IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

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

CIV-2022-485-11
[2023] NZHC 1486

UNDER	the Judicial Review Procedure Act 2016, the Declaratory Judgments Act 1908 and Parts 18 and 30 of the High Court Rules 2016
IN THE MATTER OF	an application for judicial review and an application for declaratory relief under the Declaratory Judgments Act 1908
BETWEEN	NEW ZEALAND INDEPENDENT COMMUNITY PHARMACY GROUP Applicant
AND	TE WHATU ORA – HEALTH NEW ZEALAND (formerly HUTT VALLEY DISTRICT HEALTH BOARD) First Respondent

Continued…

Hearing: 21, 22 and 29 November 2022

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D La Hood, S McCusker for Te Whatu Ora – Health New Zealand (formerly Hutt Valley District Health Board)
S Bisley, J Maltby for Te Whatu Ora – Health New Zealand (formerly Hauora Tairāwhiti)
R Schmidt-McCleave, A M Kerr for Ministry of Health
M Crotty, L Mau for RX No. 8 Limited
S McKechnie, B Clifford for Pharmacy Guild of New Zealand

Judgment: 15 June 2023

Reissued: 27 June 2023

JUDGMENT OF GWYN J

… Continued

HAUORA TAIRĀWHITI
Second Respondent

THE MINISTRY OF HEALTH
Third respondent

COUNTDOWN PHARMACY (GDL RX NO8 LTD)
Fourth respondent

THE PHARMACY GUILD OF NEW ZEALAND
Intervener

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Introduction

[1] This is a challenge to the way in which the regulation of community pharmacy services in New Zealand is carried out by the relevant public health bodies.

[2] The applicant, the New Zealand Independent Community Pharmacy Group (ICPG), is a group of community pharmacists.

[3] The applicant challenges the decision by the Ministry of Health (Medsafe) to issue licences under the Medicines Act 1981 to GDL Rx No 8 Limited (RX8) to operate new pharmacies in Countdown stores in Gisborne and Wainuiomata. RX8 is a company associated with the Countdown Group.

[4] The ICPG says the Ministry wrongly interpreted the Medicines Act provision as to when a pharmacy licence can be granted to a company.

[5] The applicant also challenges decisions by two District Health Boards (DHBs), Hutt Valley District Health Board (HVDHB) and Hauora Tairāwhiti, to grant Integrated Community Pharmacy Services Agreements (ICPSAs) to RX8.

[6] A key factor in the ICPG's challenge to the DHBs' decisions is that Countdown Pharmacies discount the co-payment on funded prescription medicines. The ICPG alleges that HVDHB and Hauora Tairāwhiti failed to recognise the co-payment discount as a loss-leading strategy and concluded that Countdown Pharmacies' marketing strategy was "pro-equity".

[7] The applicant says that the failure to correctly identify the nature of the co-payment discount led to errors of law by the DHBs.

Factual background

Medsafe licences

[8] On 21 May 2020 RX8 applied to the Medicines Control branch of Medsafe, within the Ministry of Health, under the Medicines Act, for a licence to operate a pharmacy at Countdown Pharmacy, Penrose. Medsafe assessed and approved the

application. RX8 submitted further applications for licences to operate pharmacies, including in Wainuiomata and Gisborne, and Medsafe carried out licensing audits for those premises. The licences were granted to Countdown Pharmacy Wainuiomata on 11 May 2021 and to Countdown Pharmacy Gisborne on 22 May 2021.

[9] Until 1 July 2022 HVDHB and Hauora Tairāwhiti were DHBs. DHBs were Crown agents funded by the Ministry of Health to provide health and disability services to the local population. They were established and governed by the New Zealand Public Health and Disability Act 2000 (NZPHDA).

[10] Subject to the national direction set by Government health policy, DHBs were responsible for deciding how the mix, level and quality of health and disability services could be best delivered for their specific region.

Pharmacy services

[11] DHBs funded community pharmacy services to their local regions. In order to do so, they entered into service agreements with private pharmacies who in turn provided pharmacy services in the community.

[12] Most medicines in New Zealand are subsidised by the Government. Pharmac sets the price for the subsidised medicine. When a patient purchases subsidised medicine, the pharmacist will invoice Te Whatu Ora – Health New Zealand (previously, the relevant DHB) for the price of the medicine, plus a dispensing fee, minus a $5 pharmaceutical co-payment charge.

[13] The pharmaceutical co-payment is an amount of money set by the Government that the public pay towards the cost of medicines. Until 2013 the pharmaceutical co-payment was $3. In 2013, this was increased to $5. This sum is not received by the pharmacy, so when a pharmacy waives the $5 co-payment fee, the pharmacy is absorbing that cost. There are no regulatory restrictions on pharmacies discounting or waiving the co-payment.[1]

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[1] On 18 May 2023 the Government announced, as part of the 2023 Budget, that the co-payment would be waived with effect from 1 July 2023: New Zealand Government *Wellbeing Budget 2023* (18 May 2023) at 11.

ICPSA

[14] Since 2012 community pharmacy services had been provided under the "Community Pharmacy Services Agreement". DHBs funded pharmacies by reference to how much medicine was actually dispensed. It was a one-size-fits-all approach, that largely funded all pharmacies to provide the same services.

[15] In 2018 the DHBs, the Ministry and a number of representative bodies, including the Pharmacy Guild of New Zealand (Pharmacy Guild), negotiated the terms of a Standard National Service Agreement, the ICPSA, to fund the provision of pharmacy services through community pharmacies. The ICPSA is a nationalised services agreement for the funding and provision of integrated community pharmacy services and was used by all DHBs.

[16] The ICPSA is reviewed every year by stakeholders. It sets out generic service and quality requirements in general terms that apply in respect of services provided under it and provides the basis for funding. The specific services of the pharmacy (for example, dispensing and professional advisory services) are attached to the ICPSA as schedules.

[17] Until the DHBs were disestablished in July 2022, the ICPSA was a bilateral contract between a DHB and a pharmacy. The pharmacy was obliged to provide services to eligible patients as set out in the head agreement and service schedules. There were clear contractual provisions regarding standards of care, breach, termination and reporting. DHBs were able to vary the generic terms, for example to include contractual obligations in relation to pharmacy opening hours, where necessary or desirable.

[18] There was no national policy or direction limiting a DHB's decision about whether or not to enter into an ICPSA with a particular provider. DHBs were free to develop their own policies and processes to address the needs in their own regions, including by adopting localised pharmacy strategies or contracting policies.

The parties

The ICPG

[19] The ICPG, the applicant, is an incorporated society. It was established on 9 November 2021 to represent and promote the interests of independent community pharmacists and pharmacies in New Zealand.

Hutt Valley District Health Board

[20] The first respondent, HVDHB, provided health services for the Hutt Valley, including Wainuiomata. Wainuiomata is a community in a valley adjacent to the main Hutt Valley, which is linked by one access road over a steep hill. The total population of Wainuiomata is approximately 19,410.[2]

[21] Wainuiomata's population includes a high proportion of Māori, Pasifika, Asian and other ethnicities. As at the 2018 Census,[3] in Wainuiomata, 30.4 per cent of the population identified as Māori and 15.9 per cent identified as Pasifika, compared to the wider Hutt Valley total population where 17.9 per cent identify as Māori and 9.8 per cent as Pasifika.[4]

[22] Wainuiomata is a region of high economic deprivation.[5] Measures of deprivation are strongly linked with health or social outcomes and are therefore an important part of health system analysis for identifying inequities in health outcomes.

Hauora Tairāwhiti

[23] Hauora Tairāwhiti, also a DHB, provided and funded health disability services in the geographical area of Te Tai Rāwhiti (Gisborne and East Cape District). The total population of the Te Tai Rāwhiti region is approximately 52,000.[6] Three-quarters

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[2] Stats NZ *Subnational population estimates (RC, SA2), by age and sex, at 30 June 1996-2022*.

[3] Stats NZ *Ethnic group (detailed single and combination) by age and sex, for the census usually resident population count, 2013 and 2018 Censuses (RC, TA, SA2, DHB)*.

[4] People can identify with more than one ethnicity.

[5] New Zealand Index of Deprivation *NZDep2018* (2018); and see also June Atkinson, Clare Salmond and Peter Crampton *NZDep2018 Index of Deprivation: Final Research Report* (University of Otago, December 2020).

[6] Stats NZ, above n 2.

of the population live in the city of Gisborne. That population is characterised by both urban and highly rural communities and a large proportion of young people (39 per cent). Over 51 per cent of the population is Māori.[7]

[24] Te Tai Rāwhiti has the highest level of deprivation in New Zealand in terms of health. Te Tai Rāwhiti has:

(a) the highest rates of overall avoidable mortality and morbidity in New Zealand;

(b) high rates of ambulatory sensitive hospitalisation;

(c) high rates of smoking and obesity and of long-term conditions such as diabetes, heart disease, arthritis and gout; and

(d) relatively low immunisation rates.

[25] Those factors mean there is high inequity in accessing health services in Te Tai Rāwhiti which is exacerbated by secondary factors, such as lack of access to reliable vehicles, long work hours for those in the main employment sectors (agriculture, forestry and fishing) and poor internet connectivity.

Te Whatu Ora

[26] On 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 (Pae Ora Act) came into force, disestablishing all DHBs and establishing Te Whatu Ora.

RX8

[27] There are currently 42 pharmacies operating within Countdown stores in New Zealand (Countdown Pharmacies).[8] Countdown Pharmacies are operated by entities within the Woolworths New Zealand Ltd group of companies, including RX8.

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7 Stats NZ, above n 3.

8 On 14 March 2023 — after the hearing, but before completion of this judgment — the first and second respondents advised that the ICPSA between Hauora Tairāwhiti and RX8 had been terminated.

RX8 is the party to the IPSCAs for the Countdown Pharmacies in Wainuiomata and Gisborne. RX8's corporate structure is discussed in relation to the sixth ground of review below.

[28] The intervener, the Pharmacy Guild, is the largest membership organisation in the community pharmacy sector in New Zealand. It represents approximately 600 members across New Zealand; in Tairāwhiti it has six members and in the Hutt Valley it has 19 members. It provides a range of support and services to community pharmacy owners. The Pharmacy Guild acted as the representative of its members in their contractual discussions with DHBs for the ICPSA.

Legal framework

[29] In between the filing and hearing of this application for review, significant legislative change occurred in the New Zealand health sector. As noted, on 1 July 2022 the Pae Ora Act repealed the NZPHDA and replaced DHBs with Te Whatu Ora.

[30] While the application for judicial review concerns the pre-1 July 2022 legal framework which applied when HVDHB and Hauora Tairāwhiti entered into ICPSAs with RX8, the ICPG also seeks general declaratory orders relating to both the NZPHDA and the Pae Ora Act, under the Declaratory Judgments Act 1908.

[31] For that reason, it is necessary to set out both legislative frameworks.

Pre-1 July 2022 framework — NZPHDA

[32] The NZPHDA took effect from 1 January 2001. The purpose of the NZPHDA was to provide for the public funding and provision of health and disability services and to establish new publicly owned health and disability organisations, in order to pursue the objectives set out in s 3. Those objectives included:

(a) To achieve for New Zealanders the improvement, promotion and protection of their health.

(b) To reduce health disparities by improving the health outcomes of Māori and other population groups.

(c) To provide a community voice in matters relating to personal health services, public health services and disability support services, by providing for elected board members of DHBs, board meetings and certain committee meetings to be open to the public, and consultation on strategic planning.

[33] Section 4 of the NZPHDA stated that, in order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, pt 3 provided mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

[34] Part 3 established and provided for DHBs. Each geographical area in New Zealand had a DHB that was responsible for funding and providing health services to the resident population in that area.[9]

[35] DHBs were Crown entities, governed by the Crown Entities Act 2004 (CEA), except to the extent that the NZPHDA expressly provided otherwise.[10] Specifically, DHBs were statutory entities and Crown agents under the CEA.[11]

[36] As statutory entities, DHBs were required to act consistently with their objectives in performing their statutory functions.[12] A DHB could do anything authorised by the NZPHDA or the CEA,[13] and anything that a person of full age and capacity may do,[14] as long as it acted only for the purpose of fulfilling its functions.[15]

[37] As Crown agents, DHBs were required to give effect to government policy when directed by the responsible minister (Minister of Health). The role of the

9 New Zealand Public Health and Disability Act 2000 [NZPHDA], sch 1.
10 Section 21.
11 Crown Entities Act 2004 [CEA], sch 1, pt 1.
12 Section 14.
13 Section 16.
14 Section 17.
15 Section 18.

Minister was to oversee and manage the Crown's interests in, and relationships with, DHBs, and to exercise any statutory responsibilities.[16]

[38] DHBs had broad objectives in relation to their resident populations.[17] These included to:

(a) Improve, promote, and protect the health of people in the community.

(b) Seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs.

(c) Reduce health disparities by improving health outcomes for Māori and other population groups.

(d) Reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes for those and other New Zealanders.

[39] Each DHB was required to pursue its objectives in accordance with any annual plan prepared under s 38, its statement of intent, and any directions or requirements given to it by the Minister under the NZPHDA or the CEA.[18]

[40] Section 23 set out the functions of each DHB for the purpose of pursuing its objectives. These included to:

(a) Ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement.

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16 Section 27.
17 NZPHDA, s 22(1).
18 Section 22(2).

(b) Establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement.

(c) Continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori.

(d) Monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services.

[41] The Minister of Health could give directions to DHBs,[19] or require the provision of services.[20]

[42] Every year DHBs had to submit an annual plan to the Minister for approval. The annual plan was to set out each DHB's plan to meet local, regional and national needs for health services.

[43] Under the NZPHDA, health services were funded and provided pursuant to service agreements between DHBs and health service providers.

[44] Section 25 authorised DHBs to enter into service agreements. A DHB could, if permitted to do so by its annual plan and in accordance with that plan, negotiate and enter into service agreements containing any terms and conditions that may be agreed.[21] A DHB that had entered into a service agreement was required to monitor the performance under that agreement of the other parties to that agreement.[22]

[45] Each DHB was governed by its board.[23] The board had the authority, in the DHB's name, to exercise the powers and perform the functions of the DHB.[24] All decisions relating to the operation of the DHB had to be made by, or under the

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19 Section 32.
20 Section 33.
21 Section 25(1).
22 Section 25(2).
23 Section 26; and CEA, s 25.
24 CEA, s 25(1).

authority of, the Board in accordance with the CEA and the NZPHDA.[25] For example, the board had to ensure that the DHB:

(a) Acted in a manner consistent with its objectives and functions, annual plan, and any Ministerial directions.[26]

(b) Performed its functions efficiently and effectively and in a manner consistent with the spirit of service to the public.[27]

(c) Operated in a financially responsible manner.[28]

[46] Each DHB board consisted of seven elected members and up to four members appointed by the Minister.[29] The Minister was required to ensure Māori membership of the board 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.[30]

[47] The Minister had the power to appoint persons to sit on boards as Crown monitors, if the Minister considered it would be desirable to do so for the purpose of assisting and improving the performance of the DHB.[31]

[48] If the Minister was seriously dissatisfied with the performance of a board of a DHB, the Minister could dismiss all members of the board and replace the board with a commissioner.[32] In addition, the Minister could, at any time and entirely at his or her discretion, remove an appointed member of a DHB,[33] or an elected member, for a reason specified in cl 9 of sch 3.[34]

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25 Section 25(2).
26 NZPHDA, s 27.
27 CEA, s 50.
28 NZPHDA, s 41; and CEA, s 51.
29 NZPHDA, s 29.
30 Section 29.
31 Section 30.
32 Section 31(1).
33 Schedule 3, cl 8(1AA), in accordance with s 36 of the CEA.
34 NZPHDA, sch 3, cls 8(1)(b) and 9.

[49] All DHBs were also required to have a community and public health advisory committee, a disability support advisory committee and a hospital advisory committee.[35]

Pae Ora Act

[50] On 1 July 2022, the Pae Ora Act repealed and replaced the NZPHDA. The purpose of the Pae Ora Act is to provide for the public funding and provision of services to achieve the objectives set out in s 3, which include achieving equity in health outcomes among New Zealand's population groups, including by striving to eliminate health disparities, particularly for Māori.

[51] The Pae Ora Act created two new entities:

(a) Te Whatu Ora as the national organisation to lead and co-ordinate delivery of health services across the country.[36] Te Whatu Ora is a Crown agent and subject to the CEA.[37]

(b) Te Aka Whai Ora, an independent statutory Māori Health Authority,[38] to co-commission and plan services with Te Whatu Ora, commission kaupapa Māori services and monitor the performance of the health system for Māori.

[52] At the same time, the Act disestablished all DHBs (including their boards and advisory committees). The assets, liabilities, contracts and employees of DHBs have been transferred to Te Whatu Ora.[39] Any act or omission of a former DHB is treated as being done or omitted by Te Whatu Ora.[40]

[53] Te Whatu Ora is governed by a board appointed in accordance with s 12. The functions of Te Whatu Ora are set out in s 14 of the Pae Ora Act.[41] One of the functions

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35 Sections 34–36.
36 Pae Ora (Healthy Futures) Act 2022 [Pae Ora Act], s 11.
37 Section 11.
38 Section 17.
39 Schedule 1, cl 10.
40 Schedule 1, cl 10.
41 Section 14.

of Te Whatu Ora is to develop and implement commissioning frameworks and models for the purpose of providing and arranging for the provision of services at a national, regional and local level.[42] However, the Pae Ora Act does not include the equivalent of s 25 of the NZPHDA, providing for service agreements.

[54] The Pae Ora Act provides for the Crown's intention to give effect to the principles of te Tiriti o Waitangi (the Treaty of Waitangi),[43] including by establishing the Māori Health Authority.

[55] Section 7 of the Pae Ora Act contains a number of health principles,[44] which must guide the exercise of statutory powers under the Act.

[56] As a Crown entity, Te Whatu Ora has the general power under the CEA to do anything that a natural person of full age and capacity may do.[45] That would include entry into service agreements.

Medicines Act 1981

[57] The Medicines Act is also relevant as the sixth ground of review challenges the Ministry's decision to issue licences under the Act to RX8 to operate the Countdown pharmacies.

[58] The Ministry of Health administers the Medicines Act. The Act regulates therapeutic products and activities relating to therapeutic products, including regulation of pharmacy practice activities in New Zealand through the Pharmacy Licensing Framework.

[59] Under the Medicines Act, no person shall in the course of any business carried on by that person operate any pharmacy otherwise than in accordance with a licence issued under pt 3 of the Act.[46] Medsafe may issue a licence to operate a pharmacy if it is satisfied that the statutory criteria are met.

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42 Section 14(1)(c) and (d).
43 Section 6.
44 Section 7.
45 CEA, s 17(1).
46 Medicines Act 1981, s 17(1)(d).

[60] Licences are issued for one year and may then be renewed.[47]

The ICPSAs

HVDHB enters into ICPSA with RX8

[61] From January 2020, HVDHB's Pharmacy Contracting Policy applied to any requests received by HVDHB for a new ICPSA.[48] The Pharmacy Contracting Policy has subsequently been amended in September 2020 and July 2021. The Pharmacy Contracting Policy sets out the process for applying for an ICPSA and matters HVDHB would take into account when making decisions about new pharmacies.

[62] The evidence of Rachel Haggerty, who was at relevant times Director, Strategy, Planning and Performance for both HVDHB and the Capital and Coast District Health Board, is that the purpose of the Pharmacy Contracting Policy was to enable HVDHB to make contracting decisions that would advance the objectives of the *Pharmacy Action Plan: 2016 to 2020*[49] and HVDHB's five-year strategy for pharmacy services *Future Pharmacist Services*.[50]

[63] The Pharmacy Contracting Policy was also to give effect to HVDHB's statutory functions and objectives under the NZPHDA, including the obligation under s 22(1)(ba) to "seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local … needs".

[64] *Our Vision for Change 2017–2027*[51] was a strategy developed to support and shape the direction and approach HVDHB would take over that 10-year period. It set out eight principles for decision-making to ensure that HVDHB was making good investment decisions, including:[52]

(a) Equity – our decisions will support the elimination of health inequalities;

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47 Section 53.
48 Hutt Valley District Health Board "Pharmacy Contracting Policy: Strategy, planning and outcomes" (January 2020).
49 Ministry of Health *Pharmacy Action Plan: 2016 to 2020* (May 2016).
50 Hutt Valley District Health Board *Future Pharmacist Services 2018–2023: Our five year strategy*.
51 Hutt Valley District Health Board *Our Vision for Change: How we will transform our health system 2017–2027*.
52 At 8.

(b) People-centred – our decisions will improve individuals and whānau experiences of care and address what matters most to them;

(c) Outcomes focused – our decisions will improve health outcomes and wellbeing for individuals and whānau;

(d) Needs-focused – our decisions will be based on where the greatest need lies;

…

(h) Stewardship of resources – our decisions will ensure we get the best value from our funding and carefully balance the benefits and costs of our investments.

[65] *Our Vision for Change* included the need for HVDHB to pay particular attention to the health needs and aspirations of the Māori population, to support equitable opportunities for Māori to attain good health and well-being. The strategy also placed an emphasis on improving the health outcomes for other populations with high health needs, including Pacific peoples, people with disabilities and those living in poverty.

[66] In 2018 HVDHB published *Te Pae Amorangi*[53] which was HVDHB's Māori Health Strategy for 2018–2027. *Te Pae Amorangi* was intended to support the framework provided by *Our Vision for Change*, building on the eight decision-making principles in *Our Vision for Change,* with guidance as to how to use those principles when considering Māori health and equity.

[67] In 2018 HVDHB published its five-year strategy for pharmacy services, *Future Pharmacist Services*, developed to support the *Our Vision for Change* strategy. It set out the priorities for pharmacy service development. The key themes of *Future Pharmacist Services* included improving equity by channelling more resources to the DHB's priority populations. It also sought greater "[a]ccess to medication for priority populations that meets their health needs"; "[m]ore focus on addressing equity, with more targeted services to those whānau with social vulnerabilities"; and "[i]mproved access to medication by reducing financial and other barriers" and "[b]etter access to high cost, low volume medication."

53 Hutt Valley District Health Board *Te Pae Amorangi: Hutt Valley DHB Māori Health Strategy 2018 – 2027*.

[68] In accordance with the Pharmacy Contracting Policy an evaluation panel (Panel) was established to evaluate applications for an ICPSA. At the time the application for an ICPSA was received from RX8 the Panel was compromised of HVDHB's Clinical Director of Primary and Integrated Care, its Chief Pharmacist, a Māori Health Representative, its Service Planning Integration Manager, and a Strategy and Planning Representative.

[69] RX8 applied to HVDHB for an ICPSA on 24 July 2020. The application proposed opening a pharmacy at the Countdown Wainuiomata store, and proposed, amongst other things, opening hours from 9.00 am to 8.00 pm, Monday to Sunday and waiver of the $5 co-payment fee.

[70] The Panel assessed the RX8 application in accordance with the decision-making criteria set out in the Pharmacy Contracting Policy and made a recommendation to the Director, Strategy Planning and Performance, Ms Haggerty.

[71] The decision-making criteria were set out in a matrix with a weighting for each criterion, as follows:

Decision Making Criteria	**Weighting**
• Applicant information – Annual Practicing Certificate (including any conditions) and good character information;	Required
• Pharmacy information – proposed location, proposed services, opening hours, staffing FTE and qualifications;	High
• Proximity to other pharmacy services in the proposed location – what services, distance from proposed site, staffing;	High
• Alignment of the application with relevant national and local strategic priorities for pharmacy services (as per the Policy Statement);	Critical
• The population needs in the proposed pharmacy's location, how are they being met at present, and whether they will be enhanced by the proposed pharmacy;	High
• How the pharmacy will work with other providers (particularly local general practices) to ensure integrated and continuity of care to patients;	High
• The support the applicant has from general practice providers in the area;	Medium

• The overall impact that approving the application might have on the provision of pharmacy and pharmacist services;	Medium
• Any other matters that the DHB considers relevant to its assessment of the application.	Medium

[72] The Panel was convened on 25 August 2020 to consider RX8's application. Each of the Panel members completed the evaluation form. The Service Planning Integration Manager (Keith Fraser), Chief Pharmacist (Katrina Tandecki), Senior Service Development Manager (Russell Cooke) and General Practice Leader (Chris Masters) recommended against the application. They all agreed that RX8's proposal to waive prescription fees and have extended opening hours was advantageous from an equity perspective. The majority of the Panel expressed concerns about Countdown's staffing levels and its ability to provide services in an integrated manner.

[73] Mr Fraser noted that "equity (HRS + free scripts) is the greatest advantage but it fails on the other key elements", namely, releasing pharmacists from dispensing to enable patient and prescriber advice, and better managing medication information and care plans. Mr Fraser noted it was a "tight decision given potential impact on equity". Ms Tandecki noted that the proposal to provide free prescriptions would advance equity goals and would provide more choice for the local population, but queried Countdown's intended staffing levels and recommended that the application be declined. Mr Cooke noted that the application presented a "difficult decision" and that free prescriptions were "an advantage to the population as are the extended hours". He also expressed concerns as to proposed staffing levels and recommended that the application be declined.

[74] Mr Masters noted the proposal for longer hours would increase access but questioned whether there was support from local GPs and the ability of Countdown to work in an integrated way. He also considered there to be a risk to the viability of other pharmacies in the area. He recommended that the application be declined.

[75] HVDHB's Acting Director of Māori Health, Kiri Waldegrave, recommended that the application be approved, on the basis that RX8's proposal to offer free

prescriptions and extended access had the potential to improve access in terms of cost and hours of service.

[76] On 10 September 2020 the Panel sent a memorandum to Ms Haggerty (who was the decision-maker) recommending against the application on the basis that its pro-equity aspects did not outweigh the failure of the application to support other aspects of the Pharmacy Contracting Policy. The memorandum noted the low proposed level of staffing and therefore limited opportunity to free pharmacists from the supply function to focus on providing services. The opening of a Countdown Pharmacy would detract from the ability of existing Wainuiomata pharmacies to operate efficiently and effectively. The memorandum also noted that the proposals of extended hours and zero co-payments had some attraction from an equity perspective but there were already some good hours at the existing pharmacies and arrangements to enable financial access to medications.

[77] On about 10 September 2020 Ms Haggerty met with Ms Waldegrave to discuss RX8's application. Ms Waldegrave expressed her view that outcomes for Māori and higher needs families had not been given adequate consideration by the majority of the Panel. She reiterated her view that the proposal by RX8 had the potential to increase access to medicines for those in Wainuiomata.

[78] On about 24 September 2020 Ms Haggerty convened a videoconference with all members of the Panel, where the advantages and disadvantages of Countdown's proposal were discussed further.

[79] Following that videoconference, Ms Haggerty considered the application.

[80] On 23 October 2020 Ms Haggerty advised the Panel of her decision to approve RX8's application for Wainuiomata. Ms Haggerty acknowledged the concerns of the majority of the Panel, but in summary concluded that increasing free access to pharmaceuticals in the Wainuiomata community, at no cost to the DHB, allowing people to collect scripts with ease of access and no financial barrier, outweighed the risks identified by the majority of the Panel.

[81] On 3 November 2020 Ms Haggerty advised RX8 that the DHB had approved an ICPSA for Countdown Wainuiomata. In doing so she noted that the key feature of the application was the "lower cost access and longer opening hours that will assist more people to access their medications more easily" and that "Wainuiomata is an area where there are a number of people who will benefit from the service you will provide."

[82] HVDHB entered into an ICPSA with Countdown Wainuiomata in May 2021.

Hauora Tairāwhiti's ICPSA with RX8

[83] RX8 applied to Hauora Tairāwhiti for an ICPSA in August 2020. It proposed to open a pharmacy in Countdown Gisborne that would, among other things:

(a) be open from 9.00 am to 8.00 pm, seven days per week; and

(b) waive the $5 pharmaceutical co-payment.

[84] At that time, Hauora Tairāwhiti was in the process of developing a pharmacy strategy to guide decisions about whether or not to approve ICPSAs to new or existing providers. While that strategy was being developed, applications for an ICPSA were considered by applying the "New and Existing Provider Policy" (Provider Policy), a policy used by Hauora Tairāwhiti to assess all applications for service agreements, including ICPSAs, and its existing processes.

[85] Ariana Roberts was at the time a Portfolio Manager at Hauora Tairāwhiti. In accordance with the Provider Policy, Ms Roberts sent RX8 a "Provider Assessment Form" setting out the criteria against which the application would be assessed and the information required from RX8.

[86] Having reviewed the information provided by RX8 in the first instance, Ms Roberts sought additional information about RX8's vulnerable child policy and how the pharmacy would deliver services to meet the specific, local needs of Tairāwhiti.

[87] In considering the RX8 application, Ms Roberts noted, first, that the pharmacy would be located in the supermarket. Her assessment was that would be useful for some people who come into town once from rural areas to do their shopping and other errands. It would mean one less stop which could encourage people to pick up their scripts when they would not usually do so.

[88] Ms Roberts also noted there was not another pharmacy in Tairāwhiti that waived the pharmaceutical co-payment. Ms Roberts observed that the non-picked up medication bill each month was increasing and that any initiative that reduced cost to whānau was attractive.

[89] RX8's proposal of longer hours was relevant. At that time, of all local pharmacies, only two had extended opening hours. Extended opening hours would allow some people, for example shift workers, to access pharmacy services outside of normal business hours.

[90] Ms Roberts' evidence is that she did not carry out any specific research about the effect of the co-payment waiver, or any other aspect of the application, at that time. She observed that detailed research into each application was not practical and her assessment was fundamentally pragmatic and practical (unless the Board or a committee asked for research later in the process). She drew on her own knowledge and experience, being from Tairāwhiti and having worked in the health area there for many years.

[91] Ms Roberts observed that the objections raised by existing local pharmacists who did not want a large competitor were not relevant to her assessment of the application under the Provider Policy, which focussed on the needs of the local population and service provider, not the commercial interests of incumbent providers.

[92] Ms Roberts also observed that while RX8 had provided robust information about its financial viability, she had some questions about its proposed service and the equity component to that, in particular the rural reach. She also noted missing important information in relation to how Countdown Pharmacy Gisborne would deliver services to meet the specific, local needs of Tairāwhiti.

[93] Accordingly, on 27 November 2020 Ms Roberts emailed RX8 requesting further information on:

(a) any policy RX8 had regarding the Vulnerable Children Act 2014;

(b) recognising Countdown's national approach on waiving co-payment fees, how RX8 would address the needs of the Tairāwhiti population specifically and potentially equitable approaches/initiatives RX8 had considered for the rural population and the Māori population; and

(c) whether RX8 had given any consideration to, or how it could work with, other local health providers in the region.

[94] After further correspondence, on 20 January 2021, RX8 provided an updated ICPSA application, together with a copy of the signed Countdown policy on vulnerable children. The updated application explained:

(a) How Countdown Pharmacy Gisborne would engage with the mental health and addiction services in Tairāwhiti.

(b) That Countdown Pharmacy Gisborne endeavoured to remove the barriers to delivery of high-quality healthcare for Māori and was intending to implement a system to capture ethnicity, to be able to target services at Māori patients.

(c) Examples of specific services that would be offered in Countdown Pharmacy Gisborne.

(d) A commitment by Countdown Pharmacy Gisborne to increase Māori representation within its workforce.

[95] On 10 February 2021 Ms Roberts presented a paper to Te Rōpū Rauemi Rautaki (Funding Management Group), an internal governance committee at Hauora Tairāwhiti that reviewed funding applications. Ms Roberts' evidence is that Te Rōpū Rauemi Rautaki was aware of the nature of the application, the co-payment issue, the

proposal to capture ethnicity data and the resistance to RX8's application from existing local pharmacists.

[96] Te Rōpū Rauemi Rautaki supported the application going forward to the relevant advisory committees.

[97] To prepare a paper for those committees and the Board, Ms Roberts assessed RX8's application using a "Health Equity Assessment Tool" (HEAT). That tool had been introduced by the Māori Relationship Committee of Hauora Tairāwhiti, Te Waiora o Nukutaimemeha, to ensure that any new service being provided in Tairāwhiti would not contribute to, and was intended to address, health inequity.

[98] Ms Roberts also scored the application against weighted "benefits criteria" relating to population health (for example, elimination of health inequity), patient experience, value for money (for example, return on investment in monetary terms) and enablers (for example, workplace development).

[99] The application was then referred to Hiwa-i-te-Rangi, a statutory advisory committee established under s 36 of the NZPHDA. Its members comprised appointed community members, members of Te Waiora o Nukutaimemeha and board members. The role of Hiwa-i-te-Rangi was to advise the Board on the needs of Tairāwhiti and how to maximise the overall health gain for the Tairāwhiti community. Hiwa-i-te-Rangi was accountable to the Board and required to act consistently with The New Zealand Health Strategy.[54]

[100] Hiwa-i-te-Rangi considered the RX8 application, together with an updated paper (including the HEAT and benefits criteria analysis) from Ms Roberts on 16 February 2021. Hiwa-i-te-Rangi concluded that Countdown Pharmacy Gisborne would benefit the community. The evidence from James Green who was the Chief Executive of Hauora Tairāwhiti at the time, and present at the Hiwa-i-te-Rangi discussion, was that RX8 was offering another option for the community to access pharmaceutical services in a different way. That, together with longer hours, waiver

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[54] Ministry of Health *The New Zealand Health Strategy* (December 2000).

of the co-payment and delivery of specified services that the community needed, were all proposals the Committee considered would benefit their community.

[101] The Committee considered the impact of Countdown opening on other community pharmacists, noting that there was no evidence to support their concerns and that Hauora Tairāwhiti was not responsible for protecting the economic interests of incumbent providers in a competitive market. Mr Green's evidence is that Hiwa-i-te-Rangi was aware that RX8's waiver of the co-payment was a policy that could be revoked by RX8 at any time. The co-payment was one factor, but was not determinative, in the Committee's recommendation that the application proceed to the Board for approval.

[102] The application next proceeded to Te Waiora o Nukutaimemeha, a Māori relationship committee of the Board. Te Waiora o Nukutaimemeha considered the application on 17 February 2021 noting, in particular, improved access as Māori who went to the supermarket would be able to access the pharmacy as part of their normal routine; RX8's commitment to improve equity within its organisation; and waiver of the co-payment. In that regard it noted that any initiative that reduced cost on individual families in a deprived region was positive.

[103] Te Waiora o Nukutaimemeha recommended that the application go to the Board.

[104] Members of the Board were elected or appointed by the Minister. The Board governed Hauora Tairāwhiti and was responsible for major decisions, including entry into service agreements.

[105] The Board met on 23 February 2021 to consider RX8's application. Members of the Board were familiar with the application, having attended the Hiwa-i-te-Rangi meeting, seen the recommendation from Te Waiora o Nukutaimemeha and read the paper prepared for the Board.

[106] The Board considered the recommendations of Hiwa-i-te-Rangi and Te Waiora o Nukutaimemeha. It discussed that Countdown would provide an added service in

Tairāwhiti, because prescriptions could be picked up while shopping and the co-payment waiver would reduce or remove the costs of some scripts. It also had regard to the opposition of local community pharmacists.

[107] Having noted the concerns of incumbent pharmacists, the Board recommended that a meeting take place to discuss those concerns with Board representatives. That occurred on 3 March 2021.

[108] On 29 April 2021 Mr Green signed the ICPSA with RX8 on behalf of Hauora Tairāwhiti. The ICPSA took effect on 3 June 2021.

Evidence

[109] The parties filed extensive affidavit evidence.

[110] For the applicant, evidence was filed from a number of community pharmacists and staff and clients of those community pharmacists.

[111] The applicant also filed expert evidence from Dr Richard Meade, Professor Papaarangi Reid and Ms Shelley Cunningham. The first and second respondents sought an order excluding the expert affidavits on the basis that they are inadmissible. I discuss that application below.

[112] For the first respondent, HVDHB, evidence was provided by Rachel Haggerty, who at relevant times was the Director, Strategy, Planning and Performance for Capital and Coast District Health Board and HVDHB.

[113] For the second respondent, Hauora Tairāwhiti, evidence was provided by James Green, who at relevant times was the Chief Executive of Hauora Tairāwhiti; Ariana Roberts who at relevant times held the role of Portfolio Manager, Primary Health and Community at Hauora Tairāwhiti; Nicola Ehau who at relevant times was the Group Manager – Planning and Funding, Hauora Tairāwhiti; Na Raihania who, prior to disestablishment of the DHBs, was the Chair of Te Wairoa o Nukutaimemeha which was the Māori Relationship Board for Hauora Tairāwhiti.

[114] Jeremy Armes, the Merchandise Manager – Pharmacy, Woolworths New Zealand Ltd, filed an affidavit on behalf of RX8.

[115] Michael Haynes, the Manager of the Medicines Control branch within Medsafe, filed an affidavit for the Ministry.

Admissibility of expert evidence

[116] The first and second respondents, supported by the third respondent, applied to exclude the expert evidence filed for the ICPG, by Dr Meade, Ms Cunningham and Professor Reid. The respondents say that evidence is inadmissible: it is irrelevant, addresses the substantive merits of the DHB decisions under review, although it was not before the decision-makers; in addition, the evidence is speculative.

[117] Dr Meade is an economic consultant and researcher. He frames the purpose of his evidence as to give an expert opinion on whether a pharmacy offering to waive the $5 prescription co-payment for patients is likely to result — particularly for Māori — in more inequitable:

(a) access to medicines, pharmacy services and/or facilities;

(b) quality of pharmacy services; and/or

(c) health and wellbeing outcomes.

[118] The applicant says Dr Meade's evidence provides an economic perspective on the relationship between waiver of the $5 co-payment and health equity, including barriers to accessing this type of health benefit, which (the applicant says) puts claims of benefits to health equity (including Māori health equity) into context and will therefore assist the Court.

[119] The ICPG relies upon Dr Meade's evidence to support its submission that the waiver of the co-payment fee could over time be accompanied by price discrimination and form part of a predatory pricing strategy. The applicant says the evidence is relevant because it helps the Court understand the full commercial nature of RX8's

discounting strategy and that in turn is directly relevant to the applicant's argument that the DHBs fundamentally mischaracterised Countdown's proposal.

[120] Ms Cunningham, the Deputy Chief Executive of Te Puna Ora o Mataatua (Te Puna Ora), a regional Māori health provider in the Eastern Bay of Plenty. Ms Cunningham's evidence identifies the process that Te Puna Ora adopts when making decisions about Māori health (although Ms Cunningham does not discuss the provision of pharmaceutical services).

[121] Ms Cunningham's evidence is put forward to assist the Court to understand what "sufficient evidence" means in the context of measures intended to benefit Māori health equity and to demonstrate what te Tiriti principles require of DHBs. Ms Cunningham's evidence also addresses the need to correctly identify a commercial co-payment discounting strategy, relevant to the applicant's submission that the DHBs mischaracterised Countdown's application and asked themselves the wrong question.

[122] Ms Cunningham's evidence provides examples of necessary considerations for the development and successful implementation of health measures that benefit Māori health equity. The applicant submits that will also assist the Court by informing what constitutes sufficient evidence, the necessary information, and/or the correct questions to ask, in the context of claims by decision-makers that certain pharmacy services would be beneficial for Māori health equity.

[123] Professor Reid is a Professor of Māori Health. Her affidavit provides expert opinion on what is needed to assess whether certain pharmacy services are beneficial from a Māori health equity perspective. The applicant says the evidence will assist the Court by providing the Māori health-centred context needed to inform what constitutes sufficient evidence, the necessary information and the correct questions to ask, in the context of claims by decision-makers that certain pharmacy services would be beneficial for Māori health equity.

[124] The first and second respondents do not challenge the independence or expertise of the three deponents — they acknowledge that Ms Cunningham and Professor Reid are well-known experts in Māori health — but seek to exclude it on

the basis that it is substantially irrelevant in the context of a judicial review of a contracting decision. The respondents note first that the evidence was brought into existence after the impugned decisions were made and is therefore not useful to assist the Court in evaluating the legality of those decisions.

[125] Further, the evidence seeks to establish that the decision-makers' decisions were irrational, and is therefore irrelevant, because that is a question for the Court. It also addresses the process the witnesses say the decision-makers should have followed and for that reason is irrelevant, because that too is a matter for the Court.

[126] In addition, the respondents say, the evidence tends to focus on only one of several factors taken into account by the DHBs in their decisions and it is fundamentally speculative.

Discussion

[127] Section 7 of the Evidence Act 2006 provides that evidence is admissible if it is relevant. It is relevant "if it has a tendency to prove or disprove anything that is of consequence to the determination of the proceeding."

[128] The admissibility of expert opinion evidence is governed by s 25 of the Evidence Act. Expert opinion is admissible only "if the fact-finder is likely to obtain substantial help from the opinion in understanding other evidence in the proceeding or in ascertaining any fact that is of consequence to the determination of the proceeding."

[129] The utility of expert evidence is diminished in the context of a judicial review application, where the Court is considering the decision-making process, not the correctness of the decision taken. For that reason, expert evidence going to the merits of the decision, which was not before the decision-maker, is not relevant or substantially helpful and therefore is not admissible.

[130] Similarly, expert evidence that goes to questions of law such as an alleged failure by the decision-maker to take relevant matters into account or to apply the

correct legal test will generally not be substantially helpful because the decision-maker's legal obligations are a matter for the Court.

[131] I acknowledge the experts' expertise and independence. In particular, I acknowledge that Professor Reid and Ms Cunningham have significant expertise in issues regarding Māori health. The question for the Court however is whether their evidence, in the form in which it is presented, is substantially helpful in relation to this application for judicial review.

[132] Dr Meade's evidence does not take account of the full context or the full range of issues considered by the DHBs in their decision-making processes. The evidence does not analyse any data relevant to the pharmacy market in Gisborne or the Hutt Valley. Dr Meade's evidence focuses almost entirely on the effect of the co-payment waiver, although he acknowledges there are other factors relevant to access. Dr Meade only briefly addresses the proposal to increase operating hours, by reference to studies in Europe. He does not give a view on the other factors taken into account by the DHBs. As the first and second respondents submit, it is not credible to advance the argument that another conclusion could have been reached by the DHBs on the basis of Dr Meade's evidence around co-payments, where there is no accompanying evidence on the relative significance of increased opening hours, location and convenience and the impact of those factors on greater access, in New Zealand.

[133] Many of Dr Meade's conclusions are speculative: for example, co-payment waivers "tend to benefit patients for whom access is already possible"; discounters "might" withdraw the co-payment waiver once "rival" pharmacies have left the sector.

[134] I also accept that Dr Meade's evidence is in effect evidence on what he, as an expert, would have considered had he been in the decision-maker's position. It is an attempt to challenge the reasonableness of the substance of the decisions.[55] I conclude that the evidence is inadmissible in this judicial review proceeding.

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[55] See for example *Diagnostic Medlab Ltd v Auckland District Health Board* HC Auckland CIV-2006-404-4724, 27 November 2006 at [30]–[31] and [34].

[135] As with Dr Meade, Ms Cunningham's commentary on the DHBs' decisions is limited to the co-payment discount. Her evidence too goes to the applicant's submission of a "basic error" made or "wrong question" asked by the DHBs. For example, Ms Cunningham notes that "[c]orporate-backed pharmacies do not have Māori health equity as their objective." As the respondents note, the issue in this case is not RX8's decision to waive the co-payment, but the DHBs' decision to enter into ICPSAs with RX8. Ms Cunningham's evidence is about one process for making decisions about Māori health. Her experience is clear, but it relates to a different community.

[136] It appears that Ms Cunningham's evidence proceeds on the basis that the DHBs did ask themselves the "wrong question" in relation to RX8's possible motivation to waive the co-payment and the impact of that on health equity for Māori. That assumption is not useful, as I discuss below in relation to the applicant's first three grounds of review. I conclude that Ms Cunningham's evidence, like Dr Meade's, is insufficiently specific to the context and factors relevant to the DHBs to be substantially helpful and is excluded for that reason.

[137] To a large extent, Professor Reid's evidence is undisputed: Māori experience significant health inequities, that raises complex issues and requires a systemic and in-depth analysis. However, Professor Reid's evidence goes further to discuss the substantive issue before the DHBs. Again, I conclude that the evidence is not substantially helpful to the Court and should not be admitted.

Grounds of review

[138] The applicant pleaded six grounds of review. The first to fourth grounds seek judicial review of the decisions of HVDHB and Hauora Tairāwhiti to enter into ICPSAs with RX8:

(a) First ground of review – the decisions were invalid and unlawful because HVDHB and Hauora Tairāwhiti decided to enter into the ICPSAs without sufficient and suitable evidence.

(b) Second ground of review – the decisions were invalid and unlawful because HVDHB and Hauora Tairāwhiti asked themselves the wrong question and failed to take reasonable steps to acquaint themselves with the information necessary to enable the correct question to be answered.

(c) Third ground of review – there was no rational connection between the evidence and the decisions.

(d) Fourth ground of review – the decisions were not taken in accordance with te Tiriti o Waitangi.

[139] The ICPG seeks:

(a) declarations that the decisions were unlawful and invalid; and

(b) orders that HVDHB and Hauora Tairāwhiti reconsider their decisions.

[140] The fifth ground of review is that Hauora Tairāwhiti failed to monitor the delivery and performance of services by RX8. In relation to that ground, the applicant seeks orders requiring the DHB to withdraw from the ICPSA.

[141] The sixth ground of review is brought against the Ministry. It challenges the Ministry's decisions under the Medicines Act to grant licences to RX8 to operate Countdown Pharmacies and seeks a declaration that the decisions were unlawful and invalid and revocation of all pharmacy licences held by RX8.

[142] In addition to the relief sought on the judicial review application, the ICPG also seeks declarations under the Declaratory Judgments Act in respect of the construction of the NZPHDA and the Pae Ora Act.

Are the decisions by HVDHB and Hauora Tairāwhiti reviewable?

[143] The first, second and fourth respondents raise a threshold question about the scope of review. They say the decisions in this case do not engage the Court's full supervisory jurisdiction: the decisions were commercial, contracting decisions, made

in the course of a procurement process, and therefore the scope of review is prima facie narrow, unless the context (nature of the decision, nature of the body, statutory setting, nature of the interests sought to be protected by the applicant) indicates a need for broader review. They rely on *Mercury Energy Ltd v Electricity Corporation of New Zealand Ltd*,[56] *Lab Tests Auckland Ltd v Auckland District Health Board*,[57] *Healthcare of New Zealand Ltd v Capital and Coast District Health Board*,[58] *Ririnui v Landcorp Farming Ltd*,[59] and *Attorney-General v Problem Gambling Foundation of New Zealand*.[60]

[144] The DHBs were not making strategic or policy decisions. Those decisions had already been made through annual plans, government strategy and strategic or policy development implemented through the NZPHDA. The DHBs were acting pursuant to, and in fulfilment of, those plans and policies. That was akin to the Ministry seeking to implement strategy through contracts with private providers in *Problem Gambling*.

[145] In deciding whether to enter into an ICPSA with RX8, HVDHB and Hauora Tairāwhiti were choosing whether to fund the provision of health services through a particular provider, by entering into a contract that would set out each party's rights and obligations. That was the case with any service agreement entered into by the DHBs. It does not mean that each individual contracting decision imports the full range of judicial review.

[146] The essentially commercial nature of the decisions was reflected in the fact that the DHBs had procedures for deciding whether to enter into any service agreement. Both HVDHB and Hauora Tairāwhiti followed their usual processes in deciding to enter into ICPSAs with RX8.

[147] Hauora Tairāwhiti had a single policy for all service agreements. It carried out due diligence on the commercial viability of the proposed provider and considered whether there was any need for the service. Its assessment was pragmatic and

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56 *Mercury Energy Ltd v Electricity Corporation of New Zealand Ltd* [1994] 2 NZLR 385 (PC).
57 *Lab Tests Auckland Ltd v Auckland District Health Board* [2008] NZCA 385.
58 *Healthcare of New Zealand Ltd v Capital and Coast District Health Board* [2012] NZHC 3417.
59 *Ririnui v Landcorp Farming Ltd* [2016] NZSC 62.
60 *Attorney-General v Problem Gambling Foundation of New Zealand* [2016] NZCA 609.

practical, using checklists, the HEAT and benefits criteria. It did not consult publicly on any decision to enter into a service agreement.

[148] HVDHB had its own contracting policy for ICPSAs. In accordance with its pharmacy contracting policy, the RX8 application was submitted for consideration by the evaluation panel, comprising a cross-section of senior health leaders within the organisation. The panel made a recommendation to the decision-maker who considered the recommendations of the panel and formed her own view on the merits of the application.

[149] The first and second respondents acknowledge that the contracts involved the use of public funding and there was therefore a public interest component to the DHBs' decisions. But, as in *Lab Tests*, *Healthcare* and *Problem Gambling*, the fact that contracts relate to the provision of health services does not necessarily call for the full panoply of review. The applicant's argument would make any act of a public entity, including Crown entities, broadly reviewable.

[150] Plainly DHBs were public bodies but, as statutory entities,[61] they were a step removed from the core machinery of government and legally distinct from the Crown. They were required to act commercially in some circumstances, for example in respect of the efficient and effective provision of public health services and use of public funds. DHBs were primarily accountable to the Minister of Health, who had broad powers of supervision in the conduct of their functions.

[151] DHBs were responsible for making day-to-day decisions about funding and health services and better equipped to do so than the Court.

[152] DHBs were empowered to negotiate and enter into service agreements on any terms and conditions, without following a specific process. Any failure by a DHB to comply with its statutory duties would not affect the validity or enforceability of those agreements.[62] Entering into a contract for the provision of health services is fundamentally about whether there is a need for provision of that service and whether

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[61] CEA, s 15.
[62] NZPHDA, s 87.

the provider is qualified and able to provide the service. These were essentially commercial considerations.

[153] The first and second respondents say that the nature of the ICPG, as a special interest business group, seeking to advance its own commercial interest, supports a narrow standard of review. The respondents submit that, in the past, individual members of the ICPG have objected to DHBs approving ICPSAs for new providers, including (but not limited to) discount pharmacies, on anti-competitive grounds. All of the pharmacists who have provided evidence for the ICPG are direct competitors of the two pharmacies in issue, with a direct commercial interest in those ICPSAs being invalidated and in this proceeding in effect the ICPG wants the contracts between the DHBs and RX8 to be set aside.

Applicant's submissions

[154] The applicant says that the courts should have a robust role in exercising the supervisory jurisdiction of judicial review and the starting point is expansive: "all exercises of public power are reviewable".[63] It argues against a categorical approach.

[155] The Court of Appeal in *Attorney-General v Problem Gambling* did not go so far as to say procurement decision will always give rise to a commercial context that renders a public body's decision non-reviewable: the procurement process is, rather, "a powerful indicator that the context was commercial."[64] It is simply an indicator.

[156] Drawing on *Ririnui*, *Problem Gambling* and *Lab Tests*, the applicant approaches the contextual factors in the following way.

Statutory and policy setting

[157] The applicant says the public service obligations set out in the NZPHDA underscore that DHBs are not simply commercial commissioning agents. One of the objectives in s 3(1)(b) is "to reduce health disparities by improving the health outcomes of Māori and other population groups". That explicit focus on addressing

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[63] *Ririnui v Landcorp Farming Ltd*, above n 59, at [1].
[64] *Attorney-General v Problem Gambling Foundation of New Zealand*, above n 60, at [47].

inequality suggests DHBs are not operating as commercial providers with priorities to reduce costs or to act as a business.

[158] The NZPHDA's key themes of community-centred care, improving health outcomes, meeting the needs of Māori and the public safety dimension to operation of a pharmacy are important.

[159] Section 4 of the NZPHDA refers to the need "to recognise and respect the principles of the Treaty of Waitangi"; that reinforces the centrality of the statutory objective of improving health outcomes for Māori.

[160] There is a focus on "outcomes" and that is relevant to how DHBs should conceive of their priorities.

[161] The scheme of the Medicines Act reinforces the public safety dimension involved in the provision by DHBs of community pharmacy services.

Nature of the body

[162] While DHBs are not core government departments, like the Ministry of Health in *Problem Gambling*, they are public bodies; they were Crown agents under the CEA. They are more proximate to government departments and Ministers than State-owned enterprises. That points more strongly for, rather than against, reviewability.

Nature of the decision

[163] The applicant and the Pharmacy Guild say the decisions challenged have a regulatory character: they involve enabling new bodies to operate as a pharmacist within the public health system.

[164] The position of the DHBs and the community pharmacy sector is not genuinely "commercial". The DHBs held a monopoly over the ability to award this contract — without an ICPSA, a community pharmacy cannot distribute subsidised pharmacy medicines. To that extent, the contracts have an authorising or regulatory element. They are not a merely operational or administrative decisions. They can be contrasted

with a decision to award a tender or contract to one provider or another, which may be characterised as more operational. The grant of an ICPSA does not involve selecting one applicant over another; it is a decision that requires the applicant to meet independent standards for the provision of healthcare services to a particular population.

[165] The DHBs were not in competition with each other (as they were in other, genuinely commercial procurement processes) as a community pharmacy could only contract with the DHB where it was physically located.

[166] Nor is the ICPSA negotiated between the parties. All 20 DHBs used a single central "evergreen" contract. That ICPSA is then promulgated to all community pharmacy contract holders in New Zealand. Each of the more than 1,000 community pharmacies must sign an ICPSA; there is no ability for an individual community pharmacy to negotiate on the terms of the core ICPSA.

The nature of the interest(s) affected

[167] The applicant acknowledges that some members of the ICPG have a commercial interest in the outcome of the decision in this case. It says though that this will often be the case where a commercial operator challenges a regulatory decision, including on public law grounds. The key question should be whether a question of law arises, and whether legal obligations have been breached.

[168] In any event, the interests involved do not simply relate to a pharmacy and the DHB. The issuing of a licence and the grant of an ICPSA have downstream consequences for patients, other pharmacies, and community well-being. The nature of the interest points to decision-making being reviewable on standard public law grounds.

[169] The Pharmacy Guild supports the position taken by the applicant. It says the provision of community pharmacy services is a fundamental element of primary and community healthcare that DHBs are required to provide to the public — more so than either laboratory tests services or gambling support programmes. As demonstrated by the role of the pharmacy sector during the COVID-19 pandemic, community

pharmacy is an essential service. The decisions to award ICPSAs are not "ordinary commercial transactions" and have a sufficient public content and context that the Court should exercise its supervisory jurisdiction.

Discussion

[170] The starting point is *Mercury Energy*,[65] where the Privy Council concluded (in the context of the State-Owned Enterprises Act 1986 (SOE Act)), that bare contractual relations are not subject to judicial review, but if there is an element of acting in the public interest in those contractual relations, that may not be the case.

[171] Lord Templeman's dictum is often relied on:[66]

> It does not seem likely that a decision by a state-owned enterprise to enter into or determine a commercial contract to supply goods or services will ever be the subject of judicial review in the absence of fraud, corruption or bad faith.

[172] However, the SOE Act is a very different piece of legislation from the NZPHDA. The distinction between the respective subject matters is obvious. As Eichelbaum CJ observed in *Southern Community Laboratories Limited v Healthcare Otago Limited*:[67]

> In New Zealand, historically the provision of health services was regarded as one of the core functions of the State. While that concept has undergone modification, the provision of such services is not regarded as a trading activity in the same sense, or to the same extent, as other services once provided directly by Government agencies.

[173] On the other hand, broader considerations such as social responsibility and the interests of the community are relative rather than absolute. Ultimately it is a question of degree. There is no doubt that the provision of community pharmacy services has a public interest component. By the same token, again, quoting from Eichelbaum CJ,[68] virtually every administrative decision made by or on behalf of a DHB must have at least the potential to impact directly or indirectly on the quality of

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65 *Mercury Energy Ltd v Electricity Corporation of New Zealand Ltd*, above n 56.
66 At 391.
67 *Southern Community Laboratories Ltd v Healthcare Otago Ltd* Dunedin, CP 30/96, 19 December 1996 at 13, in relation to a Crown Health Enterprise.
68 At 16.

healthcare services. "That alone cannot be sufficient to attract the availability of public law remedies."[69]

[174] As Cooke J said in *New Zealand Institute of Independent Radiologists v Accident Compensation Corp*,[70] one way of addressing the question whether a commercial contract should be subject to judicial review (absent fraud, corruption or bad faith) is to focus on the legal limits or controls that exist with respect to contractual powers:[71]

> The most straightforward question is to ask what the legal limits on the exercise of discretionary powers are in a particular case, and then assess whether the public body has complied with them.

[175] The DHBs were required to exercise their contractual powers in a manner that was consistent with their statutory duties as set out in ss 22 (objectives) and 23 (functions) of the NZPHDA:

> **22 Objectives of DHBs**
>
> (1) Every DHB has the following objectives:
>
> (a) to improve, promote, and protect the health of people and communities:
>
> …
>
> **23 Functions of DHBs**
>
> (1) For the purpose of pursuing its objectives, each DHB has the following functions:
>
> …
>
> (b) to actively investigate, facilitate, sponsor, and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:
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> …

[176] However, as might be expected, these provisions are framed at a level of generality. While s 23 describes the DHBs' functions, it does not purport to create particular legal requirements in relation to any individual decisions.

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69 At 16.

70 *New Zealand Institute of Independent Radiologists v Accident Compensation Corp* [2022] NZHC 3547 at [33].

71 At [36].

[177] Section 25 is a generic power to enter into service agreements. It does not refer to particular kinds of agreement or set out criteria and procedures for doing so, but rather refers to "any terms and conditions that may be agreed".[72] Section 25 did not impose procedural requirements on DHBs.

[178] A consideration of the number of service agreements entered into by the DHBs provides useful context. As Blanchard J observed in *New Zealand Private Hospitals Association – Auckland Branch (Inc) v Northern Regional Health Authority*, in the context of a tender process by the Northern Regional Health Authority for hospital continuing care services, a regional health authority will be required to enter into many such contracts:[73]

> It would be quite intolerable if, in addition to rules of contract law and other principles of the general law (including equity), a statutory body of this type, which is after all exercising a trading function, should also be subject to judicial review…

[179] In the 2020/21 financial year, HVDHB entered into eight new service agreements, including one ICPSA (the Countdown Wainuiomata ICPSA); entered into 218 contract variations for existing service agreements; and maintained and monitoring a total of 246 service agreements.

[180] In the 2020/21 financial year Hauora Tairāwhiti entered into or varied 73 service agreements.

[181] Both HVDHB and Hauora Tairāwhiti followed their usual processes and criteria — the Pharmacy Contracting Policy in the case of HVDHB and its Provider Policy in the case of Hauora Tairāwhiti — when deciding to enter into ICPSAs with RX8. That reflected the essentially commercial nature of the decisions.

[182] Legislative accountability mechanisms are relevant.[74] DHBs were governed by a largely elected board and accountable to the Minister. The accountability

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72 Section 25(2)(a).

73 *New Zealand Private Hospitals Association – Auckland Branch (Inc) v Northern Regional Health Authority* HC Auckland CP 440/94, 7 December 1994 at 42–43.

74 *Lab Tests*, above n 57, at [89].

mechanisms in the NZPHDA, including direct elections of boards and intervention by the Minister, reduced the need for broad supervision by the Court.

[183] The applicant and the Pharmacy Guild submit that the extensive regulatory and ethical obligations and standards to which pharmacists are subject highlight the significant public interest factors and public safety implications attached to the role of community pharmacy.

[184] However, in my view, the public safety regulatory context points against a broad scope of review. A pharmacy must have a licence before it can provide services to the public. The Ministry of Health is the licensing authority and regulates the conduct of pharmacies under the licensing regime. It is that regime that is primarily concerned with public safety. It was only once a DHB entered into an ICPSA with a pharmacy that the pharmacy owed contractual obligations to the DHB and could be held to account under the contract. Given that, a DHB's decision to enter into an ICPSA did not require close supervision by the Court to ensure public safety.

[185] The two factors that weigh strongest in my assessment are, on the one hand, the quasi-regulatory nature of the granting of an IPCSA and, on the other, the commercial interests of the applicant group.

[186] As to the first, this case involves a contracting environment different from, for example, *Lab Tests* and *Problem Gambling*. In the former a tender process was used, with the three DHBs issuing a request for proposals and two tenderers, directly competing with each other. In *Problem Gambling*, a request for proposals was issued as part of a nationwide contestable procurement exercise. Nor is this a commercial decision in the same way as in *Healthcare of New Zealand v Capital and Coast District Health Board*,[75] which involved decisions about whether and how savings could be made in the delivery of relevant services. Here, the DHBs were not making choices in that sense.

[187] As the Pharmacy Guild notes, the DHBs held a monopoly over the ability to award the ICPSA. DHBs were not in competition with each other. Nor is the ICPSA

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75 *Healthcare of New Zealand Ltd v Capital and Coast District Health Board*, above n 58.

negotiated between the parties — all DHBs used a single, central "evergreen" contract. That ICPSA is then promulgated to all community pharmacy contract holders in the country. This is not therefore a case where more onerous procedural obligations may unduly fetter a public body's ability to negotiate effectively in the context of commercial negotiations with private sector service providers.

[188] But I cannot ignore the clear commercial nature of the applicant's interest. The ICPG is a special interest business group. It was incorporated shortly before this proceeding was filed to "represent and promote the interests of independent community pharmacies and pharmacists". The ICPG members are independent community pharmacists who are commercial competitors of the two Countdown pharmacies. As in *Problem Gambling*,[76] that commercial interest is a critical contextual factor. While having a level of commercial interest in the outcome of a judicial review is not a disqualifying factor,[77] as noted in *Problem Gambling*,[78] it is not the function of judicial review to advance private interests in a competitive business market.

Conclusion on scope of review

[189] Taking all of the contextual factors into account, I conclude that a narrow scope of review is appropriate.

[190] In addition to the applicant's commercial interest, I particularly note the NZPHDA did not impose procedural requirements on DHBs for granting service agreements. They were empowered to negotiate and enter into service agreements on any terms and conditions, without following a specific statutory process. While the ICPSA was not a "standard" service agreement, nevertheless it was governed by each DHB's policy and procedures, which in each case were adhered to. The Court should be reluctant to impose its own procedural requirements.

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76 *Attorney-General v Problem Gambling Foundation of New Zealand*, above n 60, at [43].
77 See for example *Laker Airways Ltd v Department of Trade* [1977] QB 643.
78 *Attorney-General v Problem Gambling Foundation of New Zealand*, above n 60, at [42].

[191] The accountability mechanisms on the entities, through the direct elections of boards and intervention by the Minister, reduce the need for broad supervision by the Court.

[192] While the grant of an ICPSA has a regulatory flavour, and there is a public safety factor to the provision of community pharmacy services, that was not directly engaged in the DHB decisions on the ICPSAs. Public safety concerns are more directly addressed by the Medicines Act, including the power of the Ministry of Health to grant a licence to operate a pharmacy.

[193] The applicant does not allege fraud, corruption, bad faith or analogous circumstances which would render the decisions reviewable on narrower grounds and the judicial review causes of action against the first and second respondents must therefore fail.

Specific grounds of review

[194] In the event I am wrong in my conclusion that the decisions are reviewable only on the narrow *Mercury Energy* grounds, I have also considered the specific grounds of review.

Rationality — first, second and third grounds of review

"Correct question"

[195] The first three grounds of review all centre around the zero co-payment — how the DHBs perceived it and how they assessed it. Essentially the same evidence is relevant to each of the three grounds of review.

[196] At the hearing, the applicant advanced the second ground of judicial review in a somewhat different way than pleaded. The pleading is that each of HVDHB and Hauora Tairāwhiti asked themselves the wrong question. In its amended statement of claim the applicant says the question the DHBs asked was whether disparities exist between Māori and non-Māori in access to medicines. The "correct question" as pleaded was "whether there was sufficient evidence that zero co-payments and longer

hours… would have a material effect in reducing health disparities by improving health outcomes for the [DHB's] resident population …".[79]

[197] At the hearing the correct question was submitted to be "whether Countdown's zero co-payment approach as a commercial marketing strategy would improve access to medicines and health outcomes for disadvantaged population groups, including Māori." That question points to an allegedly mistaken understanding of RX8's commercial motivations and future actions.

[198] That "basic error" of both DHBs, being their failure to identify the co-payment discount offered by RX8 as a commercial loss-leading strategy, and instead proceeding as if Countdown was benevolently removing fees in the public interest, is essential to the applicant's case. It says that error led the DHBs to conclude that the Countdown proposals were "pro-equity" and therefore justified approving the ICPSAs in each case. The ICPG says it was akin to "confusing a bribe for a charitable donation" or "assuming that a payday lender offering high interest rates is making money available to allow families to meet their basic financial needs".

[199] That formulation of the case colours all of the first to third causes of action and also, to some extent, the fourth (in relation to te Tiriti).

[200] The first and second respondents say that because the alleged error was not raised in the pleadings, it was not addressed in their evidence and the Court ought not to consider that aspect of the claim as framed at the hearing. RX8 too notes that "loss leading"/"commercial marketing strategy" was not pleaded and there is no probative evidence of "loss leading".

[201] I agree with the respondents that the failure by the applicant to plead what it now says is the "correct question" is significant. The question as framed in the amended statement of claim and as framed in the ICPG's submissions are fundamentally different questions. The question posed in the submissions does, as the first and second respondents submit, call into question the credulity of DHB decision-makers and RX8's commercial ethics, without a proper basis.

[79] Amended Statement of Claim (11 July 2022) at [133(b)].

[202] It also invites a judicial inquiry into an alleged "commercial marketing strategy" by Countdown and the allegations/inferences that the decision-makers in HVDHB and Hauora Tairāwhiti were "removing fees benevolently in the public interest". I accept that, if this had been pleaded, the respondents would have filed evidence in response.

[203] The high point of the applicant's evidence appears to be a 28 June 2019 article in *Pharmacy Today*. That article quotes Countdown Pharmacy's business manager Jeremy Armes, where he says that the experience of the Auckland Countdown pharmacies' discounting of the co-payment has been that "prescription volumes grew and that customers were more likely to buy OTC [over the counter] products." He was directly quoted as saying "[i]t is economically viable, or we wouldn't be doing it."

[204] The submission for the applicant is that Ms Haggerty (the decision-maker at HVDHB) does not refer to how Countdown Pharmacy might be sustaining the discount or whether there might be trade-offs elsewhere as a result, notwithstanding Countdown's publicly stated position in *Pharmacy Today*. As the first and second respondents submit, if the "correct question" is to be reframed, they ought to have had the opportunity for Ms Haggerty to respond on that issue.

[205] I conclude that on this issue the ICPG is bound by its pleadings.

[206] In any event, I do not accept that the DHBs asked the wrong question. I accept that even if removal of the co-payments might be characterised as a commercial marketing strategy, that would not invalidate the HVDHB and Hauora Tairāwhiti decisions to grant the ICPSAs.

[207] First, and self-evidently, pharmacies operate as businesses. One might expect that all pharmacies would have a strategy to ensure they remain profitable.

[208] The criteria applied by the DHBs, including effects on equity and ongoing financial viability, are effects or outcomes focussed. These are assessed objectively

and qualitatively (to the extent reasonably practicable), rendering RX8's subjective intention irrelevant.

[209] In any event, it is common sense — and I am prepared to take judicial notice of the fact — that reducing or removing the co-payment would reduce the cost barrier to access and increase access to everyone, but most particularly to those for whom the cost barrier was significant. That appears to have been borne out in practice. Ms Haggerty's evidence is that following the introduction of zero co-payments at the Countdown Pharmacy in Wainuiomata, there has been an increase in dispensing rates in the Hutt Valley District and that increase is the same for all demographic groups.

[210] The "correct question" posed by the ICPG in its submissions presumes that the decisions by both DHBs to enter into an ICPSA with RX8 were predicated solely on Countdown's zero co-payment approach. But it is clear from the evidence that both decisions were based on a number of factors.

[211] The HVDHB decision was made in the context of its Pharmacy Contracting Policy, which required the Panel and Ms Haggerty, as the decision-maker, to consider the application in accordance with the decision-making criteria set out in the Policy.

[212] In addition to the co-payment discount, the decision by HVDHB was also based on Countdown's proposal to have longer opening hours than the other two pharmacies in Wainuiomata. Ms Haggerty's evidence, and her correspondence with RX8 at the time, make it clear that increased hours was a key factor in her decision.

[213] The Hauora Tairāwhiti decision was made in the context of the Provider Policy, consideration by three committees, and assessment by the Board. Hauora Tairāwhiti considered the commercial elements of the application, how the services would meet the needs of the local population, and the effect on reducing inequities.

[214] As Ms Roberts' evidence notes, the Hauora Tairāwhiti Provider Policy was designed to assess financial considerations (for example, the financial viability and sustainability of the applicant) and the applicant's business plan (for example, how it would serve the local population specifically).

[215] Hauora Tairāwhiti's decision was based on a number of factors, including the benefits of having another pharmacy option in Tairāwhiti, the proposal from Countdown to have extended opening hours on weekdays and weekends, shopper convenience through customers being able to collect their groceries and medicines at the same place, Countdown's proposal to address Hauora Tairāwhiti's strategic priorities in relation to mental health and addiction, and the prospect of increasing the local and Māori workforce.

[216] It is also apparent that Hauora Tairāwhiti was aware of concerns from local pharmacists about RX8's commercial model. Its Board referred to the communications from those pharmacists when making its decision and Hauora Tairāwhiti sought more information about national pharmacy sector views on discounting the co-payment.

[217] I accept that RX8's proposal to discount co-payments was not determinative of either of the HVDHB or Hauora Tairāwhiti decisions.

[218] The multifactorial nature of the DHBs' decisions is relevant to the level of inquiry they ought to have undertaken. See for example *R (on the application of Friends of the Earth Limited) v the Secretary of State for International Trade/Export Credits Guarantee Department*:[80]

> … where a decision involves a high degree of policy judgment, it may be permissible for the decision maker to adopt a less rigorously technical approach to an individual feature that bears consideration as one feature amongst many than would be the case if that feature were to be the only material feature or the sole determinant for the decision. In the same way, where a decision maker decides that a particular feature or consideration is not to be determinative (which decision may only be vitiated on irrationality grounds), it may be permissible to adopt a less technically rigorous approach to that feature than would be the case if it were necessarily or potentially determinative of the outcome of the decision.

[219] It follows that I am not persuaded that either of HVDHB or Hauora Tairāwhiti failed to ask the right question or to obtain the relevant information to answer the right question. Each of them had sufficient and suitable evidence to make their respective

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[80] *R (on the application of Friends of the Earth Limited) v the Secretary of State for International Trade/Export Credits Guarantee Department* [2022] EWHC 568 at [101].

decisions to grant the ICPSAs. For the same reasons, I cannot conclude that there was not a rational connection between the evidence and the DHB decisions.

[220] The first to third grounds of review fail.

Te Tiriti

[221] The ICPG says that HVDHB and Hauora Tairāwhiti each acted unlawfully by failing to enable Māori to contribute to decision-making in the appropriate way and thereby acting inconsistently with te Tiriti.

[222] In particular, it says that HVDHB:

(a) had no separate committee or grouping to provide Māori-specific advice or allow for differences of view among Māori partners;

(b) did not solicit any Māori input when considering the Countdown ICPSA; and

(c) did not follow the requirements of its own *Te Pae Amorangi* policy.

[223] The applicant also says that HVBHB created a legitimate expectation (through *Te Pae Amorangi*) that te Tiriti would be honoured in the DHB's approach to pharmacy services, that expectation was relied on, but HVDHB did not follow through on the expectation.

[224] In relation to Hauora Tairāwhiti, the ICPG says it:

(a) did not have an appropriate Māori policy guiding pharmacy decisions;

(b) failed to consult externally with Māori communities on its Countdown ICPSA decision; and

(c) failed to be adequately informed of the impact of the Countdown ICPSA on equitable Māori health outcomes.

[225] For those reasons the decisions by both DHBs to grant the application by Countdown for an ICPSA was unlawful and invalid.

[226] In response, the first and second respondents note that DHBs are Crown entities, legally separate to the Crown. They are not a Treaty partner.

[227] The NZPHDA recognises Treaty principles, through the mechanisms in pt 3,[81] which included requirements for mechanisms to enable Māori to contribute to decision-making on, and participation in the delivery of, health and disability services. Section 25 did not impose additional Treaty requirements when a DHB entered into a service agreement. DHBs discharged their Treaty obligations if they acted in accordance with the NZPHDA.

[228] In any event, each DHB had policies and structures which provided for Māori to be part of the decision-making process; each considered the RX8 application from an equity perspective.

[229] In its 2020/21 annual plan, Hauora Tairāwhiti recognised the principles of the Treaty, as stated by the Waitangi Tribunal in the Hauora Report, and explained how it would apply those principles in its decision-making, including the use of Te Waiora o Nukutaimemeha, the iwi relationship committee of Hauora Tairāwhiti. Te Waiora o Nukutaimemeha consisted of a variety of iwi representatives, community-elected members and a Māori health provider, to ensure Māori had a central decision-making role in Hauora Tairāwhiti. External consultation was not necessary for the community because Māori in the community had selected their experts, Te Waiora o Nukutaimemeha members, to speak on their behalf.

[230] Te Waiora o Nukutaimemeha considered RX8's application from an equity perspective. This ensured that the Māori voice informed Hauora Tairāwhiti's decision-making process.

[231] Te Waiora o Nukutaimemeha developed the HEAT tool and 'benefits criteria' analysis to inform every application for a service contract made in Hauora Tairāwhiti,

81 NZPHDA, s 4.

to ensure Hauora Tairāwhiti could accurately assess the impacts of the application from an equity perspective. Te Waiora o Nukutaimemeha did not consider a Māori-specific policy was required for Hauora Tairāwhiti's decision-making.

[232] Hauora Tairāwhiti refutes the allegation that Hauora Tairāwhiti was not informed of the impacts of its decision on equitable Māori health outcomes. 51 per cent of the population in Tairāwhiti identify as Māori and Tairāwhiti district also has the highest level of deprivation in the country. Hauora Tairāwhiti was part of Te Manawa Taki Leadership Group. That group partnered with Te Manawa Taki Iwi Relationship Board to develop its Regional Equity Plan 2020–2023 and establish Te Manawa Taki Governance Group, a "Te Tiriti inspired governance group" which demonstrated shared leadership and decision-making. Inevitably, Hauora Tairāwhiti was well aware of the impact of these factors on access to health services. Te Waiora o Nukutaimemeha specifically considered that the impact of the Countdown ICPSA on equitable Māori health outcomes would be positive, in that it could improve access for Māori as they could access that service in their normal routine, and RX8 had committed to improving equity in their organisation, including by growing the Māori workforce.

[233] In relation to HVDHB, its Pharmacy Contracting Policy required a Māori representative on its evaluation panel. For the Countdown Wainuiomata application, this was Ms Waldegrave in her capacity as the Acting Director of HVDHB's Māori Health Unit. Ms Waldegrave was an experienced researcher and had insight into local communities, including Wainuiomata. The Māori Health Unit was a team established to "support whānau, the community, and the health workforce to improve health outcomes for Māori." The Unit played an important role and voice in relaying Māori perspectives to the evaluation panel.

[234] Ms Haggerty gave the views of Ms Waldegrave (who supported the application) greater weighting than the rest of the panel (who advised against the application), on the basis of her agreement with Ms Waldegrave that Countdown's proposal to discount co-payments and increased operating hours had the potential to increase access to pharmacy services.

[235] As to the ICPG's breach of legitimate expectation submission, HVDHB notes first the general nature of the alleged commitment. Second, it says the representative function of the Māori Health Unit on the evaluation panel is entirely consistent with HVDHB's commitment to involve Māori in decision-making and ensure "appropriate engagement and partnership" with Māori communities. There is no express commitment to "internal or external structures for Māori decision-making," as submitted by the ICPG, and the document expressly cautions that there cannot be a "one-size-fits-all approach" to partnership. To the extent *Te Pae Amorangi* may have created a legitimate expectation, HVDHB submits it is one that has been met.

Discussion

[236] The DHBs were Crown entities owned by, and legally separate from, the Crown.[82] They were not the Crown[83] and therefore not a Treaty partner.

[237] DHBs did not have a general statutory objective or function to act consistently with the principles of the Treaty. They were required to comply with their empowering statute, the NZPHDA.

[238] Section 4 of the NZPHDA provided that:

> **4 Treaty of Waitangi**
>
> 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.

[239] Part 3 of the NZPHDA established DHBs. Part 3 included requirements for mechanisms to enable Māori to contribute to decision-making on, and participation in the delivery of, health and disability services:

(a) Māori membership on DHB boards.[84]

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82 CEA, s 15.
83 *Stafford (CA125/2018) v Accident Compensation Corp* [2020] NZCA 164, [2020] 3 NZLR 731 at [33] per Gilbert J and [129]–[131] per Courtney J.
84 NZPHDA, s 29(4).

(b) Māori representation on advisory committees.[85]

(c) The statutory functions of DHBs to:

(i) develop processes to enable Māori to participate in and contribute to strategies for Māori health improvement;[86] and

(ii) continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori.[87]

[240] The applicant says that s 4 of the NZPHDA did not limit Parliament's intention in respect of the DHBs or limit decision-makers' duties to those found in pt 3. However, I accept the first and second respondents' submission that the express wording of s 4 demonstrates that the Crown intended "to recognise and respect the principles of the Treaty" through the mechanisms provided in pt 3 of the Act. I accept the intention at the time the legislation was passed was that the Crown's Treaty's obligations would be discharged primarily through the mechanisms in pt 3.

[241] I am satisfied that Hauora Tairāwhiti was aware of the issues facing Māori in Tairāwhiti. The specific decision to enter into the ICPSA with RX8 was made in accordance with Hauora Tairāwhiti processes and was informed by a local Māori voice, both at a governance and operational level. Accordingly, Hauora Tairāwhiti acted so as to discharge its obligations in respect of the Treaty principles.

[242] In relation to HVDHB, its Pharmacy Contracting Policy required a Māori representative on its evaluation panel. Ms Waldegrave was the representative of HVDHB's Māori Health Unit on the evaluation panel for the Countdown application. In my view, the applicant's criticism of Ms Waldegrave as a "singular Māori" involved in HVDHB's decision-making process, is a misstatement of the position. The purpose

85 Sections 34–36.
86 Section 23(d).
87 Section 23(e).

of the Māori Health Unit was to understand the perspective of local Māori. Through Ms Waldegrave it had a voice on the evaluation panel.

[243] To the extent that *Te Pae Amorangi* could be said to have created a legitimate expectation, I am satisfied that expectation was met.

[244] I am satisfied on the evidence that both HVDHB and Hauora Tairāwhiti did discharge their Treaty obligations under the NZPHDA and, in entering into the ICPSAs, did follow their own policies and processes (regardless of whether more might be required of the Crown). As detailed above, those policies and processes allowed for each DHB to receive Māori-specific advice, including reflecting external Māori views, both generally and in relation to the potential impact of the Countdown ICPSAs on Māori equity.

[245] I conclude that the fifth ground of review is not made out.

Authority to make Treaty arguments

[246] For completeness I note a preliminary issue which arose about the applicant's ability to make arguments on behalf of local iwi, who were not a party to the proceeding.

[247] While they do not challenge standing, the first and second respondents refer to *Students for Climate Solutions Inc v Minister of Energy and Resources*,[88] where an issue was raised as to who could make arguments on behalf of local iwi, who were not a party to the proceeding and therefore not before the Court, in a judicial review application.

[248] In that case the applicant challenged decisions by the Minister of Energy and Resources to grant petroleum exploration permits to two companies. The grounds of review included that the Minister had not engaged with the principles of the Treaty in a meaningful way by taking into account the effects of climate change on Māori. The applicant was not affiliated with any iwi or hapū.

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88 *Students for Climate Solutions Inc v Minister of Energy and Resources* [2022] NZHC 2116, [2022] NZRMA 612 at [103].

[249] The Court observed that it should be careful to not itself act inconsistently with the principles of the Treaty by reaching decisions based on the views expressed by a particular iwi (or other recognised body) without having them formally before it. To do so might by itself be considered inconsistent with rangatiratanga and tikanga.[89] In addition, reliance on the views of one iwi about matters within another iwi's rohe, without consideration of localised issues, is misguided.

[250] Here, the ICPG is not affiliated with any iwi or hapū of the regions associated with HVDHB and Hauora Tairāwhiti and nor had the ICPG sought to obtain the views of those iwi or hapū in relation to the decisions under review.

[251] The ICPG says it was not required to speak to iwi about what te Tiriti means — the DHBs, as the decision-makers, carried the obligation of ensuring they had sufficiently informed themselves of the relevant facts to make their decision and, where required, had engaged in appropriate consultation.

[252] Given my finding on the substance of this ground of review, it has not been necessary for me to express a view on this issue.

Monitoring

[253] Under the fifth ground of review, the ICPG says that HVBHB and Hauora Tairāwhiti were obliged to monitor the delivery and performance of the services provided by Countdown Gisborne and Countdown Wainuiomata under the IPCSAs.

[254] The applicant says that the monitoring obligation was of particular importance in relation to Countdown Pharmacy Gisborne because Hauora Tairāwhiti was aware of concerns raised by community pharmacists, including about the quality of services that Countdown would provide.

[255] The ICPG relies on the specific, comprehensive commitments made by Countdown Pharmacy Gisborne in its application for an ICPSA. The Countdown Gisborne application for the ICPSA had represented to Hauora Tairāwhiti that all

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89 At [103]–[112].

Countdown pharmacies are open from 9.00 am to 8.00 pm, seven days per week. Countdown Pharmacy Gisborne failed to meet those hours:

(a) It failed to open on weekends, from at least October 2021; and

(b) It failed to be open until 8.00 pm since at least October 2021.

[256] The applicant says Hauora Tairāwhiti failed to monitor the delivery and performance of services by Countdown Pharmacy Gisborne, including by failing to monitor the extent to which it complied with its representations as to the services it would provide.

[257] The ICPG says that monitoring requires systematic, continuous, regular checking of services that have been promised. Ad hoc communications between Hauora Tairāwhiti and Countdown Pharmacy Gisborne, focussed on reduced opening hours because of problems staffing the pharmacy, did not discharge the general duty to monitor performance.

[258] The second respondent responds that the obligation to monitor, under s 25 of the NZPHDA, is an obligation to perform a function, in pursuit of its statutory objectives. The function was not a "general" monitoring obligation as the ICPG submits.

[259] What was required was considering available information. The NZPHDA did not prescribe how DHBs must seek and analyse that information. There was no obligation to audit providers on a regular basis, or by a particular means. The Act did not require a "systematic, continuous, regular checking of services" as asserted by the ICPG. Nor did the NZPHDA direct DHBs to take any action as a result of their monitoring.

[260] Hauora Tairāwhiti says it did comply with its statutory obligations to monitor RX8's contractual performance. First, the ICPG is mistaken as to what those contractual obligations were, relying on the matters set out in RX8's application. In fact, it was not a term of the ICPSA that, for example, Countdown Pharmacy Gisborne

must operate from 9.00 am to 8.00 pm, seven days per week. RX8 did not breach any contractual obligations by failing to do so.

[261] Hauora Tairāwhiti did monitor RX8's performance under the ICPSA through regular correspondence and hui, from the commencement of the ICPSA on 3 June 2021, until the disestablishment of Hauora Tairāwhiti on 1 July 2022. After that date Te Whatu Ora continued to monitor the ICPSA. Ms Roberts' evidence is that, in the course of that monitoring, she did not have any concerns that RX8 was not meeting its contractual obligations or otherwise providing a good service.

[262] The second respondent further submits that, in any case, if RX8 had breached a contractual obligation it could be held to account for that breach under the ICPSA. It would not follow that Hauora Tairāwhiti had breached a statutory duty to monitor.

Discussion

[263] A specific monitoring duty in relation to service agreements arises under s 25(3) of the NZPHDA: "A DHB that has entered into a service agreement must monitor the performance under that agreement of the other parties to that agreement." One of the functions of DHBs under s 23(1)(i) of the NZPHDA is "to monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services".

[264] Section 6 of the NZPHDA defines "monitor" in relation to the functions specified in ss 23(1)(i) and 25:

> (a) means to analyse on the basis of information provided under any relevant agreement and any other relevant substantiated information; and
>
> (b) includes assessing the timeliness of provision of information required to be provided under any agreement.

[265] The ICPG's pleading and submission is that monitoring requires "systematic, continuous, regular checking of services that have been promised". I do not accept

that proposition. The NZPHDA did not impose any procedural or substantive requirement on DHBs in respect of monitoring and, as illustrated by *Jeffries v Attorney-General*,[90] monitoring does not necessarily require a constant stream of requests.

[266] The ICPG's pleaded claim was confined to allegations about monitoring of opening hours. First, as noted, the opening hours were not a specific contractual obligation. The second respondent did in any event adduce evidence to address those allegations. Hauora Tairāwhiti and, subsequently, Te Whatu Ora, continued to monitor the Countdown Gisborne Pharmacy appropriately, in the circumstances. Ms Roberts' evidence was that when the issues regarding staffing and opening hours were more severe, in September 2022, more extensive monitoring was implemented.

[267] In any event, as the respondents submit, any alleged failure to monitor cannot have any bearing on the validity of Hauora Tairāwhiti's decision to grant an ICPSA in the first place.

[268] I conclude that, on the facts, Hauora Tairāwhiti has discharged its monitoring obligations. This ground of review is therefore dismissed.

Licence to operate a pharmacy — "effective control"

[269] The sixth ground of review is that, when the Ministry granted licences to RX8 to operate the Countdown pharmacies, it failed to administer the "effective control" test in s 55D of the Medicines Act in accordance with the statute.

Medicines Act

[270] The Medicines Act regulates the supply of therapeutic drugs to protect the safety of the public. The Act prohibits (among other things) the operation of a pharmacy otherwise then in accordance with a licence issued under pt 3. There is no right to such licences; their issue is strictly controlled by statutory criteria. For all licences, the licensing authority must be satisfied of all the requirements in s 51(1).

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90 *Jeffries v Attorney-General* HC Wellington CIV-2006-485-2161, 20 May 2008 at [73]. The decision was unsuccessfully appealed to the Court of Appeal and Supreme Court.

These include whether the applicant is a fit and proper person to hold the licence,[91] whether the applicant has sufficient knowledge of the obligations of a licensee and the hazards associated with medicines,[92] that the premises and equipment are suitable,[93] and that there are adequate arrangements for adequate records in respect of medicines.[94]

[271] Further criteria are also imposed on pharmacy operators. Under s 55A the licensing authority must not grant a licence to operate a pharmacy unless it is satisfied that, in addition to satisfying the criteria in s 51(1), the applicant is also qualified under one of ss 55D, 55E or 55G.[95] Section 55D applies in the case of RX8.

[272] The relevant parts of s 55D provide:

> **55D Restriction on companies operating pharmacies**
>
> (1) No company may be granted a licence to operate a pharmacy unless any of paragraphs (a) to (e) of subsection (2) apply.
>
> (2) A company may be granted a licence to operate a pharmacy if—
>
> (a) at all times more than 50% of the share capital of the company is owned by a pharmacist or pharmacists, and effective control of the company is vested in that pharmacist or those pharmacists; or
>
> …

RX8's ownership structure

[273] RX8's ownership structure, both now and at the time of its application to hold a pharmacy licence for Countdown Pharmacy Penrose, is set out below.

[274] RX8's shareholding is comprised of three shareholders who are registered pharmacists (the Pharmacist shareholders), who hold 51 Class A shares (51 per cent of the shares). General Distributors Ltd (GDL), which is wholly owned by Woolworths New Zealand Ltd, holds 49 Class B shares (49 per cent of all shares).

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91 Medicines Act, s 51(1)(b).
92 Section 51(1)(d).
93 Section 51(1)(e).
94 Section 51(1)(f).
95 Section 55A(1)(a).

[275] RX8's Shareholders' Agreement and Constitution also provide (among other things):

(a) The day-to-day pharmacy operations of pharmacies and any matters relating to legislation or regulation governing the operation of pharmacies, are controlled or determined by the Pharmacist shareholders;

(b) The Class B shares entitle GDL to receive 100 per cent of all dividends and a 100 per cent share in the distribution of the surplus assets of RX8 on liquidation.

(c) RX8 shall have no more than two directors. The Pharmacist shareholders can appoint one director, and the GDL shareholder can appoint one director. Board decisions must be unanimous. The Chairperson does not have a casting vote.

(d) A Class B director will have authority to enter into contracts of the type listed in sch 5 of the Act (including, licences to operate and ICPSAs) but only after consent has been given by a Class A director to enter into those agreements.

The Ministry's decision

[276] RX8 applied for a licence to operate a pharmacy in the Penrose Countdown store on 21 May 2020. The application was assessed by MedSafe. Michael Haynes, the Medicines Control Manager of Medsafe, holds a delegation from the Director-General of Health as licensing authority for pharmacies under the Medicines Act. Mr Haynes assessed the RX8 application.

[277] As it was the first time that RX8 had applied for a licence, a MedSafe Registrar assessed its legal structure against the statutory criteria under the Act. The Registrar recommended the application be approved, meaning they were satisfied that RX8's ownership structure met the statutory requirements.

[278] The only written record of the MedSafe Registrar's reasons for this decision is a Registrar Assessment Memo dated 21 May 2020. It records that the Registrar reviewed RX8's Constitution and Shareholders' Agreement, noted "Yes" on the question of majority pharmacist shareholder control of directors' meetings, noted majority pharmacist board control to be "50%", and concludes "Negative control". The recommendation to approve the application was on the basis that "Pharmacist director must be present and resolution carried if unanimous (pharmacists have negative control)."

[279] This Registrar's memorandum was reviewed by Mr Haynes, who agreed the Pharmacist shareholders have "negative control" and who was also satisfied the ownership structure met statutory requirements.

[280] As this was the first application for this specific premises to be licensed, an initial licensing audit of the premises was conducted to assess compliance of the proposed premises with the regulatory requirements. The premises was assessed as compliant.

[281] The subsequent applications from RX8 for licences to operate pharmacies at Grey Lynn, Wainuiomata, Gisborne and Richmond included application forms and accompanying materials that were materially the same, in relation to the issue of effective control. No reassessment of the ownership structure was conducted for each subsequent application made by RX8.

[282] At the time of the hearing of this matter there were five licences granted to Countdown pharmacies, being Penrose, Grey Lynn, Wainuiomata, Gisborne and Richmond.

Submissions

[283] The ICPG says that effective control means that the Pharmacist shareholders must be able to make decisions relating to both governance and operational matters for the pharmacy company. However, on the basis of the company structure detailed above, they cannot do so because GDL is able, through its appointed director, to

prevent the pharmacy-appointed director from making any such decision if it chooses to do so.

[284] In practice, "effective control" in s 55D must require the amount of control that owning more than 50 per cent of a company would ordinarily provide under the Companies Act 1993.

[285] The applicant says that the relevant provisions of the Companies Act, taken together, mean that the amount of control ordinarily expected of a majority shareholder is determinative control over ordinary shareholder decisions, including the composition of the board. This, in turn, must mean the ability to control the number of directors required for directors' resolutions to be passed; there would be little purpose in controlling a minority of the board. That is what "effective control" over a company ought to require, at a minimum, for the purposes of s 55D(2)(a).

[286] It then assesses the position of RX8 against that "default" position under the Companies Act and concludes that the actual position in relation to RX8 is that the Pharmacist shareholders do not have control over the board; they may appoint and remove only one out of two directors, with the other being appointed by GDL. They do not have control over the ability to hold shareholders' meetings, as quorum requires GDL to be present. Board decisions must be unanimous; therefore, while the Pharmacist shareholders effectively have a veto from their director, so too does GDL. The pharmacist-appointed director cannot make any decision without the approval of the GDL-appointed director.

[287] If there is a deadlock between the two directors and that cannot be resolved between the Pharmacist shareholders and GDL, the status quo remains; there is no overriding mechanism in favour of the pharmacist shareholders. The GDL-appointed director is expressly permitted to act in the best interests of GDL, contrary to the best interests of RX8.[96]

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[96] Clause 29.4 of RX8's Constitution provides: "**Joint venture company**: As the Company has been incorporated to carry out a joint venture between the Shareholders, a Director may, when exercising powers or performing duties as a Director in connection with the carrying out of the joint venture, act in a manner which he or she believes is in the best interests of a Shareholder or Shareholders, even though it may not be in the best interests of the Company."

[288] The applicant says that the Pharmacist shareholders are subject to the interests of GDL (ultimately Countdown) and cannot make (or cause to be made) any significant strategic or business decisions without GDL's permission.

[289] In response, both the Ministry and RX8 rely on the concept of "negative control" which they say is sufficient to establish effective control:

(a) the Pharmacist shareholders have oversight and control of the day-to-day management of the pharmacies;

(b) the Pharmacist shareholders have the ability to maintain the status quo, including to block any resolution or action that could or would be contrary to public safety or professional or ethical standards of pharmacy practice; and

(c) GDL is not able to effect change other than in situations where the majority Pharmacist shareholders also agree.

[290] RX8 says the negative control test denotes an ability to block any resolution or action that is contrary to public health and the specific operational requirements under the Act. That interpretation is supported by s 5A(4) of the Medicines Act.[97]

[291] RX8 also points to all of the licensing requirements imposed under s 51(1), which go to safety and other issues, set out at [270] above.

[292] The Ministry notes that the Licensing Authority has been applying the negative control test since at least 2008. It submits that the scope of a particular statutory power is for the decision-maker's discretion and different approaches may be open. Provided the decision-maker addresses itself to the right question and reaches a decision reasonably open to it, the reviewing Court should not disturb its decision. That argument is supported by reference to the Licensing Authority's specialist function.

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97 Medicines Act, s 5A(4): "… any covenant, condition, or stipulation … in any contract or agreement restricting the operator of a pharmacy in the purchase of pharmaceutical requirements or other stock in trade is to be treated … as a device or arrangement affecting the management and control of the pharmacy practice carried on in that pharmacy."

The Ministry submits that where a public body exercises a specialist function the reviewing court should show deference to that technical expertise.

[293] The intervener, the Pharmacy Guild, also addressed this ground of review. It submitted that the meaning of "effective control" is an orthodox question of statutory interpretation for the Court, not a matter of discretion, as contended for by the Ministry and supported by RX8.

[294] The Pharmacy Guild says the Court is not bound by the past, "negative control", approach of the Licensing Authority. If that habitual practice reflects an incorrect interpretation of the statute, the Court should clarify the correct meaning.

[295] In company structures, the orthodox definition of "control" of a company means to have majority control.[98] This encompasses a positive power over the operational performance of a company and the ability to make the company do as you wish. The ability to stop change (a veto), but not positively affect it, cannot be sensibly seen as "effective", nor consistent with the statutory scheme.

[296] RX8 emphasised what it says are the practical ways in which effective control is achieved by the pharmacist shareholders. In response the Pharmacy Guild noted that all 10 of the RX8 companies (at the time of the hearing) had three common pharmacist shareholders. That means each would need to be having effective operational control of 15 pharmacies. The Pharmacy Guild submits it is difficult to see how this could allow for effective control of each pharmacy in any meaningful sense.

Legislative history

[297] Counsel traversed the legislative history and context of the "effective control" requirement in some detail. All parties agreed that the statutory scheme is concerned with public safety and the safe and effective delivery of prescription medicines. The history of the provision shows that the ownership and control restrictions exist to preserve the independence of pharmacists from non-pharmacist interference.

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[98] Companies Act 1993, s 7.

[298] The Pharmacy Amendment Act 1954[99] introduced a partial consenting regime based on a "one pharmacist, one pharmacy" principle, whereby individual pharmacists could each operate one pharmacy without the consent of the Pharmacy Authority.

[299] The 1954 amendment also allowed pharmacists to operate a pharmacy through a company without the need for consent, provided the pharmacists owned at least 75 per cent of the shares of the company.[100]

[300] The 1954 Amendment Act unintentionally left a loophole whereby pharmacists could circumvent the "one pharmacist, one pharmacy" principle by owning shares in multiple companies, each running pharmacies. The Pharmacy Amendment Act 1957 addressed that gap, inserting a new subsection, subs 3(1A),[101] which re-enacted the 75 per cent ownership proviso.

[301] The Pharmacy Amendment Bill 1957, as drafted, did not contain the "effective control" requirement. That was added to the Bill during the committee stage, after a Member of Parliament raised concerns during the second reading that the proposed drafting would not achieve the intended purpose of "confin[ing] controlling interests in chemists' shops to genuine practising chemists", due to the multitude of ways a company could be structured to give control to a minority shareholder.[102]

[302] Section 3(1A) remained in place until it was repealed and re-enacted as s 42(2)(a) of the Pharmacy Act 1970.

[303] The Health Practitioners Competence Assurance (HPC) Act consolidated 11 regulatory regimes relating to health professionals (including pharmacists) and repealed the Pharmacy Act 1970. Parliament reintroduced blanket licensing for the operation of all pharmacies in the Medicines Amendment Act 2003,[103] but removed the "one pharmacist, one pharmacy" model, expanding the number of permitted pharmacies per pharmacist to five.[104] It reduced the pharmacist ownership

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99 Section 17(1).
100 Pharmacy Amendment Act 1954, s 3(1).
101 (23 October 1957) 314 NZPD 3008.
102 (23 October 1957) 314 NZPD 3252.
103 Medicines Amendment Act 2003, s 5.
104 Section 17, inserting s 55F.

requirement from at least 75 per cent to more than 50 per cent.[105] This is now reflected in s 55D(2)(a). The "effective control" requirement is retained.

[304] Before the introduction of the HPC Bill, the Office of the Minister of Health assessed two options in relation to ownership: restricted multiple ownership and licensed open ownership — that is, allowing licensed non-pharmacists to own pharmacies. The recommendation from officials to allow licensed open ownership was rejected by the Government. Rather, it enacted the 51 per cent ownership threshold. It appears, from the parliamentary debates, that the rationale for retaining a majority ownership requirement was to protect the safety of the public. Members noted that pharmacists, as health professionals, are driven by the needs of patients, and open ownership by non-pharmacists risked compromising those standards for the maximisation of revenue.[106]

Discussion

[305] The first limb of the test in s 55D of the Act, that at all times more than 50 per cent of the share capital of the company is owned by a pharmacist or pharmacists, is satisfied in the case of RX8.

[306] The outstanding question is what is meant by "effective control". In my view this is a pure statutory interpretation question, albeit not a straightforward one. It is a question of law for the Court to decide the correct meaning of those words. The Ministry's approach, to treat it as a matter of discretion for the decision-maker, is no doubt relevant to the subsequent exercise of the decision-making power, but not to the prior question of what s 55D(2)(a) means.

[307] Nor do I accept the Ministry's submission that, because the Licensing Authority has taken a "negative control" approach for some time, the Court should be hesitant to interfere with that approach. The Court is not bound by the practice of the decision-maker when considering statutory interpretation of the relevant term. As counsel for the Pharmacy Guild noted, there have been many situations where the

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105 Section 17, inserting s 55D.

106 See for example (15 October 2002) 603 NZPD (Martin Gallagher, Labour – First Reading of Health Practitioners Competence Assurance Bill).

Court has clarified the correct meaning of a statutory scheme long after it was passed and in a way contrary to the habitual practice of the decision-maker applying the statute.[107]

[308] What s 55D requires is "effective control" of the *company*. As the Pharmacy Guild submitted, the Licensing Authority has no particular expertise in company structures, shareholding agreements or company constitutional arrangements. This also militates against a suggestion that the Court should defer to any specialist expertise of the Licensing Authority when interpreting the phrase "effective control".

[309] As the applicant submits, three points follow from the wording of s 55D(2)(a):

(a) What is required is effective control *of the company* — that is, RX8 itself, not merely the pharmacy business or its day-to-day operations.

(b) Effective control is to be vested "in that pharmacist or those pharmacists" who own more than 50 per cent of the company — that is, RX8 must be effectively controlled by the Pharmacist shareholders specifically, not any person who happens to be a pharmacist.

(c) The conjunctive "and" between the majority ownership requirement and the effective control requirement means the requirement for effective control is in addition to the majority ownership requirement, recognising that being a majority shareholder does not necessarily amount to effective control of a company.

[310] I accept that the "effective control" wording was added to the legislation to ensure that the control that Parliament intended would be protected by the minimum shareholding provision could not be circumvented. That is, to ensure that the company was there to serve independent pharmacists and not some outside interest and thus to protect public safety.

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[107] For example, in *Booth v R* [2016] NZSC 127, the Supreme Court determined the meaning of s 91 of the Parole Act 2002, overruling the approach that the Department of Corrections had taken since 2003.

[311] There is no case law discussing effective control in the context of the Medicines Act.

[312] As the Privy Council noted in *Bermuda Cablevision Ltd v Colica Trust Co Ltd*, the legislative context of the phrase "control" and "controlling interest" take their colour from the context in which they appear. The expression is not a term of art.[108]

[313] So, for example, in the context of the Proceeds of Crime Act 1991, *Solicitor-General v Bartlett* (subsequently referenced in other cases, including *Solicitor-General v Huang*[109]) discussed the meaning of effective control:[110]

> *Effective control of trust property*
>
> *Meaning of effective control*
>
> [24] With respect to the concept of effective control, the legislative intent expressed in s 43(3) and (4) and s 29 of the Act suggests that the court is not to be limited in its inquiries by legal or equitable rights of ownership. This proposition derives support from the commentary on s 29 of the Act in *Adams on Criminal Law – Sentencing* (looseleaf ed), which states at para PC29.01 that:
>
> > "This section is intended to enable the Court to go behind any corporate structure, trust, family relationship, or the like disguising the true and effective control of property by a particular person. In such situations, the Court is to determine whether particular property is to be treated as the property of offenders not by reference to their legal or equitable rights, but by reference to the degree to which they are able to treat the property as their own: *DPP v Walsh* [1990] WAR 25 (1990) 43 Crim R 266. In other words, as expressed in *Connell v Lavender* (1991) 7 WAR 9, the question is whether the defendant in fact has the power to regulate possession, use, or disposition of the property in question (that is, the de facto power to give or refuse consent to a proposed course of action in relation to it)."

[314] The Court then discussed *Director of Public Prosecutions v Walsh*[111] and *Connell v Lavender*,[112] and went on to conclude:[113]

> [27] These cases support the proposition that, when considering the issue of tracing the proceeds of crime, the court is entitled to consider the real,

108 *Bermuda Cablevision Ltd v Colica Trust Co Ltd* [1998] AC 198 (PC) at 207.
109 *Solicitor-General v Huang* HC Auckland CIV 2005-404-1538, 18 December 2007.
110 *Solicitor-General v Bartlett* [2008] 1 NZLR 87, [2007] BCL 793 (HC) at [24]–[27].
111 *Director of Public Prosecutions v Walsh* [1990] WAR 25; (1990) 43 Crim R 266 (WASC).
112 *Connell v Lavender* (1991) 7 WAR 9, (1991) 5 ACSR 33 (WASC).
113 *Solicitor-General v Bartlett*, above n 110, at [27].

> de facto position of the respondent in relation to the property. The intent is that the respondent should not profit from his crime purely because of the legal structure by which he chooses to organise his assets. In order to determine whether the respondent had effective control of the property, the court must ask whether in fact the respondent had the capacity to control, use, dispose of or otherwise treat the property as his own.

[315] The Health New Zealand website includes specific guidance about s 55D of the Act:[114]

> … The majority of the share capital must be owned by an individual pharmacist or pharmacists. This pharmacist or these pharmacists must have effective control of the company at all times. For example, this may be reflected by the classes of shares held (if applicable), *the ability to appoint directors to the board and the ability to control the board of directors to the board*.
>
> …
>
> The Licensing Authority may require further information from the applicant to ensure that effective control is vested with the pharmacist(s). Company documents including company constitutions, shareholders agreements and details of the distribution of classes of shares (usually voting or non-voting rights) among the shareholders may be requested.
>
> (emphasis added)

[316] What the case law and commentary illustrate is that various factors can be relevant to determining effective control of a company, including: shareholding percentages; the ability to appoint directors; the extent of control over decision-making at the board and shareholder levels; and day-to-day management of the company. There is an emphasis on the Court looking at the "real" picture.

[317] I accept that a veto right may provide sufficient control in other legislative contexts, where the control test is aimed at preventing some mischief associated with *having* control, as opposed to not having it. But those contexts are fundamentally different from the Medicines Act context. They share a common theme, being aimed at preventing control from being too concentrated, in the interests of diversity.

[318] Section 55D is aimed at the inverse. Its purpose is to prevent some mischief associated with a lack of pharmacist control. The Ministry's approach of "negative control" would undermine the protective purpose of s 55D.

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114 Ministry of Health "Pharmacy ownership and control" (31 March 2011) <www.health.govt.nz>.

[319] I also accept that the corollary of requiring effective control by pharmacists is that there must not be effective control by non-pharmacists. Pharmacist control cannot be jointly held with non-pharmacists. Control by a pharmacist that is shared with a non-pharmacist would not be "effective control", as required by s 55D(2)(a).

[320] I do not accept the submission for RX8 that "effective control" is concerned primarily with operational management and is therefore consistent with a "negative control" test. While no doubt s 51(1)(d), (e) and (f) reinforce the public safety requirements of the Act, s 55D(2)(a) imposes an additional requirement. What it is required is effective control of the *company*, not just the pharmacy or its operational requirements. Pharmacist control over the bare minimum obligations required by legislation does not satisfy effective control.

[321] There are many active decisions required to be made at Board (and not operational) level that can have an impact on the health and safety of pharmacy patients. Examples given by the applicant include contracting decisions, where the board must agree to actively enter into a new contract. Many independent community pharmacists provide optional services for the safety and well-being of the public. Examples include COVID care in the community contracts, whereby pharmacies agreed to provide RAT tests, vaccinations and antivirals.

[322] A further example is opening hours. Changes to normal pharmacy opening hours require board approval because they impact on the sustainability of the business.

[323] Determinative power over the composition of the board, or at least over the number of directors that forms a majority of the voting rights on the board, is practically necessary to meet Parliament's policy aim.

[324] I conclude that the "effective control" test has not been administered in accordance with a correct interpretation of the Act. I uphold this ground of review.

[325] The primary remedy sought by the applicant is a declaration that the decisions to issue RX8 with licences to operate pharmacies were unlawful and invalid, and orders setting aside the decisions and the licences. The Ministry on the other hand

submitted that if the Court gets to the question of relief, the decision should be remitted to the decision-maker. However, I agree with the applicant that, the Court having found there is no "effective control", the licences cannot stand.

[326] I conclude that the licences granted by the Ministry of Health to RX8 to operate the Countdown pharmacies were unlawful and invalid and an order should be made to set aside those licences.

[327] I acknowledge that decision will have a significant impact on RX8, possibly other pharmacy-operating companies, and the Ministry of Health itself, in terms of its ongoing role in granting pharmacy licences under s 55D of the Act. Given that, it is appropriate that the date on which the quashing order comes into force be deferred, to enable RX8 to consider its position and confer with the Ministry,[115] and for the Ministry to consider the potential impact of this decision on any other licence holders under s 55D.

Conclusion

[328] In conclusion, I find that:

(a) The decisions by each of HVDHB and Hauora Tairāwhiti to enter into ICPSAs with RX8 were commercial, contracting decisions and amenable to judicial review only on narrow grounds. The applicant does not allege fraud, corruption, bad faith or analogous circumstances and therefore the first to third grounds of review must fail.

(b) In any event, I would dismiss those grounds of review on the merits.

(c) I dismiss the fourth ground of review in relation to te Tiriti/the Treaty.

(d) I dismiss the fifth ground of review, against Hauora Tairāwhiti, in relation to monitoring.

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115 See for example *Winther v Housing New Zealand* [2010] 3 NZLR 56 (HC) at [44]; and *Austin v Roche Products* [2021] NZSC 30, [2021] 1 NZLR 194 at [36]–[37], as to deferred orders.

(e) I uphold the fifth ground of review, against the Ministry of Health, and direct that the Ministry of Health and RX8 confer and file further submissions, as to when the quashing order in relation to the RX8 licences under s 55D of the Medicines Act should take effect. Submissions should be filed by four weeks from the date of issue of this judgment. Counsel have leave to apply if further time is required.

Costs

[329] Counsel should endeavour to agree on costs. If they are unable to do so, memoranda not exceeding five pages per party should be filed and served by five weeks from date of issue of judgment.

Addendum

Declaratory Judgments Act 1908

[330] After release of my judgment on 15 June 2023 counsel for the first and second respondents drew my attention to the fact that the judgment does not explicitly address the applicant's applications for declarations under the Declaratory Judgments Act 1908. While it is implicit in the judgment that no such declarations will issue, for clarity and completeness I have recalled the judgment and reissued it with this addendum.[116]

[331] In addition to relief under the Judicial Review Procedure Act 2016, the applicant separately sought relief under the Declaratory Judgments Act 1908. The declaratory relief sought related to the construction of the NZPHDA and the Pae Ora Act, as those Acts related, or relate, to DHBs and Te Whatu Ora entering into arrangements for the delivery of community pharmacy services.

[332] My reading of the applicant's amended statement of claim[117] is that the declarations sought were premised on the Court finding errors of law in the process

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[116] See High Court Rules 2016, r 11.9; and Jessica Gorman and others *McGechan on Procedure* (looseleaf ed, Thomson Reuters) at [HR11.9.01(5)(a) and (b)].

[117] Amended Statement of Claim dated 11 July 2022 at [165]–[167] and [169].

followed by HVDHB and Hauora Tairāwhiti in commissioning pharmacy services, and in monitoring the provision of those services, under the NZPHDA.

[333] I have made no findings of error by HVDHB and Hauora Tairāwhiti in entering into or monitoring performance of the ICPSAs. It is therefore implicit that no declaratory relief as to how those bodies ought to have exercised their powers is required. In addition, the NZPHDA has been repealed and the DHBs have ceased to exist. In those circumstances, there is no basis on which it would be appropriate to issue declaratory orders, which might be characterised as “abstract” or “academic”.[118]

[334] The declarations sought regarding Te Whatu Ora’s application of the relevant provisions of the Pae Ora Act[119] are different, in that the Pae Ora Act is current legislation and Te Whatu Ora a subsisting entity. But those declarations too appear to be premised on a finding by the Court of errors of law: the amended statement of claim states that it is in the public interest to grant a declaration as to how Te Whatu Ora should perform its function of commissioning pharmacy services under the Pae Ora Act to ensure that errors of law are not continued under the new legal framework.[120] There were no such findings of error of law.

[335] In any event, what is sought is essentially an advisory opinion about how Te Whatu Ora should exercise the very broadly framed statutory functions that would apply to contracting for community pharmacy services, divorced from specific facts and any current challenge. In my view it is not appropriate for the Court to entertain that possibility.

Gwyn J

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118 *Earthquake Commission v Insurance Council of New Zealand Inc* [2014] NZHC 3138, [2015] 2 NZLR 381 at [133].
119 Pae Ora Act, s 14(1)(b) and (c).
120 Amended Statement of Claim, above n 117, at [169].