BEFORE THE INDEPENDENT HEARING COMMISSIONERS

IN THE MATTER	**of the Resource Management Act 1991**
AND	
IN THE MATTER	**of the hearing of submissions on the Proposed Far North District Plan**
HEARING STREAM	**Hearing 11: Energy, Infrastructure and Transport**
HEARING TOPIC	**Transport**

STATEMENT OF PRIMARY EVIDENCE OF MONIQUE DELPHIA FOUWLER ON BEHALF OF HEALTH NEW ZEALAND – TE WHATU ORA

(CORPORATE)

14 April 2025

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1. EXECUTIVE SUMMARY

1.1 My name is Monique Delphia Fouwler. I hold the position of Head of Land and Property within the Infrastructure and Investment Group at Health New Zealand | Te Whatu Ora (**Health NZ**) and am presenting this corporate evidence on behalf of Health NZ.

1.2 When appearing before Hearing Panel (**Panel**) in relation to my evidence, I intend to be accompanied by a senior clinical colleague who will be available to answer potential questions about the existing public health facilities and community needs in the Far North. At the time of writing my evidence I have not yet confirmed which colleague is available in the scheduled hearing dates. However, I can confirm that any colleague attending with me will be familiar with my statement of evidence and the relevant matters before the Panel.

1.3 My evidence should be read in conjunction with the Statement of Planning evidence for Health NZ by Helen Hamilton. Namely, Ms Hamilton's evidence deals with the matters of detail regarding Health NZ submission points and relief sought.

1.4 The key points addressed in my evidence relate to statutory purpose of Health NZ and the strategic and operational context that inform the relief sought on Transport matters. To summarise:

(a) Health NZ is a Crown Agent established by the Pae Ora (Healthy Futures) Act 2022 (**Pae Ora Act**) with functions that include owning / operating / providing for health services at a national, regional and local level and obligations to collaborate with other agencies, organisations and individuals to improve health and wellbeing outcomes and to address the wider determinants of health outcomes

(b) The purpose of the Pae Ora Act includes the provision of services to protect, promote and improve the health of all New Zealanders and achieve equity in health outcomes…striving to eliminate health disparities, in particular for Māori.

(c) Government strategy for the health sector is expressed in the Government Policy Statement (**GPS**) and in the Government Health Sector targets. Health NZ has a statutory obligation to give effect to the GPS.

(d) The GPS 2024 – 2027 sets out 5 priority areas for the health system – related to access, timeliness, quality, workforce and infrastructure. The commitment and focus are reinforced with Government health targets including shorter emergency department stays; shorter wait times; improved immunisation and faster access to various clinical services. Collectively these drive operational prioritisation and investment.

(e) Health infrastructure is a highly regulated (quality, safety, technical compliance etc) and networked national system made up of specialised component parts located regionally and locally – including hospitals, primary care and community, social and support services (operated by varying delivery agencies and entities). Health NZ manages the health system around New Zealand to flexibly meet changing community needs, health sector targets and governance directives while managing the design life of assets, localised needs and budgetary constraints.

(f) The strategic drivers of investment and design are always focussed on needs, outcomes, quality, safety and technical performance first. Every choice about a site, a facility, the mix of services and their location / co-location and so on are fundamentally a product of these considerations. Every dollar and unit of time spent on having to be enable a site for health sector services (for example, resource consent application process that is required to be supported by an integrated traffic impact assessment) is a capex cost traded for an opex cost and outcome.

(g) What this means is that when, for example, we upgrade or extend a hospital facility this is about meeting the changing needs of New Zealanders. Often this may mean the gross floor area of a facility is larger – it can also mean new buildings for new clinical services that are an emerging need in the community. When Health NZ is proposing to deliver this, it is not about an *attracting new customers* like a commercial building increasing its retail footprint – rather it is about providing the *right mix* of clinical services to meet a community's needs.

(h) There are valid reasons why health infrastructure (and the associated health care services) should not be viewed through the traditional 'District Plan lens' of traffic generating activities with simplistic gross floor areas.

(i) Instead, my evidence is that health infrastructure requires a more nuanced level of understanding to appreciate that what – at first look – may appear like a 'typical' *expanded activity* is in fact:

a) a community service that responds and reacts to community health needs – the strategic drivers of which (e.g. deprivation, lifestyle choices etc) are not controlled by Health NZ (unlike a 'traditional' activity such as a commercial business that sells goods or services creates demand in of itself); and

b) health infrastructure investment is, at a fundamental level, about interventions and investments that are designed to lead to *avoidance* and/or *reduction* of acute emergency department visits and/or hospital treatments and admissions.

(j) The point I am making is counter-intuitive to the normative view of landuse activities and traffic generation. However, it holds true for health infrastructure that unlike 'bricks and mortar' commercial activities that may place commercial value in trip generation that is not the case for the provision of public health care services.

(k) For reasons elaborated on in my evidence it is unreasonable to impose district plan regulatory control of transport movements via the requirement for integrated traffic assessments when most, if not all, of the factors are not controlled by Health NZ. Instead, Health NZ intends to continue to manage its traffic and transport demands as best it can within existing design / site management processes and remains supportive of the Council managing other competing demands on the local roading network – on which patients rely to access their healthcare services.

2. INTRODUCTION

2.1 My full name is Monique Delphia Fouwler. I hold the position of Head of Land and Property within the Infrastructure and Investment Group at Health NZ and am presenting this corporate evidence on behalf of Health NZ.

2.2 I am a property professional with a Bachelor of Business Studies from Massey University. I have 30+ years' experience in the property sector including 10+ years working in the public sector infrastructure. I have been in the health sector for four years. During this time, I have been employed in various organisations involving:

2.2.1 infrastructure investment planning
2.2.2 Infrastructure development
2.2.3 portfolio management

2.2.4 strategic asset management

2.3 I confirm that I am authorised to give corporate evidence on behalf of Health NZ in respect of the Far North District Council Proposed District Plan (PDP).

3. PUBLIC HEALTH - STATUTORY AND STRATEGIC CONTEXT

3.1 Health NZ is a Crown Agent established by the Pae Ora (Healthy Futures) Act 2022 (**Pae Ora Act**) with functions that include owning / operating / providing for health services at a national, regional and local level and obligations to collaborate with other agencies, organisations and individuals to improve health and wellbeing outcomes and to work with other agencies to address the wider determinants of health outcomes.

3.2 The purpose of the Pae Ora Act includes the provision of services to:

i) Protect, promote and improve the health of all New Zealanders; and
ii) Achieve equity in health outcomes…striving to eliminate health disparities, in particular for Māori; and
iii) Build towards pae ora (healthy futures) for all New Zealanders.

3.3 Government strategy for the health sector are expressed in the Government Policy Statement (**GPS**) and in the Government Health Sector targets.

3.4 The GPS 2024 – 2027 sets out 5 priority areas for the health system:

1. Access – ensuring all New Zealanders have equitable access to the health care services they need, no matter where they live.
2. Timeliness – making sure all New Zealanders can access these services in a prompt and efficient way.
3. Quality – ensuring New Zealand's health care and services are safe, easy to navigate, understandable and welcoming to users, and are continuously improving.
4. Workforce – having a skilled and culturally capable workforce who are accessible, responsive, and supported to deliver safe and effective health care.
5. Infrastructure – ensuring that the health system is resilient and has the digital and physical infrastructure it needs to meet people's needs now and the future.

3.5 The commitments and focus on improving access and timeliness are also reinforced through the 5 health targets:

1. Faster cancer treatment.
2. Improved immunisation for children.
3. Shorter stays in emergency departments.
4. Shorter waits for first specialist appointments.
5. Shorter waits for treatment.

3.6 The mental health and addiction targets are:

1. Faster access to specialist mental health and addiction services.
2. Faster access to primary mental health and addiction services.
3. Shorter mental health and addiction-related stays in emergency departments.
4. Increased mental health and addiction workforce development.
5. Strengthened focus on prevention and early intervention.

3.7 Along with allied agencies, Health NZ **must give effect** to the GPS under the Pae Ora Act. In addition to our own reporting, the Ministry of Health reports on performance against the GPS annually.

3.8 This is the statutory, strategic and operational context that Health NZ operates and works with partner agencies and organisations to deliver the New Zealand Health system.

3.9 Health infrastructure is a highly regulated (quality, safety, technical compliance etc) and networked national system made up of specialised component parts located regionally and locally – including hospitals, primary care and community, social and support services (operated by varying delivery agencies and entities). Health NZ manages the health system across 4 regions– designing to flexibly meet changing community needs, health sector targets and governance directives while managing the design life of assets, localised needs and budgetary constraints.

3.10 The strategic drivers of investment and design are always focussed on needs, outcomes, quality, safety and technical performance first. Every choice about a site, a facility, the mix of services and their location / co-location and so on are fundamentally a product of these considerations. Every dollar and unit of time spent on having to be enable a site for health sector services (for example, resource consent application process that is required to be supported by an integrated traffic impact assessment) is a capex cost traded for an opex cost and outcome.

3.11 User experience, equity of access etc are design considerations that are important to Health NZ however they are matters that Health NZ is best placed to determine in the context of delivering a health system that, amongst other things, protects, promotes and improves the health of all New Zealanders while striving to eliminate health disparities. What this means is that when we upgrade or extend a hospital facility this is about meeting the changing needs of New Zealanders. Often this may mean the gross floor area of a facility is larger – it can also mean new buildings for new clinical services that are an emerging need in the community. When Health NZ is proposing to deliver this it is not about an *attracting new customers* like a commercial building increasing its retail footprint – rather it is about providing the *right mix* of clinical services to meet a community's needs.

4. WHY PUBLIC HEALTH INFRASTRUCTURE DIFFERS FROM OTHER LAND USES IN RELATION TO TRANSPORT MATTERS

4.1 In conjunction with the Health NZ Planning Evidence of Ms Hamilton, my evidence is to demonstrate the valid reasons why health infrastructure (and the associated health care services) should not be viewed through the traditional 'District Plan lens' of traffic generating activities with simplistic gross floor areas.

4.2 Instead my evidence is that health infrastructure requires a more nuanced level of understanding to appreciate that what – at first look – may appear like a 'typical' *expanded activity* is in fact:

a) a community service that responds and reacts to community health needs – the strategic drivers of which (e.g. deprivation, lifestyle choices etc) are not controlled by Health NZ (unlike a 'traditional' activity such as a commercial business that sells goods or services creates demand in of itself); and

b) health infrastructure investment is, at a fundamental level, about interventions and investments that are designed to lead to *avoidance* and/or *reduction* of acute emergency department visits and/or hospital treatments and admissions.

4.3 I acknowledge that the point I am making is counter-intuitive to the normative view of activities and traffic generation. However, it holds true for health infrastructure that unlike 'bricks and mortar' commercial activities that may place commercial value in trip generation that is not the case for the provision of health care services.

4.4 More broadly, staff and patients visit our facilities by a variety of means – including private motor vehicles and emergency medical transport. While they are real, measurable traffic movements if someone were to count them – the fundamental points I am seeking to make in my evidence are that:

a) the health infrastructure and associated health care services are by their nature reactive and responsive community services (not demand generating activities per se) e.g. no one goes to the hospital unless they must

b) the drivers that lead to the need for people to seek / participate in health care services are not controlled by Health NZ. Rather they are caused by the social, economic and physical determinants of health such as:

i) aging population,
ii) equity of access,
iii) poverty,
iv) employment status,
v) education,
vi) inadequate housing,
vii) food insecurity,
viii) lifestyle choices,
ix) access to healthcare.

c) additionally, hospitals are there when one has an accident that requires an immediate health response. Again, Health NZ does not control the number of folk that require an emergency health response due to an accident but rather is required to be available when it is needed.

d) ultimately, I conclude that it is unreasonable to impose district plan regulatory control of transport movements via the requirement for integrated traffic assessments when all the factors that create the demand for health services are not controlled by Health NZ. Instead, Health NZ intends to continue to manage its traffic and transport demands as best it can within existing design / site management processes and is supportive of the Council managing other competing demands on the local roading network – on which patients rely to be able to access their healthcare services.

4.5 And finally I pose fundamental questions – first to this Panel hearing this matter (making considered decisions on behalf of Council) and, ultimately, to the Council (as one of the agencies Health NZ works with and alongside in serving the Far North community). Can we agree that hospitals and public health care services are a critical community service that responds and reacts to community health needs – the strategic drivers of which are not controlled by Health NZ? If Health NZ did spend its precious time and resources, that could otherwise have been used to provide health care, on an integrated traffic assessment (that applies the normative approach to traffic generation and land use activities), and it was found that there was an impact on the local roading network, would the Council require Health NZ reduce health service design capacity (to not exceed modelled local road network capacity) or to upgrade the local roading network or not provide a Resource Consent? These potential responses would be antithetical to providing a public health facility. It would either require less health services to be provided because funds would be redirected to roading, which is a Council responsibility, or no change in health services would be provided because the Council deemed the impact on the traffic network less desirable than providing enhanced health services to the community. I implore the Panel to adopt the nuanced view that I have set out in my evidence and make decisions that will not redirect health funding away from the provision of public health care services for the community of the Far North.

Monique Fouwler

Date: 14 April 2025