

ARTICLE

How the Framework and Delivery of the Primary Healthcare System Can Be Changed to Combat Māori Health Inequity

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On average, Māori experience the worst health outcomes of all ethnicities in New Zealand. Research has shown that this is because a range of negative determinants of health disproportionately impact Māori. Despite numerous attempts to redesign the primary healthcare system so that it contributes to improving Māori health outcomes, Māori health inequities have persisted. This prompted a Waitangi Tribunal inquiry and a subsequent report entitled *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. The report focused on the New Zealand Public Health and Disability Act 2000, the Primary Healthcare Strategy and *He Korowai Oranga*, detailing the deficiencies in the primary healthcare system that allowed and contributed to poor Māori health outcomes. It also made a number of recommendations, some of which will be implemented by the New Zealand Government. This includes the creation of a Māori Health Authority, with the Pae Ora (Healthy Futures) Act 2022. This article argues that these recommendations, as well as three additional ones, have the potential to meaningfully reduce Māori health inequities, provided the Crown truly gives Māori adequate power and funding.

I Introduction

In order for the proposed structural reforms to the health and disability sector to be truly effective for Māori and therefore equity, a culture change must occur—within the health system, within the health professions and within us. We must accept the overwhelming

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evidence that ‘sameness’ creates inequity. Silence and inaction show us to be complicit in these inequitable and racist outcomes.

—Papaarangi Reid¹

Māori health inequities are a prominent and shocking feature of New Zealand’s health landscape. Despite the fact these inequities have been known for decades, little has improved. Since April 2021, the government has worked towards reforming the health system, culminating in the Pae Ora (Healthy Futures) Act 2022 (Pae Ora), which came into force on 1 July 2022.² In part, Pae Ora established a Māori Health Authority with the aim of improving Māori health outcomes.³ This has spurred public debate about the causes of inequitable access to healthcare and solutions like this that place decision-making power in the hands of Māori.

This article aims to achieve two things. First, notwithstanding the many different determinants of health, I will demonstrate that the structure of the healthcare system and the delivery of healthcare services are important causes of poor Māori health outcomes. Secondly, I will analyse solutions and recommendations designed to address the deficiencies in the healthcare system that contribute to poor Māori health outcomes. Here, I will argue that a Māori Health Authority has the potential to meaningfully reduce Māori health inequities. I will also argue for a range of other changes that can be made to the primary healthcare system to improve health outcomes.

To do this, Part II will introduce the concepts of health, population health, and Māori health inequity. Part III will situate this article in its important constitutional context. Part IV will set out the relevant law and policy, consisting of provisions of the New Zealand Public Health and Disability Act 2000, key policy documents, and findings from *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Hauora)*. Part V will discuss and critique recommendations and solutions. Part VI will conclude that these recommendations represent the potential for Māori to truly drive their own health solutions with support from the Crown and the rest of the health sector. These solutions will help to reduce health inequity and should be implemented immediately.

At the outset, I note that I am Pākehā. The views in this article are my own. I have endeavoured to ensure my views are always supported by indigenous research, but nonetheless, they come from my place of privilege. I do not claim to speak on behalf of Māori or understand the immense harm they suffer because of a fundamentally unjust health system.

1 Papaarangi Reid “Structural reform or a cultural reform? Moving the health and disability sector to be pro-equity, culturally safe, Tiriti compliant and anti-racist” (2021) 134(1535) NZMJ 7 at 9.
2 Pae Ora (Healthy Futures) Act 2022, s 2.
3 Andrew Little and Peeni Henare “New beginning for Health System: Pae Ora (Healthy Futures) Bill passes third reading” (press release, 7 June 2022).

II Background

A *Differing definitions of health*

Classic Western definitions of health focus on the individual and readily fit what most Pākehā expect when they use the healthcare system. For example, one definition of health is:⁴

A state characterized by anatomic integrity; ... ability to deal with physical, biological and social stress; a feeling of well-being; and freedom from the risk of disease and untimely death.

The definition directs the reader to focus on how the individual deals with these stresses by reference to their anatomic integrity. It is the individual's perspective—their ability to be free from disease—that the reader considers. Under this definition, the administering of health care centres on the doctor-patient relationship, with the doctor treating the patient based on how their individual biology and anatomy presents.

However, this is not the only conception of health. For example, hauora is often translated as a Māori philosophy of health and has four commonly cited pillars of wellbeing: physical, mental and emotional, social and spiritual. This is broader than simply anatomic integrity. Further, Sharyn Heaton argues that this English translation unduly restricts Māori understanding of hauora.⁵ According to Heaton, hauora “comprises the complete relationship between” everything from Māori connections to the cosmos, land and the “totality of the world”.⁶ While the Western definition of health does not necessarily prohibit these considerations, hauora actively includes them as part of the conception of health. While discussing these definitions of health in detail is beyond the scope of this article, it is important at this point to acknowledge that this te ao Māori⁷ definition of health is much broader than the Western definition.

B *Population health*

Population health focuses on social, economic and physical environmental conditions as “causative or determinant of the level, dynamics and distribution of health”.⁸ Contrasting this with the Western definition of health above, the focus of population health is not on the individual and their ability to deal with adverse conditions, but rather on the adverse conditions themselves. These conditions, as they impact a person's health, are called the determinants of health. The resultant impacts on a population's health are called health outcomes.

Population health experts tend to focus particularly on addressing upstream or “root causes” of population health.⁹ Consider the example of a dental cavity: upstream interventions could be a sugar-sweetened beverage tax, subsidised toothpaste and better

4 Joseph Stokes III, Jay Noren and Sidney Shindell “Definitions of Terms and Concepts Applicable to Clinical Preventive Medicine” (1982) 8 J Community Health 33 at 34.

5 Sharyn Heaton “The juxtaposition of Māori words with English concepts. ‘Hauora, Well-being’ as philosophy” (2018) 50 Educational Philosophy and Theory 460 at 462.

6 At 464 and 466.

7 The Māori world.

8 Onyebuchi A Arah “On the relationship between individual and population health” (2009) 12 Med Health Care Philos 235 at 237.

9 At 239.

dental education, whereas a downstream intervention would be treating an individual with a filling. The upstream intervention seeks to stop the adverse health outcome occurring in the first place. It is also systemic, as it reduces the incidence of poor health outcomes across the population, rather than simply for the individual who sought treatment, as is the case with downstream intervention. As population health research often uncovers inequitable health outcomes, it is important that interventions target those populations with worse health outcomes. For example, this could include Māori designed dental education occurring at marae, wharekai (dining halls) and other community centres.

Considering upstream determinants encourages thinking about health broadly. For example, the alienation of Māori from their culture due to colonisation is seen as a determinant of health, leading to negative health outcomes.¹⁰ This suggests that culture is an aspect of health, something which fits neatly into Heaton's definition of hauora, which includes improving a Māori person's connection to their culture. This article argues that considering broader definitions can improve Māori health outcomes further in Part V.

C Māori health inequities

Health inequity is “the presence of systematic disparities in health between groups”.¹¹ Māori suffer the worst health outcomes of all ethnicities in New Zealand.¹² For example, the life expectancy for Māori males is on average eight years fewer than non-Māori males.¹³ For indicators of cardiovascular disease, New Zealand's leading cause of death, Māori mortality is often more than twice as high compared to that of non-Māori.¹⁴ Māori have higher cancer mortality rates compared to non-Māori,¹⁵ and are 2.5 times more likely to be hospitalised for COVID-19 than other ethnicities.¹⁶ These statistics exemplify the inequity Māori experience across all health outcomes.¹⁷

The Crown has known about Māori health inequities since the mid-20th century¹⁸ and has attempted multiple times to improve Māori health outcomes. Unfortunately, the inequities have rarely decreased. For example, while the New Zealand population's life expectancy has steadily increased, Māori life expectancy has remained “virtually static from the late 1970s”.¹⁹ While there are some areas where improvements have been made such as lung cancer mortality rates, low birthweight rates, infant and child mortality rates,

10 Rebekah Graham and Bridgette Masters-Awatere “Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research” (2020) 44 Aust NZ J Public Health 193 at 197.

11 New Zealand Medical Association “Health Equity Position Statement” (2011) 124(1330) NZMJ 89 as cited in Reid, above n 1, at 7.

12 Waitangi Tribunal *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wai 2575, 2019) [*Hauora*] at xii.

13 At 18.

14 Ministry of Health *Wai 2575 Māori Health Trends Report* (September 2019) at 51.

15 At 72.

16 Nicholas Steyn and others “Māori and Pacific people in New Zealand have a higher risk of hospitalisation for COVID-19” (2021) 134(1538) NZMJ 28 at 34.

17 For a full report on Māori health inequity, see *Māori Health Trends Report*, above n 14. For figures on the Māori health inequities described above, see Association of Salaried Medical Specialists *Creating Solutions Te Ara Whai Tika: A roadmap to health equity 2040* (September 2021) at 9; *Māori Health Trends Report*, above n 14, at 53, 74, 86, 186, 197 and 312; and Steyn and others, above n 16, at 36.

18 *Hauora*, above n 12, at 33.

19 At 18.

and tuberculosis notification rates, Māori health inequities have overwhelmingly persisted.²⁰

Health inequity results from negative determinants of health being more present within or having a greater effect on a particular population. There are a range of determinants of health that impact Māori, “including income and poverty, employment, education, and housing, ... [and] the cumulative effects of colonisation”.²¹ The design and delivery of the health system can partially address determinants of health.²² However, if the health system is designed and delivered inadequately, it can be a “negative determinant of health outcomes”.²³ The fact that these determinants of health disproportionately affect Māori has led to the view that health inequity is fundamentally “unfair and unjust”.²⁴

Considering the range of determinants of health, broad changes (such as improving low-quality housing stock and opening a discourse on colonisation as a source of inequity) would be required to truly address “deep-rooted historical, cultural, and systemic issues”.²⁵ The fact that many determinants of health are outside the control of the healthcare system is “sometimes used by health professionals and officials to deflect responsibility for the unfair differences that show up in health”.²⁶ However, Margaret Whitehead and Göran Dahlgren noted that “where action has taken place it tends to start with small, manageable problems rather than tackling the whole subject in a comprehensive, coordinated plan”.²⁷ Thus, the fact that there are many determinants of health is no reason not to change the framework and delivery of the health system to improve Māori health outcomes. Accordingly, Part V focuses on solutions and recommendations that aim to achieve this.

III The Treaty of Waitangi / Te Tiriti o Waitangi Partnership

Underpinning this discussion of historical determinants of health and Māori-led solutions (discussed further in Part V) is a national discourse on the place of the Treaty of Waitangi in New Zealand. While the constitutional significance of the Treaty is well-accepted amongst those with a legal education, its significance might be less well-received amongst the public. The authors of *He Puapua: Report of the Working Group on a Plan to Realise the UN Declaration on the Rights of Indigenous Peoples in Aotearoa/New Zealand*, published in 2021, considered that “Aotearoa has reached a maturity where it is ready to undertake the transformation necessary to restructure governance to realise

20 *Māori Health Trends Report*, above n 14, at xix.

21 *Hauora*, above n 12, at 20.

22 At 161.

23 At 156 (emphasis omitted).

24 At 68.

25 Matthew Hobbs and others “Reducing health inequity for Māori people in New Zealand” (2019) 394 *Lancet* 1613 at 1613.

26 Gabrielle Baker “The creation of a Māori health authority is good news – but the devil will be in the details” *The Guardian* (online ed, London, 22 April 2021).

27 Margaret Whitehead and Göran Dahlgren “What can be done about inequalities in health?” (1991) 338 *Lancet* 1059 at 1059.

rangatiratanga Māori”.²⁸ Rangatiratanga Māori²⁹ can manifest in a range of ways, including independent indigenous healthcare services.³⁰ The Waitangi Tribunal in *Hauora* shares this view, stating that demand is growing for co-governance models where Māori are empowered to design and deliver their own solutions to give effect to “the principle of partnership”.³¹

The establishment of the Māori Health Authority sits within a wider constitutional context of how the words and principles of the Treaty should be given effect. This article takes the view that Māori should be empowered by the Crown to exercise rangatiratanga and shares the Tribunal’s view that this is “essential to the improvement of Māori socio-economic status”.³² Whether New Zealand can show the leadership to give effect to this remains to be seen; however, the establishment of the Māori Health Authority may be a watershed moment for true co-governance.

IV The Law and Policy Framework

This Part will discuss the key piece of legislation that governed the primary healthcare system until its repeal on 1 July 2022: the New Zealand Public Health and Disability Act 2000 (the Act). In doing so, it will also include discussion on two policy documents by the Ministry of Health that accompanied this Act and the Tribunal’s report on the deficiencies in the primary healthcare system, *Hauora*.

A New Zealand Public Health and Disability Act 2000

In the 1990s, the government was determined to eliminate Māori health inequity. However, after decades of persistence with little success, it was clear a new approach was needed. This led to the Act being introduced in 2000, radically restructuring the healthcare system. It was hailed as “light-years ahead of anything that had gone before” in terms of addressing Māori health inequity.³³ However, despite the good intentions of the government in designing and implementing the Act, the statistics in Part II make it clear that Māori health inequities have shown little improvement over the last two decades. As the Act was the main piece of legislation the Tribunal analysed and found deficiencies in, it is necessary to outline the relevant provisions.

First, in setting out the purposes of the Act, s 3(1)(b) outlined one objective as being “to reduce health disparities by improving the health outcomes of Maori and other population groups”.

Secondly, s 4 recognised the Treaty by stating that “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”. This Treaty clause was different to other Treaty clauses in

28 Claire Charters and others *He Puapua: Report of the Working Group on a Plan to Realise the UN Declaration on the Rights of Indigenous Peoples in Aotearoa/New Zealand* (Te Puni Kōkiri, November 2019) at iii.

29 Chieftainship, authority, right to exercise authority, chiefly autonomy, chiefly authority.

30 Charters and others, above n 28, at iii.

31 *Hauora*, above n 12, at 165.

32 At 165.

33 At 22.

that it was more prescriptive than general.³⁴ The drafters intended to “do the hard work” themselves as to how the Treaty should be reflected in the Act, rather than leave it up to the courts.³⁵ Although well-intentioned, this approach was criticised by the Tribunal, as discussed later in this Part.

Third, Part 3 concerned District Health Boards (DHBs) and provided four mechanisms to address Māori engagement with the primary healthcare system and Māori health inequities:

- (1) Section 22(1)(e) provided the same objective as s 3(1)(b), to reduce Māori health disparities, for DHBs.
- (2) Section 23 outlined the functions of DHBs. Section 23(1)(d) stated that DHBs would establish processes for Māori participation in and contribution to “strategies for Maori health improvement”. Section 23(1)(e) sought to increase Māori capacity “for participating in” the health system and “for providing for the needs of Māori”. Section 23(1)(f) stated that DHBs were to “provide relevant information to Maori for the purposes of paragraphs (d) and (e)”.
- (3) Section 29 concerned the membership of board of DHBs. Section 29(4) provided that:³⁶

[T]he Minister must *endeavour* to ensure that Maori membership ... is proportional to the number of Maori in the DHB’s resident population ... and in any event, there are at least 2 Maori members of the board.

- (4) Sections 34–36 required advisory committees on public health, disabilities and hospitals to have Māori representation. While these provisions appeared promising, the Tribunal found significant deficiencies in the legislation, which are outlined below.

B *The primary healthcare framework*

The Act established DHBs, which contract with Primary Health Organisations (PHOs), which contract with healthcare providers, such as General Practitioners (GPs). This results in many contracts between different levels of the primary healthcare framework, which are referred to as lower-level contracts. These contracts are important because they “tie the vast, complex network of the primary health care system together and intend to put higher-level aims and obligations into practice”.³⁷ However, many of these contracts did not mention Māori health inequity or the Treaty, or make any provision as to how Māori health inequity would be reduced.³⁸ This loss of the goals of the Act was discussed by the Tribunal and outlined below.

34 See, for example, State-Owned Enterprises Act 1986, s 9, which provides that “[n]othing in this Act shall permit the Crown to act in a manner that is inconsistent with the principles of the Treaty of Waitangi.”

35 Matthew Palmer *The Treaty of Waitangi in New Zealand’s law and constitution* (Victoria University Press, Wellington, 2008) at 101 as cited in *Hauora*, above n 12, at 76.

36 New Zealand Public Health and Disability Act 2000, s 29(4) (emphasis added).

37 At 93.

38 At 93.

C Policy documents

Alongside the introduction of the Act, the Ministry of Health released several policy documents outlining the new direction of the healthcare system to address Māori health inequity.

The Primary Health Care Strategy, first published in 2001, outlined a vision of everyone having easy access to effective primary health care in a system that focuses on reducing population inequities. To achieve this vision, it recognised the need to identify the barriers that people face in accessing primary health care,³⁹ the importance of delivering culturally competent care,⁴⁰ and the importance of supporting Māori-specific health services.⁴¹ It set out solutions such as lowering fees, localising—rather than nationalising—PHOs, and capitation funding.⁴²

He Korowai Oranga, first published in 2002, outlined the different needs of Māori, in particular the importance of whānau as central to Māori health. It set out four pathways to improve Māori health outcomes: developing Māori communities and implementing Māori models of health; involving Māori in policy design, decision-making and provision of Māori-led healthcare; addressing Māori health inequity and providing quality health information to Māori; and finding synergies across other sectors to address the broader determinants of health.⁴³

While these policy documents set out desirable aspirations, the Tribunal found that their implementation failed to realise these goals.

D Hauora

The fact that Māori health inequities are still overwhelmingly persistent today, as outlined in Part II, suggests that the Act, the primary healthcare framework and the proposed policy directions have not meaningfully achieved the goal of reducing health inequity. That is the backdrop to *Hauora*, the Tribunal's report which sought to establish whether a "cause of the inequities suffered by Māori ... is the legislative and policy framework of the primary health care system itself".⁴⁴ This section sets out the scope of *Hauora*, the Treaty principles used by the Tribunal to analyse the alleged breaches, and the Tribunal's findings.

(1) Scope

The *Health Services and Outcomes Inquiry* is a series of three Tribunal reports concerning Māori grievances with the health system. *Hauora* is the first report and focuses on the primary health care system. The second report will focus on mental health, addiction and disabilities. The third report will cover any remaining and historical issues.

39 Annette King *The Primary Health Care Strategy* (Ministry of Health, February 2001) at vii.

40 At 11.

41 At 11.

42 At viii.

43 Annette King and Tariana Turia *He Korowai Oranga: Māori Health Strategy* (Ministry of Health, November 2002) at 9.

44 *Hauora*, above n 12, at 25.

Hauora is relevant to this article given its focus on the primary healthcare system. It has four areas of inquiry: the Act and the primary health care framework; funding arrangements for primary healthcare; accountability arrangements for primary healthcare; and the nature of the Treaty partnership in the primary healthcare sector.⁴⁵

(2) Treaty principles

Because the texts of the Treaty of Waitangi and te Tiriti o Waitangi differ in meaning, legislation tends to refer to the principles of the Treaty rather than the texts themselves.⁴⁶ Since the Waitangi Tribunal's inception in 1975, the Tribunal and the courts have developed jurisprudence on the Treaty principles, which underpin the two texts. The Tribunal then uses these principles to consider whether the Crown's actions were "inconsistent with the principles of the Treaty".⁴⁷

In *Hauora*, the Tribunal analysed these focus areas by reference to four Treaty principles: partnership, active protection, equity, and options. First, partnership arises from the interplay between Māori tino rangatiratanga (self-determination; sovereignty) and Crown kāwanatanga (governorship).⁴⁸ It requires the Crown to ensure that consultation with, and input from, Māori occurs when designing policies.⁴⁹ Secondly, active protection requires the Crown to take all reasonable steps to protect tino rangatiratanga.⁵⁰ In a healthcare context, this means providing reasonable solutions that are culturally safe, may be designed by Māori and address Māori health inequity.⁵¹ Thirdly, equity requires the Crown to positively promote fairness for all citizens.⁵² It must ensure healthcare laws and their implementation promote and achieve health equity for Māori.⁵³ Finally, the principle of options "protects Māori in their right to continue their way of life according to their indigenous traditions and worldview".⁵⁴ The Crown must protect and promote kaupapa⁵⁵ Māori healthcare solutions as well as ensure that the mainstream options work for Māori so they are not disadvantaged either way.⁵⁶ As seen in the next section, the Tribunal ultimately found that all four principles were repeatedly breached by the design and delivery of primary health care.

(3) The Tribunal's findings

The Tribunal found that all four focus areas were in breach of the Treaty principles.⁵⁷ In turn, these breaches demonstrate how the deficiencies in the primary healthcare system

45 At 16.

46 Frances Hancock and Kirsty Gover *He Tirohanga o Kawa ki te Tiriti o Waitangi: A Guide to the Principles of the Treaty of Waitangi as expressed by the Courts and the Waitangi Tribunal* (Te Puni Kōkiri, Wellington, 2001) at 74.

47 Treaty of Waitangi Act 1975, s 6(1).

48 *Hauora*, above n 12, at 27–28.

49 At 28–29.

50 At 30.

51 At 31–32.

52 At 33.

53 At 34.

54 At 35.

55 Central purpose, initiative, issue.

56 *Hauora*, above n 12, at 35.

57 At 161.

have led to negative health outcomes for Māori. Overall, the consequences of these breaches were severe, with the Tribunal stating:⁵⁸

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.

This section considers the Tribunal's findings in each of the four focus areas.

(a) The Act and the framework

The Tribunal identified three main breaches under this heading. First, the Act and policy documents did not state consistently the goal of achieving equitable health outcomes. Instead, the legislation is committed to "reduc[ing] health disparities".⁵⁹ As committing to reducing disparities implies there is an acceptable level of inequity, this articulation of the Māori health goal of the primary healthcare system was in breach of the Treaty principles of active protection and equity.⁶⁰

Secondly, notwithstanding the inadequacy of this stated goal, the fact that any mentions of the Treaty principles and Māori health inequity were removed from lower-level contracts was a "concerning omission in the health sector's Treaty obligations".⁶¹ As a result of these omissions, the goals were often lost within the large, complex system.⁶²

Finally, Part 3 of the Act, which was designed to promote Māori engagement, did not go far enough in allowing Māori to meaningfully contribute.⁶³ Māori consistently made up only a minority of members on boards and committees, which limited their ability to implement initiatives targeted at reducing Māori health inequity. This hamstringing of Māori decision-making power breached the Treaty principle of partnership. Taken together, the lack of clarity surrounding the goals for Māori health, the invisibility of the goal in lower-level contracts, and the inability of Māori board members to effect meaningful change has undoubtedly contributed to negative Māori health outcomes.⁶⁴

(b) Accountability arrangements

Accountability has two important aspects: accountability between the different levels of the primary healthcare system, and the ability of Māori to hold the Crown to account for poor Māori health outcomes.

There were several levers the Ministry of Health could use to hold DHBs to account. First, funding could be withheld for "non-performance or under-performance on Māori health issues".⁶⁵ Secondly, the Minister of Health could appoint a Crown monitor to a board if they were dissatisfied with the board's performance. Thirdly, a board could be replaced by a commissioner if it was seriously underperforming. Finally, achieving Māori health outcomes could be written into executive contracts as a key performance indicator (KPI). The Crown's evidence confirmed that none of these levers had been used in

58 At 161.

59 New Zealand Public Health and Disability Act 2000, s 3(1)(b).

60 *Hauora*, above n 12, at 74 and 97.

61 At 97.

62 At 95.

63 At 97.

64 At 163.

65 At 121.

response to poor Māori health outcomes.⁶⁶ The Tribunal found that the failure to use these levers was concerning and breached the principles of equity and active protection. Additionally, the Tribunal found that even if they were used, they would still be insufficient to promote equity and actively protect Māori.⁶⁷

The Tribunal also found that there was a severe lack of mechanisms for DHBs to hold PHOs to account. As DHBs were more focused on the adequacy of hospital services in their region, they “ha[d] minimal capacity to pursue accountability in their role as a funder of primary healthcare services”.⁶⁸ Concerningly, evidence by Māori health providers showed that they were monitored more harshly and frequently than non-Māori PHOs.⁶⁹ Overall, by failing to hold DHBs and PHOs to account, the Crown has knowingly allowed Māori health inequities to persist without consequence.

The second important aspect of accountability is how Māori can hold the Crown to account. Here, the Tribunal stresses the importance of data collection. Data is an important tool in driving change, with Hector Matthews saying that “data is very compelling” in encouraging entities to start addressing Māori health inequity.⁷⁰ However, without quality data, Māori cannot hold the Crown to account for its performance on reducing health inequity.⁷¹ The Tribunal found that the amount of data being collected, the quality of the data, and the public reporting of Māori health outcomes were all deficient and in breach of active protection and equity.⁷² This has allowed health inequities to persist by depriving Māori of the knowledge required to know where to target resources, and also of a tool that can be used to compel entities into action.

(c) Funding arrangements

Important aspects of funding include the funding allocated to DHBs, funding allocated to PHOs and specific funding issues for Māori PHOs. First, DHB funding was based on the five-yearly census, which undercounts Māori.⁷³ The Northland DHB was able to show that due to census undercounting of Māori, it had been underfunded by \$30 million over three years.⁷⁴ This means DHBs with higher Māori populations were underfunded and a proportion of Māori consumers using a DHB’s services had not been subsidised by the government as intended.

Secondly, in regard to PHO funding, the Act introduced a capitated funding model. This allocated a fixed amount to PHOs per consumer enrolled. Under this model, 71 per cent of funding comes from capitated first contact funding.⁷⁵ This is adjusted only for age, gender and whether the person is a high-use consumer (based on whether they use they use the practice 12 or more times in a year for an ongoing condition).⁷⁶ The other 29 per cent of primary care funding comes from various other models. Only 19 per cent of the funding streams adjust for ethnicity.⁷⁷ The capitated funding arrangement (providing the

66 At 121.

67 At 138.

68 At 127.

69 At 128.

70 At 126.

71 At 122.

72 At 138.

73 At 103.

74 At 103.

75 At 56.

76 At 53.

77 At 56.

majority of funding) resulted in consistent underfunding of PHOs, with a greater proportion of Māori enrolled because the funding was not based on the number of times they used it, nor was it adjusted to account for ethnicity. This means that PHOs serving Māori, who have greater health needs and consequently need more health services, did not get more funding to recognise this.⁷⁸

Finally, the Tribunal also found that the funding model does not suit providers of kaupapa Māori care.⁷⁹ Evidence from Professor John Broughton explained how consultations can take longer because it is necessary to *kōrero*⁸⁰ with a patient first. This allows them to establish their *whakapapa* (genealogy), with the patient then feeling comfortable beginning the surgery.⁸¹ This “approach to primary care requires ‘time and energy’ that a mainstream provider may not have”, as a result of the funding model being predicated on the mainstream conception of healthcare delivery.⁸² This meant that, beyond the funding model not supporting Māori PHOs, it “actively undermined” kaupapa Māori care in some instances.⁸³ These deficiencies in the funding models represented a breach of partnership, active protection, equity, and options.⁸⁴

(d) Partnership in the primary healthcare sector

Finally, the Tribunal found the nature of the partnership across the entire primary healthcare system was in breach of the principle of partnership guaranteed by the Treaty.⁸⁵ This was for three main reasons: the lack of genuine partnership in reforming healthcare, Māori views being underrepresented in the Ministry of Health and health profession, and the lack of culturally appropriate services.

First, the Treaty principle of partnership “requires the Crown to consult and partner with Māori genuinely in the design and provision of social services, including health care”.⁸⁶ Instead, the Crown followed a “flawed process” when reforming the primary healthcare system because it was led by the Crown playing the dominant role with only limited opportunity for Māori to comment, rather than designed by both as equal parties.⁸⁷ The approach taken meant Māori could not exercise *mana motuhake*,⁸⁸ could not bring their ideas to the fore and, accordingly, could not effectively reduce health inequity.

Secondly, Māori are underrepresented in every part of the health profession and in the Ministry of Health.⁸⁹ *Te Kete Hauora*, a Māori health focus unit in the Ministry of Health, was disbanded in 2016, which “sent the signal that Māori health was not a priority”.⁹⁰ Both this disbandment and the fact that Māori are a minority in the profession and in the Ministry of Health led to the Tribunal’s finding that Māori views are currently “considered

78 At 107–108.

79 At 116.

80 To speak, discussion, conversation.

81 *Hauora*, above n 12, at 108–109.

82 At 108.

83 At 115–116.

84 At 117.

85 At 159.

86 At 28.

87 At 141 and 160.

88 Autonomy, self-determination, sovereignty, self-government.

89 *Hauora*, above n 12, at 142–143.

90 At 145.

lesser in value or priority”.⁹¹ This limits the ability of Māori health experts to drive solutions to reduce health inequity.

Finally, there is a lack of culturally appropriate services. Culturally safe care requires recognition of the inherent power imbalance resulting from Western culture’s domination over Māori culture and challenging cultural assumptions in the health system.⁹² A vital way to improve cultural safety is to promote kaupapa Māori solutions.⁹³ However, as outlined above, the funding models do not support Māori PHOs. This has resulted in the number of Māori PHOs decreasing from 14 to four,⁹⁴ resulting in many Māori not having access to a Māori PHO and instead having to attend a mainstream service. The lack of cultural safety here results in reduced access for Māori as they are less likely to return and receive care that meets their needs.⁹⁵ This in turn leads to poorer Māori health outcomes.

Overall, Māori are not given mana motuhake to design solutions that work for them, a meaningful voice in decision-making, or a sufficient range of culturally appropriate services, meaning Māori health inequities have persisted.

V Recommendations and Solutions

As mentioned in Part II, comprehensively improving Māori health inequity would require addressing the range of determinants of health including income, socioeconomic disparity, education, housing and the ongoing effects of colonisation. However, this article will focus on the changes that can be made to the framework and delivery of the primary healthcare system and how this can improve Māori health outcomes.

A Hauora: *Recommendations*

The Tribunal’s findings of extensive breaches in the four focus areas described above led them to recommend that the Crown strengthens and makes consistent the wording of the Act, uses and increases accountability mechanisms, reviews and modifies the funding models, improves partnership in the health sector, and explores the possibility of an independent Māori Health Authority. This section outlines each of these recommendations in more detail and provides insight on them.

(1) The Act and the framework

The Tribunal found that “reducing disparities” was not a sufficiently strong goal, and any Māori health-related goal was omitted from lower-level contracts. To rectify this, they recommended that a clear goal of achieving health equity must be present in all health sector documentation.⁹⁶ This recommendation has been included in s 3(b) of Pae Ora, which provides that one of its purposes is to “achieve equity in health outcomes among New Zealand’s population groups, including by striving to eliminate health disparities,

91 At 160.

92 *Hauora*, above n 12, at 156; and Elana Curtis and others “Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition” (2019) 18 Int J Equity Health 1.

93 *Hauora*, above n 12, at 156.

94 At 156.

95 At 155.

96 At 96.

in particular for Māori”. This recommendation will have three flow-on effects that will improve Māori health outcomes. First, it will increase the visibility of this goal. When DHBs were renewing contracts with PHOs for example, the goal of health equity in their contract will make it a topic of discussion and thus more likely to lead to action. Secondly, it will encourage more managers and clinicians to engage with Māori solutions. Matthews led evidence that:⁹⁷

[P]eople in the primary health care system still do not believe that Māori health clinicians and professionals are competent when it comes to policy and strategy design, even when it is specific to Māori health.

While it would not solve this problem entirely, consistent messaging might encourage some clinicians to support their Māori colleagues and advocate for Māori-designed solutions. Finally, requiring this goal to be common across all documentation will likely lead to more reporting of progress being made towards it. This will set up a positive feedback loop and encourage further progress as health providers amplify the initiatives that are working well.

(2) Accountability arrangements

The Tribunal found that the accountability mechanisms were underused and inadequate, and that data collection was deficient. First, as recommended above, it is important that Māori health equity is consistently stated as a goal, as this signals to health entities that they are expected to improve health equity and can be held to account if they do not.⁹⁸ The Tribunal recommended using the current levers to address health inequity, and also that more accountability mechanisms are needed.⁹⁹ While the latter remains true, consistently using current levers could also be effective. For example, levers such as making continued underperformance on Māori health outcomes a ground for dismissing executives, and making an executive KPI improving Māori health outcomes, would spur substantial action in addressing Māori health inequity.

Considering data collection, the Tribunal recommended that Māori and the Crown co-design a research agenda to collect robust data.¹⁰⁰ If there is consistent public reporting on Māori health outcomes, this would bring the health inequities into the conversation with a greater sense of urgency. In line with Matthews’ evidence that data compels people into action, Māori could use this data to encourage the Crown and its entities to address health inequity.

(3) Funding arrangements

The Tribunal found that the funding models underfunded DHBs and PHOs that served a greater Māori population, and undermined kaupapa Māori healthcare models. The Tribunal recommended that the Crown urgently review and modify funding arrangements so that Māori PHOs are not disadvantaged.¹⁰¹ Funding is essential to delivering quality care to consumers. With adequate funding, providers in high-needs areas would be equipped

97 At 154.

98 At 168–169.

99 At 168.

100 At 168.

101 At 167.

to deal with the statistical certainty that their consumers will use their services more than a provider serving a well-off region. This would improve Māori health outcomes.

The Tribunal's recommendation that funding arrangements should cater for "kaupapa Māori models of care" is also correct.¹⁰² Modifying the funding model to account for this would allow culturally safe care to be delivered to Māori, increasing the likelihood of Māori consumers continuing to use healthcare and improve Māori health outcomes.

There are three ways to "better align" funding with the aim of health equity.¹⁰³ First, funding should be adjusted to account for Māori underrepresentation in the census. As mentioned in Part IV, census-based funding led to DHBs with a higher proportion of Māori patients being severely underfunded. Under Pae Ora, funding from Health New Zealand and the Māori Health Authority, if based on census data, must be adjusted to avoid the funded healthcare providers being put under a similar strain.

Secondly, PHO funding should be adjusted for ethnicity. As mentioned above, currently only 19 per cent of the funding streams adjust for ethnicity. As Māori are, on average, the population group with the worst health outcomes, they should also be the population group using the primary healthcare system the most. Therefore, providing PHOs with more funding per enrolled Māori would allow all PHOs to better address high-needs Māori consumers, and would result in equitable funding for PHOs who service predominantly Māori populations.

Finally, PHO funding for Māori consumers should be ring-fenced for Māori solutions. This is a funding solution that would benefit mana motuhake by providing more funds for the development and delivery of kaupapa Māori solutions. As will be discussed below, these solutions improve Māori health outcomes by improving access to culturally safe care, and thus it would be desirable to support them with the increased funding that PHOs would receive for their enrolled Māori patients.

(4) Partnership in the primary healthcare sector

The Tribunal found that the partnership guaranteed by the Treaty was not present in the design of the healthcare reforms, the Māori voice was underrepresented and culturally appropriate services were not prioritised. The Tribunal recommended a strong partnership to improve Māori health outcomes.¹⁰⁴ There are two reasons why this partnership should be enhanced. First, Māori have the expertise to design care that is culturally safe and will meet Māori needs, and so should be given the authority to develop and implement this. Secondly, increasing Māori representation in the health profession will increase the comfort of Māori consumers in using the health system as they interact with more people of their own ethnicity. Therefore, a strong Māori partnership will improve Māori health outcomes and should be prioritised moving forward. This will hopefully be the case with the new Māori Health Authority.

(5) Māori Health Authority

The Tribunal recommended "that the Crown commit to exploring the concept of a stand-alone Māori primary health authority".¹⁰⁵ This was argued for by claimants to address

102 At 167.

103 At 167.

104 At 164–165.

105 At 165.

several of the breaches identified. A Māori Health Authority could ensure a strong Māori voice for design, decision-making, and implementation—something the Tribunal found was lacking in the current framework.

As mentioned in Part I, Pae Ora came into force on 1 July 2022. When the reform was announced, Gabrielle Baker argued the “critical questions of who has power and money, and who is really going to be in charge” still need to be answered to see whether this initiative will meaningfully reduce health inequity.¹⁰⁶ When the Budget 2022 provided \$188.1 million to the Māori Health Authority, compared to over \$3 billion to Health New Zealand, some critics labelled the disparity as inequitable.¹⁰⁷ However, others noted that many Māori will continue to receive services through mainstream health system,¹⁰⁸ and that the funding could increase over time as more Māori health providers become trained.¹⁰⁹ The Māori Health Authority has numerous functions, including developing policy,¹¹⁰ monitoring and providing information on health sector performance,¹¹¹ commissioning Māori health services,¹¹² and jointly commissioning mainstream health services alongside Health New Zealand.¹¹³ While it may still be too early to conclude whether this funding is adequate, it is clear that for Māori to effectively carry out this workload and improve health outcomes, the Māori Health Authority must not be underfunded and hamstrung, as has been the case with previous Māori organisations.

Even after considering issues of funding and authority, one may still view the Māori Health Authority as more of the same, dressed up differently. Indeed, the optimism and hope that the witnesses spoke of when the Act was introduced 22 years ago suggest that the similar sentiments expressed today are not new. When countless experts have spent decades trying to solve health inequity, what makes this time different?

There is one significant difference between today and 22 years ago. Back then, the standout feature of the new primary healthcare system was the recognition of Māori health disparity in legislation and policy, and an unprecedented commitment to addressing and eliminating it. Unfortunately, this admirable attempt was let down by its implementation and failure to truly involve Māori in decision-making, to adequately fund Māori PHOs and health solutions, and to hold entities to account for reducing health inequity. This has meant that the health inequities have persisted to the present day. However, today, the question is whether Māori rangatiratanga will be recognised in the health system, and whether the Crown and the New Zealand public are prepared to recognise true co-governance with Māori, as discussed in Part III.

There are four main reasons why the Māori Health Authority has the potential to reduce Māori health inequities. First, there are already examples where Māori have been able to design and deliver a health solution that has reduced health inequity. To date, these have been confined to a particular health outcome. For example, a policy aimed at reducing infant deaths that had been designed by and for Māori was successful at reducing

106 Baker, above n 26.

107 Samantha Worthington “\$188m Māori Health Authority boost ‘not enough’ – experts” (19 May 2022) 1News <www.1news.co.nz>.

108 Ian Powell “Māori Health Authority – good call but not a magic bullet” (15 June 2022) Business Desk <<https://businessdesk.co.nz>>.

109 Jo Moir “Challenge for Māori Health Authority bigger than funding” (23 May 2022) Newsroom <www.newsroom.co.nz>.

110 Pae Ora (Healthy Futures) Act, s 19(1)(a).

111 Sections 19(1)(e) and 19(1)(k)–19(1)(l).

112 Section 19(1)(f).

113 Section 19(1)(j).

infant death inequity, whereas mainstream policies had increased inequity.¹¹⁴ The Harti Hauora Tamariki tool, a kaupapa Māori intervention that prioritises relationship-building and culturally safe care, led to better engagement with healthcare by Māori.¹¹⁵ A more recent example was the vaccine rollout in the area of Te Whānau ā Apanui in rural Gisborne and Bay of Plenty.¹¹⁶ Led by local GPs and nurses, kaumatua of each hapū were vaccinated early, so they could encourage other members of their hapū to get vaccinated. Vaccination centres were held in marae and wharekai to improve access and so people were comfortable. This led to 80 per cent of the eligible population being fully vaccinated. These examples demonstrate that Māori-designed and Māori-led care can reduce the inequities Māori suffer from when receiving the mainstream model of care. The Māori Health Authority has the potential to implement small scale interventions like these nationally and develop a host of other Māori-led solutions, to further reduce Māori health inequities.

Conversely, the COVID-19 vaccine roll-out was a visible reminder of poor outcomes for Māori when they are not sufficiently involved in decision-making from an early stage. As early as February 2021, Māori health experts called on the government to roll the vaccine out equitably, by prioritising Māori and Pacific people who are at higher risk of hospitalisation and death.¹¹⁷ The government's failure to do so resulted in inequitably low Māori vaccination rates and shows how a one-size-fits-all approach does not work well for Māori.

Secondly, the Tribunal identified many of the stumbling blocks that the government will hopefully avoid. *Hauora* made clear that the Treaty requires both true partnership—that is, co-governance in the design and implementation of the health system—and adequate funding for Māori solutions.¹¹⁸ Again, the COVID-19 vaccine rollout resulted in poor outcomes for Māori when they were not sufficiently involved in decision-making from an early stage.¹¹⁹ The pressure on the government from the media and Māori leaders shows the growing momentum for the Crown to live up to their obligations as a Treaty partner. This factor, combined with the Crown's failings under the current system as outlined by the Tribunal, shows that many of those mistakes are unlikely to be made with the new Māori Health Authority.

Thirdly, there is international precedent for an indigenous-led health authority improving health outcomes for their indigenous population. The often-cited Nuka System of Care in Alaska, introduced in the 1990s, has led to reduced appointment delays, reduced time in hospital and ER, low staff turnover, and high customer satisfaction.¹²⁰ This shows some of the gains that can be made when the indigenous population is in “control of decision-making and administration”.¹²¹

114 Christopher Rutter and Simon Walker “Infant mortality inequities for Māori in New Zealand: a tale of three policies” (2021) 20 Int J Equity Health 1.

115 Bridgette Masters-Awatere and Rebekah Graham “Whānau Māori explain how the Harti Hauora Tool assists with better access to health services” (2019) 25 Aust J Prim Health 471.

116 Matai O'Connor “Māori-led vaccination drive reaches 80 percent of Te Whānau ā Apanui's population” (12 October 2021) RNZ <www.rnz.co.nz>.

117 Collin Tukuitonga and Grace Shaw “Why Māori and Pacific people should get the vaccine first” (17 February 2021) University of Auckland <www.auckland.ac.nz>.

118 *Hauora*, above n 12, at 165.

119 Steyn and others, above n 16.

120 Katherine Gottlieb “The Nuka System of Care: improving health through ownership and relationships” (2013) 72 Int J Circumpolar Health 1 at 5.

121 At 2.

Finally, an analogy can be drawn with other sectors of New Zealand society where significant authority has been given to Māori and co-governance has led to successful outcomes for Māori. For example, the Rangatahi Courts are a youth court for low-level offending held at the marae, which incorporates tikanga Māori. They have been designed by Māori judges and seek to involve the local iwi community.¹²² A 2014 study showed that participants in the Rangatahi Courts reoffended less than those who went through the regular youth court.¹²³ Another example is Treaty claims that result in natural features being given legal personhood. Research on the legal personhood of the Whanganui River showed the potential for mana whenua to develop sustainable regional enterprises that could benefit Māori communities and economies.¹²⁴ Additionally, co-governance has been called for in many other areas, even if not yet implemented, such as the welfare system.¹²⁵

One challenge the Māori Health Authority is likely to face is delivering care to a range of iwi and hapū from a national viewpoint. Whitehead and Dahlgren note that “effective policy to tackle inequalities in health has to be tailored to suit the systems operating in a specific country or district”.¹²⁶ The Māori Health Authority must get ample input from Māori all over the country in order to provide for different iwi, hapū, or regions with differing health needs. As Baker notes, “Māori are not a monolith”.¹²⁷

Overall, the establishment of the Māori Health Authority should be viewed with cautious optimism.¹²⁸ While recommendations for Māori decision making authority are not new, far less often are they implemented by the government. Given the resources and authority, there is no doubt that the many Māori health experts will deliver a service that can finally start reducing Māori health inequity.

To conclude, this article agrees with most of the Tribunal’s recommendations. A strong goal of achieving health equity, reiterated throughout the health system, would help keep this goal front and centre to help begin the process of accountability. Using the existing levers of accountability would strongly encourage health entities to focus on improving Māori health equity and the addition of new levers may not be necessary. This article agrees that the census-based and capitated funding models are inequitable, and has argued that they should be modified to account for ethnicity. A stronger Treaty partnership would improve Māori health outcomes. The new Māori Health Authority represents a real opportunity to implement such a partnership and has the potential to meaningfully reduce Māori health inequity.

122 John Walker “Taking lessons from the Rangatahi Courts” (2018) 3 LawNews 1 at 1.

123 Anusha Bradley “Success of Rangatahi Courts applauded by judges and minister” (16 October 2020) RNZ <www.rnz.co.nz>.

124 Aikaterini Argyrou and Harry Hummels “Legal personality and economic livelihood of the Whanganui River: a call for community entrepreneurship” (2019) 44 Water International 752 at 763.

125 See Māori Perspective Advisory Committee *Puao-te-Ata-tu (day break): The Report of the Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare* (Department of Social Welfare, September 1988) at 19, which states that “monocultural institutions ... simply ignore and freeze out the cultures of those who do not belong to the majority”; at 26, whereby it recommended, among other things, “sharing power and authority over the use of resources”; and at 14, where it also recommended “harness[ing] the initiatives of the Maori people and the community at large to help address the problems”.

126 Whitehead and Dahlgren, above n 27, at 1060.

127 Baker, above n 26.

128 Baker, above n 26.

B *Other recommendations*

(1) Education

Educating the public on health inequity is important for a successful equitable health reform. There is inconsistency between the expert consensus, and the political and public opinion, with Matthew Hobbs writing that “[d]espite overwhelming evidence regarding the social and economic determinants of population health, the consideration of Māori health inequity in a broader sociopolitical context remains contentious.”¹²⁹ Accordingly, more education on the causes of health inequity would help reduce the political and public opposition to equity-based solutions. To this end, it is promising to see that an updated compulsory history curriculum will be taught at all schools by 2022, which will cover colonisation and its ongoing effects.¹³⁰ This will help the public understand how poor Māori health outcomes today are partly driven by systemic causes and require equitable solutions.

Education and awareness in the medical community is also vital, as they are integral to rolling out equitable health solutions. Evidence in *Hauora* showed the explicit or passive resistance Māori health leaders face in trying to implement Māori health solutions:¹³¹

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.

This is also supported by Hobbs, who argues that “the field of public health can make positive contributions to the dialogue on health inequities ... via encouragement of equity-focused policies and practices”.¹³² As clinicians and public health officials are the experts in this field, they should, with leadership from Māori experts, encourage and drive equity-based solutions.

A study of New Zealand medical colleges in May 2021 found that most colleges offered cultural competence training, but it was mostly only compulsory for trainees.¹³³ Further, the study found that cultural competence is outdated and that cultural safety, as outlined above, should be the main focus.¹³⁴ Only some colleges were in the early stages of implementing cultural safety training.¹³⁵ Based on this, the healthcare sector’s cultural safety education must be more robust and consistent across the professions. It needs to consist of ongoing training for all members, rather than just training for new members. Coupled with the increased recognition of the goal of achieving Māori health equity across the health care framework, this training may help to combat internal resistance to Māori health solutions.

129 Hobbs and others, above n 25, at 1613.

130 Boris Jancic “New Zealand history will be compulsory in all schools by 2022” *The New Zealand Herald* (online ed, Auckland, 12 September 2019).

131 *Hauora*, above n 12, at 154 and 147–148.

132 Hobbs and others, above n 25, at 1614.

133 Marnie Carter and others *Cultural safety within vocational medical training* (Council of Medical Colleges, May 2021) at 12.

134 At 12.

135 At 13.

(2) All-encompassing definitions of health

Some of the Māori health initiatives discussed above show how Māori benefit from models of care that look at health more holistically than the mainstream system provides. For example, the Harti Hauora Tamariki tool involved building a relationship with the clinician and consumer and conversing with a Māori clinician in te reo Māori, which improved access to healthcare. This also aligns with Broughton’s evidence mentioned in Part IV that a patient felt comfortable with the procedure only after kōrero establishing whakapapa.¹³⁶ These approaches show the importance of whakawhanaungatanga (the process of establishing relationships) and whakapapa to Māori, and how this can improve their health outcomes.¹³⁷ These are aspects of Māori healthcare models not focused on clinical or medical competency and, thus, are discounted under the mainstream clinical definition.

Instead, these holistic aspects better align with a broader definition of health, such as Heaton’s in Part II, which encompass the complete relationship between Māori and the world around them. When given the opportunity, Māori healthcare providers implement healthcare initiatives using these broader views of health. The Māori Health Authority will provide a much bigger space for Māori healthcare providers to continue developing and implementing these, which will in turn improve Māori health outcomes. Further, holistic models of health need not be confined to Māori healthcare providers. Mainstream healthcare providers could likely also benefit from these models in contexts such as mental health.

(3) Removing financial barriers

Financial barriers to primary healthcare that Māori experience include co-payments, prescription filling fees and transportation costs.¹³⁸

(a) Co-payments

Co-payments are an obvious barrier to receiving care. Māori, overrepresented in lower socioeconomic positions, experience higher health needs, yet are disproportionately affected by this barrier.¹³⁹ Professor Peter Crampton advocates for primary care user costs to either be abolished or calculated according to ability to pay.¹⁴⁰ The Association of Salaried Medical Specialists (ASMS) recommends that “user charges for primary care services [should be] abolished”.¹⁴¹ Co-payments are clearly a barrier which may stop a consumer getting treatment for a preventable disease. Primary care costs can also force people to use the free, secondary care system instead, thereby putting pressure on that system.¹⁴² Both of these are outcomes the healthcare system should seek to avoid.

Dental care is also often cited as an expensive medical service. Currently, some children are eligible for free dental care, but adults have to pay privately. The Ministry of Health recommends that adults “shop around and ask about the fees for the treatment

136 *Hauora*, above n 12, at 108–109.

137 Masters-Awatere and Graham, above n 115, at 474–475.

138 Shelaine I Zambas and Jennifer Wright “Impact of colonialism on Māori and Aboriginal healthcare access: a discussion paper” (2016) 52 *Contemporary Nurse* 398 at 401–402.

139 *Hauora*, above n 12, at 24; and *Primary Health Care Strategy*, above n 39, at 15.

140 *Hauora*, above n 12, at 107.

141 Association of Salaried Medical Specialists, above n 17, at 14.

142 *Hauora*, above n 12, at 107.

you require” if cost is an issue.¹⁴³ This clearly does not work for many Māori adults, with Māori asking the government to provide free dental care for vulnerable New Zealanders who currently avoid going to the dentist due to cost.¹⁴⁴ A lack of dental care can be debilitating, and dental care should be considered primary care and should not have any user payments.

Eliminating co-payments would be straightforward as it would simply require the government to allocate more funding to Health New Zealand and the Māori Health Authority, in turn passing this on (under modified, equitable funding models) to healthcare providers. A bigger tax revenue, funded by a comprehensive capital gains tax, would likely solve any budget considerations, but that is a subject for another article.

(b) Prescription filling fees

Prescription filling fees could be solved in a similar way as for primary care co-payments. The government could increase their funding to pharmacies to account for the difference.

(c) Transport costs

Transport costs are more difficult to address. This is because they implicate income and rurality, given GPs are spread unevenly around the country. Therefore, addressing transport costs no doubt requires coordinated intervention from other social services, such as social welfare.¹⁴⁵ However, the primary healthcare system can still combat transport barriers by ensuring funding is in accordance with this goal, by incentivising health professionals to work rurally and by promoting rural initiatives such as Mobile Health.

First, equitable funding that is adjusted for ethnicity could be used by PHOs serving Māori populations to increase their opening hours. This would give Māori consumers greater ability to schedule appointments around work and may improve access.

Secondly, incentives for health professionals to work rurally need to be increased. Currently, the voluntary bonding scheme offers payments to recent graduates in “eligible hard-to-staff communities or specialties”.¹⁴⁶ While this is clearly a positive initiative, further reform is needed. ASMS uses the example that “[u]nder the current small-business model for primary care, Nelson-Marlborough ... has almost twice the number of GPs per capita as the Manawatū and the West Coast.”¹⁴⁷ Stronger incentives would increase the number of GPs working rurally, improving access for rural Māori.

Finally, funding and implementing rural initiatives on a larger scale, such as Mobile Health, would improve access for rural Māori. Mobile Health predominantly provides elective day surgeries and health education for remote parts of New Zealand.¹⁴⁸ These initiatives should also ensure they are delivering culturally safe care, given that rural Māori have fewer options for healthcare providers.

143 Ministry of Health “Publicly funded dental care” (25 June 2019) <www.health.govt.nz>.

144 Jenna Lynch “Jacinda Ardern marks free dental care as potential election issue at Waitangi” (4 February 2020) Newshub <www.newshub.co.nz>.

145 Association of Salaried Medical Specialists, above n 17, at 15.

146 Ministry of Health “Voluntary Bonding Scheme – 2022 intake information” (13 October 2021) <www.health.govt.nz>.

147 Association of Salaried Medical Specialists, above n 17, at 15.

148 Mobile Health “Equitable Access to Health care” <<https://mobilehealth.co.nz>>.

This article has made three recommendations in addition to those in *Hauora*. First, improving the education of the public and medical community on health inequities and their causes would decrease resistance to the implementation of equitable solutions in primary healthcare. Secondly, Māori models of care, using holistic definitions of health, should be more widely implemented, as they improve Māori health outcomes. Finally, removing financial barriers to primary healthcare will improve Māori access to healthcare and thus improve health outcomes.

VI Conclusion

Māori health inequities have persisted despite their identification decades ago and repeated healthcare system reforms. In the early 2000s, the Act and accompanying policy documents reformed the primary healthcare system, being partly focused on reducing Māori health disparity and improving access to healthcare. Over the last 22 years, this goal has largely been unrealised, with inequitable Māori health outcomes continuing to exist. In 2019, *Hauora* was released, comprehensively outlining how the primary healthcare system has failed Māori. The Tribunal found that the Act and its framework, accountability mechanisms, funding arrangements and partnership in the healthcare sector were all in breach of the Treaty principles.

This article outlines the Tribunal's five recommendations to help reduce Māori health inequities, and largely agrees with them. It then makes three additional recommendations to further this goal. Despite the complex and wide ranging determinants of health, the primary healthcare system is capable of being designed and delivered in such a way as to reduce health inequities, rather than contribute to them as it currently does. To effect this change, the Act and all health sector documentation need to clearly state the goal of achieving health equity. Pae Ora marks the beginning of the shift to this language. Health entities must be held to account for failing to reduce Māori health inequity. Funding must be allocated equitably, accounting for the higher health needs of Māori. Education of the public and health sector, broad definitions of health, and addressing financial barriers to primary healthcare would also reduce Māori health inequity. Finally, the Māori Health Authority should be established, a recommendation the government has already implemented.

Ultimately, the health system is one of many structures in New Zealand set up by and for Pākehā, despite numerous attempts to change this. However, with genuine power and funding, the Māori Health Authority can finally be the change the primary healthcare system needs to significantly improve Māori health outcomes. The evidence supports this: when given the opportunity, Māori are able to design and deliver interventions that reduce Māori health inequity. There are examples of such co-governance models working successfully overseas and in other sectors of New Zealand society.

I view the establishment of the Māori Health Authority with a cautious optimism and believe that it will improve Māori health outcomes. I hope that in time, other structures will undergo a similar transformation.