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KEI MUA I TE AROARO O TE RŌPŪ WHAKAMANA  
I TE TIRITI O WAITANGI

BEFORE THE WAITANGI TRIBUNAL

WAI 2575

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IN THE MATTER OF                      the Treaty of Waitangi Act 1975

AND

IN THE MATTER OF                      the Health Services and Outcomes Kaupapa  
Inquiry

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**BRIEF OF EVIDENCE OF ASHLEY ROBIN BLOOMFIELD**

7 September 2018

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<b>RECEIVED</b> Waitangi Tribunal
<b>07 Sep 18</b>
Ministry of Justice WELLINGTON

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I, Ashley Robin Bloomfield of Wellington, Director-General of Health and the Chief Executive of the Ministry of Health state:

### **Introduction**

1. My full name is Ashley Robin Bloomfield.
2. I am Director-General of Health and the Chief Executive of the Ministry of Health.

### **Background**

3. I have been in my current role since 11 June 2018. Prior to this, I was the Acting Chief Executive for Capital & Coast District Health Board since January 1 2018.
4. From 2015-2017, I was Chief Executive of the Hutt Valley District Health Board. I was the first clinician to lead the Hutt Valley District Health Board.
5. From 2012-15 I was Director of Service, Integration and Development and General Manager Population Health at Capital & Coast, Hutt and Wairarapa District Health Boards.
6. Prior to this, I held a number of senior leadership roles within the Ministry of Health. This included, in both 2010 and 2012, being the Acting Deputy Director-General, Sector Capability and Implementation.
7. I obtained a Bachelor of Medicine and Bachelor of Surgery at the University of Auckland in 1990. I specialised in public health medicine gaining a Master of Public Health from the University of Auckland in 1997 and am a Fellow of the NZ College of Public Health Medicine.
8. In 2010-2011, I was Partnerships Adviser, in the Non-communicable Diseases and Mental Health Cluster at the World Health Organization, Geneva.
9. I have had a longstanding interest in the wider social, cultural and economic determinants of health, and in improving Māori health and equity. While still training in public health medicine, I led work by the National Health Committee on the determinants of health and health inequalities

(<https://www.health.govt.nz/publication/social-cultural-and-economic-determinants-health-new-zealand>).

### **Current role**

10. The State Sector Act 1988 requires each department to have, as its administrative head, a chief executive. The New Zealand Public Health and Disability Act 2000 states that the chief executive can be referred to as the Director-General.
11. As a departmental chief executive under the State Sector Act 1988 (amended 2013) I have a responsibility to give effect to the collective interests of the government (S1A) and to be an effective steward of the resources of my agency to achieve health portfolio responsibilities (S32).
12. My responsibilities include, amongst other things, being responsible to the Minister of Health for the stewardship of:
  - 12.1 the Ministry of Health, including its medium and long-term sustainability, organisational health, capability, and capacity to offer free and frank advice to successive governments;
  - 12.2 assets and liabilities on behalf of the Crown that are used by or relate to the Ministry of Health
  - 12.3 legislation administered by the Ministry of Health.
13. I also have a large number of functions, duties and powers set out throughout the legislation that the Ministry of Health administers such as the Health Act 1956.

### **Structure of this evidence**

14. In this evidence I will provide some high level context about the New Zealand health system and this will orient the evidence of my colleagues who will talk in more detail about the primary health care system.
15. My evidence is supported by two briefs of evidence that were filed by John Hazeldine, Chief Advisor, Ministry of Health. These briefs were filed on

3 July 2017 and 9 February 2018. The purpose of these briefs was to provide an overview of the current health and disability system.

16. The main aspect of those briefs that I want to emphasise is the New Zealand Public Health and Disability Act 2000 (the Act), as this is the legislation that underpins the structure and function of the New Zealand Health sector, notably the roles and responsibilities of District Health Boards (DHBs).
17. The Act is very clear in describing the purpose of the publicly-funded New Zealand health care system that one of its functions is “to reduce health disparities by improving the health outcomes of Māori and other population groups” (Section 3(1)(a)).
18. This function is also one of the specific objectives of DHBs (Section 22(1)(e)). The focus on reducing health inequalities is also reflected in the Primary Health Care Strategy 2001, which articulates the vision that, *inter alia*, “Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.”
19. My evidence will respond to a number of topics that have been raised by claimants and referred to in statements of evidence or identified as issues by the Waitangi Tribunal. Broadly, my evidence will:
  - 19.1 Outline the current state of Māori health in New Zealand
  - 19.2 Outline some of the other factors that influence Māori health
  - 19.3 Present the need for a whole of Government response to Māori health
  - 19.4 Describe my vision for the health and disability system.
20. I want to note at this point that the policy environment for primary health care since 2000 has been, in many respects, a ‘permissive one’. That is to say that while the Crown has determined overall structures (notably primary health organisations) and funding mechanisms, it has not prescribed in detail what a primary health care system should look like. Rather, the Crown has created an

enabling environment where local communities, including general practice and other providers, can develop local responses to health need. This is a positive feature of the system but it comes with a down side. This permissive policy approach does not always respond well to the full range of consequences, intended or otherwise, of policy and funding decisions, nor does it have many 'levers' to address unintended consequences. This means that outcomes might not be distributed equitably and that participation might not be enabled for all groups. As the Director-General of Health, I welcome this Inquiry as I am of the view that while many elements of the policy direction for primary health have been beneficial for health outcomes in New Zealand, it has not sufficiently ensured good health outcomes for Māori nor enabled effective Māori participation. I thank the Tribunal for this opportunity and look forward to seeing the recommendations that arise from this Inquiry.

#### **Health outcomes for Māori**

21. Improving health outcomes for Māori is important to the Ministry and wider health sector. We know that a wide range of factors influence health and wellbeing, including factors outside the health system – the so-called 'determinants of health'. We also know that Māori experience, on average, poorer health and higher levels of premature mortality across a wide range of measures. I attach as Appendix 1 key health statistics for the Māori population. These statistics are largely taken from Tatau Kahukura, the Māori Health Chart Book 2015.
22. This state of health for Māori is unacceptable and it is the core business of the New Zealand health and disability system to respond effectively – as required by the New Zealand Public Health and Disability Act 2000. I will note that gains have been made in some areas such as immunisation rates for children and teenage girls and access to some disability support services for Māori, but significant challenges remain for the health sector in order to improve the overall health status of Māori and ensure equitable outcomes. I know that the health sector is aware of this expectation and challenge and there is a high level of commitment to addressing it effectively.

23. As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand. Many health conditions are more commonly reported by Māori adults than for other adults (including ischaemic heart disease, stroke, diabetes, medicated high blood pressure, chronic pain and arthritis – notably gout). In addition, Māori continue to experience mental health and addiction problems more frequently than any ethnic group in New Zealand.
24. Māori life expectancy continues to increase, like that of all New Zealanders, although the gap between Māori and non-Māori life expectancy at birth is 7.3 years, based on death rates in 2010–12. Likewise, not all of this ‘extra’ time is spent in good health: adjusting for age and population size, health loss in Māori is almost 1.8 times higher than in non-Māori, with more than half of Māori health loss occurring before middle age, at 45 years.
25. The age structure of the Māori population differs markedly from that of the national structure. The Māori median age of just under 24 years remains significantly younger than both the national and European median age (38 and 41 years respectively). While the Māori population structure is youthful, the number of Māori aged 65 years and older has grown rapidly over the last decade and will continue to increase at a faster rate than in other ethnic groups.
26. Given the age structure of the Māori population, and the typically higher need for health services at younger and older ages, it is likely that there will be increased demand for health services by the Māori population in coming years. There is significant variation between districts in the size and proportion of their Māori population. My DHB colleagues will talk about the approach that they talk to the health of their districts.

#### **Other factors that influence Māori health**

27. As mentioned, there are factors outside the health system that influence health and wellbeing – the so-called ‘determinants of health’. The relationship between these determinants and health is two-way: for example, good health can positively influence educational attainment, employment status and income, while poor health can have a negative influence on them.

28. Addressing the determinants of health, including poverty, housing, employment opportunities and education, is essential to improving outcomes for Māori. Other factors health behaviours, which are of course shaped in turn by these determinants, and the physical environment. The Ministry needs to work with its DHB partners, and with its broader social sector partners, to address these broader determinants.
29. Disparities in social determinants create unfair and avoidable differences in health for individuals, whānau and communities, including different ethnic groups. Not surprisingly, people living in the most socioeconomically deprived areas experience worse health outcomes than those living in the least deprived areas. In 2013, 23.5 percent of Māori lived in decile 10 (most deprived) areas compared with 6.8 percent of non-Māori, while only 3.8 percent lived in decile 1 (least deprived) areas compared with 11.6 percent of non-Māori.
30. Thus, non-Māori are more advantaged than Māori across many socioeconomic indicators including school completion, unemployment, personal income, income support, access to telecommunications, access to a motor vehicle and household crowding.
31. Furthermore, when they are unwell, people in more deprived areas are more likely to have difficulty accessing health services due to cost and other factors such as access to transport. As a result, they may delay seeking treatment, which can contribute to more serious health problems.
32. So socio-economic deprivation for Māori impacts on their ability to access good health but it is compounded by other factors, including racism. The impact of personal and institutional racism is significant on both the determinants of health and on access to and outcome from health care itself. Racism is associated with poorer health, including poorer mental health.
33. In 2013/14, Māori adults were almost twice as likely as non-Māori adults to have experienced racial discrimination in their lifetime. The disparity is even starker in some areas: for example, Māori females were more than seven times more likely than non-Māori females to have experienced unfair treatment in renting or buying houses because of ethnicity.

### **Whole of government response to improving Māori health and ensuring equity**

34. Given the wider factors that contribute to health and health status, it is very important to me that I work alongside my social sector colleagues to support the health and disability system to deliver equitable health outcomes for Māori. There has been significant thinking and effort over the years to do this but it is clear that it has been insufficient to date. This Inquiry and its recommendations will be an important input into our thinking and ongoing work in this area.
35. Part of my plan for the first three years in my role is lead the health sector to find new ways to strengthen health and social sector integration. I plan on doing this through support for our devolved sector to deliver integrated models of care that work across government portfolios to achieve better and more equitable health outcomes.
36. Wider government priorities, such as improving housing conditions, and initiatives to promote better educational achievement and higher rates of post-school education and boost employment opportunities also contribute positively to health outcomes. The Treasury's Living Standards Framework, which is under development, highlights the importance and interconnections of wellbeing across a range of dimensions. Māori models of health and service delivery such as Te Whare Tapa Whā and Whānau Ora recognise health as having a number of dimensions that are influenced by many factors. So to achieve our vision we need to address these different dimensions of health (physical, spiritual, mental and whanau) and the full range of factors influencing health, by strengthening how we work together across the health sector, with social sector partners, the non-government sector, communities, iwi and whānau.

### **Vision for the health and disability system**

37. The Government has two overarching goals for health and health care, namely: to ensure there is a strong, public health care system; and to deliver improved and more equitable health outcomes. Key areas for focus are primary health care, mental health and addictions and improved child health and wellbeing.



38. The Ministry has a key role to play in ensuring these are delivered by providing leadership of the health sector. This requires us to ensure there is clear direction and convene and collaborate with the wide range of stakeholders. We have developed a joint work programme with the wider health sector to make progress on these key priority areas and deliver the Government's overall objectives. Part of the Ministry's role is to ensure there are clear responsibilities, monitoring and accountability arrangements in place, in particular for DHBs.
39. I am of the view that the current performance and accountability arrangements, for DHBs in particular, need strengthening. As part of that strengthening, I plan to introduce more systematic accountability for ensuring that the health system is meeting the needs of Māori.
40. A further essential Ministry of Health function is that of stewardship of the health sector – that is, we need to ensure that the sector delivers the best possible outcomes for all New Zealanders, including Māori, while also ensuring our health care system is 'future proofed' to continue to deliver for our population. This requires a longer term view, with robust planning and wise investment decisions.
41. I am aware of the important role of He Korowai Oranga, the Māori Health Strategy, in ensuring the vision of the health and disability system is realised. He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. Implementing He Korowai Oranga is the responsibility of the whole of the health and disability sector. It has implications for other sectors as well.
42. I am also aware of the important role of Whānau Ora in delivering the vision of the health and disability system and in particular ensuring equitable Māori health outcomes. Whānau Ora puts families at the centre, giving them control over the services they receive and working with them to achieve their aspirations. It is models like this that push the boundaries between the health and disability system and how it works with the other sectors.

43. Implementing the Government's priorities for health, such as improving access to preventive and primary health care services, improving mental health services, working across agencies to improve child wellbeing, and increasing health equity, including for Māori, are vital to delivering on the purpose of the NZ Public Health and Disability Act and the aspirations of the Ministry of Health.
44. I am of the view that the current performance and accountability arrangements, for DHBs in particular, need strengthening. As part of that strengthening, I plan to introduce more systematic accountability for ensuring that the health system is meeting the needs of Māori.

#### **Improving system stewardship is an important focus for the Ministry**

45. As I have already stated, this whole of system leadership is an important part of my role. Stewardship is about taking a longer-term view and actively planning, managing and advising the government. This includes, for example, ensuring the way the system is configured, funded and operates is fit for purpose, resilient and adaptable and delivers good outcomes for all New Zealanders. To be an effective steward we need to ensure that together we can meet the challenges ahead such as population ageing, the increasing number of people living with long-term conditions, and to better meet the needs of those the system does not currently serve well.
46. We need to understand how we can do things differently, seize opportunities and try new things. We can't and won't do this on our own. This is a shared endeavour where different perspectives, knowledge and skills coupled with the right resources and insights need to come together. The Ministry has an important role here to lead, facilitate and guide which is why I have such a strong focus on engagement and building enduring relationships in our forward planning and day-to-day work.

#### **We are on a journey together**

47. In all of this, we are on a journey. A Performance Improvement Framework review, undertaken by the State Services Commission, The Treasury and Department of the Prime Minister and Cabinet in 2017, identified the need for

the Ministry to strengthen its stewardship role. As Director-General, I am taking steps to positively position the Ministry in this regard. This includes implementing a suite of initiatives from the Ministry's response to the PIF review that will stabilise and focus on health system performance, while designing a future-focussed health system.

48. I am also implementing organisational changes to better position the Ministry to deliver on its stewardship responsibilities and key priorities. As part of this, I wish to ensure that there is an explicit focus on both the Crown's Treaty obligations to protect and improve Māori health and wellbeing, and to drive improved equity. These goals need to be led by the whole of the Ministry's Executive Leadership Team. In addition, I propose to establish a new directorate to support our work across the organisation on improving Māori health. This directorate will ensure Māori health is identifiably a core function of the Ministry, is adequately resourced, is present at the executive leadership table, and helps to support and guide wider work in the Ministry and sector on improving Māori health. Just to reiterate – improving Māori health is an expectation on all Ministry staff and especially its leaders.
49. Taken together, I believe these changes help set a platform for strengthening the health system's performance in improving Māori health over time. The changes can also be built upon in the spirit of protection, partnership, and participation that underpin the relationship between Māori and non-Māori under the Treaty of Waitangi. It is in this context that I present this evidence for the Inquiry.

Signed:



Ashley Robin Bloomfield

Date:

7/9/2018