IN THE WAITANGI TRIBUNAL

WAI 2575
WAI 1315

IN THE MATTER The Treaty of Waitangi Act 1975

AND

IN THE MATTER of Wai 1315, being a claim to the Waitangi Tribunal by Taitimu Maipi, Tureiti Moxon, Janice Kuka and Hakopa Paul in respect of the objectives, funding and administration of Primary Health Organisations.

OPENING SUBMISSIONS

DATED 9 OCTOBER 2018

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MAY IT PLEASE THE TRIBUNAL

1. For three weeks the Waitangi Tribunal will sit at Tūrangawaewae Marae to hear evidence about how Māori have struggled to be able to care for their own within the current health system. The timing and location are significant. It is one hundred years since the 1918 influenza pandemic. The death and suffering it caused was part of the inspiration for Princess Te Puea Herangi to build the meeting house Mahinarangi. She intended it as a hospital to treat her own people but was refused a licence.

Introduction

2. Primary health care is often the first port of call for sick New Zealanders. For most, this will be a visit to their family doctor. Primary health is the frontline of the health system. In simple terms it is healthcare in the community, rather than in hospital. Primary health has traditionally been dominated by private businesses: GP clinics.

3. Yet for many years Māori have received poorer quality health care when going to the doctor. Over time, Māori have sought to create their own organisations to take control of their health care: Māori caring for Māori. In the 2000s new structures called Primary Health Organisations or PHOs seemed to present a real opportunity for self-determination. This was illusory. When Māori tried to establish PHOs they faced attack from the Crown.

4. In response a group of governors and managers of Māori PHOs and the Providers that delivered health services for them filed the Wai 1315 claim to the Waitangi Tribunal in 2005 asking for an urgent hearing. Instead they entered into three years of negotiations with the Crown which led nowhere. Today only one of the Māori PHO remains, and the others are now Māori Providers, struggling to continue to care for their communities but with the loss of autonomy that the PHO structure promised.

The Crown's Treaty Obligations

5. It is submitted that the Treaty principles of active protection, equity, partnership, tino rangatiratanga and good governance are particularly relevant to this claim.

6. The Crown has an obligation to address poor Māori health in accordance with the Treaty principle of **active protection**. The Tribunal in the recent *Tū Mai Te Rangi!* Report regarding the Department of Corrections and reoffending found that active protection included the promotion of Māori wellbeing:[1]

> The principle of active protection flows from the exchange of kāwanatanga and rangatiratanga. It is not passive: 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. The Crown is required to protect Māori interests as far as is reasonable in the circumstances. The obligation is, however, the Crown's alone and it cannot avoid it by delegating its responsibilities to others. Active protection extends beyond Crown protection of specific Māori resources, to the protection of Māori interests generally. We agree with the Tribunal in the Napier Hospital Report in saying the Treaty promise of royal protection meant that 'Where adverse disparities in health status between Maori and non-Maori are persistent and marked, the Crown is obliged to take appropriate measures on the basis of need so as to minimise them over the long run.' This meant the duty of active protection included the promotion of Māori wellbeing. We also accept the view of the Tauranga Moana Tribunal when it said the Crown had failed actively to protect Māori health outcomes in situations where the disparity between Māori and Pākehā had long been known. In such cases the Crown is obliged to do what it can to align Māori and Pākehā health standards. We consider the obligation actively to protect Māori interests to be heightened in the knowledge of past historical wrongs done by the Crown and any prejudice that has affected subsequent generations.

7. The principle of **equity** also leads to a requirement to address health disparity between Māori and non-Māori. This principle applies regardless of the causes of disparity:[2]

> The principle of equity, or the obligation of the Crown to act fairly between Māori and non-Māori, derives from the British citizenship rights granted to Māori by article 3 of the Treaty. Like the duty of active protection, it can require positive intervention by the Crown to address disparities. The Tribunal in the Napier Hospital Report found that the difficulties of applying the principle of equity in practice

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1 Waitangi Tribunal *Tū Mai Te Rangi!* Report (2017), at [4.1.2].
2 ibid, at [4.1.3].

> increases when what is sought is equity of outcomes, rather than equity of access to services, treatment or care. However, we accept as a general point that there is a wide range of potential access barriers – physical, socio-economic, cultural – that might be found to tell against Māori. A systemic or prolonged failure on the part of the Crown to reduce such barriers would, in the absence of countervailing factors, commonly be inconsistent with the principle of equity.

8. To be clear, the principle of equity does not mean treating all citizens of groups exactly the same, and this will be ineffective in any case:[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 Maori have often found that what is being provided simply does not work for them, or is so alienating that they prefer to disengage. This is bad for many reasons: it means that the Crown's money is not being spent efficiently, and that public health measures and other crucial programmes will be less successful because they are not reaching everyone. When Maori are being marginalised, it also means that the Crown is not providing them with the full benefits of citizenship as guaranteed in article 3, and is therefore in breach of the Treaty of Waitangi.

9. How the Crown and Māori go about tackling disparity in health is important. The Treaty principle of **partnership** requires ongoing dialogue and a duty to act honourably and in good faith:[4]

> The Treaty established a relationship that was subject to ongoing negotiation and dialogue, under which the Crown and Māori would work out the practical details of how kāwanatanga and tino rangatiratanga would co-exist. Both partners owe each other a duty to act honourably and in good faith. Neither partner can act in a manner that fundamentally affects the other's sphere of influence without their consent, unless there are exceptional circumstances.

10. In *Te Urewera Part VI,* the Tribunal confirmed that disparity should be addressed be in partnership with Māori or by delivering funding and autonomy to Māori organisations:[5]

> "In attempting to reduce disparity, however caused, the Crown has an obligation to do so in good faith and partnership with the hapu and iwi of Te Urewera. It cannot simply present Maori with its own

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3 Waitangi Tribunal *Te Urewera Report Part VI* Report (2015), at p 663.
4 Waitangi Tribunal *Te Mana Whatu Ahuru* Report (2018), at [3.4.4.3].
5 Waitangi Tribunal *Te Urewera Part VI* Report (2015), at p 659.

> solutions, however well-intentioned they might be; at minimum it must consult with Maori, and ideally it will either form a partnership with, or deliver funding and autonomy to, Maori organisations."

11. Particularly relevant to the efforts of the claimants to address poor Māori health by creating their own Māori PHOs and Providers is the Treaty principle of **tino rangatiratanga**. The Tribunal's most recent report *Te Mana Whatu Ahuru Report 2018* on Te Rohe Pōtae Claims calls it the principle of tino rangatiratanga, self-government, and autonomy and describes it as follows:[6]

> Māori communities retain their tino rangatiratanga, including their right to autonomy and self-government, and their right to manage the full range of their affairs in accordance with their own tikanga. As part of the Treaty exchange, the Crown guarantees to protect and provide for the exercise of Māori authority and autonomy.

12. Tino rangatiratanga is an important limit on the Crown's kāwanatanga, and the Tribunal recognises the right of Māori to control their own affairs:[7]

> "The guarantee of rangatiratanga requires the Crown to acknowledge Māori control over their tikanga, and to manage their own affairs in a way that aligns with their customs and values."

13. The Tribunal in *Te Whanau o Waipareira* Report highlighted the common sense in allowing Māori to be responsible for themselves:[8]

> This principle has some counterpart in current human rights standards that groups should be empowered, within reasonable or necessary State constraints, to be responsible for themselves, for the sake of their own dignity and to harness their capacity, so that their potential might be realised. It is a principle of common courtesy to respect others in that way, and common sense that cultural groups and communities know better than anyone else what they need or would aspire to, and how to achieve their own goals. The Treaty merely underlines the obligation to so provide for the indigenous people.

14. Finally, recent Treaty jurisprudence has emphasised the importance of Crown accountability to Māori. In the *Te Whanau o Waipareira Report* the Tribunal held that the lack of public information on the effectiveness of government policies and programmes in achieving social goals breached the partnership principle of the Treaty in that it denied Māori

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6 Waitangi Tribunal *Te Mana Whatu Ahuru* Report (2018), at [3.4.5.2].
7 Waitangi Tribunal *Tū Mai te Rangi!* Report (2017), at [4.1.1].
8 Waitangi Tribunal *Te Whanau o Waipareira* Report (1998), at [8.2.3].

communities any real opportunity to monitor the Crown's performance, and it denied the government valuable information that would enable it to improve the quality of its kāwanatanga. More recently the Tribunal in *Te Mana Whatu Ahuru Report 2018* described it as the principle and duty of **good governance**:[9]

> The Crown must keep to its own laws and not act outside the law. The Crown should be accountable for its actions in relation to Māori and subject to independent scrutiny.

The Claim

15. The Wai 1315 claimants are the governors and managers of PHOs and Providers which are owned and run by Māori. They allege that the Primary Health Care framework is not sufficiently contributing to the achievement of Māori health equity.[10]

16. 90% of health care demands can be addressed at the primary care level. Only 10% of demands require the services and skills typically associated with hospitals. Primary Health Care is generally recognised as the basis for effective, efficient, and equitable health systems.[11]

17. The Primary Health Care framework is controlled through a vast array of legislation, policy and contracts, including the New Zealand Public Health and Disability Act 200, 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.

18. These documents generally assert an intention to reduce Māori health inequality. However, in practice the Primary Health Care framework:

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9 Waitangi Tribunal *Te Mana Whatu Ahuru* Report (2018), at [3.4.5.2].

10 Wai 1315 *Amended Statement of Claim* (1 February 2018), CB Vol1: 9.

11 Global Health Action *The missing link – the role of primary care in global health* (13 February 2014), CB Vol3: 7870.

(a) does not adequately recognise or address inequity and inequality for Māori;

(b) allows little scope for Māori to determine and apply their own solutions to improve Māori health. This lack of self-determination has pervaded all stages of the development and implementation of the Primary Health Care framework and at all levels of that system;

(c) provides insufficient accountability of PHOs to DHBs, DHBs to the Ministry and Minister of Health and all parties to whānau and hapū for the outcomes of the Primary Health Care framework and any of the services provided within it; and

(d) does not adequately address the relationship between Māori health and factors which are primarily the responsibility of other arms of the Crown, such as poverty, inadequate housing, and education.

19. The claimants' experiences vividly demonstrate how the Primary Health Care framework operates in practice belies the commitment to Māori health

Māori caring for Māori

20. Māori have long complained of a poorer standard of care when going to the GP. Even though Māori turn up for GP appointments at the same rate as non-Māori, they obtain fewer diagnostic tests, less effective treatment plans and are referred to procedures at significantly lower rates than non-Māori.[12] Māori are three times as likely as non-Māori to report unfair treatment by a health professional on the basis of ethnicity.[13]

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12 Brief of evidence of Lady Tureiti Moxon (13 June 2018), #A11, CB Vol2: 127 at [10.9].

13 Ministry of Health *Tatau Kahukura Māori Health Chart* (2015), CB Vol3: 8750 at Table 8.

21. In response to this poorer standard of care, Māori began from the 1980s a process to establish their own Māori health providers.

22. Then in 2001, the Crown through the Primary Health Care Strategy introduced Primary Health Organisations or PHOs.[14] PHOs would proactively manage the health of a population of members. They would be run by the community. PHOs could take a holistic approach and create services tailored to the needs of the community, preventing members from becoming sick as far as possible. 15 minute GP appointments would become a much smaller feature of primary health.

23. The PHO structure seemed to be the perfect opportunity for Māori communities to self-determine their health care. Instead of simply being the recipients of health services they could control them, creating the services, hiring the clinicians and staff, designing the clinics and spaces. But from the outset, the Crown put up obstacles. Māori PHOs received minimal establishment funding and support and they found that they were subject to complaints from other PHOs and repeated audits by the Crown.[15]

Funding

24. Funding was also a challenge for Māori PHOs.

25. PHOs receive an annual amount per member (capitation) instead of payments per appointment (general medical services payments) as in the past. Capitation funding for first level services is the core funding for PHOs, designed to cover all of a members' appointments for the year. The lump sum should allow PHOs to take a proactive approach, looking at their whole member population and spending on services which might prevent the need for appointments for sickness.[16]

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14 Ministry of Health *The Primary Healthcare Strategy* (2001), CB Vol3: 740.

15 Affidavit of Lady Tureiti Moxon (25 October 2005), #A24, CB Vol2: 447-456, and Newsroom.co.nz *Study: Public Health blighted by institutional racism* (15 June 2017), CB Vol3: 10524.

16 For an explanation of funding see the brief of evidence of Mr Neil Woodhams (14 June 2018), #A19(b), CB Vol2: 314.

26. Very quickly it was obvious that the first level services capitation funding did not work for Māori PHOs and the Māori Providers delivering services for them. It was based on the assumption that all primary practices were the same. That they had the same mixture of sick and well members. The savings from the well members would balance out the costs of caring for the sick members.[17] But Māori PHOs had been created to cater to Māori, and as Māori suffer from poorer health, the majority of their members were much sicker and more expensive to look after than the members of an average practice.[18] Balancing out the costs for Māori PHOs would mean taking on many more healthy, non-Māori members. Some Māori PHOs experimented with this.[19] but it was not satisfactory. The point of establishing a PHO to cater for Māori who had always been poorly cared for would be undermined if Māori were a minority of the members in that PHO.

27. Extra capitated funding streams added by the Crown, some of them targeted to particular groups including Māori, were only tinkering at the edges. The core funding for first level services remained vastly insufficient for Māori PHOs and Providers.[20]

28. The capitated funding flowed to Māori PHOs through the DHBs as a small proportion of their cut of the health budget, Vote Health. What each DHB receives from Vote Health is based on their population.[21] Beyond tagged funding like the PHO capitated funding, DHBs have a wide discretion about how to spend their funding. DHBs have no requirement to pass on more to PHOs than the capitated funding, even though 90% of all issues can be addressed at the primary health level, rather than escalating to hospital with greater cost, and greater suffering. DHBs of course have many priorities to balance which

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17 ibid.

18 Brief of evidence of Ms Janice Kuka (13 June 2018), #A12, CB Vol2: 190-193.

19 Brief of evidence of Lady Tureiti Moxon (13 June 2018), #A11, CB Vol2: 130-131 at [23]-[25].

20 Brief of evidence of Mr Neil Woodhams (14 June 2018), #A19(b), CB Vol2: 333.

21 Brief of evidence of John Hazeldine (9 February 2019), #A3, CB Vol2: 15 at [11].

influence what they will pass on to PHOs, including running hospitals and providing some primary health care services themselves.[22]

29. DHBs receive more funding if their population has more Māori than other DHBs.[23] Yet DHBs have no requirement to spend a proportion of what they receive on Māori health. Māori PHOs and Providers receive on average less than 2% of DHB funding. Even as DHBs receive more funding each year, the proportion that they pass on to Māori PHOs and Providers is dropping.[24]

30. In addition, Māori PHOs and Providers must compete with larger mainstream PHOs for Māori health contracts, and increasingly are losing the competition.[25]

31. The Crown assumes that capitation for PHOs is only a contribution to costs and that half of a practice's costs will come from patient payments.[26] The members of Māori PHOs and Providers can often only afford a small payment or no payment.[27] The Crown's response, Very Low Cost Access, pays Providers to keep their fees low, but this does not come close to bringing them in line with Providers catering to wealthier members.[28]

32. In fact, the cost that Māori PHOs and Providers have carried is estimated by the Crown's own report to be $21.77 million each year which equates to $348 million since 2002.[29]

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22 Brief of evidence of Ms Janet McLean (14 June 2018), #A15, CB Vol2: 239 at [12]-[15].

23 Brief of evidence of John Hazeldine (9 February 2019), #A3, CB Vol2: 15 at [11].

24 Brief of evidence of Ms Janet McLean (14 June 2018), #A15, CB Vol2: 244 at [30].

25 Brief of evidence of Lady Tureiti Moxon (13 June 2018), #A11, CB Vol2: 158-165 and Brief of evidence of Mr Taitimu Maipi (14 June 2018), #A10, CB Vol2: 113-117.

26 Brief of evidence of Mr Neil Woodhams (14 June 2018), #A19(b), CB Vol2: 324 at [32].

27 Brief of evidence of Lady Tureiti Moxon (13 June 2018), #A11, CB Vol2: 141-142 at [60]-[61].

28 Brief of evidence of Mr Phillip Hikairo (13 June 2018), #A14, CB Vol2: 225-226 at [34]-[36].

29 Deloitte Report *Budget Advisory Estimate as part of Wai 1315 claim* (2007), CB Vol3: 4559.

Māori PHOs disappearing

33. Māori PHOs have faced constant pressure from the Crown to amalgamate to be economically "viable".[30] But amalgamation has generally meant becoming a minority in a new PHO population, with the resulting loss of control. Four of the five PHOs named on the original Wai 1315 Statement of claim (Toiora PHO, Te Kupenga o Hoturoa, North Waikato PHO and Te Kupenga a Kahu) are no longer PHOs, having amalgamated or in the case of Te Kupenga a Kahu, being forcibly shut down by their DHB.[31] Ngā Mataapuna Oranga still resists pressure to amalgamate.[32]

34. In this hostile environment Māori PHOs have not had the opportunity to move beyond survival mode to take control of proactively managing the health of their member population. At the peak, there were 14 Māori PHOs. Ngā Mataapuna Oranga is now one of only four Māori PHOs remaining in the whole country.

IPA PHOs

35. The contrasting story to Māori PHOs is IPA PHOs. In the 90s GPs had begun to group together into Independent Practitioner Associations or IPAs, organising their interactions with the Crown. IPAs introduced schemes to improve efficiencies for the Crown but which also gave them a financial benefit. With the advent of the Primary Health Care strategy IPAs were already organised and resourced and quickly transitioned into PHOs.[33] Superficially they were able to meet the Crown requirements for PHOs including by taking on some community and Māori representation and ensuring their central entity was not for profit, but were in reality still owned and controlled by GPs. They remain private businesses for the financial benefit of GPs.

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30 Brief of evidence of Lady Tureiti Moxon (13 June 2018), #A11, CB Vol2: 131.

31 See brief of evidence of Mr Hakopa Paul (14 June 2018), #A13, CB Vol2: 205.

32 Brief of evidence of Ms Janice Kuka (13 June 2018), #A12, CB Vol2: 200 at [57].

33 Research Gate article by Robin Gauld *The Unintended Consequences of New Zealand's Primary Health Care* (March 2008), CB Vol3: 4757.

36. IPAs were far better equipped to thrive as PHOs. They began with better resources, their members were a balanced mix of well and sick and they did not face the repeated, disruptive audits imposed on Māori PHOs. They had spare resource to participate fully in the early discussions about the future shape of the sector, to their ongoing benefit.

37. Today the vast majority of New Zealanders and the vast majority of Māori are members of an IPA PHO. The Crown's response has always been that Māori are free to choose their PHO and most have chosen not to enrol with a Māori PHO. But in truth they have not had that choice when the vast majority of PHOs and Providers are not owned or run by Māori.[34]

38. In contrast to the promise of what PHOs were meant to be, in 2018 Primary Health is still dominated by GPs, 15 minute appointments and treating the sick.

The Crown knew

39. The Crown has been well aware throughout that the Primary Health Care framework does not work for Māori:

    (a) The health statistics clearly demonstrate it. While overall health is improving, Māori health status is falling further and further behind. The research shows that Māori are receiving a poorer standard of care;

    (b) The Wai 1315 claimants filed this claim thirteen years ago. But they were raising the issues that are the subject of this claim with the Crown well before filing the claim in 2005. Then after filing the claim they spent three years in meetings with the Crown trying to negotiate on these very issues, but gave up when negotiations led nowhere; and

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[34] Brief of evidence of Ms Janet McLean (14 June 2018), #A15, CB Vol2: 240 at [19].

(c) The Crown's own evidence highlights that the Primary Health Care framework fails Māori.[35]

40. Over the years there have been minor changes to the Primary Health Care framework. Yet the fundamental features, which have prejudiced Māori, have remained unchanged.

Indigenous success

41. In spite of the obstacles, Māori PHOs and Providers have still had some successes in terms of outcomes, particularly where they have worked on a kaupapa Māori basis.[36] Whānau Ora, although only a tiny sliver of the health pie, has shown what might have been and what could be.[37] The Nuka system of care established in Alaska, shows what allowing indigenous communities to self-determine and ensuring they have the funding they need can look like.[38]

The witnesses

42. The following witnesses will present evidence in support of the Wai 1315 claim:

(a) The four claimants, who are all governors and managers in Māori PHOs and Providers and themselves experts in the Primary Health Care Framework and its effect on Māori:

(i) Mr Taitimu Maipi;[39]

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35 As set out in the briefs of evidence in reply of Dr Peter Jansen #A68 (20 September 2018) CB Vol2: 1112 and Ms Janice Kuka #A67 (20 September 2018), CB Vol2: 1100.

36 See for example evidence about Te Whare Kaitiaki whānau dental clinic in the brief of evidence of Professor John Broughton (13 June 2018), #A16, CB Vol2: 278-280.

37 See for example brief of evidence of Mr John Tamihere (13 June 2018), #A17, CB Vol2: 305-308.

38 Nuka System of Care Progress Report FY 2015, CB Vol3: 8285.

39 #A10 (14 June 2018), CB Vol2: 105; and #A28 (14 November 2005), CB Vol2: 484.

(ii) Mr Hakopa Paul;[40]

(iii) Ms Janice Kuka;[41] and

(iv) Lady Tureiti Moxon.[42]

(b) Two further witnesses, who with Janice Kuka comprise a case study of Bay of Plenty at the DHB, Māori PHO and Māori Provider level:

(i) Ms Janet McLean;[43] and

(ii) Mr Phillip Hikairo.[44]

(c) Other experts whose evidence confirms that of the claimants and echoes their calls for Māori self-determination:

(i) Ms Katherine Gottlieb;[45]

(ii) Mr John Tamihere;[46]

(iii) Mr Neil Woodhams;[47]

(iv) Dr Peter Jansen;[48] and

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40 #A13 (14 June 2018), CB Vol2: 205; #A30 (15 November 2005), CB Vol2: 502; and #A33 (14 August 2008), CB Vol2: 517.

41 #A12 (13 June 2018), CB Vol2: 182; #A67 (20 September 2018), CB Vol2: 1100.

42 #A11 (13 June 2018), CB Vol2: 121; #A24 (14 November 2005), CB Vol2: 428; and #A36 (14 August 2008), CB Vol2: 525.

43 #A15 (14 June 2018), CB Vol2: 235.

44 #A14 (13 June 2018), CB Vol2: 215; #A29 (25 October 2005), CB Vol2: 495; #A29(a) (16 August 2006) CB Vol2: 514; and #A32 (14 August 2008) CB Vol2: 514.

45 Nuka System of Care Progress Report FY 2015, CB Vol3: 8285.

46 #A17 (13 June 2018) CB Vol2: 302.

47 #A19(b) (14 June 2018) CB Vol2: 314; #A26 (14 November 2005) CB Vol2: 466; #A26(a) (16 August 2006) CB Vol2: 479; and #A34 (14 August 2008) CB Vol2: 521.

48 #A18 (14 June 2018) CB Vol2: 310; and #A68 (20 September 2018) CB Vol2: 1112.

(v) Professor John Broughton.[49]

Relief sought by the claimants

43. The Wai 1315 Statement of claim sought changes to the Health System generally and Primary Health Care Framework more specifically that exhibited a number of key features, summarised as Māori self-determination; Access; Quality; Equity; Partnership; Strengths based; Development approach; Recognition of government limits; Greater devolution; Effective integration and Accountability.

44. In the briefs of evidence of the four Wai 1315 claimants, they developed this further setting out a shared vision and principles and then certain details which each claimant felt was necessary. As we begin the hearing the Wai 1315 claimants have drawn together further.

45. The Wai 1315 claimants declare again their shared vision of Tino rangatiratanga and Mana Motuhake and the three principles which inform this vision, that:

(a) Māori are not the servants of the Crown;

(b) Māori will design our own for our own, based on tikanga; and

(c) Māori will take responsibility.

46. The claimants acknowledge that their vision and principles are broad. They could apply to any sector. However, they are vital to understanding the Wai 1315 claim and what the claimants say is required to do better for Māori. The vision and principles reflect an holistic view of health, and the fact that Primary Health, and the Health System are artificial constructs which in themselves likely work against reducing disparity for Māori.

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49 #A16 and #A16(a)A (13 June 2018) CB Vol2: 247.

47. At the same time the claimants work within the Primary Health Care framework. They are agreed that within this framework, realising their shared vision and principles must include at least the following:

(a) To address the past: an apology and repayment of 16 years of Māori PHO and Provider underfunding, estimated at $348m nationally;

(b) To prepare for the future: a legislated mechanism providing for Primary Health Care for Māori by Māori:

(i) Committing to:

1. the vision and principles outlined by the Wai 1315 claimants; and

2. Te Tiriti o Waitangi and its principles; and

(ii) Guaranteeing:

1. adequate funding for Māori Primary Health (which increases every year);

2. Māori control of Māori funding; and

3. that Primary Health Care for Māori by Māori will not be unduly limited by the concept of “Primary Health Care” but will address all factors that impact on Māori health as required;

(iii) Put into place immediately, to be followed by the details. The details of the legislative mechanism must be designed by Māori, led by the Wai 1315 claimants and other experts, but should at least include:

1. In terms of approach:

    a. the whānau centric approach, autonomy and flexibility of Whānau Ora;

    b. the self-determination, ownership and autonomy of the Nuka model;

2. More specifically:

    a. An Independent Māori Health Commissioning Agency;

    b. Guaranteed funding for Māori by Māori health providers;

    c. Additional (new money) on an ongoing basis for Hauora/Health services;

    d. A devolvement of DHB provider services to community providers;

    e. The provision of funding on the same level as the Crown funds itself;

    f. New funding to look at different models of health service for Māori; and

    g. An immediate cost price adjuster (CPI) to bring Māori PHOs and Providers up to the same level as the NZ Nurses Organisation negotiated salary rates.

48. The claimants also reiterate that if the Crown attempts to implement the remedies sought without Māori as co-designers, it will fail. As Taitimu Maipi describes in his brief of evidence, there must be a conversation

between Māori and the Crown. Whatever the future holds must be assessed against the vision and principles articulated by the claimants.

Date: 9 October 2018

RN Smail
Counsel for the claimants