

GOVERNANCE FRAMEWORK FOR KAHUNGUNU HEALTH AUTHORITY

Draft for Discussion



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1. Introduction: how an iwi-led hauora system expresses our Rangatiratanga

Across generations, Māori have maintained and reasserted expressions of rangatiratanga through political movements, cultural revitalisation, tribal leadership, community organisation, legal advocacy and the development of Māori-led institutions and services.

Today, iwi, hapū, Māori organisations and Māori-led enterprises continue to demonstrate increasing leadership, capability and economic strength across multiple sectors. Many Māori institutions have developed sophisticated approaches to governance, service delivery, environmental stewardship, education, investment and cultural revitalisation.

At the same time, many public (Crown) systems and institutional arrangements remain grounded in structures that were not designed to reflect Māori authority, values or aspirations. This continues to create challenges regarding representation, coordination, long-term strategic influence and the ability of Māori to exercise collective capability within systems that remain largely Crown-defined. Māori communities continue to experience persistent inequities across health, housing, education, justice, employment and broader wellbeing outcomes despite decades of Crown reform efforts and Māori advocacy.

These realities raise important questions regarding the long-term infrastructure, coordination and collective capability required to support stronger expressions of rangatiratanga and Māori-led development over the coming decades. Across the world, indigenous peoples are continuing to strengthen practical expressions of sovereignty through governance, economic development, cultural revitalisation, data capability, environmental stewardship and collective institution-building. Many of these indigenous peoples came into contact with colonisers long before Aotearoa (in some cases 200-300 years before), so have experiences that we can learn from as they come out of those colonial periods to re-assert their rangatiratanga and rebuild their sovereign nations.

While constitutional arrangements differ significantly between countries, indigenous nations globally are increasingly demonstrating that forms of indigenous authority and self-determined development can be exercised within diverse political and legal environments. Rangatiratanga reflects an intergenerational vision for strengthened Māori authority, capability and self-determined development within Aotearoa and beyond.

It recognises that rangatiratanga is not solely political or constitutional in nature, but is also expressed through culture, language, governance, relationships, economic development, environmental stewardship, knowledge systems and the everyday ability of Māori communities to make decisions over matters that affect their people and futures.

This vision does not assume a single constitutional model, centralised structure or uniform pathway for all iwi and Māori communities. Rather, it acknowledges:

- the diversity of iwi, hapū and Māori realities;
- the enduring importance of mana motuhake;
- the relational foundations of Te Tiriti o Waitangi;
- and the need for approaches that are grounded in tikanga, collective responsibility and intergenerational wellbeing.

Rangatiratanga in Hauora invites consideration of what stronger practical expressions of Māori sovereignty may look like over time within the unique constitutional context of Aotearoa.

This may include:

- strengthened Māori-led governance and decision-making;
- accelerating gains through collectivising our capability and focusing on strategic coordination;
- asserting indigenous data and knowledge sovereignty;
- continuing to build Māori-led systems of research, education and innovation;
- stronger economic independence and investment capability;
- enhanced environmental and resource stewardship;
- continued revitalisation of language, culture and identity;
- and more equitable relationships between Māori and Crown institutions.

Importantly, Rangatiratanga is not framed as a singular end-state to be achieved through one constitutional event or institutional reform. It reflects an ongoing process of nation rebuilding, capability development and the strengthening of Māori authority across multiple domains over generations. The pathway toward strengthening Rangatiratanga will require:

- visionary and collective leadership (acting for the benefit of all and not just individual institutions);
- long-term strategic investment (financial, human and infrastructure);
- shared infrastructure and capability (to achieve efficiencies through economies of scale);
- policy, legal and research expertise (using Māori advocacy, political influence and Māori-generated evidence);
- indigenous data sovereignty and intelligence capability (building the ability to argue Crown analysis through Māori-interpreted analysis);
- strategic communications and narrative leadership (taking greater control of the narrative to tell our story in a way that educates and informs whānau Māori and wider public);
- and sustained collaboration across iwi, hapū, Māori organisations and communities (unity is strength – division is counter-productive and weakens our voice).

At its heart, Rangatiratanga is about working individually and collectively to thrive as self-determining peoples across generations. We in Kahungunu must work together for the benefit of all – and not for our own self-interests – if we are to lift our overall wellbeing and succeed as a sovereign people:

Ehara taku toa i te toa takitahi, engari he toa takitini

My individual success is not mine alone, but the success of many

2. Considerations for a Governance Framework

2.1 Purpose

The purpose of this paper is to consider what the governance model for the Kahungunu Health Authority (KHA) may look like. However, it is important to understand how such an entity may operate within the context of an overall coordinated Ngāti Kahungunu health and wellness eco system.

Such a “system” extends far beyond planning, funding and delivering services and programmes—it embodies an Iwi’s inherent responsibility to care for its people and others residing within its rohe. Manawhenua are charged with protecting, promoting, and restoring the physical, mental, emotional, and spiritual well-being of all citizens and the environment in which they live. Manawhenua operate under their sovereign authority, meaning their decisions, policies, and priorities reflect Iwi law / lore, cultural teachings, and community expectations. Accordingly, a Kahungunu Health Authority is accountable to the people it serves, ensuring that hauora services are planned, funded and delivered in a manner that is culturally grounded, equitable, and responsive to evolving whānau and community needs.

The Kahungunu Health Authority should envision a future where every citizen has access to high-quality, culturally aligned health services that support lifelong wellness. This vision includes a hauora system that is trusted by whānau, hapū, Iwi and the community, staffed by a skilled and compassionate workforce, and guided by cultural knowledge and traditional healing practices. A thriving community is one where health disparities are eliminated, wellness is celebrated, and future generations inherit a strong, resilient support system rooted in sovereignty and cultural identity.

2.2 Guiding Principles for a governance framework

- **Rangatiratanga / Sovereignty** Every decision made by the KHA is grounded in the Iwi’s inherent right to self-govern. Sovereignty shapes how the KHA plans, funds, designs, generates and manages data, negotiates any agreements, and interacts with outside governments. This principle ensures that the Iwi—not external agencies—sets the direction for its hauora system.
- **Cultural Alignment** Cultural teachings, traditional healing practices, and community values guide leadership, care delivery, and policy development. Cultural alignment ensures that services are not only clinically effective but also spiritually and culturally meaningful.
- **Community Accountability** The KHA is accountable to the community it serves. Transparency, open communication, and opportunities for community input are built into governance processes. This ensures that the KHA reflects community priorities and maintains whānau and public trust.
- **Health Equity** The KHA is committed to eliminating health disparities and addressing the social, economic, and environmental factors that influence hauora. Equity means ensuring that all whānau—regardless of age, income, or location—have access to the care and resources they need to maintain their wellbeing
- **Data Sovereignty** A Kahungunu hauora system owns, governs, and controls all hauora-related data. This principle protects privacy, strengthens self-determination, and ensures that data is used to benefit the community rather than external interests.

- **Holistic Wellness** The KHA recognizes that health is multidimensional. True wellness includes physical health, emotional balance, spiritual grounding, cultural identity, and strong relationships. Activities are designed to support all aspects of well-being.
- **Transparency between governance and operations** The KHA acknowledges that political roles need to have an appropriate separation from operational roles. Political representation needs to be strategic, active in advocacy, well-informed with robust technical advice and information, and skilled in diplomacy. Operations includes experts in planning, whānau engagement, funding, monitoring and data management and front-line service delivery. Operations should generate expert technical advice as the day-to-day operators within the system, to the political representatives to inform their advocacy.
- **Intergenerational Responsibility** Decisions made today must support the health and wellness of future generations. The KHA considers long-term impacts, ensuring that the health system remains sustainable, culturally grounded, and adaptable.

2.3 International indigenous models to consider

International indigenous experiences highlight that sovereignty is not expressed solely through constitutional recognition or political independence. It is also expressed through the ability of indigenous peoples to:

- govern and invest collectively;
- protect language, culture and knowledge systems;
- exercise stewardship over lands and resources;
- develop independent economic capability;
- influence policy and legislative environments;
- lead research and data systems;
- and sustain intergenerational leadership and institutional capability.

In North America, many Native American tribes and First Nations exercise varying degrees of jurisdictional authority, economic autonomy and governance capability through tribal governments, treaty relationships, indigenous enterprises, health systems, educational institutions and resource management arrangements.

Native American health “authorities”

Over 350 Tribes in the USA now self-manage their own health systems having assumed control from the Federal government, with many overseeing and managing health entities and corporations that include hospital care, primary care, mental health and addictions, and public health in facilities that they design and own. Below are some examples:

- **Gila River Health Care (GRHC), Phoenix:** Has its own Health Board appointed by the Tribal Council and oversees the planning, funding and delivery of several secondary care and primary care services. They have been operating for over 30 years as a self-governing Tribe
- **Cherokee Nation Health Services, Oklahoma:** Cherokee Nation Health Services (CNHS) is the largest tribally operated health care system in the United States. CNHS is a growing multifaceted health care system. With almost 160 full-time care providers (clinical/medical) and over 2,200 health services employees, CNHS is the gem of the region in continuity of care.

Committed to improving patient access, Cherokee Nation has invested substantially in technology, building new facilities and expanding existing locations. Their hospital and nine health centers deliver “world-class patient care”. The W.W. Hastings Hospital is a 60-bed inpatient hospital that Cherokee Nation assumed on October 1, 2008. CNHS recently opened a new four-story outpatient health center on its Tahlequah campus including the Cherokee Nation Medical School. Some of the services offered includes optometry, audiology, physical rehabilitation, behavioral health, radiology, lab, pharmacy, primary care, and dental, ambulatory surgery center, with five surgical suites, and two-endoscopy suites.

- **Seneca Nation Health System, New York State:** Seneca Nation’s programs provide a full range of primary and preventive care for acute and chronic illness and injuries including medical, dental, pharmacy, mental health and addictions and community programmes. In addition, they have service agreements with several local hospitals, professional groups and agencies for inpatient treatment and specialty care.

The “Alaska Tribal Health System” (ATHS)

The Alaska Tribal Health System (ATHS) is a diverse and multifaceted healthcare system that has developed over the last 35 years. It represents the diversity of Alaska Native people. Alaska has 229 federally recognized tribes that live across 586,412 square miles of predominantly road-less land, the underlying reason for the creation of this innovative and essential statewide health system. Tribal health organisations in most areas are the only healthcare providers available and therefore serve everyone in the area regardless of race. In 2024, there were 234,000 Alaska Native people eligible to receive services through the ATHS. With 178 village clinics who employed more than 468 community health aide/practitioners, Alaska is the only state in which over 99 percent of health programs are managed by tribes and Native organizations.

Alaska Native Health System

Facts

229 Federally Recognized Tribes (Villages)

SCF:

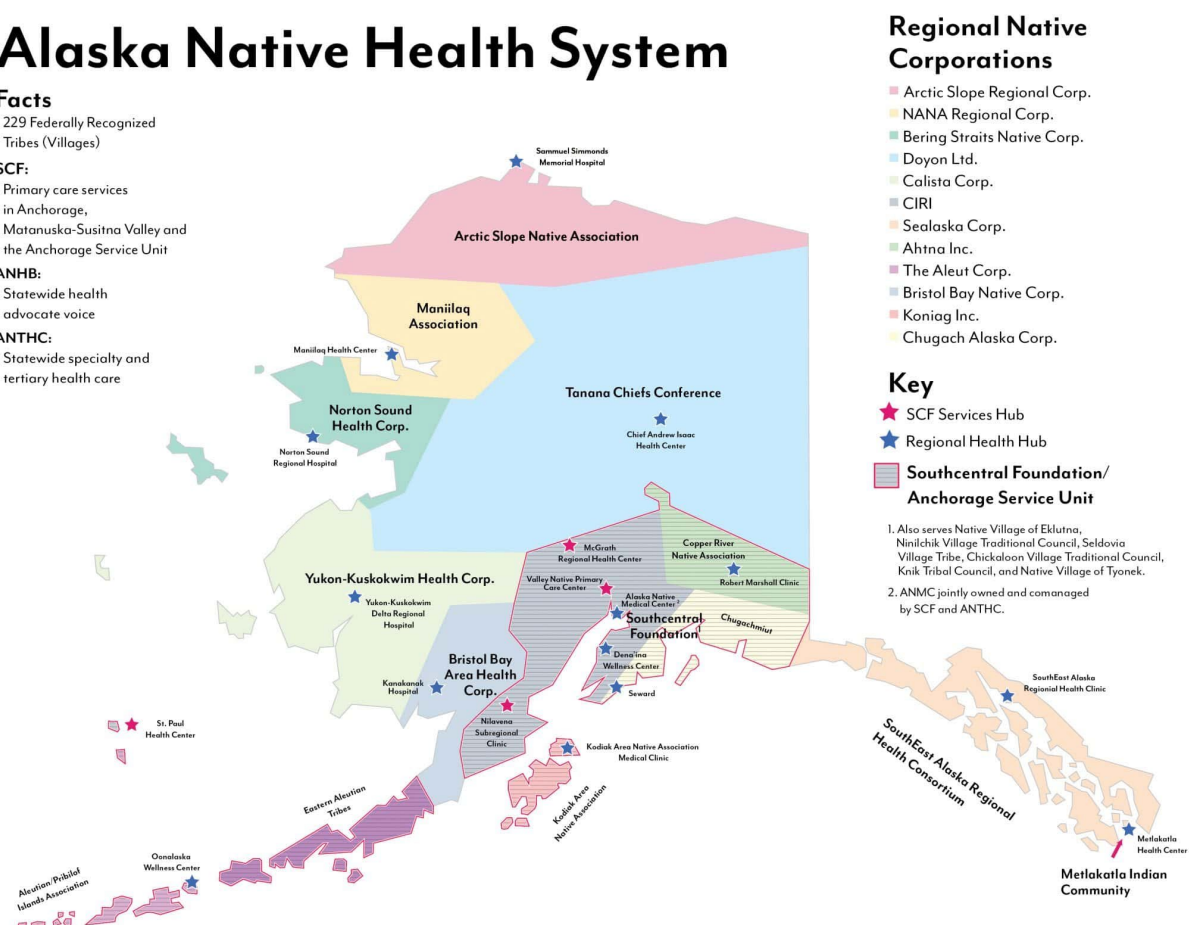
Primary care services in Anchorage, Matanuska-Susitna Valley and the Anchorage Service Unit

ANHB:

Statewide health advocate voice

ANTHC:

Statewide specialty and tertiary health care



Established in 1968, the Alaska Native Health Board (ANHB) serves as the statewide voice on Alaska Native health issues. ANHB's mission is to promote the spiritual, physical, mental, social, and cultural well-being, and pride of Alaska Native people. As the statewide Tribal health advocacy organization, ANHB supports Tribal partners, state and federal agencies to achieve effective communication and consultation. ANHB provides in-depth policy analysis, technical expertise, coordination, and training. In this process, ANHB advocates for the health and well-being of all Alaska Native people. Health service delivery agencies such as ANTHC and the range of health providers – deliver technical advice and work with ANHB to set annual priorities.



The Alaska Native Tribal Health Consortium (ANTHC) has been operating since 1998 and has *“helped usher in a new era of self-governance and self-determination where the healthcare Alaska Native people receive is directly in their hands”*. ANTHC is a consortium of Tribal representatives. They undertake functions best done together centrally – rather than by each Tribe alone. This includes design of wellness programs for all citizens, research and prevention, workforce development for Alaska Natives across the State, designing and building rural water and sanitation systems, infrastructure projects, climate change aid, and much more.

Over the years, the Consortium has grown into the largest, most comprehensive Tribal health organisation in the United States. They employ more than 3,700 employees who provide a vast array of world-class health services at the Alaska Native Medical Center hospital (ANMC) in Anchorage and directly in communities through field clinics and telehealth.

Regional Tribal health organisations and village clinics deliver routine secondary and primary care to communities in their respective areas.

Sámi Parliament, Scandinavia (Finland, Norway, Sweden)

In Scandinavia, Sámi institutions provide examples of indigenous political representation, cultural protection and transnational indigenous collaboration across state boundaries. The Norwegian Sámi Parliament for instance has 39 representatives elected by direct vote from 7 constituencies. The plenary is the highest body in the Sámi Parliament, and it is sovereign in the execution of the Sámi Parliaments duties within the framework of the Sámi Act.

The parliament works with political issues it considers relevant or of interest to the Sámi people. The responsibilities are: "(1) to serve as the Sámi's elected political body to promote political initiatives and (2) to carry out the administrative tasks delegated from national authorities or by law to the Sámi Parliament." The extent of responsibility that was assigned and transferred from the Norwegian government at the time of establishment was modest (1989). However, more responsibilities have been added including management of the Sámi Development Fund, which

is used for grants to Sámi organization; responsibility for the development of the Sámi language in Norway, including allocation of funds to Sámi language municipalities and counties; responsibility for Sámi culture, including a fund from the Norwegian Council for Cultural Affairs; protection of Sámi cultural heritage sites; development of Sámi teaching aids, including allocation of grants for this purpose. Funding is granted by the Norwegian state over various national budget lines. But the parliament can distribute the received funds according to its own priorities.

Australia

One example of a health care Aboriginal-led entity is in Cape York, Australia, known as the Torres and Cape Health Care (TORCH) Commissioning Fund reform program, which has evolved into the Cape and Torres Health Commissioning Ltd (CaTHC). CaTHC is an independent, community-controlled regional healthcare commissioning body. It was developed to empower local communities (including Aboriginal and Torres Strait Islander peoples) to plan and purchase their own health services rather than relying solely on the government. It is headquartered in the Torres and Cape region of Queensland. CaTHC is governed by an expert board of regional community leaders. Over a phased 10-year period, health service planning and funding administration for the region will transition into the hands of this community-controlled entity.

These international experiences do not provide a singular model for Aotearoa to replicate. Rather, they demonstrate that practical expressions of indigenous sovereignty can evolve differently across constitutional contexts while remaining grounded in indigenous values, histories and aspirations.

International Indigenous Context

Many nations. Shared journeys. Collective learning.

Indigenous peoples around the world are strengthening practical expressions of sovereignty through governance, culture, economic development, data sovereignty, environmental stewardship and collective institution-building.

Constitutional arrangements differ. Our values endure.

Governance
Self-determined leadership and decision-making

Culture & Identity
Language, tikanga and knowledge revitalisation

Economy
Indigenous enterprise, investment and economic autonomy

Taiao & Resources
Kaitiakitanga and stewardship of lands, moana and ecosystems

Data & Knowledge
Indigenous data sovereignty and research leadership

Influence & Relations
Policy influence, diplomacy and inter-indigenous collaboration

Different paths. Shared purpose. One future.

For generations, Māori have maintained enduring relationships with whānau across te Moananui-a-Kiwa through whakapapa, voyaging, trade, diplomacy and the exchange of mātauranga, experiences and leadership.

Reciprocity in action. Collective strength in relationship.

For Māori, the challenge is not whether international models can be directly imported into Aotearoa. The challenge is how Māori continue to strengthen our own expressions of rangatiratanga, mana motuhake and collective capability in ways that are grounded in:

- Te Tiriti o Waitangi;
- tikanga Māori;
- iwi and hapū realities;
- and the unique constitutional environment of Aotearoa.

Across the Pacific, indigenous peoples have long exchanged mātauranga, leadership approaches, environmental practices and strategies for sustaining collective wellbeing across changing political and social landscapes.

These relationships continue today through ongoing indigenous collaboration, scholarship, governance dialogue and community exchange. Experiences shared between Māori, First Nations peoples, Native American tribes, Pacific nations and other indigenous communities continue to contribute to the evolution of indigenous governance, leadership and expressions of sovereignty both internationally and within Aotearoa.

This reciprocity reflects an enduring indigenous tradition of learning through relationship, collective experience and intergenerational exchange while remaining grounded within our own distinct histories, tikanga and aspirations.

3. Responsibilities

3.1 Governing Board

The Governing Board serves as the primary oversight body responsible for guiding the KHA's strategic direction, ensuring accountability, and upholding the Iwi values. Board members act as stewards of the hauora system, making decisions that reflect both community needs and long-term sustainability.

- **Strategic Direction** The Board establishes the mission, vision, and long-term priorities of the KHA. This includes setting strategic goals, approving major initiatives, and ensuring that the organisation remains aligned with Iwi values and community expectations.
- **Policy Oversight** The Board approves policies and compliance frameworks that govern the KHA's operations. This includes reviewing and updating policies to ensure they remain relevant, culturally aligned, and legally compliant.
- **Fiscal Stewardship** The Board oversees the KHA's financial health by approving budgets, reviewing financial reports, and ensuring strong internal controls. Fiscal stewardship protects Iwi resources and ensures that funds are used responsibly and transparently.
- **Risk Management** The Board identifies and monitors legal, financial, and operational risks. It ensures that the KHA has appropriate safeguards, insurance, and contingency plans in place.
- **Quality Oversight** The Board monitors health outcomes and whānau satisfaction- based on evidence from the technical / operational arm. It ensures that KHA activities meet whānau expectations.

3.2 Operations: planning and service delivery

Operations is responsible for the day-to-day management of the KHA. This includes overseeing any staff, managing budgets, and ensuring compliance with all regulatory requirements.

- **Operational Management** Executive leadership manages daily operations, supervises staff, and ensures that services are delivered efficiently and effectively for the Board
- **Service / Programme Implementation** Providers continue to ensure that services and programmes meet clinical standards, cultural expectations, and community needs and feed expert advice into the KHA operations to shape and advise the governance.
- **Reporting & Accountability** Executive leadership provides regular performance, financial, and compliance reports to the Board. This ensures transparency, supports informed decision-making, and maintains accountability.

3.3 Whānau Voice

Whānau voice mechanisms are created or included to ensure that the KHA remains grounded in whānau and community needs, tikanga and lived experiences. This may include for instance:

- patient experience, service quality, and access to care
- youth and kaumatua who offer unique perspectives that help shape policies
- culture, language, and traditional healing practices advice

4. Governance Structure Options

4.1 The current health system in the Ngāti Kahungunu rohe

The health system within the rohe is made up of services largely oriented toward treating illness and accidents – in Māori terms it would not be classified as a Hauora system as it excludes health of the taiao, cultural wellbeing, connection and identity, and Rangatiratanga.

Those who operate within the current health system include policy and law makers; planners and funders; advocates; and service deliverers. Hauora Māori providers make up a small proportion of the service delivery ecosystem (2% of the health budget) and Māori voice and influence across the rest of the system is even smaller. The system is largely controlled by the Crown and private sectors. It is a complex system that presents multiple challenges for our whānau:



The specific Iwi / Māori components of this ecosystem are whānau + Manawhenua entities + Tihei Takitimu IMPB + Māori providers. The rest of the ecosystem is controlled by a range of Crown, private and non-profit entities so for now are not included in the design of the Kahungunu Health Authority. This is not to say that some of their functions may not be considered for devolution or

transfer to the Kahungunu Health Authority in the future – but it signals the important stakeholders who need to have a role in the proposed Authority at the outset.

This is an opportunity to organise the Iwi / Māori component of the health system so that collectively we can exert greater influence and voice over (a) the current health system which whānau will still be accessing and (b) those aspects of hauora that sit outside the health system such as environmental, cultural and social wellbeing.

4.2 Structural options available

The Kahungunu Health Authority may adopt one of several governance models depending on its size, culture, and political structure. Each model offers distinct advantages and disadvantages. Like other indigenous models – there could be a single new entity, endorsement of an existing entity, a consortium / collective entity, or a formal / informal collaboration. Given form should follow function – the option for governance structure should primarily be based on what the proposed functions of the Kahungunu Health Authority should be. Until functions are formally designed, any governance model implemented now may be seen as an interim design to progress the work moving forward, that might be subject to change once final functions and priorities are confirmed.

Legal entity options remain as:

- Company structure: Where Directors are appointed and shareholders are identified (with specific shares assigned to each) that could be a profit or non-profit entity
- Incorporated Society: With a minimum of 10 members. No one has “shares” but each has an equal voice to appoint the Board of Trustees or Committee
- Charitable Trust: Where Trustees are appointed by an establishment group and the “beneficiaries” are less defined (not shareholders or named members) such as “the trust exists for the benefit of all people living within the rohe of Ngati Kahungunu”

Decisions on formal structure can be made later once the design model is chosen.

4.3 Design considerations

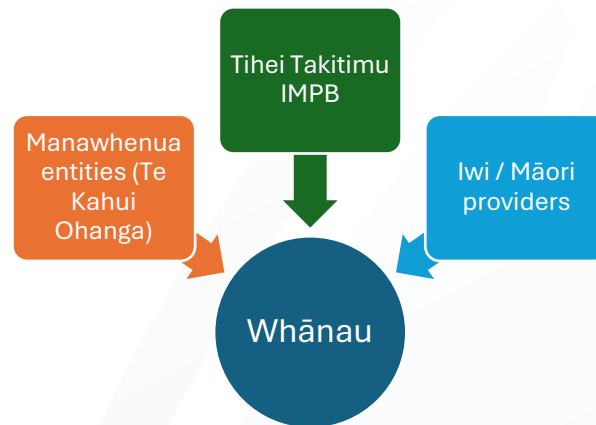
The governance framework for the Kahungunu Health Authority should:

- be representative
- be inclusive
- create logical and appropriate separation between political and technical (or governance and operations) levels of decision-making
- be fit for purpose
- not duplicate current structures – but build and enhance these

4.4 Options for consideration

Option A — Status quo

Status quo relates to the current situation and suggests an informal collaboration that would loosely be referred to as a Kahungunu Hauora Authority “forum”. Participating entities would meet regularly simply to try to coordinate advocacy efforts, messages and priorities.



ADVANTAGES	DISADVANTAGES
▪ Open invitation within each cluster for anyone to participate (inclusive) ▪ Offers opportunities to prioritise together and speak common messages - albeit independently ▪ Participating entities maintain current roles and expertise – protects current scope ▪ Doesn't require a new legal entity	▪ Status quo has existed for several years and is not having the overall impact needed to accelerate hauora gains for whānau ▪ Risks varied participation and loose commitment ▪ Does not unite the hauora voice across Kahungunu as there is still a risk that messaging is inconsistent and fragmented ▪ Lacks opportunities to formalise unification of political, advocacy and service delivery expertise on behalf of Ngati Kahungunu ▪ Does not offer clear visibility externally of a unified Ngati Kahungunu voice on Hauora ▪ Engagement by outside systems with Ngati Kahungunu remains fragmented ▪ Does not offer opportunities to combine and share evidence of whānau voice & aspirations gathered by each participating entity individually ▪ Enables larger part of the Hauora ecosystem to continue to dominate voice (advocacy), influence and resourcing while entrenching health inequities for whānau

Option B – Manawhenua endorsement of Tihei Takitimu as an interim KHA governing Board

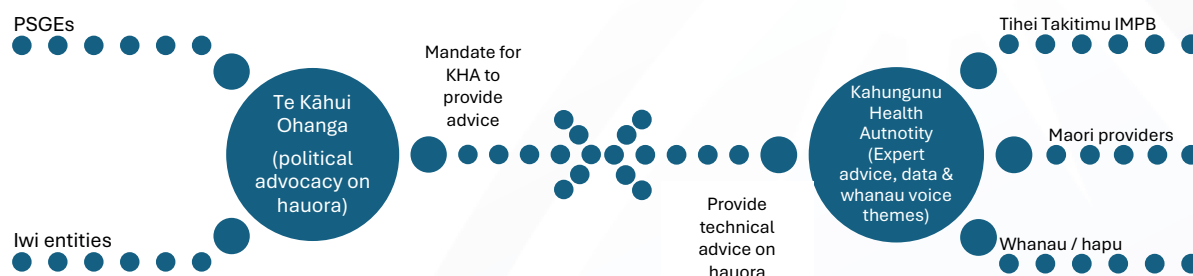
In this model, the manawhenua entities may endorse members of the governing board of the Kahungunu Health Authority (KHA) from an existing entity. This would ensure strong alignment between the KHA and manawhenua leadership, reinforcing manawhenua political, cultural, and strategic priorities while allowing endorsed board members to focus on hauora. Such a board would need to include people with health and hauora expertise (including clinical professionals) and community tikanga representatives, creating a balanced governance body that reflects both expertise and cultural knowledge.

Tihei Takitimu IMPB Board is an existing Board with a specific hauora focus that is not conflicted by being a service provider – and is already accountable to whānau. Such a political endorsement of the Tihei Takitimu board by manawhenua entities, to be the (interim) KHA board, would strengthen the connection between manawhenua entities and Tihei Takitimu and provide a strong interim mechanism until the final functions of the KHA are determined. Tihei Takitimu project sponsors could also consider an interim establishment board reporting to the Tihei Takitimu IMPB Board as a subcommittee - as one option to keep reporting and relationships in tact:

ADVANTAGES	DISADVANTAGES
▪ IMPB is established already with specific hauora expertise and leadership functions that focus on hauora (no other competing priorities) ▪ IMPB Board has appropriate expertise for the kaupapa ▪ IMPB already has a history of gathering whānau voice, influencing the system and monitoring the system for its performance for whānau ▪ IMPB has a statutory legitimacy with the health system from the Pae Ora Act 2022 ▪ IMPB does not have any conflicts as a service provider (for service funding) ▪ IMPB can mediate between manawhenua and providers ▪ Low-cost option and provides an interim solution until functions of the KHA are finally designed which may shape a new legal entity design ▪ Ready to go option – can move to next stage quickly	▪ Manawhenua may not “see themselves” in the IMPB structure so may require a formal reporting arrangement between IMPB and Te Kāhui Ohanga ▪ Māori providers may not see their voice in the KHA interim structure so will require a more formal reporting and accountability arrangement between the IMPB and providers including ability for providers to influence advice to the KHA Board ▪ IMPB legislated role and KHA independent role may run into conflict especially since IMPB role is government-funded (could be mitigated through interim nature of the KHA establishment board mechanism)

Option C: Manawhenua endorse a new KHA Hauora board of technical / operational entities

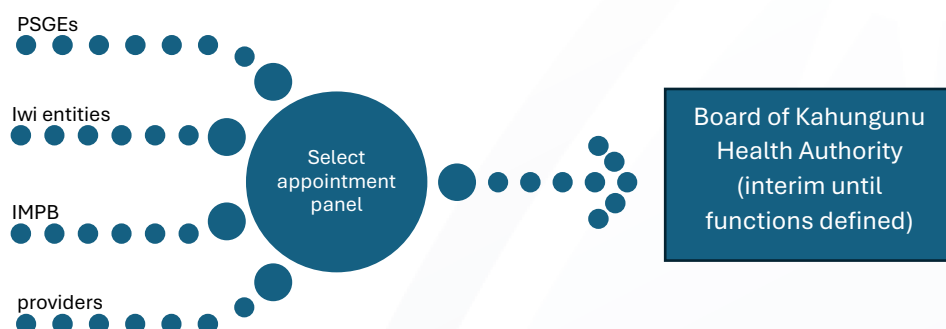
Another option may be for Te Kāhui Ohanga – an existing forum of manawhenua entities – to endorse a collective of the IMPB and providers to be the (interim) board for the Kahungunu Health Authority. Te Kāhui Ohanga would remain responsible for political advocacy based on the technical advice of the interim KHA made up of the IMPB and Māori providers.



ADVANTAGES	DISADVANTAGES
▪ Uses an existing forum of manawhenua organisation (albeit not a legal entity) to prioritise together and speak common messages ▪ Manawhenua act as the “political” arm to advocate politically while the technical experts in hauora formally provide the forum with expert advice (governance and operations separation) ▪ Gets all manawhenua on the same page while maximising the expertise of those in the front-lines of health care every day ▪ Māori providers and IMPB would form the interim KHA and allow time for future functions and final legal design to be shaped and finalised (low-cost option) ▪ Provides a mechanism for expert advice to be gathered, analysed and coordinated to feed into Te Kāhui Ohanga ▪ Is inclusive for enabling provider voice to be a key input / participant	▪ Difficult to clarify accountabilities without a formal agreement between Te Kāhui Ohanga and the KHA made up of IMPB and providers ▪ Te Kāhui Ohanga may have too many other high priorities (e.g. local government reform) to attend to hauora priorities

Option D — Independent Health Authority Board

This model establishes the KHA as a new autonomous entity where new governors could apply for roles and be appointed by a selected committee made up of hauora and manawhenua representatives. Such a board would operate independently from any political or provider governing cycles, allowing for long-term planning, stability, and continuity. This model may work for operational independence, specialized oversight, and the ability to make decisions based on health system needs rather than political dynamics.



ADVANTAGES	DISADVANTAGES
- Independent entity without interference or obligation to the Crown - Collective and representative appointment of all stakeholders to create “ownership” by all groups	- Creates yet another entity to find governors for when existing manawhenua and provider entities are already challenged to find governors with hauora expertise - New entity would have no existing infrastructure or funding to operate so would need to be funded - New entity may run the risk of duplicating existing roles of manawhenua, IMPB and providers - A new entity may confuse whānau about “who does what”?

Option E — Consortium Governance Model

Under this model, multiple entities collaborate to form a regional Kahungunu Health Authority. Each manawhenua, provider and IMPB entity appoints delegates to a governing assembly, ensuring shared decision-making and inclusive representation. This model is particularly useful for rohe where various Iwi / hapū / Māori entities wish to pool resources, share services, and strengthen collective bargaining power. It supports economies of scale and allows smaller groups to access services and expertise that might otherwise be financially or operationally out of reach.



ADVANTAGES	DISADVANTAGES
▪ Inclusive model ▪ Each could be a member (Incorporated Society or Shareholder) and appoint a smaller Board ▪ Everyone could have an equal voice / equal share ▪ Wide variety of skills from political to advocacy / planning / monitoring to service delivery	▪ Potentially large entity that may be difficult to sustain and facilitate ▪ Risk of some participants not consistently participating due to competing priorities ▪ Groups would need to fund the new entity as it has no infrastructure or funding ▪ Muddies the water between political and operational matters ▪ Another entity for participating entities to join and commit to (may add unwanted workload, meetings, time)

5. Decision time

What design options for the governance framework do stakeholders support?

- ☐ Option A – status quo (loose informal collaboration of all participants as exists today)
- ☐ Option B – manawhenua endorse Tihei Takitimu as (interim) KHA Board until functions finalised and an entity is designed to match the functions (or Tihei Takitimu could establish a subcommittee KHA establishment group)
- ☐ Option C – manawhenua through Te Kāhui Ohanga endorse a new independent KHA Board (made up of reps from IMPB and service providers) to provide a clean separation between political manawhenua role and hauora-specific entities
- ☐ Option D – all stakeholders (manawhenua, IMPB, providers) appoint a panel to select a new KHA Board based on applications for positions
- ☐ Option E – all stakeholders form a consortium/collective entity to which they belong and then each has a rep on the KHA Board resulting in a large governance table