IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

I TE KŌTI MATUA O AOTEAROA
TE WHANGANUI-A-TARA ROHE

CIV-2021-485-553
[2021] NZHC 2942

UNDER	the Judicial Review Procedure Act 2016
AND	Part 30 of the High Court Rules 2016
BETWEEN	TE POU MATAKANA LIMITED First Applicant
	WHĀNAU TAHI LIMITED Second Applicant
AND	ATTORNEY-GENERAL Respondent
AND	PRIVACY COMMISSIONER Intervener

Hearing:	26 October 2021
Counsel:	J B Orpin-Dowell, M R G van Alphen Fyfe and T J G Allan (by VMR) for the Applicants S M Kinsler, V E Squires and L N Wilson (by VMR) for the Respondent B Keith and A de Joux for the Intervener
Judgment:	1 November 2021

JUDGMENT OF GWYN J

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Introduction

[1] In early 2020 a new coronavirus (SARS-CoV-2) spread quickly around the world, causing a serious disease called COVID-19. The World Health Organization records that as at 29 October 2021 there have been more than 245 million confirmed cases of COVID-19, including more than 4.9 million deaths.[1] After eliminating COVID-19 in the community in 2020, New Zealand is currently experiencing a community outbreak of the Delta variant of COVID-19.

[2] As part of its response to the COVID-19 pandemic, the New Zealand government is presently rolling out a COVID-19 immunisation programme using the Pfizer-BioNTech vaccine, which involves two vaccine doses.[2]

[3] It is clear from the Ministry's publicly available information that the percentage of the eligible Māori population who have received COVID-19 vaccinations is materially lower than the percentage of other eligible populations.[3]

[4] The applicants bring judicial review proceedings relating to the decision of the Ministry of Health (the Ministry) not to provide the applicants with individual data to enable them to direct their services to Māori not vaccinated against COVID-19, for the purpose of providing targeted and appropriate vaccine delivery to those people and thereby preventing or lessening the serious threat posed to Māori by the COVID-19 pandemic.

[5] The applicants challenge the Ministry's decision primarily on three grounds: error of law, on the basis the Ministry incorrectly applied the relevant legal test for disclosing health information; the Ministry has acted inconsistently, having provided similar data to another health service provider; and the applicants had a legitimate expectation the Ministry's decision would be made in accordance with the principles

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[1] "WHO Coronavirus (COVID-19) Dashboard" World Health Organization <www.covid19.who.int>.

[2] The Ministry of Health presently recommends these doses be spaced apart by six weeks; although, following the spread of the Delta variant of COVID-19 in the community, the Ministry now also recommends that individuals consider a shorter gap between the two doses, of three weeks.

[3] See below at [27].

of Te Tiriti o Waitangi (Te Tiriti), but the decision is inconsistent with the principles and tikanga.

Background

[6] Whānau Ora is a government funded, Māori delivered, whānau-centred approach to supporting whānau wellbeing and development. The funding for Whānau Ora is primarily delivered through Te Puni Kōkiri/Ministry of Māori Development. Te Puni Kōkiri contracts with three Whānau Ora commissioning agencies:

(a) The first applicant, Te Pou Matakana Limited (trading as Whānau Ora Commissioning Agency (WOCA)), works with whānau and families in Te Ika-a-Māui/North Island. The shareholders of WOCA are the National Urban Māori Authority (NUMA), Te Whānau o Waipareira Trust (Waipareira), and the Manukau Urban Māori Authority (MUMA).

(b) Te Pūtahitanga o Te Waipounamu works with whānau and families in Te Waipounamu/South Island.

(c) Pasifika Futures works with Pacific Island families across Aotearoa/New Zealand.

[7] The second applicant, Whānau Tahi Limited, is WOCA's information systems provider.

[8] Te Puni Kōkiri has contracted WOCA to provide assistance and support to whānau to address the adverse impacts of COVID-19 restrictions, including providing vaccination related services.

[9] WOCA has a network of 96 Whānau Ora partner providers across Te Ika-a-Māui/North Island. Those providers have 200 COVID-19 vaccination sites, either fixed or mobile. As at 18 October 2021, WOCA's Whānau Ora partners had delivered approximately 496,000 COVID-19 vaccinations across the network.

[10] In Tāmaki Makaurau/Auckland, Whānau Ora providers engaged by WOCA have provided vaccination services through a range of options:

(a) the establishment of semi-permanent vaccination centres to carry out large scale vaccination;

(b) clinic-based appointments for vaccinations at existing healthcare services; and

(c) mobile vaccination clinics.

[11] WOCA has designed its COVID-19 vaccination services to overcome the barriers Māori traditionally face in accessing healthcare services. In particular, the mobile vaccination clinics, which are run from campervans:

(a) are a by-Māori, for-Māori programme;

(b) allow whānau to be vaccinated close to their homes, at a time that suits them;

(c) allow for a range of other COVID-19 related services to be offered in conjunction with vaccination, including COVID-19 saliva testing, hygiene packs and kai packs;

(d) travel to whānau (the daily location of the campervans is widely publicised in the local community using mail drops, social media, radio, and announcements from cars driving around the location of the campervans).

Engagement between the applicants and the Ministry

[12] In August 2021 the applicants and the Ministry entered into discussions. Mr John Tamihere (who is the Chief Executive of WOCA, Chief Executive of Waipareira, and an executive member of NUMA) asked the Ministry to enter into data

sharing arrangements with the applicants, and to provide them with relevant details of unvaccinated Māori.[4]

[13] To support their Whānau Ora work, the applicants asked the Ministry to share information with them about unvaccinated Māori in Te Ika-a-Māui/North Island – their personal details, contact details, vaccination status and vaccination booking status. The applicants wish to use that information in their provision of COVID-19 vaccination related services, and they say it would enable them to increase the Māori vaccination rate by targeting their services to those Māori who:

(a) have not received any dose of the vaccine; and

(b) have received only one dose of the vaccine.

(collectively, unvaccinated Māori)

[14] On 27 September 2021 the applicants and the Ministry entered into a data sharing agreement, which put in place a range of privacy protection mechanisms, including that data provided may "only be used … to identify and engage unvaccinated or unbooked individuals to encourage them to access vaccinations", and that the data supplied will be securely destroyed no later than 31 January 2022. On 1 October 2021, the Ministry confirmed that it would provide the applicants with the COVID-19 vaccination and booking status data of individuals who had previously been provided services by one of WOCA's Whānau Ora partners. It declined to share the same individual data in relation to Māori within Te Ika-a-Māui/North Island who have not previously been provided services by one of WOCA's Whānau Ora partners.

The decision under review

[15] Further discussions between the applicants and the Ministry about what information might be provided in relation to unvaccinated Māori who had not previously been provided with WOCA services continued until Ms Joanne Gibbs (the

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[4] Mr Tamihere's evidence records that WOCA had developed and submitted a business case to the Ministry for the roll-out of COVID-19 vaccinations to Māori on 24 February 2021. The business case emphasised the known and expected comparatively low rate of Māori response to other government vaccination programmes. The Ministry did not respond to WOCA.

National Director COVID-19 Vaccination and Immunisation Programme for the Ministry) made a decision on the applicants' request on 20 October 2021 (the Decision). Ms Gibbs' decision was based on a memorandum dated 19 October 2021 from Ms Caroline Greaney (Group Manager Office of the National Director, COVID-19 Vaccine and Immunisation Programme) (the Decision Paper).

[16] Ms Gibbs accepted the two recommendations in the Decision Paper, that the Ministry:

> a. **agree** to authorise the sharing with WOCA of anonymised (to street level) mapping representations that show areas with unvaccinated communities (SA1 or similar, in accordance with WOCA's "Targeted vaccination resources" request), subject to the resolution of technical issues, and the execution of a data sharing agreement that meets the Ministry's due diligence requirements as set out above.
>
> b. **decline** to authorise the sharing of individual identifiable data for individuals who are not vaccinated (ie, the "Direct contact with WOCA" request).

[17] WOCA questions the Ministry's approach in dividing the request for information into two separate requests, but it is the second aspect of the decision, declining to share individual data about unvaccinated Māori who have not previously been provided services by one of WOCA's partners, that is the specific focus of this application for judicial review.

What the decision means in practice

[18] Before considering the parties' submissions on the law it is necessary to set out the detail that sits behind the Decision and how it would be given effect in practice.

[19] The relevant part of the Ministry's Decision was that it will supply "anonymised (to street level) mapping representations that show areas with unvaccinated communities (SA1 or similar …)".

[20] Mr James (Jim) Brown is contracted to the Ministry as the Digital Suppliers and Sector Engagement lead for the COVID-19 Vaccination and Immunisation Programme. Mr Brown explains that "mapping representations" or "mapping level data" are used to describe areas within New Zealand that are defined and used by

Statistics New Zealand for collecting and producing statistical data about the population within that area. The smallest geographic unit used by Statistics New Zealand for this purpose is called a "meshblock". Meshblocks are anonymised mapping representations and include on average approximately 90 people. Meshblocks are the building blocks from which larger geographical statistical units are built.

[21] As Mr Brown describes, the next largest geographical unit used by Statistics New Zealand is called a Statistical Area 1 (SA1). SA1s have an ideal size range of 100-200 residents and a maximum population of approximately 500 residents. Some may have more, for example where they include high density residences such as apartment blocks and retirement villages. There are currently 29,910 SA1s in New Zealand.

[22] Mr Daymon Nin is the Chief Product and Consulting Officer of Whānau Tahi Limited, the second applicant. Mr Nin's evidence is that the SA1 data that the Ministry has agreed to provide will not enable the applicants to readily connect with all unvaccinated individuals. With SA1 data alone the applicants would not know who within a particular SA1 is vaccinated and who is not; would not know when people will be home (that could to some extent be predicted if the demographic information sought by the applicants was supplied, or could be confirmed by a prior telephone call, if contact details were provided); would not know who has opted out of vaccination services and requested they not be contacted; would not know who has been recently deceased, with the consequence that contact might add to the grief and anxiety of recently bereaved whānau; and would need to visit the area multiple times, at different times of the day, to make contact with all relevant inhabitants.

[23] Mr Nin gives an example of a rural SA1, Awhitu, which covers 16 square kilometres and has 10 streets, covering a total of 20 kilometres. Mr Nin says that if the Ministry advised that 50 Māori live within this SA1,[5] 50 per cent of whom are not vaccinated, the applicants would be searching for 25 Māori of a population of 195. He says it would take "considerable effort and resource" to go through those streets

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[5] The Ministry confirms it will provide data for Māori rather than at a general population level.

looking for those unvaccinated people, and even with that effort the applicants are likely to reach only a small proportion of them.

[24] Mr Nin also gives an example of an urban SA1, Ranui South West. This SA1 covers an area of 0.02 square kilometres, within which are two streets and multiple long rights of way, with high density infill housing and a large number of dwellings, possibly including apartment blocks or retirement villages. In that example too, Mr Nin says the applicants would face the same challenges of identifying in which homes Māori live and which are unvaccinated. Many residents are likely to be absent from home at any one time and it would take repeat efforts to reach all unvaccinated Māori within the SA1.

[25] Mr Nin concludes that the SA1 data is a tool that really only assists in areas of high-density need, which are the areas where the applicants and other providers have already concentrated their efforts. It does not assist in reaching the unvaccinated in other areas.

What is agreed

[26] Before turning to WOCA's specific claims and the legal framework that applies to the Decision, it is important to note what is agreed by the parties, as this provides significant context to the claims.

[27] The Ministry and the applicants agree that the COVID-19 immunisation programme has not so far achieved equitable coverage between Māori and other ethnic groups: the percentage of the eligible Māori population who have received COVID-19 vaccinations is materially lower than the percentage of other eligible populations. Vaccinations were first offered to high-risk groups and were then offered to the general population on a staged basis based on age. In New Zealand, as at 19 October 2021, the Ministry's data shows that the eligible population in New Zealand vaccinated, by ethnicity, was as follows:[6]

	First dose	**Second dose**
Asian	>95.0%	81.7%

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[6] "COVID-19: Vaccine data" Ministry of Health <www.health.govt.nz>. As at that date the eligible population was 12 years and over.

European / other	86.0%	69.1%
Pacific Peoples	81.0%	60.5%
Māori	66.9%	45.8%
TOTAL	85.4%	67.4%

[28] The underlying reasons for that inequitable situation are also agreed. That is, there are significant barriers to Māori accessing primary healthcare services, including cost, access to services, poor service delivery, cultural barriers, poor communication by health providers, and different approaches and models to wellbeing. Those barriers are reflected in the percentage of the Māori population enrolled with a primary health organisation (PHO), which is materially lower than the percentage of the general population – as at July 2021, the estimated percentage of the Māori population enrolled was 84 per cent, compared with 94 per cent for the total population.

[29] It is also accepted that one of the reasons why the Māori vaccination rate is lower than other groups of New Zealanders is a lack of trust by Māori in government institutions.

Relevant privacy law

[30] Before discussing the detail of WOCA's claims and the Ministry's response, I set out the law that applies to the disclosure of health information.

[31] The Privacy Act 2020 (the Act) applies to "personal information", which is relevantly defined as "information about an identifiable individual."[7] The purpose of the Act is to promote and protect individual privacy by providing a framework for protecting an individual's right to privacy of personal information, while recognising that other rights and interests may at times also need to be taken into account.[8]

[32] Where that information relates to the health of that individual and any health services that are being, or have been, provided to that individual or any incidental

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[7] Privacy Act 2020, s 7(1) definition of "personal information", para (a).

[8] Section 3(a).

information, the Health Information Privacy Code 2020 (the Code) applies.[9] The Code is issued by the Privacy Commissioner under s 33 of the Act and has the effect of modifying and substituting the 13 general information privacy principles in s 22 of the Act.

[33] As the Privacy Commissioner observed in his submissions as intervener, the Code reflects the particular characteristics of the health sector and health information:[10]

> (a) Most health information is collected in a situation of confidence and trust in the context of a health professional/patient relationship.
>
> (b) Health information is often highly sensitive in nature.
>
> (c) The collection, compilation and use of health information is ongoing and interrelated: data collected as part of one episode of care is often required by the health agency and other health providers in the future.

[34] The scope of the Code is broad, encompassing information about the health of any individual and any health services, that person's medical history, any disabilities they have or have had, results of tests or examinations, and information incidental to the provision of any health or disability services.

[35] The Code applies to any person or entity that provides health or disability services. The applicants and the providers they work with, as well as the Ministry of Health, are subject to the Code.

[36] Rule 11 of the Code (which largely replicates information privacy principle 11 in the Act) is relevant to the applicants' request:

> **Rule 11**
>
> **Limits on disclosure of health information**

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[9] Health Information Privacy Code 2020, cl 4(1)(a).

[10] The Privacy Commissioner was granted leave to appear as intervener in the proceeding: *Te Pou Matakana Ltd v Attorney-General* [2021] NZHC 2833.

(1) A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds,—

- (a) that the disclosure is to—
  - (i) the individual concerned; or
  - (ii) the individual's representative where the individual is dead or is unable to exercise their rights under these rules; or
- (b) that the disclosure is authorised by—
  - (i) the individual concerned; or
  - (ii) the individual's representative where the individual is dead or is unable to give their authority under this rule; or
- (c) that the disclosure of the information is one of the purposes in connection with which the information was obtained; or
- (d) that the source of the information is a publicly available publication and that, in the circumstances of the case, it would not be unfair or unreasonable to disclose the information; or
- (e) that the information is information in general terms concerning the presence, location, and condition and progress of the patient in a hospital, on the day on which the information is disclosed, and the disclosure is not contrary to the express request of the individual or their representative; or
- (f) that the information to be disclosed concerns only the fact of death and the disclosure is by a health practitioner or by a person authorised by a health agency, to a person nominated by the individual concerned, or the individual's representative, partner, spouse, principal caregiver, next of kin, whānau, close relative, or other person whom it is reasonable in the circumstances to inform; or
- (g) that the information to be disclosed concerns only the fact that an individual is to be, or has been, released from compulsory status under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the disclosure is to the individual's principal caregiver.

(2) Compliance with subrule (1)(b) is not necessary if the health agency believes on reasonable grounds, that it is either not desirable or not practicable to obtain authorisation from the individual concerned and—

…

- (d) that the disclosure of the information is necessary to prevent or lessen a serious threat to—

> (i) public health or public safety; or
>
> (ii) the life or health of the individual concerned or another individual; or
>
> …
>
> (4) Disclosure under subrule (2) is permitted only to the extent necessary for the particular purpose.
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> …

[37] Rule 11 places limits on the disclosure of health information. Generally, information can be shared where it was a purpose of collection, or where the disclosure is authorised by the individual concerned (r 11(1)(b) and (c)). A number of exceptions are set out in r 11(2), which recognises that other interests may be engaged and may take precedence. The Decision was taken pursuant to r 11(2)(d).

[38] The Act and the Code are not displaced by the exception in r 11(2)(d). If the Ministry were to provide WOCA with the individual identifiable data sought, WOCA would remain subject to the stringent requirements of the Code and other regulatory obligations – WOCA would be obliged to treat the data in confidence, to use it only for the purpose permitted, and to retain it securely and for no longer than required.

[39] In relation to that point, it is important to record at the outset that there is no concern about the applicants' ability to keep any data provided appropriately secure. As already noted, the parties earlier reached agreement on a data sharing agreement, and the Decision Paper refers to "the very impressive technical capability demonstrated by WOCA and Whānau Tahi's current data-handling systems and personnel."

Grounds of review

[40] The applicants in their second amended statement of claim originally pleaded six grounds of review, however by the time of the hearing before me, as a result of the ongoing discussion between the parties, the applicants advanced only three grounds:

(a) error of law, on the basis the Ministry incorrectly applied the relevant legal test for disclosing health information in r 11(2)(d) of the Code;

(b) the Ministry acted inconsistently, having provided similar data to another health service provider, Healthline (a non-Māori telehealth company); and

(c) the applicants had a legitimate expectation the Ministry's decision would be made in accordance with the principles of Te Tiriti, but the decision is inconsistent with the principles and tikanga.

Error of law: r 11(2)(d) of the Code

[41] The applicants' first claim is that the Ministry erred in law in the way it applied r 11(2)(d) of the Code when deciding whether to release the information sought.

[42] 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. "Serious threat" is defined as a threat that an agency reasonably believes to be serious having regard to all of the following:[11]

    (i) the likelihood of the threat being realised; and

    (ii) the severity of the consequences if the threat is realised; and

    (iii) the time at which the threat may be realised.

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[11] Privacy Act, s 7(1) definition of "serious threat". The definition applies to the Code by virtue of cl 3(2).

[43] The parties agree that rule 11(2)(d) confers a discretion on an agency to disclose information without authorisation, where the conditions of that rule are satisfied. It does not confer a right on requestors to access such information, or a duty on agencies to disclose. The Privacy Commissioner confirms that understanding of the rule.

[44] There is no dispute that the first two requirements of r 11(2)(d) are met. The Ministry concluded that it was not practicable to obtain individual authorisation "due to the number of unvaccinated individuals, their range of geographic locations, and the time pressure".

[45] The Ministry also concluded that the COVID-19 pandemic constitutes a serious threat to public health and safety. The applicants say both r 11(2)(d)(i) (threat to public health or safety) and (ii) (threat to the life or health or an individual) are in play and both are satisfied. As the Privacy Commissioner notes, while previous iterations of r 11(2)(d) required an "imminent" threat, the current Code does not. The urgency or otherwise of the threat will be relevant to the decision to disclose.

[46] As part of its assessment the Ministry emphasised the need to reach all eligible people as soon as possible:

> Evidence suggests that the Delta variant of COVID-19 may present both a greater threat to the health of individuals who contract the infection and a greater challenge to containing the spread of the virus in an outbreak. With the August community outbreak of the Delta variant of COVID-19, it is critical that we now reach all eligible people so that they can receive two doses, appropriately spaced, as soon as possible.

[47] The Ministry particularly identified the need to increase Māori vaccination rates:

> … the percentage of Māori who have received COVID-19 vaccinations is materially lower than the percentage of other eligible populations; the percentage of Māori who are enrolled with primary healthcare providers is also materially lower than the general population. Māori are more at risk of adverse outcomes from COVID-19 due to a higher rate of poorer health including respiratory disease. It is critical to take steps to reach everyone in New Zealand, including Māori whānau, hapu and iwi, in order to support access to vaccination.

[48] The Ministry also accepted that its approaches to date have not been successful in achieving equitable vaccination rates and that it is "critical" to engage with community organisations who can "contact individuals who are unvaccinated":

> The Ministry recognises the urgent need to reach unvaccinated individuals and whānau to support vaccine access. Additional approaches are needed where existing pathways and systems have not proved successful at this point. For maximum effect, it is critical to engage organisations which, through their community networks, are positioned to contact individuals who are unvaccinated.

[49] It is only the third condition to be satisfied, under r 11(2)(d), that is in dispute – that is, whether disclosure of the information sought is necessary to prevent or lessen the acknowledged serious threat to public health (and, the applicants say, the life or health of individuals). Ms Gibbs declined to approve the sharing of the individual level data sought by the applicants on the basis that she was:

> … not satisfied disclosure of individual level data is appropriate at this point or that it is necessary to lessen the threat presented by Covid-19 at this time.

[50] In reaching her decision, Ms Gibbs took into account the "possibility that alternative, less invasive, approaches may serve to reduce the threat to public health". Ms Gibbs concluded that provision of anonymised mapping-level data to WOCA and other providers, including iwi organisations, "may enable providers … to make considerable headway in reaching the unvaccinated in the coming weeks." The Decision Paper noted:

> On the whole, we consider that it is preferable at this time to share more limited data sets and encourage providers to work with that data to support vaccine outreach activities. We may revisit this approach with providers as the programme develops.

The applicants' submissions

[51] The applicants say first that Ms Gibbs applied a "least privacy invasive" gloss on the "necessary" test in r 11(2)(d), with the effect that what was authorised was disclosure of the least information possible without reference to whether that information is sufficient to address the extent of the acknowledged threat. The applicants say that the correct approach was to disclose the least information necessary to prevent or lessen the identified threat.

[52] The applicants say that given the acknowledged seriousness and urgency of the threat, it was not sufficient for the Ministry to decline the data on the basis that it is merely *possible* that other approaches might work, over a timeframe that does not appear to have regard to the acknowledged urgency of the situation.

[53] The applicants also say that there is no evidential basis on which the Ministry could have concluded that the provision of anonymised mapping-level data would allow the applicants to make "considerable headway in reaching the unvaccinated in the coming weeks".

[54] The applicants argue that, although the three requirements of r 11(2)(d) set a stringent standard, the rule does not require something extraordinary. "Necessary" in this context means only "needed or required".[12] Although it must be more than merely "desirable or expedient",[13] it does not impose a threshold of "indispensable or essential".[14] The Privacy Commissioner's submissions endorsed that approach.

[55] Related to this point, the applicants submit that COVID-19 vaccination status no longer raises the same heightened privacy concerns that attach to other health information: COVID-19 vaccinations are frequently given in what are effectively public spaces and, with the introduction of "vaccine mandates" for employees in certain sectors and users of specified facilities and services,[15] vaccination status increasingly has a public quality to it.

[56] The applicants also say that the Decision was materially influenced by the views of District Health Board (DHB) Chairs who expressed concerns about the provision of individual level data, including on the basis that there would "appear to be real risks of the vilification and bullying of unvaccinated individuals." The applicants say this is an illogical justification for refusing to disclose information to the applicants. Unvaccinated Māori may well face a risk of vilification or bullying

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[12] *Tan v New Zealand Police* [2016] NZHRRT 32 at [77] citing *Canterbury Regional Council v Independent Fisheries Ltd* [2012] NZCA 601, [2013] 2 NZLR 57 at [18]; *Cook v Manawatu Community Law Centre* [2021] NZHRRT 10 at [58].

[13] At [77].

[14] At [78].

[15] See for example: "The COVID-19 Protection Framework" Unite against COVID-19 <www.covid19.govt.nz>.

from the community, who may blame them for ongoing alert level restrictions, but that risk is not a result of disclosure of information to the applicants. Rather, sharing the information sought by the applicants is one way to materially contribute to increasing vaccination rates and therefore materially contribute to reducing the risk that Māori will face vilification and bullying.

The Ministry's submissions

[57] The Ministry accepts that the Decision is amenable to judicial review as the exercise of a discretionary power, but says there was no error of law. It emphasises that r 11(2)(d) does not impose a duty to disclose the information sought, or a right in the requester to receive it, even if disclosure is found to be "necessary". In any event, it says Ms Gibbs' decision was that disclosure was not necessary. She reached that view, as she was entitled to do, on the basis of systematic concerns including the views of Māori, risks to public confidence in the health system, and the availability of other options.

[58] In oral submissions Mr Kinsler noted that since the Decision was made on 20 October 2021 COVID-19 vaccination rates, including for Māori, have continued to rise. In the Ministry's submission, that provides support for its position that release was not necessary because there are other options available to increase vaccination rates.

Discussion

[59] Rule 11(2) has not been previously considered by the New Zealand courts.[16] The Act and the Code must be seen in the wider context of United Nations and other official statements concerning data privacy and COVID-19 response. For example, the United Nations Special Rapporteur on the Right to Privacy, Professor Joseph Cannataci, has noted:[17]

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[16] It has been addressed by the Privacy Commissioner in his *Inquiry into Ministry of Health Disclosure of Covid-19 Patient Information* (Privacy Commissioner, September 2020); and a subsequent general public guidance statement – John Edwards "Privacy, Covid-19 and the 'Serious Threat to Public Health' exception" (6 November 2020) Privacy Commissioner <www.privacy.org.nz>.

[17] Joseph Cannataci *Report of the Special Rapporteur on the right to privacy* UN Doc A/75/147 (27 July 2020) at [1]-[2] (footnotes omitted).

> 1. … responses that are shaped by and respect human rights result in better outcomes in beating the pandemic, ensuring health care for everyone and preserving human dignity.
>
> 2. While the priority is to save lives, fighting COVID-19 and respecting human rights, including the right to privacy, are not incompatible. In fact, the trust of citizens that their privacy … is being taken into account builds confidence and willingness to proactively support State measures to prevent the spread of the virus. …

[60] And as Professor Canatacci has also noted:[18]

> Robust national-level data protection laws … assist contact tracing and vaccination registration initiatives to commence, with due regard to the necessity of protecting citizens' data and communicating that necessity to the community.

[61] As the Privacy Commissioner's submissions emphasised, and I accept, in relation to rights to privacy and to health, the actions and decisions of public bodies must be proportionate and evidence-based;[19] both in relation to whether it is necessary to disclose and use the individuals' information, and whether that disclosure and use of that information presents a realistic prospect of preventing or lessening the health risk.[20]

[62] As Dr Magdalena Kędzior notes, the Council of Europe in a joint statement of 30 March 2020 on the right to data protection in the context of the COVID-19 pandemic recalled that "data protection can in no manner be an obstacle to saving lives and that the applicable principles always allow for a balancing of the interests at stake."[21]

[63] In the context of the acknowledged serious risks to individuals and public health posed by COVID-19, an objective, evidence-based assessment was required of:

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[18] Joseph Cannataci *Report of the Special Rapporteur on the right to privacy* UN Doc A/76/220 (23 July 2021) at [75].

[19] Cannataci, above n 17, at [11]-[18]; and Magdalena Kędzior "The right to data protection and the COVID-19 pandemic: the European approach" (2020) 21 Academy of European Law Forum 533 at 538.

[20] Kędzior, above n 19, at 538, which covers a discussion of OECD and EU instruments and statements.

[21] At 538.

(a) The anticipated effectiveness of disclosure and use of the requested information.

(b) The anticipated adverse consequences, in terms of the protection of life and health, or other material and relevant harms, of that same disclosure and use.

(c) Whether there are other options to address the health risk that lessen the privacy intrusion and resulting harms, but are nonetheless effective to address the risk (including in light of the urgency of that risk), and so whether it is possible to await the outcome of lesser measures.

[64] As to (a), the Decision Paper does not specifically address the anticipated effectiveness of the disclosure of identifiable individual data sought by WOCA.

[65] As to (b), the Decision Paper notes that:

> There are a range of views within Māori and among others about the appropriateness of sharing data and at what level. At one end of the spectrum, it has been suggested only individual level data will suffice to achieve appropriate outreach activities and, at the other, it is suggested that not only will the sharing and use of SA1 level data be sufficient, but the provision of individual-level data would in fact serve only to erode trust and confidence in the health system and thereby cut against the overall efficacy of the vaccination effort.

[66] Ms Gibbs made a handwritten note on the Decision Paper recording the concerns of the DHB Chairs that sharing individual data would "undermine efforts to reach these people". In her affidavit, Ms Gibbs explained DHB chairs expressed "particularly strong views" about the "counterproductive threat to public confidence in the health system that sharing such data would create".

[67] The Ministry did not present any specific evidence about that range of views, particularly in relation to the views of Māori. For example, it is not clear from the Decision Paper whether the feedback relates to proposed release of individual level data in general terms or whether, for example, it relates specifically to release of individual-level Māori data to a Māori health provider such as WOCA. The difficulty with that general approach is that it meant the Ministry did not adequately focus on

the specifics of the applicants' request and make its own assessment of what was "necessary" in the specific context of that request.

[68] Therefore, while the Decision Paper focuses to some extent on the adverse consequences of disclosure of individual information, it does so only at a general level. The Ministry does not appear to have made an assessment of the anticipated adverse consequences of the specific disclosure sought. This highlights a more general problem with the analysis in the Decision Paper: to a large extent it focuses on the wider policy context and the risk of precedent setting, but not on the benefits and risks of the specific disclosure sought by WOCA.

[69] As to (c), the Decision Paper notes the preference for the applicants (and other providers) to spend the "coming weeks" trying to reach the unvaccinated using SA1 data. It notes that after that, the Ministry may be prepared to "revisit this approach as the programme develops". As the applicants contend, there is a mismatch between the Ministry's acceptance of the level of risk and its decision: although the Ministry accepts that addressing the threat posed by COVID-19 requires supporting all individuals to be vaccinated, it will provide only anonymised data at an SA1 level. Although it accepts that it is critical to offer two doses "as soon as possible" the Decision Paper states a preference for the applicants to spend the "coming weeks" trying to reach the unvaccinated using SA1 data.

[70] The Ministry's conclusion that provision of that more limited data "may enable providers (including WOCA providers) to make considerable headway in reaching the unvaccinated in the coming weeks" does not appear to have been the subject of any assessment (or if it was, the evidence of that assessment was not before the Court). It is contrary to the evidence of Mr Nin for the applicants. There was no evidence before the Court, and therefore presumably no information provided to WOCA, about when and on what criteria the Ministry might review its decision.

[71] The Ministry concluded it was merely "possible" that approaches other than disclosure of individual data might work. But the Decision Paper noted in relation to the identified risk: "it is critical that we now reach all eligible people so that they can receive two doses, appropriately spaced, as soon as possible." Given the seriousness

and urgency of the threat, the Ministry was required to have a reasonable level of confidence that those other measures will be effective. There was no proper basis for the Ministry's conclusion that the provision of anonymised mapping-level data would allow the applicants to make considerable headway. There is no analysis of how that might be so.

[72] On this point I accept the submission made by Mr Keith for the Privacy Commissioner, that the "least-privacy invasive" test might be relevant if the decision-maker had two equally effective alternatives before it and one of those alternatives was less privacy intrusive than the other. This was at least implicitly acknowledged in the Decision Paper, where it said "… any data shared must be no more than is necessarily to *effectively* reach people who are unvaccinated" (emphasis added). But in my view it is clear from Mr Tamihere's evidence about the level of sophistication of WOCA's outreach services and its history of operating effectively in the community, and from Mr Nin's evidence as to how the SA1 data would be utilised, that the Ministry's alternative, door-to-door approach, was not an equally effective alternative for reaching unvaccinated Māori to the disclosure of individual data.

[73] It is not sufficient to say, as the Ministry does, that COVID-19 vaccination rates have been steadily increasing since the Decision and on that basis the Court can conclude that the limited release of data approved would be "effective". While the statistical information provided during the course of the hearing makes clear that the COVID-19 vaccination programme as a whole continues to make progress - more people are getting vaccinated, including Māori - the most recent statistics made available by the Ministry during the course of the hearing indicated that the differential between Māori and the rest of the population remains at approximately 20 per cent, for both first and second doses.[22]

[74] The Government's COVID-19 Protection Framework is to take effect when each DHB reaches a level of 90 per cent overall vaccination.[23] For Māori, based on

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[22] As at the date of the hearing the applicants estimated that unvaccinated Māori in Te Ika-a-Māui number approximately 142,000.

[23] "The COVID-19 Protection Framework", above n 15.

the current differential, that will likely occur at a point where Māori vaccination levels are still at approximately 70 per cent.

[75] The applicants also argue that the Ministry's Decision was internally inconsistent. On the one hand, it determined that it is not practicable for the Ministry to obtain individual consent to disclose the affected individuals' information ("due to the number of unvaccinated individuals, their range of geographic locations, and the time pressure"), notwithstanding that the Ministry has the contact details of these individuals. But its decision to provide the applicants with only anonymised SA1 data will require the applicants to make individual contact with the unvaccinated, without the benefit of their contact details. WOCA's providers will be required to go door-to-door in the community to try and locate the individuals with the same overarching constraints – that is, a large number of unvaccinated individuals spread across a range of geographic locations, and time pressure.

[76] It is inconsistent for the Ministry to conclude that it cannot contact all of the unvaccinated, with their contact details, while at the same time asking the applicants to locate them without their contact details, for the purposes of providing urgently needed vaccine services.

[77] I conclude that the Ministry erred in its application of r 11(2)(d) of the Code in its consideration of whether disclosure of the information to the applicant was necessary. It did not conduct the necessary objective, evidence-based assessment, either of the disclosure and use of the individual identifiable data requested by WOCA, or of what it concluded was an adequate alternative by way of disclosure of the anonymised street-level mapping data.

Inconsistency

[78] The applicants also argue that the decision not to disclose individual level data to the applicants is inconsistent with the Ministry's decision to share individual level data with Healthline/Whakarongorau, and the Crown's approach under the Outreach Immunisation Service (OIS) of sharing individual level data with community organisations (including WOCA) for the purposes of reaching and vaccinating

tamariki who have missed routine childhood immunisations (such as measles, mumps, rubella, and tetanus).

[79] The applicants' evidence, from publicly available material, is that Healthline has conducted a number of "outbound vaccination information campaigns". By way of example:

(a) On the weekend of 4 and 5 September 2021 it sent messages to approximately 157,000 Māori and Pacific peoples to encourage them to book a vaccination appointment.

(b) On an unknown date the Ministry supplied Healthline with the details of some unvaccinated Māori. Healthline used that information in a call campaign over four days between 10 and 13 September 2021, making a total of 5,785 calls, 647 of which resulted in a vaccination booking being made. Those calls were made to unvaccinated Māori in Henderson in West Auckland where Whānau Waipareira, WOCA's lead Whānau Ora partner, is based.

(c) On or before September 2021, the Ministry provided Healthline with the details of more than 21,592 unvaccinated Aucklanders over 65 years of age for the purpose of Healthline contacting them directly and encouraging them to make a booking to be vaccinated. Healthline subsequently contacted those on the list to encourage and support them to be vaccinated.

(d) Healthline have conducted an "outbound campaign" over text, email and telephone to follow up with individuals who did not attend a vaccination booking.

(e) More recently, Healthline has sent text messages to unvaccinated Māori, offering to pay the cost of a taxi for them to travel to a vaccination clinic.

[80] The Ministry did not provide any evidence in response on the particular activities of Healthline.

[81] The Ministry agrees that Ms Gibbs' discretion must be exercised consistently and rationally – she must treat "like cases alike" – but says there can be a rational basis for differing treatment. It says Healthline is not in an analogous position to the applicants. Although it is a private company, it is the Ministry's direct agent, using the Ministry's data to achieve the Ministry's purposes. Disclosure of information to it is one of the purposes for which the information is obtained. The Ministry did not need to not go through a r 11(2) analysis before doing so (although I note there was no evidence before the Court on this issue).

[82] The Ministry did not call evidence about the OIS because it was first raised by the applicants in their evidence in reply. In its submissions the Ministry says that the provision of individualised data to OIS is the delivery of targeted datasets directly to local healthcare providers and "different privacy considerations apply". In the absence of further evidence on this point, it was not clear what the Ministry's submission means in practice and why different privacy considerations apply.

[83] Given my findings above in relation to the error of law ground of review, and below in relation to the Te Tiriti ground of review, it is not necessary for me to reach a conclusion on the inconsistency ground of review. However, the arguments on this ground of review reinforce my finding in relation to the error of law ground of review, that the Ministry erred in its approach to r 11(2)(d) in considering whether disclosure is necessary. As Mr Orpin-Dowell for the applicants notes, the real significance of the provision by the Ministry of individual data of unvaccinated individuals to Healthline is that it evidences a recognition that disclosure of individual data was necessary for mainstream providers to effectively target unvaccinated people. In contrast, the Decision in relation to WOCA's request agrees to sharing only anonymised (to street level) mapping representations that show areas with unvaccinated communities. That is what is inconsistent.

Legitimate expectation: the principles of Te Tiriti

[84] The applicants say that the government's specific commitments to uphold Te Tiriti in the COVID-19 vaccination rollout created a legitimate expectation that the Ministry would have regard to Te Tiriti and its principles in making the Decision. They say it did not.

The applicants' submissions

[85] The applicants point to the government's commitment to uphold and honour Te Tiriti in the COVID-19 vaccination programme, and the government's acknowledgement of its obligations that flow from the Treaty partnership, including the principle of partnership, tino rangatiratanga, equity and the duty of active protection.

[86] The applicants say that the Crown's express commitment to uphold Te Tiriti and its principles in the implementation of the COVID-19 vaccination programme limits the scope of its discretion under r 11(2)(d) of the Code, and that the principles of partnership and tino rangatiratanga require the Crown to share the information sought by the applicants.

[87] The applicants advance this argument first, on the basis of the general principle of administrative law that where a public authority promises to follow a certain course it is in the interests of good administration that it should do so, so long as it does not interfere with its statutory duty.[24] The applicants say that, while the principle is traditionally characterised as a question of "legitimate expectation",[25] it now stands as a matter of free-standing principle – that is, that policies can restrain the exercise of an administrative discretion.[26] The doctrine was articulated by Laws LJ in *R (Nadarajah) v Secretary of State for the Home Department*:[27]

> Where a public authority has issued a promise or adopted a practice which represents how it proposes to act in a given area, the law will require the promise or practice to be honoured unless there is good reason not to do so.

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[24] *Attorney-General of Hong Kong v Ng Yuen Shiu* [1983] 2 AC 629 (PC) at 638.

[25] *Comptroller of Customs v Terminals (NZ) Ltd* [2012] NZCA 598, [2014] 2 NZLR 137.

[26] *Mandalia v Secretary of State for the Home Department* [2015] UKSC 59, [2015] 1 WLR 4546 at [29].

[27] *R (Nadarajah) v Secretary of State for the Home Department* [2005] EWCA Civ 1363 at [68].

> What is the principle behind this proposition? It is not far to seek. It is said to be grounded in fairness, and no doubt in general terms that is so. I would prefer to express it rather more broadly as a requirement of good administration, by which public bodies ought to deal straightforwardly and consistently with the public.

[88] The applicants say that although the Ministry gave an express commitment to uphold the principles of Te Tiriti in the COVID-19 rollout programme, it did not do so, and the Decision is inconsistent with Te Tiriti. The applicants say this is clear from the Decision Paper itself – while the Decision Paper contains general references to Te Tiriti (although not to the principle of options), in recording the factors that were weighed in arriving at the Decision, Te Tiriti and its principles were not listed.

[89] Additionally, in Ms Gibbs' affidavit evidence on behalf of the Ministry, she gives a summary of the factors she considered in reaching the Decision. She does not mention Te Tiriti and its principles.

[90] The applicants rely on three key principles: the principle of options, the principle of active protection, and the principle of tino rangatiratanga or partnership.

Options

[91] The principle of options requires that Māori be able to pursue a direction based on personal choice. In the unique circumstances of the pandemic, it means enabling Māori to have the genuine choice of kaupapa Māori providers and actively supporting and resourcing those providers. As the applicants submit, in setting up Whānau Ora, the Crown recognised that it was itself not the best provider or designer of social services for Māori. The Crown accepts that low vaccination rates among Māori reflect a lack of trust by some Māori in government institutions. It also accepts the government will not be able to reach every one of them. In contrast, the applicants' network of kaupapa Māori organisations under the Whānau Ora umbrella, are explicitly for-Māori, by-Māori and have been engaging with Māori on their own terms since the inception of Whānau Ora.

[92] In order to enable Māori to have genuine choices, kaupapa Māori organisations such as the applicants must be sufficiently empowered and resourced. Critically, adequate resourcing necessarily includes sharing information which would enable the

applicants to best link culturally appropriate vaccination services with those who have not availed, or will not avail, themselves of mainstream health services. The applicants acknowledge the significant financial resources the government has and is employing to reach Māori, but says in the context of this case it is information, not money, that is the key factor. The applicants say the Ministry's decision has failed to resource the applicants appropriately to enable them to provide the genuine option of kaupapa Māori services to individual unvaccinated Māori.

Partnership and tino rangatiratanga

[93] The applicants point to the Waitangi Tribunal *Hauora Report* which concludes that the principle of tino rangatiratanga requires the Crown to afford to Māori the "capacity, and space, to exert their tino rangatiratanga in the primary health care system."[28] The principle of partnership is a relationship of equals; in this context it requires disclosure of the information sought, and working together, including the design of the kaupapa Māori response to COVID-19.

[94] The applicants say it is not for the Crown to dictate to the applicants who they ought to provide their services to, or that the services should be limited to only some Māori. What tino rangatiratanga and partnership require is availability of resources for the applicants to provide the care they are charged with providing across Te Ika-a-Māui/North Island, to any Māori in need.

[95] The applicants also submit that the way in which the Decision Paper divides WOCA's proposed integrated approach into two separate and discrete data requests, and provides only what it thinks will possibly be sufficient, reflects the Ministry's failure to understand the importance of tino rangatiratanga and partnership. The evidence of Mr Nin is that this approach reduces the applicants' ability to make contact with hard to reach Māori by leaving them with much the same tools as they had before the Decision. It also prevents the applicants from appropriately designing and targeting their response for Māori so that their resources are used efficiently and to the best effect.

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[28] Waitangi Tribunal *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wai 2575, 2019) at 158.

Active protection

[96] The third Treaty principle invoked by the applicants is the Crown's duty to actively protect the health rights of all Māori. That duty, they say, requires the urgent disclosure of the information to the applicants. The Crown's active protection obligations are heightened in the context of the COVID-19 pandemic: the health rights of Māori at issue are fundamental, and a failure to actively protect Māori health interests will result in irreparable harm. The significant disparities faced by Māori and the acknowledged critical urgency of reaching unvaccinated Māori require a commensurate degree of preference to Māori and an increased act of protection of their interests in the pandemic response. That is further heightened because the disparities are in part due to persistent, marked and known Crown failures to reduce Māori health disparities.[29]

[97] The applicants say that by adopting a "least-privacy invasive approach", the Ministry's decision does not do all it can to protect the health rights of all Māori. It is insufficient to rely on Government-controlled, mainstream, or non-kaupapa Māori services that have to date failed to significantly reduce the disparate rate at which Māori are vaccinated. The applicants say that nor is it sufficient to rely on primary healthcare providers who have existing connections to individuals. This leaves a significant number of Māori at risk of being excluded, with 16 per cent of Māori (approximately 136,000 people) not enrolled in a primary healthcare organisation and the majority enrolled with mainstream primary healthcare organisations, noting that 96 per cent of general practitioners are non-Māori. In addition, some 136,422 Māori individuals do not know their iwi affiliation and many more who do know their affiliation live outside their traditional rohe. Rohe-based iwi organisations may have no way of knowing that the former come within their iwi and, if they do, may have limited resources to reach them in any event.

[98] The applicants say that the Crown has exercised its power in a way that stymies and delays its delivery of kaupapa Māori health services to Māori in need, in breach of its duty of active protection.

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[29] At 31-33.

Tikanga

[99] In the applicants' submission, having regard to tikanga is an integral part of considering and applying the principles of Te Tiriti. The situation requires the application of a tikanga lens, not just a Pākehā legal lens, in assessing the rights and obligations of the applicants and the whānau they serve.[30] In this case, the applicants say tikanga requires a particular focus on the applicants' kaitiaki obligations to Māori in need, based on their demonstrable expertise, capability and leadership.

[100] Dr Carwyn Jones' evidence describes the principle of whanaungatanga as the "bedrock" of tikanga, as the source of obligations between individuals and the collective. He focuses on the principle of kaitiakitanga – the obligation to nurture and care for the mauri of people, of resources and of taonga, where a whanaungatanga relationship is established. In this context the applicants have kaitiakitanga obligations to Māori in Te Ika-a-Māui/North Island. As Dr Jones put it in his evidence:

> A pandemic is a compelling example of when tikanga would say it is necessary to disclose information. Because of the foundational principle of whanaungatanga, the relevant relationship bonds exist between those who can provide care, and those who need it. If disclosure would allow a collective with kaitiaki obligations for a rangatira role in healthcare (such as a Whānau Ora-based agency) to reach individuals who are in need of care that the collective would otherwise not be able [to] reach, and to provide those individuals with kaitiakitanga and awhina in the form of healthcare support (such as information and vaccination care), that disclosure is consistent with tikanga.

[101] The applicants say they are rangatira organisations set up and resourced specifically to meet the needs of whānau, particularly whānau who have been poorly served by standard ways of delivering social and health services.

The Ministry's submissions

[102] For the Ministry, Mr Kinsler emphasised that, although Te Tiriti principles are a valid interpretive aid and relevant considerations in statutory decision-making in relation to Māori health and personal information, they do not by themselves create enforceable legal rights. Nor do the principles mandate a particular outcome on

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[30] *Trans-Tasman Resources Ltd v Taranaki-Whanganui Conservation Board* [2021] NZSC 127 at [297], [237] and [161].

particular facts. What Te Tiriti requires is that the Crown makes decisions that are reasonable – that is, within the bounds of its own broad responsibilities and authority, in light of all the circumstances, and based on sound procedure and consideration of relevant material.[31]

[103] Mr Kinsler emphasised the importance of a good process that ensures all relevant issues, interests and risks have been understood, considered and weighed, but says that in undertaking that weighing and assessment the Crown is entitled to take into account a wide range of matters. In undertaking its own assessment of the process, the Court should be mindful that the assessment was necessarily a qualitative rather than quantitative one.[32] He also urged the Court not to focus on form over substance.

[104] Mr Kinsler says the words in the Decision Paper and in Ms Gibbs' affidavits cannot be viewed in isolation from the wider Crown response to the pandemic for Māori and the wider Māori Response Action Plan, published on 9 July 2020. The Decision forms part of the government's COVID-19 response, which has itself been designed with Te Tiriti principles at its centre, and the context of the Decision is directed towards and informed by the principles of active protection and partnership.

[105] The centrality of Te Tiriti principles to the Crown's COVID-19 response is canvassed in the evidence from the Deputy Director-General for Māori Health, Mr John Whaanga, who notes that the Waitangi Tribunal's *Hauora Report* directly informed the principles on which the Crown has built its response, being:

(a) tino rangatiratanga;

(b) equity;

(c) active protection;

(d) options;

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[31] *New Zealand Māori Council v Attorney-General* [1994] 1 NZLR 513 (PC).

[32] *Attorney-General v Problem Gambling Foundation of New Zealand* [2016] NZCA 609, [2017] 2 NZLR 470 at [98].

(e) partnership.

[106] Mr Whaanga agrees with Dr Jones about the relevant tikanga principles, at a general level, while noting that ideas and practices as to tikanga may differ as between iwi. The Ministry says that those principles do not assist in terms of concrete direction about what to do in this particular situation. The Ministry emphasises the "divergent views of Māori" as to the appropriateness of sharing individual-level data, and Ms Gibbs' evidence where she says the feedback received in relation to sharing individual identifiable data was "polarising (to put it mildly)". Ms Gibbs says there is "no consensus about whether it would ever be appropriate for the Crown to share individual identifiable Māori health data let alone in the context of the current pandemic."

[107] Mr Whaanga's evidence discusses the Ministry's engagement with Māori, through the Iwi Communications Collective, as well as with Te Tumu Whakarae (the General Managers, Māori Health at the 20 District Health Boards). He notes, too, that the Ministry's Māori Health Service Improvement Team, within the Māori Health Directorate, has worked closely with the Māori provider network. The Ministry has provided regular updates to the Māori Health and Disability Sector on the COVID-19 response. As Mr Whaanga also notes, there have been hui between the Associate Minister of Health (Māori Health), Peeni Henare and Māori health providers across Aotearoa.

[108] Mr Kinsler also refers to the significant financial investment the Crown has delivered, including through the Māori Response Action Plan and separate, additional appropriations, together with a range of active partnerships with iwi leaders and organisations and specific funding to Māori health providers, executed to deliver the COVID-19 vaccination programme.

Discussion

[109] The principles of legitimate expectation are well-established. As the Court of Appeal said in *Comptroller of Customs v Terminals (NZ) Ltd*:[33]

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[33] *Comptroller of Customs v Terminals (NZ)*, above n 25, at [121] (footnotes and citations omitted).

> [121] The concept of legitimate expectation may be viewed as an aspect of the administrative law principle that requires governments and public authorities to act fairly and reasonably. The general principle was formulated by the Privy Council in *Attorney-General of Hong Kong v Ng Yuen Shiu*:
>
> > … when a public authority has promised to follow a certain procedure, it is in the interests of good administration that it should act fairly and should implement its promise, so long as it does not interfere with its statutory duty.

[110] The Court of Appeal in *Comptroller of Customs* set out three steps in the inquiry of whether a legitimate expectation is raised:[34]

(a) first, whether in fact there was a commitment by way of a promise or settled practice or policy;

(b) second, whether the applicant reasonably relied on the promise or practice; and

(c) third, what remedy should follow if a legitimate expectation is established.

[111] Where a legitimate expectation is established, the Court may require the decision maker to follow the process that he or she has expressly or impliedly undertaken to follow.[35]

[112] I have no difficulty in concluding that there was a commitment made by the Ministry to exercise its powers in relation to the COVID-19 rollout in accordance with Te Tiriti and its principles. The overarching principles for the COVID-19 immunisation programme are stated in the following way:[36]

> Equity and Te Tiriti o Waitangi are the overarching principles for the COVID-19 Vaccine and Immunisation Programme. To achieve equity for our priority groups (Māori, Pacific, and people with disabilities) and actively protect Te Tiriti rights of Māori, requires specific responses, resources, and activities to be developed and implemented.

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[34] At [125]-[127].

[35] At [155].

[36] "COVID 19 Vaccine and Immunisation Māori Communications Fund" Ministry of Health <www.health.govt.nz>.

[113] In its public materials about the COVID-19 rollout the Ministry has said, for example:[37]

> The Government is committed to upholding and honouring Te Tiriti o Waitangi, including obligations towards Māori that flow from the Treaty partnership. We have a strong focus on:
>
> - partnership
> - tino rangatiratanga
> - options
> - equity
> - active protection.

[114] The Government has also acknowledged that partnerships with iwi and Māori are critical to the successful implementation of the vaccination programme, to maximise uptake and achieve equitable coverage. It has committed to working with Māori providers to empower them to deliver COVID-19 vaccination, including to deliver tailored and targeted approaches.[38]

[115] The Crown has made a specific commitment to uphold and honour Te Tiriti in the COVID-19 vaccination programme and has acknowledged the obligations that flow from Te Tiriti partnership, in implementing the programme. It was stated as one of the overarching principles of the rollout and it was a specific, public commitment made by the Ministry. Te Tiriti and its principles had to inform the Ministry's discretion in deciding whether or not to release the information sought by the applicants.

[116] In the context of repeated affirmations of the Crown's commitment to applying Te Tiriti and its principles in its COVID-19 response, I conclude that the applicants' reliance on that commitment was reasonable and legitimate.

[117] The question of remedy is something I will come to in due course.

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[37] "COVID-19: Supporting the vaccine rollout" Ministry of Health <www.health.govt.nz>.

[38] "COVID-19: Who we're working with" Ministry of Health <www.health.govt.nz>.

[118] The more difficult question is whether the Ministry failed to determine the applicants' request for the data consistently with the commitment to act in accordance with Te Tiriti. The Court's focus is on the decision-making process rather than the ultimate outcome, although as I will come to, the outcome may provide an indication of deficiencies in the process.

[119] I agree with Mr Kinsler's submission that it is important not to place undue weight on the specific words used in the Decision Paper and in Ms Gibbs' explanation of her decision-making process; what is important is the context and substance of the process that led to the Decision.

[120] The applicants point to that part of the Decision Paper where the factors relevant to the recommendation are weighed and note it does not refer to Te Tiriti:

> 42. We have weighed a number of factors in arriving at this recommendation, including the gravity of the threat to public health, the divergent views of Māori as to the appropriateness of sharing individual-level data, the (related) need to maintain confidence in the health system and the vaccine programme, and the possibility that alternative, less invasive, approaches may serve to reduce the threat to public health. The presence of other providers, including iwi organisations, who also seek anonymised mapping-level data informs part of this picture, as it may enable providers (including WOCA providers) to make considerable headway in reaching the unvaccinated in the coming weeks.

[121] However, there are preceding references, including a reference to the relevant principles of partnership and active protection:

> 3. The Ministry has a responsibility to contribute to the Crown meeting its obligations under the Treaty/Te Tiriti o Waitangi. This involves acting in a way that is consistent with the guarantee of tino rangatiratanga; working in partnership with Māori in the governance, design, delivery and monitoring of health and disability services; and giving effect to the Crown's duty of active protection in delivering, to the fullest extent possible, equitable health outcomes for Māori. The approach and outcomes sought by the proposals outlined in this paper are intended to give effect to the Crown's commitments under the Treaty/Te Tiriti.

[122] The Decision Paper also refers to the Ministry's commitment to share data with organisations "so as to harness community and whanaungatanga connections and empower organisations with social and kaitiakitanga obligations for particular groups."

[123] The Decision Paper acknowledges the Crown’s commitments to active protection and the delivery of equitable health outcomes for Māori:

> 29. … it is the Crown’s responsibility to protect the health of all in Aotearoa, with specific Treaty/Te Tiriti commitments to active protection and the delivery of equitable health outcomes for Māori. The Crown should be open to taking, or facilitating, all available steps to reach the unvaccinated population, given the public health emergency and the risks to individuals, whānau, hapu, and iwi communities. It is also clear that a perceived failure to confront the pandemic equitably, with disproportionate impacts on Māori and vulnerable communities, may itself serve to erode trust and confidence in the health system.

[124] However, perhaps understandably, since the Ministry was dealing with a number of requests for information about unvaccinated individuals, and no doubt was and is under considerable pressure, it used the applicants’ request as a vehicle for weighing the broader issues related to a range of requests. For example, the Decision Paper says:

> Insofar as it sketches out general considerations relevant for considering WOCA’s request, the wider decision-making framework is also applicable to similar requests the Ministry is currently processing which will shortly reach you for decision …

[125] The Decision Paper puts considerable emphasis on general concerns about the sharing of data. Those concerns are raised in the context of a number of stakeholders and providers seeking access to specific datasets. While those stakeholders include WOCA and iwi, they also include social services networks delivering services to vulnerable people (including those with issues relating to mental health and addiction, family violence, and homelessness).

[126] Additionally, as already noted, the Decision Paper also focused on a “range of views” and doubts about the appropriateness of sharing the data with the applicants, but did not present any specific evidence about the views of Māori.

[127] I acknowledge Mr Whaanga’s evidence about the range and depth of the Ministry’s engagement with Māori about the COVID-19 rollout. It is important to also acknowledge that the discussions between the applicants and the Ministry were iterative. Mr Whaanga’s evidence, which was affirmed on 15 October 2021, refers to the applicants’ request for “wholesale disclosure of wide swathes of Māori health

information to a single service provider who wishes to speak on behalf of all Māori, or even all Māori in Te Ika-a-Māui." At other points in his evidence, Mr Whaanga again refers to health information being sought on a "wholesale basis without any caution or consultation".

[128] The applicants acknowledge that their request was originally framed in broader terms, but at the time the Decision was made, it was a request for the personal details, contact details, vaccination status and vaccination booking status of those Māori within Te Ika-a-Māui – that is the area within which WOCA provides Whānau Ora services, pursuant to its contract with Te Puni Kōkiri. Any data to be provided was, as I have already noted, to be subject to stringent data protection measures.

[129] In that sense, there is a mismatch, probably occasioned by lapse of time, between Mr Whaanga's assessment of what was being sought and the request that was actually the subject of the Decision. It was the more limited request that fell to be assessed by the Ministry.

[130] The Decision Paper notes that any proposed disclosure of health information must be assessed on a case-by-case basis, ensuring that the scope and level of data shared is proportionate to each organisation's community and whanaungatanga connections and capacity to deliver. However, the Decision Paper does not in fact undertake that kind of assessment in relation to the applicants' request. The closest it comes is an acknowledgement of the "very impressive technical capability demonstrated by WOCA and Whānau Tahi's current data-handling systems and personnel."

[131] Although this failure has a particular Treaty dimension, it is also reflective of the more general deficiency already discussed, which is that the Ministry did not address WOCA's application on its terms, with an evidence-based assessment of the harms and benefits of disclosure and use of the individuals' information sought by the applicants, or of the Ministry's alternative proposal. If the Ministry had carried out such an assessment that would have brought into sharp focus its obligations under Te Tiriti and how they applied to the particular request.

[132] Given that failure, in my view characterising the assessment of the applicants' request as a "qualitative" assessment might be seen rather as an excuse for a lack of rigour in the process. While the Ministry did have to weigh a range of factors, as I have found, it did not do so on the basis of an evidence-based assessment.

[133] The Decision was to provide only the anonymised, mapping-level data, on the basis that the Ministry might, on some unspecified date, and on the basis of some unidentified criteria, review the Decision. While the Court's role is limited to scrutinising the decision-making process, rather than the Decision itself, it is difficult to see how that decision could have been informed by the principles of partnership and options, in particular.

[134] I conclude in relation to this limb of the applicants' claim that in exercising its discretion under r 11(2)(d) of the Code, the Ministry did not have adequate regard to Te Tiriti and its principles, as informed by tikanga.

Relief

[135] I grant the following relief:

(a) The Ministry's Decision of 20 October 2021 is set aside.

(b) I declare that the Ministry has erred in its interpretation and application of r 11(2)(d) of the Health Information Privacy Code 2020.

(c) I declare that the Ministry's power to disclose information under r 11(2)(d) of the Health Information Privacy Code 2020 in the context of the COVID-19 vaccination programme must be exercised in accordance with Te Tiriti o Waitangi / Treaty of Waitangi and its principles.

(d) I direct the Ministry to urgently retake the Decision, within three working days, in accordance with the law and having regard to the findings in this judgment. I reserve leave to the Ministry to apply to

> the Court if it is not able to retake the decision within three working days.

Costs

[136] If the parties are not able to agree on costs the applicants are to file a memorandum within 10 working days of this decision, with the respondent having 10 working days to respond.

Gwyn J