Aide-Mémoire

Meeting with Kevin Hague, Chair of the Public Health Advisory Committee

Date due to MO:	19 January 2024	**Action required by:**	N/A
Security level:	IN CONFIDENCE	**Health Report number:**	H2023034535
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☐ Māori Health Authority: ☐		

Contact for telephone discussion

Name	Position	Telephone
Dr Andrew Old	Deputy Director-General, Public Health Agency | Te Pou Hauora Tūmatanui	s 9(2)(a)
Kiri Waldegrave	Manager, Equity and Population Health, Public Health Agency | Te Pou Hauora Tūmatanui	s 9(2)(a)

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To:	Hon Dr Shane Reti, Minister of Health		
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Details of meeting:	11.30am – 12.00pm, 23 January 2024 Minister of Health's Office
Purpose of meeting/ proposal:	• You are meeting Kevin Hague, Chair of the Public Health Advisory Committee (PHAC), as an introductory meeting to establish your working relationship. • This meeting provides an initial opportunity for you to set out your expectations of the PHAC for 2024.
Officials attending the meeting	• Dr Andrew Old, Deputy Director-General, Public Health Agency | Te Pou Hauora Tūmatanui will attend this meeting.
Background	• The PHAC is a statutory committee established under the Pae Ora (Healthy Futures) Act 2022. The purpose of the PHAC is to provide independent expert advice on public health matters to the Minister of Health and health entities. • The PHAC's Terms of Reference is provided at Appendix 1. • The Public Health Agency | Te Pou Hauora Tūmatanui provides secretariat support to the PHAC. • The PHAC provides value in the health system by offering an independent expert voice on challenging public health issues. There are opportunities to utilise the PHAC's independent voice to promote more open public discussion on public health issues.

Issues/risks	*Membership* • The PHAC's Terms of Reference outline that the committee may have 5-7 members, appointed by the Minister of Health after consultation with the Hauora Māori Advisory Committee. • There are currently 5 members of the PHAC, which were appointed by the previous Minister of Health, with 1 member, Professor Peter Crampton, on sabbatical for the first 6 months of 2024. Sir Collin Tukuitonga recently resigned from the PHAC, and 1 position remained vacant in 2023. • Kevin Hague is the current chair of the PHAC, no deputy chair was appointed. Biographies for members are provided at Appendix 2. • s 9(2)(g)(i) [redacted] *The PHAC's current work programme* • The PHAC develops and agrees an annual work programme (with a focus on at least 1 major topic each year) with the Minister of Health. • In 2023, the previous Minister of Health asked the PHAC to look at ways to improve New Zealand's food environment for health and wellbeing. • The PHAC is in the final stages of completing its report on this topic, which is expected to be available for your review in February 2024. The PHAC has taken a strong rights-based approach to this project working with the Human Rights Commission. It also engaged with non-governmental organisations, the food industry, and government agencies to seek their views and develop their recommendations. • The PHAC is likely to call for a rebalancing of New Zealand's food system to strengthen the health and wellbeing needs of New Zealanders. • The PHAC also advised on the development of the 6 Pae Ora strategies and issued a position statement on equity, Te Tiriti o Waitangi and Māori health (provided in Appendix 3) . • Following the PHAC's input on the Pae Ora strategies, it seeks to provide advice on the draft Government Policy Statement on Health. *The PHAC's future work programme* • The PHAC proposed to the previous Minister of Health that its 2024 work programme have a major focus on determinants of health, involving a benchmarking exercise to examine where New Zealand

	has progressed or areas that need attention. This could be used as evidence base across the health system. It could help to highlight new and emerging determinants, such as digital and commercial determinants of health. • The PHAC engaged with the Public Health Agency and National Public Health Service on this proposal and the previous Minister of Health indicated she was supportive of this proposed work programme. She met with the Chair of the PHAC on a monthly basis. • The PHAC also proposed that for a subsequent year it could contribute to the health system's response to climate change. Being aware of the levers and remit the Minister of Health has in this space, they noted a cross-agency effort would be required to influence health outcomes aligned with a determinants of health approach. • The PHAC will need to develop and agree its future work programme with you. • While the PHAC operates independently of the Government, as Minister of Health you are able to request that the PHAC provide expert advice on any public health matter. Depending on your priorities as Minister, you may prefer that the PHAC focus on alternative topics if they better align with your intended policy direction for the next few years. • s 9(2)(g)(i) [redacted] • This aide-mémoire discloses all relevant information.

Ross Bell
Group Manager
Public Health Strategy and Engagement
Public Health Agency | Te Pou Hauora Tūmatanui

Talking points

s 9(2)(g)(i)

Appendix 1: Terms of Reference for the Expert Public Health Advisory Committee

Introduction – Kupu Whakataki

1. As part of the health system transformation, an expert advisory committee on public health ('the PHAC' or 'the Committee') is being established to ensure that independent, public-facing, science-based public health advice is provided to the Minister of Health.

2. The PHAC will initially be established under section 11 of the New Zealand Health and Disability Act 2000 until new legislation, the Pae Ora (Healthy Futures) Bill, has been passed.

Purpose and approach – Te Kaupapa

3. Tackling existing and future public health priorities and risks, and addressing persistent inequities in health care, requires innovative and practical thinking.

4. To support this the PHAC is expected to provide independent and strategic public health advice that:
    - recognises the special relationship between the Crown and Māori under Te Tiriti o Waitangi with a view to improve the health and wellbeing of Māori
    - prioritises equity-based approaches, particularly for Māori[1]
    - is informed by and reflects the perspectives of Māori and Pacific peoples and the wider community
    - considers the broader determinants of health and sectors affecting the health and wellbeing of people and communities
    - considers creative yet pragmatic options and solutions, and opportunities to drive and implement these at both a population and community level
    - ensures the public health system makes full use of public health intelligence, surveillance and knowledge.

5. In fulfilling its role, the PHAC will:
    - take a cross-government and cross-sectoral 'health in all policies' approach to ensure coordination with relevant work programmes, and the contribution of Māori and other community stakeholders
    - look for new ways of doing things or old ways given new vigour, including Māori, Pacific and disability concepts, models, values and holistic approaches
    - engage with and take account of individuals and whanāu experiences
    - engage with communities experiencing inequities and support the pursuit of their aspirations for wellbeing
    - prefer solutions emphasising sustainable, enduring change and recognising the costs of change and the long-term financial sustainability of the health and disability system
    - consult with the health sector, other public health entities and other sectors on their ability to implement PHAC's proposals.

[1] Reference *Whakamaua: Māori Health Action Plan 2020-2025* and *Ola Manuia: Pacific Health Action Plan 2020-2025*

Expectations and deliverables – Ngā Mahi

6. The PHAC is independent and reports directly to the Minister of Health and/or the Associate Minister/s of Health.

7. The PHAC will develop and agree with the Minister an annual work programme, which will include a focus on at least 1 major topic each year. The PHAC will also engage with the Director-General of Health, the Director of Public Health (or their delegates), the Deputy Director-General of the Public Health Agency and the Chief Executive of the Māori Health Authority in identifying this topic and the development of the work programme.

8. The PHAC will meet regularly to deliver on its annual work programme on dates discussed with and determined by the Chair.

9. The PHAC may establish subcommittees and project teams amongst its members. The PHAC may also draw on external expertise as required and may appoint expert advisors to assist in their work. These expert advisors are not board members and have no voting rights.

10. The PHAC will operate in good faith and on a 'no surprises' basis with the Minister, and is accountable to the Minister for the relevance, quality and timeliness of its advice and reports.

Secretariat – Ngā Ringa Hāpai

11. The PHAC will be supported by a Budget and Secretariat operating out of the Public Health Agency within the Ministry of Health.

12. The Secretariat will provide administrative and Secretariat support to the PHAC for its meetings, including setting up meetings, arranging travel when required, preparing, collating and distributing papers and recording minutes and actions as required.

13. The Public Health Agency, within the accountabilities and constraints it operates under, will ensure that Budget and Secretariat arrangements are sufficient for the PHAC to fulfil its accountability for its work programme and advice to the Minister.

14. The Public Health Agency and Ministry of Health have an obligation to respect the independence of the PHAC and its right to give free and frank advice to the Minister. The Public Health Agency and Ministry of Health may provide parallel advice to the Minister on the PHAC's advice and may advise the PHAC on its work programme.

15. The PHAC will consult with the Director-General of Health, Director of Public Health (or their delegates) and the Deputy Director-General of the Public Health Agency in preparing advice or reports for the Minister.

Membership and recognition – Ngā Mema me te Utu

16. The PHAC comprises a minimum of 5 up to a maximum of 7 members, including the Chair and Deputy Chair.

17. The PHAC, including the Chair and Deputy Chair, is appointed by Ministerial letter. The PHAC or any of its members may be removed or suspended by the Minister on written notice, after consultation with the Chair.

18. Members are to be appointed for a term of up to 3 years, renewable for 1 further term with a maximum of 6 years, unless an additional period of up to 12 months is confirmed by the Minister of Health to allow for continuity of projects.

19. Collectively members of the PHAC are expected to demonstrate the following expertise and attributes:
    - knowledge of and expertise in the obligations of the Crown under the Te Tiriti o Waitangi, Pae Ora (healthy futures) and of Māori expectations and aspirations
    - knowledge of and expertise in the role of the health and disability sector in achieving equity and improving health outcomes for Māori, Pacific peoples and other populations experiencing inequity
    - an understanding of population health needs (including the determinants of health) and population health approaches and interventions that can affect real change to meet current and future demands, including community aspirations for wellbeing
    - knowledge and expertise in core public health functions (including prevention, promotion and protection), commissioning and service delivery
    - an ability to think creatively to provide solutions that are not constrained by traditional health and disability sector and governmental professional boundaries or current service delivery models and which are likely to be financially sustainable.

20. The PHAC does not need to formally vote on matters and may decide by consensus or majority view. Should the Chair determine that differences of view or other specific decisions should be put to a vote, all PHAC members have full voting rights (subject to conflict-of-interest requirements).

21. The attendance of at least half the members, including the Chair, or Deputy Chair in the Chair's absence, constitutes a quorum.

22. Fees for the Chair, Deputy Chair and members are set according to the *Fees Framework for Members Appointed to Bodies in which the Crown has an Interest* (the Fees Framework) and are outlined in the letter of appointment. Members are also entitled to reimbursement for reasonable and actual expenses under the Framework for carrying out work on behalf of the PHAC.

23. The Minister may alter or reconstitute the PHAC, discharge or reappoint any member, or appoint new members in response to any changes to the key tasks that are being addressed.

24. A member may tender their resignation at any time by advising the Minister in writing.

Performance of members duties – Ngā Haepapa

25. Members of the PHAC must act in good faith, with reasonable care and with honesty and integrity when exercising their powers or performing their duties on behalf of the Minister and the PHAC.

26. Members must ensure that independent views of other members are given due weight and consideration and:
    - ensure fair and full participation
    - regularly review their own and the PHAC's performance
    - act in accordance with the principles of Te Tiriti o Waitangi.

27. Members are appointed for their knowledge, expertise and connections to communities, to advance the public health system. The PHAC should not assume that a particular group's

interests have been considered or consultation is complete because a member is associated with a particular group and their view is included in advice to the Minister.

28. A member of the PHAC (in accordance with section 90(4) of the New Zealand Public Health and Disability Act 2020) is not liable to the Ministry or the Crown for any conduct in their capacity as a member of the PHAC. This is with the provisos that they have acted in good faith, and with reasonable care, in pursuance of the role specified for the PHAC in these terms of reference.

Confidentiality and communication of information

29. Members must ensure that the confidentiality of the PHAC's business is maintained. Members must be clear about what matters are permitted to be discussed with people that are not PHAC members and, in doing so, should be familiar with the information that is publicly available about the PHAC's work.

30. The Secretariat provides assistance in responding to requests for information in conjunction with the Chair.

31. Queries about the PHAC and its advice should be directed in the first instance to the Chair. The Chair will discuss any response with the Minister or the Minister's office, where appropriate.

32. The Chair is authorised to comment publicly on the affairs and policies of the PHAC and, where appropriate, may delegate the making of comments to other members.

33. The Chair will notify the Deputy Director-General of the Public Health Agency and the Minister of Health before making media statements.

Conflicts of interest – Ngā Whakapiringa Tāhapa

34. PHAC members must avoid conflicts of interest and any conduct likely to impair their impartiality as members of the PHAC.

35. Any PHAC member who has a conflict of interest or likely conflict of interest must, as soon as practicable after becoming aware of this, bring it the Chair's attention and record it in an interests register maintained by the PHAC Secretariat.

36. A member must not take part in any discussions, decisions or quorum of the PHAC relating to a matter in which they have an interest unless permission is granted allowing the member to take part. Any such permission granted will be recorded in the minutes with the reasons for this, together with the member's comments regarding the interest.

37. The Office of the Auditor-General has produced the following general guidance on conflicts of interest, their identification, disclosure and management: *Managing Conflicts of Interest: A Guide for the Public Sector*. See following Link:
https://oag.parliament.nz/good-practice/conflicts-of-interest/conflicts-resources

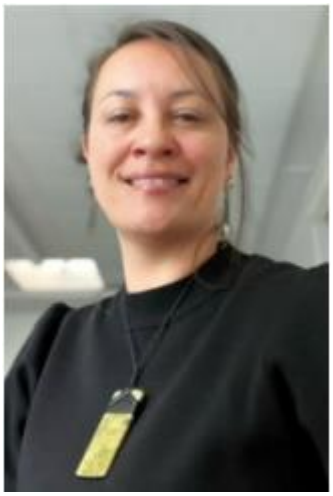
Appendix 2: Current members of the Public Health Advisory Committee

Kevin Hague, Chair

Appointed November 2022 to November 2025

- Kevin Hague is the former chief executive of the West Coast District Health Board, the Royal Forest and Bird Protection Society of New Zealand and the New Zealand AIDS Foundation, and is also a former Member of Parliament. He has considerable experience in the health and wellbeing sector, and particular expertise in public health and health promotion. He is an experienced leader in the public, private and community sectors and is currently the Deputy Chair of Te Hiringa Mahara (the Mental Health and Wellbeing Commission). He has an academic background principally in mathematics, physics and public health, and lives on the West Coast of the South Island.

Beverly Te Huia



Appointed November 2022 to November 2025

- Beverly Te Huia (Ngāti Kahungunu and Ngai Tahu) is Public Health Strategist/Manager at Kahungunu Health Services, based in Hawke's Bay. She is a public health strategic leader in local Iwi-led organisations and health services and undertakes research and evaluation in Hauora Māori.
- She has qualifications in midwifery, health science and public health, and board and chair experience on national and regional groups.

Associate Professor Jason Gurney

Appointed November 2022 to November 2025

- Associate Professor Gurney (Ngāpuhi) is Director of the Cancer and Chronic Conditions (C3) Research Group at the Department of Public Health, University of Otago, and is based in Auckland. He is an epidemiologist and public health researcher with a focus on cancer, and he is also seconded part-time to Te Aho o te Kahu (Cancer Control Agency).
- He has board and committee experience in the last 10 years in the field of health care delivery, cancer and research, and a significant list of publications with a focus on the cancer and health equity for Māori.

Associate Professor Ruth Cunningham

Appointed November 2022 to November 2025

- Associate Professor Cunningham is public health medicine specialist and epidemiologist based at the University of Otago in Wellington. Her areas of focus are mental health, improving the physical health of people with mental health conditions, and the use of linked data for health equity research.
- She led the Public Health Strategic Response Team early in the COVID-19 response and has been seconded into senior roles in mental health and addictions and public health at the Ministry of Health. She has a strong interest in public health education and workforce development and has been involved in public health education at undergraduate, postgraduate and professional levels.

Professor Peter Crampton

Appointed November 2022 to November 2025 (on sabbatical until July 2024).

- Professor Crampton is a Professor of Public Health at the Kōtahu Centre for Hauora Māori, University of Otago. He has qualifications in medicine and public health and is a Fellow of the New Zealand College of Public Health Medicine. He has an extensive career history of work in Māori and Pacific Health, is a past member of the Health and Disability Review Panel, and a past Harkness Fellow.

Appendix 3: Public Health Advisory Committee Position statement on Equity, Te Tiriti o Waitangi, and Māori Health

September 2023

Purpose of this statement

1. There is an active public and political debate over measures intended to improve Māori health outcomes. The Public Health Advisory Committee (PHAC), established under the Pae Ora (Healthy Futures) Act 2022,[1] provides independent public health advice to the Minister and Associate Ministers of Health, as well as other government agencies.
2. Public health has important perspectives on the causes of disparities in health outcomes and on effective solutions. It is, therefore, appropriate for PHAC to provide advice on this topic.
3. This statement summarises that advice.

Equity as a public health issue

4. Equal access to the determinants of good health is a fundamental human right, supported by the United Nations (UN) Universal Declaration of Human Rights[2] and enforceable under international law.[3] As such, all New Zealanders deserve, and are entitled to, an equal opportunity to enjoy a long and healthy life. Our health is a resource that we can use for everyday living.[4]
5. A society that counts fairness, equality and egalitarianism as foundational values,[5] Aotearoa New Zealand is in a position to find ways to ensure that all of its citizens have the same level of health resource available to use throughout their lives.
6. However, the determinants of good health are not evenly distributed within our population. This disadvantage does not occur randomly. While strongly patterned by sociodemographic factors, including socioeconomic deprivation and rurality, the strongest patterning of disadvantage occurs by ethnicity. The Indigenous Māori population experiences among the poorest health outcomes in our country. These are the cumulative result of generations of social, political and structural inequity, starting with the rapid colonisation that followed the signing of Te Tiriti o Waitangi in 1840.[6]

The relationship between equity, Te Tiriti o Waitangi, and Māori health

7. The government recognises that the inequities in health outcomes experienced by Māori are not only avoidable, but they are also unfair and unjust.[7] Addressing the inequities faced by Māori and other minority populations in Aotearoa New Zealand requires us, as a society, to accept that a disproportionate investment of resources is required to ensure that all New Zealanders enjoy equal health outcomes.[6]
8. Te Tiriti o Waitangi is Aotearoa New Zealand's founding document.[8] Te Tiriti o Waitangi forms part of our constitution – the basic principles that drive our system of government.[9] Te Tiriti o Waitangi

guarantees that Māori would receive 'nga tikanga katoa rite tahi ki ana mea ki nga tangata o Ingarani' (English version: 'all the rights and privileges of British subjects'),[8] and requires the government to take active measures to restore balance when Māori have been disadvantaged.[10] As such, the substantial inequities in health experienced by Māori represent breaches of our founding document.[11] However, Te Tiriti o Waitangi also provides us with the impetus and structure for enacting the kind of change that will be required to right one of our most significant wrongs.[12]

The Problem

9. Because of the substantial disadvantages faced by Māori in access to the determinants of good health, a Māori child born in Aotearoa New Zealand will, on average, experience poorer overall health and live nearly 8 fewer years than a Pākehā child.[13] During their life, the Māori child will be more likely to develop cancers with a poor prognosis (e.g. stomach, liver and lung cancers),[14] and have poorer survival outcomes once diagnosed.[15] They will be more likely to suffer a stroke,[16] have cardiovascular disease, [17-19] Type-2 diabetes mellitus,[20,21] renal disease or failure,[22] or a mental health disorder.[23,24] An important driver of these stark inequities is socioeconomic deprivation (Figure 1).

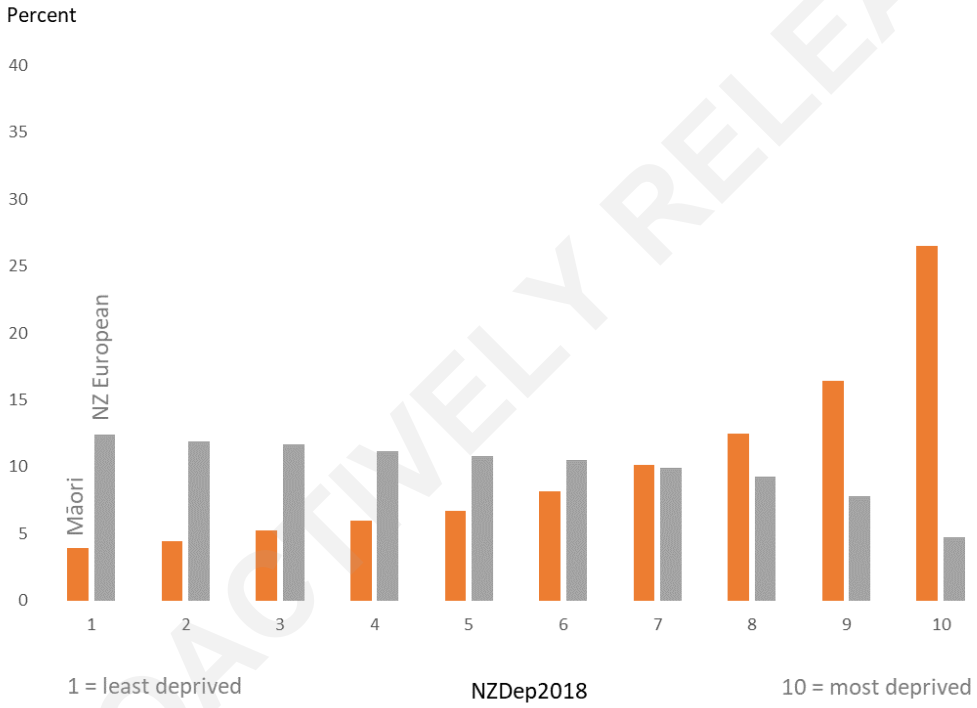


Figure 1: Māori and NZ European ethic groups by NZDep 2018[2]

10. Māori are much more likely to live in conditions of socioeconomic deprivation than Pākehā, with around 25% of Māori living in the most extremely deprived decile compared to around 5% of Pākehā.[12,25] An important marker of socioeconomic deprivation is the proportion of children living

[2] **Figure 1 shows prioritised ethnicity: each census respondent is assigned to a mutually exclusive ethnic group by means of a prioritisation system commonly used in New Zealand: Māori, if any of the responses to self-identified ethnicity was Māori; Pacific, if any one response was Pacific but not Māori; Asian, if any one response was Asian but not Māori/Pacific; the remainder non-Māori non-Pacific non-Asian (mostly New Zealanders of European descent, but, strictly speaking, not an ethnic group).**

in poverty. Latest evidence suggests that around 20% of Māori children live in material hardship, compared to around 8% of Pākehā children.[26] In terms of access to the determinants of good health, living in poverty makes everything more difficult. This starts with the quality of housing in which a child grows up, the food environment that surrounds them, and the quantity and quality of their education around health. When the symptoms of ill-health arise, living in poverty impedes timely access to care,[27] with out-of-pocket costs associated with transport, parking, accommodation and the care itself acting as barriers.[28]

11. However, we also know that the drivers of poorer Māori health outcomes are far more complex than just the stark disparities in socioeconomic deprivation. Figure 2 from the landmark Hauora report[29] shows the rate of death from all causes, separately by socioeconomic deprivation level. This figure teaches two key lessons: firstly, death is much more likely among those living in socioeconomically deprived areas, which disproportionately impacts Māori; and secondly, that the death rates of Māori and non-Māori never cross each other, regardless of deprivation level. There is more to this problem than money and resources. The structures and institutions of our society better meet the needs of Pākehā than Māori. This is referred to as institutional racism.

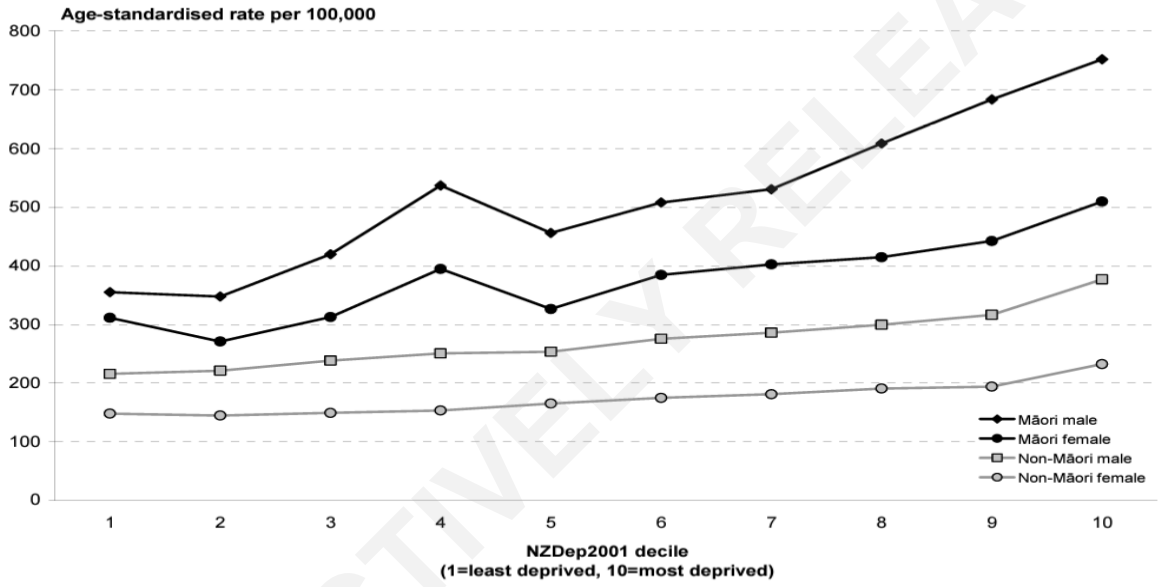


Figure 2: Rate of mortality, by deprivation and ethnicity

12. Instead of focusing on the system-level drivers of health disparities, recent debate has focused on individual-level drivers, such as individual 'choice' over food and tobacco consumption, or 'choice' regarding engagement with health services. In addition, activities aimed at directly addressing the vast inequities in health experienced by Māori are often re-framed as being racist, or counter to the principles of our egalitarian society. Such narratives are unhelpful, because they distract us from the job at hand: that is, to fulfil the promise made within Te Tiriti o Waitangi to protect Māori, by investing in systems-level changes that will meaningfully 'shift the dial' towards a system that works for Māori.

Te Tiriti o Waitangi as a solution

13. As noted earlier, Te Tiriti o Waitangi provides a solid structure for how the inequities in health outcomes experienced by Māori can be undone – both at a broad level in terms of the wider determinants of health, but also at a more specific level with respect to how our health system is

organised and operates. The Waitangi Tribunal[11] has recommended that the future delivery of health care in Aotearoa New Zealand be guided by five Treaty principles – tino rangatiratanga, equity, active protection, options and partnership. Each of these principles provides both a framework and a pathway for health services to implement solutions that will lead to improvements in Māori health outcomes. These solutions are considered below.

- ***Tino rangatiratanga*** means providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health services. An example of an active *tino rangatiratanga* solution to Māori health outcomes is the delivery of kaupapa Māori (by Māori, with Māori, for Māori) health services by Iwi-led and owned health providers. This solution incorporates Māori 'ways of knowing' and a Te Ao Māori worldview into health care systems, policies, and practices, so that they work better for Māori.
- ***Equity*** means being committed to equitable health outcomes for Māori. This means that, counter to the recent debate over treatment prioritisation algorithms,[30] it is not unusual or incongruous for the government to act in a way that prioritises Māori health outcomes in order to improve them, rather, this activity should be expected as in-keeping with the principles of Te Tiriti o Waitangi. The principle of equity also provides a clear goal for the Government when it comes to Māori health.
- ***Active protection*** means acting to the fullest extent practicable to achieve equitable health outcomes for Māori, including ensuring that both Crown agents and Māori are well-informed on Māori health outcomes and activities that aim to achieve equitable health outcomes. An example of active protection in this context is the creation of Te Aka Whai Ora – Māori Health Authority - as part of the recent health reforms. The creation of this organisation is an example of the kind of disproportionate investment by the Government in Māori health that will be required to improve Māori health outcomes and, as such, must be given adequate resourcing and time to work.
- ***Options*** means providing for and properly resourcing kaupapa Māori services. For example, a marae-based healthcare provider in South Auckland was able to meet the needs of its Māori community during the COVID-19 pandemic, providing a Te Ao Māori environment and the kind of wrap-around supportive care that are not offered through mainstream health care services.[31] Such initiatives provide Māori with the option to receive care that reflects their world view, and as such need to be scaled-up and appropriately resourced as part of the current reforms. It also means that those solutions that are not kaupapa Māori in origin – such as initiatives led by central or local government – are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care. For example, initiatives such as national cancer screening programmes should be designed to ensure that they work as well for Māori as non-Māori, in order to address existing gaps in screening access.[32,33]
- ***Partnership*** means that Government works in partnership with Māori for the governance, design, delivery, and monitoring of health improvement solutions. Because Pākehā comprise the majority of people in Aotearoa New Zealand (around 70% [34]), health-related structures or activities that are aimed at 'all New Zealanders' will tend to be designed in a way that works best for Pākehā. As such, there is a tendency to passively create systems that work poorly for Māori, despite the need for these systems to work best for Māori to address inequities in health. To improve Māori health outcomes, we need strong Māori representation in healthcare governance, decision making and policy development, so that Māori can influence the shape of our health system. The Government, and all New Zealanders, must help to facilitate this representation. In addition, working in direct partnership with Māori communities will help to ensure that the systems and structures that drive health outcomes –

from food environments to education to our health care system – reflect a Te Ao Māori worldview, and will actually serve the needs of Māori.

14. The final means by which Te Tiriti o Waitangi can drive improvements in Māori health outcomes is by providing a clear timeline for the achievement of equity. The year 2040 will mark 200 years since the signing of Te Tiriti o Waitangi, and many of the interventions required to meaningfully address inequities in health outcomes – such as improving housing standards, food environments and health care access – will take years to implement.

15. As such, the bicentenary of Te Tiriti o Waitangi provides a 'burning platform', where the achievement of equitable health outcomes for Māori is seen as a problem that we all must solve as a fair and decent society. Actions such as the creation of Te Aka Whai Ora and the empowerment of kaupapa Māori solutions are significant signs of progress that we must continue to build upon in order to deliver on the principles of Te Tiriti o Waitangi.

HP 8856

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