IN THE COURT OF APPEAL OF NEW ZEALAND

I TE KŌTI PĪRA O AOTEAROA

CA391/2023
[2025] NZCA 443

BETWEEN	NEW ZEALAND INDEPENDENT COMMUNITY PHARMACY GROUP INCORPORATED Appellant
AND	HEALTH NEW ZEALAND First Respondent
	GDL RX NO8 LIMITED Second Respondent
	ATTORNEY-GENERAL Third Respondent

Hearing:	24 and 25 September 2024
Court:	Mallon, Ellis and Cooke JJ
Counsel:	R A Kirkness, N R Coates, M D N Harris and W H Ranaweera for Appellant S M Bisley and B J Maltby for First Respondent L H Mau for Second Respondent No appearance for Third Respondent
Judgment:	2 September 2025 at 1 pm

JUDGMENT OF THE COURT

A The appeal is dismissed.

B The appellant is to pay the first and second respondents costs for a standard appeal on a band A basis, together with usual disbursements. We certify for second counsel for the first respondent.

REASONS OF THE COURT

(Given by Mallon J)

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Introduction

[1] The appellant (ICPG) is a group of community pharmacists. It appeals a High Court judgment that dismissed its challenge to decisions made by two District Health Boards (DHBs).[1] Those decisions enabled the second respondent (RX8) to operate new pharmacies in Countdown supermarkets in Gisborne and Wainuiomata. The Countdown pharmacy at Gisborne opened on 3 June 2021 before closing on

[1] *New Zealand Independent Community Pharmacy Group v Te Whatu Ora – Health New Zealand* [2023] NZHC 1486 [judgment of Gwyn J].

30 September 2022 due to staffing issues.[2] The Countdown (now Woolworths) Pharmacy at Wainuiomata opened in May 2021.

[2] ICPG contends the High Court erred:

(a) in finding that judicial review of the DHBs' decisions was limited to fraud, corruption and bad faith grounds;

(b) in excluding the expert evidence filed on behalf of ICPG;

(c) in dismissing the judicial review when the DHBs had failed to inform themselves properly of the risks to health equity posed by their decisions;

(d) in dismissing the judicial review when one of the DHBs did not act in accordance with the Treaty of Waitangi | te Tiriti o Waitangi and its principles; and

(e) in awarding costs on a category "C" basis for each step taken after 1 July 2022 (when the DHBs were replaced) without assessing whether each step taken thereafter would have taken a comparatively large amount of time.

[3] ICPG submits that this Court should allow the appeal and make declarations that the relevant decisions were unlawful. Due to the passing of time, it no longer seeks to have the decisions quashed.

[4] The first respondent, Health New Zealand | Te Whatu Ora (HNZ), takes the place of the two DHBs who made the relevant decisions: Hutt Valley DHB (HVDHB) and Hauora Tairāwhiti. It does so because DHBs were disestablished on 1 July 2022 when the New Zealand Public Health and Disability Act 2000 (NZPHDA) was

[2] Discussed below at [47]–[48].

replaced with the Pae Ora (Healthy Futures) Act 2022.[3] It says the High Court was correct to dismiss the judicial review and to find ICPG's expert evidence to be inadmissible.

[5] RX8 submits the appeal is largely moot because Countdown Pharmacy Gisborne ceased its operations from the end of September 2022 and because of the disestablishment of the DHBs. It supports the submissions of HNZ. However, if the Court were to allow the appeal, it says the Court should decline to issue declaratory relief and the appropriate relief would be referral back to the decision-maker for reconsideration in relation to the Countdown Pharmacy at Wainuiomata.[4]

[6] We dismiss the appeal for the reasons we set out more fully below. In summary we consider the scope of judicial review was not limited to fraud, corruption, bad faith or analogous grounds. We accept that the DHBs were required to take reasonable steps to be reasonably informed in respect of any mandatory relevant consideration when making their decisions under the NZPHDA. We consider the expert evidence was not substantially helpful to this question. In each case, the relevant DHB was reasonably informed as to whether the Countdown pharmacies could improve health inequity for Māori by removing potential barriers to their access to pharmaceuticals. The Treaty ground of review failed for the same the reason. The NZPHDA provided the way in which the Treaty principles were to be given effect and the challenged DHB was reasonably informed of Māori inequity before making its decision. Lastly we consider the Judge's costs decision was open to her.

Legislative framework

[7] The decisions were made by the DHBs under the NZPHDA. One of the purposes of that Act was to provide for the funding and provision of public health services in order to pursue various stated objectives to the extent they are reasonably

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3 Clause 10(1) of sch 1 provides that acts or omissions of DHBs are treated as being those of Health New Zealand and that proceedings against or in relation to a DHB may be continued against Health New Zealand without amendment.

4 RX8 filed a notice of appeal in respect of what was ICPG's sixth ground of review in the High Court, but abandoned that appeal on 10 July 2024.

achievable within the funding provided. Most relevantly for present purposes these objectives included:[5]

> (a) to achieve for New Zealanders—
>
> (i) the improvement, promotion, and protection of their health:
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> (ii) the promotion of the inclusion and participation in society and independence of people with disabilities:
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> (iii) the best care or support for those in need of services:
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> (b) to reduce health disparities by improving the health outcomes of Maori and other population groups:
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> (c) to provide a community voice in matters relating to personal health services, public health services, and disability support services—
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> (i) by providing for elected board members of DHBs:
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> (ii) by providing for board meetings and certain committee meetings to be open to the public:
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> (iii) by providing for consultation on strategic planning:

[8] Section 4 of the NZPHDA provided:

> **4 Treaty of Waitangi**
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> In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Maori, Part 3 provides for mechanisms to enable Maori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

[9] The NZPHDA established DHBs and set out their objectives and functions. Each DHB was responsible for providing health services in its specified geographical area.[6] Hauora Tairāwhiti (the DHB for Tairāwhiti) operated in the Gisborne District geographical area. HVDHB's geographical area was Upper Hutt City and Lower Hutt City which included Wainuiomata.

[10] Each DHB was governed by a board, consisting of seven elected members and up to four members appointed by the Minister of Health.[7] The Minister was required

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5 New Zealand Public Health and Disability Act 2000 [NZPHDA], s 3(1).
6 Section 19(1) and sch 1.
7 Sections 26 and 29; and Crown Entities Act 2004, s 25.

to endeavour to ensure that Māori board membership was proportional to the number of Māori in the DHB's resident population and that in any event there were at least two Māori members.[8]

[11] As Crown entities, DHBs were required to act consistently with their objectives in performing their functions.[9] The objectives of each DHB included:[10]

> (a) to improve, promote, and protect the health of people and communities:
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> …
>
> (ba) to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs:
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> …
>
> (e) to reduce health disparities by improving health outcomes for Maori and other population groups:
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> …
>
> (g) to exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services:
>
> …

[12] Every DHB was required to pursue its objectives in accordance with any annual plan under s 38, its statement of intent, and any directions or requirements given to it by the Minister under the NZPHDA or the Crown Entities Act 2004.[11] For "the purpose of pursuing its objectives", each DHB had a range of functions, including "to ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement".[12] These functions also included collaborating with organisations that provided services under a service agreement to plan and coordinate at local, regional and national levels for the most effective and

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8 NZPHDA, s 29(4).

9 Section 21 and Crown Entities Act, s 49. They could do anything authorised by the NZPHDA or the Crown Entities Act, and anything a natural person of full age and capacity may do, so long as it was for the purpose of fulfilling their functions: Crown Entities Act, ss 16–18.

10 NZPHDA, s 22(1).

11 NZPHDA, s 22(2).

12 Section 23(1)(a).

efficient delivery of health services.[13] Each DHB was also required to operate in a financially responsible manner.[14]

[13] A "service agreement" was defined as an agreement under which a DHB agreed to provide money to a person in return for the person providing services or arranging the provision of services.[15] If permitted to do so by a plan under s 38 and in accordance with that plan, a DHB was permitted to:[16]

> (a) negotiate and enter into service agreements containing any terms and conditions that may be agreed; and
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> (b) negotiate and enter into agreements to amend service agreements.

[14] If it entered into a service agreement, a DHB was required to "monitor the performance under that agreement of the other parties to that agreement".[17]

Decisions

Relevant background

[15] DHBs delivered pharmacy services in their regions though a service agreement known as an Integrated Community Pharmacy Services Agreement (ICPSA). This was a standard form contract under which a pharmacy agreed to provide services to eligible patients. The services were set out in a schedule and included dispensing pharmaceuticals and professional advisory services. The ICPSA also set out the basis for DHBs' funding of the services and the service and quality requirements of the provider of those services.

[16] The ICPSA was developed through negotiations between the Ministry of Health and DHBs, as well as other stakeholders. It was reviewed each year. In addition to the generic service and quality requirements and other terms, DHBs could make their own arrangements about the process for deciding whether to enter into an

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13 Section 23(1)(ba).
14 Section 41.
15 Section 25(1).
16 Section 25(2).
17 Section 25(3). The information before the High Court was that in the 2020/2021 financial year: HVDHB entered into eight new service agreements, and maintained and monitored 246 agreements; and Hauora Tairāwhiti entered into or varied 73 agreements and had a total of at least 88 service agreements.

ICPSA with a particular provider and whether to include additional terms (for example, as to opening hours or other requirements for the pharmacy).

[17] Most prescription medicines in New Zealand are subsidised. The public pays a $5 "co-payment fee" towards the cost of subsidised medicines. It is paid to the pharmacy when the medicine is dispensed unless the pharmacy elects to absorb the cost. The pharmacy then invoices HNZ (previously the relevant DHB) for the cost of the medicine, less $5.

[18] In addition to a national plan and DHB annual plans made pursuant to the NZPHDA, HVDHB had in place a range of health strategies and policies to guide their activities. Relevantly for HVDHB, these included a Pharmacy Contracting Policy which supported its other higher level health strategies: *Our Vision for Change* (HVDHB's 10-year strategy), *Te Pae Amorangi* (HVDHB's Māori health strategy), and *Future Pharmacist Services 2018–2023* (HVDHB's five-year pharmacy services strategy).

[19] Hauora Tairāwhiti's annual plan identified focus areas which included improvement in Māori health. Hauora Tairāwhiti was part of a DHB governance group that oversaw regional direction for five DHBs in the wider region. This group developed a Regional Equity plan which amongst other things set out a vision for the pursuit of Māori health equity. Hauora Tairāwhiti also had a New and Existing Provider Policy (the Provider Policy) and was in the process of developing a pharmacy strategy.

HVDHB

[20] The decision to grant an ICPSA for the Countdown Pharmacy in Wainuiomata was made by Rachel Haggerty, who was the person responsible for HVDHB's investment decisions to improve health and well-being outcomes at the relevant time.[18] Pursuant to the Pharmacy Contracting Policy, an evaluation panel was established to evaluate applications for ICPSAs. The panel assessed applications against weighted

[18] Ms Haggerty also had this role for Capital and Coast District Health Board (CCDHB).

decision-making criteria and made recommendations to Ms Haggerty who made the final decision.

[21] These decision-making criteria included:

(a) whether the application aligned with relevant national and local strategic priorities for pharmacy services (with a "critical" weighting);

(b) the population needs in the proposed location, how they were being met at present, and whether they would be enhanced by the proposed pharmacy (with a "high" weighting); and

(c) how the pharmacy would work with other providers (particularly local general practices) to ensure integrated and continuity of care (a "high" weighting).

[22] Ms Haggerty's affidavit evidence before the High Court provided some context in which the decision was made. Wainuiomata's population of 17,910 comprised 30.4 per cent Māori and 15.9 per cent Pacific Peoples and was a region with high economic deprivation. Ms Haggerty said HVDHB was conscious of the economic and social profile of Wainuiomata and its need for greater support and access to healthcare.

[23] RX8 applied to the HVDHB on 24 July 2020 for an ICPSA.[19] It proposed to open a pharmacy at Countdown Wainuiomata. The pharmacy would have extended opening hours and it would waive the co-payment fee. The application stated that its services would mainly be provided to the Wainuiomata population but could also attract customers from nearby suburbs. It noted that there was "a significant Māori population in the area which will benefit from Countdown Pharmacy services and convenience".

[24] A panel of five (the Panel), including Kiri Waldegrave (who was HVDHB's Acting Director of Māori Health), was convened on 25 August 2020 to consider the

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[19] We have referred to RX8 for consistency. However it appears that the application may have initially been made by another entity (GDL RX No7 Ltd).

application. The members of the Panel other than Ms Waldegrave recommended that the application be declined. Concerns were around whether pharmacists would be focussed on dispensing rather than patient and prescriber advice and managing medication information and care plans, whether staffing levels would be sufficient to provide a quality service, whether there was support from local GPs and whether Countdown would work in an integrated way. One member of the Panel also considered the proposed pharmacy would risk the viability of others in the area. Although the positive aspects of the application were seen as being the longer opening hours, free prescriptions and increased choice for the local population, the majority of the Panel saw these aspects as being outweighed by the concerns discussed.

[25] Ms Waldegrave regarded the extended opening hours as "important for increasing access to services to Māori". She saw the free prescriptions as providing a "significant difference" from the existing pharmacies. Her recommendation that the application be approved concluded that free prescriptions and extended hours looked "on the surface" to provide "improved access" and both aspects were "important from an equity perspective".

[26] On 26 August 2020, Ms Waldegrave emailed Mr Fraser (the Panel member who was coordinating the Panel) attaching two links which she described as "relevant reading around equity and access to medicines" for Māori. Both links were to pages on the Pharmaceutical Management Agency's (Pharmac) website. One referred to research indicating that Māori were continuing to receive medicines in the community at a lower rate than non-Māori. The other referred to Pharmac actively working to eliminate inequitable outcomes for Māori.

[27] Mr Fraser replied to Ms Waldegrave on the same day. He said he was familiar with the themes of the material and noted that the studies highlighted inequities but did not indicate how they were to be addressed. He regarded increased hours and costs as only two parts of a complex issue which involved many factors. He set out various local initiatives that HVDHB had implemented to increase access to medicines in Wainuiomata.

[28] The Panel's recommendation was set out in a memorandum from Mr Fraser, on behalf of the Panel, to Ms Haggerty dated 10 September 2020. The memorandum:

(a) referred to HVDHB's contracting policy for new pharmacies to "take a more planned and thoughtful approach to proposals for establishing new pharmacies" in the district in keeping with its legislative responsibility to "seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local … needs";[20]

(b) noted the aims of the policy were to release pharmacists from supply activity to enable them to better provide patient and prescriber advice, integrate pharmacists with the wider general practice team to provide shared care for complex patients, and improve equity by channelling more resources to the DHB's priority populations;

(c) noted the proposal followed the same model that was operating in other parts of the country, including Petone and Lower Hutt, would be staffed by two pharmacists and two technicians, and operate from 8 am to 8 pm seven days a week;

(d) noted that the pharmacy would be located 200 m and 500 m from two existing pharmacies:

(i) one of which was located across the road from the only general practice in Wainuiomata and whose opening hours aligned with that practice except that the pharmacy was also open on the weekends, and whose current staffing levels gave them the ability to spend 20 to 30 minutes counselling a patient;

(ii) both of which offered patient accounts (which the proposed Countdown pharmacy would not) to which the Disability Allowance could be redirected enabling patients to collect

[20] Referring to NZPHDA, s 22(1)(ba).

medicines at no cost, and which also enabled patients to pay medication costs over time with a maximum charge of $2 per week over the year; and

(iii) both of which also offered delivery, one at no cost and the other for a $5 delivery fee;

(e) noted a key point of difference with the application was the zero co-payment fee which may be attractive to people in Wainuiomata and was "pro-equity in addressing one important barrier to medicines collection";

(f) noted there was no evidence of engagement with or support from general practice providers, and the low staffing level suggested that staff would mostly be occupied in supplying medicine with little ability to integrate with primary care and provide advanced cognitive services;

(g) advised that the extended hours and zero co-payment fee had "some attraction from an equity perspective" and was the main reason why Ms Waldegrave recommended it be approved; and

(h) noted that there were other aspects of access to medication services and advised that the remaining members of the Panel recommended that the application be declined because the pro-equity aspects were not seen as outweighing the failure to support other aspects of the strategy.

[29] On or around the same day, Ms Waldegrave and Ms Haggerty discussed the recommendation. There was no written record of the conversation. Ms Haggerty's evidence was that Ms Waldegrave led a team of six others in the Māori Health Unit that met regularly with Māori providers and had insight into difficulties economically disadvantaged Māori experienced in Wainuiomata and the Hutt Valley more generally. Ms Waldegrave explained her view that Countdown's proposal to offer free prescriptions and extended hours had the potential to increase access to medicines. They discussed the research Ms Waldegrave had provided to Mr Fraser as to how high

proportions of Māori and Pacific Peoples did not pick up prescriptions due to cost barriers.

[30] Ms Haggerty convened a meeting of the Panel by video conference on 24 September 2024 to ensure she understood all viewpoints. Ms Haggerty deposed that no written record of the video conference was made but the pros and cons of the application were discussed. This included reference to research obtained by the HVDHB which showed that 12 per cent of Countdown Pharmacy Petone patients were from Wainuiomata. It was also discussed that Countdown's proposal to absorb the co-payment for patients would come at no cost to the HVDHB.

[31] Ms Haggerty advised the Panel of her decision to grant an ICPSA to Countdown Wainuiomata by email dated 23 October 2020. In that email Ms Haggerty explained her decision as follows:

> I have given careful consideration to the recommendation of the panel regarding denying a pharmaceutical agreement to … Countdown Pharmacy. I do understand the intention of the Hutt Valley pharmacy strategy is to improve the quality of pharmaceutical advice given to people accessing pharmaceuticals. Access to MSD funded support for scripts and high user health cards do assist people on very low incomes, and those who have multiple prescriptions. Alongside this I have advice from our Director, Maori and our community that lower cost access, longer opening hours will assist more people to access their medications more easily.
>
> I am also aware that the local Clive's Pharmacy provides a range of services to the local community and is open business hours and Saturday morning, and that Wainuiomata Pharmacy is open seven days a week. The zero co-payment offered by Countdown Pharmacy was identified by the Director Maori as a significant advantage and a removal of a barrier for all people accessing pharmacies. The current reduced co-payment access is for those with complex and high needs, or who access benefit support. Zero co-payments will provide lower cost access for a much wider proportion of the population.
>
> In weighing up the risks and opportunities it is my decision that it is unreasonable to withhold an Integrated Community Pharmacy Services Agreement from the proposed Countdown Pharmacy. The weight of consideration given to the view of our Director Maori and my own view that increase[d] free access to pharmaceuticals in the Wainuiomata community outweighs the risk.

[32] On 3 November 2020, Ms Haggerty advised Countdown that HVDHB was granting an ICPSA for Countdown's Wainuiomata store.[21] The ICPSA was entered into on 13 May 2021. Subsequent data analysis indicated that the number of Wainuiomata people accessing medicines from the three Wainuiomata pharmacies had increased following the opening of the Countdown Wainuiomata store compared with the Hutt Valley. As Ms Haggerty puts it, that may be because more Wainuiomata people were now collecting their medicines or because more Wainuiomata people were collecting medicines locally or a combination of the two.

Hauora Tairāwhiti

[33] The affidavit evidence in the High Court included affidavits from James Green, the Chief Executive of Hauora Tairāwhiti at the relevant time, Nicola Ehau, a manager with oversight of commissioning services for the DHB at the relevant time, and Ariana Roberts, a Portfolio Manager at the relevant time. Amongst other things, the affidavits provided the context in which the decision to grant an ICPSA to Countdown for the Gisborne pharmacy was made.

[34] The district has both urban and rural communities. It has a high proportion of young people (39 per cent) and a high proportion of Māori (51 per cent). It has high rates of unemployment, dependency on government benefits and substandard housing. It also has the highest rates of avoidable mortality and morbidity in New Zealand, high rates of ambulatory sensitive hospitalisations, high rates of smoking, obesity, diabetes, heart disease, arthritis and gout, and relatively low immunisation rates. Mr Green said that these factors meant there was high inequity in accessing health services in Tairāwhiti and this was exacerbated by other factors such as the lack of access to reliable vehicles, long work hours in the main employment sectors (agriculture, forestry and fishing) and poor internet interconnectivity.

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[21] The letter advised that a decision had taken longer than expected due to the need to weigh up several factors and HVDHB's desire to ensure that any new pharmacy was capable of supporting the HVDHB's pharmacist services strategy. The letter explained that the key features of the application were the lower cost access and longer opening hours which would assist more people to access their medications more easily. Improving equity was a key issue for DHBs and Wainuiomata was an area where people would benefit from the pharmacy services Countdown would provide.

[35] The ICPSA had been in use in Tairāwhiti from 2018. There were eight pharmacies in the district, all of which were in the city of Gisborne (comprising about 75 per cent of the total population of the district).[22] Three of the eight had over 70 per cent of the market share. The ratio of pharmacists to population was 5.83 per 10,000 people compared with the national average of 7.89.

[36] All eight pharmacies provided the emergency contraceptive pill and all provided extended clinical services (for health conditions that required support for their medicine regime). Five pharmacies provided vaccinations. Most of the pharmacies offered a medicines delivery service, usually for a delivery fee. Two pharmacies offered extended weekend opening hours. Two pharmacies provided a rural medication depot service, providing access to medicines for people living rurally. However, this was a limited service with little opportunity for pharmacist to patient interaction.

[37] Mr Green explained that its Provider Policy was to guide its decision making when entering into a new service agreement. In the first instance, a portfolio manager would liaise with the applicant and carry out due diligence. The portfolio manager would assess the application using a "HEAT" (Health Equity Assessment Tool) tool which measured equity considerations and a "Benefits Criteria". The application would then be considered by three advisory committees: Te Rōpū Rauemi Rautaki (an informal governance committee), Hiwa-i-te-Rangi (a statutory advisory committee) and Te Waiora o Nukutaimemeha (a committee which sought to apply Māori whakairo, tikanga and ways of practice). They would make a recommendation and ultimately Hauora Tairāwhiti's Board would make a decision.

[38] In August 2020 RX8 applied to Hauora Tairāwhiti for an ICPSA so that it could open the Gisborne pharmacy. Amongst other things, the proposal involved extended opening hours, a private consultation room and waiving the co-payment charge. In accordance with Hauora Tairāwhiti's practice, Ms Roberts reviewed this application against the Provider Policy. Once the approval of Te Rōpū Rauemi Rautakai was given to progress the application, Ms Roberts reviewed the application against the Benefits

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[22] The number of pharmacies in the area has been relatively stable since 2007, occasionally dipping below eight but never more than eight.

Criteria and the HEAT tool. Ms Roberts also met with existing pharmacists who expressed concerns that the Countdown pharmacy would threaten their market and that there might be issues with the quality of service provided by Countdown as a large conglomerate.

[39] Assessing the application against the Provider Policy, amongst other things, Ms Roberts noted that:

(a) a pharmacy located in a supermarket would be useful for those coming into town from rural areas to do their shopping and errands and encourage them to pick up their scripts which they might not otherwise do;

(b) there was no other pharmacy in Tairāwhiti that waived the co-payment and reducing the cost to whānau was attractive in light of anecdotal information that the rural population were picking and choosing which medicine to pick up; and

(c) longer hours would allow some people such as shift workers to access pharmacy services outside normal business hours.

[40] Ms Roberts sought further information from RX8 about the proposal. This was provided on 20 January 2021. Amongst other things, this explained how the proposed pharmacy would engage with mental health and addiction services, was intending to implement a system that would enable services to be targeted to Māori patients and included a commitment to increase Māori in its workforce. The latter reflected that 52 per cent of the Tairāwhiti population identify as Māori and a strategic priority of Hauora Tairāwhiti was to address equity by increasing the Māori workforce in local health sectors. Ms Roberts also considered the intended targeting of Māori to be significant given that equity was a strategic priority for Hauora Tairāwhiti.

[41] Ms Roberts prepared a paper dated 18 January 2021 to go to Te Rōpū Rauemi Rautaki. She presented that paper at its meeting on 10 February 2021 and recommended that the application progress to Hiwa-i-te-Rangi for decision. At this

meeting Te Rōpū Rauemi Rautaki supported the application progressing to Hiwa-i-te-Rangi and Te Wairoa o Nukutaimemeha.

[42] Ms Roberts then prepared a paper for consideration by those two committees. The application scored 9.2 out of 12 on the Benefits Criteria (which considered the application under various categories, including "[i]mproving access to populations with high health needs (Māori)" and "[e]liminating health inequity"). The HEAT tool involved assessing what was known about existing inequities, how the application would improve Māori outcomes and reduce health inequities experienced by Māori and how these outcomes would be measured.

[43] Hiwa-i-te-Rangi discussed the Countdown application at a meeting on 16 February 2021. Its minutes recorded that fully funded script items could be an opportunity for easing access for customers and it recommended the paper go to the Board for approval. Mr Green's affidavit elaborated on the discussion at that meeting. Hiwa-i-te-Rangi discussed the absence of evidence to support the concerns of existing local pharmacies that a new pharmacy would affect their viability and that in any event it was not responsible for protecting the economic interests of incumbent providers in a competitive market. Rather Hiwa-i-te-Rangi's role was to consider how the local population could access healthcare. The different option of access provided by a supermarket, along with longer hours, waiver of the co-payment and delivery of specified services were considered to have a net positive effect.

[44] Te Waiora o Nukutaimemeha considered the application on 17 February 2021. The minutes record its recommendation that the application go to the Board for approval. Mr Green's affidavit again elaborates on why that was, namely the committee considered that the pharmacy could assist in addressing equity issues because of its convenience and because of cost considerations. An affidavit from Na Raihania, the chair of this committee, confirmed the committee was "very happy" with the application from an equity perspective. Services at a pharmacy made sense because it was one less stop for whānau with children in the car or coming in from the coast. The committee also regarded the commitment to growing the Māori and local workforce as a key point.

[45] Ms Roberts also prepared a paper for the Hauora Tairāwhiti Board's consideration of the application. On 23 February 2021 the Board met and approved the application. Mr Green attended the meeting in his capacity as chief executive. His evidence is that the Board discussed similar matters as that discussed by Te Waiora o Nukutaimemeha and Hiwa-i-te-Rangi. The one-stop shop aspect of the proposal (picking up a script while shopping) was seen as providing an added service that would be unique in Tairāwhiti. The co-payment waiver, although not applying to all scripts, would reduce or remove costs for some and was therefore considered to be an advantage.

[46] The Board recommended a meeting take place between Board representatives and the existing pharmacies who had expressed concerns about the proposed Countdown pharmacy. The meeting between Board representatives and the existing pharmacies took place on 3 March 2021. This meeting did not assuage the concerns of those pharmacies, further correspondence ensued and ultimately this proceeding was commenced.

[47] The ICPSA was signed with RX8 on 29 April 2021. It commenced on 3 June 2021. Shortly before it opened, RX8 advised it was having trouble recruiting a second pharmacist. It was agreed that it would reduce its hours for the first month. The staffing issues continued after the first month. This was because RX8 had been flying down a locum from Auckland to provide cover but it did not want to continue to do so with the presence of COVID-19 in Auckland. Difficulties continued despite various efforts by RX8 to recruit staff, including by increasing salary offers and direct recruiting from universities.

[48] On 30 September 2022 HNZ (which by this stage had replaced the DHBs) agreed to the temporary suspension of the ICPSA following RX8's advice that it had been unable to staff the Gisborne pharmacy. The pharmacy closed at 7 pm on that date. Following continued difficulties in recruiting a permanent pharmacist and other necessary staff, RX8 advised on 14 February 2023 that it was unable to resume services at the pharmacy. The ICPSA terminated that day.

Scope of review

High Court decision

[49] One of the issues in the High Court was the scope of review. HNZ and RX8 contended that the scope of review was narrow because the decisions involved commercial, contracting decisions. The Judge accepted this submission. In doing so, the Judge placed particular emphasis on the commercial nature of ICPG as a special interest group representing independent community pharmacists who were commercial competitors of the two Countdown pharmacies. The Judge regarded this commercial interest to be a "critical contextual factor".[23] The Judge said it was not the function of judicial review to advance private interests in a competitive market.[24]

[50] The Judge also considered that the NZPHDA did not impose procedural requirements on DHBs for granting service agreements and each DHB had their own policies and procedures for deciding whether to grant a service agreement to a provider. The Judge was of the view that the Court should be reluctant to impose its own procedural requirements.[25] Further, while the grant of an ICPSA had a "regulatory flavour", any public safety concerns were more directly addressed by the Medicines Act 1981, including the power of the Director-General of Health to grant a licence to operate a pharmacy.[26]

[51] The Judge concluded that ICPG's claim must fail because it did not allege fraud, corruption, bad faith or analogous circumstances.[27]

Analysis

[52] HNZ submits the High Court was correct to find that the grounds for judicial review were narrow, because the decisions related to commercial contracts, were made by decision-makers who are accountable to their local populations and ICPG's challenge is motivated by commercial self-interest. However, we agree with ICPG

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23 Judgment of Gwyn J, above n 1, at [188].
24 At [188].
25 At [190].
26 At [192].
27 At [193]. The Judge nevertheless went on to consider the grounds of review in case she was wrong about the scope of review.

that the scope of review was not confined to fraud, corruption or bad faith or analogous situations for the reasons we now turn to.

[53] The "fraud, corruption or bad faith" scope of review comes from *Mercury Energy Ltd v Electricity Corporation of New Zealand Ltd*.[28] It involved a decision of a state-owned enterprise to terminate a commercial contract for the supply of electricity. That decision was made in pursuance of the state-owned enterprise's statutory objective rather than any specific statutory power.[29] The Privy Council accepted the decision was amenable to review,[30] but emphasised that judicial review is concerned with the legality of a decision.[31] In the context of that case, the Privy Council's view was that illegality was likely only to arise if it involved fraud, corruption or bad faith.

[54] Subsequently, the courts have emphasised that, to the extent that analysing the scope or intensity of judicial review as a preliminary issue is relevant,[32] context is critical. That includes both the particular statutory context,[33] as well as the factual context. In *Ririnui v Landcorp Farming Ltd* the parties did not challenge the limits on the scope of review as indicated in *Mercury Energy Ltd*.[34] Without endorsing those limits, the Supreme Court considered they did not necessarily apply to all contracting decisions made by a state-owned enterprise.[35] In that case there was a Treaty of

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28 *Mercury Energy Ltd v Electricity Corporation of New Zealand Ltd* [1994] 2 NZLR 385 (PC) at 391.

29 The state-owned enterprise model was intended to make state trading organisations as efficient and financially accountable as limited liability companies seeking to be profitable: see for example Philip A Joseph *Joseph on Constitutional and Administrative Law* (5th ed, Thomson Reuters, Wellington, 2021) at [12.7.7(1)]. The principal statutory duty was to operate as a successful business, by becoming profitable and efficient, by being a good employer and by exhibiting a sense of social responsibility: State-Owned Enterprises Act 1986, s 4.

30 *Mercury Energy Ltd v Electricity Corporation of New Zealand Ltd*, above n 28, at 388: the state-owned enterprise made decisions in the public interest which might adversely affect the rights and liabilities of private individuals without affording them any redress.

31 At 388.

32 See *Minister of Justice v Kim* [2021] NZSC 57, [2021] 1 NZLR 338 at [51].

33 Emphasised in *Lab Tests Auckland Ltd v Auckland District Health Board* [2008] NZCA 385, [2009] 1 NZLR 776 at [92].

34 *Ririnui v Landcorp Farming Ltd* [2016] NZSC 62, [2016] 1 NZLR 1056.

35 At [65] per Elias CJ and Arnold J; Glazebrook and O'Regan JJ agreeing at [147] and [150] respectively.

Waitangi dimension in addition to the commercial elements of the decision.[36] The decision of the state-owned enterprise (Landcorp) to sell a large block of land to the highest tenderer was reviewable on the basis that a material mistake had been made (that Ngāti Whakahemo did not have a credible claim to the land).[37]

[55] In *Moncrief-Spittle v Regional Facilities Auckland Ltd* (a decision that post-dates the Judge's decision in the present case) the challenged decision was made by a company owned by the Auckland Council whose main function was to operate venues owned by the Council's predecessor entities.[38] Having decided to hire out one of its venues for a speaker presentation, it subsequently revoked that decision because of concerns that subsequently arose about the event and security issues. These concerns arose from inquiries it made after receiving complaints about the event.

[56] The Supreme Court considered that the grounds of review in this context were not limited to those identified in *Mercury Energy Ltd*.[39] While accepting that the purpose of venue hire was predominantly to generate revenue, it was not a decision approached in a purely commercial way. The trust deed under which the company held the venues required its assets to be administered with a "prudent" commercial approach and this operated alongside the wider social objectives of the legislative scheme.[40] The decision also had broader impact beyond the decision-maker and the party seeking to hire the venue.[41] The decision was reviewable on the pleaded grounds that the decision was not reasonable or rational or there was a failure to act consistently with the New Zealand Bill of Rights Act 1990.[42]

[57] The present case involves a quite different kind of statutory Crown entity with a different statutory objective to that in *Mercury Energy* where there were no legal

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36 Landcorp's statement of corporate intent showed that assisting the Crown to meet its Treaty obligations was one of its legitimate activities. In accordance with protocols in place, Landcorp sought advice from the Office of Treaty Settlements (OTS) whether the land was of interest to the Crown for Treaty settlement purposes. OTS advised that it was not of interest as it wrongly (as was later accepted) considered that all of Ngāti Whakahemo's historical claims were settled.

37 *Ririnui v Landcorp Farming Ltd*, above n 34, at [76] and [98] per Elias CJ and Arnold J; Glazebrook and O'Regan JJ agreeing at [147] and [150] respectively.

38 *Moncrief-Spittle v Regional Facilities Auckland Ltd* [2022] NZSC 138, [2022] 1 NZLR 459.

39 At [110].

40 At [110] and [111].

41 At [112].

42 At [113].

constraints on the decision to terminate a contract. Here, the DHBs made their decisions under an Act aimed at, amongst other things, providing and funding health services for the public to improve, promote and protect health to the extent they are reasonably achievable within the funding provided. As set out earlier, the aims also included providing funding and services to provide the best care or support for those in need of services and to reduce health disparities by improving the health outcomes of Māori and other population groups to the extent reasonably achievable with the funding provided.

[58] The DHBs' statutory objectives aligned with this. DHBs provided funding for these health services to meet their objectives via service agreements. DHBs made their decisions for the public and in the public interest as reflected by those objectives. If DHBs were satisfied that they should provide funding for health services with a particular party, they entered into a service agreement with that party. The fact that the decision was given effect by way of a contract does not alter the fact that the decision to enter into that contract was one made in the public interest under a statute with public health objectives. Nor does the fact that the provider of health services under a service agreement would provide those services in competition with other providers alter the public interest nature of the decision.

[59] The DHB decisions to enter into service agreements with RX8 are amenable to review. The scope of review is not restricted to fraud, corruption or bad faith or analogous situations. The legality of the decisions depends upon whether they are consistent with the statute under which they were made. Here, this meant decisions that were consistent with the relevant DHB pursuing its statutory objectives in accordance with any annual plan under s 38, its statement of intent, and any directions or requirements given to it by the Minister under the NZPHDA or the Crown Entities Act. As relevant to the grounds pleaded here, it also meant taking into account relevant considerations that the statute required the DHB to take into account as a matter of legal obligation. That obligation can arise expressly, impliedly or because of the particular context.[43] Other of the traditional grounds of review, including *Wednesbury* unreasonableness, were also available for a decision of this kind.

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[43] See, for example, *Joseph on Constitutional and Administrative Law*, above n 29, at [2.3.2.3(2) and (4)].

[60] HNZ relies on *Lab Tests Auckland Ltd v Auckland District Health Board* as supporting a limited scope of review in relation to contracts made under s 25 of the NZPHDA. There this Court relied on *Mercury Energy* as indicating that courts will intervene in limited circumstances in judicial review in relation to commercial contracting decisions by a public body. But it also qualified this by saying it depended on the context.[44] While the statutory context was essentially the same as in the present case,[45] the factual context (the decision challenged and the grounds for that challenge) was quite different.[46] What "particularly troubled" this Court in that case was that, under the broader scope of review contended for, the DHB could comply with its statutory procedures yet still be found to have breached additional public law obligations.[47] Importantly, this Court emphasised that a public body, even when involved in a commercial contracting process, "must exercise the contracting power in accordance with its empowering statute".[48]

[61] This Court in *Attorney-General v Problem Gambling Foundation of New Zealand*, also relied on by HNZ, applied *Mercury Energy* in restricting the scope of review to fraud, corruption, bad faith or analogous situations.[49] Its approach was to consider whether there were any "compelling contextual factors that *shift* the scope of review from this position"; the Court found there were none.[50] This must now be

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44 *Lab Tests Auckland Ltd v Auckland District Health Board*, above n 33, at [59].

45 Albeit that after *Lab Tests*, DHBs were given an additional objective of seeking the optimum arrangement for the most effective and efficient delivery of health services in order to met local, regional and national needs, and an additional function of collaborating with relevant organisations (including organisations that provided services under a service agreement) to plan and coordinate at local, regional and national levels for the most effective and efficient delivery of health services: NZPHDA, ss 22(1)(ba) and 23(1)(ba).

46 It involved a decision to award a single contract for the provision of pathology services to one provider following a competitive tender process. It was alleged that a member of the DHB's board had a conflict interest because of an alleged interest in the successful tenderer. It was also alleged that there was a duty to consult about the proposed changes to the provision of pathology services. However, the Crown Entities Act set out the duties of DHB members in relation to confidential or inside information and the board member had complied with those duties. Further, the NZPHDA set out the consultation duties and these duties were not engaged in the situation at issue.

47 *Lab Tests Auckland Ltd v Auckland District Health Board*, above n 33, at [91] and [93].

48 At [56]. Similarly, *Healthcare of New Zealand Ltd v Capital and Coast District Health Board* [2012] NZHC 3417 (which HNZ also relied on) focussed on whether the DHB's annual plan conformed with the statutory requirements or whether the DHB's decisions to release the annual plan to the Minister for approval, to release a request for proposals (RFP) and to enter into contracts pursuant to the RFP was unreasonable. It contains no reference to *Mercury Energy* and the pleaded grounds were considered in detail but ultimately rejected as not established.

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

50 At [53] (emphasis in original).

read in light of *Moncrief-Spittle* which rejected this as the appropriate analysis. Rather the correct approach was to analyse the particular context.[51]

[62] We do, however, agree with HNZ that the empowering statute left considerable discretion to a DHB about the service agreements that were to be entered into in pursuit of the DHB's statutory objectives. The scope of that discretion is relevant to whether any ground of review is established. But it is wrong to take the approach that, because the service agreement was awarded to a provider in a competitive market for the provision of those services, the scope of judicial review was limited to fraud, corruption, bad faith or analogous circumstances. Moreover, we add that the proper scope of judicial review is not limited because ICPG represents competitors of the Countdown pharmacies. Depending on context, competitors may bring judicial review applications against statutory decisions or decisions made by public bodies that affect their rights and interests.

Information as to the risks to health equity posed by their decisions

Ground of review

[63] ICPG submits the DHBs were required to inform themselves properly of the risks to health equity posed by granting ICPSAs to the Countdown pharmacies but failed to do so. HNZ says this submission is not clearly reflected in ICPG's pleading which alleged that: the DHBs "asked themselves the wrong question"; made the decisions "without sufficient and suitable evidence"; and that there was "no rational connection" between the evidence and the decisions.

[64] ICPG's emphasis appears to have been somewhat different in the High Court and was rejected by the Judge on the basis that it was not properly pleaded. However, the Judge was also not persuaded that either DHB had failed to ask the right question or to obtain the relevant information to answer the right question. The Judge considered that the DHBs had sufficient and suitable evidence to make their respective decisions to grant the ICPSAs and there was a rational connection between the evidence and the decisions.[52]

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51 *Moncrief-Spittle v Regional Facilities Auckland Ltd*, above n 38, at [110].
52 Judgment of Gwyn J, above n 1, at [195]–[220].

[65] We consider the alternative formulations in ICPG's pleadings reflect that, as is often the case, an alleged error can be analysed under more than one of the traditional grounds of review. We also consider that the pleading fairly put the respondents on notice as to the alleged error. In crystalising the error into a single formulation of the DHBs failing to inform themselves properly, ICPG refer to a duty to carry out sufficient inquiry discussed in *Secretary of State for Education and Science v Tameside Metropolitan Borough Council*.[53] HNZ submits that this ground of review is one of irrationality whereas ICPG submits it is more appropriately viewed as part of the requirement to consider mandatory relevant considerations.

[66] We consider the latter better focuses on the nature of the alleged error relied upon, and we note that this Court recently reached a similar view in response to a similar argument in *ALT New Zealand Ltd v Attorney-General*.[54] Both the purpose of the NZPHDA and the DHB objectives included "to reduce health disparities by improving health outcomes for Maori and other population groups".[55] While that does not mean that every decision a DHB makes must have that purpose, if a DHB is to make a decision in pursuit of the objective, ICPG's argument is that it would not be doing so if it has not reasonably informed itself of whether its decision may involve risks to health equity.

[67] In putting it this way, ICPG relies on McGechan J's decision in *CRA3 Association Industry Association Inc v Minister of Fisheries* where, under the heading "[f]ailures to take into account relevant considerations/to obtain and consider relevant information", the Judge said:[56]

> [59] I proceed on the *Tameside* basis that a decision-maker must not only ask the right question, but must "take reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly". … The simple *Tameside* principle is adequate. The obligation is to take "reasonable" steps to self inform. The criterion of reasonableness always depends very much upon the facts and circumstances of individual situations. …

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53 *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014 (HL) at 1065 per Lord Diplock.

54 *ALT New Zealand Ltd v Attorney-General* [2025] NZCA 344 at [108]–[119].

55 NZPHDA, ss 3(1)(b) and 22(1)(e).

56 *CRA3 Association Industry Association Inc v Minister of Fisheries* HC Wellington CP317/99, 24 May 2000.

> [60] There is a duty on a Minister charged with exercising a statutory power to inform himself to a reasonable extent commensurate with what he must do and what is at stake. What is "reasonable" will also depend on circumstances prevailing at the time. Matters such as time available, resources to hand, existing knowledge and expertise, and reliability or apparent reliability of sources all can have a bearing, along with all else. … Many decisions, and reasonably, must be made on the basis of information to hand or practicably obtainable within an available timeframe. …

[68] To that can be added several appellate authorities. For example, in *CREEDNZ Inc v Governor-General* Richardson J put it this way:[57]

> If relevant considerations are to be taken into account it is obvious that the decision-maker should not be misinformed as to established and material facts, including in that expression incontrovertible expert opinion; and as Lord Diplock put it in the *Tameside* case he must take reasonable steps to acquaint himself with the relevant information. The emphasis must be on what is reasonable in all the circumstances and that obligation does not, of course, require the decision-maker to ascertain and consider the views of everyone who may have an opinion on the point.

[69] We accept the general point that the DHBs were required to obtain adequate information to enable them to assess whether the proposed decision was likely to have the relevant intended benefit (here improving health inequities particularly for Māori). But that is not to say that there was any requirement as to how they were to do so and as to the type of information they needed to obtain. The question is what was reasonable in the circumstances of the decision to be made.

Expert evidence

[70] This ground of review relies in large part on the affidavit expert evidence that ICPG contends was wrongly ruled inadmissible in the High Court. That is because the expert evidence is said to go to the issue of what would have been discovered had due inquiry been made.[58] It is said that the evidence is therefore relevant and likely to offer substantial help in understanding the evidence in the proceeding or in ascertaining any fact that is of consequence to the determination of the proceeding.

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[57] *CREEDNZ Inc v Governor-General* [1981] 1 NZLR 172 (CA) at 200; see also, for example, *Air Nelson Ltd v Minister of Transport* [2008] NZCA 26, [2008] NZAR 139 at [54]–[55]; and *Taylor v Chief Executive of Department of Corrections* [2015] NZCA 477, [2015] NZAR 1648 at [94].

[58] *Diagnostic Medlab Ltd v Auckland District Health Board* HC Auckland CIV-2006-404-4724, 5 December 2006 at [17].

[71] It is necessary to consider this evidence to determine whether it was relevant and substantially helpful. One of the expert affidavits was from Richard Meade. He is an economic consultant and researcher.[59] His affidavit was intended to provide expert opinion evidence on whether a pharmacy offering to waive the $5 co-payment for a prescription was likely to result, particularly for Māori, in more equitable: access to medicines, pharmacy services or facilities; quality of pharmacy services; or health and well-being outcomes.

[72] Dr Meade's opinion is that:

(a) The cost of medicines is only one type of access barrier preventing patients from obtaining medicines. The wavier of co-payments will not improve access for patients who cannot overcome other access barriers, such as the time and cost of obtaining the prescription from prescribers. They will benefit those who do not face the same barriers.

(b) Small co-payments are unlikely to have major impacts on medicines access. But co-payment waivers by non-traditional (discounter) pharmacies risked worsened medication adherence and continuity of patient care where they led to patients spreading their demand across multiple providers. Culturally appropriate services are also an important driver of consumer behaviour.

(c) A co-payment waiver by discounters can lead to reduced quality in the provision of services. Moreover, they might lead to rival pharmacies leaving the market, and once gone from the market, the discounters can withdraw the co-payment waiver if there are no restrictions on them doing so.

(d) Waiver of co-payments can frustrate the achievement of health policy goals such as reducing pressure on overall pharmaceutical budgets, or

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[59] Dr Meade's professional and research experience and expertise includes competition economics and consumer decision-making. He also has significant experience in the Māori sector.

encouraging prescribers and patients to opt for medicines that place less strain on pharmaceutical budgets where suitable options are available.

[73] ICPG also sought to rely on evidence from Shelley Cunningham, the Mana Whakahaere Tuarua | Deputy Chief Executive of Te Puna Ora o Mataatua, a charitable trust that is the regional Māori Health Provider for the eastern Bay of Plenty. Based on her experience in developing and implementing healthcare initiatives designed to address equity in the context of Māori health, Ms Cunningham expresses the opinion that it is always necessary to:

(a) identify the equity measure in question and its purpose;

(b) obtain information and data about local needs and existing inequities to determine whether the measure is appropriately targeted;

(c) understand and engage with the community on the potential impact of a measure to ensure there are not unintended consequences and that any risks can be mitigated; and

(d) once a measure has been adopted, undertake regular monitoring.

[74] ICPG also sought to rely on the evidence of Papaarangi Reid, a professor of Māori Health at the University of Auckland. Professor Reid's affidavit discusses the factors contributing to inequities in health for Māori and the "complex web of interwoven and overlapping factors that are layered through time and generations". Professor Reid says that, given this complex causation, simple solutions run the risk of failure. Her view is that a "wider more systematic inquiry is required to evaluate whether equity has been secured". Professor Reid says this inquiry must take into account the following "dimensions of access":

(a) Approachability: for example, are all groups aware the services exist and are all groups aware of the need for the service?

(b) Acceptability: for example, is the service provided in a way that is culturally safe and age-appropriate, is the perception of the provider in

the community positive and trusted, are privacy and confidentiality needs well met, and is communication from the service providers clear and effective for all groups?

(c) Availability and accommodation: for example, what is the geographic service coverage for the population groups in need, is the service in a building which is physically accessible, is the location close to where people live/go about their lives, is there good public transport and parking, and are the services open when people need to access them?

(d) Affordability: for example, what is the cost of the service, what is the cost of getting to the service (transport and parking etc), and are there unintended consequences of the service (such as enticing consumers to pay more for co-located goods/services)?

(e) Appropriateness: for example, does the range of services offered meet the needs of all groups in the population (scope/range of services, continuity, integration with other providers) and are the services delivered well for all groups (best-practice care, right treatment, identification of errors, continuity, and integration with other providers)?

[75] Professor Reid also says that the effectiveness of interventions needs to be actively assessed as they may have unintended health consequences. She also discusses that increasing access for Māori is not the same thing as improving equity in access for Māori. Increasing access for everyone to pharmaceutical services including some increase for Māori does not equate to achieving equity for Māori. Professor Reid gives the example of locating a low- or no-cost pharmacy in a wealthy suburb, and says this may result in no increases in access for low-income Māori who do not live in that suburb.

Policies

[76] As mentioned, there were several policies in place which had a focus on health equity. ICPG says the DHBs were required to act consistently with these policies but

did not clearly identify the ways in which the decisions did not do so. Nevertheless, we set out some of the key points from these policies as they are useful in understanding how improving health equity for Māori was emphasised.[60]

[77] Specifically:

(a) The Ministry of Health's *Pharmacy Action Plan: 2016 to 2020* (the Action Plan) was a plan intended to contribute to the *New Zealand Health Strategy: Future direction* issued pursuant to s 8(1) of the NZPHDA. It referred to "access and equity" as one of the challenges faced by the health system. It referred to the World Health Organization (WHO) definition of "equity" as "the absence of avoidable or remedial differences among populations or groups or defined socially, economically, demographically or geographically". It described improved "access and equity of health outcomes for Māori, Pacific and other priority populations" as an "overarching principle" of the Action Plan. A key goal was to understand and meet people's needs and improve their experience of services. A partnership approach, involving people in planning and designing services, was said to be helpful in achieving this goal. It also said that proactively increasing Māori and Pacific Peoples in the pharmacy workforce would improve cultural competence and help achieve the partnership approach.

(b) *Our Vision for Change* (2017–2027) (an HVDHB policy) referred to the Treaty of Waitangi, said "particular attention" needed to be paid to the health needs and aspirations of HVDHB's Māori population and that there were "well-documented inequalities" in the determinants of health between Māori and non-Māori which flowed through to inequalities in health outcomes.

(c) *Te Pae Amorangi* (HVDHB's Māori health strategy for 2018–2027) which set out eight principles for decision making, of which "equity" was one. It referred to the above WHO definition of equity. It said

[60] We were not referred to anything in particular in relation to Hauora Tairāwhiti's policies.

HVDHB would "analyse and monitor our achievements and performance for Māori compared with non-Māori and make decisions that address gaps in our performance". An "example" of the application of this principle was to set out equity expectations in new funding and monitoring performance of these.

(d) *Future Pharmacist Services 2018–2023* (HVDHB's five-year pharmacist services strategy) explained that the strategy had been developed with input from pharmacists, patients, general practitioners and non-government organisations. This said that "[r]educing inequity by reducing the cost barrier was the single greatest need identified". It also referred to having funding follow the patient, by advocating for extending the period of supply to six months, as well as creating better public awareness of the services that pharmacists can provide.

Assessment

[78] In relation to HVDHB, ICPG submits that the co-payment waiver was a material factor in HVDHB's decision and yet its analysis was superficial. It says Ms Haggerty failed to consider what equity required and did not identify the risks posed by the Countdown proposal. It says that the evidence of Dr Meade and Professor Reid highlights the risks and the kind of assessment that is necessary to advance equity.

[79] We do not accept this submission. We consider it was not necessary for HVHDB to obtain the kind of generic expert evidence that is discussed by Dr Meade and Professor Reid about possible risks of waiving co-payments to be properly and reasonably informed about whether granting an ICPSA to Countdown for a pharmacy in Wainuiomata could improve access for Māori and other sectors of the population in the area to pharmaceuticals. The decision was of a kind where those involved in the decision could call on their own expertise, experience and assessment models to reach their decisions.

[80] Ms Haggerty has worked as a senior executive for over 30 years in the New Zealand health service in a variety of roles. Her extensive experience includes

working with Māori, Pacific and high needs communities. As discussed above, a new application for a services agreement is first evaluated by a Panel against the criteria earlier mentioned. As Ms Haggerty explained, this Panel comprises personnel with relevant expertise and experience.[61] It included Ms Waldegrave as a Māori health representative. In her role as the HVDHB's Acting Director of Māori Health, Ms Waldegrave led a team that met regularly with Māori providers and had insight into the difficulties for disadvantaged Māori in Wainuiomata and the Hutt Valley more generally.

[81] Nor do we accept that HVDHB was required to undertake Professor Reid's systematic inquiry in order to be appropriately informed as to whether the proposed decision would have one of its intended benefit (here improving health inequities particularly for Māori). Professor Reid provides a thorough and comprehensive model for evaluating equity. But the NZPHDA did not require this of DHBs in the context of decisions on whether to grant an ICPSA to a provider of pharmaceutical services.

[82] Moreover, many of the dimensions of that model and the risks of co-payment waivers were considered. For example, the pharmacy was to be located in an area with a relatively high proportion of disadvantaged Māori. Further, as discussed above, the Panel considered the quality of service, whether it would work in an integrated way with local GPs, the risks to other pharmacy services as well as whether extended opening hours and the co-payment waiver would benefit equity. There were differences in view about the latter but Ms Haggerty gave weight to Ms Waldegrave's view about this which was consistent with her own view.

[83] Similarly, Ms Cunningham's evidence sets out a model for assessing an initiative intended to address health inequity. However, it is not the case that the NZPHDA required a DHB to adopt this model in relation to any decision it makes to enter into a service agreement for the provision of health services. Moreover, Ms Cunningham's model was in substance met by HVDHB's processes. The purpose of the equity measure was clear (remove a cost barrier to improve access), information

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[61] The Panel comprised the Clinical Director of Primary and Integrated Care, the Chief Pharmacist, a Māori health representative, the Service Planning and Integration Manager Pharmacy Services for HVDHB, and a DHB Strategy and Planning Representative.

and understanding about local needs was met through the experience of those making the decision and the risks to other pharmacies were considered. Subsequent to the decision we note that there has been data analysis to see whether there has been an increase in the uptake of medicines.

[84] ICPG submits that HVDHB's policies were relevant to whether it was properly informed before it made its decisions. In our view nothing has been pointed to in these high-level policies to suggest that HVDHB was not reasonably informed. A key theme of these policies was the need to advance equity for Māori and other disadvantaged populations. HVDHB was entitled to place emphasis on the Countdown pharmacy in Wainuiomata improving access for Māori and other disadvantaged populations because of the increased opening hours and the waiver of the co-payment.

[85] As to Hauora Tairāwhiti's decision, ICPG submits that it was not properly informed before it made its decision because Ms Roberts did not carry out any specific research about the effect of the extended opening hours and the waiver of the co-payment fee. It also says Ms Roberts incorrectly applied the HEAT tool because she described the "unintended consequences" as "unknown". It also says that Hauora Tairāwhiti made the same error as HVDHB because it did not have sufficient evidence that health outcomes would be improved through improving equity.

[86] For similar reasons as those discussed in relation to HVHB we do not accept these submissions. Hauora Tairāwhiti was appropriately informed for the decision it made. As with HVDHB it could call on its own expertise, experience and assessment models to reach its decisions and was not required to follow the kinds of models discussed by Ms Cunningham and Professor Reid. Nor did it need to investigate the kinds of generic risks that Dr Meade identified. As with HVDHB, there was considerable expertise and experience through the model that Hauora Tairāwhiti used to consider, in accordance with its Provider Policy, whether the application would advance equity and whether an ICPSA should be granted.

[87] Part of Hauora Tairāwhiti's process included engagement by Ms Ehau and Ms Roberts with local pharmacies as part of its pharmacy strategy. As discussed earlier, when the application by Countdown was received Ms Roberts carried out the

initial assessment. As part of that assessment Ms Roberts met with existing pharmacies who had expressed concerns about the proposal. Ms Roberts also used the HEAT tool which provided a model for measuring equity considerations and benefits of the proposal. This tool involved assessing the application with reference to particular topics: understanding health inequities; how the application would intervene to tackle this issue; how Māori health outcomes would improve and health inequities experienced by Māori reduced; reviewing and refining intervention; and how a reduction of inequities would be measured. Under each of these headings there were several topics to be considered.

[88] The Benefits Criteria took into account population health, patient experience, value for money and whether it made contributions to workforce development or infrastructure capacity, with weighting criteria. On Ms Roberts' assessment, Countdown's application scored 9.2 out of 12 scoring highly on population health (improving access to populations — Māori — with high health needs, contributing to prevention, and eliminating health inequity) and value for money (return on investment, impacting acute demand and delivering effective care).

[89] ICPG criticises Mr Roberts' HEAT tool analysis as inadequate in one respect. This related to the topic "reviewing and refining" intervention. Under this topic, the HEAT tool asked four questions, namely: what the predicted outcomes for health inequities were; who stood to benefit the most from this intervention; whether there were "any unintended consequences that [could] be foreseen"; and what needed to be done to ensure the benefits would accrue to the intended population. In relation to the "unintended consequences" question, Ms Roberts' response was "[q]uality of service is unknown in Tairāwhiti as new provider".

[90] ICPG submits this was inadequate. It says this response foreclosed the inquiry the HEAT tool was intended would be carried out. It says Hauora Tairāwhiti, as a matter of legal obligation, was required to make reasonable inquiries as to the unintended consequences.

[91] We disagree that this is evidence that Hauora Tairāwhiti failed to make reasonable inquiries. As a matter of statutory obligation, Hauora Tairāwhiti was not

required to review literature or commission an expert such as Dr Meade or any other similar steps.

[92] We take this view even if unintended consequences, by necessary implication, could be said to be a mandatory relevant consideration (which is at least doubtful) when a decision to enter a service agreement is made in part because improving health equity is seen as a benefit of the agreement. This is because the inquiries that are to be made must be reasonable in relation to the decision at hand. Here it was reasonable for Ms Roberts to consider that she did not need to carry out further inquiries about the unintended consequences because her "risk mitigation" response to this issue was that analysing and monitoring the case mix and prescription data would "ensure that the service [was] reaching the intended population". Ms Roberts' process also involved regular communications with providers.

[93] Additionally, Ms Roberts' assessment was only part of the process. After Ms Roberts' assessment, it was then considered by the informal governance committee (Te Rōpū Rauemi Rautaki) and two other advisory committees (Hiwa-i-te-Rangi and Te Waiora o Nukutaimemeha), each with different relevant expertise, and finally by the board of Hauora Tairāwhiti. As to whether waiver of the co-payment and extended opening hours would improve access for Māori, the Te Waiora o Nukutaimemeha committee was informed and well placed to make this assessment.[62]

[94] Under the Hauora Tairāwhiti process, there was also a monitoring process as the models discussed by Professor Reid and Ms Cunningham contemplate. A portfolio manager such as Ms Roberts, aimed to have quarterly contact with providers for performance monitoring purposes. Additionally, her role included having monthly meetings (by video call at this time) with primary health organisations and she was in regular contact with community pharmacists. As it transpired, the Countdown pharmacy in Gisborne kept Hauora Tairāwhiti informed of its difficulties in staffing the pharmacy that eventually led to its closure. We do not regard this as evidence of a failure by Hauora Tairāwhiti to be reasonably informed of mandatory relevant

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[62] This committee was made up of three community elected members, one rangatahi, one Māori health provider, one Ngāti Porou Runanganui representative, one Tūranganui-a-Kiwa representative and one ex-officio member.

considerations as ICPG submits. Rather, the ICPSA was granted because it could advance Māori health inequity if the new business was successful. Ultimately it was not successful but that does not mean that it was an unlawful decision under the NZPHDA.

Conclusion

[95] We conclude that the decisions were within the scope of the power given to DHBs under the NZPHDA. HVDHB and Hauora Tairāwhiti were appropriately informed to make their decisions to grant ICPSAs to the two Countdown pharmacies in part because those pharmacies could improve Māori health inequity by removing cost and inconvenience barriers to access. The mandatory relevant considerations were properly addressed.

[96] We also conclude that the expert evidence that ICPG sought to rely on was not substantially helpful in determining whether HVDHB and Hauora Tairāwhiti had sufficient information to make their decisions in accordance with their power to do so under the NZPHDA. The Judge was therefore correct to rule the evidence inadmissible.

Treaty of Waitangi

Submission

[97] ICPG submits that the HVDHB did not act in accordance with the Treaty of Waitangi.[63] It says it did not do so because it did not take active steps to be sufficiently informed about the equitable impact of the decision. Rather, at best it took a "surface-level", "overly simplistic" assessment of this. It says HVDHB did not create mechanisms to enable adequate Māori input at a local level. It says a "singular Māori voice" from Ms Waldegrave was insufficient and there was no evidence of broader consultation and engagement by Ms Waldegrave with the Māori Health Unit.

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[63] This submission was also made in the High Court in respect of Hauora Tairāwhiti. It was rejected by the High Court and is not pursued on appeal.

High Court

[98] The High Court Judge rejected this submission. The Judge noted that s 4 of the NZPHDA provides that it recognises and respects Treaty principles through the mechanisms of pt 3 of that Act pursuant to which Māori contribute to decision-making on, and participate in the delivery of, health and disability services.[64] Those mechanisms did not include additional obligations when entering into a service agreement under s 25 of the NZPHDA.[65] The Judge was satisfied that, through its policies, Ms Waldegrave's experience and insight in the local community, and the Māori Health Unit, the HVDHB provided for Māori to be part of the decision-making process.[66]

Assessment

[99] There is no stand-alone duty to comply with the Treaty in this context.[67] We agree with the Judge that the NZPHDA provided for the Treaty principles to be recognised and respected through the pt 3 mechanisms. Amongst other things under pt 3:

(a) Every DHB had as one of its objectives to reduce health disparities by improving health outcomes for Māori.[68]

(b) Every DHB had functions that included establishing and maintaining processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement; to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori; and providing for the needs of Māori.[69]

(c) The Minister was to endeavour to ensure that Māori membership of a DHB board was proportional to the number of Māori in the DHB's

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64 Judgment of Gwyn J, above n 1, at [227].
65 At [227].
66 At [242].
67 See *Smith v Attorney-General* [2024] NZCA 692, [2025] 2 NZLR 1 at [150].
68 NZPHDA, s 22(1)(e).
69 Section 23(1)(d)–(f).

resident population and, in any event, there were at least two Māori members of the board.[70]

[100] Additionally, as discussed, HVDHB had put in place the policies *Te Pae Amorangi*, *Future Pharmacist Services 2018–2023* and *Our Vision for Change* (2017–2027). The first of those was directed to decision making for Māori and all emphasised Māori health inequity.

[101] We consider this ground of review is again better framed as a duty to take into account the Treaty as a mandatory relevant consideration and a requirement to be reasonably informed in order to do so.[71] Framed in this way it must fail in the same way as the ground of review just considered. That is to say, we do not agree that HVDHB was inadequately informed in making its decision to grant Countdown an ICPSA about whether this would be of benefit in addressing Māori health inequity.

[102] We consider this submission downplays Ms Waldegrave's experience.[72] It is not necessary for there to be evidence that she utilised her team members' experience and insights as it is obvious that as the leader of the team, she had access to that experience and insights in the course of her role. She could represent the views and knowledge of her team without involving them directly in her recommendation.

[103] Moreover, Ms Waldegrave was a strong advocate for addressing Māori inequity as the background we have set out earlier shows. It was her view that the decision would benefit Māori in the area. Ultimately her views prevailed over the majority view of the Panel. We also note that no Māori whom it was anticipated would benefit from the decision have joined ICPG's challenge and ICPG does not purport to speak for Māori (other than that it says it seeks to hold HVDHB to its Treaty obligations).

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70 Section 29.

71 *Smith v Attorney-General*, above n 67, at [147] and [151].

72 Prior to her role as Acting Director, Ms Waldegrave's previous roles included being a Senior Public Health Adviser and later Team leader, Analytical and Policy for the Regional Public Health services of the Greater Wellington Region. Ms Haggerty also described Ms Waldegrave as a respected researcher.

Conclusion

[104] This ground of review is not made out.

Costs

[105] ICPG submits that the High Court erred by awarding costs to HNZ on a blanket 2C basis for all steps taken after 1 July 2022 (when DHBs merged into HNZ) without assessing whether each step taken thereafter would have taken a comparatively large amount of time.[73] It says there are three steps in this period which should have been assessed at 2B which would reduce the costs by $6,214.

[106] Costs were the subject of detailed consideration in the High Court in a 61-paragraph judgment. The Judge turned her mind to how to address costs given the merger. For the steps taken for the period prior to 1 July 2022, the Judge considered that 2B costs for two counsel for each DHB was appropriate whereas 2C for HNZ was appropriate thereafter. The Judge then specifically addressed those steps before and after 1 July 2022 that at that time were the subject of challenge by ICPG. In some instances the Judge accepted ICPG's challenge. In these circumstances, we consider it is not appropriate to interfere with the Judge's discretion.

Result

[107] The appeal is dismissed.

[108] The appellant is to pay the first and second respondents costs for a standard appeal on a band A basis, together with usual disbursements. We certify for second counsel for the first respondent.

Solicitors:
Tripe Matthews Feist, Wellington for Appellant
Buddle Findlay, Wellington for First Respondent
Russell McVeagh, Auckland for Second Respondent
Te Tari Ture o te Karauna | Crown Law Office, Wellington for Third Respondent

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[73] *New Zealand Independent Community Pharmacy Group v Te Whatu Ora – Health New Zealand* [2023] NZHC 3314 [costs judgment].