9 December 2021

Tēnā koe

“Me haere tahi tātou mo te hauora me te oranga o ngā iwi katoa o Aotearoa”
“Let us journey together for the health and wellbeing of the people of Aotearoa”
(Rev Leo Te Kira 15/12/05).

On behalf of Te Rūnanga o Aotearoa Tōpūtanga Tapuhi Kaitiaki o Aotearoa (Te Rūnanga), the bicultural Te Tiriti o Waitangi (Te Tiriti) partner to New Zealand Nurses Organisation (NZNO) members, we submit an independent exclusive Māori membership response to the Department of Prime Minister and Cabinet on the new proposed legislation, Pae Ora – Healthy Futures Bill (Pae Ora Bill).[1]

The context of this submission reflects the needs, concerns, and perspectives expressed by our nehi Māori (Māori nurses) workforce, leaders, and the communities we support. We provide a suite of recommendations and supporting rationale specific to the needs and aspirations of our workforce and whānau Māori as tāngata whenua of Aotearoa, New Zealand. As indigenous peoples we have the sovereign authority to exercise our mana motuhake and tino rangatiratanga.

As Māori health professionals, we are obligated to ensure that Māori is appropriately represented and given equal opportunity to participate in the transformation and decision-making process to influence the final iteration of the Pae Ora Bill. Accordingly, we welcome the realignment and disestablishment of existing structures such as the District Health Boards to introduce the new health entities, Māori Health Authority and Health New Zealand. Further, we understand the urgency to deconstruct the entire health system following the ongoing extreme inequities experienced by Māori and other cultures such as Pacific people; and equally recognise the ongoing response to prevent the spread of Mate Korona - Covid-19 pandemic.

We commend the government’s decisions to initiate the health reform process that we see as considering Māori experiences of inequities and unintended consequences. The subsequent expectation following the reform is to have ability to assure our members, workforce, whānau and communities that this transformation guarantees equitable returns by creating a fair and just system for all.

[1] A wider response from NZNO our bicultural partner has been submitted.

In principle, we support the health reform transition and the introduction of the Pae Ora Bill. However, following consultation with our regional members and communities. The consensus was components of Pae Ora Bill appears to:

- *limit the application of human rights frameworks for Māori*. For example, provisions for local authority[2] do not amount to a right to veto parties[3] under the dispute provisions relating to decision-making and structural performance,[4] and
- little reference to *promote and improve health equity outcomes specific to wāhine and tamariki*.[5]

We provide the following recommendations and associated supplementary advice (attached) for consideration.

1. Amendment to clause 6 to give ***explicit reference to the intention and purpose of Te Tiriti o Waitangi by applying*** across the provisions and enactment of the Bill - it should read: *"providing explicit authority to recognise Māori as tāngata whenua and partner to the Crown to apply active protection principles of Te Tiriti o Waitangi under the obligation of rangatiratanga…."*

2. We would like to add ***additional concepts such as Kaupapa Māori, Mana Motuhake, and Tino Rangatiratanga*** to the interpretations section.

3. We would like to see *an* ***exclusive reference for Māori wahine (iwi, hapu including the named iwi-partnership boards) to design the governance structural mandate arrangement for the Māori Health Authority and the Māori Health Strategy.*** Currently no nurses with lived experiences represented on any boards/committees.

4. We recommend ***te reo Māori version of the Bill*** following the Pae Ora Select Committee report back to Cabinet in April 2022.

5. We suggest ***Te Tiriti clause to include a subsection referencing core international human rights instruments[6]*** (below) to strengthen constitutional obligations:[7] These include:

- **Declaration on the Rights of Indigenous People**
- **Convention on the Rights of the Child (CRC) (like Sec7AA – Oranga Tamariki Act)**
- **Convention on the Elimination of All Forms of Discrimination Against Women, (CEDAW)**
- **Convention on the Rights of Persons with Disabilities (CRPD),**
- **Convention on the Elimination of All Forms of Racial Discrimination (CERD).**

[2] Local Authority refers to the Iwi-Partnerships Boards and governing entity – the Māori Health Authority that is representing Māori accessing kaupapa Māori services

[3] Partner(s) include Health New Zealand, the Ministry of Health – Public Health Business Unit and associated Health Institutions such as Pharmac, New Zealand Blood Organ Service,

[4] Is Te Tiriti o Waitangi effectively position in the Bill to enable the iwi-Māori partnership boards to make all final decisions on all implications to Māori, i.e. will they have the power to ensure they drive healthy equity through the endorsement process of an exclusive Māori led, Māori Health Strategy?

[5] Increase targeted and responsive services for wahine Māori and tamariki. For example, improve cervical, breast screening, maternal, mental health, family planning, staff training, quality improvement programmes and system improvements in General Practice.

[6] Domestic Human Rights law such as the Bill of Rights Act 1990; Human Right Act 1993; Privacy Act 1993, Crime of Torture Act, 1989 have been considered. We therefore seek to extend this process to include international law/treaties that are specific to Māori.

[7] Other international instruments that should be considered include International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (IESCR); Universal periodic review; Universal Declaration of Human Rights.

We are committed to honouring the duty of care and protection to lead and support our membership and workforce to seek ways to improve the health and wellbeing of whānau and communities. As we consider the cultural values of Pae Ora and other models of care such as Sir Mason Durie's Te Whare Tapa Whā, Te Pae Māhutonga, He Korowai, and Dr Rangimārie Te Turuki Arikirangi Rose Pere, Te Wheke model. We are reminded of the integral role these and other models have played in all our professional and personal lives. Sir Mason Durie (2019) Pae Ora – Māori Health Horizons mahi that formed part of his Paerangi lecture series, resonates with our workforce professionally and culturally in terms of setting aspirational cultural and whānau outcomes.[8]

The mana and conceptual application of Pae Ora must be upheld and empowered to ensure Māori self-determination means, iwi, hapū, and whānau have the power to shape the future of Māori health outcomes.

We thank the committee for the opportunity to participate in the submission process. As required, we look forward to discussing our recommendations as part of the oral submission process and equally signal our interests to be represented on any future health entity reference groups.

Nō reira, e mihi kau ana ki a koutou katoa.

Nāku nā noa

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[8]Sir Mason Durie described Pae Ora as the primary focus to position the future of health in contemplating consequences of local, global, environmental, and whānau determinants on Māori health See Sir/Ta Mason Durie (2009). Pae Ora Māori Health Horizons. The Paerangi Lectures Māori Horizons 2020 and Beyond - Pae Ora - Maori Health Horizons.pdf

Supplementary Advice Paper

The following information provides analysis and specific advice on components of the Pae Ora Bill that seeks to address implications for Māori.

Te Rūnanga applied the following guiding questions to inform the Pae Ora Bill review and subsequent consultation with members.

They include (but are not limited to):

a. Does the Pae Ora Bill explicitly guarantee the application of Te Tiriti articles to actively protect the indigenous human rights of tāngata whenua as the equal partner to the Crown, to promote and improve health outcomes?

b. Is the Pae Ora Bill supported with the associated te reo Māori version of the Pae Ora Bill, given the role and breadth of knowledge that iwi partnership boards provide?

c. How is data sovereignty being considered? Maori inherent rights and interests are to exercise tino rangatiratanga through an equal democratic voice to collect, own, and apply Māori data (including creation, collection, access, analysis, interpretation, management security, dissemination, use and reuse of Māori data).

d. Is the new Māori Health Authority (MHA) established as an independent statutory entity providing provisions and functions that guarantee cultural safety, security, and equity for Māori?

e. Is the intention of equity in relation to wāhine and tamariki[9] reflected in the purpose of the Pae Ora Bill?

Background

Te Rūnanga and NZNO entered a Memorandum of Understanding (MOU) in July 2000. The agreed MOU assures NZNO is committed to embracing Te Rūnanga as Te Tiriti partner to guide NZNO with applying te ao Māori tikanga, kawa and matauranga across the organisation and work to improve the health status of all peoples of Aotearoa, New Zealand through participation in health and social policy development. The tikanga determines the values that contribute to the health and wellbeing of Māori. As the tāngata whenua governing body, our relationship with NZNO is based on building a solid and dynamic workforce. There are over 4,000 Māori self-identified members who affiliate to Te Rūnanga. We are proud to form part of an organisation that includes a union and professional body. As we grow, so does our international connection with other indigenous nursing global communities, which includes the International Council of Nurses and the Canadian Indigenous Nurses.

The values, philosophy, and bicultural commitment to diversifying traditional methodologies of knowledge, has for the global indigenous nursing community been received with standing admiration. However, indigenous nursing communities struggle to be heard against structural and institutional racism and conscious bias governments who are the decision-makers.

[9] https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Performance-and-monitoring/Section-7AA/S7AA-Improving-outcomes-for-tamariki-Maori.pdf -

The key objective has been to limit inequities within internal and external systems. Te Rūnanga members gave evidence at the Waitangi Tribunal 2575 – Kaupapa Māori health inquiry hearings and were influential in shaping the recommendations in the Heather Simpson Health Final Report Pūrongo Whakamutunga - Disability System Review and the Health and Disability Reform. As a lead claimant in Waitangi Tribunal Oranga Tamariki and Mana Wahine Hearing, Te Rūnanga members influenced the outcomes from the hearings which reported work is underway to support, advise and develop a transition strategy to support legislative and structural change for children where care and protection is a concern. As active contributors and influencers advocating for change, we continue to be disruptors to the system by challenging legislative frameworks that are oppressive of Māori rights, and are integral to ensuring history does not continue to repeat itself.

Despite the impacts of Covid-19 on our communities we continued to advocate and support all members. During the lockdown period, Te Rūnanga imposed a state of rāhui and supported NZNO in providing appropriate support to all 51,000 members. As the health sector transitions through significant operational and strategic changes, there must be a call to increase effective and responsive leadership at all corners. Therefore, aligning to the structural arrangement that Te Rūnanga provides, which includes a Kaiwhakahaere, Tumu Whakarae, Kaumātua, Māori Regional Council Representatives, Māori Tauira and Māori members.

As a collective, we continue to lobby on important issues affecting Māori members and communities, including pay parity for nurses working in Māori and iwi providers. The pay gap is 25 per cent compared with DHB colleagues. Particular attention should be given to the needs of LGBTIQA+[10] groups, including young people, older people, indigenous people, and those form culturally diverse backgrounds. Therefore, ensuring equitable outcomes is paramount. Keeping connected through collective action means raising the importance of upholding cultural and tikanga practices, which presents a different approach to the traditional union advocacy model. However, equally the perspectives provide for an effective way and a belief that we continue to champion all voices. The call for action from those in positions of influence is crucial, particularly as the voices of our nursing community continue to be silenced. In 2020 we hosted the indigenous Nurses Conference, where the theme was “Raising an Army of Nurses” which led to the 2021 theme “Heeding the Call of the Maunga”. This theme returned nursing practice to our whakapapa beliefs and values.

The following section provides specific feedback including examples of potential changes or questions that may help support future development with the health reform.

[10] The acronym LGBTIQA+ refers collectively to people who are lesbian, gay, bisexual, trans, intersex, queer (see below) or questioning (those who are exploring their orientation and identity). The ‘+’ is used to include people with alternative sexual, orientation, or sex or gender identities who do not identify with the terms contained within the ‘LGBTIQ’ acronym. The ‘A’ may refer to people who identify as asexual or alternatively to allies of LGBTIQ+ communities

Specific Commentary

Part 1 – Preliminary provisions – Purpose of this Act / Interpretation Section

As the purpose statement places emphasis on the Pae Ora Bill to 'give effect' to the principles of Te Tiriti through the provisions of the Crown's obligation to 'give effect'.[11] The term 'give effect' as per the interpretation section of the Pae Ora Bill, still implies that the Government of the day has the mandate to make decisions in accordance with the Ministers responsibility.

Provisions in the Crown Entities Act 2004 (section 112), Public Service Act 2020, the Public Records Act 2005, State Sector Act 1988, the Public Finance Act 1989, and the Official Information Act 1982, including particular statutes, support the broad propositions of power. Therefore, Te Tiriti reference appears to limit the Māori self-determination due to constraints that other primary legislation, convention, practice, and public acceptance provide. Therefore, it appears the Crown power to action seems to interfere with giving effect to te Tiriti rights, simply through the Crowns ability to continue to oversee the responsibility to govern in the interest of all New Zealanders.[12]

As there are differences expressed in the translations of 'te Tiriti' and 'the treaty', the Bill must reflect this difference, particularly if it truly wants to give effect to the promises that Te Tiriti and the Treaty intended to provide. The endeavour is to commit to an equity responsive approach that leads with tikanga Māori matauranga to inform social, economic, cultural, environmental and political development of Māori tino rangatiratanga that is guided by iwi and hapū mana motuhake.[13]

Further, the interpretation section that identifies Te Tiriti (Clause Six) **states to provide for the Crown's intention to give effect to the principles of te Tiriti this Act requires health entities to be guided by:**

- the healthy system principles….
- requires the Minster to establish a permanent committee, the Hauora Māori advisory committee, to advise the Minister; and seek the advice or agreement of the committee before exercising certain powers.
- specifically requires the MHA to have systems in place for the purpose of engaging with Māori and enabling the responses from that engagement to inform the performance of its functions; and
- requires the MHA to report back to Māori on how the engagement under section 20(1)(c) has informed the performance of its functions.

Therefore, irrespective of the Pae Ora Bills intention to give effect to the principles of Te Tiriti. The intention for Te Tiriti to 'give effect', requires MHA to meet an extensive number of statutory conditions. What is ambiguous is that the conditions appear to be exclusive to the MHA, not Health New Zealand. So, does giving effect to Te Tiriti seems arbitrary for one side more than the other? Is

[11] identified in the Waitangi Tribunal 2575 Inquiry which recommended that legislation would need to support a system-wide accountability statutory requirement for Māori health outcomes

[12] Muriwhenua Fishing Report, above n 15, at 227. See the Treaty of Waitangi Fisheries Claims Settlement Act 1992 that addressed fisheries settlements, which provided evidence to establish frameworks through which local Māori could customarily manage fisheries.

[13] See Judge Michael Brown's address, Actualising the Partnership (Te Oru Rangahau Mäori Research and Development Conference, Massey University 7–9 July 1998). Additionally, see Te Kani Kingi, The Treaty of Waitangi: A framework for Māori health development, 2007. The treaty makes clear references to Māori health, with the Māori version promoting self-determination. See http://www.nzaot.com/downloads/contribute/TheTreatyofWaitangiAFrameworkforMāoriHealth.pdf

Māori continuing to be reduced to a participatory role as reported in the Hauora Report on Stage One of the Health Services and Outcomes Kaupapa Waitangi Tribunal Inquiry, where the treaty clause sets out in section four of the New Zealand Public Health and Disability Act 2000 seem to unduly narrow and limit Māori.[14]

Further, in the Hauora Report on Stage One of the Health Services and Outcomes Kaupapa Waitangi Tribunal Inquiry, interpretations of Māori control are expressed as:

> "in essence, Māori must have not only full control of kaupapa Māori organisations but also a real stake in policy-making and implementation in the whole health sector…an independent statutory health body with oversight of policy, research, and funding,… ensures mana motuhake…"[15]

To summarise clause six, we would expect that all parties contributing to the governance design of the Pae Ora Bill, that there would be explicit expressions of rangatiratanga, active protection, and partnership to strengthen Māori relationships with the Crown. We note that the health system principles seem to define Te Tiriti as a subsection of what rangatiratanga looks like. Therefore, moving away from Te Tiriti, providing a constitutional arrangement to define Māori as an equal partner to engage a shared authority. It seems too restrictive and conflicted in the application within the Pae Ora Bill.

More generally part 1 interpretation section guide to the act includes many new language to consider, such as Code of Consumer Participation; Healthy Entity (Health NZ, Health Quality and Safety Commission, the Māori Health Authority), Locality, Health Plan, Health Strategy, Public health Services (a-c) which defines services as personal health services, public health service, disability, services provided for EOLCA 2019.

Terminology that appears to not feature in Pae Ora Bill, but superficially referred to in *the Regulatory Impact Statement: Decision on the organisational form of a Māori Health Authority and Preamble Explanatory Note*, includes:

- kaupapa Māori services
- definition of equity – move away from using reducing health disparities
- LGBTQIA+ also limited – Indigenous peoples experience multiple levels of marginalisation and discrimination
- context of the role and function of the Māori Health Authority services
- the defined function of what commissioning is – which should be a main feature of the MHA

What we see as debilitating to achieving the aspirations of Māori is a reference to equity in the context of reducing health disparities among New Zealander's population groups for Māori. The term disparity in health immediately defaults to the deficit theory and assumes demographic superiority that shows how individualisation, detribalisation, and education will improve Māori Health (Reid and Robson, 2007; Lange, 1999). As Sir Mason Durie identified in his Whaiora report where he defined Māori health development he noted:

[14] See the New Zealand Public Health and Disability Act 2000 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.

[15] See Hauora Inquiry Section 1.2 - The National Hauora Coalition claim (Wai 2687)

> 'Māori health development is essentially about Māori defining their own priorities for health and then weaving a course to realise their collective aspirations' (Durie, 1994).

While we understand that disparity needs to be considered to nuance learnings of equity, through quantitative measures of Aotearoa, New Zealand's health care system. For instance, the role of the Health Quality and Safety Commission as coordinators to lead health epidemiology research that monitors how to achieve better equitable outcomes.

In 2022, we would like to see a shift away from health disparities which creates racial/ethnic biases to an equity focused approach that strengthens the concepts of health equity in the context of ethics and human rights. For instance, lets focus on prevention not extinction, where racial blame has incited negative experiences, particularly for Māori with recent criticism regarding Mate Korona – Covid-19 vaccination rates. Let's not name, shame, and blame but provide equitable solutions and learnings to move beyond this health crisis and crisis of deficit kōrero.

Clause 7 Health system principles

- Health system principles seem to apply to the institutions within the health system (Health entities, Mental health wellbeing commission, health and disability commissioner, artificial limbs service and health research council) but what is significant to this section is noted in subsection (1)(b) and (c) do not apply to Pharmac and the performance of its functions. When referring to working with Māori to achieve aspirations and opportunities to exercise…nature of Māori interests. Consequently, those principles do not apply to Pharmac, NZ Blood and Organ Group, and Health Quality and Safety Commission, which may be due to commercial /commerce relationships.

- Even though clause 7 (1)(d) includes the word **'choice'** of quality services to Māori and is further defined by referencing and resourcing kaupapa Māori and whānau centred service, providing services that are culturally safe and culturally responsive to people needs… Interestingly, participation in decision-making for the likes of Pharmac does appear to conflict with the word 'choice' is defined. This needs to be clarified particularly for prescribing nurses.

- Requires more clarity, and it may benefit the Act if it refers to the Wai2575 Hauora Inquiry (p.35) where the Waitangi Tribunal describes the **principle of option** as being:

> "…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"[16]

- Furthermore, applying the definition of the 'principle of options' to the Act, will require the Crown under the duty of Te Tiriti to enable access to available culturally appropriate kaupapa Māori services or mainstream if they wish. This would ensure the protection of Kaupapa Māori service

[16] Waitangi Tribunal, Report of the Waitangi Tribunal on the Muriwhenua Fishing Claim (Wellington : Waitangi Tribunal, 1988), p195 ; Waitangi Tribunal, The Ngai Tahu Sea Fisheries Report 1992 (Wellington : Brooker and Friend Ltd, 1992), p274 ; Waitangi Tribunal, The Napier Hospital and Health Services Report, p65 ; Waitangi Tribunal, The Tarawera Forest Report (Wellington : Legislation Direct, 2003), p28.

pathways, including when kaupapa Māori solutions are applied in mainstream service so that Māori do not continue to be disadvantaged by lack of 'choice'.

Part 2 – Key roles and health documents

Subpart 1 Minister of Health

Clause 10 – Overview of Minister's role section

Subsection (a) The Minister's role in the New Zealand health system includes issuing a Government Policy Statement and the following health strategies:

- We anticipate that the Minister's role to issue the overarching Government Policy Statement (GPS) that sets the direction for the year will align with the four health strategies (NZ Health, Hauora Māori, Pacific Health, Disability Health) and the two entities principles.

- In considering the idea of the disability health strategy in relation to GPS we see that this should broaden the approach and shift delivery from support services it provides to a broader holistic approach to support the needs of those with lived experiences of disabilities. We commend this approach and insist that there lived experiences are the driver of ensuring the idea of equity is appropriately applied.

Subsection (c) – approving the New Zealand Health Charter and the Code of Consumer Participation; and

- Code of Consumer Participation in conjunction with the Health Charter, which includes guidance for those working in the sector and the expectations set by the HQSC and defined in the RIS paper this is determined by how entities under the proviso of them adopting the nationally set principles for consumer engagement and aligning to the locality assessment network that includes patients, whānau and communities voices. It will be interesting to see how that translates across the entities and institutional health systems. Each entity and institution will likely have different viewpoints on engagement, particularly regarding function, roles, responsibilities, and application.

- Will the code of consumer participation ensure there is a specifically tailored response and pathway for wāhine and tamariki to access improved health services and associated systems? Particularly when considering hospital admission for general and mortality rates, limited access or response to primary care, accident, compensation, corporation (ACC) and pharmaceutical claims, mental health outpatient consultation. The inequities for Māori wāhine and tamariki are extreme and an immediate response that assures equitable outcomes is crucial.

Clause 12 (a-b) – Board of Health New Zealand

Subsection 4 - the chairperson of the Māori Health Authority (or the nominated co-chair- person referred to in section 22(3))—

- Considering the appointment process of the Chair of the Māori health Authority, we see limitations reflected in the composition of the appointment to acknowledge or identify their lived experiences with those who may have disabilities. There is no inclusion of that in terms of required skills. Similarly, for roles of the entities (Health NZ apart from the Chair role for MHA) is limited in that it lacks specification of mix of skills and composition; and appears to provide maximum scope to the Government to set the composition of the chair roles and

effectively the interim board committees in terms of what the Government wants. Therefore, let us return to the concept of equity and Te Tiriti obligation to provide the current specifications for appointments of Chairperson and committee members explicit role to uphold the purpose of Te Tiriti and the concept of equity? Perhaps this will be covered during the consultation process, including all participants (organisation, service, consumers etc…) who will contribute to how the Health Strategies, Plan, Charter will be defined etc. The RIS paper provides a more detailed response to this, but not so evident, and that is the consequence of this Pae Ora Bill, which provides basic definitions. However, does this mean there is more flexibility in the interpretation for the health entities to determine this?

Clause 14 Functions of Health New Zealand –

Subsection (1) The Functions of Health New Zealand are to jointly develop and implement a NZ Plan with MHA…(a-q) …

- As the plan in the context of the Pae Ora Bill refers to a joint development, with MHA advisory function of decision-making and design to set with the iwi partnership boards. How will HNZ be seen to engage with iwi Maori partnership boards (IMPBs). Subsection (f) - develop and implement locality plans is specifically health NZ function and responsibility. What does the joint process translate to for IMPBs? Our nursing workforce would be interested in the composition of what the 'joint' process is to look like; and how this might guide the regulatory monitoring and resourcing decision-making.

- Will this mean regulation across the sector will be reviewed particularly for our aged care nurses, with staffing levels already stretched? We have yet to see incentives to improve staffing standards across all areas of nursing. Particularly notable with the increase pressure on nurses working in the Managed Isolation and Quarantine (MIQ) centres and Hospital Intensive Care Units (ICU) Covid-19 wards. The hospital level of care as we know has required most health professionals to receive additional training, therefore has changed the level of care on some levels due to having to learn on the job, which has been disruptive for many. Therefore, we expect the plan will consider these outcomes for an oversubscribed workforce. This also applies to the MHA Strategy, Pacific Strategy, and the Disability Strategy.

Subsection (3) states: In performing any of its functions in relation to the supply of pharmaceuticals, Health NZ must not act inconsistently with the pharmaceutical schedule.

- Does this now limit purchasing rights, and will Pharma review this later, particularly given the lack of affordability for many pharmaceutical drugs that are not Medsafe approved. The access to the multiple types of medication for those high need patients needs to be prioritised.

- It is important that strategies continue to consider all disadvantages in access to health benefits, which includes education – Health Literacy.

Clause 15 – Health NZ must provide information to iwi-Māori partnership boards –

- HNZ must provide sufficient and timely info to iwi-Māori partnership boards… to achieve their purpose in section 92, Part 3 of the Act – which specifies the Director General request for health entity info, specify timeframe, and must not request any personal health info that may could potential breach the privacy by being identifiable. Substantially it acknowledges supply of accurate information for Māori data.

Subpart 3 – Māori Health Authority – clauses 17-22

- refers to the objectives and functions which is standard, what does stand out is subsection (f) which refers to kaupapa Māori services (g) review of locality plans, and (m) support and engage with iwi-Māori partnership boards in accordance to the MHA supporting the boards achieve purpose. Currently DHB was not consistently working with iwi to provide accurate information. Therefore, iwi- partnership schedule to achieve their purpose is positive. However, it comes down to how much investment can MHA provide irrespective of Health NZ role to support locality assessment plan. Will iwi be sufficiently resource to carry out their role and function under this Act.

Clause 19 Functions of MHA

Subsection (a)(i) - monitor in cooperation with the Ministry an Te Puni Kōkiri (TPK), the performance of the health system in relation to hauora Māori.

- Noteworthy, TPK[17] has the mandate to promote and monitor Māori achievement. Which was clear in the Waitangi Tribunal Inquiry 2019 which addressed TPK failure to discharge their statutory responsibility to monitor Crown agencies performance in providing equitable health and social outcomes for Māori.[18] It would be interesting to see how TPK are reviewing their monitoring role to support the health entities, Ministry and associated institutional arrangements.

Clause 20 - Engaging and reporting to Māori

Subsection 2 - in this section, Māori organisation includes (without limitation) iwi-Māori partnership boards, iwi and hapū authorities, Rūnanga, trust boards, Māori health professionals' organisations, and representatives of whānau and hapū relevant Māori organisation means a Māori organisation that the Māori 5 Health Authority considers relevant for the purpose of the engagement.

- It is good to see a breadth of definition that include all Māori organisations, associations and representatives that professionally and locally based. We support the expansion of current DHB reporting mechanisms.

Clause 21 MHA to support and engage with iwi-Māori partnership board

Subsection (a) ake reasonable steps to support iwi-Māori partnership boards to achieve 10 their purpose in section 92,

- To achieve purpose of administration, analytical, or financial support where needed and sufficient and timely information; by engaging with iwi-Māori partnership boards when determining priorities for kaupapa Māori investment. We are encouraged to see defined business responsibilities made explicit in the Act.

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[17] Te Puni Kōkiri was established under the Māori Development Act 1991 with responsibilities to:

- Promote increases in the levels of achievement attained by Māori in education, training and employment, health, and economic resource development.
- Monitor, and liaise with, each department and agency that provides or has a responsibility to provide services to or for Māori for the purpose of ensuring the adequacy of those services.

[18] See page Wai2575 statement regarding Te Puni Kōkiri. It says 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 as to why this situation might be persisting nor sought the necessary information needed to improve the performance of the primary health care sector.

- When reviewing the composition of the iwi-partnership boards within the schedule, the default to use existing iwi partnership boards to help set out the process of how to establish new iwi-partnership boards. All iwi in a defined district agreeing with district settings and extending it to include matawaka (iwi outside of their rohe) to contribute to districts. However, in the list provided as identified by many health professionals, seems to differ from the actual current DHB iwi-partnership boards. Therefore, perhaps there are scope that has yet to be shared across all districts, which might prove to be helpful to defining new iwi partnership boards. We assume there will be trade-offs with collective duties across district and regional spread?

Clause 22 – Board of Māori Health Authority

Subsection (c) cultural safety and responsiveness of services:

- We are pleased to see the inclusion of cultural safety standards and referred to in Clause 7 Health System Principles, subsection (d)(ii) providing services that are culturally safe and culturally responsive to people's needs. We recommend supplementary paper that refers to literature and rigour addressing cultural safety and cultural security.

- When referring to cultural safety, what type of definition is supporting the differences in the interpretations that many describe 'cultural safety' to mean and be. Particularly, as there is kōrero about this kaupapa in the past regarding the difference between cultural safety as in Te Tiriti and ethnic competencies/appropriations (i.e. Māori, Pacific etc.) and culture in the workplace, in terms of the behaviours and attitudes that impact on peoples' ability to and not participate (i.e. racism, discrimination, biases).

- For our Māori workforce the campaign and redress of cultural safety is important to be achieved, as Māori and Pacific having to work in extreme conditions of unsafe environments, where increased reports of discrimination continue to be experienced by our workforce. This conversation is not new and the late Irihapeti Ramsden started lobbying for such change over 30 years ago with her mahi (refer to Ramsden, education paper - Kawa Whakaruruhau)[19] on cultural safety standards being upheld and implemented across the sector.

- We offer the following definition that Rangatira Irihapeti Ramsden as referred above and other rangatira have provided:

> *Cultural Safety is about exercising the ability to act in good faith, respect, and acknowledge the diversities of people. If we consider the wider perspective of cultural appropriation and safety. Then Te Tiriti o Waitangi is the overarching framework and foundation that should be guiding the principles and standards of safety. Further, to incorporate cultural safety standards means ensuring Māori as the partner to Te Tiriti have access to and are able exercise tino rangatiratanga. It also means other groups such as Pacific, Muslim, Asian etc are equally provided the same opportunities. However, advocating change towards a genuinely bicultural health system that improves equity for health and*

[19] See Kawa Whakaruruhau – Cultural Safety in nursing Education in Aotearoa. - https://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/707224BC1D4953C14C2565D700190AD9/$file/kawa-whakaruruhau.pdf or

wellbeing of all New Zealanders, requires people to equally participate in changing the system to be inclusive not exclusive.[20]

Subsections (3) The Minister must appoint a chairperson or 2 co-chairpersons of the board. If co-chairpersons are appointed, the Minister must nominate a co-chairperson to 30 be a member of the board of Health New Zealand; and (4) Sections 28 (other than section 28(1)(b)) and 29 of the Crown Entities Act 2004 apply to the appointment of members of the board of the Māori Health Authority, except that the Minister must consult the Hauora Māori advisory committee before appointing any member.

- Although the sentence 'must' be applied and referred to in the that the Minister must consult with the MHA - Hauora Māori Advisory committee before appointing any member. We would recommend changing the word 'must' to 'should' and adding a precondition that mandates the Minister to follow a ballot system when finalising the decision with MHA. As it stands the statutory role to make final appointments remains exclusive with the role of the Minister.

Subpart 3 MHA continued – overview relating to engagement

- in relation to RIS paper – weighed up many trade-offs in terms of mandate, accountability, function, and costs. The supporting context of this RIS paper did provide for wider scope of autonomy, and we are unsure whether the Act weighs in on the breadth of research, data and evidence provided by the Waitangi Tribunal and decades of information. We also stress there is no right of veto guaranteed to MHA if they do not agree with outcomes of HNZ, therefore is escalated to the Minister supersedes authority and makes the final decision on the monitoring process.

Subpart 4 – Disputes

Clause 28 - Disputes between Health NZ and MHA.

- The 20 working days to resolve dispute may not provide a sufficient timeframe when investigation may require adopting a cultural restorative approach, which in accordance with clause 6 that gives effect to Te Tiriti, this will suffice. Considerations of restrictive access to private information particularly if it breaches the privacy act.
    - We would recommend the option to apply an extension if applicable. The Official Information (OIA) Act section 15A provides the option to request for an extension beyond the 21 days. If requested within the timeframe specified by the OIA Act, proposed extensions are approved for a further 20 days.

Clause 29 Overview of important health documents.

Subsection (g) the Minister to determine a Code of Consumer Participation to support consumer participation and enable the consumer to be voiced to heard –

- grammatical punctuation to be amended to read: "consumers voice to be heard"

Clause 30 Government Policy Statement on Health (GPS) –

subsection (1) the Minister must issue a GPS at intervals of no more than 3 years apart.

20 https://trc.org.nz/sites/trc.org.nz/files/digital%20library/Cultural%20safety%20in%20nursing%20education%20in%20Aotearoa.pdf

- When in the electoral cycle will the GPS set the direction for the government of the day? We are interested in the potential influence that this will determine in terms of strategies directive to address long-term outcomes due to the initiation of these new structural arrangements.

Clause 37 - New Zealand Health Strategy

Subsection (c) - set out opportunities and priorities for improving the health system over at least the next 5 to 10 years, including workforce development.

- It is great to see a 5-10-year, investment in long-term trends and risk that will impact on health outcomes and health system performance. We also anticipate that locality settings will play a pivotal role in setting the investment standards. We consider wider social impacts to improve health such as housing and employment will be significant determiner of how this will guide the strategy. Particularly given the Māori homelessness and poverty rates.

Clause 44 New Health Plan

Subsection 4 (b) In developing the plan, Health New Zealand and the Māori Health Authority must also take into account - the role of the Cancer Control Agency, Health and Disability Commission, Health Research Council, Mental Health and Wellbeing Commission, and Ministry (including the Public Health Agency) within the 15 health system.

- We would encourage this section of the act to be strengthened particularly for the Cancer Control Agency and the Mental Health and Wellbeing Commission. However, the expectation should be for all to have definitions that outlines their roles and contribution to setting the standards of care and protection.

Clause 45 - Content of New Health Plan

Subsection (f) which sets out the Health plan key services and activities to be delivered, and key performance measures.

- Health system improvement framework in terms of alignment with the productivity commission, will this be inclusive of everything?

Clause 48 Determination of localities and plan –

- requires all New Zealand to be covered by a locality and the boundary of locality is consistent with any regional arrangement specified in regulations and made public knowledge. This is encouraging and completely different from current district determination. We will keep a watching brief of this.

Clause 49 Locality plans

- We understand the consultation process includes the MHA, IMPBs, individual organisations and consumers to help develop and design the locality assessment plan. We recommend that consideration of variety of territorial geographical boundaries be consider. Particularly, as electoral, Te Ture Whenua, Waitangi Tribunal Whenua Claims, Government geographical boundaries do slightly differ. For instance, iwi/hapū boundaries are different compared to government boundaries. Which was identified in the Family Violence Reform and the governments Social Sector mahi. We advise ongoing consultation that takes all those differences into consideration.

- Is there a particular entity leading the locality planning, it is not specified in the Act?

- We understand the locality plan will not take effect until 2023/24. We anticipate that extensive people with lived experiences will be influencing the locality plans.

- Will locality planning include investment in supporting out of region training opportunities for those working in primary health care located in smaller regions where training resources are limited or time permits due to service capacity and capability being exhausted. Will there be specific funding tagged to increase workforce capabilities for additional FTEs and upskilling.

Clause 50 NZ Health Charter – subsection (1-3).

- As we refer to the definition of Health entities, in only includes MHA, HNZ, HQSC, Pharmac, and NZ Blood and Organ Services. In the act it does not refer to NGOs and independent communities and primary health care providers. However, clause 51 subsection (a) supports a contracting capability to include these groups that sit outside those defined in the Act. Therefore, is this the function of commissioning (which is not defined in the Act) and will this allow iwi-partnership boards in support of MHA to determine who is included.

Clause 53 Code of Consumer Participation –

subsection (1-4) which is developed by HQSC where principles for the purpose of supporting consumer participation and conditions around health services.

- We understand HQSC issued guidance around the consumer experience via DHB. There is also a call to rescope the surveying of consumers to include a wider audience that is more culturally diverse. We understand that many consumers, particularly those with disabilities may require alternative means to engage in this planning. How and who is managing the design and development of this Code of Consumer Participation. We would hope a reset is being initiated and an environmental scan underway to determine the diverse voices required. We would expect engagement with our nursing workforce for follow to help determine approaches for those with clinical needs.

- We also consider outcomes of safe staffing approaches that benefits our workforce and the whānau we support, those working with high needs. Will this be addressed as part of this approach.

Part 3 – Other roles

- The clauses are standard in terms of existing entities such as Pharmac, NZBOS, HQSC and ministerial committee objectives. We would only add why has the Cancer Control Agency been excluded given cancer has one of the country's highest mortality rates, which is prevalent in Māori with 1.5 times higher rates than non-Maori, particularly with Cervical and Breast Cancer.

Clause 84 Hauora Māori advisory committee.

- The intention is for the Minister **must** establish a Hauora Māori advisory committee with the functions to provide advice, advise on purpose. Which supports the Minister seek and consider the committee's advice before exercising any power to – appoint or remove members of the MHA Board, require MHA to develop a an improvement plan, issue letters of expectation to the MHA, issue directions, and make amendment to the MHA Statement of Intent or Statement of Performance Expectations.

- This includes trusted advisors to work with the Minister, this confirms that this is not a decision-making body.

Part 4 Subpart 1 – Powers in relation to service commissioning

- No real significant changes that would not be unknown in terms of transactional administrative. There is no significant difference in terms of Crown mandated role with funding and monitoring of performance. This section does not limit an y enactment or any powers that the Minister or the Crown has under any enactment or rule of law. Particularly subsection (3) where the Ministry may exercise the Minister's powers… except to the extent that the Minister determines by written notice.

Clause 92 – Accountability documents,

- Refers to a health entity must ensure that its accountability documents comply and Clause 93 Director – General may require information from Health entities, for purpose of monitoring the performance of any health entity or health system. Compliance by the health entities to meet request within a timeframe, can initially be specified. However, the DG must not request personal information that may identify any persons.

- Other areas cover provisions made for entitlement cards – still to be clarified and inspected and may likely be determined in the Health Plan, Charter, and Code of Consumer Participation?

- Will reporting be required for those providers working between the MHA and HNZ entities. This could prove to problematic for our primary health care nursing workforce, working for small providers in the community and little administrative support. Are considerations to invest in resourcing our community primary health care services/providers included in the budget?

Employment as in stands in the act, we understand from the explanatory note and the RIS assures that "All transferring employees will retain their existing terms and conditions of employment on transfer, including arrangements that had been specific to particular district health boards".

Schedule 1 – Transitional, savings, and related provisions Part 1

- Provisions relating to this Act as enacted define terms of collective agreement to mean a collective agreement within section 5 of the Employment Relations Act 2000, that is in force immediately before the commencement date. The commencement date to take effect within 12 months after the new institutional arrangements are implemented.

Subpart 4 – District Health Boards –

Subsection 15 - Employment policies of DHB

We support alignment of Employment Policies and will be discussing employment outcomes concerns with our members as they arise. We note the following section of DHBs conditions which seem to be equitable. However, as the transition of entities human resource administration develops, we suspect further discussions will be required to ensure our employment contractual obligations are continuing to be met.

(1) The employment policies of a DHB—

> (a) continue to apply, after the commencement date, with all necessary modifications, as if they were employment policies of Health New Zealand; and
>
> (b) may be replaced by Health New Zealand by written notice.
>
> (2) Health New Zealand must undertake a reasonable consultation process before introducing any employment policy that is reasonably likely to have a material effect on employees.
>
> Note section 21 refers to redundancy restrictions which overrides Part 6A of the Employment Relations Act 2000

We are happy with the employer and employee obligations within this act.