The primary healthcare claims to the Waitangi Tribunal

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Over the past 40 years, primary healthcare policy in New Zealand has developed in a context of competing political, social, economic and professional forces. Among these competing forces, since the early 1980s Māori aspirations for full participation at all levels in the system, from governance to service delivery, have become increasingly prominent. Māori participation has included active contribution to and influence within health policy debates, and a growing presence in the ownership of primary healthcare provider organisations.[1,2]

The recent commencement of a kaupapa inquiry into health services and outcomes by the Waitangi Tribunal, starting with primary healthcare claims,[3,4] marks the opportunity for the Tribunal to make a highly significant contribution to health policy formation.

Background: the Waitangi Tribunal

The Waitangi Tribunal has a unique role in New Zealand's legal system. Its existence is predicated on the foundational significance of the Treaty of Waitangi in New Zealand's (unwritten) constitution. The constitutional relationship between the two parties to the Treaty—the Crown and Māori—is defined by the Treaty. The Tribunal was established in 1975 as an independent permanent commission of enquiry following the passage of the Treaty of Waitangi Act (1975).[5] Its primary purpose is to receive and report on claims of alleged Crown breaches of the principles of the Treaty of Waitangi, and make recommendations on the practical application of the principles of the Treaty relating to those claims. Its jurisdiction was initially limited to claims dating from 1975 onwards, but in 1985 the Act was amended to allow claims dating back to the time of the signing of the Treaty of Waitangi on 6 February 1840. In summary, the Tribunal's function is to provide an independent, impartial, public and accessible forum for Māori to bring allegations of Crown breaches of Treaty principles (Section 6 of the Treaty of Waitangi Act 1975 outlines the jurisdiction of the Tribunal to consider claims). These alleged breaches result from acts of commission or omission by the Crown that result from legislation, Crown policies or practice.

Each Tribunal makes a determination on which principles of the Treaty of Waitangi it should apply to the claims before it, so does not have a master list of principles to be applied. Table 1 sets out the principles often used by the Tribunal and the Treaty principles referenced in health sector documents.

The members of the Tribunal include a chairperson, Māori Land Court judges, plus others, comprising roughly equal numbers of Māori and Pākehā.[5] In carrying out its work the Tribunal must take account of both the Māori and English language versions of the Treaty.[5] On concluding its deliberations in any particular hearing the Tribunal can make non-binding recommendations that the Crown must consider. That is to say, however significant a breach may be judged to be by the Tribunal, it cannot force the Crown to take action, it can only recommend.

There continues to be considerable debate and contention around the intentions of the Māori language and the English language versions of the Treaty, which have very different meanings.[9] The Tribunal considers the Treaty to embody the principle of reciprocity that balances the Crown's right to govern, kāwantatanga (acquired in article one of the Māori language version of the

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Table 1: Treaty principles used by the Tribunal and those referenced in health sector documents.

Treaty Principles from the Waitangi Tribunal*	Treaty Principles used in the health sector**
Partnership	Partnership
Reciprocity	Participation
Autonomy	Protection
Active protection	
Options	
Mutual benefit	
Equity	
Equal Treatment	
Redress	

*Derived from Te Tau Ihu District Inquiry (2008) by the Waitangi Tribunal http://www.waitangitribunal.govt.nz/treaty-of-waitangi/principles-of-the-treaty/ (accessed 14 May 2019); Reid et al 2017.[6]

**Derived from the Royal Commission on Social Policy (1988) and referenced in the New Zealand Health Strategy (2000)[7] and He Korowai Oranga (2014);[8] Reid et al 2017.[6]

Treaty), and the Māori right to retain sovereignty, tino rangatiratanga (retained in article two of the Māori language version) (see Figure 1). It is this principle of reciprocity that the Tribunal considers to be the over-arching guide to the interpretation and application of other principles.[5] The Tribunal's interpretation can be contrasted with that of the courts: while the Tribunal's position may be summarised as meaning that kāwantatanga is subject to rangatiratanga, the Court of Appeal argues that rangatiratanga is subject to kāwantatanga (see Figure 1).

To date, the Tribunal has prioritised historical claims on a district-by-district basis. For claims that didn't fit with this approach, for example because they are national in scope, the options have been to try and have claims heard under urgency or to wait. For those claimants who were waiting, the impasse was broken in 2015 when the Waitangi Tribunal Chairperson, Chief Judge Isaac, issued a memorandum on how the Tribunal would tackle the large number of unheard claims by 2025—by grouping them into 11 thematic, or kaupapa, inquiries (Table 2).[10] 'Health services and outcomes' is one of the 11, and itself subsumes over 200 individual claims that relate to health services and outcomes.

This is not the first time the Tribunal has considered the Crown's obligations in relation to Māori health. In the Napier Hospital and Health Services claim the Tribunal looked into a range of issues including the claim of a general Crown obligation deriving from the Treaty to provide for the health and wellbeing of Māori. In its 2001 report the Tribunal found "that, in

Figure 1:

Kāwantatanga, tino rangatiratanga and taonga

Kāwantatanga means government. Kāwana is a transliteration into Māori of the English word governor.

Tino rangatiratanga means absolute sovereignty.

The text from the Napier Hospital Report[12] reads: "There are significant differences between the two texts. In particular, in the Maori text the chiefs ceded 'kawanatanga katoa' (complete government) rather than 'sovereignty'. They were guaranteed 'tino rangatiratanga' (the unqualified exercise of their chieftainship) over their 'taonga katoa' (all their treasures, or valued possessions) rather than 'other possessions'. 'Taonga' has a broader meaning than physical assets and, according to Sir Hugh Kawharu, refers to 'all dimensions of a tribal group's estate, material and non-material'. The Maori version of the Treaty thus conveyed more complex meanings, and a sense of mutuality."

See Orange C. The Treaty of Waitangi. 2nd ed. Wellington: Bridget Williams Books, 2011 (p.47-) for a fuller discussion of the above terms.

Table 2: Topic areas covered by kaupapa inquiries undertaken by the Waitangi Tribunal.

Military veterans
Constitution, self government and electoral system
Health services and outcomes
Marine and coastal (Takutai moana)
Mana wāhine
Education services and outcomes
Identity and culture
Natural resources and environmental management
Social services, social development and housing
Economic development
Justice system
Citizenship rights and equality

Source: http://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/ (accessed 21 February 2019);[10] The Chairperson. Memorandum of the Chairperson concerning the Kaupapa Inquiry Programme 27 March 2019.[11]

failing since 1980, and more particularly from 1993 to 1998, to address with urgency the improvement of the health status of Ahuriri Maori, the Crown and its health agencies have breached the principles of *active protection* and *equity*".[12] Consistent with the views of many health professionals at the time, the Tribunal considered the introduction of health reforms introduced through the New Zealand Public Health and Disability Act 2000 offered some hope for long-term change.

The primary healthcare claims

The Tribunal has opted to hear the health claims in tranches, and the hearings for the first tranche, which related to two specific primary healthcare-related claims, commenced in October 2018.

The two claims covered by the first primary healthcare-focused stage of the inquiry were: Wai 1315 claims (with two groups, Taitimu Maipi with Hakopa Paul and Tureiti Moxon with Janice Kuka), and Wai 2687 (led by Simon Royal and Henare Mason, and supported by the National Hauora Coalition, the largest Māori-led PHO in the country).

Although each of these claims had its own distinct areas of focus and grounds for concern, their shared views included the contention that the way the Crown has designed and run primary healthcare services constitutes a breach of the principles of the Treaty. The claimants shared their disappointment in the implementation of the primary healthcare reforms that introduced Primary Health Organisations (PHOs) in the early 2000s, and promised a focus on 'reducing inequalities' and support for Māori and Pacific provider development.

Included in the evidence presented in the Tribunal by a witness for the claimants[13] was the central thesis that the 2001 Primary Health Care Strategy[14] was a strong piece of policy making that, along with its associated reforms, had a lot of hope attached to it. But the promise of the Strategy in terms of equity has not been realised in its implementation. From the beginning, the stated aim of the Strategy was to address inequity, but there were always risks that the building blocks and the way the reforms were implemented would not achieve health equity, particularly for Māori. Some of these risks were identified early in the implementation process (for example see Hefford et al[15]), but effective remedial actions were not taken.

For example, the evidence stated that at the time of the Strategy, as now, New Zealand experienced significant and enduring health inequities in relation to both ethnicity and socioeconomic deprivation. The most consistent and compelling ethnic inequities are between Māori and non-Māori. The Māori population in the 2001 census constituted 15% of the total population. Life expectancy for Māori was about nine years less than for other New Zealanders (non-Māori, non-Pacific populations). In 2002, mortality for Māori at all ages exceeded other New Zealander mortality. A large number of the excess deaths were considered avoidable, and the avoidable mortality rate for Māori was more than twice that of other New Zealanders.[13] Witnesses also highlighted health inequities resulting from inequitable access to the determinants of health that privilege non-Māori as well as the legacy of colonisation and historical trauma.[16] An expert witness for the Crown drew attention to the lack of equity analysis at the time the

Strategy was written, which might have identified the need for additional plans or policies to make the Strategy more effective for Māori.[17] Having set the scene, the evidence went on to describe how the Primary Health Care Strategy's aim was to redesign the primary healthcare system to have, as a guiding principle, an explicit focus on reducing health inequities. The evidence then described how some key aspects of the Strategy have not been fully implemented and, at least partly as a result of this implementation failure, some of the Strategy's desired outcomes have not been achieved—particularly those outcomes related to equity of health outcomes for Māori, Pacific and low-income populations.

The Tribunal received extensive evidence from claimants that encompassed lived experience in the primary health sector and research on the causes, nature and extent of Māori health inequity. Included in this evidence were arguments of continued health system inaction in the face of demonstrated Māori health need, as well as calls for a health system founded on mana motuhake (Māori self-government).[18] There was also substantial Crown evidence, for example that of the Director General[19] and of Brooking,[20] presented to the Tribunal, much of it open about the need for the Crown to do more to respond to Māori health outcomes. For example, the Director General, Dr Bloomfield, stated in his evidence the primary health framework "has not sufficiently ensured good health outcomes for Māori nor enabled effective Māori participation".[19] This paper makes no attempt to summarise that evidence, or the diversity of issues that were raised. Rather, by way of summary, we determine that the claimants and witnesses wished certain conclusions to be drawn from the evidence. Those conclusions included that New Zealand's system of providing primary healthcare services, despite some courageous policies, does not fully meet the needs of all populations. Specifically, in respect of Māori, this fact, along with the resulting health inequities, represents a breach of the Crown's Treaty obligations.

The Tribunal's findings to date

The Tribunal released its report—*Hauora*—on the primary healthcare claims on 1 July 2019.[21] The Tribunal found that a number of principles of the Treaty had been breached by the Crown in respect of primary healthcare. The report also provides a critique of the Treaty principles of partnership, participation and protection used in the health sector, instead setting out a more comprehensive set of principles it considers applicable to the primary healthcare system (Table 3).

Table 3: The Waitangi Tribunal's recommended Treaty principles for the primary healthcare system.

The guarantee of tino rangatiratanga, which provides for self-determination and mana motuhake in the design, delivery and monitoring of primary healthcare.
The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents and its Treaty partner are well informed on the extent, and nature of, both Māori health outcomes and efforts to achieve Māori health equity.
The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary healthcare services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery and monitoring of primary healthcare services. Māori must be the co-designers, with the Crown, of the primary health system for Māori.

Source: Waitangi Tribunal. HAUORA, Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry, Pre-publication version, WAI 2575 WAITANGI TRIBUNAL REPORT 20192019 14 July 2019. Available from: http://forms.justice.govt.nz/search/Documents/WT/wt_DOC_150429818/Hauora%20Pre-PubW.pdf (accessed 14 July 2019).

This paper does not attempt to summarise all the many findings of the Tribunal in its *Hauora* report. However, it is worth noting two of the main recommendations to the Crown. The first is to amend the Treaty of Waitangi clause in the New Zealand Public Health and Disability Act 2000, as a first step to ensuring that the primary healthcare system recognises and provides for the Treaty of Waitangi and its principles. The second is for the Crown to commit to achieving equitable health outcomes for Māori, and to reflect this in legislation. The Crown should leave behind the frequently used language of 'reducing disparity' or 'reducing inequality', and ensure more system-wide accountability for its equity goals. The Tribunal's recommendation here is informed by its findings that, despite the initial intentions of the Primary Health Care Strategy, primary care funding has become "anti-equity in practice", that Māori providers have been underfunded from the outset, and that the Crown does not collect, use or make readily accessible data that track its performance in achieving health equity.

As a consequence of the Tribunal having only heard from two claimants in stage one of the kaupapa inquiry, some of its recommendations are interim. These include an interim recommendation to explore the possibility of a stand-alone Māori health authority of some kind. The Tribunal has asked the Crown to work with the primary healthcare claimants and report on progress in January 2020.

The Tribunal has indicated that its second tranche of hearings will include claims pertaining to mental health, disabilities, addictions and substance abuse, and will be underway towards the end of 2019.[22]

What might this mean for New Zealand's health system?

The Waitangi Tribunal process is extraordinary in that it provides Māori, the indigenous people of Aotearoa, with the opportunity to speak their truth and to hold the Crown to account in respect of governance and delivery of health services that meet the Crown's Treaty obligations to Māori individuals, whānau and communities. In respect of the health kaupapa inquiry, even though the process is highly legalistic and inquisitorial in nature, it represents a legal process that allows Māori to take concerns to the Crown regarding alleged acts of omission and commission in the provision of health services.

During the process of the health kaupapa inquiry the Tribunal members will continue to receive and synthesise a huge amount of complex information, and their recommendations will be based on the evidence put before them. The delivery of health services is centred around human relationships, and the New Zealand health system has had for a very long time the opportunity to construct a relationship with Māori that represents a beholden partnership in the design, governance and delivery of health services that meet the needs of Māori individuals, whānau and communities. Thus far in our history this opportunity has not been properly grasped. The Waitangi Tribunal's findings may well provide renewed impetus for the health system to reconstruct its relationship with Māori in a way that gives expression to the aspirations of both Māori and the system, and to push hard towards equitable health outcomes.

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