

A Critical Tiriti Analysis of the Pae Ora (Healthy Futures) Bill

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ABSTRACT

AIM: The Pae Ora (Healthy Futures) Bill is the framework for a reformed health system intended to embed Te Tiriti o Waitangi and centre equity. The Bill is informed by the Wai 2575 Health Kaupapa Waitangi Tribunal Inquiry and the Health and Disability System Review, both of which established an urgent mandate to transform the health sector. This desktop review explores to what extent the proposed Bill is likely to uphold Te Tiriti.

METHODS: This paper uses Critical Tiriti Analysis to review the Pae Ora Bill. The analysis involves five phases: (i) orientation; (ii) close reading; (iii) determination; (iv) strengthening practice and (v) Māori final word. As part of that, a determination is made whether the Bill is silent, poor, fair, good or excellent in relation to the Preamble and the four articles (three written, one verbal) of te Tiriti o Waitangi (Māori text).

RESULTS: The desktop analysis showed fair engagement with most of the Te Tiriti elements; but with good commitment to address equity issues. The Bill was silent in relation to wairuatanga (spirituality) and there is no evidence of Māori values informing it.

CONCLUSION: The dominant Crown narrative that interprets kāwanatanga as the right to govern over all peoples pervades this legislation. There are significant power sharing shifts within this Bill and these are welcomed, but whilst the Crown maintains ultimate power and authority only a partial fulfilment of Te Tiriti will be evident within the health system.

The health system in Aotearoa has been restructured by successive governments.¹ The last major reforms (early 2000s) had an explicit equity aim.² Māori have consistently advocated for change and documented the systemic failure of the health system to address the health needs of Māori.³ The Wai 2575 health hearings to investigate Te Tiriti breaches remain active.

Entrenched health inequities⁴ prove the failure of previous reforms to fulfil Te Tiriti responsibilities. Stage one Wai 2575 report⁵ found Māori health was underfunded, and for over a decade the Crown knew and did not act. Māori were unable to “exercise tino rangatiratanga in the design and delivery of primary health care”.⁵ The Waitangi Tribunal recommended the transformation of health policy, practice and restructuring the sector including establishing an independent Māori Health Authority (MHA).

Evidence from Wai 2575 influenced the Health and Disability System Review,⁶ hereafter referred to as the Review. Instead of furthering the opportunity to address Māori health inequities, the Review created additional Te Tiriti breaches.⁷ The Review Panel rejected the Māori Expert Advisory Group recommendation for an independent

MHA with commissioning functions, which was “the defining moment of the Simpson-led review” (p.79). This pivotal decision blocked Māori expressions of tino rangatiratanga.

Minister of Health Andrew Little has articulated the aim of the health reforms is to create an equitable health system.⁸ The reforms will retain the Ministry of Health to lead the system. Health New Zealand (HNZ) will consolidate all DHBs, and the MHA will be charged with commissioning Māori health services and monitoring HNZ. Geographically defined localities will be created and with the MHA will work alongside Iwi-Māori partnership boards.

Currently, we have a unique window to advance Māori health, reduce inequities and move towards a Tiriti based system.⁹ However, Māori have been hopeful about past health reforms only for those hopes to be dashed. Reid¹⁰ has argued that many of the functions proposed for the new MHA, such as monitoring and holding the health system to account for inequitable health outcomes, already exist, albeit ineffectively, within the system.

This paper will add to informed discussions on the health reforms. It examines to what extent the Bill is in alignment with Te Tiriti.

Methods

Critical Tiriti Analysis (CTA)¹¹ is a methodology to ascertain policy alignment with Te Tiriti. Specifically, CTA examines engagement with the preamble, the three written articles of *kāwanatanga* (honourable governance), *tino rangatiratanga* (unfettered authority) and *ōritetanga* (equity), and the oral article, *wairuatanga* (spirituality). A CTA has five distinct stages of analysis. The first stage is orientation. It asks high level questions about how does the Bill represent Māori health? Does it refer to Te Tiriti (the Māori text), the Treaty (the English version) or the Treaty principles? The second stage is a close reading against the five elements of Te Tiriti.

In the third stage a determination is made in relation to the five indicators (see Table 1). The determination makes an informed desktop judgement of whether the policy is silent, poor, fair, good or excellent in relation to each Te Tiriti element. Each author made their own independent CTA determination on the Bill and then a final consensus determination was negotiated. The fourth stage focusses on providing practical suggestions to strengthen the Bill. Māori leadership, engagement and critique are inherent to CTA. The final stage is a Māori overall assessment of Te Tiriti alignment.

CTA pertains only to what is written in the Bill; it does not capture the intentions of the writers. The CTA process does not in any way seek to diminish the mana of the policymakers. This particular CTA has been carried out by Māori and Pākehā critical scholars with a background in public health and a commitment to racial justice and Te Tiriti. No ethical approval was required for this study.

Results

Stage one: Orientation

Phase one of the CTA involves a consideration of the orientation of the Bill to Te Tiriti. The explanatory note confirms: “The Bill is intended to give effect to the *principles* of Te Tiriti o Waitangi (the Treaty of Waitangi)” (p.1). It is noted that the Bill’s proposed “health system principles” are based on the recommendations from the Wai 2575 inquiry.⁵ The intent of setting out these principles is for “Tiriti/Treaty-informed decision-making at the heart of the system” and to “support system-wide accountability for Māori health outcomes” (p.2). The Bill sets out nine ways in which it will give effect to the principles.

Stage two: Close reading

Preamble

Within the Bill, the Crown acknowledges that historically the health system has not operated in partnership nor fulfilled its Te Tiriti obligations. Māori are described as a priority group within the Bill due to their poor health outcomes. Health system strategic accountability and monitoring documents are required to include consideration of outcomes and performance for Māori.

Kāwanatanga

HNZ is the new proposed Crown agency to lead system operations, planning, commissioning, and delivery of health services with the MHA.

The MHA will drive improvement in hauora Māori. They will be an independent statutory entity with clear accountabilities to both Māori and the Crown. They will co-commission and plan services with HNZ and commission kaupapa Māori services, prepare national strategies and provide advice to the Minister. The MHA is responsible to ensure that planning and service delivery respond to the aspirations of whānau, hapū, iwi and Māori in general.

Alongside the MHA, will be a Hauora Māori Advisory Committee and Iwi-Māori partnership boards for each region. The Advisory Committee will advise the Minister on matters related to the MHA including consultation on membership of the MHA board, although final appointment decisions remain with the Minister.

Tino Rangatiratanga

There are two mechanisms for enabling Māori decision-making within the Bill: the MHA and the Iwi-Māori partnership boards. The former will function nationally and the latter at a regional or locality level.

The Iwi-Māori partnership boards are described as a vehicle to represent Māori perspectives on health needs and aspirations, feedback on health system performance and to inform the design of services. They are represented within the Bill as a mechanism for Māori to exercise *tino rangatiratanga* and *mana motuhake* (autonomy) within localities (p.2).

The Bill asserts Tiriti/Treaty-informed decision-making will be at the heart of the new health system due to the incorporation of Wai 2575 principles. The Tribunal recommended: “the guarantee of *tino rangatiratanga* which provides for Māori self-determination and *mana motuhake* in the design, delivery and monitoring of primary

health care”.⁵ Within the Bill this appears to be reinterpreted to read: “the health system should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori and for that purpose, have regard to both (i) the strength or nature of Māori interests in a matter; and (ii) the interests of other health consumers and the Crown in the matter” (p.9).

Ōritetanga

An explicit focus on equity is evidenced in the Bill through the stated purpose: “achieve equity by reducing health disparities among New Zealand’s population groups, in particular for Māori”. This is aligned to the Tribunal⁵ principle of “equity which requires the Crown to commit to achieving equitable health outcomes for Māori”. The centrality of equity is reinforced whereby the Bill states no direction may be given to the MHA unless it relates to improving equity of access and outcomes for Māori.

Wairuatanga

Wairua or wairuatanga is not mentioned in the Bill.

Stage three: Determination

HNZ is represented as the lead Crown agency who must work with the MHA. However, there appears to be limited authority and autonomy in the MHA to have reach across other Crown health and social entities. Although it is clear what the MHA will work on with HNZ, there is no information on whether the MHA will work with other health entities, including PHARMAC, Health Quality & Safety Commission, or groups that have an influence on Māori health. The Iwi-Māori partnership boards have tino rangatiratanga authority at a local level; there are potential implications

for mana motuhake of hapū and iwi who are not part of these boards locally. Noticeably, the key term ‘Pae Ora’ within the title of the Bill is never explained, nor is it evident how this holistic hauora model will be embedded across the Bill. A commitment to equity is explicit throughout the Bill, but it is worth noting this rhetoric was also explicit within the New Zealand Public Health and Disability Act 2000. Wairua, rongoā and tikanga are invisible within the Bill.

Discussion

Stage four: Strengthening practice

Te Tiriti o Waitangi (the Māori text) and the Treaty of Waitangi (the English version) are distinct documents with different meanings.¹² It is problematic to use the terms ‘Te Tiriti’ and ‘the Treaty’ interchangeably. Under the international legal doctrine of *contra proferentem* Te Tiriti is the authoritative text; Te Tiriti reaffirmed Māori tino rangatiratanga as previously declared in the 1835 He Whakaputanga o te Rangatiratanga Nū Tīreni (the Declaration of Independence). Te Tiriti is the text that the overwhelming majority of rangatira (chiefs) and Captain Hobson signed, and is further reinforced by the findings of the Waitangi Tribunal¹³ which ruled Ngāpuhi never ceded sovereignty.

Misinformation about Te Tiriti and the Treaty is a longstanding tradition within the public sector. O’Sullivan et al,¹⁴ in a critique of the 2019 Cabinet Circular¹⁵ on the Treaty and Te Tiriti note the Circular unashamedly privileges the English version. This has the effect of making Māori political authority subservient to the Crown in ways that Te Tiriti did not intend. O’Sullivan et al argued the rangatira agreed to the British Crown establishing government over their own (non-Māori), people

Table 1: Critical Tiriti Analysis determination Pae Ora (Healthy Futures) Bill against indicators

	Silent	Poor	Fair	Good	Excellent
Māori are lead or equal partners			X		
Equitable Māori leadership in setting priorities, resourcing, implementation and evaluation		X			
Evidence of inclusion of Māori values influencing and holding authority		X			
Māori exercising their equitable citizenship				X	
Acknowledge wairuatanga, rongoā and tikanga	X				

but did not agree to the colonial relationship which may be read into the English version. It seems this problematic cabinet circular has informed this Bill.

The introduction of Treaty principles into this Bill remains problematic. Important Māori scholars such as Durie, Jackson and Mutu have always maintained Māori are more concerned with what is in the Māori text, rather than the Treaty principles. The principles have often diluted the meaning and substance of Te Tiriti. Certainly, the Waitangi Tribunal⁵ have described the three Ps—participation, partnership and protection—as reductionist and out of date. It is unclear yet whether the new Wai 2575 principles will deepen engagement. These important but technical issues could easily be remedied by the Bill consistently referring to the Māori text and recognising Māori as sovereign Tiriti partners.

Intriguingly, the Bill explicitly identifies nine ways it will give effect to the Treaty principles. Although this provides an explicit acknowledgement of the principles within the Bill, it also limits their potential application through this ring fence. The application of the principles is limited by statements within the Bill that make engagement with them optional. The Ministry of Health and listed health entities must be guided by these Treaty principles only “as far as reasonably practicable, having regard to all the circumstances, including any resource constraints”. Of note PHARMAC has been exempted from two of the five health system principles.

Te Tiriti compliance would be strengthened by the removal of reference to Treaty principles and critically, the removal of all opt-out clauses. It is an outright breach of Te Tiriti to legislate for Crown agencies to opt out of Tiriti responsibilities.

A regulatory impact statement on the organisational form, governance and accountability arrangements for the MHA informed the Bill development.¹⁶ This asserted that the “Māori Health Authority is not the Treaty partner for the purpose of the health and disability sector, and it does not hold or exercise tino rangatiratanga or mana motuhake – this authority resides with iwi and hapū”. This view denies that Māori are entitled to express tino rangatiratanga from both inside and outside of the Crown.¹⁴

The regulatory statement goes on to note that the MHA “will operate in the space where the exercise of kāwanatanga and rangatiratanga over-

lap”, and is seen as a mechanism for the Crown to meet its obligations of partnership and accountability to Māori.¹⁶ If the MHA is operating in the relational space¹⁷ and is viewed by the Crown as a mechanism to meet Treaty obligations but is not the Treaty partner—then who is the Crown partnering with? Is it Iwi-Māori partnership boards? Their remit has been confined to a locality level. Te Tiriti responsibilities must extend to every level of the health system.

A review of the policy papers informing the Bill reveals strong equity intent to transform the system. However, this all sits within a frame of ultimate power and decision-making residing with the Minister and the Crown. This reflects a Crown understanding that privileges the Treaty and incorrectly interprets the kāwanatanga granted to non-Māori to apply across all New Zealanders.

The absence of any mention of wairuatanga reflects the worldview that this Bill was written from. The requirement for the development of a New Zealand health charter which aims to provide common values, principles and behaviours for organisations and workers has potential to shape cultural change. A Bill review and rewrite are required to ensure Māori worldviews are centred.

Conclusion

Stage five: Māori final word

There is optimism around the proposed health reforms. Nonetheless, there are limitations to the Pae Ora Bill in its current form at conceptual and procedural levels. The Bill currently does not live up to its Māori name. The Bill should provide an explanation of Pae Ora and the clarification of how Pae Ora will shape the health system, including how it will aid good governance, relationships, capacity and accountability with Māori and relevant Crown entities. There is a need for broader public policy that engages Māori by helping to give a public profile to priority Māori health areas, and recognise that Māori have the right to a health and disability system that will fulfil their holistic health needs and aspirations.

A Te Tiriti approach is something Māori and the Crown agree on. Considering the concerns of the Review and Wai 2575, the Bill needs to centre Māori health priorities and aspirations.

Many Māori individuals, organisations and com-

munities may share common values, but they may differ on priorities. Although, it is expected that Māori will hold perspectives of wellbeing as more than physical health or the absence of disease and will include a holistic view that balances the physical, emotional, mental and spiritual elements of life.

Māori need to decide who represents Māori locally and nationally and it will be problematic if this remains a Crown decision. The presence of opt-out clauses proposed within the Bill demonstrates extraordinary patch protection from Crown entities that will only be accommo-

dated by status quo positioning of current policy. All of which raises fundamental Te Tiriti concerns about Te Tiriti compliance and authentic Māori and Crown partnerships. The Bill needs to be reworked so that Māori are not structurally the junior Tiriti partner. The Bill does not engage Māori tino rangatiratanga. Transformation needs to occur within the health system, but also in how the Crown engages with Māori in system design. The Pae Ora Bill has the potential to be an influential policy instrument in support for a Te Tiriti centred health and disability system in Aotearoa.

COMPETING INTERESTS

Nil.

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