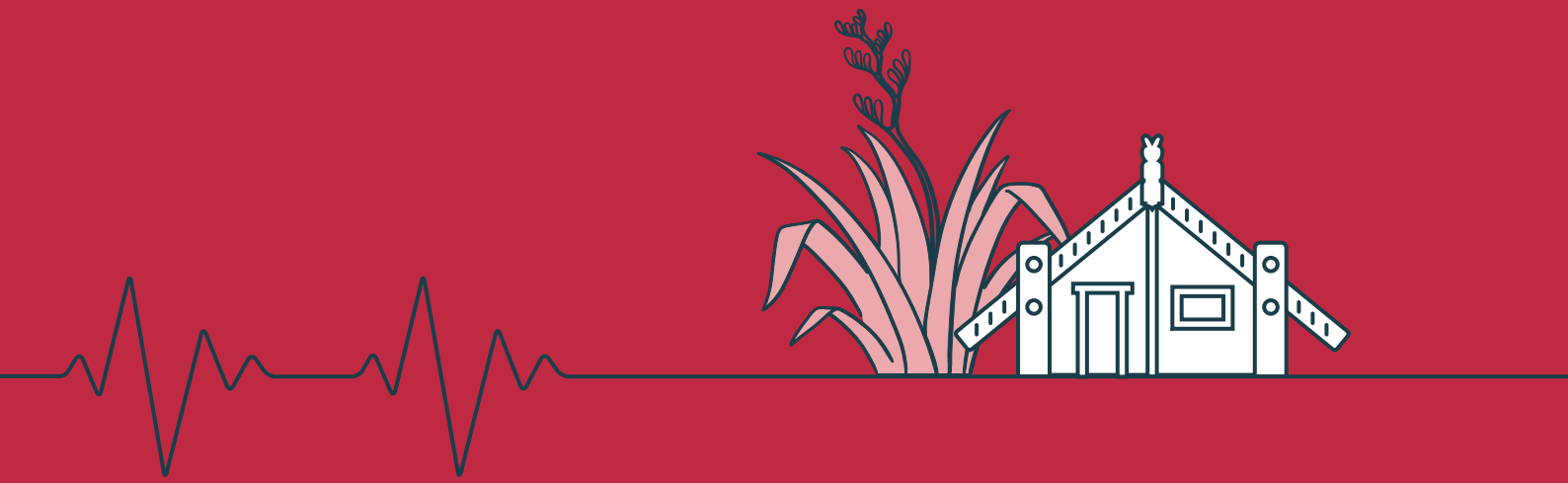
Māori health, Te Tiriti o Waitangi, and the impacts of outsourcing

An exploratory report



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About the author

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Contents

Foreword

Health and wellbeing are inextricably linked to rights and protections under Te Tiriti o Waitangi. Article two guarantees Māori tino rangatiratanga, or self-determination, over treasured things, such as health; and article three guarantees Māori the same rights and privileges as non-Māori, like the right to equal health outcomes.

Yet the gulf between the Crown's obligations under Te Tiriti o Waitangi and the lived experience of Māori in the health system is vast, and persistent.

In 2025, the life expectancy gap between Māori and the population as a whole remains – 6.4 years for men, and 5.5 years for women[1]. Tamariki Māori are more than twice as likely to be diagnosed with asthma, and more than 40 times more likely to be hospitalised with acute rheumatic fever than Pākehā children[2]. Māori experience worse survival rates for 23 out of the 24 most common cancers in Aotearoa New Zealand[3]. When Māori seek healthcare, there is evidence that the quality of care provided is lower than the quality of care received by non-Māori[4].

It was not until the 1970s and the passing of the Treaty of Waitangi Act that the government was forced to acknowledge the existence of New Zealand's founding document in contemporary legislation and policy.

The emergence of the "Three Ps" – principles of Te Tiriti o Waitangi that would shape engagement between the Crown and Māori – were to ensure that partnership, participation and protection would be front and centre. Yet the application of the principles remained at best unequal and, at worst, perpetuate inequities that Aotearoa New Zealand continues to tolerate.

These health outcomes are inequitable. They are also systematic, avoidable, unjust, and unfair.

The Crown has acknowledged this: giving evidence during the hearings for the Wai 2575 Kaupapa inquiry into Māori Health Outcomes, the Director-General of Health stated that the health system had neither ensured good health outcomes for Māori nor enabled effective Māori participation.

> **"Further changes are proposed to the Pae Ora (Health Futures) Act 2022… If passed, the proposed changes will further entrench a system that fails to deliver for Māori. This comes at a time when the health system is under immense pressure, the consequences of which are likely to be felt disproportionately by Māori."**

1 Statistics New Zealand. National and subnational period life tables: 2022-2024. Statistics New Zealand. 2025.

2 Cure kids. 2023 State of Child Health in Aotearoa New Zealand. Cure Kids. 2024.

3 Gurney J; Stanley J; McLeod M; Koea J; Jackson C; Sarfati D. Disparities in Cancer-Specific Survival Between Māori and Non-Māori New Zealanders, 2007-2016. JCO Glob Oncol. 2020.

4 Health Quality and Safety Commission. A window on the quality of Aotearoa New Zealand's health care 2019 – a view on Māori health equity. Health Quality and Safety Commission. 2023.

The gulf between the Crown's obligations under Te Tiriti o Waitangi and the lived experience of Māori in the health system is vast, and persistent.

The Tribunal's seminal 2019 report *Hauora* sought to clarify these principles. Active protection, equity, options, partnership, and tino rangatiratanga were to reset the Crown-Māori relationship as it applies to the health system, and shift policy, implementation and transform outcomes.

Subsequent health reforms saw the Pae Ora (Healthy Futures) Act 2022 passed into law, signalling the Crown's "intention to give effect to the principles of Te Tiriti o Waitangi." It established Te Aka Whai Ora (the Māori Health Authority) as a Crown entity, embedded health equity for Māori as a health sector principle, and established roles for Iwi-Māori Partnership Boards (IMPBs) in service design and delivery within local communities.

A change of government swiftly saw these aspects of the reforms rolled back. Te Aka Whai Ora was disestablished in 2024, and further changes are proposed to the Pae Ora (Healthy Futures) Act 2022 to reduce the role of IMPBs; remove principles that signalled a commitment to equitable health outcomes for Māori; and remove requirements for Health New Zealand's Board to have expertise in Te Tiriti and tikanga Māori.

If passed, the proposed changes will further entrench a system that fails to deliver for Māori. This comes at a time when the health system is under immense pressure, the consequences of which are likely to be felt disproportionately by Māori.

The current government continues to roll back reforms intended to improve health equity and now touts health targets and outsourcing as the fix for New Zealand's health system crisis. Branded as "Elective Boost," the strategy involves outsourcing as many elective procedures to the private sector as possible. In a recent press release, the Minister of Health has stated that people of all ages and backgrounds have benefited. The office of the auditor-general has already found that this is not the case.[5]

This paper, commissioned by Toi Mata Hauora, considers what impact long-term outsourcing and privatisation is likely to have for Māori.

The paper also sets out what would be required to make outsourcing equitable for Māori, including: improved performance data; greater support for Māori to participate in private hospital services; effective implementation of the Ngā Paerewa health and disability standards; investment in the Māori health workforce; and stronger mechanisms for partnering with Māori at all levels of the health system.

Needless to say, none of these elements are visible in the current Government's "Elective Boost" response.

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5 Office of the Auditor-General. Providing equitable access to planned care treatment. Office of the Auditor-General. 2025.

Executive Summary

Te Tiriti o Waitangi (Te Tiriti) is the founding document of New Zealand. It is from Te Tiriti that the Crown claims the right to govern the country and make decisions on how to provide for its citizens. Over time, the Crown's governance has extended to include the creation of a health system, which – although influenced by other health systems – has its own peculiarities and unique features.

This health system separates health care[6] broadly into two main areas:

- Primary health care, which can include a comprehensive range of services like general practice and mental health, and is mostly provided in the community, by private, non-governmental organisations (NGOs), or Māori-owned health services. Large portions of primary health care attract government funding, for example through primary health care funding or ACC funding for injuries, but consumers usually pay at least part of the cost, and
- Secondary and tertiary level care, much of which is provided in hospitals and fully funded by government for New Zealand citizens. However, not all specialist services are funded (for example, in most instances adults pay the full costs of specialist services like dermatology and dental surgery). Individuals can also choose private hospital or specialist care over and above what is provided in the public health system, which they pay for directly or through their own health insurance.

On the other hand, Māori have continued their own health practices and have maintained and developed their own ideas of health and wellbeing. In parallel, Māori have sought to influence the Crown and its approach to health policy and health care.

This report is organised into two substantive sections. The first looks at Te Tiriti and the New Zealand health system. This section provides a brief description of the ways Te Tiriti has been used in relation to health, with particular attention to the Waitangi Tribunal's first stage of its kaupapa inquiry into health services and outcomes.

Since at least the 1970s, Te Tiriti has been part of national conversations about the health and social policy obligations of the Crown and its executive branch (the Government). National hui and a standing committee on Māori in the mid-1980s made calls for Te Tiriti to be seen as the foundation of good health and for Te Tiriti to be included in all health legislation. However, translating these calls into tangible action made slow progress. While Māori and the Crown have worked (sometimes together, and sometimes at odds) to articulate what applying Te Tiriti in health means, the health system and health care services have continued to deliver inequitable outcomes for Māori and the guarantees and rights outlined in Te Tiriti have not been fully realised.

One response to Crown actions and inaction in Māori has been to take claims to the Waitangi Tribunal. This report looks briefly at two Waitangi Tribunal reports (Wai 692: *The Napier Hospital and Health Services Report* and stage one report of Wai 2575: *Hauora*) both of which found breaches of Te Tiriti principles by the Crown in relation to Māori health.

This section of the report concludes by outlining five principles of Te Tiriti that the Tribunal has applied to health care.

6 This report focuses on hospital-level health services delivered to individuals, so this description of health services is very simplified – the health system in New Zealand includes a broader range of activities including public and environmental health and health research, which are not included here and there are some discrete parts of the publicly funded health care system, such as the prison health service run by the Department of Corrections, which are not discussed further in this report.

Five principles of Te Tiriti applied by the Waitangi Tribunal

- **Active protection**, which requires the Crown to act – to the fullest extent practicable – to eliminate inequities for Māori and be well informed on the nature and extent of those inequities,
- **Equity**, which requires the Crown to commit to and achieve equitable outcomes for Māori,
- **Options**, which requires the Crown both to properly resource Māori health services (so that Māori can choose to access kaupapa Māori services) and to ensure all healthcare is provided in a culturally appropriate way,
- **Partnership**, which requires the Crown and Māori to work together on the governance, design, delivery, and monitoring of healthcare, and
- **The guarantee of tino rangatiratanga**, which provides for self-determination and mana motuhake in the design, delivery and monitoring of healthcare.

However, as the more than 200 health service and outcomes outstanding Waitangi Tribunal claims indicate, articulating these principles does not guarantee that the Government will apply them in their work, especially when the health system is under strain. It is also notable that most of the discussion about Te Tiriti in health has assumed that the health system is either mostly subsidised by the Crown (as in primary health care) or is provided through public hospitals. What if health care is delivered outside of primary health care or public hospitals and is still publicly funded? What if health services that have always been provided in a public hospital, free to anyone in need, were outsourced to the private sector?

The second part of this report considers concepts of privatisation in health. Privatisation can be seen as a process of shifting what is (or has been) considered a core public service delivered through public facilities (like hospitals) to being delivered by non-government organisations (be they for profit or not-for-profit). While there is a spectrum of activity that falls within the definition of privatisation, this report focuses on outsourcing of surgery and specialist services to private hospitals as a current approach, relied on as the solution to health system pressures.

Outsourcing is a common Government response to inadequate capacity within the public health system and has been used by both Labour Party-led and National Party-led coalition governments. However, under the current Government outsourcing is one of the main responses to reducing waiting times for hospital services – branded as "Elective Boost". Through Elective Boost the Government aims to deliver an extra 21,000 procedures for New Zealanders this year.[7]

There are questions about the long-term effectiveness of outsourcing, and this report briefly canvasses some of the arguments raised in international and national evidence. In general, outsourcing works for routine procedures, and it works especially well for those who are more well off, and for 'white' populations. The flip side is that it has the very real potential to increase inequities in health outcomes in New Zealand for Māori and other minoritised ethnic groups, and for those who are less well-off materially. This calls into question the ability for the health system to meet obligations under the principles of active protection and equity.

7 https://www.beehive.govt.nz/release/elective-boost-get-more-kiwis-out-pain

> **“For outsourcing to be a long-term solution there should also be the opportunity for Māori to partner in the delivery of outsourced health care, which will require either partnerships between Māori and existing services or the support for Māori health providers to expand into the delivery of private health services. To date, all the publicly available material on Elective Boost is silent on the role of Māori in decision making and investment.”**

The lack of transparent data from private hospitals also limits performance monitoring by the Crown (a requirement of active protection), and the ability of Māori themselves to exercise their Te Tiriti o Waitangi rights to monitor and evaluate health system performance and uphold Māori Data Sovereignty (“the inherent rights and interests that Māori have in relation to the collection, ownership, and application of Māori data”).[8]

Unlike in primary health care, outsourcing for secondary and tertiary health care is always with non-Māori providers, and in fact usually with one of three large private hospital providers, meaning Māori patients and their whānau are unlikely to have the option to access outsourced services from Māori providers, putting the obligation on the Crown to ensure any ongoing support for outsourcing includes investment in Māori providers.

The Crown also has obligations to ensure all care accessed by Māori, wherever it is provided, is culturally safe and appropriate. Within the public health system, the Crown has struggled to ensure culturally safe care for Māori, and the task is – at least potentially – more complicated when it comes to private hospitals. Current checks and balances on care quality need strengthening if outsourcing is to continue in any substantial way and there needs to be a rapid increase in the Māori health workforce working both in public and private hospitals.

The principle of partnership has rarely been displayed in the Crown’s outsourcing decisions. Current decision-making processes in the health system provide very little opportunity for partnership between Māori and the Crown and will provide even fewer opportunities under the proposed Healthy Futures (Pae Ora) Amendment Bill. For outsourcing to be a long-term solution there should also be the opportunity for Māori to partner in the delivery of outsourced health care, which will require either partnerships between Māori and existing services or the support for Māori health providers to expand into the delivery of private health services. To date, all the publicly available material on Elective Boost is silent on the role of Māori in decision making and investment.

Like the principle of partnership, the guarantee of tino rangatiratanga, is difficult to see reflected in outsourcing decisions and implementation, especially under Elective Boost. However, outside of government, there are examples of where Māori have made decisions to fund private health insurance (as Ngāti Whatua o Orakei have). It is outside the scope of this project to consider this scheme in any depth other than to acknowledge it was a decision made by Māori, for Māori and as such is different in nature from outsourcing.

This report concludes with a set of recommendations for the Crown, and its contracted providers, if it is to continue to use outsourcing as a response to health sector pressure while also meeting its obligations under Te Tiriti.

8 Te Mana Raraunga. (2018).

Six recommendations for the Crown

1. **Greater transparency in decision-making:** health sector funding and policy proposals must respond to Māori health needs and be assessed for their potential impact on Māori health. Analysis from the Ministry of Health and Te Whatu Ora to ministers should be explicit about the impacts on Māori health and health equity – consistent with obligations on the public service to be free, frank, and fearless.
2. **Improved ethnicity data quality** is required of all hospital services, whether they are delivered in the public or private sector. This, and all Māori data, should be governed in line with the principles of Māori data sovereignty, with greater transparency for public performance data on outsourced health services.
3. **Supporting Māori health providers** and other Māori groups to participate in private hospital services where they choose to. This will require significant additional investment and improvements to government funding and contracting practices with Māori providers.
4. **Investing in capacity and capability (by both HealthCERT and private hospitals) to effectively administer and implement Ngā Paerewa** health and disability sector standards, including publicly releasing performance reporting to the Hauora Māori Advisory Committee, IMPBs, and the wider public.
5. **Investment in the Māori health workforce,** with a focus on in supporting an increased number of Māori senior clinicians and specialists and providing medical education that addresses experiences of racism, discrimination, bullying, and harassment for all parts of the Māori health workforce, including Māori medical students and physicians.
6. **Stronger mechanisms for partnership with Māori** at all levels of the health system, starting with the IMPBs and extending both national and regional oversight and monitoring and to local partnerships between private hospitals and Māori whānau, hapū, iwi, and communities. As a minimum this would mean restoring the original intent of the Pae Ora (Healthy Futures) Act for IMPBs to be local level health sector partners in service delivery and design.

A note on terminology

Throughout this report the term Te Tiriti o Waitangi (or Te Tiriti) is used to refer to the agreement between the Crown and Māori signed in 1840. The only times 'the Treaty of Waitangi' (or the Treaty) is used is in reference to government policy or legislation or where it is specifically referred to in a quote. While this report acknowledges there are two different versions (the Māori version – Te Tiriti o Waitangi – and the English version – the Treaty of Waitangi), and that only Te Tiriti o Waitangi is seen as legitimate by many Māori, it is not a work of legal scholarship. As such, it does not explore the arguments around different versions of Te Tiriti or their implications.

Introduction

Te Tiriti o Waitangi (Te Tiriti) is the founding document of New Zealand. It is from Te Tiriti that the Crown claims the right to govern the country and make decisions on how to provide for its citizens. Over time, the Crown's governance has extended to include the creation of our health system.

New Zealand's national health system as we know it, has its roots in "a patchwork of rate-payer funded local hospital boards, voluntary organisations, and medical practices"[9] that operated from the 1840s. These facilities were, of course, on Māori land. While each site has its own story, the ability for the Crown or other settlers to use the land was sometimes negotiated with hapū and iwi on the promise that the settlements would also include hospitals that would be of benefit to Māori.[10] In reality, the benefits to Māori were often unrealised. Access to these early health care services were ad hoc,[11] and dependent on individual doctors, missionaries, or citizens.[12]

Throughout the 1900s, more structured approaches to the health system emerged, culminating in the Social Security Act 1938. While there have been several legislated changes to the structure and operation of the health care system, the 1938 Act set the framework for the health system today which, public health and some community health care provision aside, still exists today and fits broadly into two categories:

- Primary health care, which can include a comprehensive range of services like general practice and mental health, and is mostly provided in the community, by private, NGO, or Māori providers. Large portions of primary health care attract government funding, for example through primary health care funding or ACC funding for injuries, but we usually pay at least part of the cost as consumers, and
- Secondary and tertiary level care, much of which is provided in hospitals and fully funded by government for New Zealand citizens. However, not all specialist services are funded (for example, in most instances adults pay the full costs of specialist services like dermatology and dental surgery). Individuals can also choose private hospital or specialist care over and above what is provided in the public health system, which they pay for directly or through their own health insurance.

Concurrently, Māori have continued their own health practices and have maintained and developed their own ideas of what constitutes health and wellbeing. At best these practices have been ignored by the Crown but at times they met with resistance and punishment.[13] Nevertheless, Māori have continued to exercise both rangatiratanga over our own health and wellbeing systems while also seeking to influence the Crown, as its partner, in the development and running of the New Zealand health system.

9 Williams (2007), p4.

10 For example, in November 1851, Donald McLean made a verbal promise of a government hospital to Ahuriri Māori on behalf of the Crown and this promise in turn became part of the consideration (or payment) for the Ahuriri land transaction. The Waitangi Tribunal found in 2001 that this promise was enduring, for the benefit of Māori generally. Waitangi Tribunal (2001).

11 Dow (1999) notes that in 1969 the then Health Department said that the first four hospitals in New Zealand were opened in 1847 and 1848 'for the treatment of sick and destitute Europeans, and free treatment for all Māori', and goes on to observe that what this means has been debated amongst historians for a range of reasons, including that not "all" Māori were able to access the hospitals, the hospitals made no provision specifically to meet the needs of Māori, and the hospitals were themselves a tool of colonisation to "amalgamate Indigenous peoples without stationing a large body of troops to subjugate them". (p27).

12 Williams (2007), p7.

13 The Tohunga Suppression Act 1907 being perhaps the most notable example, but by no means the only one.

Māori have continued their own health practices and have maintained and developed their own ideas of what constitutes health and wellbeing. At best these practices have been ignored by the Crown but at times they met with resistance and punishment.[13]

This report begins by exploring the obligations Te Tiriti creates for the New Zealand health system and how this has been used in health care policy and practice. This very brief history includes a summary of how the Waitangi Tribunal has articulated the principles of Te Tiriti in relation to health and notes how this has been adopted in the health system.

This report goes on to consider the application of Te Tiriti obligations in the context of a health sector under pressure and turning to the private sector for added capacity. Specifically, this report focuses on the outsourcing of specialist care to private hospitals as one of the finite number of strategies[14] available to Ministers of Health and other health sector decision-makers when the health system pressures are making headlines[15] and creating significant criticisms of the Government.

The development of this report

The analysis in this report is based on Kaupapa Māori methodologies, with the aims of being beneficial to Māori, transformative (leading to "some kind of change"),[16] and aligned with an understanding of the structural determinants of health and wellbeing.[17]

The report has been informed by a series of rapid environmental and literature scans.

Environmental scans looked at Māori health policy, Te Tiriti o Waitangi, the Waitangi Tribunal, outsourcing, health sector standards, social investment, and the New Zealand health workforce. Literature scans covered Te Tiriti o Waitangi and health, privatisation and health care (and health equity, Indigenous health outcomes, quality outcomes), health sector pressures, outsourcing, neo-liberalism and health, social investment (and Indigenous populations, Māori, health outcomes), and hospital ownership.

One request was made to the Ministry of Health under the Official Information Act 1982, and workforce survey data was obtained from the Medical Council of New Zealand following a request on the ethnicity breakdown of the medical workforce in private hospitals compared with public hospitals.

Limitations

This report provides only a high-level assessment of outsourcing as a solution to public health system pressure. While the current Government's Elective Boost programme, which puts greater emphasis on outsourcing, is referenced throughout there is no detailed assessment of how the current policy meets (or does not meet) Te Tiriti obligations.

14 Page et. al. (2024).

15 For a relatively recent example, see: Radio New Zealand. (2024). What's gone wrong with New Zealand's health system? Link here.

16 Smith. (2011).

17 Curtis. (2016).

Te Tiriti o Waitangi has been part of health policy for 50 years

Although Te Tiriti o Waitangi (Te Tiriti) should always have been part of the national conversation on the New Zealand health system, it wasn't until the mid-1970s that challenges from Māori forced the Crown to give greater recognition to Te Tiriti.[18]

This included the establishment of the Waitangi Tribunal under the Treaty of Waitangi Act 1975. Professor Sir Mason Durie describes the 1970s as the start of the Mana Māori period, characterised by Iwi and Māori-led initiatives, increasing recognition of Māori perspectives, and Māori development that included an increase in Māori health professional numbers and the creation of a Māori community health workforce.[19]

Key developments from the 1980s that are still influencing the way Te Tiriti is used in the health sector today, include:

- Growing evidence of the unfair differences in health outcomes between Māori and non-Māori and better understandings of Māori health. Two of the most notable of reports were the 1980 report from Dr Eru Pōmare which looked at life expectancy gaps for Māori compared with non-Māori for the period 1955 to 1975,[20] and a community-based research report from the Māori Women's Welfare League, which explored the holistic nature of Māori health.[21]
- Hui Whakaoranga (1984), sponsored by the (then) Department of Health. This hui is regarded as 'among the most important ever held in stimulating government and Māori efforts to involve Māori in health care and to adapt health services to Māori needs'.[22]
- The New Zealand Board of Health, which at the time gave advice to the Minister of Health, set up a Standing Committee on Māori Health in 1984.[23] Within a year, the Standing Committee recommended that Te Tiriti be regarded as a foundation for good health in New Zealand.[24] The New Zealand Board of Health then recommended that "[a]ll legislation relating to health should include recognition of the Treaty of Waitangi".[25]
- The Royal Commission on Social Policy (1987) endorsed features of a fair society,[26] including the development of Te Tiriti policy based on three principles (partnership, participation, and protection). Following a change in government, the Royal Commission's work was not a significant feature of social policy of the 1990s but from the election of a Labour-led government in 1999, these three principles became an accepted part of health sector policy and legislation (such as the New Zealand Public Health and Disability Act 2000).

18 Ministry of Health (2018).
19 Durie (1998).
20 Pōmare (1980).
21 Murchie (1984).
22 Williams (2007), p29.
23 Williams. (2007); Ministry of Health (2018).
24 Williams. (2007), p32.
25 New Zealand Board of Health. (1988), as quoted in Durie. (1998), p81.
26 Barnes et. al. (2011).

The 1990s, although a period of considerable hardship for Māori whānau,[27] saw several Māori health development initiatives that continue to be hallmarks of the New Zealand health system. While informed by the progress made in the 1980s, and often using language that included "the Treaty", these developments owed as much to neo-liberal health sector policy as they did to Te Tiriti commitments. For example, the growth in the number of Māori health providers at the time was enabled by opportunities for Māori to be involved in the 'business of health'.[28] These opportunities came as the result of health sector policy that split off the purchasing of services from the provision of those services so that public hospitals no longer had a monopoly on public funding, and a range of non-government providers could bid for health service contracts and different planning processes and obligations meant different kinds of health services could be purchased.

The way we use Te Tiriti o Waitangi in the health sector has been tested in the Waitangi Tribunal

Despite nearly fifty years of high-level policy statements around Te Tiriti and health, it has not always been clear how these statements turn into tangible actions at a policy and health care level. One response to this non-performativity[29] by the Crown has been for Māori to challenge government decisions on health in the Waitangi Tribunal.

In the late 1990s, Māori from Ahuriri raised claims in the Waitangi Tribunal that the closure of the Napier hospital was a breach of Te Tiriti obligations. This claim was based both on historical commitments made to Māori by the Crown, and on the enduring requirements for the Crown to meet the health needs of Māori. The Tribunal report notes that in making decisions over the 1980s and 1990s to transfer acute hospital services to Hastings from Napier and to close Napier hospital (and replace it with a new health centre) the Crown breached the principle of partnership and its duty to consult. The Tribunal found the Crown failed to meet the duty of good faith by presenting options on the regional hospital after decisions had already been made. The Tribunal also observed that the evidence suggested a failure on the part of the Crown to ensure levels of Māori health expenditure met the levels of Māori health need.[30]

Soon after the 2001 Napier Hospital decision, Māori primary health care providers began to raise concerns about the impacts of policy on Māori health. Specifically, providers argued that the intentions of the *Primary Health Care Strategy*,[31] which acknowledged the "special relationship between Māori and the Crown under the Treaty of Waitangi",[32] did not match the strategy's implementation (especially its funding formula). Claims were first raised with the Waitangi Tribunal in 2005 and would go on to become the first heard in the Waitangi Tribunal's kaupapa inquiry into health services and outcomes (known as Wai 2575) in 2018.

In considering the primary health care claims, the Tribunal found that "the legislative and policy framework in the primary health care system fails to address adequately the severe health inequities experienced by Māori".[33] The Tribunal went on to say that the Crown did not lead and direct the primary health care system in a way that adequately resourced and supported Māori "to design and provide through their own wellbeing through designing and delivering primary health care to Māori."[34] Although not discussed in any detail, either in evidence or in the Tribunal's report, the fact that primary health care was delivered by private providers rather than by the government (through district health boards) was an important part of the findings, reinforcing that the Crown's responsibilities extend to where they contract services from external providers.

In making its findings on primary health care, the Tribunal also set out five principles of Te Tiriti that it considered the Crown should adopt.

27 Ajwani et. al. (2003).

28 For example, the proceedings of the Māori Health Decade Hui (Te Puni Kōkiri, 1994), a number of speakers are recorded as suggesting Māori get into the business of health. This includes calls to "get into gear now if you want to take advantage of the new business opportunities in health", and to build an asset base that allows Māori to purchase the services they require when they need them.

29 Ahmed (2006).

30 Waitangi Tribunal (2001).

31 King (2001).

32 King (2001), p10.

33 Waitangi Tribunal (2023), p161.

34 Ibid.

Five principles of Te Tiriti applied by the Waitangi Tribunal

- **Active protection**, which requires the Crown to act – to the fullest extent practicable – to eliminate inequities for Māori and be well informed on the nature and extent of those inequities,
- **Equity**, which requires the Crown to commit to and achieve equitable outcomes for Māori,
- **Options**, which requires the Crown both to properly resource Māori health services (so that Māori can choose to access kaupapa Māori services) and to ensure all healthcare is provided in a culturally appropriate way,
- **Partnership**, which requires the Crown and Māori to work together on the governance, design, delivery, and monitoring of healthcare, and
- **The guarantee of tino rangatiratanga**, which provides for self-determination and mana motuhake in the design, delivery and monitoring of healthcare

Since the Tribunal issued its primary health care report, there have been significant changes in government health policy. In 2022 Te Aka Whai Ora (the Māori Health Authority) was established under legislation[35] that (to some extent) drew on the Tribunal's five Te Tiriti principles. In 2024, following a change in government, Te Aka Whai Ora was disestablished. Parliament is currently considering a Bill[36] that will further alter the Pae Ora (Healthy Futures) Act 2022, removing the substance of its Te Tiriti clause. However, a legislative change of this nature by itself does not amend or diminish the obligations and guarantees of Te Tiriti o Waitangi and the requirements on the Crown to be a good Te Tiriti partner. As the Waitangi Tribunal noted in the Napier Hospital report that while statutory recognition of Te Tiriti is fundamental to the Crown's Treaty obligations, if the obligations aren't in legislation, it does not prevent the Crown from meeting those Treaty obligations.

The Waitangi Tribunal's kaupapa inquiry into health services and outcomes is still ongoing, with a report on the most recent phase (focused on disability-related claims) expected soon. Following the disability phase the Tribunal is expected to consider claims around mental health and addictions and then move on to all remaining claims.[37]

An issue the Tribunal has yet to explore in relation to health is the Te Tiriti implications of privatisation and transferring services that have been delivered in public hospitals to private, for-profit, hospitals. However, it is likely, based on the progress of the health services and outcomes kaupapa inquiry that the same five principles of Te Tiriti would be considered. On this basis, the second half of this report considers how these five principles could be applied to one aspect of privatisation: outsourcing.

35 Pae Ora (Healthy Futures) Act 2022.

36 Health Futures (Pae Ora) Amendment Bill.

37 Information on Wai 2575 is available on the Waitangi Tribunal's website: https://www.waitangitribunal.govt.nz/en/inquiries/kaupapa-inquiries/health-services-and-outcomes

Te Tiriti o Waitangi and emerging responses to health system pressure

A truism in the New Zealand health system is that demand for health care seems greater than the system's capacity to deliver those services. This leaves people waiting for (or missing out on) health services, which in turn can lead to public outcry (including from patients), concern amongst health professionals, and media headlines.[38] Much of the criticism is then directed at the Government of the day and usually the minister of health.

A minister then has a limited range of options available to address these capacity issues:[39]

- Increase or redirect investment to public hospitals and other publicly owned services
- Build a health workforce that will create capacity for the future
- Restructure by creating or removing health sector entities (for example, to improve health sector decision-making).

However, these are solutions that take a relatively long time to bear fruit and provide little relief for services struggling today. There are very few short term strategies to increase hospital capacity, but they include creating efficiencies (so that more can be done within existing resources) and managing demand (for example, by introducing prioritisation criteria).[40] A third option is to buy additional capacity either from other facilities within the public health system (insourcing) or to buy additional capacity from the private health system (outsourcing).

In response to the current health sector pressures, the Government has put a strong emphasis on performance in terms of a narrow set of health sector targets (set out in figure 1). As four out of five of these targets rely on services traditionally provided in public hospitals, it is this third, short term, option (buying in additional capacity) that is the main feature of the Government's investment in the health system. Specifically, the Minister of Health, Hon Simeon Brown, has launched the Elective Boost programme, which increases the use of outsourcing and aims to provide an extra 21,000 surgical procedures in the next year.[41]

The remaining sections of this report will consider whether, given what we have seen of the Crown's obligations under Te Tiriti, the Crown can meet these obligations while outsourcing health services.

38 See, for example, https://www.rnz.co.nz/news/national/523686/what-s-gone-wrong-with-new-zealand-s-health-system
39 Page et. al. (2024).
40 Ibid.
41 https://www.beehive.govt.nz/release/elective-boost-get-more-kiwis-out-pain

Figure 1: Government health targets as at September 2025

- Faster cancer treatment: 90% of patients to receive cancer management within 31 days of the decision to treat.
- Improved immunisation: 95% of children fully immunised at 24 months of age.
- Shorter stays in emergency departments: 95% of patients to be admitted, discharged, or transferred from an emergency department within six hours.
- Shorter wait times for first specialist assessment: 95% of patients wait less than 4 months for a first specialist assessment.
- Shorter wait times for elective treatment: 95% of patients wait less than 4 months for elective treatment.

At the time of writing, a primary care target is under development with the intention of it taking effect from 1 July 2026.

Source: Ministry of Health (www.health.govt.nz)

Outsourcing can be part of a broader move towards privatisation

Colloquially, privatisation and outsourcing are used interchangeably when talking about public health services provided by private health providers. However, privatisation as a term is broader – referring to the range of ways the private and for-profit sector replaces or displaces the public sector in the provision of goods or services.[42]

An understanding of privatisation requires a basic understanding of the four main ownership models used in the New Zealand health system.

- **The state-owned and state-run health services**, which are the responsibility of Health NZ. This includes most of the country's hospitals,[43] some child oral health services, some community mental health services and, in exceptional circumstances,[44] primary health care.
- **Private, for-profit, services.** This ownership model covers smaller professionally controlled organisations, like owner-operator general practice, dentistry, and community pharmacy, but increasingly features corporate ownership 'where business models ultimately drive professional behaviour'.[45] This category also includes a number of surgical hospitals across the country, although the Ministry of Health information makes it difficult to know if a hospital is run for-profit or if it is part of the not-for-profit sector.[46] Health New Zealand advice released under the Official Information Act suggests there are three major providers who make up 70% of the private hospital market (Evolution Healthcare, Southern Cross, and Healthcare Holdings).[47]

42 Mercille. et. al. (2017).

43 As of 28 August 2025, the Ministry of Health listed 93 certified public hospitals across the country.

44 Reidy et. al. (2023).

45 Ibid.

46 As of 28 August 20205, the Ministry of Health lists 76 certified private hospitals, 40 of which are surgical hospitals, providing around 1400 beds.

47 https://www.tewhatuora.govt.nz/assets/Uploads/HNZ00077475-Aide-memoire-Private-Sector-Relationships.pdf

While privatisation can encompass the move from the public system to any of these three alternative models of service ownership, much of the literature focuses on the private, for-profit, models. This tends to suggest that the Te Tiriti implications of privatisation have not been well explored in research.

- **Not-for-profit, community and NGO services.** Since the 1800s, New Zealand has had non-government, non-profit service provision (often connected to religious groups), which over time included the provision of hospital and other health services (such as ambulance services).[48] From the 1980s, this expanded into (often low- or no-cost) primary and community health care, largely in response to unmet health needs (for example to provide comprehensive primary health care in areas of high socio-economic deprivation, for Māori, Pacific populations or young people).[49]
- **Māori-owned health services.** As mentioned already, while Māori have always had our own systems and ways of supporting health and wellbeing, participation in the Crown's health system started in the 1980s and 90s. The Ministry of Health defines Māori health providers as suppliers of health care services that are owned and governed by Māori and are providing health and disability services primarily but not exclusively for Māori. There are currently around 285 Māori health providers across New Zealand.[50]

While privatisation can encompass the move from the public system to any of these three alternative models of service ownership, much of the literature focuses on the private, for-profit, models. This tends to suggest that the Te Tiriti implications of privatisation have not been well explored in research.

Mercille and Murphy (2017) suggest a continuum of privatisation, which has been used as the framework for the examples set out in Figure 2. At one end of the spectrum is corporatisation. This first step begins to separate out core public services from public services that can be more arms-length from government and usually run along business lines. New Zealand tried a version of this in the 1990s with Crown Health Enterprises (CHEs), which were to be run on a commercial basis and make hospital care more efficient. However, in practice, CHEs have been viewed as a failure by many commentators.[51] Outsourcing comes next in the continuum, where functions that were previously handled by government (or government organisations – like public hospitals) are delivered by the private sector, while still being publicly funded. Elective Boost and delivering publicly funded elective surgeries through private hospitals in general are examples of outsourcing. Next along the spectrum is public private partnerships (PPPs) where the public sector enters into a longer-term arrangement with a private supplier. While these have typically been for infrastructure projects like roading or construction of prison facilities,[52] it could include long term arrangements for surgery if, for example, private for-profit providers build new facilities in a form of PPP that ensures additional surgical capacity for the public health system. It is also possible that there is overlap between PPPs and the social

48 Tennant. et. al. (2008).

49 Reidy et. al. (2023).

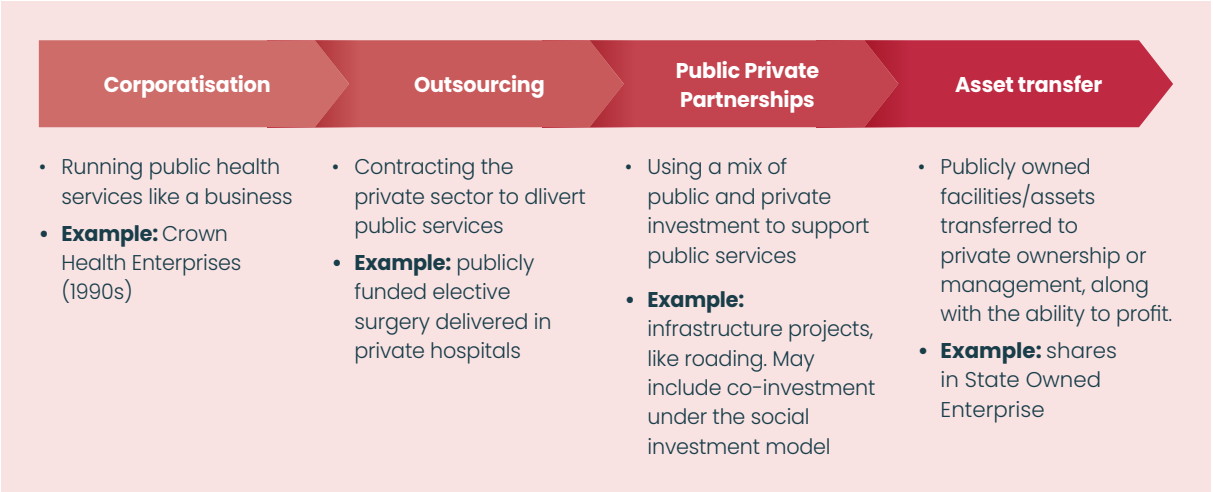
50 Most of the services delivered by Māori health providers fit into the broad category of community and primary health care. Although the Ministry of Health does not provide details on whether any of the country's private hospitals are also Māori providers, based on the August 2025 list there appears to be only one Māori private hospital, which delivers maternity services only (Turuki Health Care Limited).

51 For a discussion, see Howell (2000).

52 https://www.beehive.govt.nz/release/investment-summit-investment-christchurch-men%E2%80%99s-prison

investment model as it is evolving in New Zealand.[53] At the far end of the spectrum is described divestiture or asset transfer, which occurs when private investors assume ownership or management of public assets (like the sale of shares in state owned enterprises, or private providers taking responsibility if not ownership over public facilities like hospitals), with the intentions of making a profit.

Figure 2: Continuum of privatisation activities, with examples



Source: Adapted from Mercille and Murphy (2017)

Internationally, outsourcing does not benefit everyone equally

There are questions about the long-term effectiveness of outsourcing, and this report briefly canvasses some of the arguments raised in the literature and environmental scans.

By its proponents, outsourcing is claimed as an effective way to increase capacity, support health system efficiency, and improve patient outcomes. While advice to the Minister of Health from Health NZ indicates that these benefits can be achieved within an acceptable price, there is also a caution that short term, waiting list focused initiatives, "take time to stand up, are not efficient, and put pressure on workforce availability for Health NZ and private providers who are competing for the same limited workforce".[54]

Other cautions about outsourcing, identified through the literature review and environmental scan include:

- There is evidence that private sector outsourcing can correspond with statistically significant increases in treatable mortality.[55] A 2024 rapid review[56] observed that patient outcomes and quality analysis showed surgery outsourced to independent service providers was at least as safe as it is in the NHS England, but this was an exclusively quantitative measure. One qualitative measure considered (patient satisfaction) suggested individual surgeons had the same levels of patient satisfaction both when they worked in public hospitals and when they worked in private hospital settings.

53 For example, the newly announced social investment fund has four "pathways", one of which is co-investment. Co-investment is described as "a mechanism to enable partnerships with philanthropic organisations or other funders to co-invest in initiatives that amplify collective impact and drive innovation." For more information on social investment and co-investment, visit the Social Investment Agency website: https://www.sia.govt.nz/social-investment-fund/pathway-four-co-investment

54 https://www.tewhatuora.govt.nz/assets/Uploads/HNZ00077475-Aide-memoire-Private-Sector-Relationships.pdf

55 Goodair et. al., (2022).

56 Fletcher (2024).

There are some concerns that outsourcing can increase the fragmentation of health services (leaving patients to navigate a range of unconnected health providers).[59]

- Assessing quality is complicated by the fact private hospitals tend to provide lower-risk surgeries than what is provided in public hospitals. The previously mentioned 2024 rapid review also noted that some private surgeries needed to be corrected in public hospitals, which could put additional pressure on the public system to act as a safety net.[57] The British Medical Association suggests that relying on this safety net puts pressure on public hospital intensive care beds, which can increase wait times in the public system.[58]
- There are some concerns that outsourcing can increase the fragmentation of health services (leaving patients to navigate a range of unconnected health providers).[59]
- Outsourcing can increase inequities.[60] Outsourcing usually applies to lower-complexity surgeries – which tend to support wealthier, younger, and white populations disproportionately. Private hospitals are also more likely to be in affluent regions (meaning that those living nearby are in turn more likely to benefit). System efficiencies and increased capacity (like reduced waiting times and reduced length of stay) through outsourcing require increased investment in the health system, and this investment is more likely to benefit more well-off populations. For example, NHS England hip replacement data showed procedures had increased by 12%, but that the least deprived 10% of patients benefited three times more than the poorest 10%.[61]
- There can be negative impacts on the health workforce working in private hospitals. While the previously mentioned 2024 rapid review was unable to include insight into professional job satisfaction, there were findings that the workforce had decreased training opportunities, were affected by profit driven culture and experienced a loss of professional identity.[62]
- Reliable private hospital data is generally limited. This is a global issue, with, for example, a report from Australia identifying significant gaps in performance data for privatised hospitals.[63] This means that it is often impossible to compare the performance of public and private hospitals and that neither health sector funders, nor consumers, are able to make informed decisions about private hospitals. The commercially sensitive nature of financial information for private hospitals also means there is limited information on the cost effectiveness outsourcing.[64]
- The overall financial benefits of outsourcing are difficult to track. The British Medical Association has noted that the proportion of public spending on independent service providers has substantially increased over the past two decades – from 0.02% of elective activity in 2003/04 to around 5.2% in 2020/21, without any additional transparency.[65]

57 Fletcher (2024).

58 BMA (2022).

59 BMA (2022).

60 Fletcher (2024), Anaf et. al. (2024).

61 One study included in the rapid review found "reduced waiting times benefited the richest patients twice as much as the poorest, and white people six times as much as ethnic minority patients" (Kelly (2021) as quoted in Fletcher (2024)).

62 Fletcher (2024).

63 Torpy (2017).

64 Mills et. al. (2025).

65 BMA (2022).

Te Tiriti o Waitangi principles and outsourcing in the NZ health system

Outsourcing for surgery has been a feature of the New Zealand health system for some time, but with the longer-term approach suggested by the Government's Elective Boost programme, proposed 10-year contracts, and higher volumes of surgery included in outsourcing arrangements, it is an opportune time to consider how outsourcing meets (or fails to meet) the Crown's obligations to Māori under Te Tiriti o Waitangi.

Active protection

Active protection requires the Crown to be well informed about Māori health and take action to eliminate inequities for Māori. As shown in the previous section, outsourcing has a poor track record when it comes to eliminating inequities, with international evidence suggesting it has the opposite impact: being most effective for those with lower complexity health issues and international evidence suggesting it works best for the most well-off populations.

In New Zealand, private surgical hospitals are not evenly distributed throughout the country, with private hospitals tending to be in large urban areas (for example, there are 22 private hospitals in the wider Auckland district, but only one in Tairāwhiti).[66] The Office of the Auditor General has recently noted that this means that "some districts can outsource patients more easily and at shorter notice than others".[67] This is likely to disproportionately have a negative impact on those who live in rural areas (as private hospitals have little incentive to serve smaller populations where it is difficult to generate profits or break even),[68] which in turn disproportionately impacts Māori. For example, Northland is a largely rural area,[69] and only has one surgical hospital (based in Whangārei). It also has a large Māori population with 8.2% of the national Māori population living in the Northland region (compared to 3.9% of the total population).[70]

The focus on outsourcing as a solution also raises questions about whose health needs are being prioritised when the Government is deciding on health sector investment. For example, although some Iwi Māori Partnership Boards have touched on the importance of hospital level care as a whānau priority,[71] the interim Māori Health Authority commissioned work on Māori health priorities in 2022, and none of the resulting priorities included access to elective surgery.[72] In reviewing the advice to the Minister of Health, from Health NZ and from the Health Workforce and Systems Efficiency Committee, released under the Official Information Act on 14 May 2025,[73] there is no suggestion that outsourcing is a way to improve Māori health outcomes nor is there any analysis of the impacts of outsourcing on health equity.[74]

66 https://www.health.govt.nz/regulation-legislation/certification-of-health-care-services/certified-providers/private-hospitals

67 Office of the Auditor General (2025). Para 3.45.

68 Mills et. al. (2025).

69 Whitehead et. al. (2022).

70 Stats NZ https://tools.summaries.stats.govt.nz/ethnic-group/maori#usual-residence-address

71 For example Te Tauraki (the Iwi Māori Partnership board for the Ngāi Tahu Takiwa) notes on its website that Māori in their rohe are much more likely to have a missed first specialist appointment than non-Māori. For more information see: https://tetauraki.co.nz/whanau-maori-voice/

72 Curtis et. al. (2022).

73 The Official Information Act response has been proactively released on the Health NZ website, here: https://www.tewhatuora.govt.nz/publications/outsourcing-elective-treatments-advice

74 It is noted some sections of the advice released under the Official Information Act were redacted under s9(2)(b)(ii) – that is would be likely unreasonably to prejudice the commercial position of the person who supplied or who is the subject of the information. While it is unlikely that equity analysis would be withheld under these grounds it is possible that some of the material on Māori health and equity may have been redacted from the material reviewed in this report.

Active protection requires the Crown to be well informed about Māori health and take action to eliminate inequities for Māori.

Equity

The principle of equity requires the Crown to commit to and achieve equitable outcomes for Māori. As already noted, equity is not an explicit aim of the current outsourcing policy and investment, meaning that the standard required of the Crown has not been met.

It is possible, in theory, for outsourcing to be focused on achieving equitable outcomes for Māori. To do this, the Crown must be well informed on the nature and extent of Māori health outcomes and inequities, which in turn requires robust data and monitoring processes. Private hospitals are not usually subject to the same level of scrutiny and accountability, and data is difficult to obtain.[75] While Health NZ may be able to obtain some data through their contracts with private providers, the quality of this data is unknown. However, we know that data sets within the public health system fail to adequately collect ethnicity, particularly for those with multiple ethnicities,[76] and undercount Māori. These ethnicity data issues, which represent a breach of Te Tiriti o Waitangi themselves, must be addressed with urgency.[77]

There is also no evidence that the data that is available is being maintained in line with the principles of Māori Data Sovereignty that recognise Māori data should be subject to Māori governance, nor are there processes, structures, accountability mechanisms, legal instruments and policies through which ensure Māori exercise control over relevant Māori data.[78] This highlights another area where the government and its contracted providers should take considered action to meet Te Tiriti obligations, and overlaps with the guarantee of tino rangatiratanga (discussed below).

Options

The principle of options has two elements – firstly that Māori should be able to access kaupapa Māori services as part of the public health system and secondly that Māori can receive culturally safe and culturally appropriate care from mainstream providers.

For the first of these elements, Māori currently have no option to access kaupapa Māori providers of elective surgery. As mentioned, although the Ministry of Health does not provide ownership data on private hospitals a preliminary assessment is that none of the surgical hospitals are Māori-owned and Māori-governed and three major providers make up 70% of the private hospital market.

Māori may wish to enter the 'business' of offering private specialist and surgical health care. However, doing so is likely to be prohibitively expensive for Māori groups, even those with a significant asset base, without additional investment and support over several years. For example, existing Māori health providers tend to operate in the community and primary health care using funding approaches that have systematically underfunded Māori providers. This underfunding has been calculated as being up to $531 million between 2003 and 2021,[79] which means that providers are unlikely to have reserved sizeable profits, hampering their

75 Mills et. al. (2025).
76 Blackmore et. al. (2024).
77 Harris et. al. (2022).
78 Te Mana Raraunga. (2018).
79 Love et. al. (2021).

Under the principle of options, Māori should also be able to receive care from Māori health professionals, even in mainstream private services. The number of Māori in the health workforce, and the underrepresentation of Māori (and disabled and Pacific people), is a noted limitation of the New Zealand health sector.[84]

ability to invest in new services. Both because the historic underfunding was the result of Crown actions and inactions, and because the Crown's obligation to ensure Māori have the option of kaupapa Māori providers must extend to the outsourced services it spends public health funding on, meeting this Te Tiriti obligation requires the Crown to provide appropriate investment to Māori directly, or to work with other potential investors with the intention of supporting Māori health providers.

The second element of options requires the Crown to ensure all publicly funded mainstream health services are clinically and culturally safe and culturally appropriate, including private hospitals delivering outsourced care. However, the New Zealand health system has struggled to provide culturally safe care, free of racism,[80] even within its public hospitals where the Health NZ is directly in charge of the operation of services and employs the workforce directly. So, it is difficult to see how the Crown can ensure cultural safety when providers are 'arm's length' from Health NZ.

Currently, the main mechanisms for ensuring appropriate care in private hospitals is certification against the *Ngā Paerewa* health and disability sector standards,[81] which are administered by HealthCERT. Under *Ngā Paerewa*, certified hospital services (whether public or privately owned) must provide care in a manner that upholds cultural and individual values and beliefs (standard 1.1), recognise and commit to Māori mana motuhake (standards 1.3 and 1.4), provide culturally and clinically safe services for Māori (standard 1.5), and honour Te Tiriti and ensure Māori participate in governance (standard 2.1). A 2024 evaluation of the implementation of *Ngā Paerewa*, while being positive about the standards themselves, highlighted te ao Māori expertise gaps within HealthCERT (which could mean that the standards around culturally safe and appropriate care are not being applied as robustly as clinical standards), and identified that "ongoing education on Te Tiriti is necessary" for providers.[82] In 2024, the then Minister of Health was asked a series of written parliamentary questions about whether the recommendations of the *Ngā Paerewa* evaluation were being actioned. The response then was that "there is no current or planned work relating to this consideration, but this has been noted for future projects".[83] This lack of priority for work to strengthen the application of *Ngā Paerewa*, even when there is increased use of outsourcing, raises concerns under the principle of options.

Under the principle of options, Māori should also be able to receive care from Māori health professionals, even in mainstream private services. The number of Māori in the health workforce, and the underrepresentation of Māori (and disabled and Pacific people), is a noted limitation of the New Zealand health sector.[84] Māori doctors make up 5.7% of all doctors employed in the New Zealand health system, which is well below the proportion of Māori in the general population (17.1%).[85] However, data from the Medical Council of New Zealand's workforce survey shows that an even smaller proportion of Māori doctors work in private hospitals than in public hospitals, with Māori doctors making up 2.9% of all doctors employed by private hospitals compared to Māori doctors

80 Harris et. al. (2024).

81 Standards New Zealand (2021).

82 Malatest International (2024), p7.

83 Written Parliamentary Question 75774(2024). Written Parliamentary Questions are available online, here: https://questions.parliament.nz/written-questions?tab=0&col=1&dir=1

84 Ministry of Health. (2023).

85 Stats NZ (2024). https://www.stats.govt.nz/information-releases/maori-population-estimates-at-30-june-2024/

making up 5.8% of all doctors employed by public hospitals.[86] This means Māori patients are less likely to be seen by a Māori doctor if they receive care in private hospital than if they receive care in a public hospital, constraining the ability for the Crown to meet its obligations under the principle of options while outsourcing.

The small number of Māori doctors is also concerning, in general, especially against the backdrop of Māori medical student and physician exposure to racism, discrimination, harassment, and bullying,[87] and the evidence of additional duties, tasks or obligations carried by Māori doctors.[88]

Partnership

The principle of partnership requires the Crown and Māori to work together on the governance, design, delivery, and monitoring of healthcare. There are two existing mechanisms, under the Pae Ora (Healthy Futures) Act 2022 that could have been used by the Government in making decisions on outsourcing. The first is the Hauora Māori Advisory Committee which can advise the Minister on any matter relating to hauora Māori that the Minister requests.[89] Based on a review of the Hauora Māori Advisory Committee's minutes from 2024 and the first four months of 2025, released under the Official Information Act,[90] there is no record of advice being sought on outsourcing. The second possible mechanism is the use of Iwi Māori Partnership Boards (IMPBs), which were established under the Pae Ora (Healthy Futures) Act 2022 to represent local Māori perspectives on the design and delivery of services and public health interventions within localities[91] and work with Health New Zealand in developing priorities for improving hauora Māori.[92] Notwithstanding the adequacy or otherwise of these partnership mechanisms, there is no evidence in the publicly available information to suggest that IMPBs have been part of the governance or design of Elective Boost or advice on outsourcing. Furthermore, the proposed changes to the Pae Ora (Healthy Futures) Act 2022, which reduce the voice of IMPBs in the health system means that ongoing decision-making on outsourcing will be exposed to less scrutiny from any Te Tiriti-partner.

The guarantee of tino rangatiratanga

Māori have the right to self-determination and to mana motuhake in the design, delivery and monitoring of healthcare. As illustrated under the principle of partnership, there is no evidence that Māori have been involved in the design, delivery, and monitoring of current outsourcing decisions. There is also there is no transparency over how well private hospitals are performing for Māori compared to other populations (or compared to public hospitals).

The lack of transparency about outsourcing, including its costs, places a constraint on the ability of Māori to monitor healthcare in line with this Te Tiriti principle.

At an individual or whānau level, there is also limited choice available to Māori patients as to whether the health care they receive is delivered in the public or private system.

It is possible for Māori to exercise control over the design and delivery of private surgical services – and this already happens outside of the public health system. For example, Ngāti Whatua o Ōrakei provide health insurance for its Iwi members through NIB.[93] While this example is entirely Iwi-funded, and noting that the need for such a programme could be seen as evidence of the failure of the public health system, it shows there is potential for Māori to make their own decisions on private hospital services.

86 Medical Council of New Zealand (2025).

87 Cormack et. al. (2024).

88 Tipene-Leach (2024).

89 Pae Ora (Healthy Futures) Act 2022, s89.

90 The Official Information Act response has been proactively released on the Ministry of Health website, here: https://www.health.govt.nz/information-releases/information-relating-to-the-hauora-maori-advisory-committee-and-the-ministrys-maori-monitoring-group

91 Pae Ora (Healthy Futures) Act 2022, s29(c).

92 Pae Ora (Healthy Futures) Act 2022, s30(1)(c).

93 Publicly available information on the NIB health insurance plan includes up to $300,000 per person per year for private surgical hospitalisation and $200,000 per person per year for non-surgical hospitalisations. Ngāti Whatua o Ōrakei have negotiated the insurance package with NIB and pay the premiums and any excess. The benefits for members are stated as including having greater choice and control over when, how, and who you are treated by. The insurance programme also includes a dedicated kaiārahi (navigator) for members. Information on the insurance programme is available online, here. https://ngatiwhatuaorakei.com/toi-ora/nib/

Conclusion

While there have been explicit references to Te Tiriti for nearly 50 years, this has not always been matched with tangible action by the Crown to protect Māori health and respond to Māori health needs. In response, Māori have from time to time turned to the Waitangi Tribunal to uphold their Te Tiriti rights, and over the past twenty-five years jurisprudence has developed that suggests there are a minimum set of five principles that the Crown is required to meet.

However, when the health system is under pressure, for example where demand for services exceeds the level of service available, ministers of health tend to rely on short term fixes and – especially where the solutions tend towards the privatisation of public health services – there is little analysis of how the Government can implement these solutions while meeting their Te Tiriti obligations.

By looking at one kind of privatisation activity – outsourcing elective surgery to private hospitals – this report has shown that the Crown has failed to demonstrate its commitment to Te Tiriti. Figure 3 sets out each of the five Te Tiriti principles and the extent to which outsourcing meets the required standard of each of the principles.

Figure 3: Application of Te Tiriti o Waitangi principles to outsourcing to private hospitals

Te Tiriti o Waitangi principle	Extent to which outsourcing meets required standard
Active protection: Requires the Crown to act – to the fullest extent practicable – to eliminate inequities for Māori and be well informed on the nature and extent of those inequities	Outsourcing has a poor track record when it comes to equity, with it being most effective for those with lower complexity health issues and international evidence suggesting it works best for the most well-off populations. Current outsourcing policy does not appear to be based on Māori health priorities, and publicly released advice to Ministers does not provide analysis of the impact on Māori.
Equity: Requires the Crown to commit to and achieve equitable outcomes for Māori	No commitment to equitable outcomes in any of the Elective Boost package. Private hospital data is traditionally limited, with the quality of ethnicity data questionable (an issue likely to disproportionately impact Māori) and there is no evidence that the data has been governed in line with the principles of Māori Data Sovereignty.
Options: Requires the Crown both to properly resource Māori health services (so that Māori can choose to access kaupapa Māori services) and to ensure all healthcare is provided in a culturally appropriate way	Currently no Kaupapa Māori options / Māori providers participating in outsourced surgical care. Significant barriers to Māori in this area – even if there was interest from existing Māori providers to expand their health services. Current mechanisms to ensure cultural safety of private hospitals services needs stronger implementation. Limited Māori workforce in private hospital service provision means Māori patients are less likely to be seen by a Māori doctor than in the public system.
Partnership: Requires the Crown and Māori to work together on the governance, design, delivery, and monitoring of healthcare	Existing policy has not been developed in partnership with Māori, and IMPBs have not been used as mechanism despite their current statutory purpose and function.
Guarantee of Tino Rangatiratanga: Self-determination and mana motuhake in the design, delivery and monitoring of healthcare	At a policy level, there are few formal mechanisms for Māori to be involved in the design, delivery, and monitoring of outsourcing. No evidence in papers released under OIA of Māori influence or involvement in decisions on outsourcing or the greater use of the private hospital system. At a patient level there is limited choice over whether or not the health care you receive is delivered in the public or private system.

Recommendations

In short, this report reinforces that Te Tiriti must be foundational to all health sector decision making. Drawing on the assessment of outsourcing and Te Tiriti obligations, the report makes the following recommendations:

1. **Greater transparency in decision-making:** health sector funding and policy proposals must respond to Māori health needs and be assessed for their potential impact on Māori health. Analysis from the Ministry of Health and Te Whatu Ora to ministers should be explicit about the impacts on Māori health and health equity consistent with obligations on the public service to be free, frank, and fearless.[89]
2. **Improved ethnicity data quality** is required of all hospital services, whether they are delivered in the public or private sector. This, and all Māori data, should be governed in line with the principles of Māori data sovereignty, with greater transparency for public performance data on outsourced health services.
3. **Supporting Māori health providers** and other Māori groups to participate in private hospital services where they choose to. This will require significant additional investment and improvements to government funding and contracting practices with Māori providers.
4. **Investing in capacity and capability (by both HealthCERT and private hospitals) to effectively administer and implement Ngā Paerewa** health and disability sector standards, including publicly released performance reporting to the Hauora Māori Advisory Committee, IMPBs, and the wider public. This should be supported by an audit of private surgical hospitals against Ngā Paerewa.
5. **Investment in the Māori health workforce**, with a focus on supporting an increased number of Māori senior clinicians and specialists and providing medical education that addresses experiences of racism, discrimination, bullying, and harassment for all parts of the Māori health workforce, including Māori medical students and physicians.
6. **Stronger mechanisms for partnership with Māori** at all levels of the health system, starting with the IMPBs and extending both national and regional oversight and monitoring and to local partnerships between private hospitals and Māori whānau, hapū, iwi, and communities. As a minimum this would mean restoring the original intent of the Pae Ora (Healthy Futures) Act for IMPBs to be local level health sector partners in service delivery and design.

89 For a discussion on obligations to be free, frank, and fearless see Kibblewhite (2016).

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