FINAL SUBMISSION (COLLECTIVE IMPB) ON PAE ORA ACT PROPOSED CHANGES

INTRODUCTION

Te Tiratū Iwi Māori Partnership Board (IMPB) covers the greater Waikato Region. Our significant Māori population is approx. 121 000 with 50% under the age of 25 years old.

Te Tiratū would like to provide the Minister of Health and the NZ Government with information about the considerable value that IMPBs bring to the health system and achievement of health targets and outcomes.

It is our view that the proposed Pae Ora Act changes to the roles and functions of IMPBs (Section 30) **are not evidenced based** on reliable Māori health data including expert research to provide the government with sound rationale articulating why these proposed reforms are needed. Nor do we think that these proposed changes will adequately support achievement of the Government or whānau generated health targets and expected outcomes.

This submission seeks for Section 30 of the Pae Ora Act related to IMPB functions, to remain unchanged.

Te Tiratū considers that our leadership, knowledge and influence is substantive and an asset to the Ministry of Health, Health NZ and other relevant government agencies (e.g. Te Puni Kokiri, Oranga Tamariki, Kainga Ora, MSD) to prioritise and optimise resources and services to produce positive health outcomes for Māori. In this submission, we outline how we have given effect to the present IMPB statutory roles and functions including how our advice and solutions will assist the NZ Government to deliver enduring health outcomes and better return on investment from tax funding.

Te Tiratū has board leadership representing our Member Bodies from the iwi of Maniapoto, Hauraki, Raukawa, Waikato Tainui, Ngāti Hāua ki Taumarunui and mataawaka organisations Te Runanga o Kirikiriroa and Te Kohao Health.

Their leadership is demonstrated by clearly articulating the health priorities of whānau Māori in our rohe conveyed in our Community Health **Plan** that we presented to the Minister of Health in October 2024. We use this plan as a key advocacy tool in correlation with our Health Priorities **Report.** This assists Health NZ to easily understand what is important to our whānau, their challenges and potential solutions collected from regularly attending events and hui across the greater Waikato rohe. In 2024 we collected important Whānau Voice information from each of our Te Tiratū Member Bodies and whānau have completed over 300 **surveys** since February 2025 that included Primary Care, Cancer Treatment and Screening. This data can inform Health NZ's key regional planning documents and strategic commissioning for Te Manawa Taki.

Te Tiratū produced a Monitoring **Report** of Health NZ and specifically the progress they are making to assist whānau with their hauora in our rohe. The key findings in this report are that inequity persists, there are low cancer screening rates and access to treatments, longer wait

times for surgery and treatments, missing data for oral health, immunisations & mental health, unmet Te Tiriti o Waitangi obligations, there are barriers to increase Māori Health Provider funding and that there were some gains in mental health and addictions access. We are presently preparing to produce the next Monitoring Report for Jan-July 2025.

Te Tiratū has a sound understanding of the social determinants of health and provides leadership as one of three consortium partners for **Rangitāmiro** Whānau Ora Commissioning Agency for Region 1 (from Taupō, Waikato, Hauraki to Cape Reinga) with the National Hauora Coalition PHO and Ngaa Pou Hauora o Tāmaki Makaurau IMPB. Rangitāmiro commenced on 1 July 2025 and we have approximately 90 full time navigators across the greater Waikato employed by Whānau Ora Providers many of whom also provide health services. This opportunity is significant for Te Tiratū to influence where resources will be provided and prioritised to assist whānau to have a high quality of life, health and standard of living. We have been proactive about understanding Social Return on Investment, engaging with Māori health providers about this and considering how our collective work in the health sector correlates and complements the objectives of the Social Investment Agency.

THE CURRENT IMPB LEGISLATED FUNCTIONS ARE A DEMONSTRATION OF GOVERNMENT'S OBLIGATIONS UNDER TE TIRITI

When the Health and Disability System Review (2020) was completed, it emphasized upholding Te Tiriti o Waitangi and achieving Māori health equity through system transformation and reiterated that Te Tiriti-based partnership was crucial to Māori health outcomes.

IMPBs are an efficient mechanism for the health system to engage with Iwi-mandated entities who cover the entire geography of New Zealand. Iwi have organised themselves in Hauora through the IMPBs to drive local and regional improvements based on the voice of whānau, hapu and communities. It is an effective Te Tiriti based arrangement as it locates Iwi-mandated entities alongside Health NZ and local services to drive change. IMPBs are close to the action (i.e. close to local hospitals, health centers, GP practices and other services) and already work at this level to drive better use of resources and more impactful service delivery.

We urge the government to ensure it does not make an avoidable error in diminishing the IMPB functions outlined in Section 30 of Pae Ora Act. There has been a significant investment in time and resources by Iwi Māori to work together to establish and appoint their IMPBs. Similarly, taxpayers have also invested millions in this system infrastructure. It would be negligent to waste those investments without sufficient reason to do so, especially when those investments were all about establishing a platform for specific attention to be paid to the persistent health inequities which exist in NZ. Those inequities remain. The need for targeted efforts remains.

When the then Cabinet[1] considered the roles of IMPBs they were correct in their rationale. It was noted then that there were a large number and variety of decisions made in the health system every day, at different levels - and Iwi-Māori partnership boards were determined as

[1] [CAB-21-MIN-0092 refers]

having "*a critical role in the process for settling locality plans for primary and community care to ensure the plans reflected local needs and priorities*". Furthermore, the positioning of Iwi-Māori partnership boards to play a greater role in shaping national, regional and local planning for hauora Māori was seen as critical. This has not changed.

Iwi-Māori partnership boards were intended to:

- Enable Iwi Māori to exercise tino rangatiratanga as a tangata whenua partner in planning around health priorities and services at the locality level, within their rohe or coverage area;
- ensure the voices of whānau Māori are elevated and made visible within the health system; and
- embed mātauranga Māori within the system to influence and inform national planning and investments.

The fundamental purpose of iwi Māori partnership boards was to create a local Te Tiriti o Waitangi partnership between Health New Zealand commissioners and iwi and hapori Māori, and to ensure that Māori aspirations and needs were reflected in local planning and commissioning. This purpose is still relevant today – and was a very specific intervention to take the persistent health inequities seriously. The key functions need to remain if Government is serious about tackling pervasive health inequities.

Iwi-Māori partnership boards' most significant impact is at the locality level, and through the planning and prioritisation process that determines local health services. The process of locally-based planning weaves together national and local expectations. IMPBs are a very effective mechanism for Iwi Māori to play a vital role in the health sector.

LACK OF CONSULTATION WITH IWI, HAPU AND WHĀNAU AS TIRITI PARTNERS

It is understood that Government sought advice from within its own health system (HMAC, HNZ, MOH) before considering changes to the Act. There was no engagement with IMPBs so that Government could actually make informed decisions and health directly from IMPBs about our achievements and our aspirations to continue to work with Government to achieve mutual goals.

Engagement limited to the Hauora Māori Advisory Committee does not meet the Crown's Te Tiriti o Waitangi obligations and certainly not our IMPBs functions and roles. The Hauora Māori Advisory Committee is composed of ministerial appointees and does not represent the independent voices or tino rangatiratanga of iwi, hapu and whānau who sit with our IMPB. Iwi Māori are the Crown's Tiriti partners - not HMAC. Relying on the Hauora Māori Advisory Committee alone excludes iwi from direct participation in shaping legislative reforms that affect Māori health outcomes, undermining and completely ignoring the principle of partnership and abhorrently breaching the Crown's duty to engage meaningfully with Māori guaranteed under Te Tiriti o Waitangi. It also completely contradicts the Crown's own regulatory standards, which require inclusive engagement with affected communities.

MĀORI HAVE ACHIEVED EXCELLENT RESULTS WHEN 'ENABLED' TO DO SO

Since 1983 the New Zealand public health sector has undergone six structural transformations[2]. With each change there was a new set of organisations to fund and deliver health services:

- **1983-1993 Area Health Boards (AHBs).** This model was implemented to address inconsistencies in health care quality and unequal access to health care services caused public and political concern.
    - *Neither Iwi or Māori-service provision had any visible presence in the sector during this time and there were only scattered concentrations of effort to tackle Māori health inequities.*
- **1993-1997 Regional Health Authorities (RHAs) and Crown Health Enterprises (CHEs)** – reform led by the National Government as a result of a Ministerial Taskforce report "*Your health and the public health*, 1991", The review recommended the separation of the purchaser and provider roles of the Area Health Boards and the establishment of a competitive, quasi-market approach to the provision of health services. Four Regional Health Authorities (RHAs) were designed to purchase services from a range of providers in a competitive health market.
    - *The opening to a market approach actually created significant opportunities for emergence of Māori providers as it interrupted the status quo. The 1990's saw* ***the most significant investment*** *in service delivery by Māori providers and a growth in the number and presence of Māori-delivered services across NZ. Additionally, Government resourced Iwi Māori partner organisations such as MAPO (Māori Co-Purchasing Organisations) and MDOs (Māori Development Organisations) to work with the RHAs / HFA in purchasing / commissioning, planning, engagement and advocacy.* ***This is the same partnered activity performed by IMPBs with the difference being legislated powers that require the system to partner (and moving the relationship from a discretionary one to a mandatory one).*** *For the current National-led coalition to not build on their previous successful approach of the 1990s in strengthening the Tiriti-based relationship through IMPBs – is a confusing and inconsistent policy.*
- **1998-2001 Health Funding Authority (HFA) and Hospital and Health Services (HHSs)** – reform led by National / NZ First Government to respond to cost shifting concerns and variation across the 4 RHAs.
    - *This evolution of the system continued to strengthen the health system's relationship with Iwi partnerships (MAPO and MDOs) with many benefits began to reveal themselves in terms of health access and health gains.*
    - *Additionally the increased role of MAPO and MDOs in working alongside the system with providers, started to see improved accountability, understanding and capability development on both sides – Iwi and government.*

[2] Includes information from https://www.parliament.nz/en/pb/research-papers/document/00PLSocRP09031/new-zealand-health-system-reforms

- **2001: District Health Boards (DHBs)** – reform led by Labour Government which reintegrated purchasing (into Planning and Funding commissioning teams) and service provision by hospital and health services.
    - *This effectively returned the system to an integrated funding and delivery model by the government health system. The system began to pull services back into its delivery arm and to use community-assigned resources for propping up escalating hospital costs.*
    - *The removal of the market approach heavily impacted Māori participation in the sector and the impact on Māori health outcomes through provision of expanded Māori-delivered care. In fact - many DHBs reduced their investments in Māori-delivered care, and most had poorly resourced 'Māori Relationship Boards' with minimal advisory influence and capacity. This period saw investment, participation, influence and dynamic transformation of the system completely flatline.*
- **2022: Health NZ and Māori Health Authority** – reform led by Labour Government which followed the Health and Disability System Review[3] (Simpson et al - report March 2020). The merger of the 21 DHBs into a single Health NZ and the creation of a Māori Health Authority were intended to address several challenges: New Zealand's diverse population with a history of experiencing significantly different health outcome; an indigenous Iwi Māori population frustrated by the lack of authentic participation and more effective options for kaupapa Māori care; increasing populations of Pacific peoples and a growing Asian population; more disabled people; an ageing population, and a rural population that often felt they were invisible to urban decision-makers. It was firmly acknowledged that New Zealand has a level of intergenerational poverty which negatively impacts on health outcomes. The health and disability system was identified as again (like the 1991 reforms) being under serious stress. Financially, it had difficulty managing within the resources provided to it for some years (DHB deficits were rampant).
    - *For Iwi Māori this period held both promise and trepidation. It was affirming to see that the government acknowledged that Iwi Māori participation (both as partners and as providers) had been heavily diminished and marginalised since 2001. Projected improvements in influence through Māori appointees on the Health NZ Board; the Māori Health Authority promise of change; the introduction of IMPBs – all provided positive signs and hope for change.*
    - *IMPBs wondered whether the new system would operate similar to the Health Funding Authority of the 1990s having a transformative, more market driven approach that invested in results and effectiveness. However there has been insufficient time to truly measure this.*
- **2024: Removal of Māori Health Authority** – reform led by National led Coalition Government.

[3] https://www.health.govt.nz/system/files/2022-09/health-disability-system-review-final-report.pdf

- *Our view is that while the MHA had merits, the entity was accountable to the Crown and not to Iwi Māori. IMPBs are best placed to hold this role and accountability and to maintain the significant role of whānau, hapu and Iwi voice; accountability back to Iwi (the Tiriti partner) and to drive the influence and change needed to make the system work for Māori and other vulnerable populations.*
- *IMPBs are best placed, and willing, to be the key Iwi Māori change agent in the system as our advice comes from whānau, hapū and Iwi – and IMPBs are mandated and supported by local Iwi.*

We urge the Government to re-energise its successful focus of working with Iwi Māori and Māori providers in the 1990s where our participation is "real', influential, effective and where is good return on investment - demonstrated by the movements in access to care, improved outcomes and impact on inequities. For this reason, the functions of IMPBs should not change.

IMPBs were invested in by taxpayers two years ago to be the voice of whānau, hapū, Iwi and communities the system. It would be negligent to waste that investment. IMPBs have recruited good governors (including health professionals / clinicians; academic leaders; Iwi Māori leaders; community voices) and strong teams - who have delivered community engagement; needs analysis; Community Health Plans; and monitoring reports. These tools provide us and the system with an evidence base to now influence commissioning and investment so that both we as Iwi Māori partners and taxpayers – and the Government – both achieve the results that we all deserve.

MĀORI HEALTH INEQUITIES HAVE PERSISTED OVER CENTURIES - WE NEED A CIRCUIT-BREAKER LIKE IMPBs WITH INFLUENCE

The health status of indigenous peoples worldwide varies according to their unique historical, political, and social circumstances. Disparities in health between Māori and non-Māori have been evident for all of the colonial history of New Zealand. Explanations for these differences involve a complex mix of components associated with socioeconomic and lifestyle factors, availability of health care, and discrimination. Improving access to care is critical to addressing health disparities, and increasing evidence suggests that Māori and non-Maori differ in terms of access to primary and secondary health care services. In some IMPB areas we have evidence from PHOs that as much as 30 – 40% of the Māori population is not enrolled in primary care.

Inequities have been recorded as far back as the 1950s – and still **the problem of Māori health inequity has not been solved - even after 85+ years** - by successive governments. It was our aspiration as IMPBs that legislated (and not advisory) roles in the health system would be the circuit-breaker to finally lead to transformative change. Advisory roles have not worked over the decades. Officials within the system choose whether to take the advice or not. Officials in the system are often entrenched in the usual way of doing things, despite the fact that evidence shows these typical approaches are not working. These 'typical' institutionalised approaches waste time, they waste taxpayer resources, and they do nothing but to entrench ineffective methods in the system to protect individual and institutional power and control positions. If our advice recommends further investment in Māori solutions to the issue – the reaction is that this

will lead to loss of control and power by those who currently hold it. The focus is not on addressing the inequities – it is on protecting the status quo.

The current Pae Ora legislative provisions for IMPB functions, ensure the system listens and acts and ensures IMPBs can hold those with authority accountable for Vote Health; for investing in what works (and not what is comfortable); and ensures the focus remains on addressing persistent inequities and achieving measurable outcomes. The current legislation makes the system listen to local knowledge and expertise offered by IMPBs. Every layer of the system from national to regional to local management in the hospital down the road – needs to be influenced to change. This can only be done with "boots on the ground" like IMPBs constantly engaging, solution-finding together, and officials acting on what the evidence (from whānau and from HNZ data) tells them works. IMPBs perform this role already and must be supported to continue this level of influence.

Data[4] from 1954 through 1975 provides a comprehensive overview of Māori health status. During this period, rates of cause-specific mortality, including deaths from respiratory diseases, infectious diseases, cardiovascular diseases, diabetes, cancer, and unintentional injuries, were higher among Maori than non-Maori. There is recent evidence of increasing cancer mortality rates among Māori; higher hospital discharge rates among both Maoris and non-Maoris increased in all age groups between 1970 and 1992, Maori rates continue to be 1.4 to 2.5 times higher than non-Maori rates. In 1997, compared with non-Maori rates, Maori hospitalization rates were 40% higher for both infectious diseases and respiratory disorders and more than 100% higher for endocrine disorders.

Government has the opportunity to rewrite the inequity story in New Zealand's history. But it must empower and enable Iwi Māori to have an authentic and real role in the health system – not advisory, not diminished, not marginalised. Functions in Section 30 of the Pae Ora Act must remain for this to occur. The consequence of not doing so is that the same reported inequities will be reported once again in the next 2 – 3 decades when likely more system restructures and reviews will occur.

OUR WAY WORKS! CASE IN POINT – COVID-19 SUCCESS[5]

A key success factor that helped prevent extensive illness and deaths among at-risk groups in NZ was the mobilisation of these groups themselves, including the rapid response by community health providers, Iwi and Māori organisations, and ethnic communities. Public submissions to the Covid-19 Royal Commission in 2024 praised Māori-led pastoral care and outreach to isolated community members (Māori and non-Māori), as well as similar efforts by Pacific communities.

The Royal Commission heard many examples of iwi and Māori health providers quickly adapting, developing new models, and taking a holistic and flexible approach to ensure their

[4] Ellison-Loschmann L, Pearce N. Improving access to health care among New Zealand's Maori population. Am J Public Health. 2006 Apr;96(4):612-7. doi: 10.2105/AJPH.2005.070680. Epub 2006 Feb 28. PMID: 16507721; PMCID: PMC1470538.

[5] NZ Royal Commission: Covid 19 Lessons Learned (Nov 2024) Lessons from Covid 19 to prepare Aotearoa New Zealand for a future pandemic

communities had ongoing access to essential services, including healthcare. The Ministry of Health recognised and supported the strength of this response – as one senior health official told the Royal Commission: '*Māori got the "why" of the protection measures and mobilised rapidly – sometimes ahead, sometimes more rigorously than the national response*'.

Māori have proven time and time again that we have the solutions to address stark health inequalities; to protect from illness (immunisation and screening); and to promote wellness through educating whānau around self-care. But the 'system' fails to recognise that Māori are more successful than HNZ or long-time mainstream services at addressing these challenges. Officials are afraid to shift the resources to those who deliver better results. We consider that this is a waste of taxpayer resources and continued missed opportunities to hit health inequities head-on.

THE SYSTEM HAS BEEN WRITING MĀORI HEALTH PLANS FOR DECADES – AND IT HASN'T MADE THE KIND OF IMPACT NEEDED

After 40 years of Māori engagement in health planning since the 1980s, Māori continue to face systemic inequities and poor health outcomes. Despite repeated input from Māori, the health system has failed to deliver on the promises of transformation.

Since 1984, Māori have participated in numerous health planning processes (e.g., Hui Whakaoranga, Whakamaua, Whānau Ora, Te Aka Whai Ora). Despite strong engagement, Māori health outcomes remain largely unchanged or worsening, particularly in chronic disease, access to services, and life expectancy. The process of engagement has often felt tokenistic and repetitive, with Māori constantly being asked for feedback without meaningful implementation or system transformation. Current processes risk being yet another "planning for planning's sake" exercise—fulfilling Crown obligations on paper without delivering real outcomes for whānau.

1. Persistent Health Inequities:

- Māori health statistics (e.g., cancer screening, CVD outcomes, life expectancy) remain worse than non-Māori.
- The only real improvement has been in smoking rates—other indicators either stagnant or are regressing.

2. Inadequate Investment in Māori Health:

- Investment in Māori providers remained under 2% until 2021, despite Māori making up ~20% of the population.
- Te Aka Whai Ora funding created some momentum, but new appropriations have stalled since 2022.
- Meanwhile there has been disproportionate growth in PHO and general primary care funding, where Māori are least well served. This is evidenced by the number who are not

enrolled in primary care and the number who are enrolled but not accessing services (yet PHO are funded for those whānau regardless). As an example, for one of our IMPBs (Te Tiratū) it is estimated that 21,000 Māori are not enrolled, and over 10,000 who are enrolled – have not seen a GP in the past 12 months[6]. These statistics are evidence across multiple IMPBs and demonstrate a failure of the current primary care system to adequately serve many Māori. Furthermore, it contributes to the ongoing burden of disease on both the whānau and the health system.

3. Systemic Failure to Implement Māori-led Solutions:

- Plans and strategies often incorporate Māori models (e.g., Te Whare Tapa Whā), but implementation is weak.
- There is no real accountability, resourcing, or performance monitoring to drive outcomes based on the agreed Māori health plans.
- Māori services that do succeed are not scaled or invested in further as current service providers and delivery models are entrenched in the system with little commitment or willingness to disrupt the status quo.

4. Disconnected Strategy-Policy-Practice Pipeline:

- Policies fail to translate into tangible action due to:
    - Misalignment of government priorities with grass-roots priorities
    - Lack of Māori provider support
    - Provider capture in the system
    - Inadequate evaluation and performance frameworks to disrupt providers and models that are not working (including ending contracts and resourcing for services that are not working)
    - Absence of consequences for poor performance

Example Case: Cardiovascular Disease (CVD) – Then vs Now:

- CVD disparities have persisted for over 20 years.
- E.g., Māori in Bay of Plenty are:
    - 2.2x more likely to be hospitalised for circulatory disease
    - 5.6x more likely to be hospitalised for heart failure
    - 3.9x more likely to die before age 75 from circulatory disease

[6] Te Tiratū IMPB: Hauora Māori Priorities Report – Sept 2024

- These data mirror early 2000s trends, showing a failure of the system to make progress despite decades of health plans.

Barriers to Transformation:

- There has been an absence of bold leadership willing to disrupt the status quo in transformational ways – often due to provider capture or fear of backlash from institutional providers
- There has been little or no decommissioning of ineffective services – despite evidence clearly showing failure to perform, over decades
- There has been a failure to scale or fund Māori-led services despite the repeated evidence that demonstrates they have major successes with whānau and communities (e.g. Covid vaccination and testing rates as one example)
- System's inertia and institutional racism

IMPBs are reluctantly engaging in yet another round of Crown-led health reforms but remain optimistic that Government will see that their investment to date in IMPBs, and the promise of real transformation, resides in their hands by retaining IMPB roles in Section 30 of the Act.

The health system has amassed an archive of Māori input over 4 decades - but failed to transform the system. Iwi Māori are no longer satisfied with performative planning exercises. Without radical system shifts, investment, and power-sharing, the status quo will persist and we will see the significant health inequities persist. Taxpayer funds will continue to be wasted through ineffective responses that lack support from Iwi. The next steps must include transparent accountability, targeted funding, and a reset of Crown-Māori health partnerships grounded in Te Tiriti o Waitangi through retention of Section 30 functions.

THE GOVERNMENT COMMITTED TO WHĀNAU ORA – THE SAME DECISION CRITERIA NEED TO APPLY TO IMPBs

Te Puni Kokiri[7] noted in a report to the current Minister of Māori Development, that since 2014, Whānau Ora commissioning has achieved positive results for whānau in need. It is because of these positive outcomes, which have been both externally verified and publicly demonstrated during the COVID pandemic, that Whānau Ora has become an exemplar of the value of devolved services; supported by government, but locally led within communities.

One of the critical strengths of Whānau Ora has been that it fosters locally led devolved services. Based on the evidential base we consider this is a better way to effectively deliver many social services to whānau – as opposed to direct government services, or services focused on a singular type of need, or individual person. Despite the positive evidence base, including returns on investment and recommendations from the Auditor-General for agencies to

[7] Te Puni Kokiri: HEI WHAKATAU | BRIEFING: Strategic Review of Whānau Ora (31 March 2025)

engage further, Whānau Ora has not been extended across the public sector and remains almost solely within the remit of Te Puni Kōkiri.

Following the Government-led procurement process, new Commissioning Agencies were selected and contracted. Region 1 includes two IMPBs backed by their Iwi as part of the commissioning consortium. Region 2 is Iwi-led. Region 3 is IMPB-led and Iwi mandated. For Government to have been satisfied that Iwi and IMPBs could lead the oversight, management and investment of $155m p.a. yet not commit to ongoing IMPB roles and functions at a mere cost of $15m p.a. is an inconsistent policy approach and sends mixed messages.

"GOING FOR GROWTH WITH MĀORI": TONUI MĀORI INFRASTRUCTURE INVESTMENT

The Government's "Going for Growth" agenda is structured around five main themes aimed at boosting New Zealand's economic growth and productivity[8]:

1. Developing Talent: Building a skilled workforce to meet future economic needs.
2. Fostering Competitive Business Settings: Creating an environment that supports business growth and innovation.
3. Promoting Global Trade and Investment: Expanding international trade and attracting investment.
4. Advancing Innovation, Technology, and Science: Encouraging innovation to drive economic progress.
5. Investing in Infrastructure for Growth: Supporting sustainable development through infrastructure projects.

These themes are interconnected and designed to create a dynamic, sustainable economic environment for long-term prosperity. The priorities and strategies of the Minister for Māori Development to accelerate Māori economic growth as part of the Government's "Going for Growth" agenda – align well with the contribution of IMPBs.

Government's goal is to double the Māori Economy by 2035: The Māori economy currently contributes 8.9% to New Zealand's GDP ($30 billion in 2023) and aims to grow significantly over the next decade. Healthier whānau Māori are needed if we are to contribute to Māori economic growth. Jobs in health are needed whether with Māori providers or across health professions. Iwi Māori potential for investment in health infrastructure and technology has not been explored – but is something IMPBs can facilitate and mediate if they have a role in health planning and commissioning. Increasing Māori 'suppliers' into the health system in areas such as property management, technology, cleaning and maintenance, construction – are again opportunities that can be enhanced by IMPBs if they retain their role in innovating commissioning.

[8] NZ Government: Going for Growth with Māori | Tōnui Māori: Minute of Decision [CAB-25-MIN-0086.03]

The Government's Going for Growth strategy aims to empower Māori communities, unlock economic opportunities, and contribute to New Zealand's overall prosperity. IMPBs can play a key role in driving these same goals across the health system, but they must retain their resourcing, and their legislated role, to have the influence needed to do so.

CONCLUSION

We seek retention of all IMPB functions outlined in Section 30 of the Healthy Futures (Pae Ora) Amendment Bill. The proposed changes undermine Te Tiriti commitments, equity, and iwi, hapu and whānau authority and they undermine our joint ability to tackle health inequities that have persisted for far too long.