Document A62, para 176.

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

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

4.5.2 Planning documents

4.5.2.1 Annual plans

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

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

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

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

District health boards are required to deliver on their annual plan under a Crown Funding Agreement (see below). They report progress in delivery on either

82. Document A3, paras 132, 133.

83. Document A3, para 235; New Zealand Public Health and Disability Act 2000, ss 32–33(b).

84. Document A3, para 216.

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a quarterly or six-monthly basis, depending on the priority area. The Ministry has a structured web-based feedback process in place for each deliverable. Summary reports are provided to the Minister each quarter. These reports are also shared with district health boards' Chairs and Chief Executives and central government agencies.

4.5.2.2 Regional service plans

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

The regions are:

- ▶ the Northern region, which comprises the Northland District Health Board, the Waitemata District Health Board, Auckland District Health Board, and Counties Manukau District Health Board;
- ▶ the Midland region, which comprises the Waikato District Health Board, Bay of Plenty District Health Board, Lakes District Health Board, Tairāwhiti District Health Board, and Taranaki District Health Board;
- ▶ the Central region, which comprises the Capital & Coast District Health Board, Hawke's Bay District Health Board, Hutt Valley District Health Board, MidCentral District Health Board, Wairarapa District Health Board, and Whanganui District Health Board; and
- ▶ the South Island region, which comprises the Nelson Marlborough District Health Board, West Coast District Health Board, Canterbury District Health Board, South Canterbury District Health Board, and Southern District Health Board.⁸⁶

4.5.3 Relevance to this stage one inquiry

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

4.5.4 Accountability documents

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

85. Document A3, para 224; doc A3(a), app 6, pp 37–39.

86. *Regional Services Planning: How District Health Boards Are Working Together to Deliver Better Health Services* (Wellington: Ministry of Health, 2012).

4.5.4.1 Statement of Intent

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

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

4.5.4.2 Statement of Performance Expectations

Each district health board includes their Statement of Performance Expectations in their Annual Plan. As well as setting out the non-financial performance measures against which the entity's performance can be assessed, it also contains the forecast financial statements for the current year. The board signs it off and the Minister tables it in Parliament.⁸⁸

4.5.4.3 Crown Funding Agreement

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

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

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

87. Document A3, paras 201–202; Crown Entities Act 2004, s139.

88. Document A3, paras 204–205; Crown Entities Act 2004, s149(e).

89. Document A3, paras 208–209; doc A3(a), app 7, p 64; New Zealand Public Health and Disability Act 2000, s10.

90. Document A3, para 210; doc A3(a), app 8, pp 177–178.

4.5.4.4

4.5.4.4 Annual report

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

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

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

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

4.5.5 Financial and non-financial performance measures

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

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

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

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

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

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

- › reducing hospital admission rates for children aged 0–4 years old;
- › reducing how long people stay in hospital;
- › reducing amenable mortality;⁹⁵
- › improving patient experience of care;
- › increasing the proportion of babies living in smoke-free homes at six weeks post-birth; and
- › improving youth access to and use of appropriate health services.⁹⁶

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

4.5.6 Managing arrangements between district health boards and primary health organisations

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

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

93. Document A3, para 228.

94. Document A3, para 233.

95. Amenable mortality is premature death that could potentially have been prevented, given effective and timely health care.

96. Document A3, para 234.

97. Document A3, paras 230–234.

4.5.7

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

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

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

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

4.5.7 Relevance to this stage one inquiry

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

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

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

98. Document A65, paras 16–18, 36–37; doc A62, paras 294–295.

99. Document A65, paras 41–42.

100. Document A65, paras 44–45.

101. Submission 3.3.3, para 14.

CHAPTER 5

**IS THE NEW ZEALAND PUBLIC HEALTH AND
DISABILITY ACT 2000 TREATY-COMPLIANT?***Ko te hau tonga ka maranga mai rā***5.1 INTRODUCTION**

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

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

The Crown also submitted that the Act and major strategies contain ‘goals and objectives aimed at giving effect to the Treaty relationship between Māori and the Crown’, though acknowledged that some of these expressions could be seen as outdated.³

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

1. *Tatau Kahukura: Māori Health Chart Book*, Public Health Intelligence Monitoring Report No 5 (Wellington: Ministry of Health, 2006), p 1.

2. Submission 3.3.32, paras 65–66.

3. Submission 3.3.32, para 31; transcript 4.1.5, p 351.

4. We take into consideration and respond to the issues posed in sections 2, 3, 7 and 9 of the Statement of Issues (document: 1.4.1).

5.2 EQUITY AND THE NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

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

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

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

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

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

5. Submission 3.3.32, para 65.

6. New Zealand Public Health and Disability Act 2000, s 3(1)(b).

7. Crown Response to Statement of Issues, 1.3.1, p 1.

8. Submission 3.3.32, para 24.

9. Submission 3.3.32, para 65.

10. Submission 3.3.35, para 3; submission 3.3.4, para 76.

11. Submission 3.3.30, paras 5.35, 5.36.2.

12. Submission 3.3.30, para 5.34.

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

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

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

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

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

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

As such, in order to be consistent with the Treaty principles of active protection and equity, health equity needs to be an explicit aim of the health system. Overall, all parties to this inquiry were of the same mind that achieving equitable health outcomes should be the kaupapa, or central purpose, of the health system.¹⁵ Director-General of Health Dr Ashley Bloomfield, who appeared before us as a Crown witness, stated that one of the Government's overarching goals for health care is 'to deliver improved and more equitable health outcomes.'¹⁶ We were told that a population-based approach to health that attempted to focus on improving inequities was the broad motivation behind the primary health reforms ushered in by the passing of the new Act in 2000 and the Primary Health Care Strategy in 2001.¹⁷

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

14. Submission 3.3.30, para 5.1.

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

16. Document A59, paras 37.

17. Document A9, paras 15–20; doc A9(b), pp 16–19; doc A63, paras 192, 229.

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

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

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

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

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

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

In the *Napier Hospital Report*, released in 2001, the Tribunal said that the Act's commitment to reduce health disparities of population groups was 'fully consistent with the Treaty principle of equity'.²² We understand why the Tribunal came to this conclusion at that time. The Act was new: it had introduced specific provisions aimed at improving Māori health outcomes and allowing for greater participation

18. Transcript 4.1.7, p 177.

19. As Dr Rawiri Jansen pointed out in his evidence (see doc A2, para 15).

20. Transcript 4.1.5, p 43. See also Professor Crampton's comments in doc A9, para 20.

21. Submission 3.3.30, paras 2.60–2.61.

22. Waitangi Tribunal, *The Napier Hospital and Health Services Report* (Wellington: Legislation Direct, 2001), p 64.

in governance and input into decision-making by Māori, at least at the district health board level. The reforms, at the time, created a sense of optimism.

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

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

5.3 EQUITY AND THE POLICY FRAMEWORK

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

The National Hauora Coalition claimants acknowledge that the Primary Health Care Strategy has more precise wording around committing the primary care sector to addressing health inequalities.²⁸ One of the six key directions of the Primary Health Care Strategy is to ‘identify and remove health inequalities’. The outline of this goal mentions that Māori and Pasifika health outcomes are poor compared to the rest of the population. It also specifically acknowledges that these health disparities cannot ‘be explained by socioeconomic differences alone.’²⁹

23. Waitangi Tribunal, *The Napier Hospital Report*, p 64.

24. Waitangi Tribunal, *The Napier Hospital Report*, p 64.

25. *New Zealand Health Strategy: Future Directions* (Wellington: Ministry of Health, 2016), pp 6, 14.

26. Submission 3.3.30, paras 4.30–4.31; 5.34.2.

27. Document A60, para 32.

28. Submission 3.3.30, paras 4.51–53, 5.35.

29. *Primary Health Care Strategy* (Wellington: Ministry of Health, 2001), p 10.

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

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

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

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

In these and other ways, *He Korowai Oranga* was much more specific in its objectives relating to health inequalities. In the foreword, the responsible ministers acknowledged that public policies should address the social and economic determinants of health, including institutional racism.⁴⁰ Indeed, the goals and

30. Transcript 4.1.4, p 600.

31. Document A60, para 38.

32. Transcript 4.1.5, p 466.

33. Transcript 4.1.4, p 596.

34. Transcript 4.1.4, pp 597–598.

35. Submission 3.3.18, para 103; submission 3.3.23, para 12; submission 3.3.30, para 5.36.3; submission 3.3.32, para 32.

36. *He Korowai Oranga: Māori Health Strategy* (Wellington: Ministry of Health, 2002), p 8.

37. *He Korowai Oranga*, p 26.

38. *The Guide to He Korowai Oranga: Māori Health Strategy* (Wellington: Ministry of Health, 2014), p 9; ‘Equity’, Ministry of Health, last modified 13 October 2015, <https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/key-threads/equity>.

39. *The Guide to He Korowai Oranga*, p 12.

40. *He Korowai Oranga*, p iii.

discussion in He Korowai Oranga are reflective of hauora rather than a Western model of health, at least compared to the other overarching strategies. Director-General Dr Bloomfield emphasised the centrality of He Korowai Oranga in his evidence:

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

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

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

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

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

District health boards' statutory obligation 'to reduce health disparities by improving health outcomes for Māori and other population groups', and further to reduce disparities between population groups 'with a view to eliminating' them, is also reinforced in the district health boards' Crown Funding Agreement and its appended *Operational Policy Framework*.⁴⁷ The *Operational Policy Framework* is more specific in its commitment to equity, providing for the following: 'Each

41. Document A59, para 41.

42. Submission 3.3.18, para 103–104; submission 3.3.23, para 8.

43. Submission 3.3.32, para 61–62.

44. New Zealand Public Health and Disability Act 2000, s8(1).

45. Submission 3.3.30, para 5.36.3.

46. Document A59, para 37.

47. New Zealand Public Health and Disability Act 2000, s22(1)(e), (f); submission 3.3.30, paras 4.57, 4.61.

DHB must aim to achieve health equity between various population groups within New Zealand, including Māori, by developing and implementing services and programmes, in consultation with Māori.⁴⁸

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

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

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

The System Level Measures framework, formally initiated in 2016, also sets expectations of equity for district health boards, with incentives for pursuing or achieving equitable outcomes. However, while developing plans for System Level Measures is a mandatory accountability mechanism, Professor Crampton said that ‘there is very little monitoring from an equity perspective’ in relation to the framework.⁵³ Interested party witness Amy Downs, who in 2017 published a report on the nature and efficacy of funding for New Zealand health care, agreed. Her concerns included the relatively small level of funding and the fact that incentive

48. *Operational Policy Framework 2018/19*, revised ed (Wellington: Ministry of Health, 2019), <https://nsfl.health.govt.nz/accountability/operational-policy-framework-o/operational-policy-framework-201819>, para 3.10.6.

49. ‘PHO Services Agreement – Version 6’, Ministry of Health (1 December 2018), <https://tas.health.nz/dhb-programmes-and-contracts/primary-care-integration-programme/primary-health-organisation-service-agreement-amendment-protocol/>, last modified 20 March 2019, pp 31, 32.

50. Submission 3.3.30, paras 4.69–4.70.

51. Document A60, para 30.

52. Submission 3.3.30, paras 4.68–4.69.

53. Document A9, para 41.

payments were, at least according to the people she interviewed, likely to be paid out regardless of performance.⁵⁴ Professor Cumming was cautiously positive about System Level Measures in her evidence but nonetheless pointed out that the measures chosen by the Ministry ‘do not distinguish between Māori and other populations.’⁵⁵

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

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

5.4 HEALTH DISCOURSE

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

The conflation of terms in health discourse highlighted by the National Hauora Coalition claimants, then, is important. Indeed, this was acknowledged in the fourth volume of the Eru Pōmare Health Research Centre’s *Hauora* series, released in 2006. The first chapter, co-authored by Professor (then Dr) Papaarangi Reid and Bridget Robson, painstakingly defined equity, differentiated it from ‘health inequalities’, and then acknowledged:

54. Document A43, para 26.

55. Document A60, para 31.

56. Document A3, paras 230–232; doc A62, paras 278–282.

57. Transcript 4.1.7, pp 322–323.

58. *Tū Mai te Rangi! Report on the Crown and Disproportionate Reoffending Rates* (Wellington: Legislation Direct, 2017), p 60; Waitangi Tribunal, *The Napier Hospital Report*, p 64.

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

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

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

. . . I would say that over the course of the Primary Health Care Strategy as evidenced by where we are today that the focus on Māori health has not been enough by virtue of the evidence and performance.

Q. Would you agree that there has been a lack of emphasis on Māori health?

A. Certainly. If you look at the Government strategic priority areas over the 18 years that the Primary Health Care Strategy has been in place, Māori health is what I would call a marquee or a headline strategy as compared to others.⁶²

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

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

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

The National Hauora Coalition noted that, in addition to failing to say that equity is an objective of the health system, the language in the Act emphasises the *pursuit* of an objective to reduce health disparity ‘as opposed to a requirement that equity be achieved.’⁶⁴ Conversely, the Crown argued that the statutory

59. Robson, B. and Harris R. (eds), *Hauora: Māori Standards of Health* iv (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 2006), p 4.

60. Transcript 4.1.7, p 321.

61. Document A62(a), p 3.

62. Transcript 4.1.7, p 285.

63. Document A23, para 7.

64. Submission 3.3.30, para 4.14.

obligation to pursue rather than achieve objectives, as set out in section 3(1), is important because it recognises how difficult it is to fully achieve this objective, given the Ministry cannot address all determinants of Māori health status. They further state that the qualification in section 3(2) of the Act, which provides that the 'objectives are to be pursued to the extent that they are reasonably achievable within the funding provided', is consistent with the Treaty.⁶⁵

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

5.5 THE TREATY CLAUSE IN THE NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000

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

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

The claimants criticised the Treaty clause for being unduly narrow and limiting Māori to a participatory role only in the delivery of health services.⁶⁷ Counsel for the National Hauora Coalition claimants submitted that the Treaty clause is unusual 'as it does not require the Act to be interpreted and administered to give effect to the principles of the Treaty of Waitangi'; rather, 'it provides mechanisms that are intended to implement the principles of the Treaty in a practical way'.⁶⁸ The Crown argued that the clause eventually settled on in the Act was an early attempt to 'recognise and respect Treaty principles' and is not as 'open ended as some other Treaty clauses'.⁶⁹ In closing submissions, Crown counsel argued that the legislation broke 'new ground'.⁷⁰ They further submitted that the Treaty clause, and the provisions in part 3 of the Act to which it refers, are 'meaningful and [assist] Māori to exercise tino rangatiratanga in relation to health services and outcomes'.⁷¹

65. New Zealand Public Health and Disability Act 2000, s 3(2); submission 3.3.32, para 26.

66. New Zealand Public Health and Disability Act 2000, s 4.

67. Submissions 3.3.30, paras 4.22–4.23.

68. Submission 3.3.30, para 4.23.

69. Transcript 4.1.5, p 348.

70. Submission 3.3.32, para 33.

71. Submission 3.3.32, para 29.

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

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

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

Palmer said that by 2000 '[a] new trend in legislative statements by Parliament about the Treaty began' and that the passing of the New Zealand Public Health and Disability Act 2000 appeared to signal that this trend was gaining traction. He summarised that the Act provided several specific ways that the Treaty would be recognised, through 'the objectives, functions, composition of and training in District Health Boards' under part 3. The approach taken in the 2000 Act was also used for subsequent Acts, including the Local Government Act 2000; the Land Transport Management Act 2003; and the Public Records Act 2005.⁷⁶

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

[W]e would have liked to have done a lot better, but what it was, was we had to evolve from a generic principal clause to trying to imbed it and the idea behind the wording that you have just expressed would work if it was supported by good will to

72. Transcript 4.1.4, p 156.

73. Matthew Palmer, *The Treaty of Waitangi in New Zealand's Law and Constitution* (Wellington: Victoria University Press, 2008).

74. Palmer provides the following examples: Te Ture Whenua Maori Act 1993; the Māori Fisheries Act 2004; and the Maori Language Act 1987.

75. Matthew Palmer, *The Treaty of Waitangi in New Zealand's Law and Constitution*, p 96.

76. Matthew Palmer, *The Treaty of Waitangi in New Zealand's Law and Constitution*, pp 100–101.

77. Matthew Palmer, *The Treaty of Waitangi in New Zealand's Law and Constitution*, p 101.

operationalise it. We can play with words in regards to making them mandatory and the like but ultimately it falls back on the good faith and the good will of those that you're working with, engaging with to assert the intent of the law. The intent is there and I don't think you can walk away from that. The way in which you would evidence how that works, clearly that's why we're here today because it hasn't.⁷⁸

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

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

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

Also, because it is focused on district health boards, part 3 does not adequately recognise that the Treaty prescribes further Crown obligations to Māori under the principle of equity: where reasonably practicable, Māori are guaranteed to have access to, and receive, the health care that they need. While the objectives set out in section 22 are partly relevant to this guarantee, reducing disparities – even 'with a view to eliminating them' – is not directly synonymous with equity. As we concluded earlier in this chapter, clarifying the objective of the health system as health equity is an important point for an Act that sets out in statute the direction of the health sector.⁸¹

Finally, the extent of the Treaty and its principles is further narrowed as the clause goes on to talk about the role of Māori being limited to contributing to

78. Transcript 4.1.4, p 156.

79. New Zealand Public Health and Disability Act 2000, ss 11–18.

80. Submission 3.3.32, para 111.

81. New Zealand Public Health and Disability Act 2000, ss 22(1)(e), (f).

decision-making and participating in the delivery of services, at the district health board level. Such wording downgrades the principle of partnership to mere ‘participation’ and ‘contribution’.⁸² We appreciate the Crown’s submission that ‘the participation provided for is meaningful’, but in our view, it does not go far enough to adequately, as Crown counsel put it, ‘assist Māori to exercise tino rangatiratanga’.⁸³

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

the following Treaty principles are central to evaluating the extent to which the two claims under inquiry are well-founded:

- The principle of partnership;
- The principle of equity; and
- The principle of active protection.⁸⁴

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

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

Counsel for interested party claimant Owen Lloyd, of Ngā Ariki Kaipūtahi, submitted that stronger provisions for acting consistently with the Treaty were considered before the passage of the Act. He argued that the Crown had ‘a number of significant opportunities’ to ensure that the Act and the new arrangements for the health system were Treaty-compliant. For example, a Cabinet paper dated 20 June 2000 reveals that a much stronger partnership model was being pondered, including the annual convening of a ‘National Maori Forum’ to provide policy advice at the Ministerial level, and another provision that would have mandated district health boards to partner with Māori in their district.⁸⁵

82. New Zealand Public Health and Disability Act 2000, s 4.

83. Submission 3.3.32, para 29.

84. Submission 3.3.2, para 44.

85. Submission 3.3.14(a), paras 7–8.

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

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

In that case, the Supreme Court said:

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

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

5.6 TREATY PRINCIPLES IN THE PRIMARY HEALTH CARE FRAMEWORK – THE ‘THREE PS’

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

The Crown referred to the preferred expression in the health sector of the relevant Treaty principles during the last 20 years as ‘partnership, participation and protection’ or the ‘three Ps.’⁹⁰ These expressions were derived from the 1988 Royal Commission on Social Policy and are set out in both the 2002 and 2014 versions of He Korowai Oranga. The Crown acknowledged that the Ministry’s ‘three Ps’ could be regarded as a ‘reductionist view of Treaty principles’, but submitted that they were an attempt to create a common language for use by a large workforce, which

86. Submission 3.3.14(a), para 12.

87. Conservation Act 1987, s 4.

88. *Ngāi Tai Ki Tāmaki Tribal Trust v Minister of Conservation* [2018] NZSC 122, para 48.

89. Submission 3.3.32, para 31.

90. Document A59, para 49; transcript 4.1.5, p 351.

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was about to undertake a new journey of understanding about what the Treaty means.⁹¹

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

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

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

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

The Crown was careful to emphasise that He Korowai Oranga included the 'pursuit of rangatiratanga' as a 'key thread' in the achievement of the strategy's objectives.⁹⁷ The Crown further argued: 'The exercise of te tino rangatiratanga is a feature of the Māori health strategy. In addition, aspirations for mana motuhake

91. Transcript 4.1.5, p 351.

92. Submission 3.3.32, para 41.

93. *He Korowai Oranga*, p 2.

94. *He Korowai Oranga*, p 15.

95. *New Zealand Health Strategy: Future Directions*, p iii; submission 3.3.32, para 48.

96. Transcript 4.1.5, p 436.

97. Submission 3.3.32, para 41.

and self-determination can be explored in line with the Declaration on the Rights of Indigenous Peoples.⁹⁸

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

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

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

Having said this, ‘rangatiratanga’ in and of itself is not strictly what is guaranteed in the Treaty. ‘Tino rangatiratanga’ is guaranteed active protection in the Treaty. Tino rangatiratanga means indigenous autonomy, and is an equivalent term to mana motuhake.¹⁰⁴ Far from being an ‘aspiration’ for Māori communities, ‘tino rangatiratanga is the basis of Māori political and social organisation and

98. Submission 3.3.32(a), p 1.

99. *He Korowai Oranga*, p 7.

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

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

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

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

104. Waitangi Tribunal, *Tauranga Moana, 1886–2006: Report on the Post-Raupatu Claims*, 2 vols (Wellington: Legislation Direct, 2010), vol 1, p 18; 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: GP Publications, 1996), pp 5–6, 20.

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the foundation of Māori decision-making.¹⁰⁵ Tino rangatiratanga is the fullest expression of the Māori right to exercise authority over their own communities with ‘minimum Crown interference’; however, this expression is balanced against Māori obligations to act in good faith and what is reasonably practicable for the Crown in the circumstances.¹⁰⁶

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

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

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

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

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

We note that giving effect to the Treaty partnership was a ‘significant concern’ for Māori involved in the consultation period, begun in March of 2000, on the development of the Primary Health Care Strategy. Crown counsel noted the

105. Waitangi Tribunal, *The Ngātiwai Mandate Inquiry Report* (Wellington: Legislation Direct, 2017), p 27.

106. Waitangi Tribunal, *He Maunga Rongo*, vol 4, p 1241; *New Zealand Maori Council v Attorney-General* [1994] 1 NZLR 513 (PC), p 517.

107. *He Korowai Oranga*, p iii.

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

109. Transcript 4.1.4, pp 49–50.

consultation, which included 'Māori providers and co-funders,' but did not make a submission on its adequacy.¹¹⁰ Crown witness Dr Frances McGrath recalled some participants saying that the documentation proposing the reforms to primary care did not, in their eyes, reflect 'a commitment to partnership or to the action required to make it a reality'.¹¹¹

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

5.7 THE ACT'S PROVISIONS FOR DISTRICT HEALTH BOARDS

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

5.7.1 Māori representatives on the boards of district health boards

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

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

The Crown argued that section 29 partly affords a reflection of rangatiratanga rights by allowing Māori membership on these boards as decision makers.¹¹³ Claimant groups broadly argued that section 29 does not actually afford decision-making power in practice, because Māori board members are always in the minority.¹¹⁴ Further, claimant groups argued that the Crown has not consistently

110. Crown Response to Statement of Issues 1.3.1, p 5.

111. Document A63, para 174.

112. New Zealand Public Health and Disability Act 2000, s 29(4).

113. Submission 3.3.32, paras 32–33.

114. Submission 3.3.18, para 76; 3.3.30, paras 5.156–5.157.

ensured that district health boards are meeting the statutory requirements under section 29.¹¹⁵

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

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

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

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

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

Other evidence we received about Māori membership on other boards or decision-making bodies indicated further shortcomings with this approach. We note that when a national agreement to determine primary care contracting was being prepared, Māori involved in that process were in the minority.¹²² National

115. Submission 3.3.18, para 75; submission 3.3.30, para 5.159.

116. Memorandum 3.2.19, response to Dr Bloomfield question 6.

117. Memorandum 3.2.19(a), Appendices 1–2; 3.2.91(a), Appendices A–E.

118. Memorandum 3.2.19(a), Appendices 1–2; 3.2.91(a), Appendices A–E.

119. Transcript 4.1.4, pp 620–621.

120. Document A46, para 16.

121. Submission 3.3.14(a), para 38.

122. Document A60, para 40; submission 3.3.32, paras 5.166–5.167.

Hauora Coalition witness Tereki Stewart was a member of the body preparing the agreement in 2009 and noted that the ‘few Māori voices’ involved were drowned out simply because they were outnumbered.¹²³ Dr Heather Came-Friar and Professor Tim McCreanor said that research they were in the process of producing on the experiences of Māori and Pacific peoples’ involvement on advisory boards indicated that the Māori members are not only outnumbered but also flatly ignored by others present.¹²⁴

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

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

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

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

But, as the period since the *Napier Hospital Report* has revealed, the district health board model overall does not afford Māori sufficient control of decision-making to be a fulfilment of the Treaty principle of partnership. Māori board representatives operate within significant limitations, including the fact that they are a minority. Board appointees are Ministerial appointees, the board is the Minister’s board, and thus they are ultimately ‘accountable and answerable to the Minister and Government’.¹²⁸ As such, the statute itself is insufficient to reflect the Treaty’s guarantee of decision-making power for Māori. Further, the Crown has

123. Document A20, para 10.

124. Transcript 4.1.5, pp 201–202.

125. Submission 3.3.14(a), para 40; transcript 4.1.4, p 621.

126. Document A45, para 8.

127. Waitangi Tribunal, *Napier Hospital and Health Services Report*, p 317.

128. Submission 3.3.14(a), para 39.

5.7.2

not even been able to satisfy the proportionality requirement: any assumption that the proportionality provision would be consistently achieved by the Minister has been found to be incorrect. Taking these factors into consideration, the board representation model is not a full reflection of the principle of partnership.

5.7.2 Partnership arrangements with district health boards

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

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

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

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

What has been generally referred to as the ‘Māori/iwi relationship boards’, are intended as advisory boards for district health boards, and constitute an attempt at interpreting sections 22 and 23.¹³² While the Act does not require that district health boards have a formal relationship with a Māori entity that represents or is linked to the mana whenua, currently all district health boards have a form of this arrangement.¹³³

The claimants argued that the oversight and decision-making power of these boards vary considerably, and often are not robust enough to give effect to the

129. Document A64, para 94.

130. New Zealand Public Health and Disability Act 2000, ss 22–23.

131. *Operational Policy Framework 2018/19* (Wellington: Ministry of Health, 2016), <https://nsfl.health.govt.nz/accountability/operational-policy-framework-o/operational-policy-framework-201819>, para 3.10.4.

132. Document A65, para 52.

133. Document A3, para 242.

Treaty principle of partnership adequately.¹³⁴ While Crown counsel argued that these boards ‘can provide an opportunity for involvement in decision-making at governance, executive, strategic and operational levels’, they broadly acknowledged the criticisms forwarded by the claimants and Crown witnesses.¹³⁵

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

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

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

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

Dr Nick Chamberlain, the Chief Executive of Northland District Health Board, agreed under questioning that these boards ‘do not typically have a governance role, a financial delegation, or an effective way to hold DHBs to account’.¹³⁹ Dr Chamberlain specifically related his observations of the difficulties experienced by Northland District Health Board’s own Māori relationship board, Te Kahu o Taonui. He said that many of the members of that body do not have expertise in health, limiting their capacity to contribute meaningfully.¹⁴⁰ Oral evidence from Hector Matthews and Dr Chamberlain showed that the members of these boards,

134. Submission 3.3.30, paras 5.160–5.163.

135. Submission 3.3.32, paras 217, 307–310.

136. Transcript 4.1.7, p 204.

137. Submission 3.3.32, para 308.

138. Transcript 4.1.4, p 289.

139. Submission 3.3.32, para 309.

140. Transcript 4.1.6, pp 32–33.

as iwi and hapū representatives, often have multiple responsibilities competing for their time; for example, at the last meeting of Te Kahu o Taonui, only two of the nine iwi leaders were present.¹⁴¹

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

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

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

I think there’s a lot of well meaning, well intentioned people but that doesn’t always translate because you’re right it comes down to those values. You know if you and I are sitting down having a kōrero and you know, manuhiri turn up at the gate we know instinctively what to do and we make decisions based on those value sets that we’ve been raised in.

Q. Yes.

A. And I met a lot of really good people who have been raised differently and they make decisions based on different sets of values and so therefore we end up with that rubbing of knuckles at the point of implementation.¹⁴⁴

District health board members are statutorily required to take cultural competency training.¹⁴⁵ The Crown provided information collected from district health boards on the type of training offered, and this information indicated

141. Transcript 4.1.6, p 35; transcript 4.1.7, p 213.

142. Transcript 4.1.7, p 165.

143. Transcript 4.1.7, p 185.

144. Transcript 4.1.7, p 186.

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

that the training varies broadly and is not always undertaken by every board member. A concerning number of district health boards were vague, or provided no information at all, on the type or extent of training provided. Capital and Coast District Health Board provided no response at all.¹⁴⁶ Some district health boards do not keep a training register of their board members as is statutorily required.¹⁴⁷

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

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

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

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

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

The evidence of Janet McLean indicates that this was certainly the experience of Māori providers under the Bay of Plenty District Health Board, after it decided in 2017 to restructure its Māori Health Planning and Funding team by terminating some roles and dispersing others across mainstream teams (as the Ministry had done with its own Māori health business unit, Te Kete Hauora, the year before). The Bay of Plenty District Health Board engaged in a consultation and submission

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

147. Memorandum 3.2.94(a), app 5.

148. Document A12, para 36.

149. Document A65, para 9.

150. Submission 3.3.18, para 76.

process in June and August of that year, and Māori providers were reportedly clear on their rejection of the proposed restructure.¹⁵¹ However, McLean noted that:

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

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

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

We did not receive detailed evidence on how district health boards are currently fulfilling this requirement. In its review of the Bay of Plenty District Health Board in 2004, Te Puni Kōkiri found that the terms of reference for its Māori relationship board, the Māori Health Rūnanga, afforded oversight ‘at the governance, rather than operational, level’, despite the District Strategic Plan assuring operational oversight. Te Puni Kōkiri’s review said that the rūnanga monitored some funding allocated for Māori health, and said that the General Manager Māori Health, Janet McLean, provided ‘monthly reports to the Rūnanga’ detailing progress made against the goals in the district health board’s strategic and annual plans. The review makes no mention of the nature or quality of these reports.¹⁵⁶ It did, however, recommend that the terms of reference for the rūnanga be amended.¹⁵⁷

Teresa Wall, who appeared as an interested party witness and has held various senior positions at the Ministry and elsewhere in the health sector, specifically noted that Māori groups who partnered with district health boards used their Māori Health Plans to have a ‘more informed discussion’ about actions and initiatives in their communities.¹⁵⁸ We agree that they were likely useful in this

151. Document A15, para 37.

152. Document A15, para 38.

153. Document A15, para 39.

154. New Zealand Public Health and Disability Act 2000, s 23(f).

155. *Operational Policy Framework 2018/19* (Wellington: Ministry of Health, 2016), <https://nsfl.health.govt.nz/accountability/operational-policy-framework-o/operational-policy-framework-201819>, para 3.10.3.

156. Document A76(a), app 4, pp 191–192.

157. Document A76(a), app 4, p 195.

158. Transcript 4.1.5, p 108.

regard, and as such the Ministry's decision to rescind the requirement that they be produced would have affected Māori groups' ability to participate in these discussions meaningfully.

Crown witnesses, including the Director-General, broadly acknowledged that these partnership and consultation arrangements are not always effective, especially at implementation level.¹⁵⁹ Dr Nick Chamberlain said that the depth and quality of these partnerships vary from district to district.¹⁶⁰ This degree of variability is not Treaty-consistent, and we consider that this is partly due to the insufficient clarity of the major strategies and other documents in relation to the sector's Treaty obligations.

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

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

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

We accept that, broadly, district health boards are cognisant of their need to reflect the populations that they serve, including Māori, but we are unconvinced that district health boards actually manifest this to the extent needed.¹⁶¹ This was certainly our impression from claimant and interested party evidence, but was also confirmed by Crown witnesses. Dr Nick Chamberlain accepted that Northland District Health Board needed to do more to achieve this aim.¹⁶² Hector Matthews, too, agreed under cross-examination that Canterbury District Health Board does not reflect the values imbued in te ao Māori, and that this is unacceptable.¹⁶³ We agree. As the Tribunal broadly stated in *Ko Aotearoa Tēnei*:

Fundamentally, there is a need for a mindset shift away from the pervasive assumption that the Crown is Pākehā, English-speaking, and distinct from Māori rather than

159. Transcript 4.1.5, p 414.

160. Document A66, para 10.

161. Document A66, para 22.

162. Transcript 4.1.6, p 102.

163. Transcript 4.1.7, p 174.

representative of them. Increasingly, in the twenty-first century, the Crown is also Māori. If the nation is to move forward, this reality must be grasped.¹⁶⁴

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

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

On the Crown's part there must be a willingness to share a substantial measure of responsibility and control with its Treaty partner. In essence, the Crown must share enough control so that Māori own the vision, while at the same time ensuring its own logistical and financial support, and also research expertise, remain central to the effort.¹⁶⁵

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

As part of the Treaty settlement process, the Crown and Māori have in recent years explored and utilised the concept of co-governance in the return of natural assets to Māori. Several innovative examples have occurred that are intended to assist in the re-establishment of Māori relationships with natural resources. Co-governance and co-management arrangements have been utilised concerning the return of mountains, rivers, and national parks.¹⁶⁶

In the local government sphere, the Auckland City Council has an Independent Māori Statutory Board, which was highlighted by interested party witness Patricia Tuhimata as an example of a broadly effective co-governance arrangement.¹⁶⁷ That board has specific powers under the Local Government (Auckland Council) Amendment Act 2010, which enables two board members to sit, with voting rights, on a number of council committees. The board provides direction and

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

165. Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims concerning New Zealand Law and Policy affecting Māori Culture and Identity: Te Taumata Tuatahi* (Wellington: Legislation Direct, 2011), pp 161–162.

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

167. Document A48, para 81–83.

guidance to the Council on issues affecting Māori. Every three years, the Board conducts a Te Tiriti o Waitangi Audit to assess the Council's performance in acting in accordance with statutory references to the Treaty and statutory responsibilities to Māori in Auckland.¹⁶⁸ The Office of the Auditor-General has published a report highlighting co-governance models for natural resources around the country, and suggesting principles for co-governance generally.¹⁶⁹ Such models already exist and go some way towards a recognition of Treaty rights and obligations. They are examples of what can happen in practice.

5.8 TREATY OBLIGATIONS IN LOWER-LEVEL ACCOUNTABILITY DOCUMENTS

As foregrounded earlier, flowing down from the major strategies that set the direction of the health system are further accountability documents, such as policies, action plans and contracts. These tie the vast, complex network of the primary health care system together and intend to put higher-level aims and obligations into practice. Most of these accountability documents are features of the district health boards' relationships with the primary care sector organisations in their area, though the Ministry also does direct contracting. For our purposes, we will borrow terminology from Crown counsel and refer to these as 'lower-level' accountability documents in this section.¹⁷⁰

On 15 December 2006, in a letter from Acting Director-General Māori Health Teresa Wall, the Ministry directed all district health boards to 'no longer make any direct reference to the Treaty of Waitangi or its principles in any new policy, actions, plans or contracts'. Instead, the 'way forward' would be to rely on the provisions provided for in section 4 of the Act, which would 'still guide action and be a focus for DHBS'.¹⁷¹

Lady Moxon noted in her evidence that she and some of her contemporaries involved with Māori non-governmental organisations, including the Waikato District Health Board's Māori partnership entity, the Iwi Māori Council, strongly protested this change. The Iwi Māori Council stated in its correspondence that the move amounted to a downgrading of the Treaty and of the importance of Māori health.¹⁷²

The Deputy Director-General Public Health and Minister of Health at the time (Don Matheson and Pete Hodgson) responded to these concerns by letters dated 4 April and 24 July 2007 respectively. They essentially repeated the explanation in Wall's December 2015 letter: because section 4 of the Act remained, as well as commitments expressed in He Korowai Oranga and other strategies, the Crown was still committed to the Treaty and to Māori health. The Deputy Director-General

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

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

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

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

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

Public Health stated that the Ministry was operating under instructions ‘not to downgrade the Treaty’ and that the specific operationalisation of these commitments in lower-level documents, such as contracts, was more important; putting these commitments into practice would not be assisted, as the Minister said in his letter, ‘by restating high-level wording around the Treaty of Waitangi’.¹⁷³ Crown counsel, in his cross-examination of Lady Moxon, emphasised that the focus appeared to be the “‘what to do” and “how to do” in relation to the sector’s responsibilities to the Treaty and to improving Māori health outcomes.’¹⁷⁴

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

Teresa Wall wrote the letter dated 15 December 2006, which gave a clear directive to remove references to the Treaty and its principles from lower level policies, plans, and contracts. When asked in our inquiry about the factors driving the removal of Treaty references, she highlighted the political context of the day, including the 2004 Orewa speech, the seabed and foreshore hikoi, and the government of the day’s fear of a backlash from the New Zealand public.¹⁷⁵

As for why the removal of references to the Treaty is an important issue, for many witnesses this appeared to centre on a loss of the Treaty’s visibility. We agree with the Crown that the clear focus of these lower-level documents is the practical implementation of actions which are intended to give effect to the aims of the framework. It is appropriate, from a Treaty perspective, that this same focus be applied to Treaty responsibilities and obligations in these lower-level documents. As Crown counsel pointed out, one practical use of mentioning the Treaty in these documents is, at the most basic level, to ‘orient’ these documents and the relationships or actions to which they give effect in a manner that reflects the Treaty and its principles.¹⁷⁶ Indeed, in its letter to the Minister, the Iwi Māori Council stated that removing Treaty references from operational documents and contracts would render it ‘invisible’.¹⁷⁷

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

173. Document A11(a), app x, p 483; see also doc A11(a), app v, p 478.

174. Transcript 4.1.4, p 353–354.

175. Transcript 4.1.5, p 122.

176. Transcript 4.1.4, p 360.

177. Document A11(a), app w, p 481.

that lack of explicit statement I think pervades through lots of our systems in health and in social services and that adds to the vagary. Again, it's a reflection of what happens in New Zealand society because most New Zealanders have little or no knowledge. Lots of people have opinions about the Treaty, very few have read it.¹⁷⁸

It strikes us that having explicit references to key concepts that are intended to underpin the health sector – like Treaty principles and obligations, but also concepts as central as health equity – would relieve some of the tensions inherent in the complexity, size, and devolved nature of the primary health care system. Dr Rawiri Jansen, for example, noted how constructive ideas and attitudes do not always permeate through the system: ‘The most difficult place that we have to operate in is tier 2 and tier 3 of those Crown agencies. We often get really inspiring rhetoric from boards and chairs and CEOs and it turns to dust when you get busy trying to run a programme with the bureaucratic tier 3 managers of a programme.’¹⁷⁹ In this respect, explicitly articulating the Treaty and other key concepts at every level of the system would be a positive thing in our view – especially given resistance to, and misunderstandings of, the Treaty, and what it means for this country.

Beyond simply ensuring the visibility of the Treaty and its meaning, having the Treaty as a part of all the so-called lower-level documents provides an imperative to give effect to the Treaty at every level of the sector. As acknowledged by Crown counsel, district health boards are Crown agents, and as such have Treaty obligations. Dr Frances McGrath noted in her evidence for the Crown that the consultation period at the outset of the primary care reforms revealed that ‘nearly two thirds’ of Māori consulted said that the Treaty partnership ‘should be reflected in the service agreements between DHBs and primary health care service providers.’¹⁸⁰ Insofar as primary health organisations and providers are concerned, Treaty principles should be expressly stated and clearly so as to be firmly in the minds of such organisations. Higher-level documents cannot be relied on in this respect. We are not convinced that the staff of every primary health organisation or provider will be familiar with He Korowai Oranga, for example, but they will certainly be intimately familiar with their own organisation’s contracts and the deliverables associated with them.

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

178. Transcript 4.1.7, p 206.

179. Transcript 4.1.4, p 552.

180. Document A63, para 173.

the Treaty is visible to, and understood and abided by, all actors in the health sector is a Treaty responsibility of the Crown.

5.9 TRIBUNAL FINDINGS

In the 2001 *Napier Hospital and Health Services Report*, the Tribunal broadly concluded that the Act contained provisions that ‘committed the Crown and its health agents to a number of particular obligations consistent . . . with the principles of *partnership* and *equity*’ (emphasis in original).¹⁸¹

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

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

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

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

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

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

Further, we find that:

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

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CHAPTER 6

ARE THE FUNDING ARRANGEMENTS FOR THE PRIMARY HEALTH CARE SYSTEM TREATY-COMPLIANT?*Toki tā wahie te toki nui***6.1 INTRODUCTION**

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

6.2 THE FUNDING FOR PRIMARY HEALTH CARE

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

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

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

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

1. We take into consideration and respond to the issues posed at sections 4.3, 5, 7.2.3, 7.2.5 and 9 of the Statement of Issues (document: 1.4.1).

2. Memorandum 3.2.95, pp 1, 3.

3. Memorandum 3.2.95, pp 3–4.

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

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

As a significant lever for change, additional funding was needed to enable the change in approach and focus, improve universal access and reduce equity gaps. The amount of funding was a significant investment in primary care, one of the largest in recent history – over \$620 million between 2004/05 and 2007/08.⁶

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

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

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

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

4. Submission 3.3.32, paras 259–262; doc A60, para 44; doc A62, para 102; transcript 4.1.4, pp 164, 578, 581; transcript 4.1.5, p 97; transcript 4.1.7, p 267.

5. Transcript 4.1.4, p 581.

6. Document A62, para 102.

7. Transcript 4.1.5, p 406.

8. Submission 3.3.32, para 37.

9. Submission 3.3.32, paras 273–278.

10. Submission 3.3.32, para 279.

11. Document A43, para 47.

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

6.3 WERE MĀORI PRIMARY HEALTH ORGANISATIONS ADEQUATELY FUNDED AT THE POINT OF ESTABLISHMENT?

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

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

The Crown acknowledged that the way the Ministry determined funding at the point of establishment for primary health organisations was inadequate. The Ministry did not develop a national formula or set of criteria for the establishment funding and therefore the establishment funding that primary health organisations received varied.¹⁷ For example, Independent Practitioner Associations, collectives

12. New Zealand Public Health and Disability Act 2000, s3(2).

13. Document A43, para 8.

14. Document A11, paras 20–21.

15. Document A30, para 10.

16. Document A12, para 35.

17. Document A62, paras 59, 117, 122.

6.3

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

At hearings, she elaborated:

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

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

18. Document A28, para 10.

19. Crown Response to Statement of Issues 1.3.1, p 4.

20. Document A62, para 59.

21. Transcript 4.1.7, p 286.

22. Document A63, para 172.

23. Document A62, para 117.

6.4 ARE THE FUNDING ARRANGEMENTS FOR THE PRIMARY HEALTH CARE SYSTEM ADEQUATE TO PURSUE EQUITY OF HEALTH OUTCOMES FOR MĀORI MEANINGFULLY?

6.4.1 Funding for district health boards

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

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

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

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

24. Transcript 4.1.6, p 96.

25. Transcript 4.1.6, p 16.

26. Kukutai, Tahu and Donna Cormack, 'Census 2018 and Implications for Māori', *New Zealand Population Review* 44 (2018), p 137.

27. Transcript 4.1.6, pp 96–97.

6.4.2

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

6.4.2 Capitation and other funding

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

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

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

The Crown acknowledged that a review of the base formula for capitation has not been carried out since its inception 'to see whether changes in levels are

28. Document A60, para 29; transcript 4.1.5, p 477. See also doc A43, para 19.

29. Document A62, para 108.

30. Crown Response to Statement of Issues 1.3.1, p 5.

31. Document A43, para 11(b).

32. Crown Response to Statement of Issues 1.3.1, p 4.

33. Transcript 4.1.4, pp 600–602; transcript 4.1.4, p 564; doc A19, para 33; doc A11, para 185.

34. Document A62, para 119. See also paras 116–120 for a fuller explanation of Brooking's appraisal of capitation.

35. Transcript 4.1.5, pp 463–464, 483–484.

required to meet the needs of more vulnerable groups including Māori,³⁶ despite several internal reports since 2013 recommending that this should occur.³⁶

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

Further, in 2006 the Ministry appointed an Expert Advisory Group to review the funding formulas. When reporting back, the Expert Advisory Group made several findings including the following:

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

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

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

Respondents also outlined:

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

36. Crown Response to Statement of Issues 1.3.1, p 5; Transcript 4.1.5, p 465.

37. Document A62, paras 202–213; transcript 4.1.7, p 67; transcript 4.1.5, p 465; doc A19(b), para 56.

38. Document A62, para 210.

39. Transcript 4.1.7, p 289.

40. Document A63, para 172.

41. Document A63, paras 176.1–176.4.

6.4.2

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

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

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

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

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

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

42. Transcript 4.1.6, pp 212–213.

43. Document A60, para 13.4.

44. Transcript 4.1.4, p 169.

45. Document A60, para 51.

46. Document A60, para 51.

47. Transcript 4.1.5, p 478.

48. Transcript 4.1.5, p 463.

49. Transcript 4.1.5, p 165.

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

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

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

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

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

6.4.3 The impact on Māori primary health organisations and health providers

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

50. Document A3(a), Appendix 1, p 6.

51. Memorandum 3.1.175(a), para 2.

52. Document A60, para 53.9.

53. Document A69, para 7.

54. Document A69, para 8.

55. Transcript 4.1.4, p 593.

56. Transcript 4.1.4, p 618.

6.4.3

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

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

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

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

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

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

Q. Right.

57. Submission 3.3.32, para 290.

58. Transcript 4.1.4, p 341.

59. Transcript 4.1.4, pp 301, 303.

60. Transcript 4.1.4, p 190.

61. Document A14, para 32.

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

The Crown acknowledged these issues in principle, conceding that inadequacies with 'funding streams' could undermine the ability for Māori to apply their own solutions.⁶³ In the case of the claimants in this inquiry, we heard that this was certainly one of the many effects of inadequate funding.

Issues of establishment costs and ongoing resourcing for Māori primary health organisations were a catalyst for the Māori Primary Health Organisations and Providers claimants (Wai 1315) lodging their claim with the Waitangi Tribunal in 2005. Neil Woodhams gave evidence about the so-called Sustainability Project, the response of the Ministry to the claimants' allegations of underfunding. The purpose of the project was to quantify the 'financial, clinical and cultural issues which the claimants allege negatively impact on the sustainability of' primary health organisations and providers serving predominately Māori populations.⁶⁴

The Ministry engaged management consulting company Deloitte in 2007 to attempt to quantify the additional costs that primary health organisations serving predominantly Māori populations incurred, compared with other primary health organisations.⁶⁵ Deloitte produced a high-level report, which estimated that, based on the organisations involved in the study and the information provided for 2007, Māori primary health organisations were under-funded by approximately \$21.77 million a year, as they faced higher costs, for a range of reasons including: 'higher presentation rates of Māori at clinics, longer consultation times due to the . . . complexity of [the health needs of] those patients, [and] additional costs for providing a culturally appropriate service'.⁶⁶

We note that the figure of \$21.77 million a year was a provisional, high-level estimate of underfunding, and was intended to act as a marker for Ministry budget purposes while a second phase of this project was undertaken. The scope of the second stage was widened to include non-Māori primary health organisations and providers who serviced predominantly high-needs communities, such as Pacific Islanders.⁶⁷ This culminated in a further report by Deloitte, delivered in draft to the Ministry in 2010.⁶⁸ This report was never released because, according to Brooking, some of the report's 'statements were regarded as subjective by the Ministry'.⁶⁹

62. Transcript 4.1.4, p 218.

63. Crown Response to Statement of Issues 1.3.1, p 3.

64. Document A60, para 234.

65. Document A19, para 8.

66. Transcript 4.1.4, p 166.

67. Document A62, para 238.

68. Document A77, pp 3566–3595.

69. Document A62, para 239.

6.4.3

Woodhams summarised the 2010 draft report as follows:

high needs providers have a significantly different patient mix in terms of both age and ethnicity, much higher than average fee for service deductions, much higher than average patient turnover, and a smaller percentage of their income generated by patient co-payments. They also had more patients with chronic and long-term illness.⁷⁰

Woodhams noted that the estimation of underfunding by Deloitte in its original report did not consider other impacts these providers may be facing, such as having to offer a lower salary to staff and rely on unpaid volunteers' contributions, and the unmet needs of eligible patients who were not accessing the services. He said a report he prepared in 2011, in response to the Deloitte's work, confirmed that providers who serve largely high-needs patients were seriously disadvantaged by the inadequacy of the capitated funding formulas.⁷¹

Lady Moxon and Kuka seek payment of \$348 million, extrapolated from the annual underfunding estimated by Deloitte in the 2007 report, for the historical underfunding of Māori primary health organisations and providers. They say this payment is reparative, and should be given to the existing Māori primary health organisations and providers today.⁷² We agree with Crown counsel's submission that the 2007 Deloitte report referred to by Woodhams is too high-level to extrapolate either to the entire sector or to accurately estimate funding shortfalls in previous or subsequent years and was limited by its small sample size.⁷³

We note, nonetheless, that the 2007 report was only ever meant to be an initial assessment of underfunding as part of a longer project. For us, the crucial point is that the sustainability issues identified in both the 2007 and 2010 Deloitte reports about small primary health organisations and providers serving predominantly high-needs populations, including Māori, were repeated during this inquiry. We are concerned that the project was never completed by the Ministry for reasons which were not explained to us.

What is clear to us is an acceptance by all concerned, including Crown witnesses, that primary care health funding for primary health organisations and providers serving predominantly high-needs communities were underfunded at the point of establishment and throughout their operation.⁷⁴ What we are unclear about is to what extent. As the evidence discussed in this chapter shows, Māori organisations and the patients they serve are particularly affected by the shortcomings of the current arrangements for capitated funding.

Professor Peter Crampton pointed out that non-Māori primary health organisations which had grown out of the original Independent Practitioner Associations

70. Transcript 4.1.4, p 166.

71. Transcript 4.1.4, p 167.

72. Submission 3.3.18, para 153.3.

73. Submission 3.3.32, para 291.

74. Submission 3.3.32, para 290.

‘were inexperienced in designing and delivering services for Māori.’⁷⁵ Dr Nick Chamberlain, the Chief Executive of Northland District Health Board, said that this tension was recognised by Northland District Health Board when primary health organisations began to be established in that district:

Northland DHB was particularly explicit with PHO establishment groups (six at the time) that they needed to demonstrate a high level of Māori engagement and Treaty-based ownership and governance to form a PHO . . . Northland DHB would not allow a PHO to form if Māori interests were not seen to be a priority. For example, Manaia PHO, an Independent Practitioner Association-based PHO, experienced delays in establishment as it needed to demonstrate a shift away from Independent Practitioner Association-based working arrangements towards an approach that enabled high levels of Māori engagement, ownership and governance.⁷⁶

The Director-General accepted that the Crown’s response to the inadequacy of the formulas has been insufficient ‘in that there are still obviously quite significant barriers to access to primary care and . . . some PHOs and practices serving high needs populations have continued to really struggle.’⁷⁷ However, he pointed out that, while some districts underfunded Māori non-governmental organisations in primary care, other district health boards have recognised the inefficacy of the base funding provided under the primary health care framework and have reprioritised their discretionary funding accordingly.⁷⁸ In his written evidence, Dr Chamberlain detailed how Northland District Health Board uses discretionary funding to resource and support Māori organisations outside of the regular funding arrangements provided for under the primary health care framework.⁷⁹ He said:

It is important to note that Northland DHB’s policy is not to ‘apply resources equally to Māori and non-Māori’ but to invest more in services that will improve equity. All programmes, initiatives and funding are designed to explicitly target Māori and our prioritisation tools have heavy weightings for equity and Māori health.⁸⁰

The Northland District Health Board’s focus on equity has allowed it to realign the priorities of its discretionary funding accordingly, and its efforts in this area are to be acknowledged. However, the evidence suggests that this board’s actions do not constitute a representative case. We heard in fact that discretionary funding is, like supplementary capitation funding, very small in the scheme of things. Brooking estimated that it was about 5 per cent of the funding for each district

75. Document A9, para 32.

76. Document A66, paras 48–49.

77. Transcript 4.1.5, p 465.

78. Transcript 4.1.5, p 464.

79. Document A66, paras 53–59.

80. Document A66, para 60.

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health board.⁸¹ When asked about district health boards reprioritising funding to primary health organisations with large high-needs populations (as Northland District Health Board appears to have done), Hector Matthews stated:

It happens but it only happens on the fringes. In my experience DHB's actually have very limited latitude, very little discretionary funding, I think there's this view that the Ministry gives us 1.4 billion dollars and we can allocate that 1.4 billion out in our case . . . [B]ut actually the reality is that we have to pay all the doctors in the hospital, we have to pay all the nurses in the hospital, we have to pay all . . . the 10 and a half thousand staff and then we've got to fund the PHO's and the Primary Health Care . . . [A]t the end of it . . . there's less than 5% discretionary funding and then everyone is scrapping over that five . . . [S]o we've done that on limited occasions . . . – to get to our immunisation target we did that but it would be fair to say that it's a very rare event and it's pocket change in that 1.4 [billion] dollar spend that we have in Canterbury.⁸²

Director-General Dr Bloomfield also made the point that the Global Financial Crisis seriously affected the way that district health boards used their discretionary funding. Crown counsel summarised his comments as follows:

Prior to the GFC [Global Financial Crisis], the health sector as a whole received annual increases in funding of around 7 to 8 per cent per annum. These increases diminished after the GFC to around 2 to 3 per cent per annum. This confined funding growth affected the ability for the health system generally to invest in primary health in light of the growing health need[s] of an aging population and an increased prevalence of chronic diseases.⁸³

Crown counsel quoted the Director-General's comments on the effects of the reduced funding:

the challenge for District Health Boards was two-fold. First of all, they had sort of built a system that was based on seven to eight percent increases each year and then those dried up somewhat. So there [were] a lot of costs locked into the system and so you will see from about 2009/10 onwards the District Health Boards increasingly had to try and find ways to, as it were, balance the budget while delivering on the Minister and the Government's expectations. At that time there was more discretion, what one might call, discretionary expenditure by District Health Boards including in primary care but also in other NGO providers including Māori and Pacific providers. And so that discretionary expenditure was scrutinised and in some cases and increasingly it became harder for District Health Boards to sustain that expenditure . . .⁸⁴

81. Transcript 4.1.7, p 272.

82. Transcript 4.1.7, p 164.

83. Submission 3.3.32, para 267.

84. Transcript 4.1.5, p 382.

Crown counsel were also careful to emphasise that many district health boards operate under a ‘level of financial deficit’.⁸⁵ The Director-General said that after the Global Financial Crisis, district health boards were ‘not so much looking after themselves but doing their best to juggle resources in a very resource constrained environment’.⁸⁶

We accept that these pressures are acute for district health boards, and that this has likely impacted on the ways that they invest discretionary funding. Nonetheless, we note the evidence of Hector Matthews, who remarked: ‘often these Māori health contracts have terminal dates, hit their expiry date and it is easier to deal with cutting [them than] it is for example to say, “Let’s stop five procedures in the hospital,” or something like that.’⁸⁷

In this way, discretionary funding invested by district health boards, whether invested into primary care organisations or other health initiatives, is tied to systemic bias arising from the fact that district health boards are both funders and providers of secondary care. Amy Downs pointed out that this arrangement creates an ‘inherent conflict of interest’ whereby district health boards are naturally more likely to preserve funding for their secondary care provider arm than they are to preserve funding for externally provided discretionary spending, such as that on primary health organisations and providers.⁸⁸ Professor Cumming agreed, noting that public health research identified a concern that district health boards’ ‘joint planning, funding and delivery roles would lead them to prioritise their own services’.⁸⁹ She speculated that this may have been partly because it appeared district health boards had been hamstrung during the implementation of the Primary Health Care Strategy:

A key problem, however, was that DHBS were then not adequately supported in developing a role with respect to primary care, and when funding then began to flow through them, they were not provided with funding to support a key role in primary care: neither in terms of their own staffing (in contrast to PHOs which receive management support funding) nor in terms of service development funding. It is still my understanding that the main contract for primary care is a national one, agreed through a national Primary Health Organisation Service Agreement (PSAAP) process. I believe that this has hampered the role of DHBS in developing primary care services over time; we lament the strong focus that DHBS have on hospitals as opposed to primary care, but it is not clear to me that DHBS have been given a sufficient mandate in primary care to overcome their perceived hospital focus.⁹⁰

Whatever the pressure on district health boards, the loss of direct contracts was highlighted as a significant issue by both sets of claimants. Lady Moxon

85. Submission 3.3.32, para 268.

86. Transcript 4.1.5, p 383.

87. Transcript 4.1.7, p 224.

88. Transcript 4.1.5, p 179.

89. Document A60, para 27.

90. Document A60, para 40.

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highlighted the loss of smoking cessation contracts by Māori providers working with the Waikato District Health Board as a situation that demonstrates the tough contracting environment for Māori primary health organisations. She stated that ‘in terms of disinvestment, this reflects a disinvestment in Māori health services for Māori by Māori of \$1,045,269.96’ since 2010.⁹¹

Dr Rawiri Jansen presented two National Hauora Coalition-developed Māori health initiatives that showed proven positive outcomes: Mana Kidz and Auckland Wide Healthy Homes Initiative. He said that, despite their proven results and endorsement from the Ministry, the National Hauora Coalition struggles to contract with district health boards to provide these services.⁹²

Director-General Dr Bloomfield discussed these allegations of a pattern of rejection and loss of contracts, emphasising that ‘this is by no means unique to these programmes or Māori driven innovation.’⁹³ In light of the incomplete picture given by the evidence before us, we accept this point. District health boards are coping with a myriad of factors, not least of which is the impact of financial restraints.

Nonetheless, this issue is concerning to us because it was indicated that, since establishment funding and funding through capitation and other channels is insufficient, Māori organisations need to access other funding in order to make up for that shortfall.⁹⁴ Some of this funding, presumably, comes out of district health board discretionary funding, which Crown witness Hector Matthews accepted does not allow much flexibility in practise and, often is not a reliable form of revenue for Māori organisations.⁹⁵

We also heard evidence on the Māori Provider Development Scheme, which was established in 1997 and run by the Health Funding Authority to provide grants and support to Māori health and disability support service providers. Since the reforms in 2000, the scheme has been managed by the Ministry.⁹⁶ The scheme is designed to provide organisational development support to Māori providers and to improve the Māori health and disability workforce by offering scholarships. We heard that since its initiation, the scheme has funded an average of 130 health providers and 550 Māori health students per annum.⁹⁷ We also heard that funding for the scheme, approximately \$9 million annually, has remained virtually unchanged since its establishment more than two decades ago.⁹⁸ As well as being a relatively small amount of money, the fact that it is used to fund scholarships and develop the Māori health workforce means that it is not, in reality, solely for provider development, as its title suggests. Workforce development initiatives should not be developed using funding that is, in principle, set aside for a different purpose.

91. Document A11, paras 83–84.

92. Document A21, paras 25, 32.

93. Transcript 4.1.5, pp 457–459.

94. Transcript 4.1.8, pp 37–38.

95. Transcript 4.1.7, pp 164, 224.

96. Document A63, para 98.

97. Document A62, para 181.

98. Document A62, para 176.

These issues concern us. The evidence before us shows that the scheme needs to be reviewed and properly directed, funded and administered to support and develop Māori providers.

The Crown acknowledged that ongoing resourcing and development for providers has varied from district to district, and is insufficient for those providers serving high-needs populations, as is the case for many Māori providers.⁹⁹ In her written evidence, Professor Jacqueline Cumming further critiqued the severe underfunding of Māori providers:

One useful piece of information is spending by the Ministry of Health and DHBs on Māori health providers, including in relation to other spends in health care. This shows, however, how small the proportion of funding going to Māori health providers is (1.86%) and that increases in health spending each year are not always matched by increases in spending on Māori health providers. Although Māori receive services from a wide range of providers, this tiny proportion clearly demonstrates that few Māori have opportunities to receive services from Māori-led organisations.¹⁰⁰

Janet McLean was aware of this tension when she was General Manager Planning and Funding Māori Health at the Bay of Plenty District Health Board, and made sure that the district health board invested in Māori organisations to help them remain economically viable.¹⁰¹ McLean said:

There are three PHOs in the region, Western Bay PHO, Eastern Bay Alliance and Nga Mataapuna Oranga, the Māori PHO. There are only four GPs clinics under Nga Mataapuna Oranga, but the two mainstream PHOs have around forty GPs clinics between them. Their Māori members were not making a 'choice' as such to be with them, in most cases it would simply be . . . that they have chosen the closest clinic. If we did not invest in Māori GP clinics and other Māori Providers, there would never be the opportunity for them to grow and give Māori more choice for their health care needs.¹⁰²

We agree with the evidence of Professor Cumming and Janet McLean, which essentially concludes that the underfunding of Māori providers is a failure of the Crown to act consistently with the principle of options.

6.5 TRIBUNAL FINDINGS

The Crown devolved significant responsibilities to primary health organisations and providers to deliver primary health care. As such, the Crown has a Treaty obligation to support and fund Māori primary health organisations and providers

99. Document A66, para 55; submission 3.3.32, para 290.

100. Document A60, para 34.

101. Document A15, paras 16, 18.

102. Document A15, para 19.

so that they can do this job. The funding arrangements for primary health care did not facilitate this, and in some cases actively undermined the Crown's Treaty partner.

The Crown accepted much of the claimants' allegations regarding insufficiency of primary health care funding arrangements. We note the Crown's acknowledgements, and the evidence of Crown witnesses, detailing that establishment funding was unequally distributed and that this negatively impacted on Māori primary health organisations.¹⁰³

Accordingly, we find that:

- ▶ the Crown broadly allowed variability of establishment funding for primary health organisations, with no consistent recognition of the existing capital they may have had or the needs of the populations they would serve. This disadvantaged many Māori organisations seeking to become a Māori primary health organisation, and as a result, Māori patients with high needs who enrolled with these organisations. The failure to implement a system to allocate equitably establishment funding is a breach of the Treaty principles of partnership, options, active protection and equity.

The shift to capitation funding for primary care was intended to be equity-enhancing. Professor Peter Crampton stated that the current funding arrangements for primary care 'run the risk' of being anti-equity.¹⁰⁴ The evidence before us indicates that they are, in fact, anti-equity in practice.

From the evidence before us, we conclude that the funding arrangements for primary care are barely sufficient to pursue the stated goals in the New Zealand Health and Disability Act, let alone ensure that the primary health care system is consistent with the principles of active protection and equity. Changes to funding that have been introduced have tended to be ad hoc and have not sufficiently focused on the goal of achieving equity. And yet the sector has not been held to account for failing to deliver on this fundamental component of the health reforms. The necessary 'rigorous risk adjustments' highlighted by Amy Downs as crucial to a successful capitation-based system were not put in place, either when the reforms were first introduced or subsequently.

Accordingly, we find that:

- ▶ both the population-based funding formula for district health boards and the funding arrangements for the primary health care system have not worked to address Māori health needs;
- ▶ the funding arrangements for the primary health care system particularly disadvantage primary health organisations and providers that predominantly service high-needs populations, and particularly impact on Māori-led primary health organisations and providers in that category;
- ▶ the funding arrangements for the primary health care system do not adequately provide for kaupapa Māori models of care; and

103. Crown Response to Statement of Issues 1.3.1, p 4; transcript 4.1.7, pp 286–287.

104. Document A9, para 46.

- both individually and when taken together, these Crown failures constitute a breach of the Treaty principles of partnership, active protection, equity and options.

In discussing the merit of the Crown's various responses to funding and access issues with Crown counsel, Professor Crampton said:

What I see is a recognition of financial barriers to access for those most in need . . . [T]he incremental funding changes are a partial response to those barriers, and I welcome them on that basis. I would still class them as ad hoc incremental changes in the context of a set of issues around access barriers which are not being systematically addressed. The net result, if we waited 100 years, might be the systematic addressing of those access barriers. I, from where I'm sitting, do not see a natural end point to this process of incremental changes.¹⁰⁵

The Crown was more than well-informed about the problems with the funding arrangements in primary health care. Given the persistence of inequitable Māori health outcomes, its failure to address these issues properly is a serious failure. Accordingly, we find that:

- the Crown's failure to amend or replace these funding arrangements for over a decade adequately, in the face of both consistent advice to do so and persisting Māori health inequity, is inconsistent with the duty of good faith, and a breach of the Treaty principles of partnership, options, active protection and equity.

The funding regimes for primary care are a crucial component to the success of the system. The cumulative effect of these breaches partly explains why only four Māori primary health organisations remain.¹⁰⁶ Further, the funding arrangements for primary health care have hampered – and at times, it appears, outright undermined – the ability of the primary care sector to improve inequitable Māori health outcomes. The Crown understands this is the case, and from what we have seen in this inquiry is open to making the substantial assessment of, and changes to, funding arrangements that appear to be required.

105. Transcript 4.1.4, p 602.

106. Claimant counsel said that at the height there were 14: submission 3.3.3, para 34.

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CHAPTER 7

IS THE WAY HEALTH ENTITIES ARE HELD
TO ACCOUNT TREATY-COMPLIANT?*Toki tā wahie te toki roa***7.1 INTRODUCTION**

The Tribunal has already established in previous reports that the Crown is ultimately responsible for the provision of health care and the performance of the health system.¹ As such, we were broadly interested in the ways that the sector is held to account. In chapter 4, we outlined the planning and accountability documents established in the primary health care sector.

We have already concluded that the primary health sector's statutory objective 'to reduce disparities' is not Treaty-compliant. As we alluded to in previous chapters, the current state of Māori health outcomes confirms that the sector is not meeting its statutory requirement and indicates that it is not pursuing health equity in a way consistent with the Treaty principles of active protection and equity. Accordingly, in this chapter, we look at the effectiveness of this system for holding the health sector to account for reducing inequities in a Treaty-compliant way.²

7.2 ACCOUNTABILITY MECHANISMS FOR PRIMARY HEALTH CARE

Broadly, health entities are held to account through three, often overlapping, processes: planning, measuring and reporting. *Planning* sets the expectations of what health entities need to deliver. For district health boards, which distribute most of the funding for primary care, planning documents include annual plans and regional service plans, and for those that still prepare them, Māori Health Plans.

Health entities are *measured* against the expectations set in their planning documents to assess their performance. The health measures set at a high level include the national health targets and the System Level Measures framework, as well as the Minister's annual Letter of Expectations to district health boards. Some can be set at a more local level, for example through contracting documents like the Crown Funding Agreements for district health boards, PHO Services Agreements

1. Waitangi Tribunal, *The Napier Hospital and Health Services Report* (Wellington: Legislation Direct, 2001), p xxiv; Waitangi Tribunal, *Tū Mai te Rangi! Report on the Crown and Disproportionate Reoffending Rates* (Wellington: Legislation Direct, 2017), p 22.

2. We take into consideration and respond to the issues posed at sections 7.1, 7.2.4, 7.2.6 and 9 of the Statement of Issues 1.4.1.

for primary health organisations, and contracts between primary health organisations and health providers.

Reporting against these expectations, which is generally done through annual reports, is how health entities are intended to be held to account by Parliament and the public.

Broadly, the claimant groups argued that existing accountability measures and mechanisms are not used often enough to hold health entities to account for improving Māori health outcomes. They further argued that the current raft of accountability measures is insufficient and could afford to be expanded.³

The Crown agreed that holding health entities to account for their performance is critical to the successful operation of the system, including how it is performing for Māori and whether it is fulfilling its Treaty obligations.⁴ Crown witness Keriana Brooking acknowledged that the complexity of the devolved system means it is difficult to orientate the sector towards some health priorities, including Māori health equity.⁵ Again, while the Crown broadly argued that the deficiencies of the system were due to insufficient implementation rather than significant problems with the levers themselves, we note that the Crown broadly acknowledged many of the claimants' allegations in this area, and has committed to strengthening accountability arrangements.⁶ Nonetheless, we are required to traverse and analyse these issues to assess whether there has been a breach of the Treaty principles.

7.3 HOLDING DISTRICT HEALTH BOARDS TO ACCOUNT

The evidence before us showed that, when it comes to addressing Māori health outcomes, the performance of district health boards across the country varies, and that the Ministry has been aware of this.⁷ Claimants firmly stated that the state of Māori health inequity indicates that district health boards have clearly not been held to account for their statutory responsibilities to reduce Māori health disparities.⁸

The Crown submitted that the existing accountability mechanisms for district health boards 'provide a potentially adequate basis for the Crown' to monitor their performance.⁹ The Crown nonetheless acknowledged that the current accountability measures need strengthening. The Director-General accepted that, in spite of some isolated successes in improving outcomes, the overall performance of district health boards to date was 'largely not good enough'.¹⁰ He also acknowledged that accountability for district health boards, in particular, needed strengthening.¹¹

3. Submission 3.3.18, para 114; submission 3.3.30, para 5.171.

4. Submission 3.3.32, para 177.

5. Document A62, paras 18.1–18.2.

6. Submission 3.3.32, paras 24, 182.

7. Document A62, paras 26, 34; transcript 4.1.5, pp 20–21; transcript 4.1.7, p 148.

8. Document A23, para 91.

9. Submission 3.3.32, para 211.

10. Transcript 4.1.5, p 396.

11. Document A59, paras 39, 44.

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He said that he plans ‘to introduce more systemic accountability for ensuring that the health system is meeting the needs of Māori.’¹²

Crown witness Professor Jacqueline Cumming similarly stated that there is a lack of accountability for Māori health under the current framework.¹³ Part of the problem, she said, was that ‘there is inconsistency over time in whether or not Māori health has been a key priority’ of district health boards. She asserted that ‘[g]overnments could and should do more consistently in ensuring that key organisations are better held to account for achievements in Māori health and in reducing inequities.’¹⁴

In their oral opening submissions, Crown counsel acknowledged that key mechanisms in place that could be used to hold district health boards to account are often not or have not been exercised in relation to Māori health.¹⁵ For example, under Crown Funding Agreements, funding can be withheld for poor performance; however, the Director-General could not provide an example of this mechanism being exercised in relation to non-performance or under-performance on Māori health issues.¹⁶

Similarly, the Minister can appoint Crown monitors in response to an extreme circumstance or severe under-performance; however, the Director-General confirmed that, despite the well-known and on-going existence of Māori health inequities, the Crown had never appointed a Crown monitor to audit a district health board’s actions in relation to Māori health.¹⁷ The same appears to be true of the mechanism provided for under section 31, whereby the Minister can opt to dismiss a board and replace it with a commissioner if it is seriously underperforming. Non- or under-performance in relation to Māori health has never been specified as the reason for sacking a board.¹⁸

Crown witness Dr Nick Chamberlain, the Chief Executive of Northland District Health Board, noted that senior executives have key performance indicators in their employment contracts that relate to Māori health outcomes, and specifically highlighted as an example that his contract includes a key performance indicator for improving Māori mortality rates.¹⁹ He said that the Ministry does not have prescribed ordering or weighting to the key performance indicators in his contract, however he did note the following: ‘at the end of the day, what I’m probably going to lose my job about is financial – lack of financial performance and significant

12. Document A59, para 39.

13. Transcript 4.1.7, p 65.

14. Document A60, para 35.

15. Transcript 4.1.5, p 359.

16. Transcript 4.1.5, p 419.

17. Transcript 4.1.5, pp 493–494.

18. ‘Sacked Hawke’s Bay DHB Members Reinstated’, *Stuff*, <http://www.stuff.co.nz/national/health/757786/Sacked-Hawkes-Bay-DHB-members-reinstated>, 31 January 2009; ‘Southern District Health Board Dismissed by Health Minister over Deficits’, *Stuff*, <https://www.stuff.co.nz/national/politics/69465196/null>, 17 June 2015; ‘Health Minister David Clark Sacks Waikato DHB Board’, *Stuff*, <https://www.stuff.co.nz/national/health/112512137/health-minister-makes-decision-on-future-of-waikato-dhb>, 7 May 2019.

19. Transcript 4.1.6, p 119.

issues around staff or patient safety. I'm not sure if I would lose my job over not achieving my KPIs [key performance indicators].²⁰

While we discuss district health board annual plans in the next section, we note here Keriana Brooking's evidence that, while Ministers must personally sign annual plans and have the power to refuse to approve them and ask them to be reviewed, this has only ever been done for financial reasons. No annual plan has ever been rejected because of issues in their reporting or planning relating to reducing Māori health disparities.²¹

7.4 THE IMPORTANCE OF EFFECTIVE MEASURES AND REPORTING

The evidence before us indicates that appropriate measuring of, and reporting on, Māori health inequities needs to be a key accountability mechanism in the health sector. Indeed, the claimants cite Tribunal jurisprudence indicating that a lack of public information on the effectiveness of government policies and programmes breaches the partnership principle of the Treaty in that it denies Māori communities any real opportunity to monitor the Crown's performance.²² Dr Heather Came-Friar and Professor Tim McCreanor, who appeared as interested party witnesses, highlighted research commissioned by the Ministry in 2014 that stressed the importance of 'setting targets and monitoring progress and the normalisation of equity analysis'.²³ In their closing submissions, counsel for Tureiti Lady Moxon and Janice Kuka submitted that 'there are few measures in place' that can be used to hold district health boards to account effectively for the persistence of Māori health inequity.²⁴

Keriana Brooking, giving evidence for the Crown, similarly noted the importance of effective measuring and reporting multiple times in her oral evidence when asked about Māori Health Plans, at one point stating:

So certainly, there needs to be agreement across parties about what the measures are that we consider to be important and who [is] the 'we' [that] needs to be described and developed. So, the Māori health plans were a set of constructs that happened within ourselves, so Māori Health Managers and Planning and Funding staff within the Ministry of Health sought to determine what the measures were. So, from my perspective that means that people were absent in the developing of what appropriate measures could be. So, if I started back there, what would be the appropriate measures that we would all consider, then certainly how would we work on those measures to improve them and publish those measures in order for people to see the progress that is being made.²⁵

20. Transcript 4.1.5, pp 120–121.

21. Transcript 4.1.7, p 316.

22. Submission 3.3.3, para 14.

23. Document A46, para 39.

24. Submission 3.3.18, para 114.

25. Transcript 4.1.7, p 294; see also transcript 4.1.7, pp 319–320.

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Māori Health Plans were often referred to as an example of a planning document that specifically referred to Māori health outcomes in particular districts and then outlined what the district health board was planning to do to reduce Māori health disparities. The Ministry implemented a requirement for Māori Health Plans in response to a review of district health boards conducted in 2008–09 by the Office of the Auditor-General.²⁶ The Auditor-General's report found that district health boards 'did not provide detailed information on the level of disparity in their district and did not report consistently on Maori health disparities in their annual reports.'²⁷ Māori Health Plans were not required to be public – they were seen by district health boards, who could choose to make them public if they wished.²⁸ In 2010–11, in response to a further review by the Office of the Auditor-General, the Ministry required all district health boards to describe in their Māori Health Plan how Māori health would be improved and how health disparities would be reduced.²⁹

The Ministry rescinded the requirement for district health boards to prepare Māori Health Plans in 2016.³⁰ In the last year that district health boards had to produce Māori Health Plans, the Ministry emphasised their intrinsic role in assisting district health boards with their responsibilities to Māori health:

MHPs are fundamental planning, reporting and monitoring documents, that underpin the DHB's efforts to achieve health equity and improve health outcomes for Maori. As key planning and monitoring documents, it is important that these plans are comprehensive, complete and robust.

The MHP provides a summary of a DHB's Maori population and their health needs. The plan then documents and details the interventions and actions the DHB plans to undertake to address health issues to achieve indicator targets set nationally and locally.³¹

Interested party witness Teresa Wall, who was closely involved with the formulation of Māori Health Plans when she was the head of Te Kete Hauora and Deputy Director-General Māori Health, spoke generally of the practical usefulness of Māori Health Plans in principle for district health board planning. She particularly emphasised their usefulness to Te Kete Hauora's activities as the

26. Document A2, para 36; doc A15, para 21.3.

27. Document A15, para 21.3. Teresa Wall, then-head of Te Kete Hauora, noted that some early work pursued by her team in 2008 similarly found that district health boards were not adequately monitored against their performance on reducing Māori health disparities. In response, Te Kete Hauora worked on a set of indicators for Māori health intended for district health board reporting. This work was then picked up by the Auditor-General's report in 2011 (see transcript 4.1.5, pp 84–85).

28. Transcript 4.1.7, pp 293–294.

29. Document A15, para 21.3; submission 3.3.32, para 170.

30. Document A2, para 38; doc A3, para 216; doc A62, para 50.

31. Document A50, para 24; 'Māori Health Plan Guidance 2016/2017', Ministry of Health, <https://nsfl.health.govt.nz/dhb-planning-package/201617-planning-package-and-review-plans/mhp-guidance>, last modified 4 March 2016.

Ministry's Māori health unit. Many witnesses, including Crown witnesses, broadly agreed with her assessment.³²

Māori Health Plans themselves were by no means perfect. Witnesses acknowledged for example that the indicators that were selected for inclusion in the plans were likely inadequate.³³ Further, Keriana Brooking said that while some Māori health officials in the Ministry and in district health boards were involved in the creation of Māori Health Plans, the wider health sector and Māori communities were not involved in their formulation.³⁴ Her view was that Māori Health Plans were, plainly, not developed in partnership with the Māori communities.³⁵

We were told that from 2017, the information included in Māori Health Plans was to be incorporated into district health board annual plans.³⁶ Nevertheless, the claimants stated that their disestablishment (along with the disestablishment of Te Kete Hauora at the same time) contributed to a perception that the Ministry did not consider Māori health a priority, and further risked detracting focus from Māori health inequity.³⁷

We note Keriana Brooking's evidence that, when the Ministry announced in 2016 that they were discontinuing Māori Health Plans, 'some' district health boards expressed their disapproval of the move; however, it appears that Te Tumu Whakarae, a national collective of Māori managers from district health boards, offered more significant resistance.³⁸ The Ministry ultimately ignored their recommendation not to remove the requirement for Māori Health Plans, and did not heed their specific advice on how to include improving equity as a priority in annual plans.³⁹

The Ministry's explanation for the removal of the requirement for Māori Health Plans was summarised in evidence before us as follows:

The Ministry of Health's rationale for amalgamating the Māori health plans with DHB annual plans was to improve Māori health outcomes by strengthening the accountability, focus and profile on Māori health not only to the Minister of Health but also to DHB Chairs and Boards.

While the amalgamation of the Māori health plans has meant a reduction in visibility for Māori health, there are certain DHBs who continue to develop a stand-alone Māori health plan. The amalgamated plan aims to ensure all priorities of the

32. Transcript 4.1.5, pp 87–88; transcript 4.1.7, pp 179–180, 293. The Office of the Auditor-General has also endorsed their usefulness: doc A12, para 54; *Health Sector: Results of the 2010/11 Audits* (Wellington: Office of the Auditor-General, 2012), p 37; *Health Sector: Results of the 2012/13 Audits* (Wellington: Office of the Auditor-General, 2014), p 55.

33. Document A50, para 26; doc A70, para 17; transcript 4.1.5, pp 39–40, 84; transcript 4.1.6, pp 23–24; transcript 4.1.7, pp 149–150.

34. Transcript 4.1.7, pp 309, 319.

35. Transcript 4.1.7, p 309. Professor Jacqueline Cumming also made a similar point about community consultation on their development: transcript 4.1.7, p 141.

36. Document A2, para 38; doc A3, para 216; doc A62, para 50.

37. Document A20, paras 20–20.1; transcript 4.1.4, p 301; transcript 4.1.5, p 40.

38. Document A62, para 51.

39. Document A64, paras 21–22; transcript 4.1.7, p 216.

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government and DHB are given equal status. The amalgamated Annual Plans are formally approved by the Minister of Health, while Māori health plans were not.⁴⁰

Hector Matthews stated that this incorporation did not result in any information being 'lost', but made the point that explicit data about Māori health outcomes is harder to find in annual plans.⁴¹ Referring to the latest examples of the Canterbury District Health Board annual plan and Māori Health Plan, Matthews also agreed that attempting to elicit the actions that district health boards will undertake to address inequitable Māori health outcomes, detail that was required in Māori Health Plans, is difficult to find in the Canterbury District Health Board Annual Plan.⁴² He further stated that the new equity action guidelines for annual plans are not sufficient.⁴³

When asked about Māori Health Plans, the Director-General essentially repeated the Ministry's explanation quoted above: that the idea was that amalgamation would broaden accountability for Māori health.⁴⁴ In our view, and in practice, amalgamation has achieved the opposite.

Having discussed the circumstances of their removal, in our view Māori Health Plans themselves are not the central issue: the key point is that appropriate measures for Māori health inequities need to be developed in consultation with the rest of the sector as well as Māori. These measures need to be visible and easily understood both by the sector and the wider public. Further, health entities such as district health boards need to report against these measures.

Crown witnesses agreed that district health boards should revert to measuring and reporting separately against Māori health outcomes more effectively to hold them accountable for addressing Māori health inequities in their districts. Dr Nick Chamberlain and Professor Jacqueline Cumming indicated that work would need to be undertaken to make sure that this did not end up simply being a box-ticking exercise, as this had been a criticism of Māori Health Plans when they were required.⁴⁵ Witnesses considered the visibility of health measures for Māori an important internal accountability tool in, and of, itself. Hector Matthews highlighted that, at a minimum, clear visibility of data detailing inequitable health outcomes was an important way to inform and motivate health professionals:

It is much easier for me to say, 'Look, look at these 15 indicators that we haven't hit.' Now I've got to hunt through a 100-page document to find it . . . but you see I'm motivated to do that. The specialist sitting in Ward 24 at Christchurch Hospital isn't necessarily motivated. He needs something easily visible to go to see how the system

40. Document A62, paras 52–53. See also doc A64, para 14.

41. Transcript 4.1.7, p 209.

42. Transcript 4.1.7, pp 220–222. We note that the Auditor-General's report on the health audit results from 2011–12 expressed similar concerns about district health board annual plans: *Health Sector: Results of the 2010/11 Audits* (Wellington: Office of the Auditor-General, 2012), pp 35–36, 38.

43. Transcript 4.1.7, pp 156, 161.

44. Transcript 4.1.5, pp 526–527.

45. Transcript 4.1.6, pp 23–24; transcript 4.1.7, pp 140–141.

that he's working in is going for him. So, visibility of our accountability is a really important tool to make change within the system at an operational level.⁴⁶

Matthews provided a specific recent example:

last year we had 30% of Māori kids enrolled in our dental health service so 70% weren't and our board, literally, pointed a big finger at the clinical director of our community dental services and said, 'Sort that out.' Now, they didn't have an answer for that but they've started to sort that out. They haven't nailed it yet, they haven't even cracked 50% but we are getting there, so what I find is data is very compelling, despite people's belief. If you show them that actually, this is the requirement and you have a difference between non-Māori and Māori what are you going to do about it, what I find with clinicians is they don't like looking at data which makes them look bad.⁴⁷

We accept the evidence we received indicating that the information previously contained in Māori Health Plans is now included in annual plans. However, we agree with Matthews that this results in a lack of clear visibility (at least in the annual plans provided and shown to us in this inquiry).⁴⁸ Further, as the Tribunal's exchange with Matthews about Canterbury District Health Board's planning documents indicates, the new Annual Plans lack specificity, or at least lack clarity, about the action points or the 'how' of addressing inequities.

We are not convinced that the current iteration of annual plans is as useful for separately identifying and setting out what actions district health boards are taking to address Māori health inequities. Our impression is that this information is very difficult to glean from annual plans. Indeed, Professor Cumming said that district health board Annual Plans are, on the whole, difficult to interpret.⁴⁹

The lack of measuring and reporting inequitable health outcomes is a feature of other mechanisms, too. Professor Cumming highlighted that the measures in the new System Level Measures framework do not break down information by population groups.⁵⁰ Further, she made the point that the annual Health and Independence Report, which is prepared by the Director-General, and is one of the central mechanisms that holds the Ministry accountable to Parliament, 'does not always report on key issues consistently over time, or report on trends, it does not break information down by DHB, and does not always report on inequities.' She, too, emphasised the importance of reporting on the sector's progress on reducing health inequities, 'including on Māori health'.⁵¹

While some district health boards and other organisations in the primary health care sector still practice separate measuring and reporting, the Ministry's failure to

46. Transcript 4.1.7, p181.

47. Transcript 4.1.7, p169.

48. Counsel for Kuka and Lady Moxon made a similar comment in their closing submissions: 3.3.18, para 118.

49. Transcript 4.1.7, p140.

50. Document A60, para 31.

51. Document A60, para 30.

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require this amounts to a weakening of the statutory obligation to focus on reducing Māori health disparities. It follows that this weakening constitutes a breach of the Crown's obligations to the Treaty principles of equity and active protection.

7.5 HOLDING PRIMARY HEALTH ORGANISATIONS AND PROVIDERS TO ACCOUNT

Like district health boards, the performance of primary health organisations, and their commitment to Māori health, varies across the country. The Crown accepted that, broadly, the framework has not, in its implementation, ensured 'sufficient accountability from PHOs to DHBS'.⁵² Lady Moxon said that the commitment of primary health organisations to improving Māori health outcomes varies from organisation to organisation.⁵³ The fact that the accountability arrangements in primary care appears to allow this variability concerns us, too.

Representatives and witnesses from all parties acknowledged that accountability for primary health organisations and providers is severely lacking. The Crown's independent witness, Professor Cumming, confirmed that accountability measures for primary health organisations 'have kind of been set aside'.⁵⁴ Director-General Dr Bloomfield also agreed, acknowledging that existing levers available to district health boards are difficult to utilise in practise. The Director-General also said that 'no agreed performance framework' exists between district health boards and primary health organisations and providers.⁵⁵ Broadly, it appears to us that health entities face few negative consequences if they fail to provide sufficient care for the citizens they are responsible for.⁵⁶ The lack of consequences not only acknowledges that the levers in place are not utilised to their full extent, but also that important accountability mechanisms are arguably missing from the system.

We heard that primary health organisations essentially self-audit, as Amy Downs – an American scholar who completed a study of funding flows in the New Zealand primary care system in 2017 – emphasised in her evidence:

PHOs conduct self-audits of their performance. I would not consider that this activity introduces accountability into the system. My perception is that DHBS are so concerned with the challenges of serving as a provider of hospital services that they have minimal capacity to pursue accountability in their role as a funder of primary healthcare services. According to the chief executives of PHOs who I interviewed, DHBS pass on the primary care funding to PHOs with minimal follow-up regarding how those funds are spent. Some reporting does occur but is generally not scrutinised in a meaningful way.⁵⁷

52. Submission 3.3.32, para 185.

53. Document A11, paras 107, 110.

54. Transcript 4.1.7, p 88.

55. Document A65, para 51. See also transcript 4.1.5, p 385.

56. For examples, see: submission 3.3.18, paras 117–118, 178; submission 3.3.30, paras 5.185–5.188; doc A65, paras 50–51.

57. Document A43, para 22. See also transcript 4.1.5, p 168.

Downs also said that throughout the interviews she conducted for her research, staff of primary health organisations told her that accountability for funding under the System Level Measures framework and the Flexible Funding Pool was weak, with ‘little to no follow-up’ from district health boards.⁵⁸ Her impression was that health providers, similarly, are given funding by primary health organisations without scrutiny of their practices or their responses to Māori inequities.⁵⁹

Despite this alleged loose accountability for primary health organisations and providers, counsel for Lady Moxon and Janice Kuka argued that Māori primary health organisations and providers ‘experience high levels of compliance monitoring and auditing’ in comparison to non-Māori organisations. She cited research co-authored by interested party witnesses Dr Came-Friar and Professor McCreanor, comprising a nation-wide survey of 150 providers, which similarly indicated difference in district health board and Ministry treatment of Māori organisations and non-Māori organisations.⁶⁰ The research indicated that Māori organisations in the survey were more likely than non-Māori organisations to perceive the monitoring of their organisations as ‘burdensome’. Further, the research established that the Māori health providers surveyed were audited more frequently than their non-Māori counterparts, and that audits were more often perceived by Māori providers to be unnecessarily harsh and taxing on their time and resources.⁶¹

One specific example in evidence before us related to Te Kupenga a Kahu, a Māori primary health organisation, which used funds allocated under the Services to Improve Access framework to pay for general administration costs instead, a practise known as ‘top-slicing’. Te Kupenga a Kahu was pursued by its district health board and directed to repay the money it had top-sliced from the Services to Improve Access funding. The evidence before us appears to show that the practice of top-slicing was more widespread than just in Te Kupenga a Kahu, but was not uniformly policed. Te Kupenga a Kahu later closed because it could not repay the money it owed to its district health board, though the district health board did eventually stop pursuing Hakopa Paul and others formerly involved with Te Kupenga a Kahu for the repayment.⁶²

The broad indications are that the high-level of scrutiny most Māori organisations contrast with the auditing and monitoring environment that other, non-Māori, organisations experience. The Crown accepted that the experience of Te Kupenga a Kahu exemplified a weakness in the permissive approach to accountability inherent in the primary health care framework.⁶³

58. Document A43, paras 25–27. Dr Rawiri Jansen appeared to agree with Downs’ assessment: transcript 4.1.4, pp 554–555.

59. Document A43, para 30.

60. Submissions 3.3.18, para 72.

61. Document A46, para 36; H Came, C Doole, B McKenna, and T McCreanor, ‘Institutional Racism in Public Health Contracting: Findings of a Nationwide Survey from New Zealand’, *Social Science & Medicine*, 199 (2017), pp 135–136.

62. Document A30, para 9; doc A13, paras 22–24; doc A11, para 35; transcript 4.1.5, p 90; doc A13(a).

63. Submission 3.3.32, para 240.

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Like district health boards, primary health organisations also used to produce Māori Health Plans. Hector Matthews noted that as early as 2007 some primary health organisations were resistant to producing stand-alone Māori Health Plans. He attributed this resistance to the fact that primary health organisations were essentially uncomfortable with publishing any data that revealed persisting Māori health inequities in their enrolled population.⁶⁴

The Ministry rescinded the requirement for primary health organisation Māori Health Plans in 2013. Primary health organisations were instead required to contribute to the district health boards' Māori Health Plans.⁶⁵ Matthews was of the view that primary health organisations' resistance to producing these plans may have been part of the pressure to lift the requirement.⁶⁶ As noted in the previous section, the Ministry has not required district health boards to produce Māori Health Plans since 2016. Again, we think that separately publishing measures on Māori health outcomes and then reporting against those measures is an equity-enhancing approach.

7.6 THE DETAIL OF DATA AND INFORMATION COLLECTED FROM PRIMARY HEALTH ORGANISATIONS AND PROVIDERS

Many witnesses stressed that robust public reporting is a key form of accountability. They broadly emphasised that data on health inequities and the actions being taken to address them is useful not only for those working within the system but also for academics, researchers and entities which are involved or adjacent to the health sector, such as Māori relationship boards, and the public more generally. Director-General Dr Bloomfield agreed that the health sector '[needs] to be providing much more data publicly on system performance including on Māori health and key Māori health indicators and outcomes.'⁶⁷

We heard that most of data relating to primary care is collected by health providers and primary health organisations, but they are not required to provide much of this data to district health boards or to the Ministry.⁶⁸ Amy Downs' research found that primary health organisations only submit a quarterly report detailing the number of visits by enrolled patients, but that even this data is incomplete as it only records the last visit in any given quarter: '[i]f a member had four visits in one quarter, only the last date is recorded.'⁶⁹ Her overall impression was that the data provided to the Ministry was extremely limited, to the extent that, in her view, '[t]here are no policy incentives or requirements to ensure that New Zealand learns the outcomes of its investment in primary care.'⁷⁰

64. Document A64, para 39; transcript 4.1.7, p 217.

65. Document A20, para 20.3; doc A64, para 40.

66. Document A64, para 39.

67. Transcript 4.1.5, p 466.

68. Document A43, para 28; doc A44, para 21; transcript 4.1.5, pp 147–148, 153, 167–168.

69. Document A43, para 28.

70. Document A43, para 30.

Public health academics and researchers who appeared before us consistently stated that, while ample evidence of Māori health inequities existed, more detailed Māori health data – and especially performance data for health entities – is not readily available. Dr Suzanne Crengle, for example, said limited data was published relating to the performance of district health boards, primary health organisations and health providers:

The paucity of publicly available data limits opportunities to monitor and evaluate the performance of the health sector. Furthermore, in my view if the Crown had a comprehensive commitment to Māori health it would also have a comprehensive range of outcomes and indicators . . . that it was monitoring. This does not appear to be the case.⁷¹

Dr Crengle also said that ethnic-specific health data had been more readily available in the past than it is today.⁷² Under cross-examination, she said that while the *Māori Health Chart Book* (the latest edition of which was published in 2015) was useful, it was not as detailed as some previous reports. She confirmed that the last published report which, in her view, thoroughly assessed Māori health standards was released in 2007.⁷³

‘Trendly’, a government website that publishes measures of, and reporting on, health outcomes across the health sector, was set up about the time that Māori Health Plans were developed. Dr Crengle praised the principle of public reporting on district health board performance that was behind ‘Trendly’, and noted that it was a positive national approach to hold district health boards to account for addressing inequitable health outcomes.⁷⁴ However, she noted that only three primary care-related indicators are published on ‘Trendly’: breast cancer screening, cervical cancer screening, and immunisation rates.⁷⁵ She noted that outcomes reported for all of these indicators show inequities for Māori.⁷⁶

We heard that Te Kete Hauora, previously the Ministry’s Māori health business unit, provided useful information and data on Māori health by producing or commissioning the *Hauora* series of reports and research, the last occurring in 2007. The unit then went on to produce three editions of the *Māori Health Chart Book*, the last of which was in 2015. According to Dr Crengle, the range of information and data provided and the depth of analysis in the last one, was more limited than the previous two.⁷⁷ Dr Crengle’s evidence was that this knowledge base had progressively lessened since 2007.⁷⁸ We also received evidence that Te Kete Hauora

71. Transcript 4.1.5, pp 21–22. See also doc A52, para 12.

72. Document A52, para 28.

73. Transcript 4.1.5, p 27.

74. Transcript 4.1.5, p 89.

75. Document A52, paras 17–21.

76. Transcript 4.1.5, p 21.

77. Transcript 4.1.4, p 312; transcript 4.1.5, pp 28, 36, 37, 119.

78. Transcript 4.1.5, pp 27–28.

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had prepared information concerning levels of funding to Māori health providers for the years 2011–12 to 2015–16. We heard that a further such report has not been provided since Te Kete Hauora was disestablished by the Ministry in 2016.⁷⁹

As well as the amount of data no longer available to researchers, other witnesses said that some data that could prove useful as evaluative tools for the performance of the system was not even being collected. Professor Papaarangi Reid noted that because data was often quantitatively focused rather than qualitative, ‘we can see when something clicked or went through a system, but we don’t know how was that process, was it a good engagement, was it timely, all those sorts of other types of data that we need to reinforce and to do better.’⁸⁰

After noting that even the quantitative data that primary health organisations provide to the Ministry is essentially incomplete, Amy Downs echoed Dr Crengle and Professor Reid: ‘the data submitted is so limited that it does not provide meaningful or actionable intelligence to address primary healthcare utilisation needs, quality or coordination with secondary care.’⁸¹

This failure to collect meaningful and actionable information appears to have been an issue even when the framework was being designed and introduced. We refer to Professor Cumming’s appraisal of the Primary Health Care Strategy, partially quoted in chapter 5, in full:

It is worth noting that although a key goal of the PHCS [Primary Health Care Strategy] was to enhance equity, no equity analysis / programme logic was ever completed to my knowledge. This would have provided clarity about the various features of the PHCS and careful thinking and documenting of how those features would likely affect equity. It might also have identified the need for additional policies and programmes to support Māori health. Future policies, programmes and plans aiming to improve equity should include a clear programme logic relating to how equity is to be improved. There should be regular monitoring about achievements against such plans.⁸²

Professor Cumming also highlighted the lack of information about primary health organisations’ governance arrangements or how primary health organisations are held to account:

It is unclear how today’s PHOs meet these requirements, and research is urgently needed to identify how PHOs are governed and how they work with local communities, including Māori. It would be of concern if Māori are not involved in local PHO governance where there are many Māori patients enrolled.⁸³

79. Document A67(a), pp 1–2; transcript 4.1.5, p 476.

80. Transcript 4.1.5 p 62. Amy Downs agreed: doc A43(a), pp 5–6.

81. Document A43, para 28.

82. Document A60, para 38.

83. Document A60, para 41.

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Professor Cumming also stated: ‘It is difficult to know how the Ministry of Health and DHBs work to hold PHOs to account, including in relation to Māori health, as such research does not, to my knowledge, currently exist.’⁸⁴

It appears, then, that the type of data and information that is collected, and how it is utilised, and what is made publicly available, is significantly deficient. We are particularly concerned that the Crown has not robustly assessed how the primary health care framework is operating, or provided the means to conduct research in this area.

We noted earlier that public reporting, as well as being key to academic research, which may assist in improving the responsiveness of the health system, also allows for the general public to see how health entities are performing and hold them to account. We heard evidence indicating that public reporting of performance, and the associated reputational risk, were key means of holding health entities to account. The Director-General, for one, said that, in his experience, public reporting was an effective way of motivating district health boards and primary health organisations to focus on particular areas.⁸⁵

In 2009, the government renewed its national health targets, which slimmed down the targets reported on and clarified their focus.⁸⁶ Matthews summarised this change as follows:

The government introduced public reporting of health targets as a way of using reputational concerns as a lever for improving performance against health targets. At the same time, the new government also removed differential targets for different ethnic groups, reinforcing the expectation that all New Zealanders should receive the same level of care and service regardless of ethnicity. The government continued to require reporting by ethnicity (not publically [*sic*]) to ensure visibility of results and monitored DHB performance by ethnicity.⁸⁷

To emphasise, district health boards have not been required to report publicly on Māori health outcomes, or indeed the specific outcomes of any population group by ethnicity, since 2009. Matthews indicated in his written evidence that the ‘robust ethnicity data’ shared internally by district health boards has been key to improving the district health boards’ responsiveness to Māori health inequity since 2009, and he used improved Māori outcomes achieved in his organisation’s district as an example.⁸⁸

However, this does not discount the evidence supplied by the Crown and others in relation to reporting that shows district health board performance varies considerably, and is poor overall. It is perplexing to us that the Crown would at

84. Document A60, para 43.

85. Transcript 4.1.5, p 385. Hector Matthews agreed: doc A64, para 11; transcript 4.1.7, pp 181–183.

86. Document A62, paras 249–250.

87. Document A64, para 47.

88. Document A64, para 49.

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once recognise the power of public reporting while at the same time not use that mechanism to its fullest extent.

As noted by Dr Crengle and Professor Reid, among others, open availability of quality data would ideally lead to improvements to the ways the system addresses Māori health inequities. Despite the *Operational Policy Framework* contractually requiring that district health boards ‘provide relevant information, including ethnicity data, to Māori’, it appears that district health boards are not consistently complying with the obligations in their contracts.⁸⁹ The onus for this responsibility is mostly on district health boards, but also on the Ministry for not holding them accountable for insufficient action.

A discussion of the health sector’s use of data demonstrated the importance of visibility to the public. Dr Rawiri Jansen said that the National Hauora Coalition publishes data on the health outcomes of their enrolees, and emphasised how important it was to publish data. He acknowledged that publishing data showing insufficient progress was uncomfortable, but necessary, saying ‘we have to use data to tell uncomfortable truths’.⁹⁰

The Office of the Auditor-General’s report on their 2011–12 audit of the health sector suggested that the improvement in immunisation rates for Māori and Pacific peoples was expressly due to setting specific targets for these groups and then publishing the results for public view.⁹¹ At hearings, Matthews clarified his written evidence and said he personally disagreed with the Ministry’s and with some of his colleagues’ justification for limited public accountability, and made the point that ‘visibility within the system’ is not enough.⁹² He further remarked under cross-examination:

clinicians who work within the health system are quite proud of the efforts they make and you know when they see that some of those efforts aren’t actually leading to results people generally respond in two ways. They either you know pull their socks up and go to change that or they get quite defensive about it and generally our system gets quite defensive about inequitable results.

Q. But isn’t that the point of an accountability?

A. Indeed.⁹³

We agree. It is not solely for the Crown to determine what will be measured and how it will be reported. We emphasise that the Crown cannot be the sole auditor of its own performance – the Treaty obliges Crown agents to ensure that the health system is accountable to their Treaty partner.

89. *Operational Policy Framework 2018/19* (Wellington: Ministry of Health, 2016), <https://nsfl.health.govt.nz/accountability/operational-policy-framework-o/operational-policy-framework-201819>, para 3.10.3.

90. Transcript 4.1.4, pp 540, 546–547.

91. *Health Sector: Results of the 2010/11 Audits* (Wellington: Office of the Auditor-General, 2012), p 38.

92. Transcript 4.1.7, p 183.

93. Transcript 4.1.7, pp 182–183.

7.7 EXTERNAL MONITORING OF THE MINISTRY OF HEALTH

In addition to the Director-General's Health and Independence Report referred to in section 7.4, the Ministry of Health makes two presentations to Parliament's Health Select Committee each year. The first is to address appropriation estimates and funding. The second is where the Minister is statutorily required to report 'on progress in implementing the New Zealand health strategy'.⁹⁴ The Ministry's financial and non-financial outputs are also audited and reported to Parliament each year by the Office of the Auditor-General.⁹⁵

Te Puni Kōkiri also has a statutory responsibility to monitor the health sector and we heard that such monitoring was an important mechanism for holding the health sector to account.

Section 5 of the Ministry of Māori Development Act 1991 states:

5 Particular responsibilities of Ministry of Maori Development

- (1) The responsibilities of the Ministry of Maori Development include—
 - (a) Promoting increases in the level of achievement attained by Maori with respect to—
 - (i) education;
 - (ii) training and development;
 - (iii) health;
 - (iv) economic resource development;
 - (b) monitoring, and liaising with, each department and agency that provides or has a responsibility to provide services to or for Maori for the purpose of ensuring the adequacy of those services.
- (2) The responsibilities of the Ministry of Maori Development under subsection (1) are in addition to the other responsibilities conferred on that Ministry from time to time.
- (3) Nothing in this section limits the provisions of the Treaty of Waitangi Act 1975 or of any other Act.⁹⁶

Teresa Wall, a former Deputy Director-General of Health, was critical of the failure by Te Puni Kōkiri to deliver on its monitoring function under the Act. She characterised Te Puni Kōkiri's responsibility as: 'A critical monitoring and accountability opportunity to improve performance in Māori primary health services which has been lost because it has simply not been implemented.'⁹⁷

Lisa Davies, a Deputy Chief Executive at Te Puni Kōkiri, was called as a Crown witness and confirmed that Te Puni Kōkiri completed four agency reviews in the health sector between 1993 and 2004. Only one, a 2004 review of the Bay of Plenty District Health Board, was conducted after the establishment of the current

94. New Zealand Public Health and Disability Act 2000, s 8(4); submission 3.3.32, para 168.

95. In sections 7.3 and 7.5, we referenced criticisms made by the Office of the Auditor-General in its 2008–09 and 2010–11 audits.

96. Ministry of Māori Development Act 1991, s 5.

97. Document A50, para 28.

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primary health care framework.⁹⁸ She stated that with regard to Te Puni Kōkiri's responsibility to monitor other agencies:

The Act gives no specific guidance as to the method Te Puni Kōkiri should use to monitor and liaise with agencies, or promote increases in levels of achievement attained by Maori with respect to health and other outcomes. Te Puni Kōkiri's approaches to addressing its section 5 responsibilities have been refined over time to accord with Government priorities of the day and the prevailing public sector management environment. The approaches used have varied and included monitoring, evaluation, research, policy, relationships, capability building and investments.⁹⁹

Davies' evidence asserted that, from 2004, the leadership of Te Puni Kōkiri underwent a 'distinct shift' in direction, which resulted in the 'discontinuation of agency reviews and effectiveness audits, and an increased focus on policy and programme development'. As a result, as expressed in their 2006 annual report, Te Puni Kōkiri is now 'more involved at the front-end of policy development', rather than monitoring the outcomes or results of policy initiatives.¹⁰⁰ She explained during our hearings that Te Puni Kōkiri saw itself as fulfilling its monitoring responsibility by 'monitoring' policy development and 'trying to influence' that process. She did, however, acknowledge that a shift away from monitoring 'in a formal sense' had occurred, and further that since 2004 'there hasn't been a huge deliberate focus on monitoring the health sector along with other sectors'.¹⁰¹

Under cross-examination, Davies further agreed that Te Puni Kōkiri had departed from the original philosophy underpinning its formation. Counsel for Patricia Tuhimata and David Ratu, an interested party, submitted that prior to Te Puni Kōkiri being established, the Government had intended to devolve significant public sector responsibilities, largely handled by what was then known as the Department of Māori Affairs, to iwi groups. When the new Government was voted in at the turn of the 1990s, it abandoned this approach and instead resolved to transfer those responsibilities to 'mainstream' agencies, including social sector agencies such as the Ministry of Health.¹⁰²

Counsel for Tuhimata and Ratu stated in closing submissions:

[because] Te Puni Kokiri no longer carries out agency reviews of this kind, it is submitted that Te Puni Kokiri is in breach of section 5(1)(b) of the Ministry of

98. Document A76, para 18.

99. Document A76, para 15.

100. Document A76, paras 38–39.

101. Transcript 4.1.7, pp 240, 247.

102. Transcript 4.1.7, pp 245–247; see also Richard Hill, *Maori and the State: Crown–Maori Relations in New Zealand/Aotearoa, 1950–2000* (Wellington: Victoria University Press, 2009), pp 233–237, 241–252; Aroha Harris and Melissa Matutina Williams, 'Rights and Revitalisation, 1970–1990', in *Tangata Whenua: An Illustrated History*, ed Atholl Anderson, Judith Binney, and Aroha Harris (Wellington: Bridget Williams Books, 2014), pp 449–450.

Māori Development Act 1991. As a consequence, the Crown is in breach of its Treaty obligations.¹⁰³

Counsel for the Māori Nurses stated that Te Puni Kōkiri's relinquishing of its monitoring responsibility was 'alarming' given the poor state of Māori health.¹⁰⁴

We agree with both counsel. Te Puni Kōkiri operates under an express statutory function to monitor and liaise with certain public sector agencies, including the Ministry of Health, to ensure that the design and delivery of services is adequate for Māori.

That responsibility has not changed since Te Puni Kōkiri was established. What has changed is the type and scope of monitoring undertaken by Te Puni Kōkiri. Notwithstanding the lack of specific guidance in the Ministry of Māori Development Act, we know that Te Puni Kōkiri has not:

- ▶ monitored or reviewed whether the implementation of the Primary Health Strategy or He Korowai Oranga has improved Māori health outcomes;
- ▶ monitored or reviewed whether the Ministry and district health boards have adequately ensured the sustainability of Māori primary health organisations and providers;
- ▶ assessed the effectiveness of governance structures that exist between district health boards and Māori; and
- ▶ monitored or reviewed the effectiveness of the capitated funding formula for its impact on improving Māori health outcomes.

Beyond the provision of some policy advice and a sole, discrete review of the Bay of Plenty District Health Board in 2004, Te Puni Kōkiri has not undertaken any formal monitoring of the health sector since the commencement of the New Zealand Public Health and Disability Act 2000. In light of the well-known Māori health statistics, we consider that this is wholly inadequate. In our view, section 5 of the Ministry of Māori Development Act 1991 places a firm responsibility on Te Puni Kōkiri to monitor the health sector in its delivery of achievement of improved Māori health outcomes, which it has failed to do.

7.8 ACCOUNTABILITY IN A PERMISSIVE SYSTEM

Much of the hearings and evidence focused on the 'permissive' policy environment for primary health care described by the Director-General.¹⁰⁵ The claimants have alleged that this 'permissive', semi-devolved system is problematic, in part because, as district health boards operate semi-autonomously, it is difficult to roll out programmes nationally that are beneficial to Māori.¹⁰⁶ We accept the Crown's position that the permissiveness of the system was not intended to abrogate the Crown's responsibilities to Māori health, but rather to foster local solutions and

103. Submission 3.3.15, para 174.

104. Submission 3.3.20, para 300.

105. Document A59, para 20.

106. Submission 3.3.4, paras 74–75.

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community ownership of health care design and delivery.¹⁰⁷ However, we find Dr Jansen's appraisal of the Crown's permissive approach compelling:

the [Primary Health Care Strategy] of 2001 was aspirational but wonderfully naïve . . . to think that you can have a permissive system that will achieve everything by allowing different ways to flourish without direction . . . without strong monitoring, without refocussing people and continual improvement imbedded in the system is flawed. If you allow people to develop their own ideas but not strengthen them, reposit them in the right direction and strongly monitor them it won't succeed, you'll get increasing disparity.¹⁰⁸

Professor Peter Crampton was similarly critical:

That promise has not been realised, systematically not realised over the intervening 17 plus years. The risks associated with its implementation were identified, and written about, and noted, and commented on from earlier on but there was inadequate monitoring and the necessary adjustments and strengthening of implementation, those steps were not taken. As a result, we're confronted with this situation now in 2018 whereby Primary Health Care in our system fails in its core functions of meeting the basic health care needs of those who are most in need, as evidenced by huge amounts of data which convey the human reality of the system which is not meeting the needs of those most in need.¹⁰⁹

This arguably reflects a broader failing of leadership on the part of the Ministry. We agree with the claimants that, good intentions notwithstanding, the consistent signals sent by the Ministry and district health boards since the beginning of the primary health care framework indicated that achieving equitable Māori health outcomes has not been a high priority.

The permissive nature of the primary health care framework, with its considerable devolution of responsibilities, permits actors in the health sector to downplay their responsibilities to improve inequitable health outcomes for Māori and to abide by Treaty obligations. If the Ministry is to fulfil its role as the steward of the health system, it must demonstrate strong leadership. This includes strengthening accountability mechanisms throughout the sector to ensure the sector is performing well, but also extends to leading by example and expressing core concepts and directions for the sector thoroughly and clearly. The language of leadership the Ministry uses as the steward of the health system is important.

The central point we are making is that a permissive approach to health that allows for local control and delivery of primary care should not preclude strong accountability mechanisms and measures.

107. Submission 3.3.32, paras 43, 238.

108. Transcript 4.1.4, p 240.

109. Transcript 4.1.4, p 582.

7.9 TRIBUNAL FINDINGS

We agree with the parties that not only are accountability measures not always used to hold the Ministry and district health boards to account for insufficient action to address Māori health inequity, but that the current raft of accountability measures appear to be insufficient. In our view, the accountability arrangements set out in the primary health care framework barely work to achieve the statutory aim to reduce Māori health disparities, let alone pursue or achieve Māori health equity. As with the funding arrangements for primary health care, the Crown was more than well-informed that its permissive approach to primary health care had significant drawbacks and resulted in grave impacts both on Māori organisations and on Māori as patients.

These serious weaknesses in the Crown's permissive approach are compounded by the fact that, as we concluded in chapter 5, there are few actual expectations of equitable outcomes, either in general or specifically for Māori health, in the primary health care framework at a high level. While the 'language of equity' may be in common usage in the health sector, aiming to 'reduce disparities' is the language expressed in the Act and is the language that permeates all levels of the health system, from high-level strategies down to practical implementation through lower-level accountability documents. It follows, then, that 'reducing disparities' is the firm reference point for the primary health care sector in understanding how to address Māori health issues, not the concept of health equity. 'Reducing disparities' is what the sector is held accountable to, when it is held accountable at all.

The extent and persistence of Māori health inequity dictates that the failures of the accountability mechanisms put in place and governed by the Crown are unacceptable.

We find that:

- ▶ The ways health entities are held to account does not support the pursuit of equitable Māori health outcomes, and that this is a breach of the Treaty principles of active protection and equity.
- ▶ The Crown does not collect sufficient qualitative or quantitative data to fully inform itself how the primary health care sector is performing in relation to Māori health and this is a breach of the Treaty principles of active protection and equity.
- ▶ The Crown also does not use the data it does collect effectively, including by making it accessible to, and understandable by, the public. This failure, similarly, has acute repercussions for Māori health, which is not systematically separately measured and reported on. The ineffective use of data, particularly the failure to measure and report separately on Māori health outcomes, is a breach of the Treaty principles of active protection, equity and partnership.
- ▶ Te Puni Kōkiri's failure to carry out its statutory duty to monitor the health sector through conducting agency reviews, under section 5 of the Ministry of Māori Development Act 1991, is a breach of the Treaty principle of active protection and the duty of good governance.

CHAPTER 8

**IS PARTNERSHIP FOR MĀORI IN THE PRIMARY
HEALTH CARE FRAMEWORK TREATY-COMPLIANT?**

*Toki tā wahie te toki matarau;
Ka whanatu au ka hahau i te takapū o Rangi e tū nei*

8.1 INTRODUCTION

In chapter 5, we concluded that the New Zealand Health and Disability Act 2000 is not Treaty-compliant and that the primary health care framework does not properly articulate, or give effect to, the Treaty principles, particularly the principle of partnership. We analysed the partnership arrangements for district health boards provided for in the Act, and discussed how these arrangements attempt to give effect to the Treaty partnership, but broadly fall short.

Our focus in this chapter is to expand on our discussion in chapter 5 to discuss more broadly the ways in which the Māori voice, or Māori influence, is afforded the centrality guaranteed by the Treaty partnership. We were concerned with the experiences of Māori working with and within Crown entities and their relative decision-making power. In this way, we were interested in how these entities account for, and then implement, Māori perspectives on health issues; and more broadly, whether the framework adequately ensures that Crown entities, and the health sector generally, are focused on addressing Māori health inequity.

The Crown agreed that ensuring Māori influence decision-making on health policy is a Treaty guarantee.¹ Crown counsel submitted that there were various expressions in the legislative and policy framework recognising this, and highlighted several areas where it said Māori are afforded decision-making responsibilities.² However, as shown in the discussion throughout this chapter, they also importantly acknowledged weaknesses with these arrangements.

We were also specifically concerned with how tino rangatiratanga is provided for under the framework. Again, the Crown broadly submitted that the framework recognises these rights, and that the permissive approach to the primary health care system is partly intended to foster community control, and balance that local control against national interests and priorities.³ Again, however, as shown in this chapter, Crown witnesses broadly acknowledged weaknesses in the ways that the framework ensures recognition and support for tino rangatiratanga.

1. Submission 3.3.32, para 48.

2. Submission 3.3.32, paras 32–34, 48–49.

3. Submission 3.3.32, paras 22, 32, 249–257.

The Crown said it was particularly interested in the Tribunal's guidance on how to practically implement the Treaty partnership.⁴ Crown counsel said:

Serious and persistent health inequities that exist at a population level cannot be overcome by short term emergency-style actions. The Crown cannot affect real and long lasting change without acting across a range of domains – not just the health sector – with its Treaty partners. Similarly, there is no sense or cause in Māori being left to tackle this alone.⁵

In this chapter, we look at how the principle of partnership is reflected in the current implementation of the primary health care framework.⁶

8.2 DESIGNING THE PRIMARY HEALTH CARE FRAMEWORK

Both the claimant groups said that a proper, equitable partnership between the Treaty partners is central to the successful implementation of the aspirations of the primary health care framework.⁷ During our inquiry, Director-General Dr Ashley Bloomfield related his personal understanding of the Treaty principle of partnership as follows:

my understanding of the principle of partnership is that there should be a sense of equality in a partnership. It's a two-way relationship and I talked yesterday about the alliancing framework which is characterised by high trust, high shared accountability, so that's how I would think about partnership. It's in a sense a contract between the two parties to behave in a certain way and to work together not just on some aspects of the work but on all aspects of the work.⁸

We acknowledge the Director-General's recognition of the importance of a Treaty partnership in primary care, and his openness to co-design arrangements. In our view, his understanding aligns with the spirit of the Treaty partnership.

However, the claimants allege that their experience of partnership does not match with Director-General Dr Bloomfield's understanding. For example, the National Hauora Coalition claimants argued that the Crown did not adequately consult Māori when it designed the primary health care framework.⁹ In 2000, the Crown undertook consultation on the development of what would become the Primary Health Care Strategy, releasing a discussion document, entitled *The Future Shape of Primary Health Care* and inviting feedback on its contents. Crown

4. Submission 3.3.32, paras 6.

5. Submission 3.3.32, para 21.

6. In this chapter, we take into consideration and respond to the issues posed at sections 4.1, 4.2, 6.1, 7.2.1, 7.2.2 and 9 of the Statement of Issues (statement 1.4.1).

7. Submissions 3.3.18, paras 150, 152; submission 3.3.30, para 6.12; submission 3.3.32, para 48.

8. Transcript 4.1.5, p 436.

9. Submission 3.3.30, para 6.11.1.

counsel noted the consultation, which included ‘Māori providers and co-funders’, but did not make a submission on its adequacy.¹⁰

Crown witness Dr Frances McGrath recorded that Treaty partnership was a ‘significant concern’ raised in Māori responses to the discussion document:

[Māori respondents] did not believe the discussion document showed a commitment to partnership or to the action required to make it a reality. Several Māori respondents stated that the partnership implicit in the Treaty of Waitangi meant Māori should have a significant and equal voice in deciding their own services. They felt they had not been consulted sufficiently in the early development of the PHC Strategy and that the discussion document would have looked different if they had.¹¹

Sir Edward Taihākurei Durie, who appeared as an interested party witness, observed what ‘co-design’ arrangements with public sector agencies looked like in practice:

We do have a bit of a feeling . . . that co-design means they design and we comment. It’s inevitable with Government departments that their people will have a lot of thoughts, they will get excited about their thoughts, and so it comes still back to consultation where they have the initiative and we are commenting on their thoughts.¹²

As pointed out by these respondents and affirmed by Sir Edward Taihākurei Durie in front of us at hearings, this process in and of itself is a key failing by the Crown with regards to their recognition of the principle of partnership. National Hauora Coalition claimant Simon Royal said:

Māori were not involved in policy development nor in the implementation design for the strategy. It was only once decisions were made that Māori providers and organisations were let in to execute the policy. Māori advice, input and structures were not considered. In this way, Māori were treated as a marginal part of the health sector, rather than central to government success.¹³

Dr McGrath said that these responses to the discussion document were then considered in the development of the final Primary Health Care Strategy ‘with the assistance of a primary health care reference group’.¹⁴ She was not able to confirm how many Māori were members of this reference group, but it appears that they were in the minority.¹⁵

10. Crown Response to Statement of Issues 1.3.1, p 5.

11. Document A63, para 174.

12. Transcript 4.1.5, p 567.

13. Document A70, para 24.

14. Document A63, para 177.

15. Transcript 4.1.6, pp 264–265.

8.3

We agree that ‘co-design’ as a concept and government process runs the risk of, in practice, meaning something lesser than the actual partnership arrangements guaranteed by the Treaty. We agree with the parties that a correct balance of partnership, with recognition of tino rangatiratanga and mana motuhake, is important to get right in social services, including primary health care.

Based on the evidence presented to us, we conclude that neither the development of the Primary Health Care Strategy nor the framework itself involved a robust co-design process.

As demonstrated by our discussion in chapter 5, and by the evidence before us, the health sector does not have a clear and consistent understanding, or commitment, to the principle of partnership. In our view, this lacking is symptomatic of a failure to give sufficient emphasis to, and expression of, the principles of the Treaty. Participants told us of a lack of understanding of, or even an absence of recognition of, for example, tino rangatiratanga.

Some Crown witnesses also acknowledged that institutional racism exists in the health system.¹⁶ This, along with personal racism and stereotyping, is a significant barrier to giving effect to the meaning of the Treaty and its principles. We discuss these issues further in this chapter.

8.3 MĀORI EXPERIENCES OF WORKING IN THE PRIMARY HEALTH CARE SECTOR

We received a broad range of evidence on the small proportion of, and relatively limited influence of, Māori working in the health sector. We note that statistics filed by the Crown indicate that Māori are significantly underrepresented across all health professions. Māori general practitioners, for example, are significantly underrepresented, making up just 3.6 per cent of the total general practitioner workforce in 2017.¹⁷ Statistics from the Medical Council of New Zealand covering doctors more generally (including general practitioners but also more senior doctors and doctors employed in hospitals, for example) show that just 3.3 per cent of doctors identify as Māori.¹⁸ The latest statistics for the following professions show the following:

- ▶ nurses (7.4 per cent in 2018);
- ▶ midwives (9.4 per cent in 2016);
- ▶ oral health professionals (4.2 per cent in 2017);
- ▶ physiotherapists (4.9 per cent in 2018);
- ▶ psychologists (5.3 per cent in 2018);
- ▶ radiology (5.4 per cent in 2010);
- ▶ dietitians (3.6 per cent in 2010);

16. Submission 3.3.32, para 42.

17. *The New Zealand Medical Workforce in 2017* (Wellington: Medical Council of New Zealand, 2019), pp 30–31.

18. Document B4, p 11.

- laboratory scientists (1.7 per cent in 2010);
- laboratory technicians (4.7 per cent in 2010);
- pharmacists (2.5 per cent in 2018);
- optometrists (1.8 per cent in 2010);
- dispensing opticians (1.9 per cent in 2010);
- podiatrists (6.9 per cent in 2010);
- osteopaths (7 per cent in 2010); and
- chiropractors (12 per cent in 2010).¹⁹

Further, official statistics reveal that Māori are underrepresented within the Ministry itself, as of June 2018, Māori make up just 8.2 per cent of the Ministry's total employed staff.²⁰ We see that the proportion and relative seniority of Māori staff within Crown agents has a significant impact on the way those agents then shape their priorities, and make investment decisions. We traverse some of the relevant evidence relating to health workforce issues in the following sections.

8.3.1 Te Kete Hauora

Te Kete Hauora, a unit in the Ministry that was focused specifically on Māori health, was highlighted as a practically positive component of the Ministry's Māori health policy process. One of Te Kete Hauora's functions was to advise on, and assist with, the formulation of specific policies to address Māori health inequities, and, additionally, provide advice on consultation with Māori communities and contract management.²¹ Te Kete Hauora, then, brought an important focus on Māori health to the Ministry and to the health sector more broadly.²² Claimants suggested that the disestablishment of Te Kete Hauora in 2016 brought about a lack of focus on Māori issues, including health inequities.²³ The Crown did not explicitly submit a position on Te Kete Hauora or its disestablishment in its closing submissions; however, the issue was mentioned by Crown witnesses. Director-General Dr Bloomfield made it clear that he understood and agreed with the claimants' concerns regarding the disestablishment of Te Kete Hauora, and that he disagreed with the previous Director-General's decision to disestablish the unit. Indeed, he cited his decision to establish a new Māori health directorate within the Ministry as evidence of this.²⁴

Witnesses, however, acknowledged that, as primarily an advisory unit, Te Kete Hauora's influence was not totally effective. Teresa Wall remarked that the Ministry did not always take up the unit's policy advice and policy development about health equity.²⁵ We note that Dr McGrath's evidence indicated that at least

19. Document B4, pp 8–10, pp 12–37.

20. *Our People: Public Service Workforce Data 2018* (Wellington: State Services Commission, 2018), p 35.

21. Transcript 4.1.5, p 78; doc A63, para 47.

22. Transcript 4.1.5, p 28.

23. Submission 3.3.4, para 87.4.

24. Transcript 4.1.5, p 526; doc A59, para 48.

25. Transcript 4.1.5, pp 78–79.

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8.3.1

one previous iteration of a Māori health-focused unit in the Ministry disbanded in 1993 after all of its staff resigned.²⁶

Other witnesses related broader discussions around whether the fact that these Māori-focused and -staffed teams operate within what is ultimately the Crown's Ministry makes them particularly effective. These witnesses emphasised that having Māori control was preferable to that situation, but nonetheless acknowledged that having teams within Crown agencies who were focused on Māori health was better than not having them.²⁷

The Ministry explained that the disestablishment of Te Kete Hauora in 2016, and the spreading of its functions across other units, was intended to improve 'the whole Ministry's capacity to address Māori health inequities'.²⁸ Many claimant and interested party witnesses rejected this explanation, and instead cited Te Kete Hauora's demise and the dispersal of its functions as signalling a significant watering down of the Ministry's focus on Māori health. Māori Primary Health Organisations and Providers claimant Janice Kuka stated that in her view the change 'weakened the voice of Māori decision making and advocacy for primary health'. She further noted that she had seen district health boards take Te Kete Hauora's disestablishment as a signal that specific units focused on Māori health were not necessary.²⁹ National Hauora Coalition witness Tereki Stewart said that he saw Te Kete Hauora's disestablishment as an indication that the Crown was not wholly committed to Māori health.³⁰ Stewart remarked that his sense of the impact of the action to disperse Māori policy work across the other units was the creation of 'a policy advice vacuum': 'One [Māori] person in a room, for example, full of 20 other people that have different agendas . . . it becomes hard to kind of leverage Māori health perspectives and outcomes in that kind of context'.³¹

On this point, the Director-General observed that focusing policy development for Māori health with a specific team carries a risk that other units and teams across the organisation will not take any responsibility for Māori health.³² Professor Papaarangi Reid and Dr Peter Jansen both stated that Māori-specific issues can be the focus of a particular team as well as the responsibility of more than just those particular teams. Director-General Dr Bloomfield expressed an openness to this idea.³³ Conversely, Keriana Brooking, another Crown witness, stated that 'from the evidence and in my experience . . . the more you share something across a group the easier it is for it to get lost'.³⁴

26. Document A63, para 46.

27. Transcript 4.1.4, pp 312–313, 389.

28. 'Māori health', Ministry of Health, <https://www.health.govt.nz/our-work/populations/maori-health>, last modified 8 December 2018.

29. A12, paras 58–59; transcript 4.1.4, p 321.

30. A20, paras 20, 20.2; transcript 4.1.4, pp 651–652.

31. Transcript 4.1.4, p 651.

32. Transcript 4.1.5, pp 526–527.

33. Transcript 4.1.4, pp 266–267; transcript 4.1.5, pp 53, 527.

34. Transcript 4.1.7, p 320.

In our view, the Ministry should have a specific team which is expert in, and focused on, issues relevant to Māori health, while also requiring their entire organisation to take responsibility for Māori health issues. Indeed, as suggested by Teresa Wall, we consider that the existence and proper support of a specific Māori health directorate, as has just been established, would likely strengthen the whole Ministry's compliance with its responsibilities to address Māori health inequity.³⁵

In addition to the repercussions for Māori health policy-making, the prevailing impression from the evidence is that the disestablishment of Te Kete Hauora also broadly sent the signal that Māori health was not a priority. The rescinding of the requirement for district health boards to prepare Māori Health Plans the same year, and the cumulative signals sent in years prior by actions such as the removal of the Treaty from lower-level documents, amplify this impression. Claimant witness Janet McLean's evidence alleging that the Bay of Plenty District Health Board restructured its Māori teams and roles after the Ministry disestablished Te Kete Hauora, which we discuss in the following section, is an example of this.³⁶ McLean said the board used the same rationale as the Ministry: that improving mainstream responsiveness would provide better results for Māori.³⁷

8.3.2 District health boards

The Crown submitted information confirming that, currently, every district health board has at least one role in the top or second tier of their organisation that has responsibility for Māori health in their district. Most, though not all, report directly to the Chief Executive. The information provided does not give a full picture of the responsibilities of these roles: some appear to have direct reports and control of certain portfolios, while others operate in an advisory capacity.³⁸ In its closing submissions, the Crown argued this was another important way Māori are afforded decision-making responsibility, but broadly accepted that there was variability in the remit, oversight and budget holding of these roles.³⁹ Crown counsel highlighted the evidence of claimant witness Janet McLean, who worked as General Manager Planning and Funding Māori Health for the Bay of Plenty District Health Board, as evidence of how these roles can be effective, while acknowledging Crown witness Hector Matthews' evidence on the limitations he experiences in his current role.⁴⁰

McLean worked for the Bay of Plenty District Health Board from 2001 to 2016.⁴¹ Her position was on the executive team, with joint responsibilities and oversight

35. Transcript 4.1.5, pp 106–107.

36. Document A15, para 33.

37. Document A15, para 36.

38. Memorandum 3.2.94(a), Appendix 5.

39. Submission 3.3.32, paras 300–301.

40. Submission 3.3.32, paras 303–305.

41. Document A15, para 4. Prior to that period, she held senior roles at the Hutt Valley District Health Board and in the Ministry, from 1991 onwards: doc A15, para 2.

with the General Manager Planning and Funding of the district health board's budget process.⁴² In her written evidence, McLean stated:

What is important to understand about this joint overall responsibility is that the structure put the Māori Health General Manager in direct control of funding for Maori providers. This is in stark comparison to other DHBS where this responsibility resides principally with the General Manager Planning and Funding. It meant that the Māori health team had equivalent staffing such as service development and contract management positions directly managing the Maori providers contracts. Another key difference was the mainstream planning and funding team managed contracts based on a portfolio focus e.g. aged care, mental health, primary health and population health under more of a siloed approach. The Maori health team focused on the provider relationship noting many Maori providers delivered a range of social and health services and therefore this required a more generalist approach.⁴³

The seniority, responsibilities, budget holding and team of reporting staff that was afforded under McLean's role, then, were significant. The remit of the role, which included total control of funding for Māori providers, facilitated significant investment in Māori providers in the Bay of Plenty, such that the Bay of Plenty District Health Board invested more money in those organisations than any other district health board.⁴⁴ No other district health board gave equivalent roles this kind of budgetary oversight. The team helped ensure that the district health board also invested in non-Māori providers who were engaging in equity-focused or Māori-targeted initiatives.

McLean's evidence indicates that these efforts were specifically targeted to enhance equity, and were calibrated to fund Māori and non-Māori providers and primary health organisations in a way that would mean high needs patients, including Māori, would get the services they needed.⁴⁵ The team also worked with Tumu Whakarae (the national collective of Māori General Managers of district health boards) to implement a number of other initiatives, including tools to help district health boards monitor Māori health outcomes and training on Māori health care provision.⁴⁶ She said unequivocally that 'effective Māori leadership' was a critical factor in the number and success of equity- and Māori-focused initiatives at the Bay of Plenty District Health Board.⁴⁷

McLean said that these successes in the Bay of Plenty were secured in spite of resistance external to the team, who found themselves 'constantly fighting for and justifying the funding to Māori health'. Further, McLean said that the team often had to justify the existence of Māori providers.⁴⁸ In answer to Tribunal question-

42. Document A15, para 10.

43. Document A15, para 10.

44. Document A15, paras 13, 15.

45. Document A15, paras 15–19.

46. Document A15, para 21.

47. Transcript 4.1.4, pp 277–278.

48. Transcript 4.1.4, p 274.

ing about the attitudes of other senior personnel to Māori health issues, McLean said that:

It would be fair to say that Māori inequalities has [*sic*] been normalised in DHBS . . . it was very clear that they didn't want to have a conversation about institutionalised racism, it was never explicitly said but you could read the body language, you could understand when a conversation was not ready to be heard, it became a struggle because often part of the challenge of many Māori working in a DHB in the Ministry is having to frame the conversations in a way that are palatable so that they can be heard, so that they can be [understood], that wears you down. It wears you down.⁴⁹

Before resigning in 2016, McLean said that she became aware about a year before she left that the district health board was planning to restructure her role and team to focus on so-called mainstream responsiveness – the same approach taken with the disestablishment of Te Kete Hauora at the Ministry in the same year that she resigned. It was clear to us that she did not make the decision to resign lightly. The threat of neutering a team that could point to its successes in directly supporting and promoting kaupapa Māori models of care affected her deeply.⁵⁰

The year after McLean resigned, the Bay of Plenty District Health Board restructured the Māori Health Planning and Funding team, disestablishing her former role and dispersing most of the team's responsibilities across other units. She said that an ongoing restructure since then 'has created a culture of mistrust and grave concern for the state and future of Māori health in the Bay of Plenty'. This mistrust now extends, she said, to Māori providers' relationships with the district health board; Janice Kuka, the Managing Director of Ngā Mataapuna Oranga and the chair of several Māori providers in the Bay of Plenty, confirmed these relationships had deteriorated.⁵¹ We agree with McLean's conclusion that: 'The greatest concern is observing how the hard-fought gains achieved in Māori health over so many years by so many people can be so easily eroded.'⁵²

Hector Matthews, who gave evidence for the Crown, confirmed that much of McLean's general experiences from working for a district health board reflected his own. He similarly confirmed that he has had to fight hard to progress Māori-specific health issues.⁵³ We were struck by his answers under our questioning:

- Q. . . . how much power do you actually have to say, 'This action is really important and must be in our plan?' I mean are you simply just advising or do you have the mana to insist that things are included?
- A. Yes, gee, that's a confronting question.

49. Transcript 4.1.4, p 287.

50. Document A15, para 35; transcript 4.1.4, p 288.

51. Transcript 4.1.4, pp 275–276; doc A12, para 40.

52. Transcript 4.1.4, p 276.

53. Transcript 4.1.7, p 175.

8.3.2

Q. I mean if you were a finance specialist and you said, 'This is what it is,' everyone would fall over and go, 'Well yes, because money people know what they're talking about.' Well, does that happen for a Māori expert that Māori people know what they're talking about?

A. The short answer is no.⁵⁴

He elaborated, saying that he felt that the Chief Executive of Canterbury District Health Board does listen to his advice, but that even small amounts of funding for minor initiatives can be difficult to push for in the context of the district health board's other priorities and pressures.⁵⁵ The annual budget holding for his role is \$80,000, which he confirmed was likely similar for his equivalent roles across all district health boards, at least since McLean's former role was disestablished in 2016. He said that the money allocated to them essentially allows for them to 'work with iwi and hapū and run hui and provide kai'.⁵⁶

The variability of the remit of these roles, as described in the Crown's submissions and in evidence, concerns us. The framework does not guarantee these roles consistently have effective oversight or decision-making when it comes to Māori health, including primary health care. Indeed, they are open to the kind of restructuring undertaken by the Bay of Plenty District Health Board, which in our view was a step backwards in terms of Treaty-compliance. We note Matthews' agreement under questioning that overall the mechanisms provided for under the primary health care framework do not consistently ensure good performance when it comes to Māori health inequity; instead, the system is often only as good as the people who work within it.⁵⁷

Matthews' view was that the struggles of himself, McLean and other Māori Managers in district health boards are reflected amongst lower management and employment tiers of those organisations, too. He said this was partly because, in spite of progressive gains made in New Zealand society, on the whole district health boards do not reflect Māori values.⁵⁸

Crown witness Dr Nick Chamberlain confirmed that this tension was a specific focus of Northland District Health Board, which has pursued several targeted initiatives to employ more Māori staff, develop the Māori nursing workforce in the district, and encourage more Māori secondary school students to pursue health as a career.⁵⁹

Northland District Health Board increased the proportion of Māori staff under its employ from 13.1 per cent in 2012 to 16.15 per cent in 2017.⁶⁰ Dr Chamberlain confirmed, however, that this increase was largely in lower-paid roles.⁶¹

54. Transcript 4.1.7, pp 209–210.

55. Transcript 4.1.7, p 210.

56. Transcript 4.1.7, p 211.

57. Transcript 4.1.7, p 178.

58. Transcript 4.1.7, p 174.

59. Document A66, paras 22–25; transcript 4.1.6, pp 103–104.

60. Document A66, para 23.

61. Transcript 4.1.6, p 102.

Information subsequently provided by the Crown showed that an increase in the number of staff employed at all levels of the institution had occurred, but not in an even spread. The roles that have seen the largest proportional increase of employed Māori are made up of 'Healthcare Assistants, Orderlies, Cleaners and occupations that are considered non-regulated'. This group remained 'the highest employed occupation group for Maori' during the period where Northland District Health Board were attempting to increase its number of Māori staff.⁶²

This is plainly not a fulfilment of the spirit of Northland District Health Board's recruitment drive. Given one of the reported barriers to access to health care is an objection to engaging with institutions that do not provide for the sociocultural paradigm of Māori, this ideally needs to be reflected by the makeup of employed health practitioners, as well as senior staff.

8.3.3 Māori primary health organisations and providers

While the Crown did not make submissions on workforce retention in primary health organisations and providers, this issue was a significant one for the Māori Primary Health Organisations and Providers claimants. Janice Kuka spoke of how, in a primary care environment with scarce resources and not enough Māori health professionals, non-Māori organisations' efforts to develop their own Māori workforce sometimes came at a cost for Māori organisations:

Many of our Māori GPs and senior Māori Nurses have chosen to move to BOP DHB [Bay of Plenty District Health Board] and other less demanding general practices with the lure of better pay and less stressful working conditions. The poaching of Māori staff by BOP DHB from Hauora has been deliberate. DHBs and mainstream providers use the Māori person to make mainstream services appear more Māori friendly. It is very hard to accept after we have invested considerable time and resource on professional development, particularly in Kaupapa Māori ways of working. An example of this is an attempt by BOP DHB to lure a third Dietitian away from us at Te Manu Toroa.

Our resulting workforce turnover is always consistently high and we are constantly understaffed adding to the pressure in managing both our clinics and primary care services. The staff often liken this pressure to working in a 'pressure cooker' all day. This situation can go on for months until we can fill vacancies. Our reputation as a PHO and employing organisation has suffered as a result.⁶³

Piripi Hikairo, similarly, spoke of the same problems with workforce retention, particularly of skilled Māori clinicians, between Te Manu Toroa and the Bay of Plenty District Health Board.⁶⁴

Pay parity is another issue and was a key concern of the Māori Nurses, who appeared as an interested party. Their counsel pointed out that, while nursing

62. Memorandum 3.2.19(a), Appendix 3.

63. Document A12, paras 42–43.

64. Document A14, paras 43, 45.

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was recognised as intrinsic to the success of the reforms to primary health care, research indicates that: ‘significant pay disparities of up to approximately 25% exist for kaimahi who work in Māori and Iwi providers compared to their counterparts employed by the DHBS.’⁶⁵

As such, this is as much an issue of the discrimination against nurses working for Māori providers as it is relevant to staff retention issues faced by those providers. Professor Tim McCreanor, too, agreed that funding pressures on Māori providers had acute impacts on their workforce: ‘the funding structures that apply to Māori health providers are part of the structure of institutional racism that effectively drives down the pay of the workers in those places and contributes to disparity between different groups of nurses.’⁶⁶

Kerri Nuku, for example, related that this amounts to a difference of ‘up to \$600 in a fortnight’. She further related the difficult working arrangements that many nurses are forced to enter into as a result:

They go to work and work an eight-hour day and they go and pack the supermarket shelves at night to make up for their wages that they don’t have enough of. With the increasing cost of living they’re unable to meet those needs. For nurses that voluntarily now are sleeping in the backs of cars it’s because they can’t afford the rent; that’s a reality.⁶⁷

We heard that these pay discrepancies occur even between nurses with the same qualifications.⁶⁸ Further, we heard evidence on a Bachelor of Nursing degree offered at Whitireia Polytechnic, called the Bachelor of Nursing Māori, which appeared to be an effort in nursing workforce development. Nuku said that graduates with this degree, despite it having the same status as a professional qualification as a Bachelor of Nursing, are broadly seen as less qualified than those with a Bachelor of Nursing, despite graduates having to pass the same standards and exam requirements.⁶⁹ Given the obvious need to develop the health workforce’s overall competency in relation to culturally appropriate care for Māori, this evidence is particularly concerning to us.

Māori nurse Tracey Morgan, for example, highlighted how the Crown’s insufficient resourcing of Māori providers translates into significant extra work for their staff.⁷⁰ Further, as pointed out by counsel for the Māori Nurses Māori health professionals working in institutions that do not reflect Māori values, such as some district health boards, are asked to do work beyond their job description, such as leading pōwhiri, but are still paid the same as their colleagues who do not have this expertise.⁷¹

65. Submission 3.3.20, paras 144–145.

66. Transcript 4.1.5, p 253; doc A57, para 37.

67. Transcript 4.1.5, pp 253–254.

68. Submission 3.3.20, para 145.

69. Transcript 4.1.5, p 258; submission 3.3.20, para 122.

70. Document A39, paras 5–11.

71. Submission 3.3.20, para 128.

IS PARTNERSHIP FOR MĀORI IN THE FRAMEWORK TREATY-COMPLIANT? **8.4**

Counsel for the Māori Nurses stated: ‘Many Māori Nurses enter this career because they want to make a difference for their whānau, they want to care, but then when the system doesn’t care for them, that becomes incredibly challenging.’⁷²

The fact that Māori nurses are financially penalised if they choose to work for Māori providers, under significant strain from the way the Crown has legislated and organised primary health care, is unacceptable. Māori nurses should not be paid less or have to tolerate adverse working conditions simply to work for an employer who reflects their values, or to work for health providers which service their communities.

8.4 INACTION IN THE FACE OF NEED

All parties variously agreed that the severity and persistence of health inequity Māori continue to experience indicates that the health system is institutionally racist, and that this, including the personal racism and stereotyping that occurs in the primary care sector, particularly impacts on Māori. We accept that institutional racism is a determinant of health and wellbeing.⁷³ The Director-General acknowledged this at hearings:

Q. Would you agree that racism is also a determinant of health?

A. Yes, I would and this is one that we have learnt a lot more about over recent years and continuing to learn. I think we have now some quite good evidence that racism at a range of levels does determine access to experience of and outcomes in the health care system.⁷⁴

We heard that institutional racism manifests in a variety of different ways in primary care. We saw these terms as essentially two sides of the same coin: as ways of identifying, and ideally explaining, unconscious bias or conscious indifference, or indeed the prevalence and cumulative effects of both. Whatever the form of racism, they ultimately result in discrimination, indicating Treaty non-compliance. It is the Crown’s obligation to ensure that the health system is upholding the Treaty and its principles, including the guarantee of freedom from discrimination for Māori citizens. Māori should not experience disadvantage based on the mere fact of their identity.⁷⁵

The history of Treaty breaches, then, is part and parcel of the explanations for the social determinants of Māori health. Evidence and submissions from all parties, including the Crown, acknowledged that the legacy of colonisation manifests itself in the lived experience of Māori as a population group today.⁷⁶ Māori experience a wide range of socioeconomic inequities that the Tribunal in previous

72. Submission 3.3.20, para 149.

73. Document A51, para 17.

74. Transcript 4.1.5, p 421.

75. Document A46, para 5.

76. Document A57, paras 8–9; doc A46, para 6; submission 3.3.4, para 13; submission 3.3.30, para 2.8.1; transcript 4.1.5, pp 153–155, 432; transcript 4.1.6, p 259; transcript 4.1.7, pp 160, 167.

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reports has linked back to colonisation and breaches of the Treaty compact. In these ways, and more, the colonisation of New Zealand and its ongoing impacts are as much a determinant of Māori health outcomes as any other, and continues to manifest as institutional racism.

The definition of institutional racism the claimants and interested parties broadly used was ‘inaction in the face of need.’⁷⁷ This echoes the definition of health equity discussed in chapter 5: that population groups with the highest levels of need should receive attention and resources proportionate to that need. If a system is not doing this, it is not an equitable system. When tested against this definition, much of the evidence we have traversed and made findings upon in preceding chapters indicates that the framework is institutionally racist.

For example, funding arrangements for primary care disadvantage Māori as a population group, particularly Māori with high health needs and/or co-morbidities. Because the collective fallout from inadequately directing funding to a large extent follows racial lines, whether intentionally or not, funding arrangements for primary care are institutionally racist.

We further note that both systems and individuals can perpetuate unconscious bias and conscious indifference. The primary health care system exhibits some biases because of its framework and how that framework’s various mechanisms operate in practice. Dr Heather Came-Friar stated:

I think that institutional racism doesn’t have to be deliberate. It can be the unintended you know outcome of well-intentioned people. I am sure that the people that wrote the Primary Health Care Strategy weren’t trying to write a document that was going to produce institutional racism. But I think what we have is definitely a gap between policy and practice and we’ve got problematic policy. But I think it’s a failure in imagination, it’s a failure in monitoring, it’s a failure in reporting and it’s a failure for consequences for poor performance.⁷⁸

Again, the Crown is responsible for identifying institutional racism, in partnership with Māori, and implementing solutions to mitigate its impact. The Crown’s failure to adequately identify or address problems with primary care funding is another manifestation of institutional racism. Similarly, the Crown’s failure to institute mechanisms that ensure that Māori health outcomes are measured and reported on in a robust way undermines the ability of the system to improve the design and delivery of Māori health care. This, in turn, impacts on the way that Māori experience and receive care. We accept the evidence of claimant Simon Royal, which stated that ineffective accountability and monitoring of health entities fosters the prevalence of institutional bias and racism in the health system.⁷⁹

Other manifestations of institutional racism include common terms and language used in the health system to describe Māori health outcomes.

77. Transcript 4.1.5, p 53.

78. Transcript 4.1.5, p 211.

79. Document A23, para 8.

Director-General Dr Bloomfield agreed that the deficit-oriented language commonly used by health professionals contributes to negative stereotypes of Māori. He said that the use of the term 'hard to reach' in primary care settings to describe Māori and other non-Pākehā population groups, for example, was not constructive, and agreed that it diminishes Māori. He clarified that language should be reoriented to capture that it was a failure to deliver health care, rather than a failure on the part of individual Māori.⁸⁰

Hector Matthews agreed, saying that this attitude does not account for the myriad complexities that arise from social determinants of health, remarking as an example that if one is struggling to feed one's family, the cost of a visit to a doctor may not be a priority.⁸¹

As such, Crown witnesses agreed that the onus is on the health sector to improve its service delivery with a view to seeing every citizen receive the care that they need, but that the subtlety of language can undermine this effort. This is reflected in Ministry-funded research by the Eru Pōmare Health Research Centre, which describes that through the use of deficit-oriented language, 'Māori move from being normal to being 'different' from Pākehā . . . norms'. This thinking normalises the idea that the 'problem' lies with Māori: thus, they 'receive lower levels of health services and poorer quality of service'. Over time, even some Māori are pressured into believing the problem lies with themselves.⁸² Piripi Hikairo said:

In my experience a number of doctors and the Bay of Plenty District Health Board ('DHB') consistently state that Maori are not 'compliant' meaning that they do not take their medicine or listen to their doctor. However, most doctors work on the basis of seeing a set number of clients per hour, and are frustrated by the pathology of Maori who have multiple ailments and therefore require more time.

I firmly believe that for Maori to appropriately understand their health requirements and to be 'compliant', it is necessary for health providers to understand the cultural and holistic view of Maori rather than treating them exactly the same as non-Maori.⁸³

Again, while some of these manifestations of racism are unconscious, conscious biases still impact on the way that Māori experience primary health care. All parties accepted that personal racism of individuals towards Māori is still a feature of the primary health care system.⁸⁴ The claimants broadly said that, as professionals and clinicians involved with Māori primary health organisations and providers, they were not taken seriously by non-Māori in the same sector. Hector Matthews said that people in the primary health care system still do not believe Māori health clinicians and professionals are competent when it comes to policy and strategy

80. Transcript 4.1.5, pp 402–403.

81. Transcript 4.1.7, pp 162–163.

82. Robson, B. and R. Harris, *Hauora, Māori Standards of Health IV: A Study of the Years 2000–2005* (Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, 2007), pp 4–5.

83. Document A29, paras 8–9.

84. Submission 3.3.32, para 42; transcript 4.1.5, pp 22, 45–46, 154–155, 198.

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design, even when it is specific to Māori health.⁸⁵ Other witnesses, such as the Māori nurses who appeared before us, related similar experiences.

Matthews related his own personal experience:

I'm a 53-year-old Māori male and I have confronted racism my entire life, and it ebbs and flows, and it chops and changes, and once I got a bit more educated and a bit more articulate, some of those racists shut themselves down a wee bit and wouldn't argue with me because I can argue the toss with them, sometimes, some are clever[er] than me and I can't. But, you know, racism in its covert and overt forms exist everywhere and we see examples of that, not just in health, all over New Zealand society.⁸⁶

Matthews made the point that institutional racism and individual biases around Māori capacity mean that, even when the data plainly points to inequities or an area that needs focus, sometimes that advice is still ignored by clinicians.⁸⁷

Clearer and freer accountability to the public, then, could assist in shifting or at least overriding these biases.

Indeed, as Hector Matthews described, it is not about the individual culpability of specific general practitioners who are making conscious or unconsciously biased decisions about treatment, but rather the cumulative effects of these actions.⁸⁸ He elaborated:

individuals cumulatively are making biased decisions and we're not confronting that issue, what we are saying is that the system needs to improve access, that is good, the system does but what we find in Canterbury is Māori access Primary care at the same rate as Pākehā so access isn't the issue and yet we still have more Māori diagnosed in ED with Cancer than they do at the GP. Despite the fact that they have gone to the GP, so what that means is individuals cumulatively are making biased decisions and we're not confronting that as a society. That is the big mammoth in the room.⁸⁹

Professor Jacqueline Cumming confirmed that this is true nationally: on average, Māori children see general practitioners and primary care nurses at the same rate as non-Māori. Māori adults are in fact seeing general practitioners and primary care nurses at a rate higher than non-Māori. Despite this, Māori have on average the highest levels of unmet need of any population group.⁹⁰ If the system was truly equity-focused and was focusing resources and attention adequately on population groups with the highest need, this would not be the outcome of an average of higher visitation rates. Notwithstanding the complexity of health deter-

85. Transcript 4.1.7, p 165.

86. Transcript 4.1.7, p 167.

87. Transcript 4.1.7, p 160. Teresa Wall made similar comments in relation to the kind of action that should, in her view, be prompted by data showing lung cancer rates for Māori women: transcript 4.1.5, p 115.

88. Transcript 4.1.7, p 167.

89. Transcript 4.1.7, p 168.

90. Document A60, para 56.

minants, the primary health care system itself is not calibrated to address Māori needs.

Actions that contribute to experience of personal and institutional racism, especially on the scale indicated by the evidence before us, are breaches of the Treaty principles.

8.5 PROVIDING CULTURALLY APPROPRIATE SERVICES

The way in which health services are delivered, and the nature of the institutions which deliver them, impacts the pursuit of health equity for Māori; as such, the Crown is required to inform itself of these access issues, and address them. It is worth repeating again this passage from the Tribunal's *Te Urewera Report*, which we included in chapter 3:

A 'one-size-fits-all' model tends in practice to suit the needs of the majority, who are rarely the group in most need of help. Even when they can access mainstream aid and services, minority groups such as Māori have often found that what is being provided simply does not work for them, or is so alienating that they prefer to disengage.⁹¹

Over the course of the hearings for stage one of this inquiry, we were consistently reminded that one of the central goals of the primary health care reforms was the provision of accessible, community-led primary health care as a framework for co-ordinating care around defined population groups and reducing health inequities.⁹² The Crown has a Treaty obligation to ensure that health services are culturally appropriate. This is important because, as the passage from the Tribunal's *Te Urewera Report* illustrates, providing care in a way that respects and understands Māori sociocultural paradigms is a care access issue, and impacts on the quality of health care received, or indeed dictates whether care is received at all. Māori occupy the most deprived deciles of the population when compared to other ethnic groups. However, compounding that is the fact that Māori cultural needs, spiritual beliefs and social attitudes and priorities may differ from other population groups who live in those same areas. As such, ensuring care is culturally appropriate ensures equitable access to care.

This link between access to and quality of health care, and the recognition of sociocultural difference, is broadly captured by the concept of cultural safety, developed as a training programme for nurses in New Zealand in the 1980s and 1990s. Cultural safety intends to recognise that sociocultural difference manifests, in part, as a power imbalance between different ethnicities. It recognises the dynamics of institutional racism: that *tikanga* and *mātauranga Māori*, while centrally important to many Māori, is not recognised as 'ordinary' in the nation

91. Waitangi Tribunal, *Te Urewera Report*, 8 vols (Wellington: Legislation Direct, 2015), vol 8, pp 3776–3777.

92. *Minimum Requirements for Primary Health Organisations* (Wellington: Ministry of Health, 2001), p 3.

as a whole, and as a result is not often properly provided for by institutions.⁹³ In this way, cultural safety recognises that it is not just that services need to be *culturally appropriate*; but also, if services are delivered inadequately, then the delivery method of those services *can become a negative determinant of health outcomes*.

The adequate support of Māori organisations who design and deliver kaupapa Māori models of care is central to providing culturally safe and appropriate care. The reforms to primary care were accompanied by optimism from Māori involved in primary care. Repeatedly, we heard that Māori saw a fresh opportunity to design and deliver better health care to their own people and to narrow the inequity between the Māori and non-Māori health outcomes.

This optimism was reflected in the Māori primary health organisations that were eventually established. Counsel for Janice Kuka and Lady Moxon said that, at the peak, there were 14 Māori primary health organisations; today, only four of these organisations remain.⁹⁴ We have already established that the funding and accountability arrangements for primary care are not only insufficient to address Māori health inequity, but that they also actively disadvantage Māori primary health organisations and providers. The sustainability issues these organisations experience largely reflect the cost of Crown inaction. Keriana Brooking acknowledged that the Crown has not adequately supported Māori primary health organisations and that as a result some have had to close.⁹⁵

Crown witnesses nonetheless agreed with the claimants that Māori primary health organisations and providers are innovative, and have achieved impressive improvements in Māori health outcomes despite the limitations of the primary health care system. They broadly agreed that these organisations should be considered benchmarks for the approaches and performance of the rest of the sector.⁹⁶ The work of Māori primary health organisations and providers presented to us in this hearing demonstrates that they are faithful to the spirit of the reforms to primary care. As Professor Cumming acknowledged, much can be learnt from these organisations' approaches to care, and their many successes in relation to addressing health inequities.⁹⁷

Claimant counsel broadly agreed with Professor Cumming, arguing that Māori primary health organisations were truer to the original intent of the Primary Health Care Strategy than the bulk of the primary health sector.⁹⁸

It appears to us that Māori organisations provide culturally safe care in ways that other parts of the primary care sector should emulate, where appropriate. To do so, Māori organisations require adequate financial and logistical support. Piripi Hikairo described the approach forwarded at Te Manu Toroa, a Māori provider in the Bay of Plenty:

93. Submission 3.3.20, para 191–192.

94. Transcript 4.1.4, p 27.

95. Document A62, para 345; submission 3.3.32, para 47.

96. Transcript 4.1.5, pp 482–483; transcript 4.1.6, p 62; transcript 4.1.7, pp 159, 275.

97. Transcript 4.1.7, p 74.

98. Submission 3.3.18, para 85; submission 3.3.30, para 5.101.

Our clinics are culturally safe in a complex environment as we provide cultural training with a difference. It is unique [insofar] that staff, Māori or non-Māori, can recite karakia, partake in waiata, greet in Māori and understand and provide services within our values. Annexed and marked 'B' is an Introduction to Kaupapa Māori programme document which is the basis of the training that we provide to all new Te Manu Toroa staff. We adapt the programme as is appropriate, but Kaupapa Māori training is a very important part of working with us, and I believe something that mainstream providers cannot and do not give all of their staff.⁹⁹

Such organisations are rooted in te ao Māori. We heard repeatedly that the broader primary care sector generally failed to recognise and provide for the particular cultural, as well as health, needs of Māori.

In this regard, we heard that the optimism expressed by Māori for primary health organisations and providers after the primary care reforms stemmed from their view that these structures could provide for tino rangatiratanga and mana motuhake.¹⁰⁰ Counsel for Taitimu Maipi and Hakopa Paul stated that the claimants felt that 'the recognition of their tino rangatiratanga and mana motuhake are the overriding considerations in the area of primary health care'.¹⁰¹ The claimants broadly related that in relation to health, tino rangatiratanga extended both to the control of these organisations and the kaupapa Māori systems and models of care that they wanted to entrench, and also their right to sustain and develop the health and wellbeing of their communities. Lady Moxon said:

The reason we established Toiora PHO was a matter of survival. We were three small Māori Health Providers and at the time of establishing the PHO had a combined population of 6,000. The exciting thing about PHOs was that they were promoted as being community owned, governed and led. PHOs were an opportunity for community groups to exert our own Mana Motuhake and Tino Rangatiratanga in our own communities.¹⁰²

Janice Kuka, recalling the outset of the primary care reforms, outlined the motivations behind applying to have a Māori primary health organisation in the Bay of Plenty:

Driving this request was the desire for Ngā Mataapuna Oranga and Hauora to build on the gains we had made and move us closer to tino rangatiratanga over our own health business . . . because PHOs were designed to be purchasers of health services. That means that instead of just seeing people who come in sick every day and being reactive, we could look at a health problem across a population and be strategic about how to front foot dealing with it. And we could do it in line with Kaupapa Māori

99. Document A14, para 29.

100. Document A13, para 16.

101. Submission 3.3.23, para 32.

102. Document A11, para 19.

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values. This approach requires working in partnership with Iwi and Hauora to develop Māori designed solutions and cultural approaches rather than continuing to attempt to get Māori to fit within western systems that more often than not fail.¹⁰³

Henare Mason said:

I believe there was an exciting opportunity in the introduction of the PHO concept particularly in that [it] promoted an opportunity for Māori Providers, to exercise our own Mana and Tino Rangatiratanga within their own communities, by being community owned, governed and led. With the assumption that this would allow Māori PHOs to coordinate the services of their networks, implement sustainable options by delivering services to Māori and keeping intact their commitment to Kaupapa Māori philosophy – empowering Māori communities to come together to control their own Primary Health Care futures.

To the claimants, then, tino rangatiratanga provides for a truly holistic definition of hauora Māori, which encompasses the Māori structures and models which provide for hauora, and the people that those structures and models are for.

We consider that tino rangatiratanga over hauora Māori should be an intrinsic facet of a Treaty-compliant primary health system. Māori-led primary health organisations and providers must have the capacity, and space, to exert their tino rangatiratanga in the primary health care system.

As counsel for Lady Moxon and Kuka said in her opening submissions, Māori primary health organisations have ‘never had the opportunity to take control of looking after the health of their member population in a proactive holistic way’.¹⁰⁴ This has taken a deep personal toll on Māori health professionals and clinicians, as Janice Kuka highlighted in her evidence:

[Ngā Mataapuna Oranga faces] additional difficulty in recruiting the relevant qualified Māori and general practice workforce. Often our clinics were understaffed and placed under extreme pressure due to the complexity and acute illness of our presenting patients. Many of our Māori staff have found working in our clinics and Hauora overwhelming. Not only are they required to care for the physical needs of the Whānau and patients but they are also having to deal with the social situations that these same Whānau are confronted with every day. Staff and patients are often living in the same communities. This eventually takes its toll on staff and they leave.¹⁰⁵

Piripi Hikairo said the same of Te Manu Toroa:

When we first started, the passion was huge and the community was beside us. But it has been a struggle after that because people need to earn enough to live and we

¹⁰³. Document A12, para 21.

¹⁰⁴. Transcript 4.1.4, p 27.

¹⁰⁵. Document A12, para 41.

can't afford to pay staff to meet their cost of living. The dedication from when people initially came to see us is fading, because we have difficulty providing the long term care our sick people need under today's financial constraints and increased demand.¹⁰⁶

We saw this, too, in the evidence of Janet McLean and her difficult decision to resign from the Bay of Plenty District Health Board. We saw it in the passion Dr Rawiri Jansen had for the National Hauora Coalition's kaupapa Māori programmes.¹⁰⁷ It was also clear in the evidence of Taitimu Maipi, who highlighted the importance of whānau ora, and who said plainly and forcefully that the persistence of Māori inequities is unacceptable, and must be addressed.¹⁰⁸

We agree that it is unacceptable that the health of the most vulnerable whānau are under threat because of the way that the primary health system is organised and monitored. The Treaty partnership envisioned in *Ko Aotearoa Tēnei*, where the Crown provides financial and logistical support but otherwise gives effect to tino rangatiratanga, has not yet been achieved in primary care.¹⁰⁹ As the Tribunal stated in *Turanga Tangata, Turanga Whenua*, giving effect to tino rangatiratanga 'is the single most important building block upon which to re-establish positive relations between the Crown and Maori'.¹¹⁰

8.6 TRIBUNAL FINDINGS

In this chapter, we have covered a relatively broad range of evidence, from the recognition and incorporation of mātauranga Māori by so-called 'mainstream' entities to the broader experiences of Māori clinicians, health professionals, and patients under the primary health care system. The Crown's legislative and policy arrangements for primary care do not, either in the way they are designed or the ways they are implemented, afford Māori the central role they are guaranteed under the Treaty. Being given the opportunity to merely add commentary to the margins is not consistent with the principle of partnership, and certainly does not recognise mana motuhake and tino rangatiratanga rights in the primary care sector.

The flawed process the Crown followed when designing the reforms to primary care and the demise of Te Kete Hauora is emblematic of this inadequate support. Similarly, we are concerned that Māori are significantly underrepresented in the health sector, both in the Ministry and in every medical profession. What we saw

106. Document A14, para 46.

107. Transcript 4.1.4, pp 533–541.

108. Transcript 4.1.4, p 43.

109. Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims concerning New Zealand Law and Policy affecting Māori Culture and Identity: Te Taumata Tuatahi* (Wellington: Legislation Direct, 2011), pp 161–162; Waitangi Tribunal, *Ko Aotearoa Tēnei: A Report into Claims concerning New Zealand Law and Policy affecting Māori Culture and Identity, Te Taumata Tuarua* 2 vols (Wellington: Legislation Direct, 2011), vol 2, p 559.

110. Waitangi Tribunal, *Turanga Tangata, Turanga Whenua: The Report on the Turanganui a Kiwa Claims*, 2 vols (Wellington: Legislation Direct, 2004), vol 2, p 739.

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as the essence of claimants' allegations, that the primary health sector is fundamentally based on and designed for a community that is already in good health, is borne out by these statistics. Māori are scarcely reflected throughout the system itself, whether in its upper echelons or in medical professions directly responsible for delivery of care. We are concerned that this is evidence of further Crown omissions in relation to workforce development.

Nonetheless, for now, we find that:

- ▶ the Crown did not design the primary health care framework in partnership with Māori; and
- ▶ the disestablishment of Te Kete Hauora, and the failure to replace it at the time, is a breach of the Treaty principles of equity and active protection.

We are pleased that the Ministry has decided to establish a Māori health directorate, seemingly confirming that a unit focused on Māori health is an intrinsic part of designing and providing health care to Māori.¹¹¹ The role, oversight and support given to a Māori-focused team, unit, or agency should be given careful thought going forward.

As we concluded in section 8.5, Māori are guaranteed tino rangatiratanga rights over hauora Māori, which encompasses Māori organisations and their models of care, and Māori people who need to access these models of care. In the present system, hauora Māori is considered lesser in value or priority, even though hauora Māori is in greater need of active support. This dynamic is inconsistent with the Treaty.

Further, in order to have a Treaty-compliant primary health care system, the Crown needs to support models of health care which are culturally appropriate for Māori. Māori primary health organisations and providers are central to the development of these models of care. The Crown has failed to properly recognise through its actions that the work of these organisations, and the people that work for them, are intrinsic to pursuing Māori health equity. Tino rangatiratanga of hauora Māori is necessary to pursue health equity. Tino rangatiratanga of hauora Māori will not be possible without more active support from the Crown.

We have already found Treaty breaches regarding the inadequate funding of primary care, and the impact this has both on Māori who need to use health services and on Māori organisations. Given these breaches, and taking into account the matters discussed in this chapter, we find that:

- ▶ the primary health care framework does not recognise and properly provide for the tino rangatiratanga and mana motuhake of hauora Māori. This is a breach of the Treaty's active protection of tino rangatiratanga, as well as a breach of the principles of partnership, active protection, equity, and options.

111. Document A59, para 48.

CHAPTER 9

PREJUDICE AND RECOMMENDATIONS

*Whakataka te hau ki te muri;
Whakataka te hau ki te tonga kia mākinakina ki uta;
Kia mātaratara ki tai kia hiia ake te ātākura, he tio, he huka, he hau-hūnga*

9.1 PREJUDICE

Our task in stage one was to focus on the legislative and policy framework of New Zealand's primary health care system and its alleged flaws, when assessed against the principles of the Treaty of Waitangi. We focused on four specific areas: the Treaty-compliance of the Act and framework; funding; accountability; and the nature of Treaty partnership arrangements in the primary health care sector. In each of these areas, we found that the Crown acted inconsistently with the principles of the Treaty. Thus, we find that the claims of the Māori Primary Health Organisations and Providers (Wai 1315) and the National Hauora Coalition (Wai 2687) are well-founded.

We accept that the primary health care legislative and policy framework broadly cannot address all the determinants of health. We also are aware that this report is the result of stage one of a continuing inquiry process that will investigate the design and provision of health care beyond the scope of what we have covered in this stage one report. Even when taking these factors into account, the legislative and policy framework of the primary health care system fails to address adequately the severe health inequities experienced by Māori. Further, the Crown failed to lead and direct the primary health care system in a way that adequately supported and resourced Māori to design and provide for their own wellbeing through designing and delivering primary health care to Māori. The Crown's failures prejudicially affect the ability of Māori to sustain their health and wellbeing.

The prejudice suffered by Māori because of these Crown failures is extensive. The legislative and policy framework is insufficient in and of itself, and the Crown's renewed, specific commitments to improve Māori health are not enough to negate this insufficiency on their own. However, we are particularly concerned that the evidence before us indicates that some of the framework's provisions, intended to improve Māori health outcomes and give them input into how primary health care is designed and delivered, were not fully implemented, or in some cases ceased to operate entirely. This is unacceptable. We reiterate that the depth of inequity suffered by Māori, and particularly the fact that it has not measurably improved in the two decades since the framework was put in place, mean that the Crown's failures are very serious.

9.2 RECOMMENDATIONS

Our analysis and findings in this report into the Māori Primary Health Organisations and Providers and National Hauora Coalition claims are final, and this is reflected in our recommendations. However, we have also made several interim recommendations where we have asked the stage one claimants and the Crown to report back to us on certain matters by 20 January 2020. Where the recommendations are interim, we have clearly indicated so. Some of the interim recommendations reflect the fact that a wider discussion is needed involving other Māori stakeholders in the health sector.

In making our recommendations, we are conscious that there are other primary health-related claims that have yet to be heard. Previously, we signalled that we will hear from those other claimants on whether the Health Services and Outcomes Kaupapa Inquiry process we have pursued to date needs to be re-designed to allow for broader inquiry into other primary health-related claims. This will be an agenda item at yet to be held forthcoming judicial conferences, which will address the future planning of the overall inquiry.

Given the scope of stage one of this inquiry, we have exercised caution in making our recommendations. Our expertise is the Crown–Māori Treaty relationship. In this inquiry, that requires an assessment of the Crown's performance as it relates to the primary health care legislative and policy framework. This report outlines the Treaty standards that in our view will make the framework Treaty-compliant. With this in mind, we begin with two overarching recommendations.

9.3 OVERARCHING RECOMMENDATIONS**9.3.1 The Treaty of Waitangi and its principles**

In chapter 5, we found that the New Zealand Public Health and Disability Act 2000 does not give proper and full effect to the Treaty or its principles, and is not Treaty-compliant. We found that He Korowai Oranga and its articulation of “partnership, participation and protection” does not adequately reflect the Treaty or its principles. We considered that the removal of specific Treaty references from lower-level documents amounted to a concerning omission of the health sector's Treaty obligations. When viewed collectively or individually, these omissions by the Crown constitute breaches of the Treaty principles of partnership, active protection and equity. As such, we are of the view that the relationship between the Crown and Māori in primary health needs in future to provide for an enhanced commitment to the Treaty of Waitangi and its principles.

We recommend that the Crown ensure that the legislative and policy framework of the New Zealand primary health care system recognises and provides for the Treaty of Waitangi and its principles.

Such a commitment starts with the relevant legislation, currently the New Zealand Public Health and Disability Act 2000, section 4. We recommend that section 4 be amended to read as follows:

4 Treaty of Waitangi and its principles

This Act shall be interpreted and administered so as to give effect to the principles of the Treaty of Waitangi.

In this inquiry, we found that the Crown has failed to ensure that everyone who works in the primary health care system is aware of their Treaty obligations. The Crown's failure to abide by its Treaty obligations and ensure that its agents and the health sector as a whole are doing the same has contributed to the dire state of Māori health outcomes. It cannot continue to evade its obligations. We say this because the health inequities experienced by Māori compel an urgent, and thorough, intervention. The commitment to recognise and provide for the Treaty of Waitangi and its principles must be embedded at all levels of the primary health system and in all the relevant documents that make up the framework.

To this end, we found that the Crown's 'three Ps' articulation of Treaty principles is outdated and needs to be reformed. While the Crown accepts that is the case, it has submitted that updated principles for the health sector should be developed and articulated as part of a draft Māori Health Action Plan.¹ We consider that proposal is unnecessary.

We recommend that the commitment to recognise and provide for the Treaty of Waitangi and its principles should not be limited to a Māori Health Strategy and any Māori health action plan. The commitment should be stated expressly in all documents that make up the policy framework of the primary health system: the strategies, the plans and so-called lower level documentation.

We recommend that the following are adopted as the Treaty principles for the primary health care system:

- (a) The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery and monitoring of primary health care.
- (b) The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- (c) The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents and its Treaty partner are well-informed on the extent, and nature of, both Māori health outcomes and efforts to achieve Māori health equity.
- (d) The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- (e) The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of

1. Submission 3.3.32, para 58.

primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

9.3.2 Equity

We found that the dominant language in the legislation and policy framework is ‘reducing disparities’ or ‘reducing inequality’, rather than a commitment to achieving equity of health outcomes for Māori. We reiterate that including an expressly stated, stand-alone commitment to achieving health equity should not be controversial. Achieving health equity should be among the ultimate purposes of any just health system.

We recognise that complexities are at play. All parties to this inquiry, including the Crown, are aware of the impact of the social determinants of health and the ongoing impact of colonisation and institutional racism. While the commitment to achieve equitable health outcomes for Māori must be enduring, the contemporary circumstances heighten, under the principles of active protection and equity, the Crown’s obligations to act to address these inequities.

We recommend that the Crown commit itself and the health sector to achieve equitable health outcomes for Māori.

That commitment starts with the legislation. We recommend that:

- (a) section 3 (1)(b) of the New Zealand Public Health and Disability Act 2000 be amended to read as follows: ‘to achieve equitable health outcomes for Māori and other population groups’; and
- (b) section 3(2) remain as is, to account for prevailing factors.

We recommend that the commitment to achieve equitable health outcomes for Māori is expressly stated in all documents that make up the policy framework of the primary health system: the strategies, the plans and so-called lower level documentation.

9.4 STRUCTURAL REFORM – AN INDEPENDENT MĀORI HEALTH AUTHORITY

Both claimant groups have said that the Crown has led and controlled the design, structure and resourcing of the primary health system. This system has not addressed Māori health inequities in a Treaty-compliant way, and this failure is in part why Māori health inequities have persisted. In response, the claimants seek recommendations from the Tribunal that an independent Māori health authority be established.

The Māori Primary Health Organisations and Providers claimants led evidence on and sought recommendations that New Zealand adopt a model of health similar to an Alaskan model of indigenous health – the NUKA model. The National Hauora Coalition claimants seek a recommendation that the Crown establish an independent statutory Hauora Authority. Further, they say that this authority should have similar legal status to an autonomous or independent Crown entity under the Crown Entities Act 2004, such as the Accident Compensation Corporation or Pharmac, and carry out a variety of functions including the

provision of services, commissioning for outcomes, procuring services from providers and policy advice.

The recommendations sought in this respect reflect the evidence we heard for recognition of tino rangatiratanga and mana motuhake in the design, delivery, resourcing and control of Māori primary health.

We observe that the demand for structures and services that are ‘by Māori, for Māori’ across all sectors of social service design and delivery is a current and future reality that successive governments of the day will face. That demand will not diminish; it will only increase in the years to come. The Tribunal has made clear in its previous reports that co-governance, particularly in social service design and delivery, is an essential part not only of upholding the Treaty relationship, but also essential to the improvement of Māori socio-economic status. The Crown should be making policy decisions with a view to fulfilling this Treaty obligation under the principle of partnership, and to recognise tino rangatiratanga.

In responding to a call from one claimant counsel that it ‘should work in partnership with Māori’ to come up with and implement reforms to the primary health care framework, the Crown submitted that ‘the Health and Disability Review is supported by a Māori Advisory Group’, and that its recommendations will ‘be discussed between the Treaty partners.’² This is certainly part of a partnership process, but is not on its own a reflection of the joint obligations under the principle of partnership. Co-design must be manifested through a more robust engagement between Treaty partners.

We recognise that the Ministry is the steward of the New Zealand health system. It has responsibilities to deliver health services across all levels of the health system, not just primary health and not just for Māori. We understand that the health system is complex and resource hungry, but the Crown must do better in meeting its obligations to Māori arising out of the Treaty relationship.

We make an interim recommendation that the Crown commit to exploring the concept of a stand-alone Māori primary health authority.

The recommendation is an interim one for several reasons. We are conscious that we heard evidence from only two out of the four Māori primary health organisations. We also heard evidence from some Māori providers, but not all. The positions of non-Māori primary health organisations and providers, who deliver most primary health services to Māori, should also be considered. The claimant groups intend this new authority to be involved not just in primary health care, but in all types and levels of health care. We have not heard from all Māori stakeholders in the primary care sector, and certainly have not heard from any stakeholders beyond primary care.

We are also conscious that both claimant groups sought recommendation that either a NUKA-based model or independent Māori health authority have a much wider ambit than primary health and cover both secondary and tertiary health care. We have not gone as far as that yet because the claims before us are focused

2. Submission 3.3.32(a), p 1.

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on the legislative and policy framework of the New Zealand primary health care health system, not the entire health system.

We make further interim recommendations that:

(a) Within the next seven months, the Crown and representatives of the Wai 1315 and Wai 2687 claimants design a draft term of reference to explore the possibility of a stand-alone Māori health authority. We direct that the Crown and the Wai 1315 and Wai 2687 claimants file a joint memorandum by 20 January 2020 updating the Tribunal on progress. If the parties are unable to agree on filing a joint memorandum they may file separate memoranda.

(b) The Crown fund the process and provide the necessary secretariat support. We reserve the right to review these interim recommendations and make further recommendations depending on the outcome of this process.

Our recommendation only mentions the representatives of the Māori Primary Health Organisations and Providers and the National Hauora Coalition for the initial seven-month period. This is because they are the groups that undertook the responsibility for the prosecution of these claims. Our reasoning is also pragmatic. The process must start with someone, somewhere. We would not like to see the first step delayed by a failure to agree upon who should be involved in that process.

If a draft term of reference is agreed upon it should then go out for consultation and discussions with the wider Māori primary health sector. Obvious entities to involve would be the two Māori primary health organisations and other Māori providers whom we have not heard from, and mainstream primary health organisations who have a significant number of Māori enrolled patients. Groups who appeared before us as interested parties, such as the Māori Medical Practitioners Association, the Māori nurses and the New Zealand Māori Council, would no doubt wish to be involved. Representative iwi entities may also wish to participate.

To reiterate, we have specified only that the terms of reference should explore the possibility of a stand-alone Māori health authority. As experts in primary health care design and delivery, we are confident that the parties are best placed to formulate the rest of the terms of reference between them.

9.5 SPECIFIC RECOMMENDATIONS

What follows are a series of specific recommendations to the existing framework. We make these recommendations based on the assumption that the recommendations outlined earlier may take some time to be fully implemented.

9.5.1 Funding

In chapter 6, we discussed the initial funding of Māori primary health organisations. In broad terms, we found that the funding at the time of establishment of primary health organisations was variable, and as such disadvantaged Māori organisations and Māori patients with high needs. For some Māori primary health organisations, that resulted in severe under funding.

We make interim recommendations that:

- (a) Within the next seven months, the Crown and representatives of the Wai 1315 and Wai 2687 claimants agree upon a methodology for the assessment of the extent of underfunding of Māori primary health organisations and providers. The methodology should include a means of assessing initial establishment and ongoing resource underfunding since the commencement of the New Zealand Primary Health and Disability Act 2000. We direct that the Crown and the Wai 1315 and Wai 2687 claimants file a joint memorandum by 20 January 2020 updating the Tribunal on progress. If the parties are unable to agree on filing a joint memorandum they may file separate memoranda.

- (b) The Crown fund the process and provide the necessary secretariat support. We reserve the right to review these interim recommendations and make further recommendations depending on the outcome of this process.

We recognise that there is a compensatory aspect to this process, in that it responds to acknowledged historic underfunding. However, we make no recommendations at this stage as to the final destination of any such compensation. That is a matter which is complicated by the fact that many of the initial Māori primary health organisations and providers no longer exist. Our initial thinking is that if a final sum can be agreed upon: first, it could be used in part to compensate those Māori primary health organisations and providers still in existence; and, secondly, it could be future-focused, perhaps with a view to supporting the development of additional Māori primary health organisations and providers. That is a matter which we think should form part of the development of the methodology we recommend.

In relation to the capitated funding formulas, we have found that the formulas disadvantage primary health organisations and providers that predominantly service high-needs populations, and particularly impact on Māori-led primary health organisations and providers who predominantly serve these populations. Further, kaupapa Māori models of care are not adequately recognised or resourced by these funding arrangements. The Crown failed to amend adequately or replace those funding formulas despite being well-informed that they were insufficient and that its attempts to fix them were not working to the nature and extent required by the health needs of Māori.

We recommend that the Crown conduct an urgent and thorough review of the funding for primary health care, to better align it with the aim of achieving equitable health outcomes for Māori.

9.5.2 Accountability

In chapter 7, we discussed how the health sector is held to account for pursuing Māori health equity. We discussed the standards and processes used in the planning, measuring and monitoring undertaken by the numerous entities in the primary health sector. The evidence confirmed to us that the existing accountability

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mechanisms are not being used effectively to hold entities to account for insufficient, or no, action in relation to improving Māori health outcomes.

Moreover, we found that the Crown is neither undertaking sufficiently robust assessments of whether the primary health system is performing well for Māori, nor collecting or publishing enough quantitative and qualitative information to make any assessment useful. Further, we concluded that external monitoring of the Ministry appears severely lacking, as exemplified by the minimal monitoring conducted by Te Puni Kōkiri since 2000, particularly their failure to conduct agency reviews.

Strong accountability mechanisms, and robust, public measuring and reporting, are key to the Treaty-compliance of the legislation and policy of the primary health care sector. We find the lack of these mechanisms and measures are inconsistent with the principles of partnership, active protection and equity.

We make a general recommendation that the Crown commit to reviewing and strengthening accountability mechanisms and processes in the primary health sector, which impact on Māori.

We recommend that He Korowai Oranga is reviewed considering the content of this report. It, the New Zealand Health Strategy and the Primary Health Care Strategy, and their relevant action plans, need to state expressly how our overarching recommendations are to be integrated across the primary health care sector. Given the importance of achieving equitable health outcomes for Māori, we recommend that section 8(4) of the Act be amended to include a Māori Health Strategy.

We endorse the Crown's commitment to develop and maintain at all times an action plan for the Māori Health Strategy. We recommend that this action plan is co-designed with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants.

Further, we make the following recommendations that:

- (a) The Crown, in conjunction with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants, co-design a primary health research agenda.
- (b) The Ministry collect robust quantitative and qualitative primary care data and information relevant to Māori health outcomes. This data and information should be made public and be easily understandable and accessible. To this end, the Crown should, in conjunction with Māori health experts, including representatives of the Wai 1315 and Wai 2687 claimants, co-design measures specific to Māori as a population group.
- (c) The Crown ensure that measures relevant to Māori health outcomes are reported on separately. These measures and the reporting against them should be made public and be easily understandable and accessible.
- (d) District health boards and primary health organisations prepare, and make publicly available, an annual Māori health plan. The nature and content of these plans should have national minimum requirements that are set and monitored by the Ministry, but should also be co-designed with Māori who are associated with the particular organisation.

- (e) All health sector contracting documents should have a reference to the Treaty of Waitangi and its principles, as we have outlined in our overarching recommendations. Health sector contracts should also include a commitment to achieving equitable health outcomes for Māori.
- (f) The Crown review, with a view to redesigning, the current arrangements for the monitoring of the Ministry by external agencies, which are intended to ensure the sufficiency of the design and delivery of health services to Māori. Further, any agency/agencies tasked with these monitoring responsibilities should have particular regard to those matters we mention at section 7.7 of this report.

9.5.3 A Treaty-compliant primary health care framework

In chapter 5, we highlighted several concerns we have about how the primary health care framework fails to recognise and provide for Māori expertise and viewpoints as guaranteed by the Treaty. For example, we noted that in part 2 of the Act none of the Ministerial Advisory committees had a specific focus on Māori health, nor was there a requirement for Māori membership on those committees.

In chapter 8, we concluded that neither the development of the Primary Health Care Strategy nor the framework involved a robust co-design process. We also noted that Māori are significantly underrepresented across a range of health professions, and in the Ministry itself. We were particularly concerned at the disestablishment of Te Kete Hauora, and the impact this may have had on the efficacy of Māori-specific policy making and advice at the Ministry level. Similarly, we discussed the fact that those managers responsible for Māori health within district health boards felt hamstrung by the ambit of their role and had very minimal budget holding functions. The fact that the extent of these roles varies considerably and is effectively at the whim of individual district health boards is particularly concerning to us.

In the governance sphere, we found that Māori members of district health boards are always in the minority, they do not necessarily reflect mana whenua interests or the Māori population of the district they serve, and that the board members are ultimately appointed by the Minister of Health and are thus ultimately answerable to the Minister. Accordingly, we found that the district health board model does not reflect a true partnership relationship.

We further noted that Māori relationship boards do not have the statutory recognition and status that the committees referred to in sections 34 to 36 of the Act have. Further, the actual extent of their role in the governance and operation of district health boards varies considerably throughout the country. We found scant evidence of an accurate reflection of the principle of partnership as required by the Treaty.

We make an interim recommendation that, after considering our findings in chapters 5 and 8, the Crown review, with a view to redesign, 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.

HAUORA

9.5.4

This recommendation is an interim one because we wish to see what progress is made in the co-design of a stand-alone Māori primary health authority, as outlined earlier in this chapter. Depending on progress or otherwise in that respect, we reserve to ourselves the right to review these interim recommendations and to make more detailed partnership recommendations to the current legislative and policy framework if needed.

9.5.4 Acknowledgement

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

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Dated at Wellington this 28th day of June 20 19



Judge Stephen Clark, presiding officer



Dr Angela Ballara, member



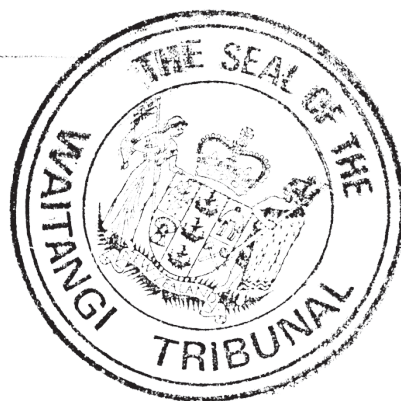
Associate Professor Tom Roa, member



Tania Te Rangingangana Simpson, member



Professor Linda Smith



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APPENDIX I

STATEMENT OF ISSUES

1.0 INTRODUCTION

- 1.1** The following statement of issues is intended for use in stage one of the Waitangi Tribunal Inquiry into Māori Health – Wai 2575. During stage one, the Tribunal will be enquiring into the claims of the Māori Primary Health Organisations (‘PHO’) and Providers (Wai 1315) and the National Hauora Coalition (Mason and Royal) (Wai 2687) claims. The focus of stage one is the legislative and policy framework of New Zealand’s primary healthcare system as a whole and its alleged flaws when assessed against the principles of the Treaty of Waitangi.¹
- 1.2** The statement of issues has been developed taking into account the following:
- 1.2.1** The statements of claim filed on behalf of the Wai 1315 claimants;²
 - 1.2.2** The statement of claim filed on behalf of the Wai 2687 claimants;³
 - 1.2.3** The proposed statement of issues filed on behalf of the Wai 1315 and Wai 2687 claimants on 17 May 2018;⁴
 - 1.2.4** The proposed statement of issues and statement of facts filed on behalf of the Crown on 25 May 2018;⁵
 - 1.2.5** A joint memorandum of counsel received on behalf of the Wai 1315 and Wai 2687 claimants on 31 May 2018.⁶
- 1.3** The statement of issues is intended to provide a guideline to the stage one claimants, the Crown and any interested party for whom leave may be granted, during the preparation of their respective cases and submissions. They are not intended to straightjacket the parties however they provide a clear indication of the issues which the Tribunal would like to be addressed during stage one of this Inquiry.

1. Wai 2575, #2.5.25, para 80. The primary healthcare framework means the legislation, regulation, policy and practice which determines the delivery of primary healthcare. It includes the New Zealand Public Health and Disability Act 2000, the Crown Funding Agreement, the Operating Policy Framework, the New Zealand Health Strategy, the New Zealand Primary Healthcare Strategy, the PHO Minimum Requirements, the PHO Services Agreement, Additional Services Contracts, the New Zealand Disability Strategy, and He Korowai Oranga Māori Health Strategy.

2. Wai 2575, #1.1.1 and #1.1.1(a).

3. Wai 2575, #1.1.2.

4. Wai 2575, #3.1.177.

5. Wai 2575, Schedule 1: Statement of Facts, #3.1.175(a) and Schedule 2: Proposed Statement of Issues, #3.1.175(b).

6. Wai 2575, #3.1.178.

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2.0 EQUITY

- 2.1 What health disparities do the Māori population experience compared to the non-Māori population?
- 2.2 What are the nature and extent of any inequities between Māori and non-Māori health status?
- 2.3 Does the Crown set expectations of equity between Māori and non-Māori in the primary healthcare framework?
- 2.4 If so, where are those expectations located?
- 2.5 Are the expectations of equity between Māori and non-Māori in the primary healthcare framework sufficient?
- 2.6 Is the Crown addressing inequity in health outcomes for Māori compared to non-Māori in relation to the primary healthcare framework? If so, how?
- 2.7 Is the primary healthcare framework prejudicial to achieving equitable Māori health outcomes?
- 2.8 Is the primary healthcare framework prejudicial to the ongoing development of Māori PHOs and Māori health providers?

3.0 THE PRIMARY HEALTHCARE FRAMEWORK

- 3.1 Does the primary healthcare framework:
 - 3.1.1 Adequately recognise the extent and nature of existing inequity between Māori and non-Māori health status?
 - 3.1.2 Remove barriers to Māori accessing and using primary healthcare services?
 - 3.1.3 Do enough to address consistent under-utilisation of health services by Māori?
 - 3.1.4 Do enough to address multiple conditions which Māori often present with when health services are utilised?
 - 3.1.5 Operate on a model that is able to address the particular health needs of Māori?

4.0 MĀORI SOLUTIONS

- 4.1 Does the primary healthcare framework allow sufficient scope for Māori to determine and apply their own solutions to improve Māori health?
- 4.2 To what extent does the primary healthcare framework support the development and use of Māori-designed solutions for Māori centred health issues? Is that support sufficient?
- 4.3 Does the primary healthcare framework adequately resource Māori PHOs and Māori providers in the following respects:
 - 4.3.1 By addressing the disparity in resources at the point of establishment between Māori PHOs and PHOs developed from established primary care providers (eg independent practitioner associations)?
 - 4.3.2 By taking into account the dispersed nature of the Māori population?
 - 4.3.3 By ensuring a constant funding stream for services provided?
 - 4.3.4 By ensuring that equitable and adequate resourcing of providers is not compromised by competition?

5.0 FUNDING

- 5.1 On what data is the current capitation formula based?
- 5.2 Is that data complete and/or reliable?
- 5.3 Does the data take into account access issues and differential health needs for Māori?
- 5.4 Is the current capitation formula adequate to meet Māori health needs?

6.0 POLICY AND STRATEGY

- 6.1 Does the primary healthcare framework provide Māori with a real and meaningful role in the development and implementation of primary healthcare policy and strategies, in particular:
 - 6.1.1 By adequately addressing concerns raised by Māori PHOs and providers and Māori communities (whānau, hapū, iwi, other groups and individuals) in submissions prior to the development of the primary healthcare strategy?
 - 6.1.2 By adequately consulting with Māori PHOs and providers and Māori communities (whānau, hapū, iwi, other groups and individuals) in the implementation of the primary healthcare strategy?
 - 6.1.3 By ensuring Māori PHOs and providers have a role in the development of contractual arrangements to implement the primary healthcare strategy?

7.0 ACCOUNTABILITY

- 7.1 Does the primary healthcare framework provide sufficient accountability:
 - 7.1.1 From PHOs to DHBS; and
 - 7.1.2 From DHBS to the Ministry of Health and to the Minister of Health; and
 - 7.1.3 From all parties to whānau, hapū, iwi and Māori communities to ensure that any of the services provided within it achieve equitable outcomes for Māori compared to non-Māori?
- 7.2 What accountability measures are there to demonstrate how the primary healthcare framework in practice:
 - 7.2.1 Meets the requirements set out in legislation and policy derived from the Treaty of Waitangi and its principles?
 - 7.2.2 Requires PHOs to be controlled by their communities, including Māori?
 - 7.2.3 Ensures that DHBS are providing sufficient resources to eliminate or reduce inequity in Māori health outcomes?
 - 7.2.4 Ensures that DHBS are taking sufficient actions to eliminate or reduce inequity in Māori health outcomes?
 - 7.2.5 Ensures that PHOs and providers are accountable for how they spend funding to reduce Māori health inequality?
 - 7.2.6 Ensures that PHOs and providers are accountable for how they achieve positive outcomes for Māori health?

8.0 SOCIAL POLICY

- 8.1 Does the primary healthcare framework:
 - 8.1.2 Adequately address the relationship between Māori health and services and all its determinants (such as poverty, housing, education, income)?
 - 8.1.3 Address or provide for hauora as a holistic concept?

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9.0 TREATY PRINCIPLES

- 9.1** Are any acts or legislative instruments that relate to the primary healthcare framework in breach of the principles of the Treaty of Waitangi?
- 9.2** Are any policies, practices, acts or omissions of the Crown, or those acting on behalf of the Crown that relate to the primary healthcare framework in breach of the principles of the Treaty of Waitangi?
- 9.3** Are any policies, practices, acts or omissions of the Crown or those acting on behalf of the Crown, that relate to the primary healthcare framework, in breach of the Crown's Treaty-based obligation to address Māori health inequality?

10.0 PREJUDICE

- 10.1** Are Māori prejudicially affected by any breach of Treaty principles that relate to the primary healthcare framework?
- 10.2** If so, has the breach of Treaty principles resulted in prejudice in relation to:
 - 10.2.1** The development and implementation of primary healthcare policy and strategy?
 - 10.2.2** The funding of Māori primary healthcare?
 - 10.2.3** Achieving equitable outcomes for Māori health?
 - 10.2.4** Enabling Māori PHOs and Māori health providers to close the inequalities between Māori and non-Māori health status?

11.0 RECOMMENDATIONS

- 11.1** What steps, if any should the Crown take to:
 - 11.1.1** Remedy any breach of the principles of the Treaty of Waitangi?
 - 11.1.2** Remove any prejudice as a result of any breaches of the principles of the Treaty of Waitangi?

APPENDIX II

INTERESTED PARTIES GRANTED LEAVE TO PARTICIPATE IN STAGE ONE OF THE WAI 2575 HEALTH SERVICES AND OUTCOMES INQUIRY

GRANTED LEAVE TO PARTICIPATE ON A WATCHING BRIEF BASIS

Claim: Wai 2655

Counsel: Lyall and Thornton

Party: Ngā Kairauhii Nannies Against p

Claims: Wai 2719, Wai 2723

Counsel: Te Mata Law Ltd

Parties: Beverly Te Huia, Maria Baker

Claim: Wai 2003

Counsel: Dixon and Co

Parties: Cheryl Turner, John Klaricich, Harerei Toia (deceased), Ellen Naera, Fred Toi, Warren Moetara and Hone Taimona on behalf of Ngati Korokoro, Ngati Wharara and Te Pouka Hapu

Cross-examination: Leave granted to cross-examine Dr Nick Chamberlain.

Claims: Wai 2634, Wai 2643, Wai 2647, Wai 2650, Wai 2688

Counsel: Oranganui Legal

Parties: Maraea Katene, Rosaria Hotere and Jane Hotere, Teresa Goza on behalf of Ngā Amo Titoki, Wiremu Bayliss, Glennis Rawiri

Cross-examination: Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, Dr Heather Came-Friar, Professor Jacqueline Cumming, Amy Downs, and Dr Frances McGrath on behalf of Wai 2647 claimants.

Claim: Wai 144

Counsel: Zwaan Legal

Party: Vernon Winitana on behalf of Ngāti Ruapani

Claim: Wai 682

Counsel: Tukau Law

Parties: Reweti Pomare Kingi Pita Paraone, Johnson Erima Henare, Samuel Kevin Prime, Pita Tipene, and Waihoroi Shortland on behalf of Ngāti Hine

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GRANTED LEAVE TO FILE SUBMISSIONS

Claim: Wai 1732

Counsel: Ranfurly Chambers

Parties: Mate M Pihema, Cyril D Chapman, and Oneroa M Pihema on behalf of themselves and Kohatutaka Hapū and Ngāti Kiore of Mangataipa

Leave granted to file: Closing submissions on the Tribunal Statement of Issues 4.1, 4.2, 9.1–9.3, and 11

Claims: Wai 2619, Wai 1670

Counsel: Morrison Kent

Parties: Dr Huhana Kickey and disabled Māori

Leave granted to file: Closing submissions

Cross-examination: Leave granted to cross-examine Hector Matthews.

Claim: Wai 1813

Counsel: Wackrow Williams

Parties: Tania Wolfgramm and Dr Rachel Maunganui Wolfgramm

Leave granted to file: Closing submissions on the Tribunal Statement of Issues 2–5

Claim: Wai 2720

Counsel: Phoenix Law

Parties: John Tamihere, on behalf of himself, and Te Whānau o Waipareira Trust, and the Manukau Urban Māori Authority, and the National Urban Māori Authority

Leave granted to file: Closing submissions on the Tribunal Statement of Issues

Claim: Wai 2623

Counsel: Phoenix Law

Party: Cletus Maanu Paul, chairperson of the Mataatua District Maori Council

Leave granted to file: Closing submissions on the Tribunal Statement of Issues 2–4, and 6–10

Claim: Wai 179

Counsel: Phoenix Law

Parties: Colin Malcom (deceased), Anne Davies, Huhana Seve, and Ruiha Collier

Leave granted to file: Closing submissions on the Tribunal Statement of Issues 2–7

Claim: Wai 996

Counsel: Phoenix Law

Parties: David Potter and Andre Paterson, for and on behalf of themselves, and the Tangihia Hapū, and Cletus Maanu Paul

Leave granted to file: Closing submissions on the Tribunal Statement of Issues 2–7

INTERESTED PARTIES GRANTED LEAVE TO PARTICIPATE IN STAGE ONE
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GRANTED LEAVE TO FILE EVIDENCE AND SUBMISSIONS**Claim:** Wai 2738**Counsel:** Afeaki Chambers**Party:** Kahurangi Fergusson-Tibble on behalf of Māori mental health and addictions workers**Leave granted to file:** Opening and closing submissions on the Tribunal Statement of Issues 4.2**Witnesses:** Kahurangi Fergusson-Tibble**Cross-examination:** Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, Dr Heather Came-Friar, Dr Nick Chamberlain, Professor Jacqueline Cumming, Francis McGrath, Taitimu Maipi, Hector Matthews, and Tureiti Lady Moxon**Claim:** Wai 2644**Counsel:** Woodward Law**Party:** Edward Taihākurei Durie on behalf of the New Zealand Māori Council**Leave granted to file:** Opening and closing submissions**Witnesses:** Sir Edward Taihākurei Durie and Teresa Wall**Claim:** Wai 2499**Counsel:** Kahui Legal**Parties:** Dr David Jansen and others on behalf of themselves as individual Māori, Te Ohu Rata o Aotearoa, and on behalf of all Māori generally**Leave granted to file:** Opening and closing submissions**Witnesses:** Teresa Wall, Dr Suzanne Crengle, and Professor Papaarangi Reid**Cross-examination:** Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, Professor Jacqueline Cumming, Dr Frances McGrath, and Hector Matthews**Claims:** Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2382, Wai 2165**Counsel:** Tamaki Legal**Parties:** Te Urunga Evelyn Aroha Kereopa, Merle Mata Ormsby et al, Te Enga Harris et al, Wiremu Reihana et al, Jasmine Cotter-Williams, Joseph Naden et al**Leave granted to file:** Opening and closing submissions**Witnesses:** Amy Downs and Mana Hape**Cross-examination:** Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, Professor Jacqueline Cumming, John Hazeldine, and Hector Matthews**Claims:** Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2638, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, and Wai 1832.**Counsel:** Te Mata Law Ltd

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Leave granted to file: Opening and closing submissions

Witnesses: Dr Heather Came-Friar and Professor Tim McCreanor

Cross-examination: Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, and Hector Matthews

Claim: Wai 2702

Counsel: Te Mata Law

Parties: David Ratu, chair, Treaty of Waitangi Issues, Te Kaunihera Māori o Tāmaki ki te Taonga; and Patricia Tuhimata, member of the Otara Māori Komiti

Leave granted to file: Opening and closing submissions

Witnesses: Patricia Tuhimata (did not attend hearings)

Cross-examination: Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, Professor Jacqueline Cumming, John Hazeldine, Dr Frances McGrath, and Hector Matthews

Claim: Wai 507

Counsel: Bennion Law

Party: Owen Lloyd on behalf of Ngā Ariki Kaipūtahi

Leave granted to file: Opening and closing submissions

Witnesses: Owen Lloyd (did not attend hearings)

Cross-examination: Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, Professor Jacqueline Cumming, Dr Frances McGrath, and Hector Matthews

Claim: Wai 2713

Counsel: Annette Skyes and Co

Party: Hineraumoa Te Apatu and Kerri Nuku on behalf of Te Rūnanga o Aotearoa Tōpūtanga Tapuhi Kaitiaki o Aotearoa

Leave granted to file: Opening and closing submissions

Witnesses: Bay of Plenty and Tairāwhiti Nurses, Kelly McDonald Beckett, Maria Briggs, Dr Heather Came-Friar, Margaret Hand, Professor Tim McCreanor, Leanne Manson, Tracey Morgan, Kerri Nuku, Keelan Ransfield, Nola Tanner, and Waiharakeke Winiata

Cross-examination: Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, Professor Jacqueline Cumming, Dr Frances McGrath, and Hector Matthews

SUBSEQUENT REQUESTS TO CROSS-EXAMINE ONLY

Claim: Wai 2727

Counsel: Watkins Law

Party: Tanya Filia

Cross-examination: Leave granted to cross-examine Director-General Dr Ashley Bloomfield, Keriana Brooking, Dr Nick Chamberlain, John Hazeldine, and Dr Frances McGrath

APPENDIX III

WITNESSES WHO GAVE EVIDENCE AT HEARINGS FOR STAGE ONE

KIMIKIMI WHARE, TŪRANGAWAEWAE MARAE

Monday 15 October 2018

Taitimu Maipi
Dr Katherine Gottlieb
Hakopa Paul

Tuesday 16 October 2018

Honourable John Henry Tamihere
Neil Bernard Woodhams
Professor John Renata Broughton
Dr Peter Martin Jansen

Wednesday 17 October 2018

Janet McLean
Janice Kuka
Piripi Hikairo
Tureiti Haromi Lady Moxon

Thursday 18 October 2018

Simon George Tiwai Royal
Dr Rawiri Jansen

Friday 19 October 2018

Professor Peter Crampton
Tereki Ross Stewart
Henare Parks Mason

Tuesday 23 October 2018

Dr Suzanne Crengle
Professor Papaarangi Reid
Teresa Wall

Wednesday 24 October 2018

Mana Hape
Amy Downs
Dr Heather Came-Friar

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Wednesday 24 October 2018—*continued*

Professor Tim McCreanor
Leanne Manson
Kerri Nuku
Keelan Ransfield
Tracey Morgan

Thursday 25 October 2018

Waiharakeke Winiata
Mairi Lucas
Jessica Tamihana
Nichola Awatere
Nola Tanner
Kelly McDonald-Beckett
Director-General of Health Dr Ashley Robin Bloomfield

Friday 26 October 2018

Director-General of Health Dr Ashley Robin Bloomfield
Margaret Hand
Kahurangi Fergusson Tibble
Sir Edward Taihākurei Durie

Thursday 1 November 2018

Dr Nick Chamberlain
John Hazeldine

Friday 2 November 2018

John Hazeldine
Dr Frances McGrath

WAITANGI TRIBUNAL UNIT OFFICES, WELLINGTON

Monday 17 December 2018

Professor Jacqueline Margaret Cumming
Hector John Rarawa Matthews

Tuesday 18 December 2018

Hector John Rarawa Matthews
Lisa Davies
Keriana Louise Brooking

APPENDIX IV

WAI 1315 SELECT RECORD OF PROCEEDINGS

Document dates are:

- Date of signature for documents generated by the Tribunal
- Date received for documents filed with the Tribunal

1. STATEMENTS**1.1 Statements of claim**

1.1.1 Taitimu Maipi, Tureiti Moxon, Elaine Tapsell, and Hakopa Paul on behalf of Te Kupenga o Hoturoa, including Raukura Hauora, Turiki Healthcare, Papakura Marae, Primary Health Organisation, Taumaranui Kokiri Trust, Te Rohe Potae o Rereahu Trust, Te Kohao Health Limited, Tom Ellis, Te Kupenga a Kahu, and Nga Mataapuna Oranga, including Te Manu Toroa, Wai 1315 statement of claim concerning primary health organisations, 11 November 2005 (received 14 November 2005)

(a) Amendment, received 1 February 2018

2. TRIBUNAL MEMORANDA, DIRECTIONS, AND DECISIONS**2.1 Registering new claims**

No data found

2.2 Amending statements of claim

2.2.1 Chief Judge Joseph V Williams, memorandum registering amended statement of claim, 7 February 2018

2.3 Waitangi Tribunal research commissions

No data found

2.4 Section 8d applications

No data found

2.5 Pre-hearing stage

2.5.1 Chief Judge Joseph V Williams, memorandum adjourning judicial conference, 24 January 2006

2.5.2 Chief Judge Joseph V Williams, memorandum convening judicial conference, 14 August 2006

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- 2.5.3** Chief Judge Joseph V Williams, memorandum granting leave to file evidence, 6 October 2006
- 2.5.4** Chief Judge Joseph V Williams, memorandum convening judicial conference, 12 January 2007
- 2.5.5** Chief Judge Joseph V Williams, memorandum granting adjournment of judicial conference, 3 April 2007
- 2.5.6** Chief Judge Joseph V Williams, memorandum granting further adjournment of judicial conference, 14 October 2007
- 2.5.7** Chief Judge Joseph V Williams, memorandum granting further adjournment of judicial conference, 22 August 2008
- 2.5.8** Chief Judge Joseph V Williams, memorandum delegating Judge Craig T Coxhead to determine urgency application, 22 August 2008
- 2.5.9** Judge Craig T Coxhead, memorandum requesting Crown response to urgency application, 21 October 2008
- 2.5.10** Judge Craig T Coxhead, memorandum adjourning urgency application *sine die*, 5 November 2008
- 2.5.11** Judge Craig T Coxhead, memorandum concerning claimant submissions on adjournment of urgency application, 24 November 2008
- 2.5.12** Judge Craig T Coxhead, memorandum concerning *sine die* adjournment of urgency application, 24 November 2009

3. SUBMISSIONS AND MEMORANDA OF PARTIES**3.1 Pre-hearing represented**

- 3.1.1** L G Powell and S J Eyre, memorandum supporting urgency application, 11 November 2006
- 3.1.2** Craig Linkhorn (Crown), memorandum requesting adjournment of judicial conference, 11 January 2006
- 3.1.3** L G Powell and S J Eyre, memorandum responding to Crown request for adjournment, 19 January 2006
- 3.1.4** C Inglis (Crown), memorandum requesting adjournment of judicial conference, 27 February 2006
- 3.1.5** Criag Linkhorn and J Eyre, joint memorandum requesting further adjournment of judicial conference, 8 June 2006

- 3.1.6** L G Powell and Craig Linkhorn, joint memorandum concerning adjournment, 20 July 2006
- 3.1.7** L G Powell and Craig Linkhorn, memorandum requesting adjournment of judicial conference, 16 January 2007
- 3.1.8** L G Powell and C Inglis, memorandum requesting further adjournment of judicial conference, 30 March 2007
- 3.1.9** S Eyre and Craig Linkhorn, memorandum providing timeframe for judicial conference, 1 October 2007
- 3.1.10** Craig Linkhorn (Crown), memorandum concerning adjournment 1 April 2008
- 3.1.11** J Eyre, memorandum concerning application for urgency, 14 August 2008
- 3.1.12** D Llewellyn and M Cooke (Crown), synopsis of Crown submissions opposing renewed urgency application, 3 November 2008
- 3.1.13** L G Powell, memorandum seeking recall of decision on urgency, 12 November 2008
- 3.1.14** S Eyre (Crown), memorandum concerning reply submissions, 16 December 2008
- 3.1.15** S Eyre, memorandum concerning Crown submissions, 25 February 2009

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APPENDIX V

WAI 2575 SELECT RECORD OF INQUIRY

RECORD OF PROCEEDINGS

Document dates are:

- Date of signature for documents generated by the Tribunal
- Date received for documents filed with the Tribunal

PANEL MEMBERS

The panel members were Judge Stephen Clark (presiding), Dr Angela Ballara, Associate Professor Tom Roa, Tania Simpson, and Professor Linda Tuhiwai Smith.

1. STATEMENTS**1.1 Statements of claim**

1.1.1 Taitimu Maipi, Tureiti Moxon, Elaine Tapsell, and Hakopa Paul on behalf of Te Kupenga o Hoturoa including Raukura Hauora, Turiki Healthcare, Papakura Marae, Primary Health Organisation, Taumaranui Kokiri Trust, Te Rohe Potae o Rereahu Trust, Te Kohao Health Limited, Tom Ellis, Te Kupenga a Kahu, and Nga Mataapuna Oranga including Te Manu Toroa, Wai 1315 statement of claim concerning primary health organisations, 11 November 2005 (received 14 November 2005) (consolidated for the purpose of stage one)
(a) Amendment (received 1 February 2018)

1.1.2 Henare Mason and Simon Royal on behalf of the National Hauora Coalition, Wai 2687 statement of claim concerning National Māori Primary Health Organisation, 11 October 2017 (received 11 October 2017) (consolidated for the purpose of stage one)

1.2 Final statements of claim

No data found

1.3 Statements of response

1.3.1 Crown statement of response to statement of issues for stage one, 2 July 2018
(a) Updated Crown response to statement of issues, 19 September 2018

1.4 Statements of issues

1.4.1 Tribunal statement of issues for stage one of inquiry, 1 June 2018

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2. TRIBUNAL MEMORANDA, DIRECTIONS, AND DECISIONS**2.1 Registering new claims**

2.1.1 Wai 1315 (claim 2.1) 22 December 2005, 22 December 2015

2.1.2 Wai 2687 (claim 2.1) 5 December 2017, 5 December 2017

2.2 Amending statements of claim

2.2.1 Wai 1315 (claim 2.2) 7 February 2018, 7 February 2018

2.3 Waitangi Tribunal research commissions

No data found

2.4 Section 8D applications

No data found

2.5 Pre-hearing stage

2.5.01 Chairperson, memorandum commencing a kaupapa inquiry into health services and outcomes, 30 November 2016

2.5.02 Judge S R Clark, memorandum concerning next steps in inquiry, 21 December 2016

2.5.03 Judge S R Clark, memorandum concerning extension requests for claimant submissions, 14 March 2017

2.5.04 Chairperson, memorandum appointing panel, 15 March 2017

2.5.05 Judge S R Clark, memorandum concerning extension requests for Crown submissions, 24 March 2017

2.5.06 Judge S R Clark, memorandum concerning the first judicial conference, 13 April 2017

2.5.07 Second Judge S R Clark, memorandum concerning the first judicial conference, 2 May 2017

(a) Appendix 1: Timetable for the first judicial conference, 2 May 2017

(b) Appendix 2: List of claimants and counsel to be heard at the first judicial conference, 2 May 2017

2.5.08 Judge S R Clark, memorandum following the first judicial conference, 26 May 2017

2.5.09 memorandum of Judge Stephen Clark concerning extension requests for claimant bibliographies, 5 July 2017

2.5.10 Judge S R Clark, memorandum concerning extension requests for post-roundtable submissions and health timeline, 31 August 2017

2.5.11 Judge S R Clark, memorandum concerning post-roundtable submissions and chronology, 13 September 2017

- 2.5.12** Chairperson, memorandum appointing a tribunal member, 14 September 2017
- 2.5.13** Judge SR Clark, memorandum concerning extension requests for further information on proposed research, 18 October 2017
 (a) Table of upcoming filing dates, 18 October 2017
- 2.5.14** Judge SR Clark, memorandum concerning further background research, 2 November 2017
- 2.5.15** Judge SR Clark, memorandum concerning extension requests for further information on proposed research, 15 November 2017, 15 November 2017
- 2.5.16** Judge SR Clark, memorandum concerning extension request for filing of supplementary evidence, 22 November 2017
- 2.5.17** Judge SR Clark, memorandum confirming next steps in the inquiry, 8 December 2017
- 2.5.18** Judge SR Clark, memorandum concerning the release of preliminary bibliography, 18 December 2017
- 2.5.19** Judge SR Clark, memorandum concerning extension requests, 22 December 2017
- 2.5.20** Judge SR Clark, memorandum concerning pre-casebook review and other matters, 19 January 2018
- 2.5.22** Judge SR Clark, memorandum concerning inquiry planning and related procedural matters, 28 February 2018, 28 February 2018
 (a) Appendix 1: Confirmed forthcoming inquiry stage one filing dates, 28 February 2018, 28 February 2018
 (b) Appendix 2: Filing dates for wider inquiry programme, 28 February 2018, 28 February 2018
- 2.5.23** Judge SR Clark, memorandum concerning participation of parties at forthcoming teleconference on the stage one inquiry matters, 6 March 2018, 6 March 2018
- 2.5.24** Judge SR Clark, memorandum concerning the issue of participation in stage one of the Health Services and Outcomes Kaupapa Inquiry, and confirming the details of a judicial conference to discuss these matters, 8 March 2018, 8 March 2018
- 2.5.25** Judge SR Clark, memorandum concerning approach to be taken to stage one inquiry, 29 March 2018
- 2.5.26** Judge SR Clark, memorandum addressing matters concerning the progression of the inquiry, 7 May 2018
 (a) Appendix 1: Confirmed forthcoming inquiry stage one filing dates, 7 May 2018
 (b) Appendix 2: Filing dates for wider inquiry programme, 7 May 2018

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2.5.27 Judge SR Clark, memorandum confirming Tribunal statement of issues for stage one of the inquiry, addressing extension requests and late filing of claimant counsel memoranda, confirming a venue for the stage one hearing weeks and confirming an agenda for the upcoming judicial conference, 1 June 2018

(a) Appendix A: Agenda for upcoming Judicial Conference on 11 June 2018, 1 June 2018

2.5.28 Judge SR Clark, memorandum confirming oral directions given at the judicial conference held on 11 June 2018, and providing an amended timetable for stage one of the inquiry, 20 June 2018, 20 June 2018

(a) Appendix 1: Confirmed forthcoming inquiry stage one filing dates, 20 June 2018, 20 June 2018

2.5.29 Judge SR Clark, memorandum concerning priorities for Stage Two of the inquiry and research, 29 June 2018

(a) Appendix A: Filing dates for wider inquiry programme, 29 June 2018

2.5.30 Judge SR Clark, memorandum concerning interested party requests for stage one, 5 July 2018

(a) Appendix 1: Confirmed forthcoming inquiry stage one filing dates, 5 July 2018

(b) Appendix 2: Filing dates for wider inquiry programme, 5 July 2018

2.5.31 Judge SR Clark, memorandum concerning the participation of stage one interested parties, 10 August 2018

(a) Appendix 1: Confirmed forthcoming inquiry stage one filing dates

(b) Appendix 2: Filing dates for wider inquiry programme, 10 August 2018

(c) Appendix 3: Interested parties granted leave to participate in stage one of the inquiry, 10 August 2018

2.5.32 Judge SR Clark, memorandum responding to requests for reconsideration of the stage two priorities and the possibility of further Tribunal-commissioned research, 30 August 2018

2.5.33 Judge SR Clark, memorandum responding to request for extension of time for filing evidence by the Crown, 6 September 2018

(a) Appendix A: Amended stage one filing dates, 6 September 2018

2.5.34 Judge SR Clark, memorandum concerning the removal of material from the Record of Inquiry, 10 September 2018

2.5.36 Judge SR Clark, memorandum concerning interested party cross-examination requests and the hearing timetable, 28 September 2018

(a) Appendix 1: List of Interested Parties granted leave to participate in stage one of the Inquiry, 28 September 2018

2.5.37 Judge SR Clark, memorandum concerning the forthcoming stage one hearing weeks, 10 October 2018

(a) Appendix A: Interested parties granted leave to participate in stage one of the inquiry, 10 October 2018

(b) Appendix B: Confirmed forthcoming inquiry stage one filing dates, 10 October 2018

2.5.38 Judge SR Clark, memorandum confirming the hearing week one timetable, 11 October 2018

(a) Appendix A: finalised hearing week one timetable, 11 October 2018

2.6 Hearing stage

2.6.1 Judge SR Clark, memorandum concerning hearing weeks one and two of the stage one inquiry, 31 October 2018

(a) Appendix A: Interested parties granted leave to participate in stage one of the inquiry, 31 October 2018

(b) Appendix B: Confirmed forthcoming inquiry stage one filing dates, 31 October 2018

2.6.2 Judge SR Clark, memorandum concerning hearing week three of the stage one Inquiry, 8 November 2018

(a) Appendix A: Confirmed forthcoming inquiry stage one filing dates, 8 November 2018

2.6.3 Judge SR Clark, memorandum inviting parties to review the hearing week one transcript and submit any corrections by 12pm, Friday 14 December 2018, 26 November 2018

2.6.4 Judge SR Clark, memorandum inviting parties to review the hearing week two transcript and submit any corrections by 12pm, Friday 14 December 2018, 29 November 2018

2.6.5 Judge SR Clark, memorandum inviting parties to review the hearing week three transcript and submit any corrections by 12pm, Friday 14 December 2018, 30 November 2018

2.6.6 Judge SR Clark, memorandum concerning hearing week four, 10 December 2018

2.6.7 Judge SR Clark, memorandum concerning the timetable for hearing week four, 14 December 2018

(a) Finalised hearing timetable for hearing week four, 14 December 2018

2.6.8 Judge SR Clark, memorandum concerning hearing week four matters, 20 December 2018

(a) Appendix A: Confirmed forthcoming inquiry stage one filing dates, 20 December 2018

2.6.9 Judge SR Clark, memorandum on hearing week 4 transcript and recent Crown extension request, 22 January 2019

2.6.10 Judge SR Clark, memorandum on matters relating to closing submissions, 26 February 2019

2.6.11 Judge SR Clark, memorandum concerning the hearing timetable for closing submissions, 11 March 2019

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(a) Appendix A: Hearing timetable for closing submissions 12, 13 March 2019, 11 March 2019

2.6.12 Judge S R Clark, memorandum concerning the hearing of stage one closing submissions, 18 March 2019

2.6.13 Judge S R Clark, memorandum on stage one closing submissions transcript, 12 April 2019

2.7 Post-hearing stage

No data found

2.8 Other matters

2.8.1 Pre-judicial discussion paper on matters of participation, process and evidential basis for this inquiry, 21 April 2017

3. SUBMISSIONS AND MEMORANDA OF PARTIES

3.1 Pre-hearing represented

3.1.1 B Lyall / L Thornton (Wai 874, Wai 1247, Wai 421, Wai 593, Wai 869, Wai 1383, Wai 1890, Wai 1666), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.2 E Rongo (Rosaria Hotere / Jane Hotere), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.3 E Rongo (Wiremu Bayliss), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.4 E Rongo (Teresa Goza), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.5 E Rongo (Maraea Katene), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.7 R Zwaan (Wai 1758, Wai 1787), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.9 B Gilling / S Dawe (Huhana Hickey, Wai 1341, Wai 1670, Wai 605, Wai 246, Wai 972, Wai 1940, Wai 1843), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 17, 13 March 2017

3.1.10 T Williams / C Linstead-Panoho / C Manga (Wai 1813), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 17, 13 March 2017

3.1.11 G Sharrock (Wai 121, Wai 1450, Wai 2108, Wai 884, Wai 1841, Wai 2179), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.12 M McGhie (Wai 1072), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.13 C Beaumont (Wai 88, Wai 89, Wai 966 and Wai 2257), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.14 D Hall / J Hamel (Wanda Brljevic), memorandum filing statement of claim of Wanda Brljevic; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.15 D Hall / J Hamel (Taipari Munro), memorandum filing statement of claim of Taipari Munro; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.16 A Warren (Wai 1589, Jack Rifle), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.17 A Sykes / J Bartlett (Wai 1835), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.18 K Dixon / A Castle (Wai 2003, Wai 745, Wai 1308), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.19 C Hirschfeld (Wai 87, Wai 861, Wai 914, Wai 1794, Wai 2244, Wai 2306, Wai 1877, Wai 2072, Wai 2006, Wai 1629, Wai 2380), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.20 A Sykes / J Bartlett (Wai 2494), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.21 A Sykes / J Bartlett (Wai 558, Wai 864, Wai 1775, Wai 2510), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.22 D Hall / J Hamel (Rangingana Noke Wade), memorandum filing statement of claim of Rangingana Noke Wade; and in response to memorandum of the, 13 March 2017

3.1.23 D Hall / J Hamel (Kereama Pene), memorandum filing statement of claim of Kereama Pene; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.24 D Hall / J Hamel (Tina Latimer, James Eruera, Ricky Houghton), memorandum filing statement of claim of Tina Latimer, James Eruera, Ricky Houghton; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 29 March 17 (Replacing memorandum filed 14 March 2017), 29 March 2017

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3.1.25 P Walker / K Tarawhiti (Wai 2499), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2) and seeking leave to provide further submissions, 14 March 2017, 14 March 2017

3.1.26 D Hall / J Hamel (John Hooker) memorandum filing statement of claim of John Hooker; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 29 March 17 (Replaces memorandum filed 14 March 2017), 29 March 2017

3.1.27 D Hall / J Hamel (Rangimahuta Easthope) memorandum filing statement of claim of Rangimahuta Easthope; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.28 Wikuki Kingi (Wai 1821), memorandum of Wikuki Kingi notifying a change in claimants for Wai 1821 and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.29 D Hall / J Hamel (Harvey Ruru) memorandum filing statement of claim of Venerable Archdeacon Harvey Ruru; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.30 D Hall / J Hamel (Dennis Emery) memorandum filing statement of claim of Dennis Emery; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.31 D Hall / J Hamel (Mereti Taipana) memorandum filing statement of claim of Mereti Taipana; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.32 T Afeaki / R Jordan / S Tofi (Wai 1536), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.33 D Hall / J Hamel (Ngaio Te Ua) memorandum filing statement of claim of Ngaio Te Ua; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.34 D Hall / J Hamel (Raukawa District Māori Council) memorandum filing statement of claim of the Raukawa District Māori Council; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.35 D Hall / J Hamel (Hamuera Hodge) memorandum filing statement of claim of Hamuera Hodge; and in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.36 J Mason (Cletus Paul, Desma Ratima, Rihari Takuira, Titewhai Harawira, Willie Jackson, John Tamihere, Wai 179, Wai 1541, Wai 1524, Wai 1673, Wai 1681, Wai 1918, Wai 996), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.37 D Stone / B Loader (Rex Timu, Lily Stone, Keri Te Aho, Leanne Te Karu, Wai 1804, Susan McKenna, Wai 2183, Pauline Kopu, Marion Wilkie, Wai 2145, Wai 2051, Wai 1622, Wai 1864), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.38 T Bennion / L Black / E Whiley (Wai 1775, Wai 1261, Wai 507), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.39 S Downs / H Jamieson (Wai 49, Wai 682, Wai 1464, Wai 1546, Wai 1544, Wai 1677), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.41 Eoin Lawless (Wai 433, Wai 2008, Wai 2049, Wai 2066, Wai 2097, Wai 2165, Wai 2002, Wai 1998, Wai 2382, Wai 1968, Wai 1957, Wai 1531), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 17 March 2017, 17 March 2017

3.1.42 D Stone / A Bagsic (Wai 1622, Wai 2051, Wai 2053, Wai 2173), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 21 March 2017, 21 March 2017

3.1.43 C Hockly (Wai 2060), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 21 March 2017, 21 March 2017

3.1.45 P Johnston (Wai 2109), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 8 March 2017, 8 March 2017

3.1.46 G Hewison (David Ratu, Turehou Māori Wardens ki Otara Charitable Trust), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.47 Z Hawke (Hapai Te Hauora), Letter to the Registrar providing a brief background on Hapai te Hauora, the extent to which it wishes to participate in the Inquiry and the evidence it is able to make available, 13 March 2017, 13 March 2017

3.1.48 B Vertongen (Raukawa Settlement Trust), memorandum seeking interested party status for Raukawa Settlement Trust and responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 13 March 2017, 13 March 2017

3.1.49 T Afeaki / R Jordan / S Tofi (Wai 619, Wai 2059, Wai 1479, Wai 774, Wai 1028), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.50 E Loach, memorandum in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

3.1.51 L MacDonald (Wai 2237), Letter to the Registrar in response to Judge SR Clark, memorandum (Wai 2575, #2.5.2), 14 March 2017, 14 March 2017

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- 3.1.52** R Smail (Wai 1315), memorandum confirming claim to be heard as part of this inquiry, 10 April 2017, 10 April 2017
- 3.1.53** A Thomas (Wai 2476), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 11 April 2017, 11 April 2017
- 3.1.54** G Melvin (Crown), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 13 April 2017, 13 April 2017
- 3.1.55** E Rongo (Wai 2425), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.2), 18 April 2017, 18 April 2017
- 3.1.56** J Mason, memorandum in relation to submissions made at the first Judicial Conference, 12 May 2017, 12 May 2017
 (a) Annex A: Excerpt from Te Paparahi o Te Raki, 12 May 2017, 12 May 2017
 (b) Annex B: Key topics, 12 May 2017, 12 May 2017
- 3.1.57** D Stone, memorandum concerning an offer to act as coordinating counsel, 2 June 2017, 2 June 2017
- 3.1.58** G Melvin (Crown), memorandum filing current Māori health strategy documents, 20 June 2017, 20 June 2017
 (a) Index and attachments, 20 June 2017, 20 June 2017
- 3.1.59** C Hirschfeld / T Sinclair / B Tupara (Wai 87, Wai 861, Wai 914, Wai 1794, Wai 2244, Wai 2306, Wai 1877, Wai 2072, Wai 2006, Wai 1629, Wai 2380), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.8) providing bibliography of relevant secondary sources, 3 July 2017, 3 July 2017
- 3.1.60** G Sharrock (Wai 884, Wai 2190), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.8) providing bibliography of relevant secondary sources, 3 July 2017, 3 July 2017
- 3.1.61** G Melvin (Crown), counsel for the Crown, memorandum responding to Judge S R Clark, memorandum (Wai 2575, memo 2.5.8); filing a bibliography of relevant secondary sources, a list of Ministry of Health reports on Māori health outcomes and disparity in outcomes between Māori and non-Māori from 1992 to 2017, and brief of evidence of John Hazeldine, 3 July 2017, 3 July 2017
 (a) Attachment 1 – List of Ministry of Health reports on Māori health outcomes and disparity in outcomes between Māori and non-Māori from 1992 to 2017, 3 July 2017, 3 July 2017
 (b) Bibliography of secondary sources relating to Māori and health, 3 July 2017, 3 July 2017
- 3.1.63** P Walker / K Tarawhiti (Wai 2499), memorandum responding to Judge S R Clark, memorandum (Wai 2575, #2.5.8) and filing bibliography of relevant secondary sources, 3 July 2017, 3 July 2017
 (a) Appendix A: Bibliography of relevant secondary sources, 3 July 2017, 3 July 2017

3.1.65 B Loader (Wai 1622, Wai 1804, Wai 1823, Wai 1834, Wai 2051, Wai 2053, Wai 2145, Wai 2173, Wai 2183, Wai 2624, Wai 2626, Wai 2633, Wai 2635, Wai 2638, Wai 2641, Wai 2642, Wai 2645, Wai 2654), memorandum seeking leave for an extension of time to file, 3 July 2017, 3 July 2017

(a) Appendix A: List of Wai 2575 Health Inquiry claims represented by Te Mata law, 3 July 2017, 3 July 2017

3.1.69 R Smail (Wai 1315), memorandum filing preliminary bibliography of secondary sources, 3 July 2017, 3 July 2017

(a) Appendix – Preliminary bibliography, 3 July 2017, 3 July 2017

3.1.70 B Gilling / S Dawe (Wai 2619, Wai 605), memorandum filing claimant bibliography of secondary sources, 7 July 2017, 7 July 2017

(a) Appendix A: Bibliography of relevant secondary sources, 7 July 2017, 7 July 2017

3.1.71 A Thomas (Wai 2476), memorandum filing claimant bibliography of secondary sources, 10 July 2017, 10 July 2017

(a) Appendix A: Bibliography of relevant secondary sources, 10 July 2017, 10 July 2017

3.1.72 C Beaumont (Wai 88, Wai 89, Wai 966, Wai 2257), memorandum filing claimant bibliography of secondary sources, 10 July 2017, 10 July 2017

(a) Appendix A: Bibliography of relevant secondary sources, 10 July 2017, 10 July 2017

3.1.73 A Sykes / J Bartlett (Wai 558, Wai 864, Wai 2510, Wai 1835, Wai 2494), memorandum filing claimant bibliography of secondary sources, 10 July 2017, 10 July 2017

(a) Appendix A: Bibliography of relevant secondary sources, 10 July 2017, 10 July 2017

3.1.74 B Loader (Wai 1622, Wai 1804, Wai 1823, Wai 1834, Wai 2051, Wai 2053, Wai 2145, Wai 2173, Wai 2183, Wai 2624, Wai 2626, Wai 2633, Wai 2635, Wai 2638, Wai 2641, Wai 2642, Wai 2645, Wai 2654), memorandum filing claimant bibliography of secondary sources, 10 July 17 (Document referred to as 'appendix A' on the record of inquiry as Wai 2575, #3.1.65(a)), 10 July 2017

(a) Appendix B: Bibliography of relevant secondary sources, 10 July 2017, 10 July 2017

3.1.75 D Stone, memorandum concerning round table discussions and the role of co-ordinating counsel, 24 July 2017, 24 July 2017

3.1.76 T Bennion / E Whiley (Wai 52), memorandum seeking eligibility to participate in the Inquiry, 11 August 2017, 11 August 2017

3.1.77 B Gilling / S Dawe (Wai 1312), memorandum seeking eligibility to participate in the Inquiry, 24 August 2017, 24 August 2017

3.1.78 C Tooley (Te Puna Ora o Mataatua), memorandum seeking interested party status, 25 August 2017, 25 August 2017

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3.1.80 G Melvin (Crown), memorandum filing a chronology of the New Zealand Health System 1840 – 2017, in response to Judge SR Clark, memorandum (Wai 2575, #2.5.8), 6 September 2017, 6 September 2017

(a) Chronology of the New Zealand Health System 1840 – 2017, 6 September 2017, 6 September 2017

3.1.81 D Stone / A Bagsic / C Leauga, Joint memorandum providing agreement reached at roundtable discussions, in response to memorandum (Wai 2575, #2.5.8), 6 September 2017, 6 September 2017

(a) Appendix A: List of counsel to the joint memorandum, 6 September 2017, 6 September 2017

(b) Appendix B: Parties present at the roundtable discussions, 6 September 2017, 6 September 2017

3.1.82 D Hall / G Davidson (Wai 2358, Wai 2631, Wai 2630, Wai 2632, Wai 2637, Wai 2639, Wai 2625, Wai 2636), memorandum concerning the health inquiry process and joint memorandum filed 6 September 2017 (Wai 2575, #3.1.81), 6 September 2017, 6 September 2017

3.1.83 G Sharrock (Wai 121, Wai 1450, Wai 2108, Wai 884, Wai 1841, Wai 2179), memorandum concerning early inquiry into Māori suicide, 6 September 2017, 6 September 2017

3.1.84 M McGhie (Wai 1072, Wai 2628), memorandum providing further submissions on the joint memorandum (Wai 2575, #3.1.81), and memorandum of G Sharrock, both filed 6 September 2017 (Wai 2575, #3.1.83), 7 September 2017, 7 September 2017

3.1.85 R Smail / P Walker / B Lyall / C Linkhorn / G Melvin (Wai 1315, Wai 2499, Wai 2655, Wai 421, Wai 874, Wai 1247, Crown), Joint memorandum in addition to the joint memorandum (Wai 2575, #3.1.81), 8 September 2017, 8 September 2017

3.1.86 L Thornton / B Lyall (Wai 1666), memorandum supporting and joining the joint memorandum filed 8 September 2017 (Wai 2575, #3.1.85), 8 September 2017, 8 September 2017

3.1.87 P Johnston / D Hunt (Wai 2109), memorandum in support of joint memorandum filed by Crown counsel on 8 September 2017 (Wai 2575, #3.1.85), 8 September 2017, 8 September 2017

3.1.88 T Bennion / L Black / E Whiley (Wai 1775, Wai 1261, Wai 507), memorandum supporting the joint memorandum filed on 8 September 2017 (Wai 2575, #3.1.85), 12 September 2017, 12 September 2017

3.1.89 D Naden / S Roughton (Wai 2382), memorandum concerning inquiry process, in response to memorandum (Wai 2575, #2.5.10), 12 September 2017, 12 September 2017

- 3.1.91** C Linkhorn / G Melvin / A Lawson (Crown), memorandum responding to memorandum directions dated 12 September 2017 (Wai 2575, #2.5.11), 13 October 2017, 13 October 2017
- (a) Appendix 1: Agreed set of statistics on Māori Health, 13 October 2017, 13 October 2017
- (b) Appendix 2: Background report on the history of the New Zealand health system and Māori health issues from the 1840s to the 1990s, 13 October 2017, 13 October 2017
- 3.1.92** P Walker / K Tarawhiti (Wai 2499), memorandum providing further information on a thematic overview of the health system and its impact on Māori, 24 October 2017, 24 October 2017
- 3.1.93** A Sykes / J Bartlett (Wai 558, Wai 864, Wai 2510, Wai 1835, Wai 2494), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.11) and subsequent submissions filed by the Crown (Wai 2575, #3.1.91) and claimant counsel (Wai 2575, #3.1.92), 24 October 2017, 24 October 2017
- 3.1.94** D Stone / C Leauga (Wai 827, Wai 1622, Wai 1804, Wai 1823, Wai 1864, Wai 2046, Wai 2051, Wai 2053, Wai 2121, Wai 2145, Wai 2176, Wai 2183, Wai 2240, Wai 2599, Wai 2624, Wai 2626, Wai 2627, Wai 2633, Wai 2635, Wai 2638, Wai 2635, Wai 2638, Wai 2641, Wai 2642, Wai 2645, Wai 2654, Wai 2672, Wai 2673, Rama Smith and Areta Koopu, Lynne Russell, and Hokimate Painting), counsel, memorandum supporting memorandum filed by claimant counsel (Wai 2575, #3.1.93), 30 October 2017, 30 October 2017
- (a) Appendix A: List of claimants represented by Te Mata Law, 30 October 2017, 30 October 2017
- 3.1.95** D Watkins (Wai 1259), counsel, memorandum seeking eligibility to participate in the Inquiry, 8 November 2017, 8 November 2017
- 3.1.97** P Andrew / C Link horn / G Melvin / A Lawson / B Lyall (Wai 1315, National Hauora Coalition, Crown, Wai 2655, Wai 421, Wai 874, Wai 1247, Wai 1666), joint memorandum updating the tribunal on discussions about the inquiry process, 15 november 2017, 15 november 2017
- 3.1.98** C Linkhorn / G Melvin / A Lawson (Crown), memorandum updating the Tribunal in respect of proposals for agreed Māori health statistics and historical background report, 15 November 2017, 15 November 2017
- (a) Appendix 1: Revised proposal for the agreed statistics report, 15 November 2017, 15 November 2017
- (b) Appendix 2: Finalised project outline for the independent background report, 15 November 2017, 15 November 2017
- (c) Appendix 3: Finalised proposal for the prime contractor selection process, 15 November 2017, 15 November 2017
- 3.1.99** D Hall / G Davidson (Wai 2646, Wai 2631, Wai 2640, Wai 2636, Wai 2625, Wai 2649, Wai 2630, Wai 2632, Wai 2637, Wai 2639), memorandum supporting the joint memorandum on inquiry process filed 15 November 2017 (Wai 2575, #3.1.97), 15 November 2017, 15 November 2017

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- 3.1.100** D Stone / A Bagsic / C Leauga, Joint memorandum updating the Tribunal on discussions about the inquiry process, 15 November 2017, 15 November 2017
 (a) Appendix A: Counsel in support of the joint memorandum, 15 November 2017, 15 November 2017
 (b) Appendix B: Counsel in attendance at the teleconference held Tuesday 31 October, 15 November 2017, 15 November 2017
 (c) Appendix C: Draft Health Inquiry process framework, 15 November 2017, 15 November 2017
- 3.1.101** P Johnston / D Hunt (Wai 2109), memorandum concerning the joint memoranda filed 15 November 2017 (Wai 2575, #3.1.97 and Wai 2575, #3.1.99) and the Crown memorandum filed 15 November 2017 (Wai 2575, #3.1.98), 17 November 17, 17 November 2017
- 3.1.103** P Walker / K Tarawhiti (Wai 2499), memorandum updating the Tribunal on collective efforts to develop a process for the Inquiry, 24 November 2017, 24 November 2017
- 3.1.104** A Sykes / R Jordan / J Bartlett (Wai 558, Wai 864, Wai 2510, Wai 1835, Wai 2494), memorandum supporting observations in the memorandum filed on 24 November 2017 (Wai 2575, #3.1.103), 5 December 2017, 5 December 2017
- 3.1.105** D Hall / G Davidson (Wai 2646, Wai 2631, Wai 2640, Wai 2636, Wai 2625, Wai 2649, Wai 2630, Wai 2632, Wai 2637, Wai 2639), memorandum updating on the Tribunal on further instructions from the New Zealand Māori Council, 12 December 2017, 12 December 2017
- 3.1.108** P Walker / K Tarawhiti (Wai 2499), memorandum on behalf of Te Ohu Rata o Aotearoa, filing brief of evidence of Dr Rawiri Jansen (Wai 2575, #A2), 22 December 2017, 22 December 2017
- 3.1.109** P Walker / K Tarawhiti (Wai 2499), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.17) concerning next steps in the inquiry, 22 December 2017, 22 December 2017
- 3.1.110** T Te Whenua (Wai 1511), memorandum seeking eligibility to participate in the inquiry, 26 January 2018, 26 January 2018
- 3.1.111** P Andrew / R Smail / P Andrew / C Linkhorn / G Melvin / A Lawson (Wai 1315, Wai 2687, Crown), Joint memorandum concerning the inquiry programme and timetabling, 9 February 2018, 9 February 2018
- 3.1.112** C Linkhorn / G Melvin / A Lawson (Crown), memorandum filing further brief of evidence of John Hazeldine, 10 February 2018, 10 February 2018
- 3.1.113** P Walker (Wai 2499), memorandum concerning next steps in the Inquiry, and participation of Wai 2499 in stage one of the Inquiry, 28 February 2018, 28 February 2018

3.1.114 D Stone / C Leauga (Wai 827, Wai 1622, Wai 1804, Wai 1823, Wai 1959, Wai 2046, Wai 2051, Wai 2053, Wai 2121, Wai 2145, Wai 2183, Wai 2240, Wai 2599, Wai 2624, Wai 2626, Wai 2627, Wai 2633, Wai 2635, Wai 2638, Wai 2641, Wai 2642, Wai 2645, Wai 2654, Wai 2672, Wai 2673, Wai 2683, Wai 2684, Wai 2686, Wai 2689, Wai 2695, Wai 2697, Wai 2701, Wai 2702, Wai 2703, Wai 2704), memorandum responding to the Judge SR Clark, memorandum (Wai 2575, #2.5.17) concerning next steps, 2 March 2018, 2 March 2018

3.1.115 D Naden / S Roughton / N Dhaliwai (Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2005, Wai 2165, Wai 2382), memorandum concerning stage one eligibility and scope matters to be heard in stage one, 2 March 2018, 2 March 2018

3.1.116 J Mason, memorandum requesting inclusion in stage one of the inquiry, 6 March 2018, 6 March 2018

3.1.117 J Mason (Wai 179, Wai 996, Wai 2623), memorandum concerning participation in stage one of the inquiry and the inquiry's staged approach, 7 March 2018, 7 March 2018
(a) Annex A: Supporting documents – Email thread from Sophia Collinson sent on behalf of Janet Mason, 7 March 2018, 7 March 2018

3.1.118 P Johnston (Wai 2109), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.23) concerning participation of parties at the forthcoming judicial conference on stage one inquiry matters to be held at Hamilton, 9 March 2018, 9 March 2018

3.1.119 SM Downs / C Terei / H Jamieson (Wai 682), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) and seeking leave to participate at the forthcoming judicial conference to be held at Hamilton, 12 March 2018, 12 March 2018

3.1.120 TK Williams / C Linstead-Panoho (Wai 1781), memorandum seeking leave to participate in stage one of the inquiry, 12 March 2018, 12 March 2018

3.1.121 C Beaumont (Wai 88, Wai 89, Wai 120, Wai 966, Wai 1837, Wai 2217, Wai 2257), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) and seeking clarification of the scope of the primary care issues to be determined in stage one, 12 March 2018, 12 March 2018

3.1.122 B Gilling / J Lang (Wai 1670, Wai 2619), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) and seeking leave to participate at the forthcoming judicial conference to be held at Hamilton, 12 March 2018, 12 March 2018

3.1.123 C Hirschfeld / T Sinclair / B Tupara (Wai 87, Wai 861, Wai 862, Wai 1732, Wai 2006, Wai 2072, Wai 2244, Wai 2380, Wai 2681, Wai 2682, Wai 2685), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) and seeking leave to participate at the forthcoming judicial conference to be held at Hamilton, 12 March 2018, 12 March 2018

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3.1.124 A Sykes / J Bartlett / R Jordan (Wai 2713), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) and seeking leave to participate at the forthcoming judicial conference to be held at Hamilton, 12 March 2018, 12 March 2018

3.1.125 D Hall / D Kleinsman (Wai 2625, Wai 2630, Wai 2631, Wai 2632, Wai 2636, Wai 2637, Wai 2639, Wai 2640, Wai 2646, Wai 2649), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) and seeking leave to participate at the forthcoming judicial conference to be held at Hamilton, 12 March 2018, 12 March 2018

3.1.126 E Rongo (Wai 2634, Wai 2647, Wai 2650), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) seeking leave to attend the forthcoming judicial conference to be held at Hamilton, 12 March 2018, 12 March 2018

3.1.127 G Sharrock, memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) and seeking leave to participate at the forthcoming judicial conference to be held at Hamilton, 12 March 2018, 12 March 2018

3.1.128 P Andrew / R Smail / E James (Wai 1315, Wai 2687), Joint memorandum concerning the forthcoming judicial conference to be held at Hamilton, 12 March 2018, 12 March 2018

3.1.129 T Afeaki / N Lambert / S Tofi (Wai 619, Wai 1309, Wai 1479, Wai 2059), memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.24) seeking leave to attend the forthcoming judicial conference to be held at Hamilton, and acknowledging the passing of Ross Gregory of Muriwhenua, 13 March 2018, 13 March 2018

3.1.130 SM Downs / C Terei (Wai 682), memorandum concerning the participation of Ngati Hine in stage one of the Inquiry, 15 March 2018, 15 March 2018

3.1.131 J Mason (Wai 2720), memorandum responding to the Judge SR Clark, memorandum (Wai 2575, #2.5.24) concerning eligibility to participate in stage one of the Inquiry, 15 March 2018, 15 March 2018

(a) Appendix A: First affidavit of John Tamihere, 15 March 2018, 15 March 2018

(a) Appendix to affidavit of J Tamihere: memorandum of understanding between the Waitemata District Health Board and Te Whanau o Waipareira Trust, 15 March 2018, 15 March 2018

3.1.132 D Hall / D Kleinsman (Wai 2625, Wai 2630, Wai 2631, Wai 2632, Wai 2636, Wai 2637, Wai 2639, Wai 2640, Wai 2646, Wai 2649), Supplementary submissions of counsel for the New Zealand Māori Council concerning eligibility to participate in stage one of the Inquiry, 15 March 2018, 15 March 2018

3.1.133 C Linkhorn / G Melvin / A Lawson (Crown), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.24) concerning eligibility to participate in stage one of the Inquiry, 14 March 2018, 14 March 2018

- 3.1.134** E Rongo (Wai 2647), memorandum clarifying submissions made at the judicial conference in Hamilton and responding to submissions of counsel for Wai 2687, 16 March 2018, 16 March 2018
- 3.1.135** A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum filing the Affidavit of Kerri Nuku, 22 March 2018, 22 March 2018
- 3.1.141** RN Smail (Wai 1315) / EA James (Wai 2687) / G Melvin (Crown), Joint memorandum of Crown and claimant counsel identifying relevant Tribunal jurisprudence on which they will rely for stage 1, 3 April 2018
- 3.1.142** A Lawson (Crown), memorandum of Crown counsel seeking extension for filing early Crown acknowledgements, 13 April 2018
- 3.1.145** G Sharrock (Wai 1460, Wai 884, Wai 1941, Wai 2108, Wai 2179), memorandum concerning participation in stage one of the Health Services and Outcomes Kaupapa Inquiry, 19 April 2018
- 3.1.146** A Sykes / J Bartlett (Wai 558, 864, 2510, 1835, 2494, 2713), memorandum filing the affidavit of Rebekah Jordan, 20 April 2018
- 3.1.149** TK Williams / C Linstead-Panoho, memorandum on behalf of Sharon Campbell concerning participation into stage one of the inquiry, 27 April 2018
- 3.1.150** TK Williams / C Linstead-Panoho (Wai 1813), memorandum concerning participation into stage one of the inquiry, 27 April 2018
- 3.1.151** C Hirschfeld / T Sinclair / B Tupara (Wai 2685, Wai 2681, Wai 1732, Wai 2006, Wai 2682, Wai 2380, Wai 2072, Wai 2217, Wai 1629, Wai 2244, Wai 862, Wai 861, Wai 87, Wai 1794) memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.25) concerning participation at the forthcoming Judicial Conference, 27 April 2018
- 3.1.152** D Hall / D Kleinsman (Wai 2646, Wai 2631, Wai 2640, Wai 2636, Wai 2625, Wai 2649, Wai 2630, Wai 2632, Wai 2637, Wai 2639) memorandum responding to Judge SR Clark, memorandum (referenced as Wai 2575, #2.5.25) concerning feedback on the outcomes of the National Health Hui and the identification of priorities for Stage Two of the inquiry, 27 April 2018
- (a) Appendix A: Resolutions for national hui on Māori Health Issues held on 6–8 April 2018, 27 April 2018
- (b) Appendix B: List of abstentions, 27 April 2018
- 3.1.153** A Sykes / R Jordan / J Bartlett (Wai 558, Wai 864, Wai 2510, Wai 1835, Wai 2494, Wai 2713), memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.25) concerning participation at the forthcoming Judicial Conference, 1 May 2018
- 3.1.154** T Afeaki / N Lambert / S Tofi / J Lewis (Wai 619, Wai 1309, Wai 1479, Wai 2059) memorandum responding to Judge SR Clark, memorandum (Wai 2575, #2.5.25) concerning participation at the forthcoming judicial conference, 1 May 2018

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3.1.155 G Melvin / A Lawson (Crown), memorandum with Crown early acknowledgements for stage one of the inquiry, 1 May 2018

3.1.157 S Roughton / N Dhaliwal (Wai 1196, Wai 1957, Wai 2005, Wai 1531, Wai 2063, Wai 2165, Wai 2382) memorandum responding to Judge S R Clark, memorandum (referenced as Wai 2575, #2.5.25) concerning participation in the forthcoming judicial conference, 2 May 2018

3.1.158 S Roughton / N Dhaliwal (Wai 1196, Wai 1957, Wai 2005, Wai 1531, Wai 2063, Wai 2165, Wai 2382) memorandum responding to Judge S R Clark, memorandum (referenced as Wai 2575, #2.5.25) concerning participation in the forthcoming judicial conference, 2 May 2018

3.1.159 D Hall (Wai 2646, Wai 2631, Wai 2640, Wai 2636, Wai 2625, Wai 2649, Wai 2630, Wai 2632, Wai 2637, Wai 2639) (New Zealand Māori Council) memorandum circulating PowerPoint presentations from National Health Hui held on 7th April 2018, 2 May 2018

(a) Appendix A: Presentation of Dr David Tipene-Leach, 2 May 2018

(b) Appendix B: Presentation of Dr Joanne Baxter, 2 May 2018

(c) Appendix C: Presentation of Simon Royal, 2 May 2018

(d) Appendix D: Presentation of Erena Wikaire, 2 May 2018

(e) Appendix E: Presentation of Teresa Wall, 2 May 2018

3.1.160 G Melvin (Crown) / A Lawson (Crown) / R Smail (Wai 1315) / E James (Wai 2687), Joint memorandum for Wai 1315, Wai 2687, and the Crown filing statistics for stage one of the inquiry, 7 May 2018

3.1.161 R Park / D Watkins, memorandum filing a statement of claim, 24 April 2018

3.1.167 C Linkhorn / G Melvin / A Lawson (Crown), memorandum updating the Tribunal on Crown-commissioned research, 18 May 2018

(a) Appendix A: Māori Health Trends 1990–2015, 18 May 2018

3.1.175 G Melvin / A Lawson (Crown), memorandum filing statement of issues and statement of facts, 25 May 2018

(a) Schedule 1: Statement of facts, 25 May 2018

(b) Schedule 2: Proposed statement of issues, 25 May 2018

3.1.176 G Melvin (Crown), memorandum updating the Tribunal and claimants on the government's health care review, 29 May 2018

(a) Appendix A: Draft terms of reference for the Review of New Zealand Health and Disability Sector, 29 May 2018

3.1.177 R Smail / E James (Wai 1315, Wai 2687), joint memorandum for Wai 1315 and Wai 2687 concerning agreed statement issues, 18 May 2018

(a) Appendix A: Wai 2687, Wai 1315 – Joint Statement of Issues, 18 May 2018

3.1.178 R Smail / K Feint / E A James (Wai 1315, Wai 2687), joint memorandum for Wai 1315 and Wai 2687 responding to Crown statement of facts and issues (referenced as Wai 2575, #3.1.175), 1 June 2018

3.1.182 T Afeaki / N Lambert / S Tofi (Wai 619, Wai 1309, Wai 1455, Wai 1479, Wai 2059), memorandum in reply to joint memorandum filed by Te Mata Law (referenced as Wai 2575, #3.1.100), 25 June 2018

3.1.183 P Walker (Wai 2499), memorandum filing an overview of proposed research and priority issues for Stage Two of the inquiry, 25 June 2018

(a) Appendix A: Proposed approach to Stage Two of Wai 2575 Inquiry, 25 June 2018

3.1.185 D Naden (Wai 433, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2005, Wai 2165, Wai 2382, Wai 2671, Wai 2729), memorandum providing further submissions, 25 June 2018

3.1.186 G Sharrock (Wai 121, Wai 884, Wai 1460, Wai 1941, Wai 2108, Wai 2179), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 26 June 2018

3.1.188 A Sykes / R Jordan / J Bartlett (Wai 558, Wai 864, Wai 2510, Wai 1835, Wai 2494, Wai 2713), memorandum clarifying the nature of the concerns around the scope of the Crown historical overview report, 26 June 2018

3.1.189 P Walker (Wai 2499), memorandum seeking leave to participate as an interested party for stage one, 26 June 2018

3.1.190 C Terei / H Jamieson (Wai 682), memorandum seeking leave to participate as an interested party for stage one of the inquiry, 26 June 2018

3.1.191 D Hall (New Zealand Māori Council), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 26 June 2018

3.1.192 J Mason (Wai 2623, Wai 996, 179), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.193 J Mason (Wai 2720), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.194 B Gilling / S Dysart (Wai 2679, Wai 1670), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.195 B Lyall (Wai 2655), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.196 D Stone (Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2683, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 2228, Wai 827, Wai 2654,

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Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, Wai 1823), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.197 D Stone (Wai 2702), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.198 D Stone (Wai 2719), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.199 D Stone (Wai 2723), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.200 P Johnston / D Hunt (Wai 2109), memorandum advising that Ngati Kapo claimants do not seek leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.201 T Afeaki / N Lambert / S Tofi (Wai 619, Wai 1309, Wai 1455, Wai 1479, Wai 2059) memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.202 D Naden / N Dhaliwal (Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2165, Wai 2382), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.203 R Park / D Watkins (Wai 2727), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.204 E Rongo (Wai 2634, Wai 2643, Wai 2647, Wai 2650, Wai 2688), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.205 K Dixon / A Castle (Wai 2003), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.206 R Zwaan (Wai 144, Wai 375, Wai 1758, Wai 1787), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.207 T Bennion / E Whiley (Wai 507, Wai 52), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.208 C Hirschfeld / T Sinclair / B Tupara (Wai 2685, Wai 2681, Wai 1732, Wai 2006, Wai 2682, Wai 2380, Wai 2072), memorandum seeking leave to participate as an interested party in stage one of the inquiry, 27 June 2018

3.1.209 A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum seeking leave to participate as an interested party in stage one of the inquiry (also referenced as Wai 2713, #3.1.2), 7 June 2018

- 3.1.210** G Melvin (Crown), memorandum filing a statement of response to stage one statement of issues, 2 July 2018
- 3.1.211** G Melvin (Crown), memorandum responding to applications for interested party status in stage one of the inquiry, 3 July 2018
- 3.1.212** R Smail (Wai 1315), memorandum concerning interested parties and evidence, 3 July 2018
- 3.1.214** K Feint (Wai 2687, National Hauora Coalition), memorandum in response to interested party applications, 4 July 2018
- 3.1.215** A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum responding to memoranda filed by Crown and stage one claimants concerning interested party participation, 4 July 2018
- 3.1.216** P Walker (Wai 2499), memorandum responding to memoranda filed by Crown and stage one claimants concerning interested party participation, 4 July 2018
- 3.1.217** K Feint (Wai 2687), memorandum responding to memoranda filed by P Walker on 5 July (referenced as Wai 2575, #3.1.215) concerning interested party participation in stage one, 5 July 2018
- 3.1.218** J Mason (Wai 2720, Wai 2623, Wai 996, Wai 179), memorandum responding to memoranda filed by Crown and stage one claimants concerning interested party participation, 5 July 2018
- 3.1.219** D Naden, memorandum filing fifth amended statement of claim for Wai 762, 27 June 2018
- 3.1.220** D Naden / N Dhaliwal (Wai 433, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2005, Wai 2165, Wai 2382, Wai 2671, Wai 2729), memorandum providing further submissions concerning Crown statistical data, 20 July 2018
- 3.1.221** C Linkhorn / G Melvin / A Lawson (Crown), memorandum concerning Crown-commissioned background historical report, 20 July 2018
- 3.1.222** B Lyall (Wai 2655), memorandum withdrawing request for participation in stage one of the inquiry, 24 July 2018
- 3.1.223** A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum seeking to file evidence, 26 July 2018
- 3.1.224** R Park (Wai 2727), memorandum seeking leave to cross-examine technical and Crown witnesses on evidence relating to matters relevant to the claim, 27 July 2018

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3.1.225 C Hirschfeld / T Sinclair / B Tupara (Wai 1732), memorandum seeking leave to participate as an interested party for the purpose of cross-examination and presentation of submissions, 27 July 2018

3.1.226 J Mason (Wai 2720), memorandum seeking leave to file evidence and submissions, 27 July 2018

3.1.227 D Naden / N Dhaliwal (Wai 762, Wai 1196, Wai 1531, Wai 1957, Wai 2063, Wai 2165, Wai 2382), memorandum seeking leave to cross-examine, present submissions and file written briefs of evidence, 27 July 2018

3.1.228 T K Williams / C Linstead-Panoho (Wai 1813), memorandum seeking participation in stage one by way of a watching brief only, 27 July 2018

3.1.229 J Mason (Wai 2623), memorandum seeking leave to file evidence and submissions, 27 July 2018

3.1.230 T Bennion / E Whiley (Wai 507, 52), memorandum seeking leave to file evidence and brief legal submissions on the election and appointment process under s 29 of the New Zealand Public Health and Disability Act 2000, 27 July 2018

3.1.231 J Mason (Wai 179, 996), memorandum seeking leave to file submissions, 27 July 2018

3.1.232 D Stone / C Leauga (Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2683, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, Wai 1823), memorandum seeking leave to file a joint brief of evidence, 27 July 2018

3.1.234 D Stone / G Hewison (Wai 2702), memorandum seeking leave to file a brief of evidence, 27 July 2018

3.1.235 A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum seeking leave to file evidence and submissions to be heard viva voce with those witnesses available for cross-examination, 27 July 2018

3.1.236 P Walker (Wai 2499), memorandum seeking leave to cross-examine witnesses and file evidence and submissions, 27 July 2018

3.1.238 K Dixon / A Castle (Wai 2003), memorandum seeking participation into stage one by way of a watching brief only, 27 July 2018

3.1.239 D Hall, (New Zealand Māori Council), memorandum seeking leave to file evidence, 28 July 2018

- 3.1.240** E Rongo (Wai 2634, Wai 2643, Wai 2647, Wai 2650, Wai 2688), memorandum seeking participation in stage one by way of a watching brief only, 30 July 2018
- 3.1.241** R Zwaan (Wai 144, 375, 1758, Wai 1787), memorandum seeking participation into stage one by way of a watching brief only, 30 July 2018
- 3.1.242** M Mahuika (Wai 2499), memorandum seeking reconsideration of the Tribunal's approach for Stage Two of the inquiry, 10 August 2018
(a) Appendix A: Select chronology of relevant procedural history of the inquiry, 10 August 2018
- 3.1.243** G Melvin (Crown), memorandum updating the Tribunal and claimants on the government's health and disability system review, 15 August 2018
(a) Appendix A: Review of New Zealand Health and Disability System, 15 August 2018
- 3.1.244** SM Downs / J Lang (Wai 682), memorandum seeking urgent clarification as to whether Ngati Hine's claims directly relate to the statement of issues in stage one of the inquiry, 17 August 2018
- 3.1.245** SM Downs / J Lang (Wai 682), memorandum seeking clarification from the Tribunal concerning Ngati Hine claims, 17 August 2018
- 3.1.246** A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum in support of the memorandum filed on behalf of Te Ohu Rata o Aotearoa dated 10 August 2018, 28 August 2018
- 3.1.247** G Melvin (Crown), memorandum seeking brief extension to file briefs of evidence for stage one, 5 September 2018
- 3.1.248** G Melvin / A Lawson / R Smail / K Feint / E James, joint memorandum for Wai 1315, Wai 2687, and the Crown filing final statistics for stage one of the inquiry, 6 September 2018, 6 September 2018
- 3.1.249** G Melvin (Crown), memorandum filing evidence for stage one of the inquiry, 7 September 2018
- 3.1.251** E Rongo (Wai 2674), memorandum seeking leave to cross examine witnesses, 14 September 2018
- 3.1.252** A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum seeking further particularisation of the hearing programme, 14 September 2018
- 3.1.253** T Bennion / E Whiley (Wai 507, Wai 52), memorandum seeking leave to cross examine witnesses, 15 September 2018
- 3.1.255** D Naden / N Dhaliwal / K Deobhakta (Wai 1196, Wai 1957, Wai 2165, Wai 762, Wai 1531, Wai 2063, Wai 2382), 19 September 2018

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3.1.256 B Gilling / S Dysart (Wai 2619), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.257 R Park (Wai 2727), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.258 D Stone / C Leauga (Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2638, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 2228, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, Wai 1823), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.259 D Stone / G Hewison (Wai 2702), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.260 M Mahuika / L Underhill-Sem / T Hauraki (Wai 2499), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.261 J Mason (Wai 2720, Wai 2704, Wai 2623, Wai 1384, Wai 996, Wai 179), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.262 G Melvin (Crown), memorandum providing the Crown's indicative cross-examination timing for witnesses and filing an updated statement of response to the Tribunal's stage one statement of issues, 19 September 2018

3.1.263 K Feint (Wai 2687), memorandum providing cross-examination timing indications, 19 September 2018

3.1.266 A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum seeking leave to cross-examine witnesses, 19 September 2018

3.1.267 D Naden / N Dhaliwal (Wai 1196, Wai 1957, Wai 2165, Wai 762, Wai 1531, Wai 2063, Wai 2382), memorandum advising Tribunal of proposed expert witness travel and attendance at stage one hearing, 20 September 2018

3.1.268 R Smail (Wai 1315), memorandum providing cross-examination timing indications, 20 September 2018

3.1.269 G Sharrock (Wai 884, Wai 1460, Wai 1941, Wai 2179), memorandum seeking leave to cross-examine witnesses, 20 September 2018

3.1.270 G Melvin / R Smail / K Feint (Crown, Wai 1315, Wai 2687), Joint memorandum updating the Tribunal about the hearing timetable for stage one of the Inquiry, 27 September 2018

3.1.271 M Mahuika / L Underhill-Sem / T Hauraki (Wai 2499), memorandum on behalf of Te Ohu Rata o Aotearoa responding to the joint memorandum filed on 27 September 2018 (referenced as Wai 2575, #3.1.270), 28 September 2018

3.1.274 G Melvin (Crown), memorandum concerning the evidence of Professor Jacqueline Cumming, 5 October 2018

3.1.275 D Stone / G Hewison (Wai 2702), memorandum requesting the evidence of Patricia Tuhimata be taken as read, 5 October 2018

3.1.277 R Smail / K Feint / G Melvin (Wai 1315, Wai 2687, Crown), joint memorandum for Wai 1315, Wai 2687, and the Crown filing a draft hearing timetable, 5 October 2018, 5 October 2018

(a) Appendix A: Draft hearing timetable for weeks 1–3, 5 October 2018, 5 October 2018

3.1.278 S-M Downs / J Lang (Wai 682), memorandum seeking leave to attend the stage one hearings as an interested party, 8 October 2018, 8 October 2018

3.1.279 G Sharrock, memorandum requesting the inclusion of documents on the record of inquiry, 5 October 2018, 5 October 2018

3.1.281 T Bennion / E Whiley (Wai 507), memorandum requesting the evidence of Owen Lloyd be taken as read, 9 October 2018, 9 October 2018

3.1.282 R Smail (Wai 1315), Amended hearing week one timetable, 11 October 2018

3.1.283 G Sharrock, (Wai 884, Wai 1460, Wai 1941, Wai 2179), memorandum seeking leave to file documents and to attend hearing week one as an interested party, 11 October 2018

3.1.286 D Hall (New Zealand Māori Council), memorandum concerning order of appearances for stage one hearings, 11 October 2018

3.2.27 R Smail (Wai 1315), memorandum providing answers to written questions by Dr Katherine Gottlieb, 13 December 2018, 13 December 2018

(a) Vacated, 14 December 2018

(a) Vacated, 14 December 2018

3.2.94 G Melvin / A Lawson (Crown), memorandum providing final information in response to information requests of Crown witnesses, 29 March 2019

3.2.95 C Linkhorn / G Melvin (Crown), memorandum filing funding information requested by the Tribunal, 29 March 2019

3.2 Hearing stage

3.2.1 M Mahuika / L Underhill-Sem / T Hauraki (Wai 2499), memorandum concerning appearances for stage one of the inquiry, 15 October 2018, 15 October 2018

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3.2.2 S McKechnie (Counties Manukau District Health Board), memorandum concerning the brief of evidence of Patricia Tuhimata (referenced as Wai 2575, #A48), 17 October 2018, 17 October 2018

3.2.3 A Lawson (Crown), Timetable for weeks 2–4 of the inquiry, 18 October 2018, 18 October 2018

3.2.4 A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum concerning the Legal Aid Services' decision on funding interested parties at hearing week one, 18 October 2018, 18 October 2018

3.2.5 A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum concerning the availability of witnesses to attend hearing week two, 18 October 2018, 18 October 2018

3.2.6 J Mason (Wai 2720, Wai 2704, Wai 2623, Wai 1384, Wai 996, Wai 179), memorandum in support of memorandum by A Sykes, R Jordan and J Bartlett (referenced as Wai 2575, #3.2.4), 18 October 2018, 18 October 2018

3.2.7 A Lawson (Crown), Finalised timetable for hearing weeks 2–4 of the inquiry, 19 October 2018, 19 October 2018

3.2.8 T Bennion / E Whiley (Wai 507, Wai 52), memorandum seeking leave to question witnesses during hearing week 3, 24 October 2018, 24 October 2018

3.2.9 R Smail (Wai 1315), memorandum providing background information on Nuka system of care (relating documents filed separately as Wai 2575, #A71, #A71(a)), 25 October 2018, 25 October 2018

3.2.10 T Bennion / E Whiley (Wai 507, Wai 52), memorandum concerning the cross-examination of Frances McGrath, 1 November 2018, 1 November 2018

3.2.11 G Melvin (Crown), memorandum updating the Tribunal on the process of the information requested of Dr Bloomfield during cross-examination, 31 October 2018

3.2.12 K Feint / E James / R Smail / G Melvin (Wai 2678, Wai 1315, Crown), Joint memorandum seeking leave to file supplementary evidence, 2 November 2018

3.2.13 G Melvin (Crown), Memorandum of counsel for the Crown on written questions for stage one, 15 November 2018

3.2.14 A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum filing written questions, 15 November 2018

(a) Appendix A: Written questions for Simon Royal, 15 November 2018

(b) Appendix B: Written questions for Dr Katherine Gottlieb, 15 November 2018

3.2.15 G Melvin / R Smail / K Feint (Crown, Wai 1315, WaiWai 2687), Joint memorandum identifying documents from the stage one common bundle not on the Record of Inquiry, 22 November 2018

(a) Appendix A: Common bundle index, 22 November 2018

3.2.17 T Maipi (Wai 1315), memorandum of claimant concerning counsel representation, 28 November 2018

3.2.18 R Smail (Wai 1315), memorandum seeking leave to file evidence, 30 November 2018

(a) Appendix A: Index and annexures of documents provided by John Tamihere, 30 November 2018

3.2.19 G Melvin (Crown), memorandum responding to information requests of Crown witnesses and update on government inquiry into mental health and addiction, 4 December 2018

(a) Appendix A: Index and annexures to Crown memorandum, 4 December 2018

3.2.20 A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum seeking leave to cross-examine Lisa Davies, 5 December 2018

3.2.21 B Gilling / S Dysart (Wai 2619), memorandum seeking leave to file questions in writing, 5 December 2018

3.2.22 D Stone / C Leauga (Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2683, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 2228, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, Wai 1823), memorandum seeking leave to cross-examine Lisa Davies, 5 December 2018

3.2.23 M Mahuika / L Underhill-Sem / T Hauraki (Wai 2499), memorandum seeking leave to cross-examine witnesses, 5 December 2018

3.2.24 D Naden / N Dhaliwal (Wai 1196, Wai 1957, Wai 2165, Wai 762, Wai 1531, Wai 2063, Wai 2382), memorandum seeking leave to cross-examine Lisa Davies, 5 December 2018

3.2.25 T Bennion / E Whiley (Wai 507), memorandum seeking leave to cross-examine Lisa Davies, 6 December 2018

3.2.26 K Feint / E James (Wai 2687), memorandum seeking leave to cross examine Tureiti Lady Moxon, 13 December 2018, 13 December 2018

(a) Vacated, 13 December 2018

3.2.28 R Smail (Wai 1315), Proposed hearing week 4 timetable, 14 December 2018, 14 December 2018

3.2.29 R Smail (Wai 1315), memorandum concerning representation of Taitimu Maipi and Hakopa Paul, 14 December 2018, 14 December 2018

(a) Appendix A: Email from Joyce Maipi concerning legal representation dated 27 November 2018, 14 December 2018, 14 December 2018

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(b) Appendix B: Email and letter attachment from Roimata Smail to the Wai 1315 claimants dated 27 November 2018, 14 December 2018, 14 December 2018

(c) Appendix C: Email from Joyce Maipi to Tureiti Lady Moxon concerning legal representation dated 28 November 2018, 14 December 2018, 14 December 2018

3.2.30 A Sykes / R Jordan / J Bartlett (Wai 2713), memorandum filing documents to assist with the cross-examination of Professor Jacqueline Cumming, 14 December 2018, 14 December 2018

(a) Appendix A: Bundle of documents for cross-examination of Professor Jacqueline Cumming, 14 December 2018, 14 December 2018

3.2.38 K Feint / E James (Wai 2687), memorandum providing answers to the written questions, 17 December 2018, 17 December 2018

3.2.39 J Ferguson (Wai 1315), memorandum concerning the representation of Taitimu Maipi and Hakopa Paul, 17 December 2018, 17 December 2018

3.2.42 G Melvin (Crown), memorandum filing corrections to weeks one, two and three of the stage one transcript, 14 January 2019

3.2.46 G Melvin (Crown), memorandum filing final scoping report for the Wai 2575 background historical research report, 28 January 2019

(a) Appendix A: Wai 2575 background history report November 20, 2018, 29 January 2019

3.2.47 B Gilling / S Dysart (Wai 1670, Wai 1619), memorandum concerning stage one closing submissions, 31 January 2019

3.2.48 G Melvin (Crown), memorandum relating to the expected filing date of the historical background report, 13 February 19, 13 February 2019

3.2.49 T K Williams / C Linstead-Panoho / T Ngawhika (Wai 1813), memorandum withdrawing request to file closing submissions for stage one, 15 February 2019

3.2.57 K Feint (Wai 2687), memorandum filing recommendations sought by the Wai 2687 claimants (National Hauora Coalition) in stage one of the inquiry, 18 February 2019

(a) Appendix A: Recommendations sought by the Wai 2687 claimants (National Hauora Coalition), 18 February 2019

3.2.58 K Feint / J Ferguson / M Mahuika / A Sykes / R Jordan (Wai 2687, Wai 1315, Wai 2499, Wai 2713), Joint memorandum requesting an urgent judicial conference, 18 February 2019

3.3 Opening, closing, and in reply

3.3.1 T Afeaki / M Tuwhare / S Tofi (Wai 2738), opening submissions on behalf of Kahurangi Fergusson-Tibble, 9 October 2018, 9 October 2018

3.3.2 G Melvin (Crown), opening submissions of the Crown, 10 October 2018

(a) Appendix A: Powerpoint presentations accompanying opening submissions for the Crown, 26 October 2018 (filed by A Lawson), 26 October 2018)

3.3.3 R Smail (Wai 1315), opening submissions on behalf of Wai 1315, 10 October 2018

3.3.4 Appendix A: Structure of the primary health care system, 10 October 2018

(b) Appendix B: Table of claim issues relating to legislative and policy framework, 10 October 2018

(c) Appendix C: Powerpoint presentation accompanying opening submissions for Wai 2687, 18 October 2018, 18 October 2018

3.3.5 D Naden / N Dhaliwal (Wai 1196, Wai 1957, Wai 2165, Wai 762, Wai 1531, Wai 2063, Wai 2382), opening submissions on behalf of interested parties, 11 October 2018

3.3.6 M Mahuika / L Underhill-Sem / T Hauraki (Wai 2499), opening submissions on behalf of Wai 2499, 11 October 2018

3.3.7 D Stone / G Hewison (Wai 2702), opening submissions on behalf of Wai 2702, 11 October 2018

(a) Appendix A: References from the New Zealand Public Health and Disability Act 2000, 11 October 2018

3.3.8 D Stone / C Leauga (Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2683, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2642, Wai 1823), opening submissions on behalf of interested parties, 11 October 2018

3.3.9 A Sykes / R Jordan / J Bartlett (Wai 2713), opening submissions on behalf of Wai 2713, 11 October 2018

(a) Powerpoint presentations accompanying opening submissions for Wai 2713, 25 October 2018, 25 October 2018

3.3.10 T Bennion / E Whiley (Wai 507), opening submissions on behalf of Wai 507, 11 October 2018

3.3.11 D Hall (New Zealand Māori Council) opening submissions on behalf of the New Zealand Māori Council, 11 October 2018

3.3.12 D Naden / N Dhaliwal (Wai 762, Wai 1531, Wai 2063, Wai 1957, Wai 1196, Wai 2165), stage one closing submissions for interested parties, 18 February 2019

3.3.13 D Naden / N Dhaliwal (Wai 762, Wai 1531, Wai 2063, Wai 1957, Wai 1196, Wai 2165), stage one closing submissions for Wai 2382, 18 February 2019

3.3.14 Vacated, 18 February 2019

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(a) T Bennion / E Whiley (Wai 507), stage one closing submissions for Wai 507, 20 February 2019

3.3.15 D Stone / G Hewison (Wai 2702), stage one closing submissions for Wai 2702, 18 February 2019

(a) Appendix A: Statutory Provisions of the New Zealand Public Health and Disability Act 2000, 18 February 2019

3.3.16 D Stone (Wai 2053, Wai 2173, Wai 2046, Wai 2051, Wai 2684, Wai 2599, Wai 2723, Wai 2641, Wai 1622, Wai 2633, Wai 2697, Wai 2626, Wai 2695, Wai 2686, Wai 2635, Wai 2645, Wai 2683, Wai 2689, Wai 2672, Wai 2725, Wai 2703, Wai 2714, Wai 1959, Wai 2673, Wai 2719, Wai 2683, Wai 2240, Wai 2627, Wai 2701, Wai 2624, Wai 2702, Wai 2228, Wai 827, Wai 2654, Wai 2145, Wai 2121, Wai 1804, Wai 2183, Wai 2642, Wai 1823) stage one closing submissions for interested parties, 18 February 2019

3.3.17 C Hirschfeld / B Tupara (Wai 1732), stage one closing submissions for Wai 1732, 18 February 2019

3.3.18 R Smail (Wai 1315), stage one closing submissions for Wai 1315, 18 February 2019

(a) Appendix A: Statement of issues, 18 February 2019

(b) Appendix B: Summary of relevant statistics, 18 February 2019

3.3.19 M Mahuika / L Underhill-Sem / T Hauraki (Wai 2499), stage one closing submissions for Wai 2499, 18 February 2019

3.3.20 A Sykes / R Jordan / J Bartlett (Wai 2713), stage one closing submissions for Wai 2713, 19 February 2019

(a) Appendix A: Index and appendices to the Wai 2713 stage one closing submissions, 19 February 2019

(b) Appendix B: Synopsis of closing submissions, 12 March 2019

3.3.22 M Mahuika / L Underhill-Sem / T Hauraki (Wai 2499), stage one closing submissions for Wai 2499, 20 February 2019

(a) Appendix A: Crown witness concessions during cross-examination, 20 February 2019

3.3.23 J Ferguson (Wai 1315), stage one closing submissions for Wai 1315, 20 February 2019

(a) Appendix A: Appendices to Wai 1315 stage one closing submissions, 20 February 2019

3.3.24 Vacated, 20 February 2019

3.3.25 J Mason (Wai 1040, Wai 179), stage one closing submissions for Wai 1040 and Wai 179, 21 February 2019

3.3.26 J Mason (Wai 996), stage one closing submissions for Wai 1040 and Wai 179, 21 February 2019

3.3.27 J Mason (Wai 2720), stage one closing submissions for Wai 2720, 21 February 2019

(a) Appendix A: Index and appendices to the Wai 2720 stage one closing submissions, 21 February 2019

3.3.28 Vacated, 21 February 2019

(a) Vacated, 21 February 2019

3.3.29 T Afeaki / M Tuwhare / S Tofi (Wai 2738), stage one closing submissions for Wai 2738, 21 February 2019

3.3.30 K Feint / E James (Wai 2687), stage one closing submissions for the National Hauora Coalition, 25 February 2019

(a) Appendix A: Structure of the primary healthcare system, 25 February 2019

(b) Appendix B: Extracts from the Mental Health Inquiry Report, 25 February 2019

(c) Appendix C: Wai 2687 response to questions on Hauora Authority, 13 March 2019

(d) Appendix D: PowerPoint presentation accompanying closing submissions of Wai 2687, 26 March 2019

3.3.31 J Mason (Wai 2623), stage one closing submissions for Wai 2623, 21 February 2019

(a) Appendix A: Index and appendices to the Wai 2623 closing submissions, 25 February 2019

3.3.32 G Melvin (Crown), stage one closing submissions for the Crown, 8 March 2019, 8 March 2019

(a) Appendix A: Crown response to recommendations sought by claimants, 8 March 2019, 8 March 2019

3.3.33 R Smail (Wai 1315), Reply submissions for Wai 1315, 20 March 2019

(a) Appendix A: Table of instances in the Crown's closing submissions where a document is preferred over a practical solution, 20 March 2019

3.3.34 M Mahuika / L Underhill-Sem / T Hauraki (Wai 1315), Reply submissions for Wai 1315, 21 March 2019

3.3.35 K Feint (Wai 2687), Reply submissions for Wai 2687, 21 March 2019

(a) Appendix A: Submissions in response to appendix A of the Crown's closing submissions, 21 March 2019

4. TRANSCRIPTS AND TRANSLATIONS

4.1 Transcripts

4.1.1 Transcript of the first judicial conference, 19 May 2017, 19 May 2017

4.1.2 Transcript of judicial conference held at the Hamilton Māori Land Court on Thursday 15 March 2018, 26 April 2018

4.1.3 Transcript of judicial conference held at the Waitangi Tribunal in Wellington on Mon 11 June 2018, 9 July 2018

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4.1.4 Transcript of hearing week 1 held at Turangawaewae Marae on Monday 15 October 2018 – Friday 19 October 2018, 26 November 2018, 29 November 2018

- (a) Appendix A: Corrections to draft hearing week one transcript, 11 February 2019
- (b) Appendix B: Corrections to draft hearing week one transcript, 11 February 2019
- (c) Appendix C: Corrections to draft hearing week one transcript, 11 February 2019
- (d) Appendix D: Corrections to draft hearing week three transcript, 11 February 2019

4.1.5 Transcript of hearing week two held at Turangawaewae Marae on Tuesday 22 October 2018 – Friday 26 October 2018, 5 December 2018

- (a) Appendix A: Corrections to draft hearing week two transcript, 11 February 2019
- (b) Appendix B: Corrections to draft hearing week two transcript, 11 February 2019
- (c) Appendix D: Corrections to draft hearing week two transcript, 11 February 2019
- (d) Appendix D: Corrections to draft hearing week three transcript, 11 February 2019

4.1.6 Transcript of hearing week three held at Turangawaewae Marae on Thursday 1st November – Friday 2nd November 2018, 5 December 2018

- (a) Appendix A: Corrections to draft hearing week three transcript, 11 February 2019
- (b) Appendix B: Corrections to draft hearing week three transcript, 11 February 2019
- (c) Appendix C: Corrections to draft hearing week three transcript, 11 February 2019
- (d) Appendix D: Corrections to draft hearing week three transcript, 11 February 2019

4.1.7 Transcript of hearing week 4 held at the Waitangi Tribunal on Monday 17th – Tuesday 18th December 2018, 11 February 2019

- (a) Appendix A: Corrections to draft hearing week four transcript (filed by D Stone, C Leauga, K Davis), 26 February 2019))
- (b) Appendix B: Corrections to draft hearing week four transcript (filed by Crown counsel), 26 February 2019))
- (c) Appendix C: Corrections to draft hearing week four transcript (filed by A Sykes, R Jordan, J Bartlett), 26 February 2019))

4.1.8 Transcript of stage one closing submissions held at the Waitangi Tribunal on Tuesday 12th and Wednesday 13th March 2019, 12 April 2019

- (a) Appendix A: Corrections to Draft stage one closing submissions transcript (filed by D Naden / S Smith), 18 April 2019))
- (b) Appendix B: Corrections to Draft stage one closing submissions transcript, 10 May 2019
- (c) Appendix C: Corrections to Draft stage one closing submissions transcript, 10 May 2019
- (d) Appendix D: Corrections to Draft stage one closing submissions transcript, 10 May 2019
- (e) Appendix E: Corrections to Draft stage one closing submissions transcript, 10 May 2019

5. PUBLIC NOTICES

No data found.

6. OTHER PAPERS IN PROCEEDINGS**6.1 Filed by the Parties**

6.1.1 C Leauga, Agenda for Health Inquiry round table discussion concerning Stage Two of the inquiry held on 3 May 2018, 27 April 2018

6.2 Other documents

6.2.1 Introduction to the Pre-casebook Research Review: A Preliminary Bibliography, 18 December 2017, 18 December 2017

(a) Preliminary Bibliography (pdf format), 18 December 2017, 18 December 2017

(b) Preliminary Bibliography (excel format), 18 December 2017, 18 December 2017

RECORD OF DOCUMENTS

- * Document confidential and unavailable to the public without leave from the Tribunal
 L document held in the Waitangi Tribunal Library

A. TO COMPLETION OF CASEBOOK

A1 J Hazeldine, brief of evidence of John Hazeldine, 3 July 2017 (filed by G Melvin, 3 July 2017))

(a) Appendix A: Powerpoint presentation summarising evidence of John Hazeldine (referenced as Wai 2575, docs A1, A3), 6 November 2018

A2 R Jansen, brief of evidence of Dr Rawiri Jansen, 22 December 2017 (filed by P Walker / K Tarawhiti, 22 December 2017)

(a) R Jansen, Index and attachments to brief of evidence of Dr Rawiri Jansen, 22 December 2017 (filed by P Walker / K Tarawhiti, 22 December 2017)

A3 J Hazeldine, Further brief of evidence, 10 February 2018 (filed by C Linkhorn / G Melvin / A Lawson, 10 February 2018)

(a) J Hazeldine, Index and appendices, 10 February 2018 (filed by C Linkhorn / G Melvin / A Lawson, 10 February 2018)

A4 K Nuku, Affidavit of Kerri Nuku (Wai 2713), 22 March 2018 (filed by A Sykes / R Jordan / J Bartlett, 22 March 2018)

(a) K Nuku, appendix A, 22 March 2018 (filed by A Sykes / R Jordan / J Bartlett, 22 March 2018)

A5 D A Dow, D A Dow, Māori Health and Government Policy, 1940–2000: A report commissioned by Crown Forestry Rental Trust (May 2006), 26 April 2018

A6 R Jordan, R Jordan, Affidavit of Rebekah Jordan (filed by A Sykes / J Bartlett, 20 April 2018)

(a) R Jordan, R Jordan, Exhibits to the Affidavit of Rebekah Jordan (filed by A Sykes / J Bartlett, 20 April 2018)

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(e) F McGrath, Signed brief of evidence of Frances McGrath (filed by G Melvin, 8 October 2018)

A7 J Te Korako, J Te Korako (Wai 1940), Brief of evidence of Jane Te Korako (filed by B D Gilling / J J Lang, 26 April 2018)

A8 Vacated, 10 September 2018

(a) Vacated, 10 September 2018

(b) Vacated, 10 September 2018

(c) Vacated, 10 September 2018

(d) Vacated, 10 September 2018

A9 P Crampton, brief of evidence of Peter Roy Crampton (filed by K Feint / E A James, 15 June 2018)

(a) P Crampton, index and annexures to the brief of evidence of Peter Roy Crampton (filed by K Feint / E A James, 15 June 2018)

(b) P Crampton, Index and annexures to the brief of evidence of Peter Roy Crampton, Volume 1 (filed by E James, 20 June 2018)

(c) P Crampton, Index and annexures to the brief of evidence of Peter Roy Crampton, Volume 2 (filed by E James, 20 June 2018)

A10 T Maipi, brief of evidence of Taitimu Maipi (filed by R Smail, 15 June 2018)

(a) T Maipi, index and annexures to brief of evidence of Taitimu Maipi (filed by R Smail, 15 June 2018)

A11 Tureiti Lady Moxon, brief of evidence (filed by R Smail, 15 June 2018)

(a) Tureiti Lady Moxon, index and annexures to brief of evidence (filed by R Smail, 15 June 2018)

A12 Janice Kuka, brief of evidence (filed by R Smail, 15 June 2018)

(a) Janice Kuka, index and annexures to brief of evidence (filed by R Smail, 15 June 2018)

A13 H Paul, brief of evidence of Hakopa Paul (filed by R Smail, 15 June 2018)

(a) Annexures to the brief of evidence of Hakopa Paul, 15 June 2018

A14 P Hikairo, brief of evidence of Phillip Hikairo (filed by R Smail, 15 June 2018)

(a) P Hikairo, index and annexures to the brief of evidence of Phillip Hikairo (filed by R Smail, 15 June 2018)

A15 J McLean, brief of evidence of Janet McLean (filed by R Smail, 15 June 2018)

A16 J Broughton, brief of evidence of John Renata Broughton (filed by R Smail, 15 June 2018)

(a) J Broughton, index and annexures to the brief of evidence of John Renata Broughton (filed by R Smail, 15 June 2018)

A17 J Tamihere, brief of evidence of John Henry Tamihere (filed by R Smail, 15 June 2018)

(a) J Tamihere, index and annexures to the brief of evidence of John Henry Tamihere (filed by R Smail, 15 June 2018)

A18 P Jansen, brief of evidence of Peter Martin Jansen (filed by R Smail, 15 June 2018)

(a) P Jansen, index and annexures to the brief of evidence of Peter Martin Jansen (filed by R Smail, 15 June 2018)

(b) Vacated, 28 September 2018

(c) Vacated, 19 October 2018

A19 N Woodhams, brief of evidence of Neil Bernard Woodhams (filed by R Smail, 15 June 2018)

(a) N Woodhams, index and annexures to the brief of evidence of Neil Bernard Woodhams (filed by R Smail, 15 June 2018)

(b) N Woodhams, Amended brief of evidence of Neil Bernard Woodhams (filed by R Smail, 3 October 2018)

A20 T Stewart, brief of evidence of Tereki Ross Stewart (filed by E James, 18 June 2018)

(a) T Stewart, index and annexures to the brief of evidence of Tereki Ross Stewart (filed by E James, 20 June 2018)

A21 D Jansen, brief of evidence of David Mark Jansen (filed by E James, 18 June 2018)

(a) D Jansen, index and annexures to the brief of evidence of David Mark Jansen (filed by E James, 20 June 2018)

(b) Appendix B: Powerpoint presentation accompanying opening submissions of Dr David Jansen, 18 October 2018 (filed by E James, 18 October 2018)

A22 H Mason, brief of evidence of Henry Parks Mason (filed by E James, 20 June 2018)

A23 S Royal, brief of evidence of Simon George Tiwai Royal (filed by E James, 19 June 2018)

(a) S Royal, index and annexures to the brief of evidence of Simon George Tiwai Royal (filed by E James, 20 June 2018)

A24 Tureiti Lady Moxon, T R Moxon (Wai 1315), Affidavit of Tureiti Moxon, 14 November 2005

(a) Tureiti Lady Moxon, Annexures to the affidavit of T R Moxon, Volume 1, 14 November 2005

(b) Tureiti Lady Moxon, Annexures to the affidavit of T R Moxon, Volume 2, 14 November 2005

A25 Vacated, 14 November 2005

(a) Vacated, 14 November 2005

A26 N Woodhams (Wai 1315), Affidavit of Neil Bernard Woodhams, 14 November 2005

(a) N Woodhams (Wai 1315), brief of evidence of Neil Bernard Woodhams, 16 August 2006

A27 Vacated, 14 November 2005

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(a) Vacated, 16 August 2006

A28 T Maipi (Wai 1315), Affidavit of Taitimu Maipi, 14 November 2005, 14 November 2005

A29 P Hikairo (Wai 1315), Affidavit of Phillip Hikairo, 14 November 2005

(a) P Hikairo (Wai 1315), brief of evidence of Phillip Hikairo, 16 August 2006

A30 H Paul (Wai 1315), Affidavit of Hakopa Paul, 14 August 2008

A31 T Maipi (Wai 1315), brief of evidence of Taitimu Maipi, 14 August 2008

A32 P Hikairo (Wai 1315), Second brief of evidence of Phillip Hikairo, 14 August 2008

A33 H Paul (Wai 1315), Second brief of evidence of Hakopa Paul, 14 August 2008

A34 N Woodhams (Wai 1315), Second brief of evidence of Neil Bernard Woodhams, 14 August 2008

A35 Vacated, 14 August 2008

A36 T R Moxon (Wai 1315), Second brief of evidence of Tureiti Moxon, 14 August 2008

A37 M Hand, Affidavit of Margaret Hand (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

A38 W Winiata, Affidavit of Waiharakeke Winiata (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

(a) W Winiata, index and annexures to affidavit of Waiharakeke Winiata (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

A39 T Morgan, Affidavit of Tracey Morgan (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

A40 M Briggs, Affidavit of Maria Briggs (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

A41 N Tanner, Affidavit of Nola Tanner (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

A42 Waikato BOP Nurses, Joint brief of evidence of the Waikato Bay of Plenty nurses (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

A43 A Downs, brief of evidence of Amy Downs (filed by D Naden / N Dhaliwal, 27 July 2018)

(a) Amy Downs, 'From Theory to Practice: The Promise of Primary Care in New Zealand' (Fulbright New Zealand, 2017) (filed by D Naden / N Dhaliwal, 27 July 2018)

A44 M Hape, brief of evidence of Mana Hape (filed by D Naden / N Dhaliwal, 27 July 2018)

A45 O Lloyd, brief of evidence of Owen Lloyd (filed by T Bennion / E Whiley, 27 July 2018)

A46 H Came-Friar / T McCreanor, Joint brief of evidence of Dr Heather Came-Friar and Professor Tim McCreanor (filed by D Stone / C Leauga, 27 July 2018)

(a) H Came-Friar / T McCreanor, appendix A: references to joint brief of evidence of Dr Heather Came-Friar and Professor Tim McCreanor (filed by D Stone / C Leauga, 27 July 2018)

(b) Powerpoint presentation accompanying opening submissions of Dr Heather Came-Friar and Professor Tim McCreanor, 24 October 2018 (filed by K Davis, 24 October 2018)

A47 K McDonald-Beckett, Affidavit of Kelly McDonald-Beckett (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

A48 P Tuhimata, brief of evidence of Patricia Tuhimata (filed by D Stone / G Hewison, 27 July 2018)

(a) P Tuhimata, appendix A: Bibliography (filed by D Stone / G Hewison, 27 July 2018)

(b) P Tuhimata, appendix B: Counties Manukau District Health Board Māori Health Profile 2015 D Stone / G Hewison, 27 July 2018

(c) P Tuhimata, appendix C: Counties Manukau Health Māori Health Plan 2017/18 D Stone / G Hewison, 27 July 2018

A49 K Fergusson-Tibble, brief of evidence of Kahurangi Fergusson-Tibble (filed by T Afeaki / N Lambert / S Tofi, 27 July 2018)

(a) K Fergusson-Tibble, index and annexures to the brief of evidence of Kahurangi Fergusson-Tibble (filed by T Afeaki / N Lambert / S Tofi, 27 July 2018)

A50 T Wall, brief of evidence of Teresa Wall (filed by P Walker, 27 July 2018)

(a) Summary of briefs of evidence of Teresa Wall (referenced as Wai 2575, #A50 and #A56), 23 October 2018 (filed by L Underhill-Sem, 23 October 2018)

A51 P Reid, brief of evidence of Professor Papaarangi Reid (filed by P Walker, 27 July 2018)

A52 S Crengle, brief of evidence of Dr Suzanne Crengle (filed by P Walker, 27 July 2018)

A53 Vacated, 27 July 2018

(a) Vacated, 27 July 2018

A54 K Ransfield, Affidavit of Keelan Ransfield (filed by A Sykes / R Jordan / J Bartlett, 27 July 2018)

A55 E Durie, brief of evidence of Sir Edward Taihakurei Durie (filed by D Hall, 28 July 2018)

(a) E Durie, Signed brief of evidence of Sir Edward Taihakurei Durie (filed by D Hall / D Kleinsman, 11 September 2018)

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(b) Summary of brief of evidence of Sir Edward Taihakurei Durie, 26 October 2018

A56 T Wall, brief of evidence of Teresa Wall (filed by D Hall, 28 July 2018)

(a) T Wall, Signed brief of evidence of Teresa Wall (filed by D Hall / D Kleinsman, 11 September 2018)

A57 H Came-Friar / T McCreanor / K Nuku / L Manson, Joint brief of evidence of Heather Came-Friar, Tim McCreanor, Kerri Nuku and Leanne Manson, 31 July 2018 (filed by A Sykes / R Jordan / J Bartlett, 31 July 2018)

(a) Appendix A: List of references, 31 July 2018, A Sykes / R Jordan / J Bartlett, 31 July 2018

(b) Powerpoint presentation accompanying opening submissions of Dr Heather Came-Friar-Friar, Professor Tim McCreanor, Kerri Nuku, and Leanne Mason (Wai 2713), 25 October 2018 (filed by R Jordan, 25 October 2018)

A58 Final statistics for stage one of the inquiry for Wai 1315, Wai 2687 and the Crown, 11 September 2018

(a) Appendix A: Māori / Non-Māori graphs – children aged 0–14 yrs: Has GP clinic or medical centre that usually goes to when unwell or injured – Age standardised rate ratios 2006/07–2016/17 (Excel spreadsheet), 11 September 2018

(b) Appendix B: Māori / Non-Māori graphs – adults aged 15+ yrs: Visited practise nurse (without seeing GP) in past 12 months – Age-standardised rate ratios, 2006/07–2016/17 (Excel spreadsheet), 11 September 2018

(c) Appendix C: Amenable mortality codes – 2012 version, codes as defined in Saving Lives: Amenable mortality in New Zealand, 1996–2006 (Excel spreadsheet), 11 September 2018

A59 A Bloomfield, Signed brief of evidence of Ashley Bloomfield (filed by G Melvin, 7 September 2018)

(a) A Bloomfield, appendix A: Current state of Māori health in New Zealand (filed by G Melvin, 7 September 2018)

(b) Appendix B: Powerpoint presentation summarising evidence of Dr Ashley Bloomfield (referenced as Wai 2575, #A59 and #A65), 26 October 2018 (filed by A Lawson, 26 October 2018)

A60 J Cumming, Signed brief of evidence of Jacqueline Cumming (filed by G Melvin, 11 September 2018)

(a) J Cumming, appendix A: Relevant publications by J Cumming, 07 September 2018 (filed by G Melvin, 7 September 2018)

(b) Appendix B: PHO Performance Management Programme, 5 October 2018

(c) Appendix C: Powerpoint presentation accompanying submissions of Jacqueline Cumming, 18 December 2018 (filed by Crown counsel, 18 December 2018)

A61 Vacated, 7 September 2018

(a) Vacated, 7 September 2018

(b) Vacated, 7 September 2018

A62 K Brooking, Signed brief of evidence of Keriana Brooking (filed by G Melvin, 7 September 2018)

(a) Appendix A: Powerpoint presentation accompanying submissions of Keriana Brooking, 18 December 2018 (filed by Crown counsel, 18 December 2018)

A63 F McGrath, brief of evidence of Frances McGrath (filed by G Melvin, 7 September 2018)

(a) F McGrath, appendix A: Bibliography (filed by G Melvin, 7 September 2018)

(b) F McGrath, appendix B: Membership of the Primary Health Care Reference Group (filed by G Melvin, 7 September 2018)

(c) Appendix C: Extracts of the Health Select Committee report on the New Zealand Public Health and Disability Bill filed for cross-examination of Frances McGrath by T Bennion, 1 November 2018 (filed by T Bennion, 1 November 2018)

(d) Appendix D: Powerpoint presentation summarising evidence of Dr Frances McGrath (referenced as Wai 2575, #A63), 6 November 2018

A64 H Matthews, Signed brief of evidence of Hector Matthews (filed by G Melvin, 12 September 2018)

(a) Appendix A: Powerpoint presentation accompanying submissions of Hector Matthews, 18 December 2018, 18 December 2018

A65 A Bloomfield, Second brief of evidence of Ashley Bloomfield (filed by G Melvin, 12 September 2018)

A66 N Chamberlain, N Chamberlain, brief of evidence of Dr Nick Chamberlain (filed by G Melvin, 12 September 2018)

(a) N Chamberlain, appendix A: Index and annexures to brief of evidence of Dr Nick Chamberlain (filed by G Melvin, 12 September 2018)

(b) Appendix B: Powerpoint presentation summarising evidence of Dr Nick Chamberlain (referenced as Wai 2575, #A66), 6 November 2018

A67 J Kuka, Signed brief of evidence of Janice Kuka (filed by R Smail, 21 September 2018)

(a) J Kuka, index and annexures to brief of evidence of Janice Kuka (filed by R Smail, 21 September 2018)

A68 P Jansen, Signed brief of evidence of Peter Jansen (filed by R Smail, 21 September 2018)

(a) P Jansen, index and annexures to brief of evidence of Peter Jansen (filed by R Smail, 21 September 2018)

A69 P Crampton, brief of evidence of Peter Roy Crampton (filed by K Feint, 21 September 2018)

(a) P Crampton, index and annexures to brief of evidence of Peter Roy Crampton (filed by K Feint, 21 September 2018)

(b) Signed brief of evidence of Peter Roy Crampton, 28 September 2018, 28 September 2018

(c) Powerpoint presentation accompanying opening submissions of Professor Peter Roy Crampton (Wai 2687), 19 October 2018 (filed by E James, 19 October 2018)

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- A70** S Royal, brief of evidence of Simon George Tiwai Royal (filed by K Feint, 24 September 2018)
- (a) S Royal, index and annexures to brief of evidence of Simon George Tiwai Royal (filed by K Feint, 24 September 2018)
 - (b) Appendix B: Powerpoint presentation accompanying opening submissions of Dr David Jansen, 18 October 2018 (filed by E James, 18 October 2018)
 - (c) Brief of Evidence of Simon Royal providing answers to written questions, 17 December 2018, 17 December 2018
 - (d) Appendix B: Exhibits to written answers of Simon Royal, 17 December 2018, 17 December 2018
- A71** Powerpoint presentation of Dr K Gottlieb, 25 October 2018 (filed by R Smail, 25 October 2018)
- (a) Supporting documents for presentation of Dr K Gottlieb, 25 October 2018, 25 October 2018
 - (b) Appendix A: Answers to written questions by Katherine Gottlieb, 13 December 2018, 13 December 2018
- A72** 2017/2018 Māori health plan for the Auckland and Waitemata District Health Boards, 22 November 2018
- A73** Bay of Plenty District Health Board, Good to great – Māori Health, 22 November 2018
- A74** T Moxon, brief of evidence of Lady Tureiti Moxon (filed by R Smail, 30 November 2018)
- (a) Appendix A: Index and annexures to brief of evidence of Lady Tureiti Moxon, 30 November 2018
- A75** S Royal, brief of evidence of Simon Royal concerning remedies (filed by E James, 30 November 2018)
- A76** L Davies, brief of evidence of Lisa Davies (filed by G Melvin, 3 December 2018)
- (a) Appendix A: Index and annexures to brief of evidence of Lisa Davies, 3 December 2018
 - (b) Appendix B: Powerpoint presentation accompanying submissions of Lisa Davies, 18 December 2018 (filed by Crown counsel, 18 December 2018)
- A77** Documents from Volume 3 of the Common Bundle of documents not already filed on the Record of Inquiry, 28 November 2018
- A78** 2017/2018 Māori Health Action Plan for the Canterbury District Health Board, 17 December 2018, 17 December 2018
- A79** 2017/2018 Annual plan for the Canterbury District Health Board, 17 December 2018, 17 December 2018

B. DOCUMENTS

B1 Māori Health Trends 1990 – 2015 Project – Diabetes Module Appendices (filed by G Melvin, 26 February 2019)

- (a) Appendix A: Excel tool – Diabetes Complications Hospitalisations, 26 February 2019
- (b) Appendix B: Excel tool – Diabetes Complications Hospitalisations: Māori vs Non-Māori Non-Pacific, 26 February 2019
- (c) Appendix C: Excel tool – Diabetes, 26 February 2019

B2

- (a) Māori Health Trends 1990 – 2015 Project – Suicide and Self-harm module appendices (filed by G Melvin, 5 March 2019)
- (b) Appendix B: Excel tool – Suicide Mortality, 26 February 2019

B3 Māori Health Trends 1990 – 2015 Project – Infant and Child Mortality Module Appendices, 28 February 19 (filed by G Melvin (Crown), 28 February 2019)

- (a) Appendix A: Excel tool – Child Mortality (all causes), age 0–5 years, Māori and non-Māori 1996–2014, 28 February 2019
- (b) Appendix B: Excel tool – Mortality for Māori and non-Māori infants under one year of age, 28 February 2019

B4 Māori Health Trends 1990 – 2015 Project – Health System, Health Workforce and Demographic Module Appendices, 28 February 19 (filed by G Melvin (Crown), 28 February 2019)

B5 Māori Health Trends 1990 – 2015 Project – Cancer Module Appendices, 28 February 2019

- (a) Appendix A: Excel tool – BreastScreen Aotearoa and National Cervical Screening Programme, 28 February 2019
- (b) Appendix B: Excel tool – BreastScreen Aotearoa coverage by 5 year age group June 2003 – June 2017, 28 February 19, 28 February 2019
- (c) Appendix C: Excel tool – National Cervical Screening Programme Coverage by 5 year age group June 2002 – June 2017, 28 February 19, 28 February 2019
- (d) Appendix D: Excel tool – Cancer Indicators for Females: Māori vs Non-Māori, Non-Pacific, 28 February 2019, 28 February 2019
- (e) Appendix E: Excel tool – Cancer Indicators for Males: Māori vs Non-Māori, Non-Pacific, 28 February 2019, 28 February 2019
- (f) Appendix F: Excel tool – Cancer Mortality Indicators for Females, 28 February 2019, 28 February 2019
- (g) Appendix G: Excel tool – Cancer Mortality Indicators for Males, 28 February 2019, 28 February 2019
- (h) Appendix H: Excel tool – Cancer Registration Indicators for Females, 28 February 2019, 28 February 2019
- (i) Appendix I: Excel tool – Cancer Registration Indicators for Males, 28 February 2019, 28 February 2019

B6 Māori Health Trends 1990 – 2015 Project – Dementia Mortality Module Appendices, 28 February 19 (filed by G Melvin (Crown), 28 February 2019)

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(a) Appendix A: Excel tool – Dementia (Including Alzheimer’s disease) mortality, age 65+ years Māori and non-Māori, 1996–2014, 28 February 19, 28 February 2019

B7 Māori Health Trends 1990 – 2015 Project – Self-Rated Health Module, 28 February 19 (filed by G Melvin (Crown), 28 February 2019)

(a) Appendix A: Excel tool – Self-rated Health – Māori / Non-Māori adults aged 15+ years, 28 February 19, 28 February 2019

B8 Māori Health Trends 1990 – 2015 Project – Cardiovascular Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

(a) Appendix A: Excel tool – Cardiovascular Disease Hospitalisations, 1 March 2019, 1 March 2019

(b) Appendix B: Excel tool – Cardiovascular Disease Mortality, 1 March 2019, 1 March 2019

(c) Appendix C: Excel tool – Cardiovascular Disease Indicators: Māori vs non-Māori, non-Pacific, 1 March 2019, 1 March 2019

B9 Māori Health Trends 1990 – 2015 Project – Interpersonal Violence Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

(a) Appendix A: Excel tool – Assault and homicide mortality, 15+ years, Māori and Non-Māori, 1 March 2019, 1 March 2019

B10 Māori Health Trends 1990 – 2015 Project – Mental Health Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

(a) Appendix A: Excel tool – Mental Health – Māori / Non-Māori Non-Pacific (NMNP) adults aged 15+ years, 1 March 2019, 1 March 2019

(b) Appendix B: Excel tool – Mental Health – Māori / Non-Māori adults aged 15+ years, 1 March 2019, 1 March 2019

B11 Māori Health Trends 1990 – 2015 Project – Socioeconomic and Racial Discriminants Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

B12 Māori Health Trends 1990 – 2015 Project – Oral Health Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

(a) Appendix A: Excel tool – Oral health for 5 year olds and year 8’s, 1 March 2019, 1 March 2019

(b) Appendix B: Excel tool – Oral health for 5 year olds and year 8’s: Māori vs non-Māori, non-Pacific, 1 March 2019, 1 March 2019

(c) Appendix C: Excel tool – Oral health – Māori / Non-Māori adults aged 15+ years, 1 March 2019, 1 March 2019

(d) Appendix D: Excel tool – Oral Health – Māori and Non-Māori children aged 1–14 years, 1 March 2019, 1 March 2019

B13 Māori Health Trends 1990 – 2015 Project – Causes of Death Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

(a) Appendix A: Excel tool – Major causes of death for females, 1 March 2019, 1 March 2019

(b) Appendix B: Excel tool – Major causes of deaths for males, 1 March 2019, 1 March 2019

B14 Māori Health Trends 1990 – 2015 Project – Infant Health Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

- (a) Appendix A: Excel tool – Breastfeeding, 1 March 2019, 1 March 2019
- (b) Appendix B: Excel tool – Low birthweight, 1 March 2019, 1 March 2019

B15 Māori Health Trends 1990 – 2015 Project – Unintentional Injury Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

- (a) Appendix A: Excel tool – All unintentional injury hospitalisations, 1 March 2019, 1 March 2019
- (b) Appendix B: Excel tool – All unintentional injury mortality, 1 March 2019, 1 March 2019

B16 Māori Health Trends 1990 – 2015 Project – Chronic Conditions Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

- (a) Appendix A: Excel tool – Chronic conditions – Māori / Non-Māori adults aged 15+ years, 1 March 2019, 1 March 2019

B17 Māori Health Trends 1990 – 2015 Project – Infectious Disease Module Appendices, 1 March 2019 (filed by G Melvin (Crown), 1 March 2019)

- (a) Appendix A: Excel tool – Infectious diseases, 1 March 2019, 1 March 2019
- (b) Appendix B: Excel tool – Infectious diseases: Māori vs non-Māori, non-Pacific, 1 March 2019, 1 March 2019
- (c) Appendix C: Māori Health Trends 1990 – 2015: Infectious Disease Module supplement appendices – Rheumatic Fever, Non-Māori Non-Pacific, 26 March 2019
- (c)(i) Excel Tool – Infectious disease first episode rheumatic fever, 26 March 2019

B18 Māori Health Trends 1990 – 2015 Project – Respiratory Disease Module Appendices, 5 March 2019 (filed by G Melvin (Crown), 5 March 2019)

- (a) Appendix A: Excel tool – Diagnosed asthma – Māori and Non-Māori adults aged 15–44 years, 5 March 2019, 5 March 2019
- (b) Appendix B: Excel tool – Diagnosed asthma: Māori vs non-Māori, non-Pacific, 5 March 2019 adults aged 15–44 years, 5 March 2019
- (c) Appendix C: Excel tool – Respiratory disease hospitalisations by sex, 5 March 2019, 5 March 2019
- (d) Appendix D: Excel tool – Respiratory disease mortality, 5 March 2019, 5 March 2019
- (e) Appendix E: Excel tool – Respiratory disease Māori vs non-Māori, non-Pacific, 5 March 2019, 5 March 2019

B19 Māori Health Trends 1990 – 2015 Project – Disability Module Appendices, 5 March 2019 (filed by G Melvin (Crown), 5 March 2019)

- (a) Appendix A: Excel tool – Disability Equipment needs, 5 March 2019, 5 March 2019
- (b) Appendix B: Excel tool – Disability Prevalence, 5 March 2019, 5 March 2019
- (c) Appendix C: Excel tool – Disability Single or Multiple Impairments, 5 March 2019, 5 March 2019
- (d) Appendix D: Excel tool – Disability: Unmet need to access health professionals, 5 March 2019, 5 March 2019

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B20 Māori Health Trends 1990 – 2015 Project – Risk and Protective Factors Module Appendices, 6 March 2019 (filed by G Melvin (Crown), 6 March 2019)

- (a) Appendix A: Excel tool – Body size – Māori / Non-Māori adults aged 15+ years, 6 March 2019, 6 March 2019
- (b) Appendix B: Excel tool – Body size – Māori / Non-Māori, Non-Pacific adults aged 15+ years, 6 March 2019, 6 March 2019
- (c) Appendix C: Excel tool – Alcohol and Drug use – Māori / Non-Māori adults aged 15+ years, 6 March 2019, 6 March 2019
- (d) Appendix D: Excel tool – Body size – Māori / Non-Māori children aged 2–14 years, 6 March 2019, 6 March 2019
- (e) Appendix E: Excel tool – Body size – Māori / Non-Māori, Non-Pacific children aged 2–14 years, 6 March 2019, 6 March 2019
- (f) Appendix F: Excel tool – Gambling – Māori / Non-Māori adults aged 15+ years, 6 March 2019, 6 March 2019
- (g) Appendix G: Excel tool – Nutrition – Māori / Non-Māori adults aged 15+ years by sex, 6 March 2019, 6 March 2019
- (h) Appendix H: Excel tool – Physical activity – Māori / Non-Māori adults aged 15+ years, 6 March 2019, 6 March 2019
- (i) Appendix I: Excel tool – Tobacco smoking, 6 March 2019, 6 March 2019

B21 Appendices for Pre-1991 data filed alongside the Māori Health Trends Project (filed by Crown, 22 March 2019)

- (a) Appendix A: Exec Tool – Cancer Breast Māori, 22 March 2019
- (b) Appendix B: Exec Tool – Cancer Breast Non-Māori, 22 March 2019
- (c) Appendix C: Exec Tool – Cancer Breast Total, 22 March 2019
- (d) Appendix D: Exec Tool – Cancer Total Māori, 22 March 2019
- (e) Appendix E: Exec Tool – Cancer Total Non-Māori, 22 March 2019
- (f) Appendix F: Exec Tool – Cancer Total, 22 March 2019
- (g) Appendix G: Exec Tool – Cancer Trachea Bronchus Lung Māori, 22 March 2019
- (i) Appendix I: Exec Tool – Cancer Trachea Bronchus Lung Total, 22 March 2019
- (j) Appendix J: Exec Tool – Ischaemic Heart Disease Māori, 22 March 2019
- (k) Appendix K: Exec Tool – Ischaemic Heart Disease Non-Māori, 22 March 2019
- (l) Appendix L: Exec Tool – Ischaemic Heart Disease Total, 22 March 2019
- (m) Appendix M: Mortality Māori, 22 March 2019
- (n) Appendix N: Exec Tool – Mortality Non-Māori, 22 March 2019
- (o) Appendix O: Mortality Total, 22 March 2019

ACKNOWLEDGEMENTS

The Tribunal would like to thank all the staff involved for their assistance with the report, most especially Ethan McKenzie, Dr Therese Crocker, Joy Hippolite, and Dominic Hurley for their support. Also, those staff assisting with the inquiry and hearings, most especially Dr Christopher Burke, Sarah Miller, Lucy Reid, Awhina Black, Rebekah Fistonich, Malesana Tietie, and Te Rangiapia Wehipeihana.

We would also like to acknowledge the skills of contractors Leon Blake, Alan Doyle, and Dr Johanna Reidy.

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Health Round Table – ELT report April 2018 to March 2019

This report gives the highlights of our Health Round Table (HRT) reports for the 12 months to March 2019. The HRT reports benchmark us against hospitals throughout Australasia. The detailed reports have a multitude of KPIs and provide us with exemplar sites which we can share practice with to find opportunities to improve our performance. The reports are published quarterly.

This table gives the highlights of the Hospital KPIs (57 measures)

HuttValley | Apr 2018 - Mar 2019 | Hospital KPI Report |



Executive Summary for HuttValley (based on the trends)

Newly Red		Leaving Green For Yellow		Newly Green	
Indicator	Page	Indicator	Page	Indicator	Page
4091 28 day emergency readmission rate (excluding short stay)	35	4130 Proportion of patients with a hip fracture receiving surgery within 2 days after admission with hip fracture	44	2010 Long stay share of bed days	6
Stubborn Red (last 4 periods)		Leaving Red For Yellow		2070 Same day elective surgery rate	15
Indicator	Page	Indicator	Page	3050 Percentage of non-admitted ED patients returning to ED within 24 hours	28
2120 Proportion of discharges before noon	21	3020 Percentage of ED waiting times within 4 hours	23	4200 Rate of blood transfusions in planned major gastrointestinal surgeries	45
3010 Percentage of ED patients seen within clinically recommended time	22	Online Indicators Submission Status		Consistent Green (last 4 periods)	
3020.1 Percentage of ED waiting times within 4 hours (admitted patients only)	24	Provided: 0 indicator(s)		Indicator	Page
		Not Provided: 23 indicator(s)		4070 Percentage of patients with pressure injuries stage 3 or 4	31

This shows 28-day readmission rate has deteriorated from yellow to red. Proportion of patients with hip fractures receiving surgery within 2 days of admission has slipped from green to yellow. Seeing patients within expected time in ED and discharging before noon have been red for several quarters. Newly green are long stay bed days, same day elective surgery, non-admitted patients returning to ED within 24 hours and rate of blood transfusions for planned gastrointestinal surgery. Pressure injuries has remained green for several quarters.

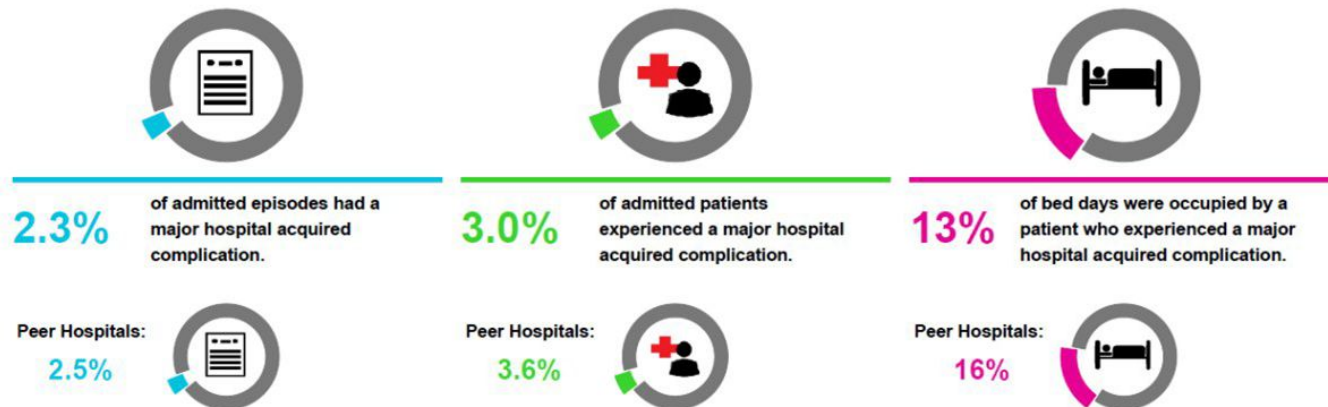
The following tables give an overview of hospital acquired complications. Note hospitals overall are becoming more consistent. Hutt's rate has been increasing however decreased in the last quarter.

HuttValley | Apr 2018 - Mar 2019 | Hospital-Acquired Complications Report |

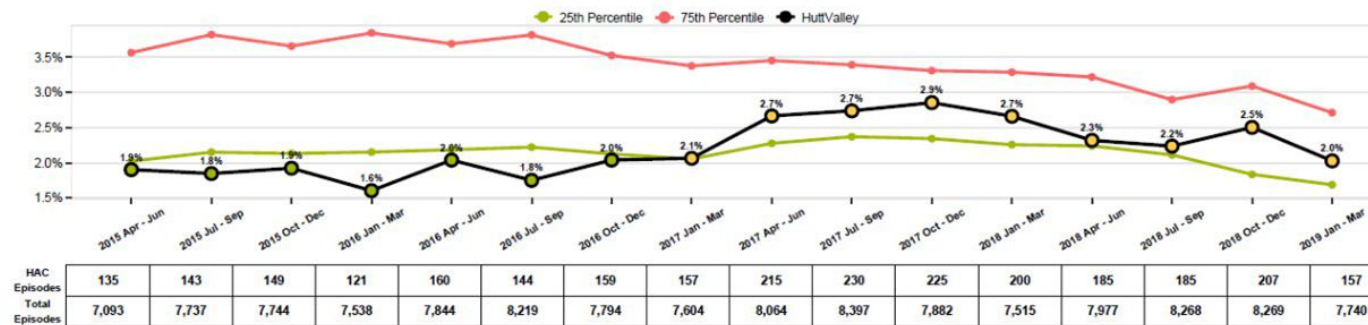


Hospital-Acquired Complications Summary for HuttValley

2018 Apr - 2019 Mar



4 Year HAC Trend For HuttValley

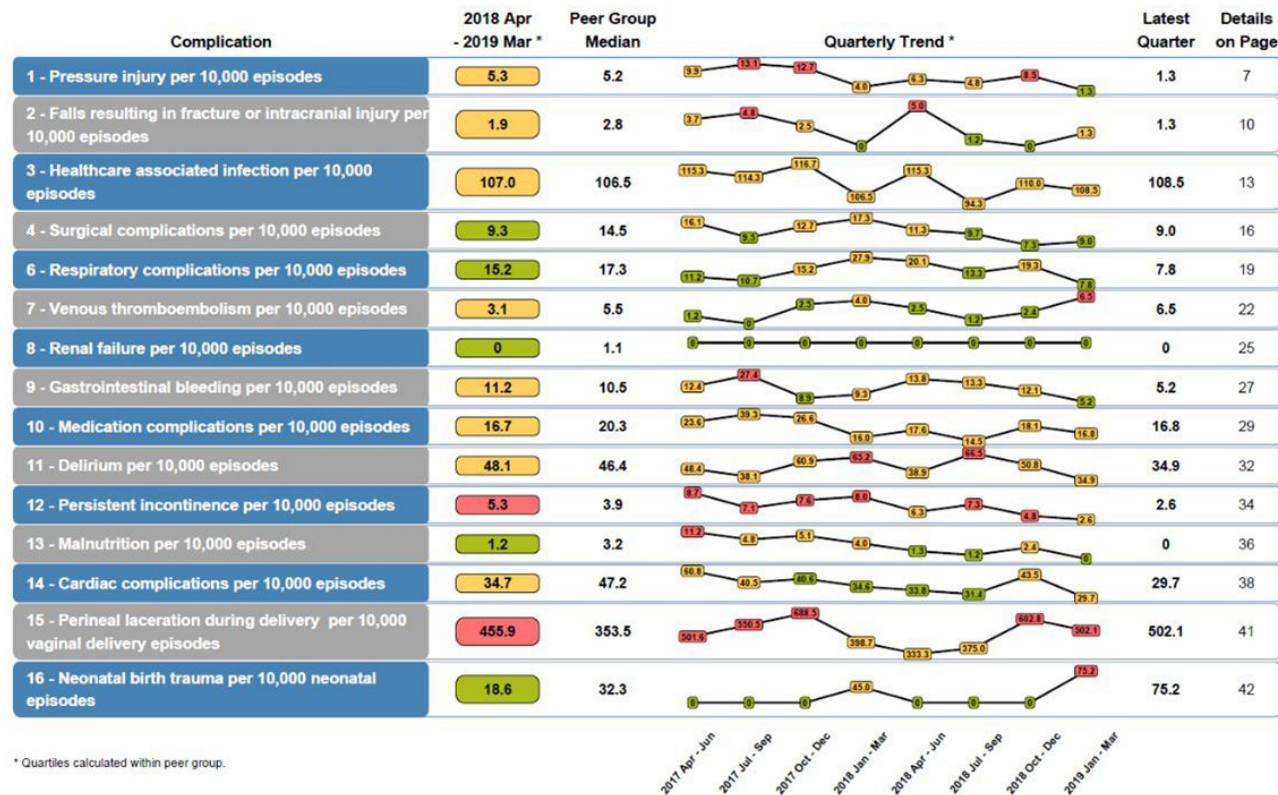


Formula: [episodes with major HAC]/[total episodes]. Description: % of episodes where the patient had one or more hospital acquired complications. An episode with a major hospital acquired complication is determined by the presence of one or more specified diagnosis codes with a condition onset flag indicating that the complication occurred during the episode of care. The list of complications is derived from the ACSQHC's Hospital Acquired Complications list. For more details visit : http://fogbugz.healthroundtable.org/default.asp?W173#toc_44

HuttValley | Apr 2018 - Mar 2019 | Hospital-Acquired Complications Report |



Hospital-Acquired Complications Summary for HuttValley



The areas of concern for Hutt are Persistent incontinence (17 events) and perineal lacerations during delivery (47 events). Venous thromboembolism went red this quarter (10 events)

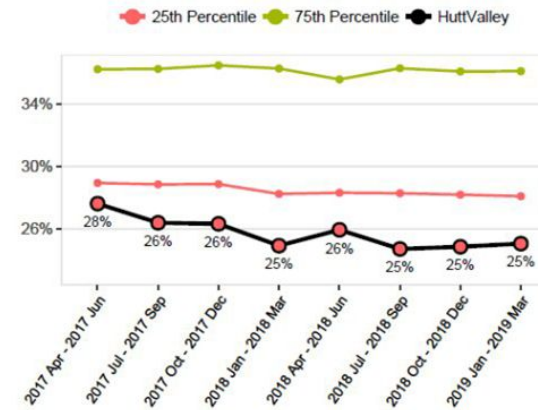


2120 Proportion of discharges before noon

Peer comparison (2018 Apr - 2019 Mar)



Stubborn Red (last 4 periods)



Formula: [episodes discharged before noon] / [total episodes]

Source: Casemix

Description: % of acute episodes discharged between 12am and 12pm.

Acute care type only. Excludes episodes where the patient was discharged from ED.

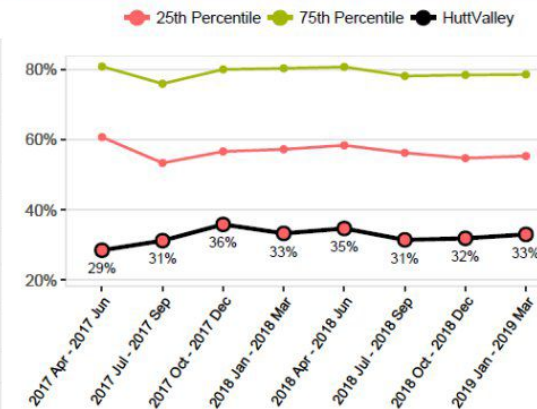
HuttValley | Apr 2018 - Mar 2019 | Hospital KPI Report |



3010 Percentage of ED patients seen within clinically recommended time

Peer comparison (2018 Apr - 2019 Mar)

Stubborn Red (last 4 periods)



Formula: [patients seen within time] / [total presentations]

Source: ED

Description: % of ED presentations that were seen within the clinically recommended time for the triage category. Includes all triage categories.

Excludes DNW, DOA, death in ED & unplanned / transit patients who were not included in the emergency department data.

Details: Based on triage time to time of first care given, treatment or diagnostic started. The benchmark times for each triage category are:

- category 1: seen within seconds, calculated as less than or equal to 2 minutes
- category 2: seen within 10 minutes
- category 3: seen within 30 minutes
- category 4: seen within 60 minutes
- category 5: seen within 120 minutes

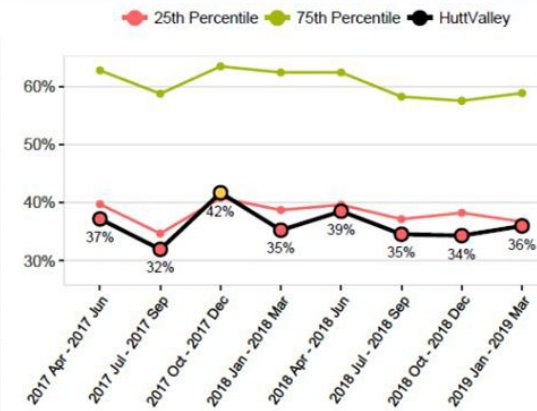
HuttValley | Apr 2018 - Mar 2019 | Hospital KPI Report |



● ● ● 3020.1 Percentage of ED waiting times within 4 hours (admitted patients only)

Peer comparison (2018 Apr - 2019 Mar)

Stubborn Red (last 4 periods)



Formula: [waiting time within 4 hrs] / [total presentations]

Source: ED

Description: % of admitted ED presentations where the time between presentation and admission is <= 4 hours.

Admitted patients only. Excludes DNW, DOA, death in ED & unplanned / transit patients who were not included in the emergency department data.

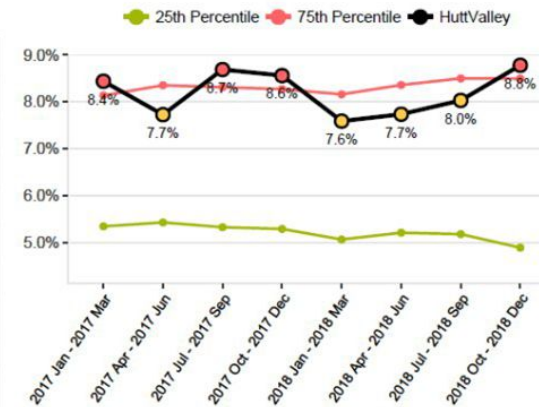
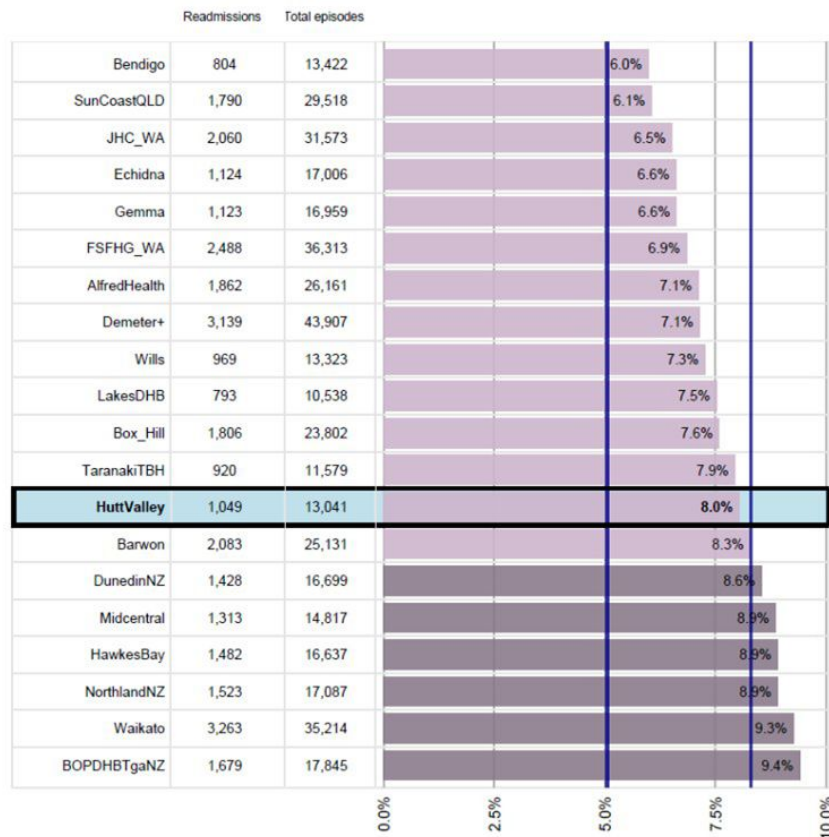
HuttValley | Apr 2018 - Mar 2019 | Hospital KPI Report |



●●● 4091 28 day emergency readmission rate (excluding short stay)

Peer comparison (2018 Jan - 2018 Dec)

Newly Red



Formula: [readmissions] / [total episodes]

Source: Casemix

Description: % of episodes discharged in the reporting period, where the patient has an emergency readmission within 28 days of original discharge.

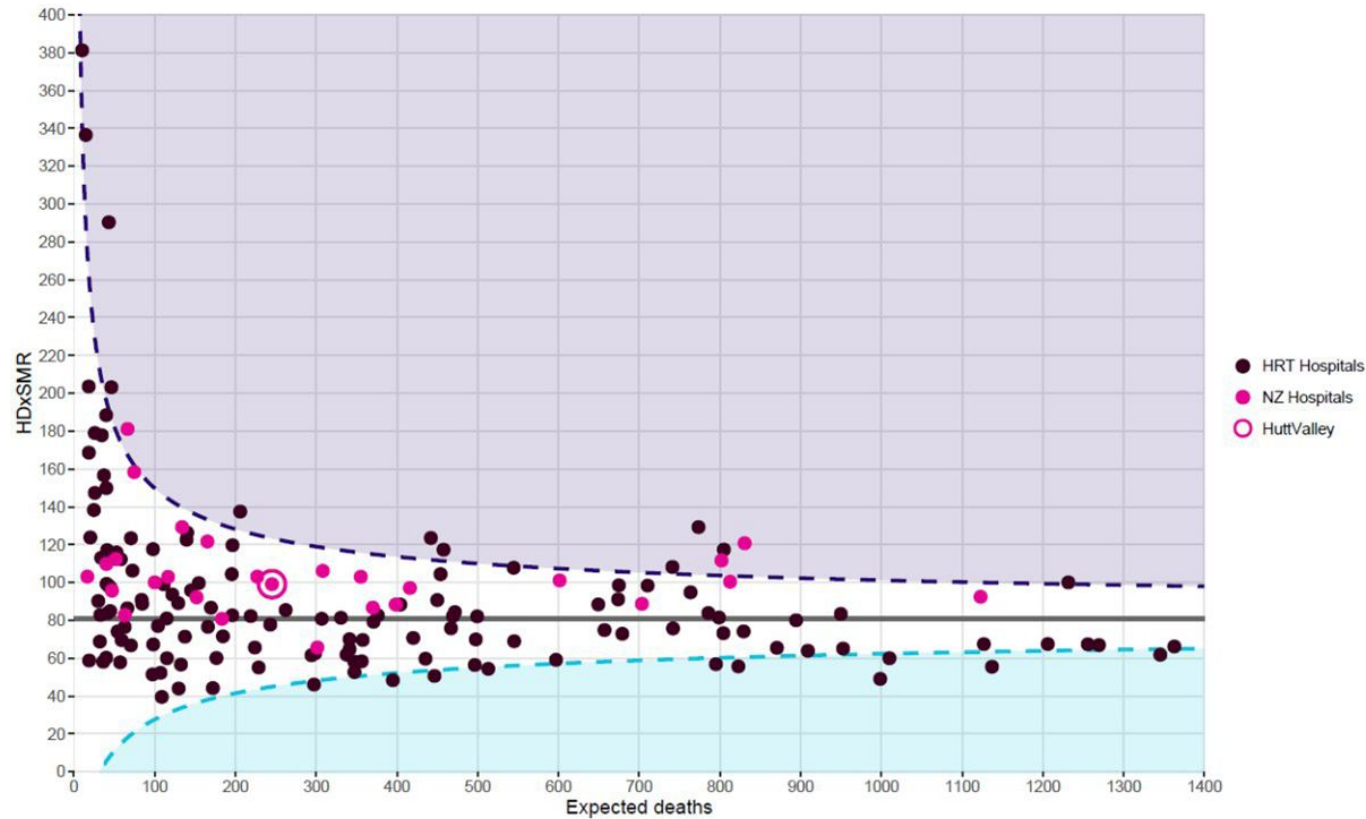
Index and readmission episode are acute or mental health care types only. Index is discharged home or to residential care. Both index and readmission must have LOS >24 hours. For the full list of inclusions and exclusions please see Appendix E.

Details: The restriction to > 24 hours is to limit the effect of short stay units on readmission rates. We suggest considering this indicator together with the previous indicator in order to determine how short stay episodes may be affecting your rate.

The standardised mortality rate for Hutt hospital is not significantly different from the NZ average.

Funnel plot of HRT HDxSMRs compared to the combined HRT HDxSMR

Apr 2018 - Mar 2019



Funnel is based on 2 standard deviations from the HRT rate, adjusted for overdispersion.

The rate was high in April to June 17 but has fallen since, it has risen again over the last two quarters but not significantly.

Hospital diagnosis standardised mortality ratio

Apr 2018 - Mar 2019

HuttValley's HDxSMR

(12 months: Apr 2018 - Mar 2019)

Episodes 29,711

Deaths 243

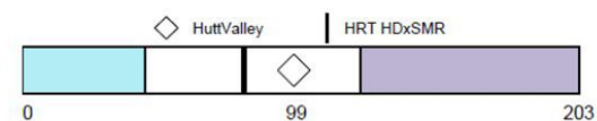
Expected deaths 245.1

Combined HRT HDxSMR for Apr 2018 - Mar 2019 81

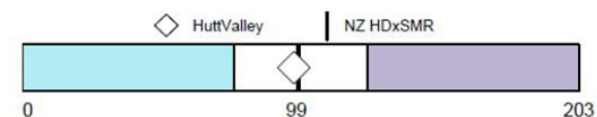
NZ HDxSMR 101

99

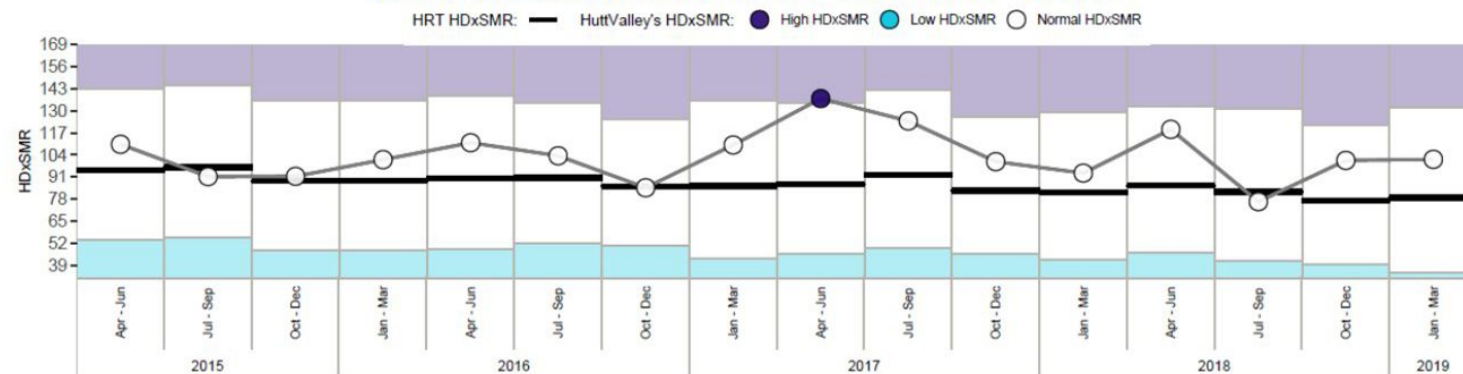
Compared to HRT (81)



Compared to NZ (101)



HuttValley's HDxSMR trend compared to the whole of HRT for each period



HRT HDxSMR

The HDxSMR for all HRT Hospitals combined for the current period (Apr 2018 - Mar 2019). As HDxSMRs are trending down, this will usually be less than the reference HDxSMR of 100.

NZ HDxSMR

The HDxSMR for all NZ HRT Hospitals combined for the current period (Apr 2018 - Mar 2019).



HDxSMR breakdown by ICD10 chapter of principal diagnosis

Apr 2018 - Mar 2019

The graphic indicates the degree to which the ratio of your SMR to the target SMR is different to 1. The estimate of standard deviation takes into account possible variation in the target SMR as well as your own SMR.

Chapter	Episodes	Deaths	Expected Deaths	SMR	HRT SMR	NZ SMR	Compared to HRT SMR	Compared to NZ SMR	Quarterly Trend
01 Infectious and Parasitic Diseases	778	25	24.5	1.02	0.76	1.03			
02 Neoplasms	3,524	15	28	0.54	0.97	0.73			
03 Blood Diseases	822	2	2.3	0.89	0.80	1.04			
04 Endocrine, Nutritional Metabolic	472	2	3.4	0.58	0.77	1.00			
05 Mental & Behavioural Disorders	191	5	3	1.69	0.83	1.08			
06 Diseases of Nervous System	654	4	5.5	0.73	0.65	0.85			
07 Diseases of Eye and Adnexa	544	0	0.096	0.00	0.27	0.15	n/a	n/a	
08 Diseases of Ear and Mastoid	361	0	0.3	0.00	0.08	0.12	n/a	n/a	
09 Diseases of Circulatory System	1,593	65	64	1.02	0.89	1.06			
10 Diseases of Respiratory System	2,067	53	43.7	1.21	0.82	1.20			
11 Diseases of Digestive System	3,690	23	17.8	1.29	0.82	1.18			
12 Skin & Subcutaneous	1,274	2	3.7	0.53	0.68	1.02			
13 Musculoskeletal	1,907	5	3.4	1.46	0.76	1.00			
14 Genitourinary	995	9	8.9	1.02	0.52	0.78			
15 Pregnancy, Childbirth	2,411	0	0.1	0.00	0.22	0.34	n/a	n/a	
16 Perinatal	564	1	2.2	0.45	0.89	0.96			
17 Congenital	394	0	0.1	0.00	0.91	0.89	n/a	n/a	
18 Symptoms, Signs	2,687	6	8.3	0.73	0.71	0.87			
19 Injury Poisoning, External	3,463	25	25.3	0.99	0.69	0.94			
21 Factors Health Status (Z-Codes)	1,320	1	0.5	2.10	0.52	1.50			

Comparisons may not be available where there are insufficient episodes in the target group or your own episodes are a large portion of those episodes.

Note that the graphic is plotted on a log scale. The control limits on this page do not take possible overdispersion of the data into account.


The table below shows the DRGs where we have the biggest opportunity to reduce length of stay and save bed days. Syncope & Collapse has returned this quarter after dropping out of the top 10 the previous quarter. Also in the top 10 this quarter are Other Hip & femur procedures these two DRG clusters have replaced disorders of the pancreas and congestive pulmonary disorders.

HuttValley Top 10 Identified Potential Savings (*)																
DRG family	Name	HuttValley			Exemplar1			Exemplar2			Exemplar3			Exemplar4		
		RSI	Eps	Savings	Name	Eps	RSI	Name	Eps	RSI	Name	Eps	RSI	Name	Eps	RSI
B70	STROKE & OTH CEREBROVAS DSRD	86%	279	424	Fox	210	59%	Bendigo	248	61%	Rebel	222	64%	SouthlandNZ	259	65%
F62	HEART FAILURE & SHOCK	99%	328	420	Demeter+	642	74%	Goanna	146	74%	Hera	291	75%	Malibu	336	75%
G70	OTHER DIGESTIVE SYSTEM DIAG	111%	473	409	Saturn	941	62%	Vega	1,315	69%	Rebel	1,291	72%	Quokka	1,406	76%
G02	MJR SMALL & LARGE BOWEL PR	103%	109	409	Lorikeet	94	60%	Rebel	166	62%	Gemini2	62	63%	SunCoastQLD	242	69%
E62	RESPIRATORY INFECTN/INFLAMM	87%	507	408	Rebel	800	65%	Vega	727	67%	Hera	481	69%	WH_Footscray	599	70%
L63	KIDNEY & URINARY TRACT INFECT	95%	259	289	Goanna2	168	59%	SunCstUH_QLD	903	61%	Redland_QLD	681	61%	Ceres	623	68%
J64	CELLULITIS	94%	497	246	Redland_QLD	671	75%	CalvaryNew	384	76%	Bendigo	416	77%	Rebel	771	78%
F73	SYNCOPE & COLLAPSE	106%	211	224	Malibu2	82	66%	Lorikeet2	94	66%	Rebel	438	69%	RPH_WA	566	69%
I08	OTHER HIP & FEMUR PROC	74%	130	213	FSH_WA	358	55%	FSFHG_WA	372	56%	RPH_WA	396	57%	SCGH_WA	220	58%
J11	OTHER SKIN, SUBC TIS & BRST PR	99%	1,694	202	NthShoreNZ	2,929	41%	CanterburyNZ	2,303	51%	NorthlandNZ	965	65%	Waikato	2,147	77%
		Savings:		3,244												

*Excludes DRG families A06 (Tracheostomy), W01 (Trauma with ventilation & tracheostomy), U (Mental Health), V (Drug & Alcohol), O (Obstetrics) and P (Newborns).

Some Hospitals have their names published others are coded. The coded ones are below.

Hera	Mater Adult Hospital Qld	Goanna	Mercy Tasmania
Demeter+	Gold Coast HHS	Goanna2	North West regional Tasmania
Lorikeet	Rockhampton Hospital	FSFHG_WA/ FSH_WA	South Metropolitan Health Service (Fiona Stanley) WA
Vega	Townsville	Malibu2	Atherton Hospital Qld
Rebel	Redcliffe Hospital QLD	Lorikeet2	Gladstone Qld
Gemini 2	Werribee Mercy Hospital	Quokka	Ipswich Qld
Fox	The Prince Charles Hospital QLD		
Saturn	Bunderberg		
Ceres	Caboolture Hospital Qld		

		CLINICAL COUNCIL
		Date: July 2019
AUTHOR	Saira Dayal, Clinical Leader Quality Service Improvement and Innovation	
SUBJECT	Innovation Fund Update: Enhancing Quality Improvement Capacity and Capability at HVDHB	
RECOMMENDATION	<p>a) NOTES that all of the \$126,600 approved has been spent or allocated as follows:</p> <ul style="list-style-type: none"> • \$71,600 has been spent on two three-day courses at Hutt Valley which trained 41 staff • \$27,500 was spent in 2018 for two people to attend the Improvement Advisor course • \$27,500 is being spent currently on two people attending the 2019 Improvement Advisor course from April to December 2019 	

1. PURPOSE

The purpose of this paper is update Clinical Council on the final quality improvement capability activities in 2018 and 2019 that were funded through the Innovation Fund.

The funding approved \$126,600 to be spent; \$99,000 was spent in 2018 on two cohorts of 20 staff to receive a three day course facilitated by Ko Awatea (the centre for improvement and innovation at Counties-Manukau DHB), and for two people to attend the Auckland based Improvement Advisor training. The final \$27,500 is allocated to two staff attending the 2019 Improvement Advisor Course and will be fully spent by September 2019.

2. BACKGROUND

In May 2017, the Executive Leadership Team received an initial plan on how the Quality Team would build quality improvement capability across the organisation. The plan used a model adapted from the Institute for Healthcare Improvement (IHI) and an NHS Trust (East London Foundation Trust) well known for its success in building capability; as well as the Health Quality and Safety Commission's document *From knowledge to action: a framework for building quality and safety capability in the New Zealand health system*. In essence, the capability plan identified key quality improvement knowledge and actions that staff in different roles should have, and provided options on how to upskill in these areas.

Figure 1: IHI approach used by East London Foundation Trust (ELFT)

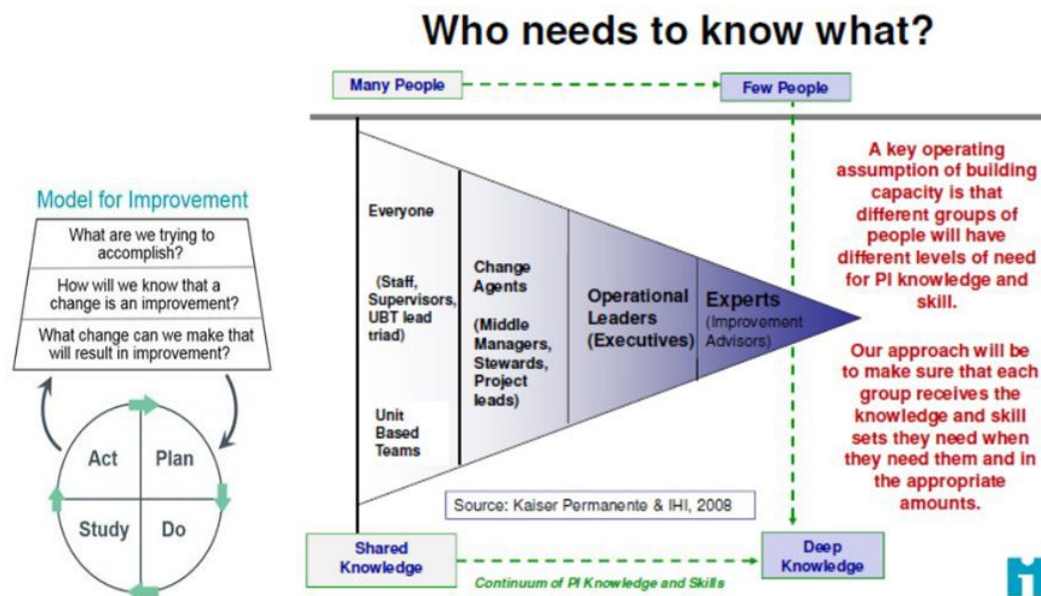


Figure 2: HVDHB QI Capability – phase one

	Need to know	Method(s)
All Staff	Model for Improvement (Mfi) How to test an idea	Face to face: Improvement Clinic 1 Mfi, or Online: HQSC's Improving Together
Staff involved in or leading QI	More in depth understanding of QI and Model for Improvement, and how to plan and deliver a small scale project using Mfi	Face to face: 3 day course (Fundamentals of Improvement or equivalent) or Online: IHI Open School
Internal experts Improvement advisors	- Expert level knowledge of improvement methodology (eg. Mfi and Deming's system of Profound knowledge), statistical techniques (eg. statistical process control), implementation and spread	9 month training course via Ko Awatea

3. INNOVATION FUND

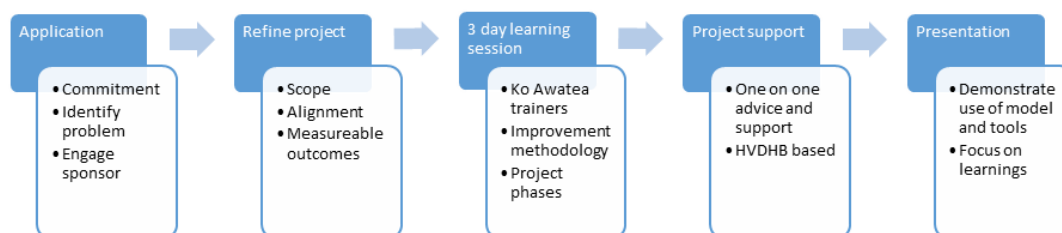
The Innovation Fund approved \$126,600 to be used as outlined below.

	2017/18	2018/19	Total
Fundamentals of Improvement (two cohorts of 20 people)	\$35,800	\$35,800	
Improvement Advisor (two people per year)	\$27,500	\$27,500	
	\$63,300	\$63,300	\$126,600

3.1 Fundamentals of Improvement courses:

As noted in October 2018, two cohorts of this course have been held in May and August 2018 with 19 and 22 staff attending respectively. All of the funding for this course has now been spent.

Figure 3: HVDHB Fundamentals of Improvement approach 2018



There was a mix of nursing, midwifery, allied health scientific and technical; and support staff attending the two courses, as well as one senior medical officer. The Ko Awatea evaluation of the course showed an improvement in the knowledge of core improvement tools for both cohorts.

After reviewing the outcomes from the first cohort the project coaching was adapted for the second cohort to provide advice early on, and increase communication with sponsors. The second cohort presented their projects on 15 November. Projects presented were of a high standard and demonstrated understanding and use of improvement methodology.

The Innovation Fund enabled this training to be delivered to a number of staff who would not otherwise have travelled to Ko Awatea for the course. Using experienced trainers has allowed the QSI&I Team to observe the training, share improvement resources and exercises, and consider options for future training to be delivered for HVDHB.

3.2 Improvement Advisor

Four Hutt Valley staff have been funded to attend the nine-month long Improvement Advisor Course delivered by Ko Awatea, with all funds now allocated. The second group will complete the course in late 2019.

The course learning outcomes are to acquire the skills needed to successfully perform the role of a change agent either in a formal improvement role or as part of another function, and to improve the success rate of improvement initiatives in their organisation by applying appropriate methodology and rigor. The programme includes three, three day workshops at Counties Manukau DHB as well as regular video-conferences. The expectation is that participants spend 0.2FTE (approximately 10 hours per week) on the course and project work. The course costs \$8,990 + GST per person, with additional travel and accommodation expenses.

In 2018 Vince Bailey, Quality Advisor (Data Specialist) and Joan Burns, Quality Advisor received the Innovation Funding to attend, with Vivian Martin (Quality Improvement Advisor) also attending after receiving funding from the Health Quality and Safety Commission. Their projects were on Improving the Outpatient Experience; Core Midwifery Support for Assisted Births and Shorter stays for Acute Patients. One participant has since resigned from the DHB, but has taken up a role elsewhere in the health sector where the skills will be well utilised.

In 2019, there were four applications and two were selected to receive the funding: Ginny Anderson, CNM Rheumatology and Cathy Whiteside, Associate Director of Nursing. Additionally, Emma Henderson, Antimicrobial Pharmacist, was successful in receiving Health Quality and Safety Commission funding for course fees, with HVDHB paying for travel and expenses.

Ginny Anderson's project is focussed on improving the journey for rheumatology patients who receive infusion therapy in the Medical Day Stay Unit. Her project aims to improve referral, treatment plans and patient engagement. Cathy Whiteside's project aims to improve the shorter stay target for patients admitted by 10% by the 31 November 2019. Her key areas to address this are matching capacity to demand, improved decision making, effective communication and team work. Emma Henderson's project uses a Choosing Wisely approach and aims to improve quality in UTI diagnosis and management in Aged Residential Care by reducing the amount of inappropriate urine culture requests and unnecessary antimicrobial prescribing. She is working with four Rest Home facilities in the Hutt Valley DHB region, on a package that has seen success in an inpatient setting previously.

Each of three attendees have fed back that the course is providing them with a new way of thinking, a large support network and the tools to turn project vision into action. They are already using the skills learnt in their current roles and projects, and in supporting colleagues in their own areas of improvement.

4. SUMMARY

The Innovation Fund has enabled a much enhanced approach to building capability in quality improvement for HVDHB than would have been possible by this stage without the funding. Progress has been made more quickly using external trainers coming to Hutt Valley DHB, and by developing the expertise necessary to support staff in using improvement methodology in their workplace, rather than attending training and not putting the skills to use.

While the Model for Improvement is only one of several methodologies (Lean Six Sigma and DMAIC being others) there is benefit in starting with a single methodology that is widely used in health to start staff using a shared improvement language and set of tools. The QSI&I Team appreciates that this proposal was prioritised for funding and looks forward to the next phase of building capability for improvement to occur across the DHB.

Number	Title	Summary	Funding request
10	Mental Health Primary and Secondary Integration	Proposal to transition consumers from secondary to primary care - ensuring robust assessment of consumer readiness to transition, facilitation of transition and packages of care to support transition.	\$120K
<p>From : Jayne Coombes, Operations Manager, Adult Community Mental Health & Addictions</p> <p>Updates</p> <p>Nov 2017</p> <p>We have advertised the Mental Health Primary Liaison post without success. First occasion we interviewed four applicants and verbally offered the post however the applicant then withdrew due to her personal circumstances changing. None of the others were suitable. We re-advertised and are considering if any applicants can be shortlisted. Liaising with PHO re next steps.</p> <p>In the meantime the caseload reviews have been completed and we are reviewing the information gathered. No costs have been incurred to date. We will need to roll over the funding into the next financial year in order to appoint for one year fixed term.</p> <p>Mar 2018</p> <p>We have appointed into the role (commenced Jan 2018). The clinician has been appointed for six months to progress the project part of the role, examining similar projects in other DHB's, literature etc. She is also completing case load reviews and identifying barriers to discharge. A report will be completed to inform next stage of transitioning consumers and implementing required packages of care. The report will inform who is needed to be appointed for second six months of the project. (Likely to be liaison nurse role rather than project role for second phase).</p> <p>Nov 2018</p> <p>The report has been drafted and findings shared with the new Mental Health Network Group. This group will consider the information from the report and support identification of next steps.</p> <p>The data from caseload reviews showed:</p> <ul style="list-style-type: none"> ▪ 100+ clients require d/c and have or will be closed off. ▪ 370+ clients present as stable, with low acuity and require discussion for d/c ▪ 86 are presenting as stable on depot medication ▪ 52 stable on Clozapine (14 meet requirements of Clozapine policy for management in primary) <p>Barriers to discharge were identified as:</p> <ul style="list-style-type: none"> ▪ Lack of available NGO support for clients who may need input ▪ Clinicians too busy to facilitate discharge transition ▪ Financial Barriers ▪ Long Term Maintenance Clients (depot and clozapine) ▪ Poor engagement with Primary Health Care <p>The secondment was continued for the second six month term with the focus moving into commencing the transition work with those clients identified as suitable for</p>			

discharge. The delayed start of the MH Network has slowed the work of addressing identified barriers but now that group is functioning the transition to Primary services where appropriate and development of further integrated services delivering shared care is expected to commence.

Costs to date have been limited to the funding of the seconded 1.0 FTE.

June 2019 Final Update

In May 2019 there were 846 clients in the Hutt South team

Discharges from the team from July 2018 to May 2019 were : 687

As part of the project work there were a further 94 clients that had been identified as stable with the potential of discharge. Between May and June 2019 32 of these clients were discharged and a further 25 of these clients have review for discharge appointments scheduled in the next month.

We have appointed two nurses, one in each of the community teams with a specific interest in how we support clients from secondary care back into primary care. This will be done by identifying those clients most suitable for transfer and working alongside the GP practise to support a positive discharge process.

Current projects we are running:

HQSC Connecting Care. Transitions from Hutt Valley Adult Community Mental Health & Addiction Teams back to Primary Care

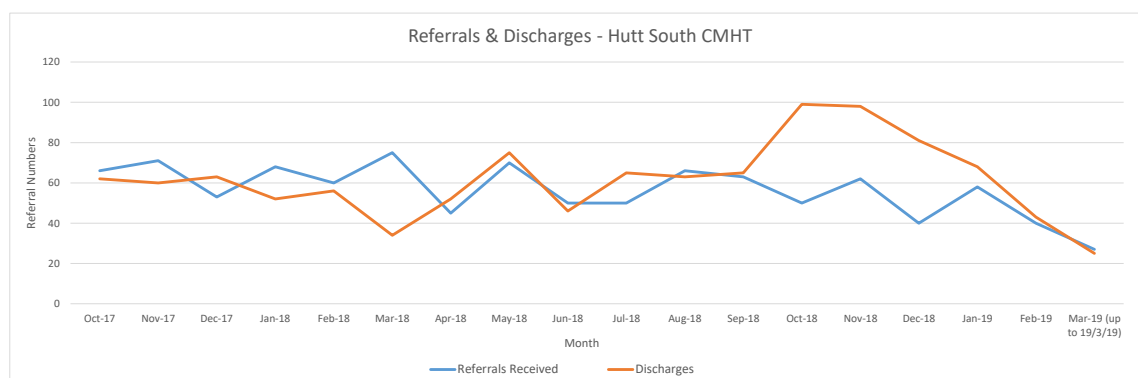
This project links with the work being done by the Mental Health and Addictions Network for Hutt Valley.

Full Team Caseload - Hutt South CMHT

	Caseload at 1/10/2017	Caseload at 1/04/2018	Caseload at 1/10/2018	Caseload at 19/03/19
Hutt Valley South Caseload	916	982	960	823

Referrals & Discharges - Hutt South CMHT

Row Labels	Referrals Received	Discharges	Net Change
Oct-17	66	62	4
Nov-17	71	60	11
Dec-17	53	63	-10
Jan-18	68	52	16
Feb-18	60	56	4
Mar-18	75	34	41
Apr-18	45	52	-7
May-18	70	75	-5
Jun-18	50	46	4
Jul-18	50	65	-15
Aug-18	66	63	3
Sep-18	63	65	-2
Oct-18	50	99	-49
Nov-18	62	98	-36
Dec-18	40	81	-41
Jan-19	58	68	-10
Feb-19	40	43	-3
Mar-19 (up to 19/3/19)	27	25	2
Total for period 1/10/17 - 19/3/19	1014	1107	-93

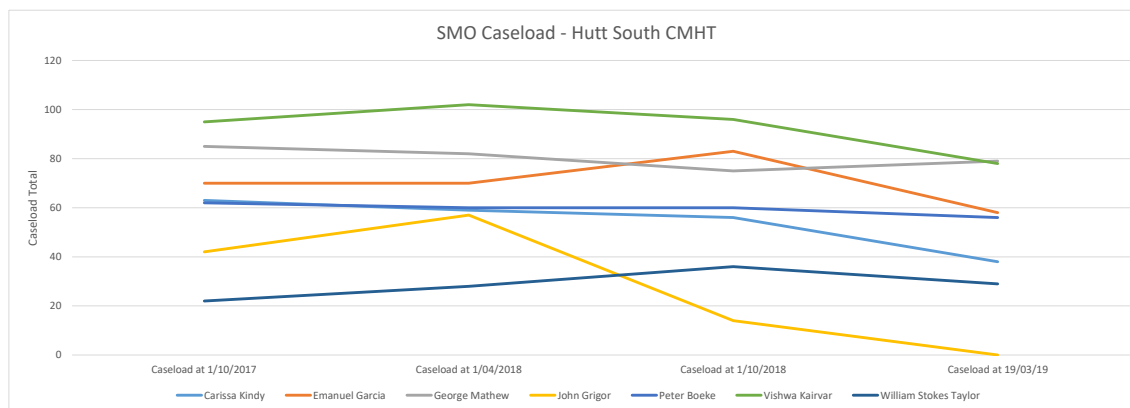



Referrals & Discharges (AOD Referrals only) - Hutt South CMHT

Row Labels	Referrals Received	Discharges	Net Change
Oct-17	5	10	-5
Nov-17	8	10	-2
Dec-17	6	11	-5
Jan-18	6	8	-2
Feb-18	2	2	0
Mar-18	5	4	1
Apr-18	7	2	5
May-18	10	5	5
Jun-18	5	4	1
Jul-18	5	3	2
Aug-18	0	6	-6
Sep-18	4	1	3
Oct-18	2	10	-8
Nov-18	2	11	-9
Dec-18	0	7	-7
Jan-19	2	3	-1
Feb-19	3	2	1
Mar-19 (up to 19/3/19)	2	2	0
Total for period 1/10/17 - 19/3/19	74	101	-27

SMO Caseload - Hutt South CMHT

Doctor Name	Caseload at 1/10/2017	Caseload at 1/04/2018	Caseload at 1/10/2018	Caseload at 19/03/19
Carissa Kindy	63	59	56	38
Emanuel Garcia	70	70	83	58
George Mathew	85	82	75	79
John Grigor	42	57	14	0
Peter Boeke	62	60	60	56
Vishwa Kairvar	95	102	96	78
William Stokes Taylor	22	28	36	29
Grand Total	439	458	420	338



		CLINICAL COUNCIL UPDATE PAPER
		Date: 24 June 2019
Author	Debbie Gell, General Manager – Quality, Service Improvement & Innovation	
Endorsed by	Dale Oliff, Acting Chief Executive	
Subject	Hutt Valley DHB Quality and Safety update	
RECOMMENDATIONS		
It is recommended that the Clinical Council:		
a) NOTES the following Quality and Safety update, which was presented to the HVDHB Board on 27 June 2019.		

1. PURPOSE

The purpose of this report is to provide the Hutt Valley Health System Clinical Council with an update on key Quality and Safety activities at Hutt Valley DHB.

1.1 Quality and Patient Safety Committee update – April and May 2019

The Quality and Patient Safety Committee (QPSC) is the key committee for enabling clinical governance, ensuring the organisation has appropriate systems and processes for patient safety, and is learning from our serious adverse events. The committee meets monthly; the agenda includes updates from committees reporting as part of the Clinical Governance Framework; reviewing the Quality and Patient Safety dashboard and considering any special cause variation; and confirming recommendations of reviewed serious adverse events.

At the April and May 2019 meetings, the QPSC welcomed new members Debbie Gell, GM Quality, Melissa Brown, Interim COO and Chief Clinical Information Officer, Steve Earnshaw. The committee received reports from the Patient Deterioration group, the Infection Prevention and Control Committee, Property and Facilities, and the Medicines Committee.

Susan Cartmell (CNM for ICU and the Patient At Risk Service) and Ravi Ramaiah (Consultant in Anaesthesia and Intensive Care) are leading the work on the deteriorating patient quality and safety marker from the HQSC. They highlighted work done in this area in recent years and the difficulty in expanding the Patient At Risk Service due to nursing capacity. In 2019 they will receive assistance from HQSC improvement advisor (Russell Tonkin), and the Interim COO and DoN will work with the CNM on the service model for the PARS nurses. The group will report back to QPSC in 3 months' time.

The Infection Prevention and Control Committee (IPCC) were represented by Matthew Kelly, Infectious Diseases Physician who presented the Annual Report. He noted the ongoing challenge of working in an integrated way across the health system and particularly into aged residential care, the progress in the management of the community CPE outbreak and celebrated recent successes in reducing IV line infections, improved hospital cleaning and point of care influenza testing in the emergency department. Next steps for the IPCC are work on the transmission-based precautions, antimicrobial stewardship rounds and a project with ACC on improving aseptic technique in out of theatre settings.

Darrell Chin, Property and Facilities Manager provided updates on a number of building and property issues that impact on patient safety. The QPSC asked for progress reports on three issues related to theatres and

radiology, and for Property and Facilities to consider a revised approach to the prioritisation of work to include clinicians and patient safety – this may follow a similar model to ICT prioritisation.

Medicines Committee has made considerable progress and is well connected with ward medicines groups. Audits in key areas (such as controlled drugs) are performed and actions being worked through. Sue O'Connor, Pain Clinical Nurse Specialist was thanked for her ongoing work on the quality safety marker on opioids.

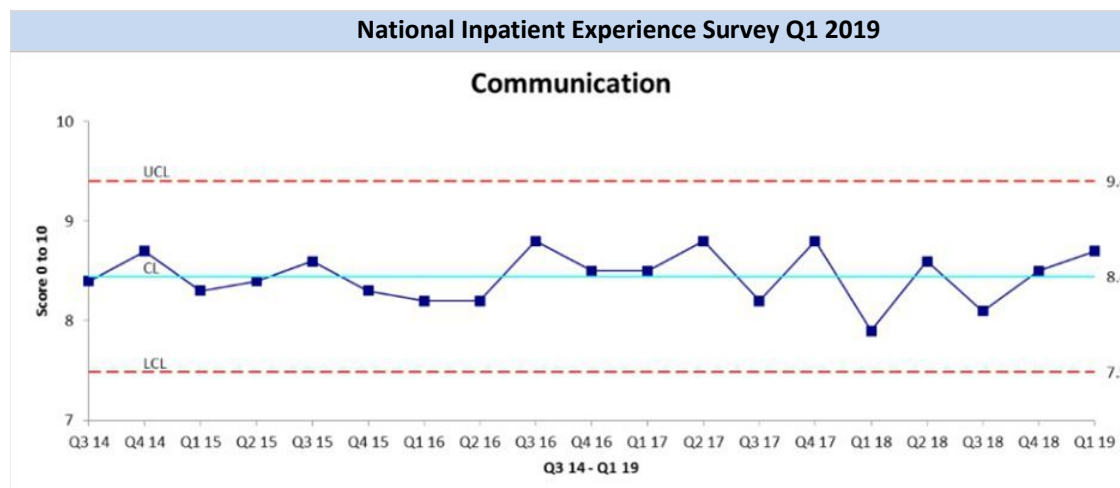
One MHAIDS serious adverse event review was received and endorsed, along with one each from Surgical, Women's and Children's and Medical and Acute Care. Preliminary reports were received for three new serious adverse events. The Quality and Safety monthly dashboards were received with special cause variation noted in total reported events. This variation is being analysed further by the Quality team and raised with the services involved to consider the factors that may be contributing.

1.2 National Inpatient Experience Survey – results for Hutt Valley Q1 2019

It is a requirement of the Ministry of Health that each DHB undertake a patient experience survey. Nationally, the Health Quality & Safety Commission (HQSC) facilitates this through a quarterly National Adult Patient Experience Survey (adult inpatients over 15 years of age, excluding Mental Health). The survey has four domains: communication, partnership, coordination, and needs (physical and emotional).

The National Inpatient Experience Survey results are presented in the same way that other quality and patient safety metrics are presented here, by control charts, with examples of the comments that are received from survey respondents.

This quarter's results include responses from 92 people who were cared for in Hutt Hospital, a response rate of 23% - similar to the national average. Across each of the four domains scores are consistent with previous quarters, but higher than the national average. The comments are examples of the verbatim responses and a useful insight into the care provided. These survey responses are now given to clinical staff in ward areas on a regular basis to both re-inforce positive aspects of care and to identify areas for improvement.

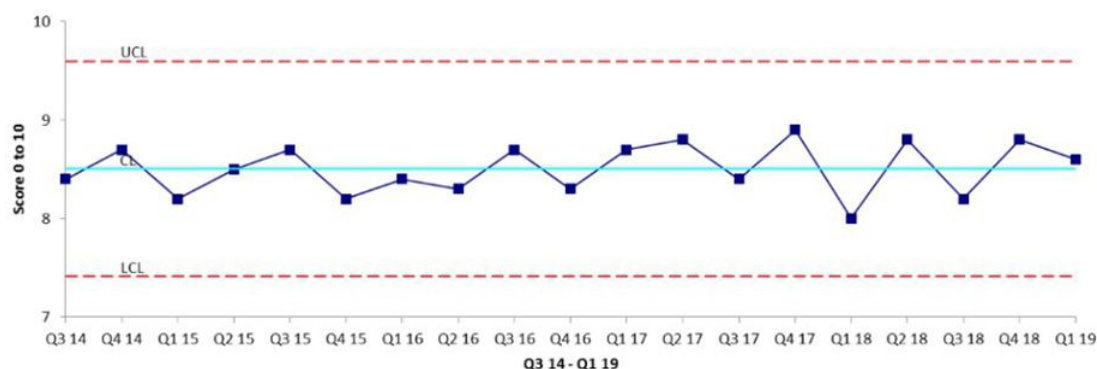


Commentary

HVDHB received a score of 8.7 (0 to 4.9 Poor, 5 to 6.9 Moderate, 7 to 8.9 Good, 9 to 10 Excellent) for the Communication Domain. This is in line with previous scores in this area and sits 0.4 above the national mean for this domain.

Example of Communication comments:

- *I had excellent care and support. I was consulted each step of the way. Explanations given as to best treatment. Did not need or require anything further.*
- *I never felt like I was being a pain when I asked questions and Drs and nurses always gave me their time when they could even though they were really busy and I appreciated that so much.*
- *We were often told things that didn't happen, nurses and doctors on occasions saying different things.*
- *The doctors were having a discussion regarding a medication I needed to go on, between themselves across my bed. The doctor who was leading the conversation apologised for talking over me. Then went on to explain what they had been discussing and why there was an issue. I appreciated that he took the time to explain.*
- *Staff were clear and respectful, no unnecessary jargon.*
- *There was very minimal communication. Would have been good to know more about what was happening e.g. when I could be discharged.*
- *The doctors and staff were very good with what had to be done for me. The best. They were good to me. They gave me a board and pencil to write down if I couldn't understand them or need something. Great.*
- *My condition was explained very well to me.*

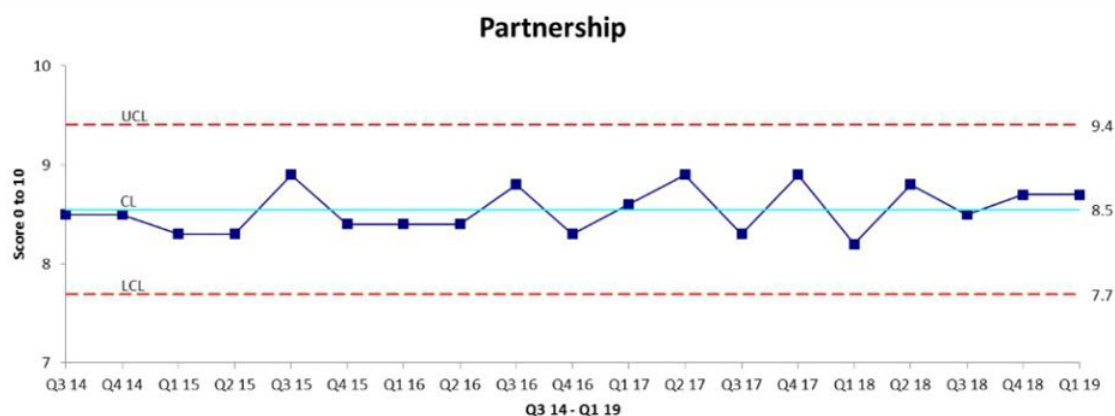
Coordination**Commentary**

HVDHB received a score of 8.6 (0 to 4.9 Poor, 5 to 6.9 Moderate, 7 to 8.9 Good, 9 to 10 Excellent) for the Coordination Domain this quarter. This is in line with previous scores and sits 0.3 above the national mean for this domain.

Examples of Coordination comments:

- *The care from the Post Natal ward was fantastic. The staff were always available. I felt like each Midwife knew my case history before they met with me. I felt comfortable to discuss all my concerns with all of the staff. The only frustration was the conflicting advice on breastfeeding.*

- Every time I was moved from one place to another (as in GP's surgery to ED, ED to the ward), I was told what was happening, why it was happening and what it meant. Also if there was a change, this was explained as soon as possible.
- Respiratory staff took time to merge 3 days appointments into 1 day.
- With the change of shifts the new staff appeared to know all about what was happening which is encouraging.
- The medical staff both occupational therapist and physiotherapists all worked exceptionally well together, it was not until I got home that I found out how well prepared I was.
- I wasn't given any discharge notes (Drs strike was on) and had to remind multiple people that I was breastfeeding to ensure I wasn't given any medication that would be harmful to that.
- Thanks for all being on the same page.



Commentary

HVDHB received a score of 8.7 (0 to 4.9 Poor, 5 to 6.9 Moderate, 7 to 8.9 Good, 9 to 10 Excellent) for the Partnership Domain. This is in line with previous scores in this area and sits 0.2 above the national mean.

Examples of partnership comments:

- I had appendix surgery on the Wednesday, on the Thursday I did not feel comfortable at all. I was still sore and groggy. The doctors asked if I was happy to be sent home and I said no, they asked why and I said that I was still sore etc. and they said that I'd better stay in another night then. The following morning I was much brighter and less sore, so they said that they were happy to let me go home.
- I like the way they talked with me and not at me.
- Always asked me before make decisions.
- My occupational therapist and physio were amazing, and they talked me through what would be involved when I went home and asked me thorough questions about everything and how I felt about being at home and whether I would be okay.
- Physio making sure that I had a chair that fitted me. Coming to walk at least 2x per day and encouraging the nursing staff to also walk with me out of physio hours. Nurses and healthcare assistants always willing to seek ways so I could manage. Attempts by kitchen staff and dietitian to get palatable substitutes when I could not tolerate some foods.

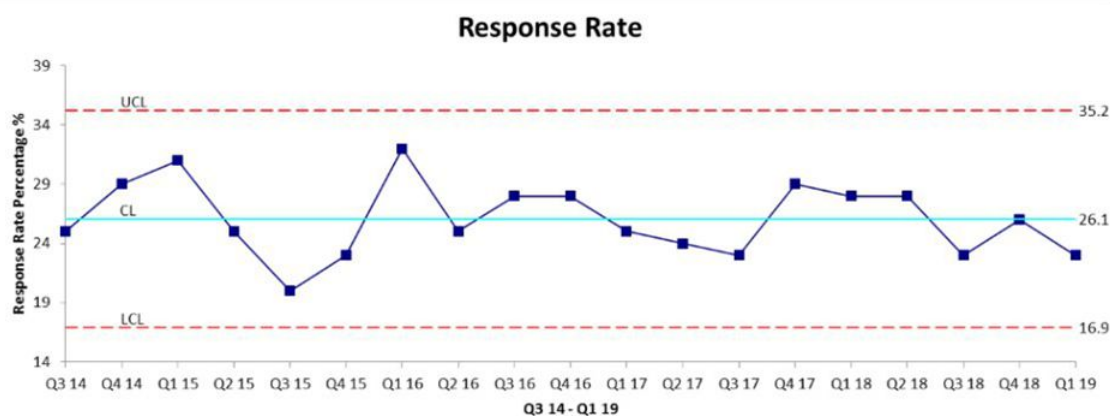


Commentary

HVDHB received a score of 8.7 (0 to 4.9 Poor, 5 to 6.9 Moderate, 7 to 8.9 Good, 9 to 10 Excellent) for the Physical and Emotional Needs Domain. This is in line with previous scores in this area and sits 0.1 above the national mean.

Example of physical and emotional needs comments:

- The staff were efficient but generous with their time. I felt I had all my questions answered in a manner that was empathetic. Issues that I might have had problems with, e.g., changing maternity pads and using the toilet after my catheter was removed, were handled with respect.
- All her needs and wellbeing always seen to. Offered to see a pastor if she needed prayer which was a lovely gesture.
- Help with going to the toilet and putting on slippers. The latter a small thing but very important when you are feeling miserable and vulnerable.
- I was impressed to see volunteers walking round ED talking to people. I was in ED alone, as I didn't think there was much wrong with me so after being taken up to the ED ward area I was a bit stressed. The volunteers were lovely to speak to. The doctors and nurses also made me feel a lot happier through talking to me and having a smile!
- Considering there was a strike the nurses were still so professional and didn't make me feel I was a burden when I pressed the caller button.
- [After vomiting] I was so embarrassed and feeling miserable and upset, and one of the staff came through and took such good care of me, took away all the embarrassment and was just so lovely. I was so grateful.



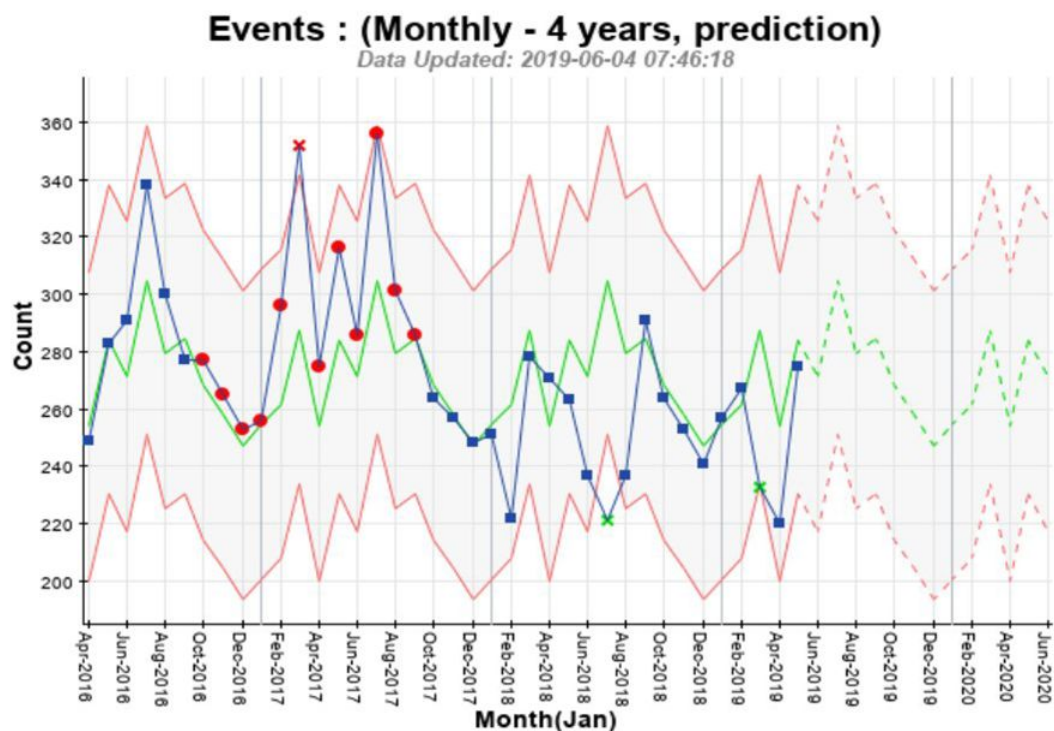
Commentary

The total number of surveys returned for the Q1 2019 survey 23% (n=92). This is in line with previous survey return. This sits 1% below the national mean. HVDHB sends out 400 surveys each quarter.

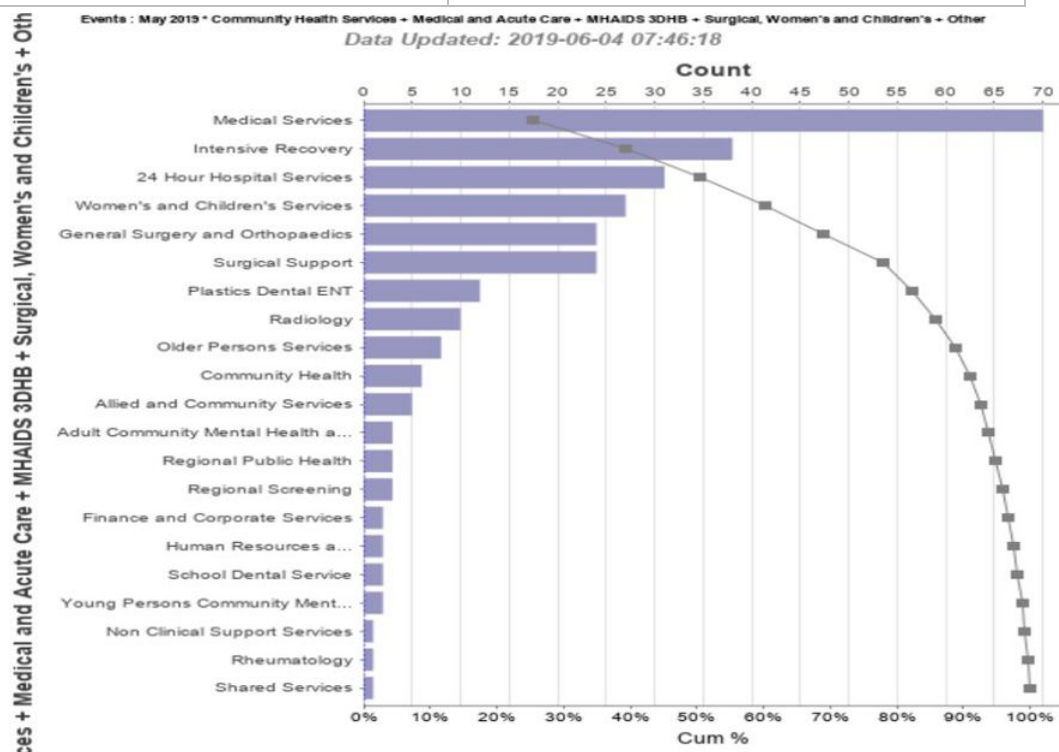
1.3 Health and Disability Commissioner's report for period 1 July to 31 December 2018

Two times each year, the Health and Disability Commissioner (HDC) releases its report for complaints involving DHBs. National data is reported, alongside a small number of case reports for DHBs to learn from. For the period 1 July to 31 December 2018 the HDC reports that national trends in complaints have remained broadly consistent with previous periods with respect to the service types and primary issues complained about. Nationally, the HDC received 444 complaints and closed 451 complaints in the six month period. Of the 451 complaints closed, 11 were investigated with the remainder being assessed as appropriate for other resolution. Seven of the 11 resulted in a breach finding.

For the 6 month time period, Hutt Valley DHB had a rate of 147 complaints received by the HDC per 100,000 discharges, or 25 complaints. While this is a higher number than in previous periods, Hutt Valley DHB is not an outlier in the rate of complaints per 100,000 discharges compared to other DHBs. The HDC notes that the number of complaints is not a proxy for the quality of care provided, and may instead, for example, be an indicator of the effectiveness of a DHB's complaints system. Over the same time period, the HDC closed 11 complaints, with one breach finding as notified to the Board in February 2019.

1.4 Dashboard**Reportable Events**

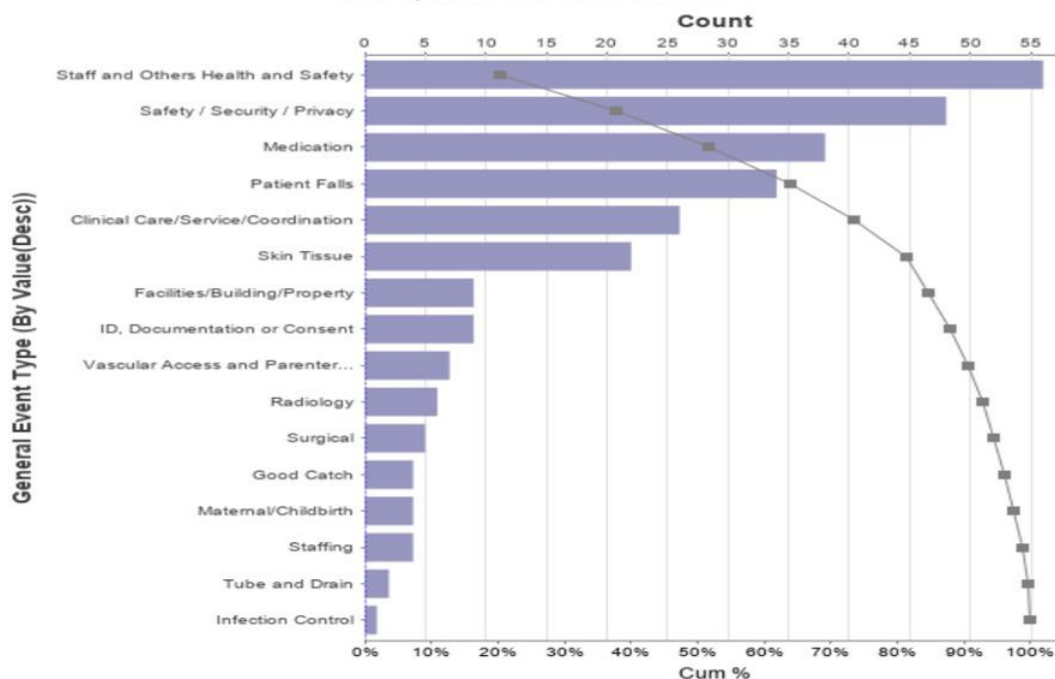
Commentary	Action
Number of Reportable Events received this month is consistent with what would be expected through common cause variation.	The reduction seen in the previous two months has not continued this month. Work with services to train staff who review and close events and feedback on outcomes is ongoing.



Commentary	Suggested Action
Of the events reported this month, 25.8% (n=72) of the total number reported originate from Medical Services, 13.6% (n=38) in Intensive Recovery and 11.1% (n=31) in 24 Hour Hospital Services. This accounts for 50.7% of all events reported. This pattern is similar to previous months.	Continue monitoring and oversight by service groups.

Events : May 2019 * General Event Type

Data Updated: 2019-06-04 07:46:18

**Commentary**

For the events reported this month, 20.5% (n=57) of all events occurred in Staff and other H&S, 17.2% (n=48) occurred in Safety/Security/Privacy, 13.6% (n=38) occurred in Medication, 12.2% (n=34) occurred in Patient Falls, 10.0% (n=28) occurred in Clinical Care/Service/Coordination – these account for 73.7% of all reportable events logged. This pattern of categories has been consistent over several months.

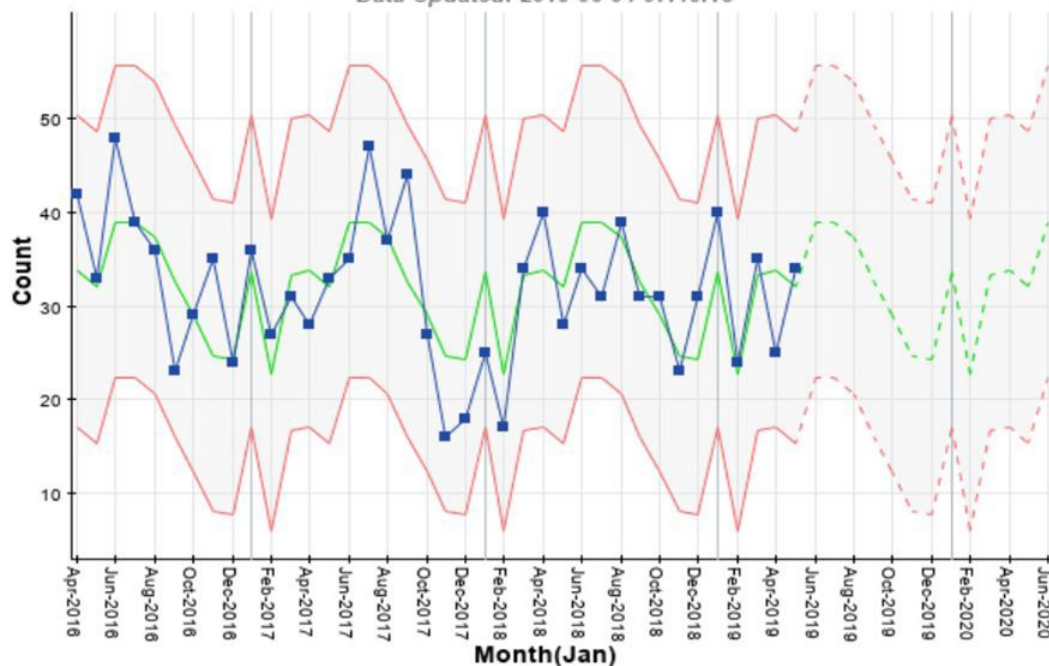
Suggested Action

Continue monitoring and consideration by the Quality and Patient Safety Committee and Health and Safety.

Reportable Events Key Clinical Indicators

Events : Patient Falls : (Monthly - 4 years, prediction)

Data Updated: 2019-06-04 07:46:18

**Commentary**

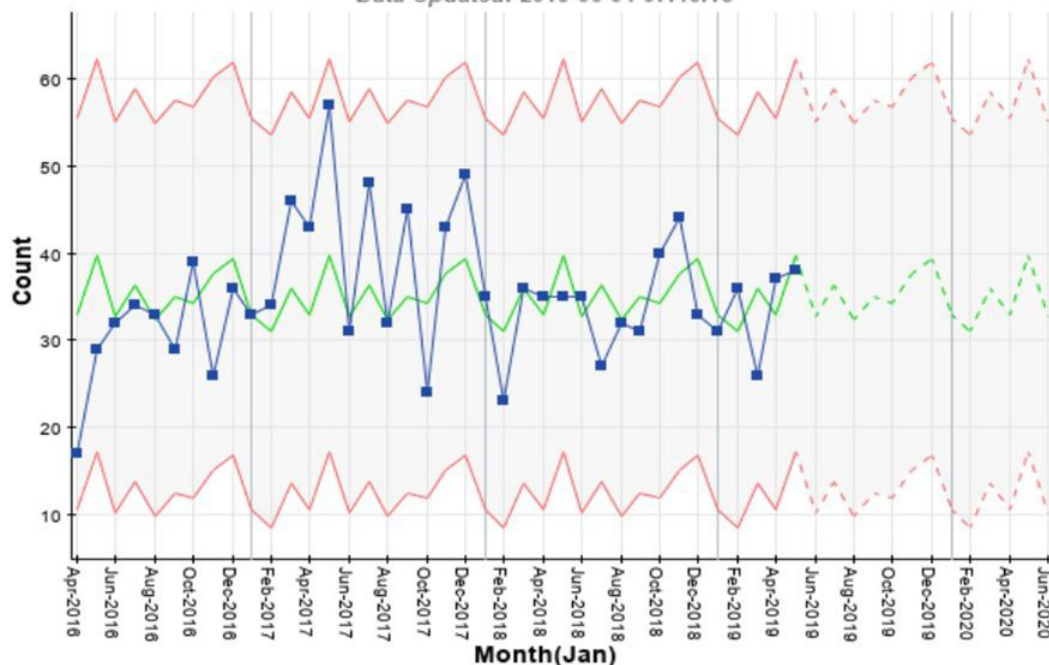
Number of patient fall events logged on SQuARE for this month is consistent with what would be expected through normal common cause variation. No special cause variance/trend identified.

Suggested Action

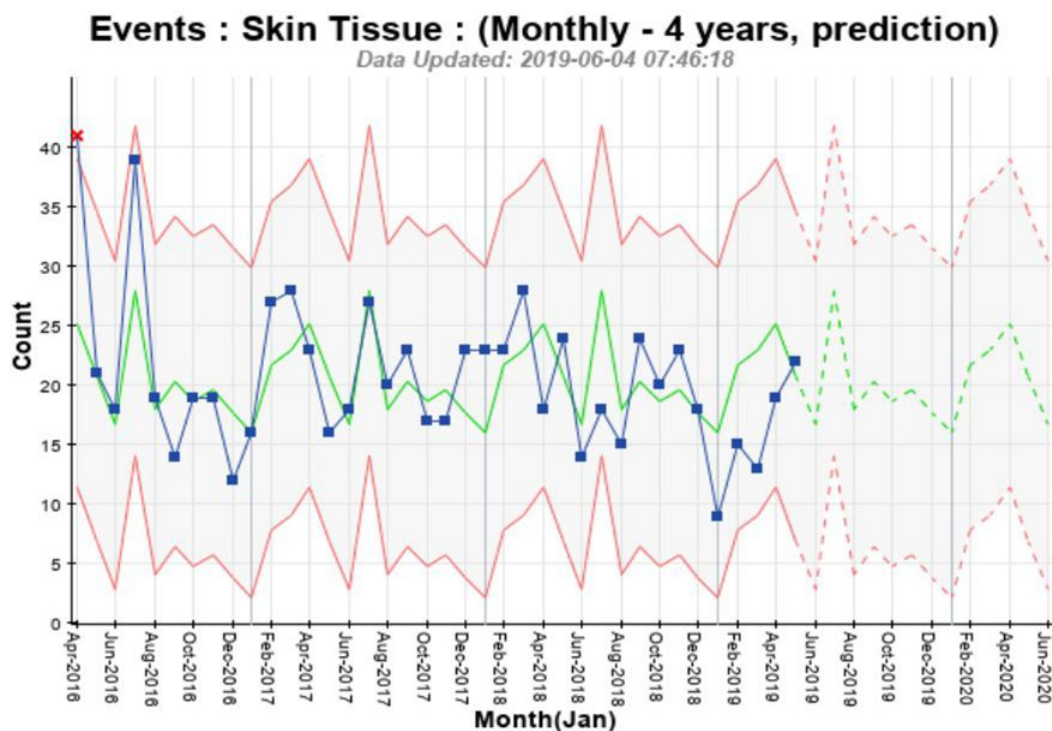
Continue monitoring by the Falls Committee with active implementation of falls minimisation strategies on wards.

Events : Medication : (Monthly - 4 years, prediction)

Data Updated: 2019-06-04 07:46:18



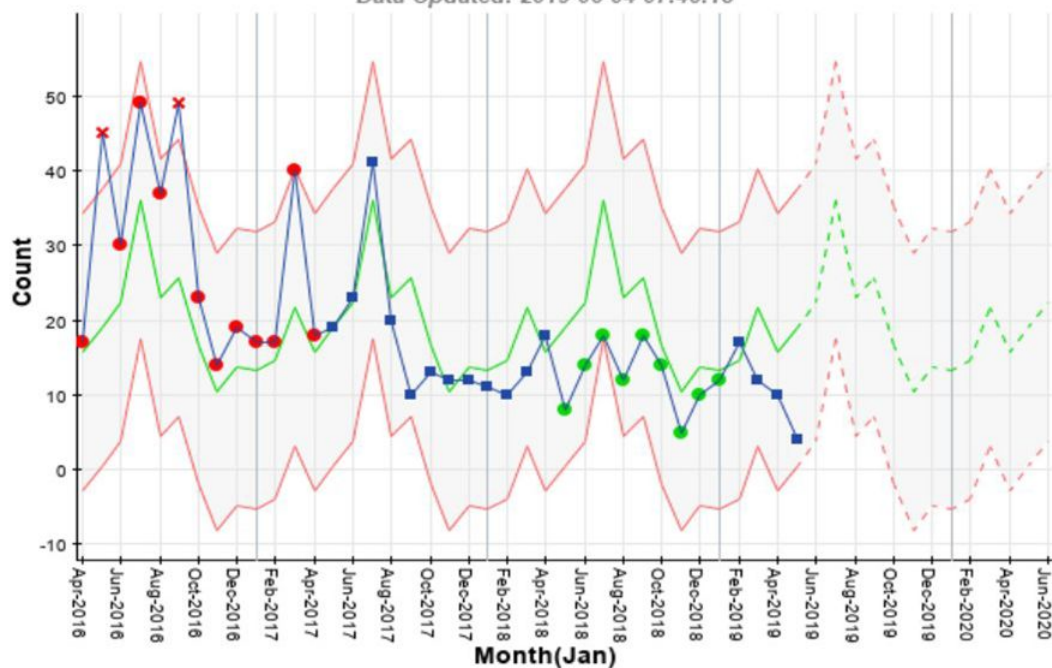
Commentary	Suggested Action
Number of medication events logged on SQuARE for this month is consistent with what would be expected through common cause variation. No special cause variation is identified.	Continue monitoring and analysis by ward medication groups and the Medicines Committee.



Commentary	Suggested Action
Number of skin/tissue events logged on SQuARE for this month is consistent with what would be expected through common cause variation. No special cause variation is identified.	Continue monitoring and analysis by the Pressure Injury Steering Group.

Events : Staffing : (Monthly - 4 years, prediction)

Data Updated: 2019-06-04 07:46:18



Commentary

The number of staffing events logged on SQuARE for this month is consistent with what would be expected through common cause variation.

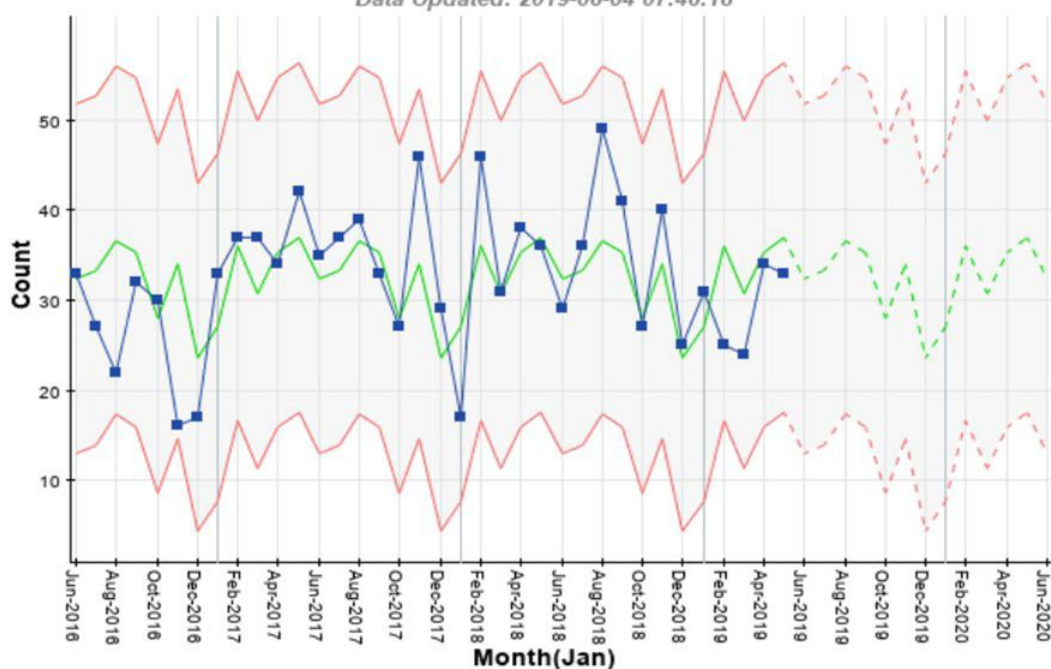
Suggested Action

Continue monitoring within services.

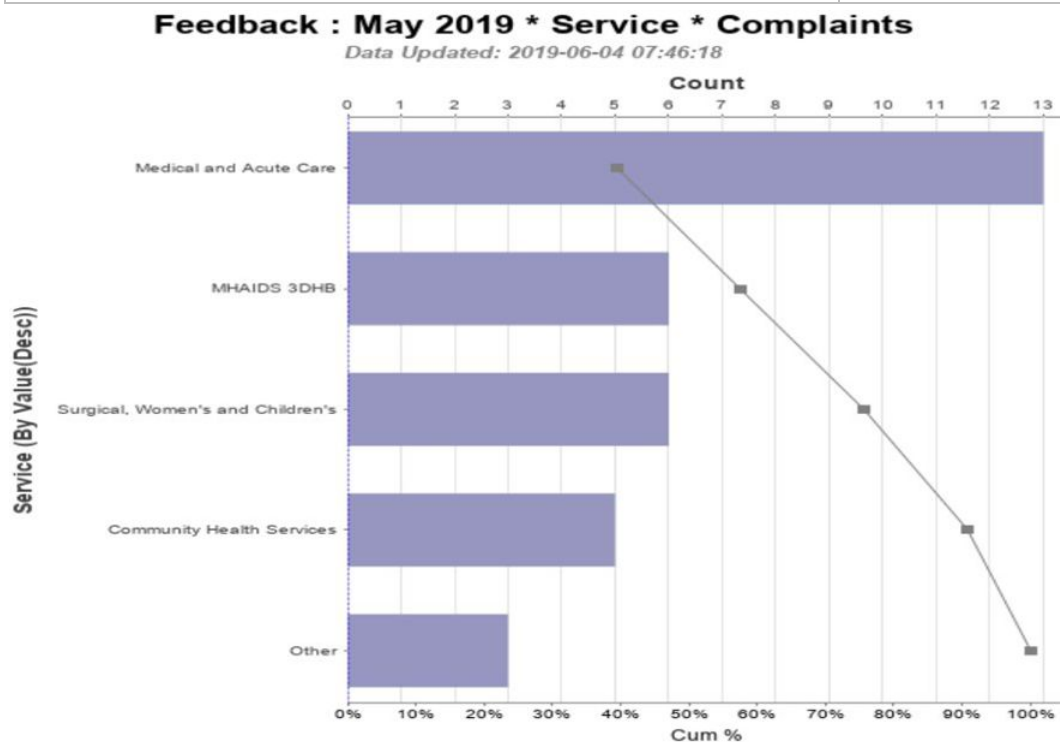
Feedback

Feedback : Complaints : (Monthly - 4 years, prediction)

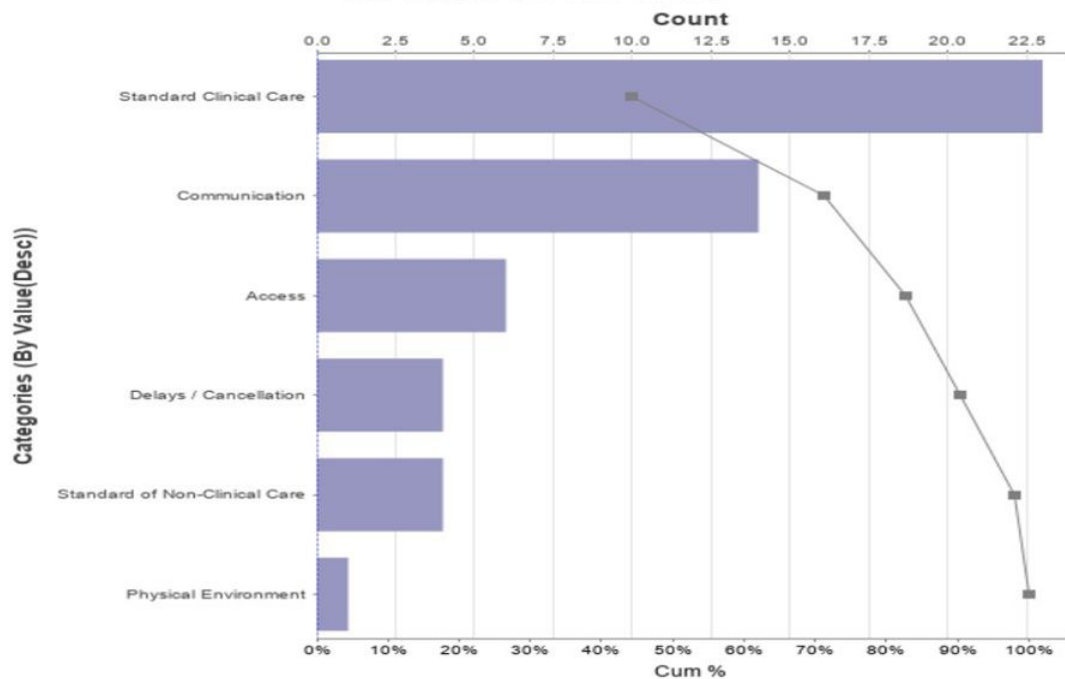
Data Updated: 2019-06-04 07:46:18



Commentary	Suggested Action
The number of complaints logged on SQuARE for this month (n=33) is consistent with what would be expected through common cause variation.	Continue monitoring.



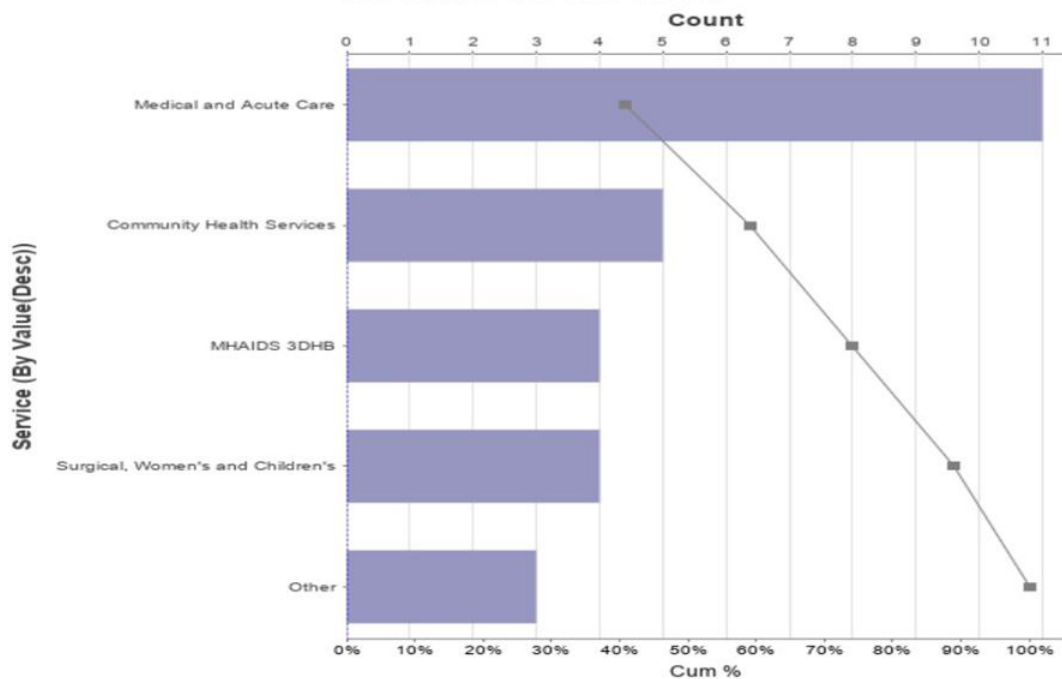
Commentary	Suggested Action
Complaints received (including HDC complaints) for this month were predominately in the Medical and Acute Care Service Group (n=13) followed by MHAIDS (n=6) and Surgical, Women's and Children's (n=6).	Services continue to respond to and learn from complaints. Continue monitoring and review at the ward/department level.

Feedback : May 2019 * Complaints * Categories*Data Updated: 2019-06-04 07:46:18***Commentary**

44.2% of the identified themes from complaints received this month were in the area of 'Standard Clinical Care'; 26.9% involved 'Communication'. These two categories account for 71.1% of the themes identified in complaints received.

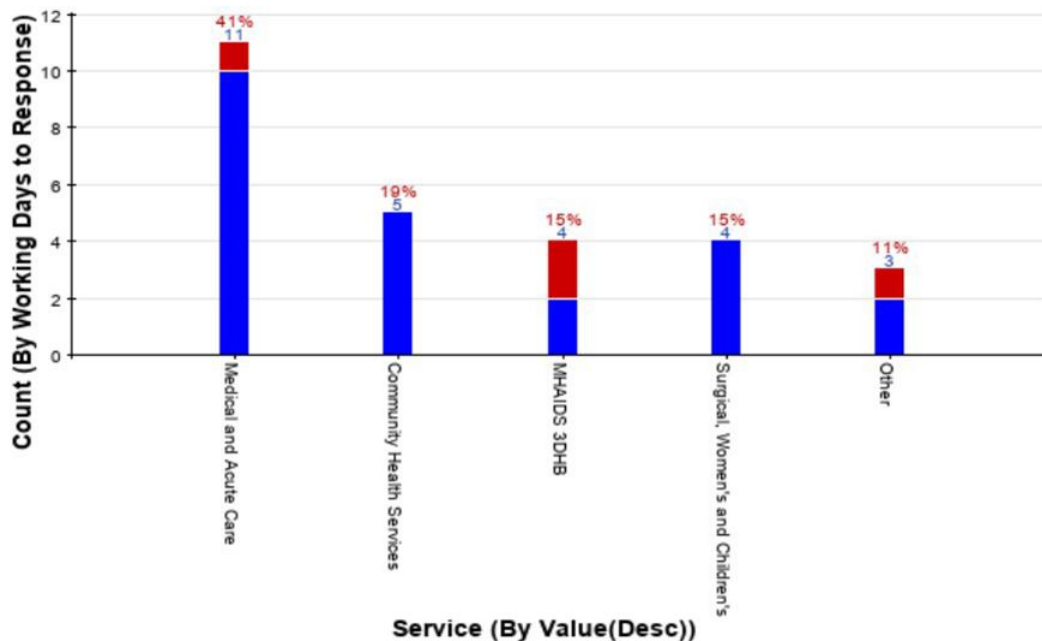
Suggested Action

Continue monitoring.

Feedback : Service * Complaint * Open * In-Progress + New*Data Updated: 2019-06-04 07:46:18*

Open complaints (excl HDC) - (red = >20 workings days to response):

Data Updated: 2019-06-04 07:46:18



<=20 days >20 days

Commentary	Suggested Action
Of the open complaints (not including HDC) 41% (n=11) are in the Medical and Acute Care Service Group and 19% (n=5) in Community Health Services. These make up 60% of the open complaints. 14.8% (n=4) are outside the 20 working day response KPI (at 01/05/2019).	Continue monitoring.

1.5 Quality Improvement Programmes and Projects Support – update

A range of quality improvement programmes and projects are underway at Hutt Valley DHB. These include projects that are led by the Improvement Advisor and other members of the Quality team, and projects and programmes that led by others and supported by the Quality team through providing specialist advice (such as data analysis, statistical process control charts, process mapping, PDSA cycles, Lean methodology).

The Improvement Advisor has recently completed the Shorter Stays for Acute Patients project which has focused on improving the flow of patients out of the Emergency Department (ED) which will inevitably have a positive impact on the 6-hour ED target.

Work is ongoing to support the medicine service improvement project workstreams (improving the team work between medical, nursing and allied health teams on the medical ward and making patient flow more efficient), the frailty service improvement project (introduction of an electronic frailty screening tool), and eHandover improvement project (enhancing consistency of doctor handovers). The eHandover Project has now been launched and is in a trial phase within Medical Services. A further improvement project is underway called *Smooth Sailing* focusing on patient flow from the Emergency Department to the General Medicine Service. The Quality Team's Improvement Advisor works in an advisory role alongside project managers and clinical staff.

Work is due to begin on a project to reduce medication / drug count errors, and the roll out of a Subcutaneous Infusion Medication tool.

1.6 Certification Audit

Certification is the auditing of inpatient services provided by Hutt Valley DHB to ensure we comply with the Health and Disability Sector Standards. Hutt Valley DHB has a service agreement with the Designated Auditing Agency (DAA) Group to provide certification services as our audit agency.

Hutt Valley DHB underwent a full on-site Inpatient Certification Audit from 4-7 June 2019.

The auditors noted the nursing staff felt supported by their senior leadership, patients and family spoken too felt positive about care they received, the infection control processes were commended and complaints were well managed.

Hutt Valley DHB is awaiting the full draft report in order to consider all of the findings. The report will include a list of Corrective Actions for the DHB to address.

Sarah Thomas, IPC CNS

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EXECUTIVE SUMMARY

In 2018 the Infection Prevention and Control (IPC) service has continued to focus on consolidating improvements made over recent years. Hutt Hospital continues to have good systems in place for monitoring infection control and escalating issues appropriately when identified.

Surveillance data for 2018 shows continued control of Multidrug Resistant Organisms (MDRO) and *Clostridium difficile* infections (CDI). Surgical site infection prevention is well established in orthopaedics with consistently high performance. The rate of healthcare-associated Staph aureus bloodstream infections was very low during 2018. This was partially the result of the 'Know your IV Lines' project which was successfully launched in September 2017. This ACC funded quality improvement project will now be made available nationally.

Infection control issues relating to facilities continue to pose a challenge although progress has been made in 2018. The designs of the Childrens Ward and OPRS Wards make these environments challenging for infection control during times of high occupancy. The staff in these wards should be commended for the successful way in which they reduce the risk of infection for patients despite these environments.

The transition of hospital cleaning to steam and microfibre and the introduction of a robust auditing system was completed for Domestic Services staff in 2018. The role out of this method to nursing and health care assistants continues.

Education remains a major focus of the IPC service with a review of the online learning package and continued teaching at the mandatory teaching sessions. There have been numerous other study days and teaching sessions provided by all members of the IPC team.

The antimicrobial stewardship programme is now well established and has delivered on the goals specified in the proposal to employ an antimicrobial pharmacist. Total antibiotic consumption has significantly reduced and the use of high-risk antibiotics continues to decline. This is likely to have reduced harm from antibiotics as reflected in a declining rate of *Clostridium difficile* infections. The outpatient intravenous antibiotic service is now embedded and provides safe and effective antimicrobial therapy allowing earlier discharge of patients.

In 2017 the IPC service indicated that future challenges in infection prevention will include the growing threat from Carbapenemase Producing Enterobacteriaceae (CPE). These extremely antibiotic resistant bacteria are increasingly found throughout New Zealand. This became a reality for the hospital in late 2018 with the identification of the first New Zealand community cluster of patients with CPE. The response to this threat will need to include improved infection prevention knowledge and practices in primary care, especially aged residential care facilities.

INTRODUCTION

The Hutt Valley DHB Infection Prevention and Control (IPC) Service is part of the Quality, Service Improvement and Innovation Group and is governed by the HVDHB Infection Prevention and Control (IPC) Committee. In late 2018 the membership of the IPCC was reviewed in line with the changes in governance at the hospital. The Committee has endorsed the IPC Programme 2018 - 2021. In accordance with this plan the Committee aims to reassure the Executive and Board that appropriate steps are taken to minimise the risk of infection to consumers, service providers and visitors.

The IPC service consists of three Clinical Nurse Specialists and an Infectious Diseases Physician, and works closely with the microbiology laboratory. The service works with departments and professional groups throughout the hospital on a broad range of issues. The broad aim of the service is to use its expertise to manage IPC issues by encouraging frontline ownership and sustained culture change with regards to infection prevention. The IPC service operates in accordance with the Health and Disability (Infection Prevention and Control) Standards NZS 8134.3:2008. This annual report is organised to reflect how the hospital is performing according to these 6 standards.

The IPC service wishes to thank all clinical staff whose actions have resulted in improved infection outcomes for our patients. The service also would like to acknowledge the continued support from the Executive Leadership to promote a culture of infection prevention throughout the organisation.

MANAGED ENVIRONMENT

Standard 1: There is a managed environment which minimises the risk of healthcare acquired infection to patients, staff and visitors.

BUILDING AND RENOVATIONS

Challenges relating to the maintenance and renovation of ageing facilities continue to be an infection control risk. Property and Facilities have addressed many of the issues outlined in previous IPC Annual Reports and are working toward solutions for the remaining issues.

Toilet facilities for patients on the childrens ward remain less than ideal given the number of beds on the ward which becomes an infection control risk during times of high occupancy. Only two of eight isolation rooms on the childrens ward have en-suite toilet facilities.

Recommendations were previously made for the Older Persons Rehabilitation Service due to inadequate facilities to properly isolate patients. A business case has resulted in one room being upgraded and having an en-suite bathroom added. This has improved isolation in OPRS East but the issues of isolating patients without en-suite bathrooms for OPRS West continue to be inadequate.

AIR HANDLING AND PRESSURISED ROOMS

As reported in the 2016 annual report there are three rooms in the plastics and burns unit used for protective isolation, however these rooms have not been functioning at positive pressure. The function and design of these rooms was investigated and from the original plans the rooms were never built to work as positive pressure rooms. Work to improve the cleanliness of the ventilation grills, change filters, and seal the doors and windows has been completed in 2018.

Five of the eight operating theatres fell just short of the required number of air-changes per hour. Air filters are now being changed more frequently to resolve the issue while it is being investigated further. Negative pressure rooms on the paediatric, medical, ICU and MAPU wards are functioning to standard.

CENTRAL STERILE SUPPLY DEPARTMENT (CSSD)

A glass wall with an interlock door between the main corridor and CSSD clean area has been installed. This will provide an air lock area to prevent cross contamination from the corridor where non-sterile goods including theatre rubbish and dirty laundry are transported.

FOOD SERVICES

Food services at HVDHB are currently supplied in house. Changes to meal delivery systems were implemented in late 2018. As part of this process Infection Control were consulted in regard to cleaning of food delivery trollies and procedures for delivering trays to isolation rooms, and recommendations were made. No infection issues relating to food services were identified in 2018.

LAUNDRY

Laundry services at HVDHB are outsourced to Allied Laundry in Palmerston North. IPC continue to support the Domestic Services Manager with any infection control issues related to linen and compliance with AS/NZ 4246. An external audit is performed annually by rotating DHB IPC teams. HVDHB took part in the 2018 audit. Findings of the audit were presented to Allied Laundry with dates for completion of corrective actions.

WATER AND PLUMBING

Hutt Hospital has a process for monthly Legionella testing of the cooling towers. Any unacceptable results are notified to Property and Facilities who are responsible for informing Infection Prevention & Control. In the event of positive results the cooling towers are cleaned, disinfected and re-tested.

The current Heretaunga Block domestic hot water system was found to not be compliant with the Building Code in 2017. In parts of the system hot water is circulated below 60°C and in other parts of the system water at the point of use can exceed 45°C presenting a scalding risk. Property and Facilities have started to address this issue which includes installation of tempering valves throughout the Heretaunga Block which will provide a solution to this problem.

Drinking water is tested monthly for the total coliform count. Results are sent to Property and Facilities, and reported to Infection Prevention & Control. In the event of a positive coliform test the sampling area is initially cleaned and then re-tested.

WASTE MANAGEMENT

Waste Management NZ have the contract for general waste and recycling. The biggest issue is a lot of recyclable waste ends up in general waste as it needs to be sorted at ward level or recycling bins are contaminated with incorrect waste. Domestic Services are currently looking at other recycling options especially around food waste but this is more expensive.

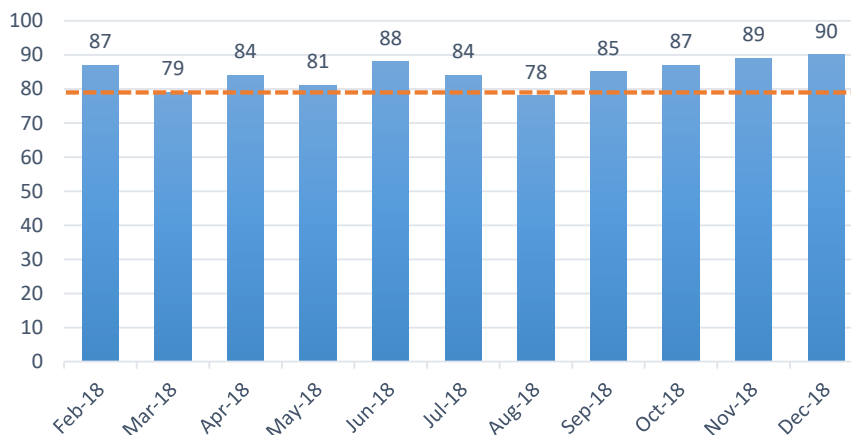
A recycling committee was established in 2015 with representation from the IPC service. A waste scoping exercise was undertaken in 2016 by Wellington Council waste minimisation fund. The recommendations of this are continuing to be worked through.

Interwaste manages hazardous waste for the hospital. Due to the reduction in general waste from improvements in recycling, hazardous waste disposal costs have risen which may be attributable to improvements in waste segregation.

CLEANING

Monthly cleaning audits are completed by Domestic Services using the Top Cat audit system. The audit focuses on the cleaning of high touch points which are most commonly associated with transfer of bacteria. By using fluorescent markers on these high touch points cleaning performance and efficacy can be demonstrated. This allows for visual feedback and teaching of cleaning technique. The graph below illustrates the average audit result for clinical areas during 2018. Significant improvements have been made for 2018 with the attainment of the 80% pass rate for all but two months.

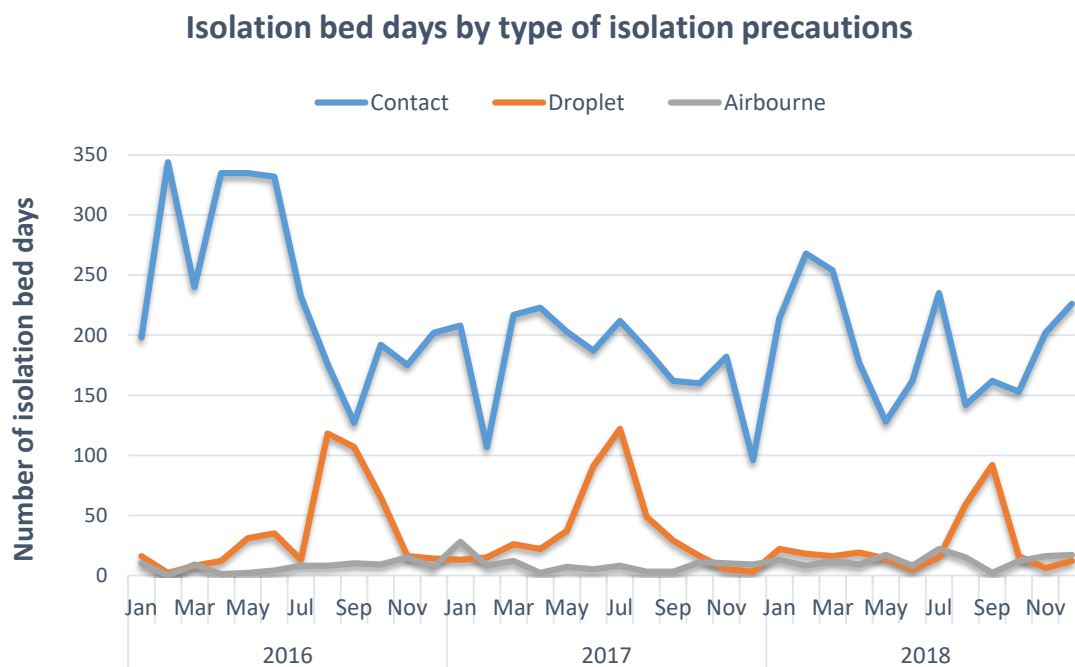
High touch cleaning audits 2018



Permission to procure microfibre cloths for cleaning by clinical staff was approved in 2017 and the tender process was completed in 2018. Microfibre cleaning for equipment in all clinical and outpatient areas has been rolled out from mid-2018 with the completion of the project estimated for mid-2019.

PATIENT ISOLATION AND ALERTS

IPC nurses perform a daily hospital round to review isolation rooms and patients. This round is done using the IPC Concerto whiteboard which was developed in 2017 to pull data from multiple sources. This has saved considerable time for the IPC nurses and so has allowed more time to assist and educate ward staff and provide education to patients and whanau. Patients are provided with written information explaining why they are in isolation and IPC nurses are able to answer any questions. During 2018 there were 2768 isolation bed days which was similar to 2017.

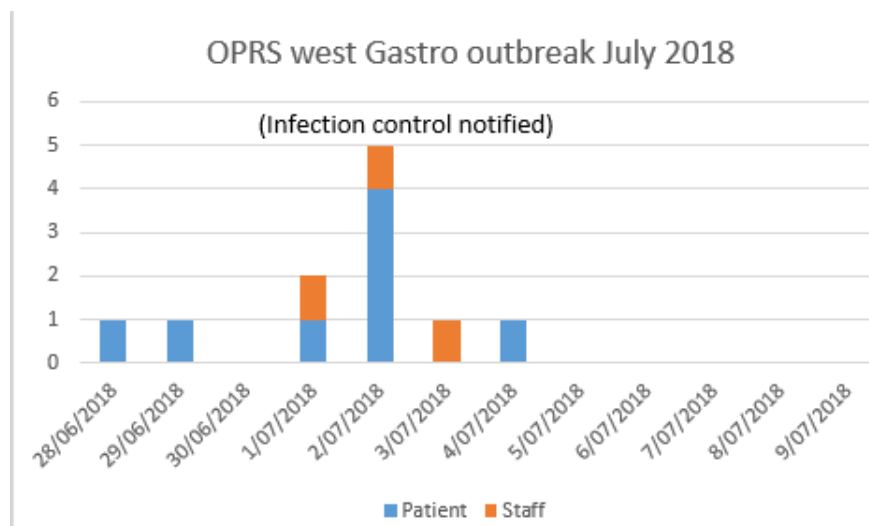


CONTACT TRACING AND SCREENING

Contact tracing and screening of patients and staff is conducted when there has been unintentional exposure to a significant infectious disease. This is done in collaboration with the Occupational Health service. In 2018 there were thirteen contact tracing events which involved referral of 18 staff to occupational health for tuberculosis; 12 staff for meningococcal meningitis; 7 staff for shingles; 2 staff for chickenpox and 30 staff for pertussis exposures.

OUTBREAK MANAGEMENT

A gastroenteritis outbreak occurred in the west wing of the Older Persons Rehabilitation Service in July 2018. This outbreak was notified to Infection prevention and Control on the 2nd July 2018 with several people ill with diarrhoea and vomiting, the earliest onset beginning on Saturday 30th June. A total of 8 patients and 3 staff were affected. Once the illness was identified the Infection prevention and control service worked with OPRS to ensure sufficient control measures to contain the spread of illness. This was in line with our outbreak policies, checklist and procedures.



Specimen testing for Norovirus was negative, the causative agent was not identified but was presumably viral gastroenteritis. This is extremely infectious and can be transmitted from person to person as well as via food and water. The distribution of cases in this outbreak indicates that it was likely to have been person to person transmission.

IPC RESOURCES

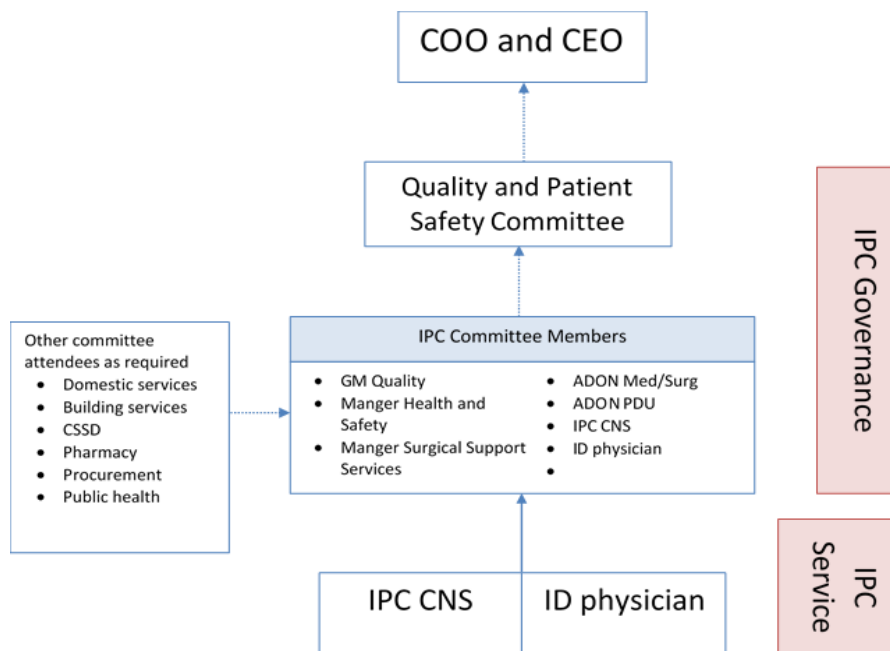
Standard 2: There are adequate human and physical resources to implement the IPC programme that meets the needs of the organisation

IPC STAFFING

Dr Matthew Kelly	Infectious Diseases Physician	0.7 FTE
Claire Underwood	Clinical Nurse Specialist	0.8 FTE
Trudy Lunn	Clinical Nurse Specialist	0.5 FTE
Sarah Thomas	Clinical Nurse Specialist	0.6 FTE

GOVERNANCE STRUCTURE

The Hutt IPC Committee was established in in 2015. The Committee terms of reference and membership were last reviewed in 2018. The IPC service works collaboratively with the IPC services at Wairarapa and Capital and Coast DHBs to ensure consistency of practice and policy where practical. The service is also actively participates in a variety of regional and national forums.



IPC TEAM CONTINUING PROFESSIONAL DEVELOPMENT

Matthew Kelly	IPCNC Conference Lower Hutt 2018 HQSC Infection Prevention Workshop May 2018 Australasian tuberculosis conference August 2018
Claire Underwood	IPCNC Conference Lower Hutt 2018 HQSC Infection Prevention Workshop May 2018
Sarah Thomas	IPCNC Conference Lower Hutt 2018 Vaccinators Course HQSC Infection Prevention Workshop May 2018
Trudy Lunn	HQSC Infection Prevention Workshop May 2018 IPCNC Conference Lower Hutt 2018

POLICIES

Standard 3: Documented IP&C and related policies reflect best practice

HOSPITAL IPC POLICIES

Hutt Hospital has documented IPC policies which reflect accepted best practice and legislative requirements. Policies are reviewed and revised on a scheduled basis or sooner if there are changes in best practice or organisational circumstances. Where feasible, policies are developed or revised in collaboration with Wairarapa and Capital and Coast DHBs to ensure consistency across the sub-region. The IPC service also provides feedback and consultation on a number of other organisational policies.

COMMUNITY SECTOR INPUT AND REVIEW

The IPC service does not have resourcing for a formal community role. Services are provided when feasible and frequently in team members personal time. Two updates for GP services were delivered through the Te Awakarangi health network in 2018 with a further three primary care services requesting input for education around office based sterilisation and infection control requirements for cornerstone or professional accreditation.

SERIOUS INFECTIONS AND PANDEMIC RESPONSE POLICIES

The Ministry of Health released the National Pandemic Response Plan in August 2017. The IPC service is now working with Emergency Management to establish a Pandemic Response working group to update the hospital pandemic response plan in line with the Ministry plan. There will be a pandemic response exercise in September 2019.

EDUCATION

Standard 4: The organisation provides relevant education on IP&C to all service providers, support staff and consumers

EDUCATION PROVIDED TO PATIENTS AND THEIR WHANAU

Written information is provided to patients who are identified as being MDRO carriers or who are in isolation precautions. The IPC nurses also provide direct education and advice to patients and their whanau around these issues when required.

EDUCATION PROVIDED TO STAFF BY IPC NURSES

The infection prevention and control online learning module for Nursing and non-clinical staff has been revised. This now includes a comprehensive learning package for new staff and a yearly update which was completed by 1,124 staff.

A mandatory training day was introduced for all Nursing staff in May 2015. This training day has been expanded during 2018 and includes a practical session on personal protective equipment and an update on hand hygiene, standard precautions and transmission based precautions.

Topic	Audience	Audience Number
Hand Hygiene auditor training	Nursing	10
IPCNC Conference 2018	Nursing and Medical	150
Personal protective equipment practical session	Nursing and Healthcare Assistants	500
NZ certificate in Health and Wellbeing, infection control module	Weltec students	60

EDUCATION PROVIDED TO STAFF BY INFECTIOUS DISEASES PHYSICIAN

Topic	Audience	Audience number
Wairarapa GP CME presentation – antimicrobial resistance	GPs	40
IPCNC Conference 2018	Nursing and Medical	15
Update on Clostridium difficile	Hutt Medical Meeting	60
HVDHB IPC Study Day	Nursing	40
Infections in obstetrics	Obstetrics SMOs and RMOs	10
RMO orientations	RMOs	50

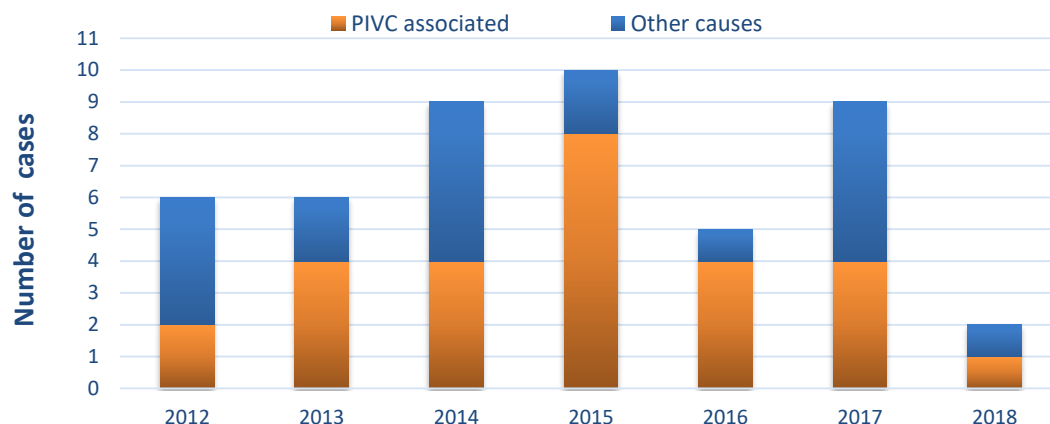
SURVEILLANCE

Standard 5: IPC Surveillance activity is carried out in accordance with specified objectives priorities and methods as specified in the Surveillance policy

HEALTHCARE ASSOCIATED STAPHYLOCOCCUS AUREUS BACTERAEMIA

In 2018 there were only 2 healthcare-associated *Staphylococcus aureus* bacteraemias with an infection rate of less than 0.04 infections per 1000 bed days. This is well below the national average and is the lowest recorded rate at Hutt Hospital for the past 6 years. Of particular note is that since the launch of the 'Know Your IV Lines' campaign in September 2017 there has only been a single PIVC-related bacteraemia. This programme will now be made available to other DHBs nationally. The challenge now will be to maintain the high level of monitoring and patient involvement around PIVC use.

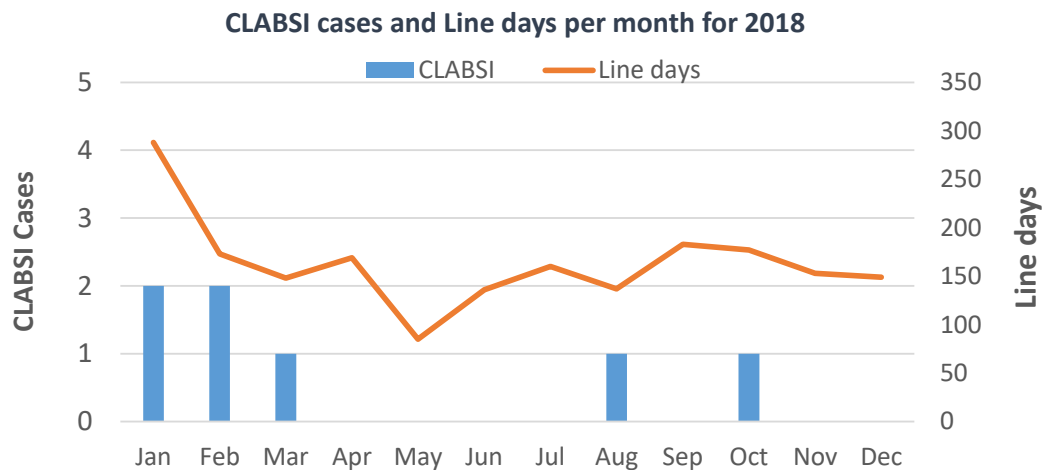
Number of cases of healthcare-associated *Staphylococcus aureus* bacteraemia



CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI)

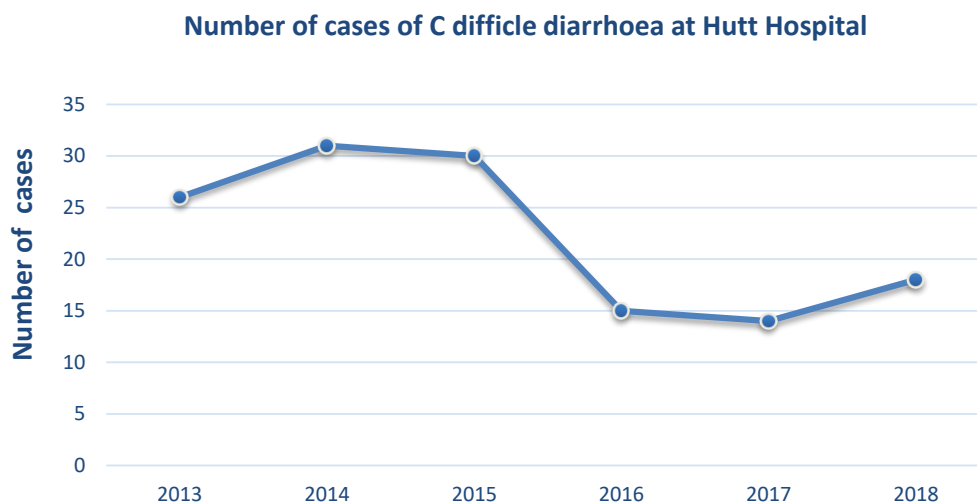
There were 7 CLABSI in 2018, with none of these occurring in ICU. This is a rate of 3.6 infections per 1000 line days which is an increase compared to the 4 cases in 2017 (rate of 1.7 per 1000 line days). The increase was attributable to a cluster of infections at the start of the year involving patients receiving total parental nutrition (TPN). In response there was increased staff education and recertification related to central lines. The insertion and maintenance form was updated to include

more checks and troubleshooting tips, and a high-risk bundle was developed. Following these measures the CLABSI rate for the remainder of the year was comparable to 2017.



CLOSTRIDIUM DIFFICILE DIARRHOEA

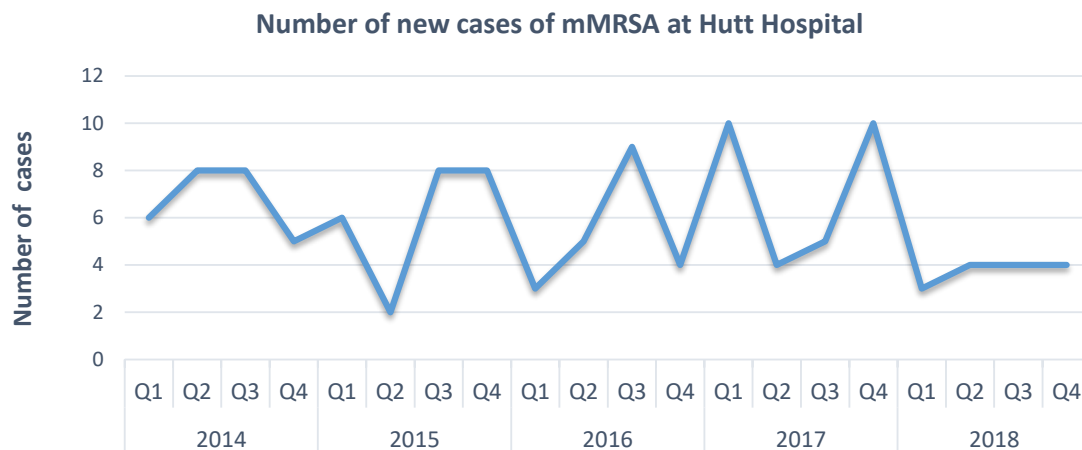
Clostridium difficile diarrhoea is strongly associated with antibiotic use and is a serious illness associated with 5% mortality. In 2018 there was a sustained reduction in *C. difficile* diarrhoea. This compares favourably to other hospitals in New Zealand and Australia. It is likely that improved hospital cleaning and improved antimicrobial stewardship has contributed to this decline.



METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

All patients found to have MRSA have an electronic alert added, however surveillance and isolation measures are more focused on multi-resistant MRSA (mMRSA) strains. Multi-resistant MRSA is more associated with hospital transmission, however this association is becoming less clear and the use of

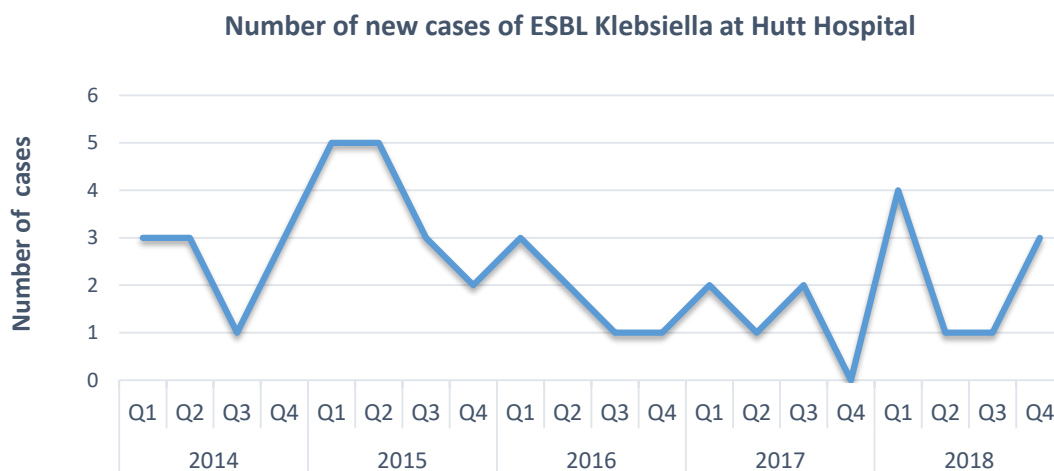
this as a surveillance measure is becoming questionable. There were no mMRSA or nmMRSA outbreaks detected in the hospital during 2018.



EXTENDED SPECTRUM BETALACTAMASE (ESBL) ORGANSIMS

Extended spectrum betalactamase (ESBL) producing organisms are highly resistant and require second or third line antibiotic therapy. ESBL producing *E. coli* are continuing to increase in the community locally and nationally and are rarely if ever cause hospital outbreaks. They are therefore no longer a useful marker of IPC in hospital and the IPC team has discontinued surveillance of ESBL *E. coli* rates in October 2018.

ESBL *Klebsiella* are more highly associated with healthcare and can cause hospital outbreaks. The number of new cases of ESBL *Klebsiella* remains low.



VANCOMYCIN RESISTANT ENTEROCOCCI (VRE)

Vancomycin-resistant *Enterococci* (VRE) is relatively uncommon in New Zealand at present and there were no detected cases at Hutt Hospital in 2018. This organism can cause hospital outbreaks which can be difficult to control or eradicate and so there is continued laboratory surveillance for this.

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE (CPE)

Carbapenemase Producing Enterobacteriaceae are extremely antibiotic resistant and pose a significant threat to the New Zealand health system. Most patients identified with these bacteria have been in overseas healthcare facilities. The number of cases of CPE is rapidly increasing nationally. This may follow the same pattern as ESBL-producing organisms, which are now widespread in the community, unless IPC and antimicrobial stewardship knowledge and practices are significantly strengthened across the whole health system.

During 2018 a cluster of seven people in the Hutt Valley were found to have CPE. The detection of CPE in all these patients was unexpected. The strain was found to be an OXA-48 and molecular analysis suggested a probable common source. This was a community based outbreak although several cases were identified when patients were admitted to hospital and 2 cases were probable hospital transmission events. A possible source of the outbreak in the community has been identified and addressed. Each identification of a CPE carrier in hospital creates a significant amount of work for the IPC service and the affected ward. So far no CPE carriers have been identified in Aged Residential Care, however if this occurs then this would require a huge amount of resource.

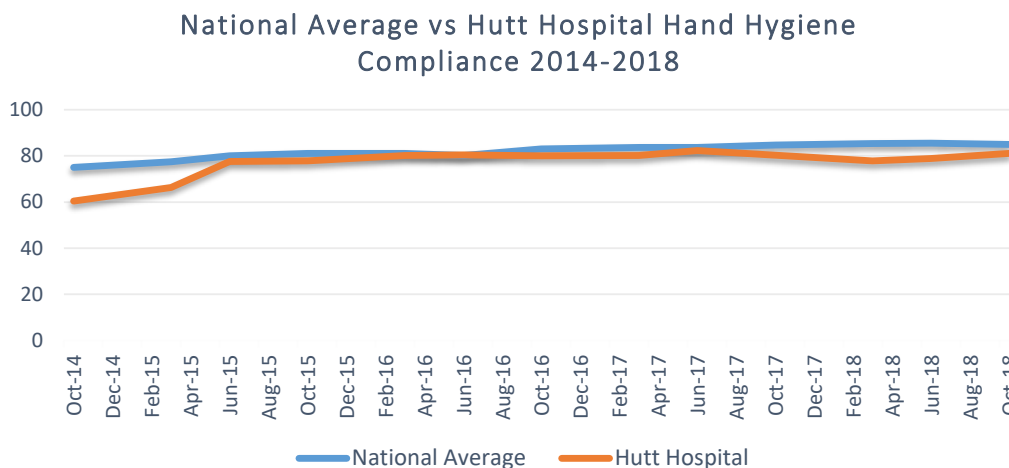
This cluster is on-going at the time of writing this report. RPH, IPC, ESR and MoH will be meeting in early 2019 to discuss what further investigation or actions will occur.

ENDOSCOPE SURVEILLANCE

The microbiological surveillance programme for endoscopes is managed by the Sterile Service and Endoscopy staff. Endoscopes are tested as per Policy. No issues have arisen with positive surveillance samples in 2018.

HAND HYGIENE

Hutt Valley DHB participates in the Hand Hygiene New Zealand auditing programme run by the Health Quality and Safety Commission. During 2018 the IPC service trained a further three staff to become hand hygiene auditors, ensuring that there are trained auditors in all departments. The last audit in 2018 showed a compliance level of 81.1% with the moments of hand hygiene. By spreading auditing throughout all hospital departments, it has enabled the hospital to have a consistent approach to the audit process and raised the importance of hand hygiene as an important patient safety issue.



ORTHOPAEDIC SURGICAL SITE INFECTION IMPROVEMENT PROGRAMME

This HQSC programme is now well established at Hutt Hospital. The surgical site infection rate for orthopaedic joint replacement surgery at Hutt Hospital is in line with the national rate of 1.0%. Process compliance in relation to prophylactic antibiotics, skin preparation and other quality markers remains consistently high with results in the range of 97 – 100%.

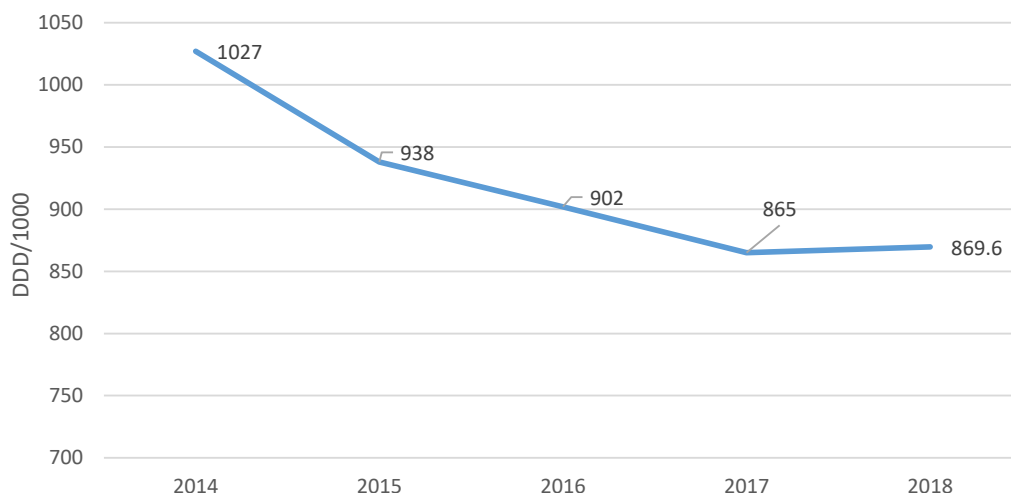
ANTIMICROBIAL STEWARDSHIP

Standard 6: Acute care hospitals will have established and implemented policies and procedures for the use of antimicrobials

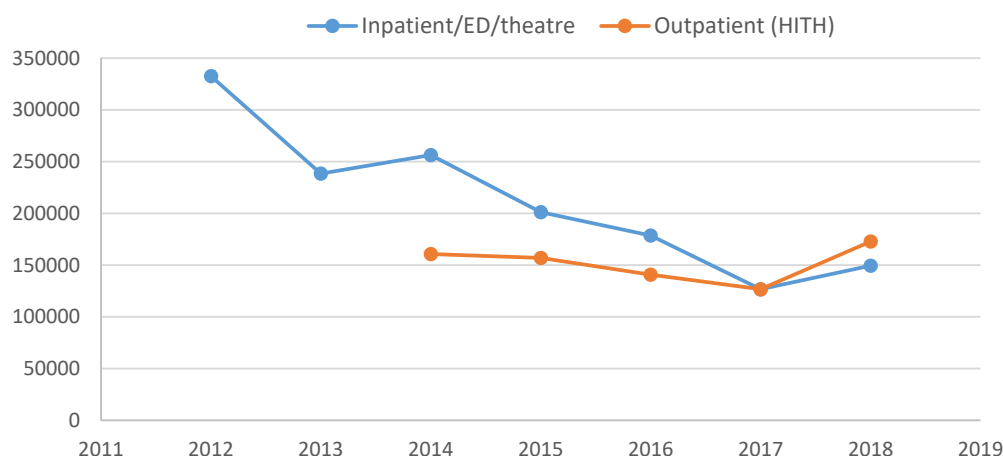
The Antimicrobial Stewardship Annual Report 2018 contains full details of the AMS programme and results. Total antibiotic consumption at Hutt Hospital remained stable in 2018 following several years of reductions after the introduction of the Antimicrobial Stewardship (AMS) programme. Although total consumption was unchanged, there were continued reductions in the use of high risk antibiotics (e.g. carbapenems and clindamycin). There was a significant increase in the number of patients treated with outpatient intravenous antibiotic therapy in 2018. This resulted in an overall increase in antibiotic expenditure for the year, however expenditure still remains significantly lower compared with the year prior to the introduction of the AMS programme.

The focus of the AMS service in 2019 will be to introduce formal AMS chart review rounds. AMS rounds will improve inpatient care by optimising antimicrobial prescribing, avoiding unnecessary intravenous devices, and reducing the use of unnecessary antibiotics, all of which can expose the patient to harm. A second focus will be to implement a beta-lactam allergy project. Only 10% of patients labelled as having beta-lactam allergy have a true allergy. A label of beta-lactam allergy is associated with increased use of broad spectrum antibiotics, antimicrobial resistance, *Clostridium difficile* infections, increased length of stay, and higher mortality when serious infection does occur.

**Antibiotic consumption as measured by DDD/1000 OBD at Hutt Hospital
for adult inpatient wards, ED and Theatres**



Antibiotic expenditure at Hutt Hospital



PRIORITIES FOR 2019

In 2019 the IPC service will work to further consolidate the improvements made during previous years while remaining ready to address new IPC issues as and when they occur. The service will have a particular focus on the following areas:

1. Complete the rollout of microfiber cleaning to nurses and healthcare assistants

There will be a consistent cleaning method used across the whole hospital by all staff. Cleaning effectiveness will be monitored through regular audit and feedback.

2. Update the screening and transmission-based precautions policies

These policies will be updated in line with latest evidence to make them simpler for staff to follow and more likely to identify and isolate patients with multidrug resistant organisms. There will be a greater emphasis on Standard Precautions for all patients and there will no longer be a requirement for staff to wear gowns and gloves on every entry into a contact or droplet isolation room. The use of universal gowns and gloves has little supporting evidence and there is evidence of harm from this practice. These changes will require a culture change among staff and changes to staff education packages.

3. Develop and aseptic technique training and assessment package

Aseptic technique applies to all invasive procedures and is relevant to medical, nursing and other healthcare professionals. There is currently a variable level of understanding and application of aseptic technique. The IPC service has agreed to develop a standardised approach to teaching and assessing aseptic technique with support from ACC.

4. Antimicrobial stewardship ward rounds

AMS rounds will be carried out twice-weekly on adult inpatient wards. This will be a chart review of all patient on antibiotics to provide expert advice and education regarding antimicrobial optimisation. Antimicrobial choice, dose, route and duration will be based on the current sub-regional antibiotic guidelines and patient microbiological results. Antibiotic allergy status will also be clarified.



Draft

Clinical Council - PUBLIC

Meeting Minutes

Date & Time	Thursday, 04 July 2019, 3.05pm – 4.15pm
Venue	Board Room, Hutt Valley DHB
Chair	Chris Kerr
Members by Appointment	Chris Masters, Barbara Moore, Angela Gillman, Chris Adams, Sally Woods, Stephen Purchas, Cathy Lindsay, Stephen Dee, Karen Coleman
Members by Position	Christine King, Chris Mallon, Fionnagh Dougan
Ex Officio	Debbie Gell (from 3.10pm)
In Attendance	Christine Rabone (Committee Secretary)
Apologies	Sisira Jayathissa, Saira Dayal, Dale Oliff

1.0	ROUTINE BUSINESS
1.1	<p>Welcome and Introduction</p> <p>The Chair welcomed attendees to the meeting and introduced Fionnagh Dougan who has recently commenced as the Joint HVDHB and CCDHB Chief Executive.</p> <p>Fionnagh Dougan gave an overview of her background and desire for strengthening synergies between HVDHB, CCDHB, and the services provided both within and to the communities they support.</p> <p>Apologies were noted.</p>
1.2	<p>Interests Register</p> <p>Members were reminded to send Christine Rabone any further updates.</p>
1.3	<p>Agenda Review</p> <ul style="list-style-type: none"> CE Update was removed from the agenda as there was nothing further to report. Laboratory eOrdering – Chris Masters and Sally Woods to meet with Wellington SCL and report back on their discussion at the Council's September meeting. <p>ACTION: Chris Masters and Sally Woods to provide an update on Laboratory eOrdering at September's Clinical Council Meeting.</p> <ul style="list-style-type: none"> Stephen Purchase raised the resignation of a Wairarapa DHB general surgeon and the significant impact this imposes on the Hutt Valley, Wairarapa, (and potentially) Manawatu regions. <p>ACTION: Christine Rabone to follow up with Stephen Purchase in regards to the wording to include in the HVDHB Risk Register.</p>

1.4	<p>Previous Minutes from 06 June 2019 Meeting</p> <ul style="list-style-type: none"> • The Public Minutes of the 06 June 2019 meeting were accepted as a true and accurate record. • The Public Excluded Minutes of the 06 June 2019 meeting were accepted as a true and accurate record.
1.5	<p>Matters Arising</p> <ul style="list-style-type: none"> • Discussion was had around how meeting papers are determined to be on public or public excluded agenda. <p>ACTION: Christine Rabone, Chris Kerr and Sisira Jayathissa to set criteria for when papers are to become Public Excluded.</p>
1.5.1	<p>Iron Infusions (Chris Masters)</p> <p>Chris Master's gave a brief update and sought clarity around the 12 month data requirement for reporting back to the Clinical Council on the equity of access following iron infusions being implemented in primary care. Whilst some initial base line figures have been collated, baseline data from Medical Day Stay Unit, and primary care versus POAC is still to be gathered. It was acknowledged that gathering this information could prove challenging.</p> <p>ACTION: Christine Rabone to update item 2.2 on the Action Register to note a due date of July 2020.</p>
1.5.2	<p>Innovation Fund Update</p> <p>1.5.2.1 Quality Improvement Capacity and Capability</p> <p>The paper was taken as read and Clinical Council members:</p> <p>a) NOTED that all of the \$126,600 approved has been spent or allocated as follows:</p> <ul style="list-style-type: none"> • \$71,600 has been spent on two three-day courses at Hutt Valley which trained 41 staff. • \$27,500 was spent in 2018 for two people to attend the Improvement Advisor Course. • \$27,500 is being spent currently on two people attending the 2019 Improvement Advisor Course from April to December 2019. <p>A discussion ensued on leadership training for staff and promotion of the Institute for Healthcare Improvement's (IHI) online training that is available for staff members unable to attend workshops. The Clinical Council support continuing training and agreed to table this for discussion at an upcoming ELT meeting.</p> <p>ACTION: GM Human Resources and Organisational Development to present to ELT and Clinical Council around future plans for leadership training given no training has been run across 2019 thus far.</p> <p>1.5.2.2 Mental Health Primary and Secondary Integration</p> <p>The paper was taken as read and Clinical Council members NOTED the update.</p>
2.0	REPORTING
2.1	CE Update – No Updates to Note
2.2	<p>Quality and Patient Safety Regular Update (Debbie Gell)</p> <p>Papers were taken as read and Clinical Council members:</p> <p>NOTED the report, which was presented to the HVDHB Board on 27 June 2019.</p>

	<p>Debbie Gell highlighted the following:</p> <ul style="list-style-type: none"> • Draft results from the Certification Audit conducted by the DAA Group have been received and our response on any factual errors is due back to them on 14 July. The final draft will be provided to the Ministry of Health on 15 July and the report will be finalised thereafter. Particularly of note from the DAA Group: <ul style="list-style-type: none"> ○ 25 identified corrective actions have been identified ○ commended the infection control process ○ complaints are well managed ○ DHB is very project heavy ○ lack of a centralised repository for recommendations and monitoring of areas for improvement. <p><i>ACTION: Fionnagh Dougan to provide Debbie Gell with contact details of someone that can assist with advice around implementing an integrated governance approach between HVDHB and CCDHB.</i></p> <ul style="list-style-type: none"> • The trend reduction in event reporting over quarter one 2018/19 has not continued and response numbers are back to normal.
2.3	<p>Infection Prevention and Control Annual Report 2018</p> <p>Clinical Council members took the report as read and NOTED the contents.</p>
3.0	PUBLIC EXCLUDED
4.0	GENERAL BUSINESS
4.1	Christine Rabone advised that Te Awakairangi Health Network are actively seeking a replacement for Hans Snoek and we will be advised once an appointment has been made.
4.2	Chris Mallon advised she has resigned as Director of Midwifery and that this will be her last meeting.
NEXT MEETING	
<p>08 August 2019, 3.00pm – 6.00pm Board Room, Hutt Valley DHB</p>	