**IN THE HIGH COURT OF NEW ZEALAND**
**WELLINGTON REGISTRY**

**I TE KŌTI MATUA O AOTEAROA**
**TE WHANGANUI-Ā-TARA ROHE**

**CIV-2021-485-**

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| **Under** | The Judicial Review Procedure Act 2016 |
| **And** | Part 30 of the High Court Rules |
| **Between** | **TE POU MATAKANA LIMITED** trading as **WHĀNAU ORA COMMISSIONING AGENCY** an incorporated company at Auckland, Whānau Ora provider<br><br>First Applicant |
| **And** | **WHĀNAU TAHI LIMITED** an incorporated company at Auckland, IT and information systems provider<br><br>Second Applicant |
| **And** | **ATTORNEY-GENERAL** sued in respect of the **MINISTRY OF HEALTH**<br><br>Respondent |

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# MEMORANDUM OF COUNSEL FOR THE APPLICANTS SEEKING URGENT SUBSTANTIVE HEARING

11 November 2021

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**May it please the Court:**

## Overview

1. This proceeding is a sequel to this Court's judgment released last week in *Te Pou Matakana Ltd v Attorney-General* [2021] NZHC 2942.

2. In that earlier proceeding, Te Pou Matakana Ltd (trading as the Whānau Ora Commissioning Agency (**WOCA**)) and Whānau Tahi Ltd brought judicial proceedings challenging the Ministry of Health's refusal to provide information necessary for the applicants to identify unvaccinated Māori and provide targeted and appropriate vaccine delivery to those Māori. The proceeding was accorded urgency, given its subject matter.

3. In the Court's judgment last week, Gwyn J ordered the Ministry to urgently retake its decision (within three working days) in accordance with the law and in accordance with the judgment.[1]

4. The Ministry retook its decision on 5 November 2021 and again declined the applicants' request. The applicants seek judicial review of the Ministry's new decision. They say that it contains multiple errors of fact and law (some of which repeat errors from its first decision).

5. On the basis of its urgent imperative to ensure more Māori are vaccinated against COVID-19, the applicants respectfully seek an urgent teleconference and expedited timetabling directions for a substantive hearing. Given Gwyn J's familiarity with the matter, the applicants also respectfully request that the matter is allocated to her Honour as that will assist with the expeditious hearing and determination of the proceeding.

## Purpose of the proceeding

6. The applicants are part of the Whānau Ora network of entities. Whānau Ora is a whānau-centred approach to the delivery of support services, established following recommendations that relationships between

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1 *Te Pou Matakana v Attorney-General* [2021] NZHC 2942 at [135].

Government, service providers, iwi, whānau and hapū reflect the spirit and intent of the Treaty partnership.

7. The percentage of the eligible Māori population who have received COVID-19 vaccinations is materially lower than the percentage of other eligible populations.

8. The Whānau Ora network is trying to reach out to as many unvaccinated Māori as urgently as possible to provide them with culturally compatible vaccination outreach services in an attempt to prevent or lessen the serious threat posed to Māori by COVID-19. They are seeking individual level data to enable them to properly target their services directly to the unvaccinated.

9. Following this Court's last judgment, the Ministry has retaken its decision (for reference a copy of the Ministry's decision paper is **attached** to this memorandum). It concluded the information can be shared, and sharing it would be consistent with its Treaty obligations and tikanga. However, it declined to share data for the unvaccinated Māori in Te Ika-a-Māui. Instead, the Ministry decided to adopt a more granular "rohe by rohe", "provider by provider" approach. The applicants say that this decision contains material errors of fact and law, set out in the statement of claim.

10. By way of example, the Ministry determined that it was not appropriate to share data for Te Ika-a-Māui because the applicants had "patchy" coverage in some areas (decision paper at [33]). The only two areas identified were Tairawhiti and Wairarapa, where the Ministry said that other providers were operating (at [34]). However, the other providers identified by the Ministry are Whānau Ora providers (and were included in the list of Whānau Ora providers put into evidence by the applicants in the previous proceeding).

11. In the decision, the Ministry said that it supported providing the applicants with further data and invited them to prioritise discussions in relation to Tāmaki Makaurau and Kirikiriroa (at [48]). The applicants have taken up that invitation but have, regretfully, concluded that it is necessary to bring further judicial review proceedings challenging the new decision because:

11.1 they consider the Ministry's approach is wrong and unless it is set aside it presents a roadblock to the provision of data on the scale required to deal with the seriousness and urgency of the threat posed to Māori by COVID-19; and

11.2 the further discussions to date with the Ministry have been underwhelming and revealed that the Ministry envisages sharing very little data with the applicants—the Ministry's initial proposal was to have discussions about whether the Ministry would share data for 15 suburbs in Auckland where the total number of unvaccinated Māori across all suburbs is only 180 (out of a total unvaccinated Māori population of about 27,000).

12. If the Ministry's approach is adopted for the remainder of Te Ika-a-Māui, the narrow window available to protect as many unvaccinated Māori as possible before the relaxation of border restrictions in Tāmaki Makaurau for Christmas will be lost, together with the ability to prevent significant increases in the rates of COVID-19 amongst Māori and to prevent increases in the rate of Māori deaths from COVID-19.

**The need for urgency**

13. The Court has already recognised the urgency of the underlying issues when it accorded priority to the previous proceeding. The urgency has only grown since then and the applicants respectfully ask that this proceeding is also accorded priority. In short, the reasons for the urgency are that:

13.1 There are currently active and spreading cases of COVID-19 in Tāmaki Makaurau, Waikato, and Te Tai Tokerau. Since the applicants filed their first proceeding on 7 October, there have been an additional 1,504 confirmed cases of COVID-19 among Māori.

13.2 The Government has announced a transition from the strategy of eliminating COVID-19 to lessening restrictions in Tāmaki Makaurau, which will see more cases of COVID-19 in the community. Its new strategy relies on increased vaccination rates to

prevent the spread of infections. It has also committed to allowing Aucklanders to travel for Christmas.

13.3 Māori are at higher risk than the general population of contracting COVID-19. Currently about 43 per cent of cases are in Māori people, whereas Māori make up 16.5 per cent of the general population.

13.4 Māori remain vaccinated at lower rates than any other population group. Only 74.9 per cent of eligible Māori having received a first dose and 58.1 per cent a second dose. This compares with 89.5 per cent of the total eligible population who have received a first dose and 79.2 per cent who have received a second dose.

13.5 Māori are at higher risk of more severe outcomes if they do contract COVID-19.

13.6 As the global rate of vaccination increases, social licence for and compliance with ongoing restrictions diminishes.

13.7 As a result, unvaccinated Māori are increasingly at risk of serious harm and loss of life.

13.8 Even once the information is provided to the applicants and currently unvaccinated Māori are booked in for vaccination, it will take five weeks from receipt of a first dose for an individual to become fully vaccinated (minimum three weeks between two doses and two weeks following the second dose for full immunity to take effect). When the first proceeding commenced, there was sufficient time for the applicants to use the information to make a material difference before restrictions were relaxed. The ability to do so in the current timeframe is diminishing rapidly.

14. The applicants respectfully request an urgent substantive hearing of their application. If urgency is not afforded to the application, the outcome the applicants seek to avoid—further spread of COVID-19 in the community among vulnerable and unvaccinated Māori—will come to pass.

**Directions sought**

15. An urgent case management conference is sought to settle an expedited timetable and allocate a hearing date.

16. Counsel for the applicants suggest the following orders:

    16.1 Evidence in support of the application to be filed and served by Friday, 12 November 2021. (The applicants intend to file as much of their evidence as possible today but given witnesses availability it may be that some affidavits are not provided until tomorrow.)

    16.2 Any statement of defence to be filed and served by Monday, 15 November 2021.

    16.3 Any evidence in opposition to be filed and served by Wednesday, 17 November 2021.

    16.4 Any evidence in reply to be filed and served by Friday, 19 November 2021.

    16.5 Submissions for the applicants to be filed and served by Sunday, 21 November 2021.

    16.6 Submissions for the respondent to be filed and served by Tuesday, 23 November 2021.

    16.7 A one-day fixture to be allocated at the earliest opportunity, if possible before Gwyn J on Thursday, 25 November or Friday, 26 November.

    16.8 Leave is reserved for further directions as required.

17. The applicants also note that some of the evidence from the previous proceeding will be of ongoing relevance. To expedite matters, the applicants seek a direction that the evidence from the previous proceeding may be referred to in this proceeding. In this respect the applicants note their understanding that a copy of all of the evidence and submissions from

the previous proceeding was attached to the decision paper and before the decision-maker.

11 November 2021

JB Orpin-Dowell / MRG van Alphen Fyfe / TJG Allen
Counsel for the applicant

MINISTRY OF HEALTH
MANATŪ HAUORA

# Memo

## Reconsideration of WOCA data request

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| **Date:** | 5 November 2021 |
| **To:** | Ashley Bloomfield, Director General of Health |
| **Copy to:** | John Whaanga, Deputy Director-General, Māori Health<br>Phil Knipe, Chief Legal Advisor, Health Legal |
| **From:** | Jo Gibbs, National Director, COVID-19 Vaccine and Immunisation Programme |
| **For your:** | Decision |

## Purpose of report

1. This memo seeks your decision to share information with the Whānau Ora Commissioning Agency (WOCA) and Whānau Tahi Limited from the Ministry of Health's COVID-19 Vaccine and Immunisation Programme datasets, including the COVID-19 Immunisation Register (CIR), for the purposes of reaching unvaccinated populations.
2. The High Court Judge in *Te Pou Matakana Ltd v Attorney-General* [2021] NZHC 2942 found that the Ministry had made an error of law by approaching whether disclosure of the information was "necessary" to prevent or lessen the threat of COVID-19 in the context of rule 11(2)(d) of the Health Information Privacy Code without adequately considering the specifics of the applicants' request. An evidence-based assessment is required in which the decision is exercised in accordance with the principles of the Treaty/Te Tiriti o Waitangi and tikanga.
3. Attached to this memorandum is a set of the evidence that was before the High Court together with a copy of the Court's judgment. We also attach correspondence from iwi and others consulted on the decision who were comfortable expressing views on the record as well as some data visualisations illustrating Māori vaccine uptake around the North Island and WOCA partner locations.

## Information request

4. The request began life seeking vaccination data for all Māori including clinical information not directly relevant to vaccine outreach activities. Following refinement, the request is at this point for personally identifiable data for people recorded as domiciled in the North Island and identifying as Māori in the CVIP dataset. Specifically it is for the data of all Māori in the North Island who have had no vaccine dose and those who have had only one dose. The data required for each person includes NHI number, name, demographics, contact details and vaccination status.
5. As at 5 November 2021, the number of Māori in the North Island captured by this information request is 252,548.

## Rule 11(2)(d) of the Health Information Privacy Code

6. Rule 11(2)(d) allows the Ministry to disclose information if it believes on reasonable grounds that the following three considerations are met:
   a. It is not desirable or practicable to obtain authorisation for the disclosure from the individual concerned.
   b. There is a serious threat to public health or public safety, or the life or health of the individual concerned or another individual.
   c. Disclosure of the information is necessary to prevent or lessen that threat.
7. The Rule confers a discretion to release the relevant information, not an obligation to do so.

## Approach to decision

8. The background to the request is set out in the decision paper of 19 October 2021 and the affidavits. Although vaccination rates have increased since that time, the threat presented by COVID-19 remains and Māori vaccination rates continue to lag behind the general population. COVID-19 represents a serious threat to public health, and Māori are disproportionally impacted by the current Delta outbreak in those locations where it is occurring. As at 3 November 2021, 35.9% of the cases reported in the delta outbreak are Māori, and of the cases reported in the past twenty-four hours 46.8% are Māori.
9. The situation requires appropriate responses that have the best chance of bringing about equity in outcomes for Māori. It remains the Ministry's goal to reach all eligible people so that they can receive two doses, appropriately spaced, as soon as possible. The Ministry also remains committed urgently to support alternative approaches where existing pathways and systems have not proved successful at this point, and to engage organisations, including the applicants, which, through their community networks, are positioned to reach individuals who are unvaccinated. Given the breadth of the personal information sought by the request, it remains impractical to obtain the consent of the individuals concerned.
10. As the serious threat threshold is satisfied and it remains impracticable to obtain individual consent, the key issue for your decision is whether disclosure is necessary to prevent or lessen the threat and, then, whether, in the Ministry's discretion it should, in all the circumstances, disclose the information.
11. The recommendations in this paper are therefore framed around the following headings:
    a. Should the Ministry be satisfied that the conditions of rule 11(2)(d) of the Health Information Privacy Code are met, considering:
       i. the information the applicants seek;
       ii. how it is going to be used and whether it will be effective to address the risks associated with the COVID-19 pandemic;
       iii. any anticipated health-related disadvantages of the disclosure;
       iv. other less privacy-intrusive options that are still effective to address the risks; and
    b. if the conditions in rule 11(2)(d) are met, should the Ministry exercise the discretion to release the requested information.

12. The COVID-19 vaccination and immunisation programme is guided by the principles of the Treaty/Te Tiriti o Waitangi. The Judge directed that the power to disclose must be exercised in accordance with the relevant principles, being:

    a. ***Partnership***: the Crown is required to work with Māori in partnership in the governance, design, delivery, and monitoring of the response to COVID-19.

    b. ***Tino rangatiratanga***: this provides for Māori self-determination and mana motuhake. This means that Māori are key decision makers in the design, delivery, and monitoring of health and disability services and the response to COVID-19.

    c. ***Options***: the Crown is required to provide for and properly resource kaupapa Māori services and ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

    d. ***Equity***: the Crown is required to commit to achieving equitable health outcomes for Māori and to eliminate health disparities resulting from COVID-19. This includes the active surveillance and monitoring of Māori health to ensure a proportionate and coordinated response to health need.

    e. ***Active Protection***: the Crown is required to act, to the fullest extent practicable, to protect Māori health and achieve equitable health outcomes for Māori in response to COVID-19. This requires the Crown to implement measures to equip whānau, hapū, iwi, and Māori communities with the resources to undertake and respond to public health measures to prevent and/or manage the spread of COVID-19.

13. The tikanga principles engaged to have regard to are mana, whanaungatanga, and kaitiakitanga, manaakitanga, and tapu.

## Consultation

14. We have invited the applicants to provide any further evidence they wish us to take into account in re-considering the request and they have provided some further information. We have also consulted with some of the group of iwi leaders that Ministers have met with regarding the pandemic response as well as with a range of Māori health experts and representatives from Māori organisations. Participants included the New Zealand Māori Council, the New Zealand Māori Authority, FOMA, Drs Rawiri Jensen and Rawiri Taonui, and the representatives of eight iwi for the Pandemic Response Group.

15. We endeavoured to invite a broad representation of Māori leaders, recognising the tight timeframes within which the conversations could take place. The engagement was with the intention that we hear from Māori leaders in order to ascertain the range, content and extent of the Māori rights and interests which may be affected by the disclosure sought, and how those interests may be affected, in order to inform your decision in light of the principles of the Treaty/Te Tiriti and relevant tikanga.

16. Some members of the Iwi Leaders Pandemic Response Group expressed a view that the appropriate tikanga recognises that information about individuals is taonga, and that there is a data sovereignty interest in play. For each iwi there is a data sovereignty relationship, with the information about the individuals who are whanau and Māori in their rohe. That personal data should not be shared with organisations that do not have a mandate for iwi information on the basis they are not partners with the Crown. Some iwi leaders indicated they have a greater interest in meshblock-level information so that we can work out which areas to focus

on together. Since the meeting, we have received a number of requests for individual level data for particular rohe.

17. Te Rūnanga o Ngāi Tahu expressed the view that given a significant number of Ngāi Tahu whānui reside in Te Ika-a-Maui, their personal information will be impacted by the applicants' request. We heard that personal health information about Māori is a taonga and should be treated with respect and protected. Decision making over Māori personal health information can be regarded as an exercise of rangatiratanga, and that appropriate processes should be followed. We were told that releasing information about all Māori who live in an area, without engaging with the iwi who are recognised as representatives for that area, would adversely impact on the ability of those iwi and hapu to exercise rangatiratanga in relation to information about their whanau and visitors to their rohe. We understand, for example, from Ngāi Tahu, that this would be the case if the information were to be shared with an entity that is not a Treaty/Te Tiriti partner and has no authority to speak on behalf of Ngāi Tahu whānui.

18. Te Rūnanga o Ngāi Tahu also expressed concerns that given the lack of trust many Māori have in government institutions, and given the discussion centres around some of the most sensitive personal information held by the Crown about Ngāi Tahi whānui (ie health information) it is imperative that proper process and the appropriate principles are applied in deciding whether to disclose the personal information requested. We were told that if the Crown distributes highly sensitive personal information in a way that does not properly consider the context surrounding that information this will further decrease the trust Ngāi Tahu whānui will have in the Crown and will discourage people engaging with the health system.

19. Some Māori health experts expressed views that in the circumstances it was both appropriate and necessary for individual level data to be shared with Māori organisations and providers that are directly mandated to work with Māori in their communities. There was acknowledgement that the serious threshold required to share data at an individual level is high but that, in light of the COVID-19 pandemic and the particular risk the Delta variant poses to Māori, the necessity threshold has been met in a general sense. There was a consistent view that the community and the people need to be protected, that Delta could be devastating for Māori, and that what counts is protecting the community and the people and making good decisions to support and protect whanau.

20. We heard that data is needed to ensure that Māori families are safe, healthy, and alive. Access to the data for providers needs to be managed to ensure access to vaccination for Māori families. COVID-19 and the likely variants have been known about for a long time. Māori are tired of feeling invisible. We also heard that the approach that will make a difference for the 20 to 34 age group is sitting down and talking to them. People want face to face conversations, and for people to answer their questions.

21. Different views were expressed about the appropriate level of data sharing. In contrast to the focus on iwi, the New Zealand Māori Council for example emphasised the role of hapu and the need to work with and empower (through funding and data) Māori agencies that represent or are directly mandated by communities on the ground, and which empower those communities to respond to the issue by talking whanau to whanau.

22. I have attached the notes from the relevant hui for you to consider.

23. In relation to views expressed that the Crown should not share Māori health information with those who are not Treaty partners, I note the Crown accepts that it contracts WOCA and its

providers in part on the basis of their reach and relationships within the relevant areas, and we are aware that the Waitangi Tribunal in the *Waipareira* report has acknowledged that in certain circumstances urban non-kin based groups exercise rangatiratanga in relation to their groups, and in that sense can be considered Treaty partners.

24. In terms of what can be taken from the consultation more broadly, it is clear that information at both an individual and collective level is viewed as taonga by iwi and hapu. It is also clear that data is required to support vaccination outreach, including on an individual level in some cases. That individual and collective level data is viewed as taonga engages mana and rangatiratanga concepts and applies both to the rohe of iwi and to affiliated individuals who are part of the relevant collective. The issue we are invited to consider is not simply the Treaty and tikanga considerations about whether the information should be disclosed, but also the question of to whom.

## Rule 11(2)(d) – Necessity threshold

25. As noted, the key issue is whether disclosure is necessary to prevent or lessen the threat presented by COVID-19. As the Judge noted, that question falls to be considered under the following headings.

### How is the information going to be used?

26. The applicants have stated to the High Court that they intend to use the individual data in their outreach process. WOCA has a network of 96 Whānau Ora partner providers across the North Island. These providers have 200 COVID-19 vaccinations sites. The providers based in Auckland have provided services through establishing semi-permanent vaccination centres for large-scale vaccinations, clinic-based appointments at existing healthcare services, and mobile vaccination clinics. The latter service allows for the location of the mobile clinics to be widely advertised in the local community, for Māori to be vaccinated close to their homes at a time that suits them, and for other COVID-19 services to be offered as well (including saliva testing, hygiene packs and kai packs).

27. The outreach process proposes to help target these vaccination strategies further. The process involves the data provided by the Ministry being stored in the Secured Navigator Datastore, which is only accessed by Whānau Tahi staff working directly on the data. The data is then used in two different ways:

    a. Call lists would be extracted and provided to WOCA's Whānau Tahi Navigator system so WOCA's call centre can directly contact individuals by text or call. Direct contact by WOCA would involve obtaining consent from individuals to refer them to a WOCA partner organisation for vaccination. Following the referral, the WOCA partner organisation would make contact with the individual to initiate the Whānau Ora process, including wrap around vaccination services. If the individual has opted out of the vaccination programme or is deceased, their information would be updated and fed back into the Secured Navigator Datastore and the Ministry notified.

    b. The data is fed through Whānau Tahi's GIS mapping system to generate maps, which highlight streets/zones to target and do not hold any individual data. Those maps are given to WOCA partner organisations to provides vaccination resources in the target areas. The information would be held in those providers' respective Whānau Tahi Navigator systems. WOCA's partners make contact with individuals and initiate the Whānau Ora process, including vaccination offers.

28. Identifiable individual data is required for the first part of the "outreach process". SA1 level maps support the second part of the "outreach process", but identifiable individual data is also necessary to narrow the target areas. WOCA maintains that both parts of the process are necessary for an effective strategy.

## What evidence is there that the proposed use will be effective to address the risks associated with COVID-19?

29. Since 27 September 2021, the Ministry has provided vaccination status data to WOCA for people enrolled with their providers. WOCA has reported, using CIR data, that in the period from 27 September to 29 October:

    a. "The number of our eligible clients who have received dose one increased from 36,106 to 51,398, an increase of 15,292 or 42%."

    b. "The number of our eligible clients who have received dose two increased from 17,562 to 33,470, an increase of 15,908 or 91%."

30. Further, WOCA reports, "On average, our providers in the North Island administered 1,486 doses per day to Māori (over the 21-day period). Across the country, Ministry data shows that 4,642 doses per day were administered to Māori. This means that in the period WOCA providers administered 32% of the doses delivered to Māori." This indicates that in areas where WOCA providers are present, it plays a material role in the vaccination rates.

31. However, when broken down to a more granular level, the data suggests that WOCA's reach and coverage is not spread evenly across the North Island. Evidence also indicates that the effectiveness of phone calls from people without an existing relationship has diminishing effect. Whakaronogorau outreach was implemented from call centres based in contact centres in Auckland, Kaikohe, Ōtara, Rotorua, Heretaunga, Wellington, and Christchurch and from homes across Aotearoa, including speakers of te reo Māori. Evidence suggested the progressively diminishing effectiveness of the calls.

32. WOCA's proposal is that call lists would be extracted and provided to WOCA's Whānau Tahi Navigator system so WOCA's call centre can directly contact individuals by text or call. Mr Tamihere has stated that the lack of trust Māori have in government services, including Whakarongorau, and the fear of judgement can be overcome by the Whānau Ora approach when directly contacting Māori. However, the proposal does not indicate what would be different between the approach that WOCA is proposing and the approach taken by Whakarongorau for many parts of the North Island. So it is not clear at this stage its approach to phone-based outreach to people without any existing relationship with a provider is likely to be materially more effective for Māori.

33. Ministry data also shows Māori vaccination rates are improving quickly, as evidenced by the timescale of the last four weeks. We have mapped the vaccination uptake rates for Māori and can identify areas where approaches to drive uptake are working well, and areas where there is more work to do. In particular, there seems to be a need for a focus on increasing vaccination rates in large rural and remote areas. When we overlay the location of WOCA providers, as shown in the attached data visualisation maps, the information indicates they have presence in multiple locations across the North Island, but the coverage is patchy. Moreover, there are areas where considerable progress has been made without the provision of the individual person data requested by WOCA. The significant progress is due to many

vaccination partner agencies working with DHBs and the Ministry. The intent of the Ministry is to continue to work with many vaccine delivery partners, including Māori providers.

34. We have viewed the WOCA request in the context of what is happening across the North Island at the current time. Below are several examples of regions in the North Island where there are existing arrangements and approaches in communities, working together to deliver vaccinations, using data at a granular level.

    a. **Tairawhiti/East coast:** Hauora, Iwi, Council and community organisations have recently implemented a partnership to vaccinate communities. The Tairāwhiti region includes pockets of geographically isolated areas, rurally dispersed communities, low socio-economic areas that are heavily influenced by gangs, and vast areas of sparsely populated hill country and coastlines. Areas of low vaccination uptake include: Ruatoria-Raukumara, Waipaoa, East Cape , Kaiti South, Outer Kaiti, Elgin and Tamarau. Since the onset of the vaccination programme, Tairāwhiti has taken a 'community response to a community issue' approach working with the two local iwi providers and the DHB. They have a five-way partnership agreement between four health providers, including PHO, and the Tairawhiti DHB, supported by all regional agencies such as education, performing arts and led by local government using emergency management partnerships. This approach crosses DHB boundaries and includes the Wairoa community. Providers in Tairawhiti already have access to individual level data about their people, as well as small area unit data about areas where people are unvaccinated. The approach is designed to achieve the wellbeing aspirations of Ngāti Porou, Te Aitanga a mahaki, Ngai Tamanuhiri, Rongo Whakata, Te Aitanga-a-Hauiti, Te Whanau a Kai.

    b. **Wairarapa:**

        i. Te Whaiora: Tekau Mā Iwa is a COVID-19 vaccination clinic born out of an iwi-led kaupapa centred on a pandemic resurgence response for Wairarapa mana whenua. In recent times the clinic has been a static model contributing to the wider strategy which has helped to enable 44.2% of Wairarapa Māori to be vaccinated against COVID-19. Whaiora has strong network links into multiple communities in Wairarapa, which includes an established trusting relationship with local (and national) gang leaders they intend to use as champions of the kaupapa within their whanau as the Mongrel Mob and Black Power have been affected by COVID-19 in Hauraki, Auckland and Waikato – they are aware of the impact COVID-19 has on their whanau and their whakapapa. Their pop up at McJorrow Park at the beginning of October was successful, and it is their intention to have a regular presence in the neighbourhood to increase the opportunity for whānau to ask questions, get clarity and trust – with the outcome being increased wellness and engagement with health providers.

        ii. Te Hauora Runanga o Wairarapa Inc (Te Hauora) has been providing kaupapa Māori services to Māori since 1985, when a group of Māori community workers noticed the service delivery gaps. They deliver community alcohol & other drug addiction counselling, mental health support, Whānau Ora navigation partnered with Te Hauora whānui and Te Pou Matakana, a collective impact to reduce childhood obesity in a Kura Kaupapa, Oral Health and Whānau direct for small contributions to whānau aspirations, Kaimahi Rongoā (mirimiri, Rongoā) health strategies for Whānau, Youth Justice support Rangatahi, Whānau Resilience, Peer support, and Parenting and Family safety advocacy for women in violence.

iii. The delivery of services across the Wairarapa is two-fold – covering a geographic of 2,500km ranging from Lake Ferry to Pukaha, Mt Bruce, included the three Territory Local Authorities: Masterton (25,200), Carterton (9,060), and South Wairarapa (9,528). Te Hauora is located in the Masterton CBD where they can direct the right resources to where they are needed and be more fluid and flexible in their approach. Being a kaupapa Māori provider enables them to take a holistic approach to wellbeing. They engage with tupuna and atua Māori. This engagement is using traditional Māori values and clinical expertise to navigate their whānau to better world views for themselves in today's society. They provide services to all New Zealanders who require their support; where 90% of their clients are Māori, and a further 5% are Pacific, with the remaining 5% being European or other ethnicities. Last year, they engaged with over 3,500 whānau across their services.

35. As with the support provided to the applicants, to progress these sorts of initiatives we have entered into an agreement to share meshblock level vaccination data with the Data Iwi Leaders Group. The Data ILG is part of the Iwi Leaders Group and one of its objectives is to enable the wellbeing of Māori people by enabling iwi, hapū and whānau Māori to access, collect and use Māori data to measure and identify areas of Māori wellbeing that require change. The roles include facilitating access to strategic level information for iwi groups through Te Whata, its data platform tailored specifically by iwi for iwi. The support provided through Te Whata is able to provide iwi, hapū and whanau Māori with access to insights from the vaccination data. This is important as many currently lack their own data infrastructure and capability and require government investment in those areas.

36. In terms of the necessity of sharing individual information with WOCA, the specific examples noted above relating to Tairawhiti and Wairarapa demonstrate that in some areas where WOCA provider coverage is more limited very positive progress is being made. In contrast, some urban areas – including areas where the current Delta outbreak is occurring in parts of Auckland and Hamilton – where WOCA providers have better coverage, there is real need for targeted resource to support further progress. It would be difficult to justify the "necessity" of providing WOCA individual data in the former examples whereas in the latter the case may be particularly strong. These regional variances in terms of WOCA coverage, threat level, and coverage by alternative providers supports a more granular "rohe by rohe", "provider by provider" approach. It suggests viewing the entire North Island as a single rohe so far as urban or rural "unaffiliated" Māori are concerned is too blunt a tool. Overall, we consider there is evidence to suggest WOCA's proposed use of the information, given its breadth, may be effective to address the risks associated with COVID-19 in relation to some areas, but the evidence is not so clear it would have an impact in all others.

## Are there any health-related disadvantages of the disclosure?

37. We have heard a range of views which have expressed concern about the erosion of trust and confidence in the health system, and the Crown more generally, associated with sharing individual level Māori personal information. DHB Chairs were particularly concerned about the risks involved with public perceptions that sensitive health information was to be disclosed without consent. They were concerned about precedent setting. They also noted that vaccine hesitancy among Māori, including within whanau, was a controversial issue and highlighted the risks associated with bullying and vilification of the unvaccinated if they could be

identified individually. Related concerns involved saturation and overload in terms of individuals receiving repeated contact from different providers. Anxiety and avoidance (of the health system) were highlighted as concerns for those with mental health and addiction issues who may feel bombarded or targeted. Generally, any loss of trust in the health system could be expected to produce health-related disadvantages, both in relation to vaccine uptake and engagement with health services more generally.

38. However, we would not recommend placing too much weight on these concerns in the current context. The Judge directed an evidence-based assessment and, beyond the authoritative status of some of those consulted within the Māori health professional community, the risks identified relate to matters which are difficult to measure at all let alone in the time available. For the same reason, however, we would not recommend placing great weight on the notion that protections provided by privacy law induce any comfort among relevant populations. We see little evidence to support that. Indeed, the number and tone of the complaints received by the Ministry since delivery of the High Court's judgment suggest the prospect of sharing individual Māori health information with the applicants has given rise to considerable anxiety for some.[1] So at best we would see these risks as neutral factors.

## Are there other less privacy-intrusive options that are still effective to address the risks?

39. Any data sharing agreement would be subject to stringent controls. Given the concerns expressed by iwi and others, a potential weakness of Whanau Tahi's process in this space arises from its lack of iwi oversight in governance terms. It is a private company operating in accordance with ordinary commercial incentives. Further consideration could be given to requiring through data sharing agreements some form of iwi oversight in relation to the use of any Māori health information provided for the duration it is held. While these sorts of options are available to explore, it is preferable in our view to restrict sharing of information to that which is necessary to achieve the purpose of confronting the risks associated with COVID-19.

40. A less privacy intrusive alternative to the applicants' broad request is to share smaller sets of personal information with trusted locally-based organisations, with an expectation they work together to reach the unvaccinated populations, as with the Tairawhiti example. Sharing information with providers who work locally on the ground, with local relationships and who can engage face to face with individuals, is a model that can be built with the consent and partnership of the relevant local iwi, hapu and whanau, and the evidence suggests it is more likely to build trust and confidence in the way information is used. Sharing datasets with local organisations, with an expectation that they work together and coordinate their effort, as with the Tairawhiti example, also reduces the likelihood that an unvaccinated person is approached in an ad-hoc way by multiple, different providers. This work is being progressed urgently and

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[1] The Ministry has received correspondence from some individuals who explicitly withdraw their authorisation for the sharing of their personal information with the Whanau Ora Commissioning Agency. The authorisation to share health information in line with the Health Information Privacy Code is sought at the time that people enrol in health services. Where people have communicated to the Ministry that they revoke that authorisation, the Ministry would need to implement a process to remove them from any information to be shared. It is likely there will be other individuals who similarly would revoke their authorisation but will not know how to communicate it.

the Ministry is currently processing a rapidly growing number of data sharing requests from Iwi and health and social services providers servicing Māori communities (with 4 processed today alone covering populations of more 100,000 people).

## Conclusions

41. Taking these considerations into account, we do not consider that it is necessary to share the North Island individual level Māori health information sought by the applicants on the broad basis it has been sought. Although the request has been narrowed from its original focus on the entire country and information which was not relevant to vaccine outreach activities, it remains over-broad. It seeks information about people and in relation to areas the evidence suggests the applicants are not well placed to reach, or which are already well serviced by other providers.

42. As the Judge suggested, an assessment of the evidence would bring the Treaty issues into sharper relief and indeed the relevant Treaty and tikanga considerations reinforce our recommendation.

43. As to equity and active protection, the Crown has committed to achieving equitable health outcomes for Māori and to eliminate health disparities resulting from COVID-19. We are not there yet, but the Crown is implementing measures to equip whānau, hapū, iwi, and Māori communities with the resources to undertake and respond to public health measures to prevent and/or manage the spread of COVID-19. The Māori Communities COVID-19 Fund is a big part of that and data resources also play a role. Both support access to kaupapa Māori services, in order to reach Māori who may not engage with mainstream health services, and also efforts to reach Māori who are not engaged with their iwi or live outside of their traditional rohe. But as with prudent and targeted deployment of financial resources, the principles do not support the broad-brush sharing of personal information.

44. Referring to relevant tikanga considerations, feedback we received suggested whanaungatanga was key. In that respect, the applicants' connections to urban Māori and those who do not affiliate with any particular iwi or rohe must be recognised and the significant sharing of individual level data for the applicants' own enrolled populations which has occurred to date supports this. At the same time, it is necessary to recognise the limits on the applicants' relationships and the whanaungatanga, rangatiratanga and kaitiakitanga obligations of others. This includes those iwi who expressed strong views about the Treaty implications of the Crown disclosing information of those who whakapapa to those iwi to the applicants. The proper process and consultation requirements were emphasised.

45. In relation to partnership and tino rangatiratanga it is also clear the Crown is working with Māori in the governance, design, delivery, and monitoring of the response to COVID-19. While the Judge framed partnership in terms of how WOCA participates in the design of the COVID-19 response for Māori and how not providing the requested information undermined WOCA's ability to target its COVID-19 response, the principles apply more broadly. The Crown is partnering with Māori on a number of levels across many regions of New Zealand to design and deliver the response. It is empowering self-determination, as seen in some of the regional examples set out above. In this instance, the mapping level data the Ministry has already agreed to provide to the applicants goes a long way to supporting them to target their response. As it has with a range of Māori providers on the ground, the Crown will continue to work with the applicants, including in encouraging them to focus their request for information. In that respect, it is worth noting the obligations of partnership apply to both

partners and may require compromise, particularly where competing Māori views about what is appropriate and effective require accommodation.

46. As to options, as the Judge said, adequate resourcing necessarily includes sharing information which would enable WOCA to best link culturally appropriate vaccination services with those who have not accessed, or will not access, mainstream health services. That is true as well for the range of other Māori providers in the field. The Crown's financial and data resourcing of the applicants and others is significant and on a practical level makes kaupapa Māori services available in a culturally appropriate way. It does not follow that it is appropriate for the applicant to access personal health information for individuals beyond the practical reach of its providers or who are supported by others in accordance with kaupapa Māori.

47. On balance we consider tikanga and Treaty/Te Tiriti principles mandate continuing to share data, including, where appropriate, individual level data, with the applicants, but not on anything like the scale they currently seek. Instead, the Crown should continue to work urgently with providers and support the targeted distribution of data sets to those who can meaningfully use them to best effect to confront the risks associated with COVID-19. This approach is more likely to support equitable outcomes and honour the Crown's commitment to active protection than the overbroad and unnecessary sharing of information which could in turn see the Crown breaching the Treaty interests of others.

48. Together, these Treaty/Te Tiriti considerations support our view that even if we had concluded North Island wide sharing of personal Māori health information with the applicants was "necessary" in accordance with Rule 11(2)(d) of the Code, we would not, in the face of the credible and more Treaty/Te Tiriti-compliant alternatives, recommend exercising the discretion to release all North Island individual level Māori health information as sought by the applicants. As advised above, however, we would support providing the applicants with further data in relation to particular rohe and enjoin them to work with the Ministry, relevant iwi, and local service providers, in partnership, towards that outcome. We would suggest prioritising discussions in relation to Tamaki Makaurau and Kirikiriroa given the current Delta outbreak in those areas.

## Recommendations

49. We recommend you:

    a. **Invite** the Whānau Ora Commissioning Agency and Whānau Tahi Limited urgently to work in partnership with the Ministry, relevant iwi, and local service delivery providers to identify those rohe where vaccination outreach to Māori is most needed, and to identify the necessary and appropriate scope of data sharing in each case;

**Yes / No**

    b. **decline** the request for access to all North Island individual level Māori health information sought by the applicants;

**Yes / No**

c. **continue** Ministry engagement with iwi, Hauroa providers and other Māori organisations to enable access to both meshblock level, and, where appropriate, individual level data to support vaccination of Māori across Aotearoa in support of the data sharing agreement with the Iwi Leaders Group.

**Yes / No**

Signature:
Date:
Ashley Bloomfield, Director-General of Health