DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of Hon Andrew Little, Minister of Health:

Health and Disability Review Reform

The following documents have been included in this release:

Title of paper: Paper: Health and Disability System Reform: Implementation and Transitional Arrangements for release (SWC-21-SUB-0080)

Title of Minute: Health and Disability System Reform: Implementation and Transitional Arrangements for release (SWC-21-MIN-0080)

Title of Minute: Health and Disability System Reform: Implementation and Transitional Arrangements for release (CAB-21-MIN-0206)

Title of Paper: Health and Disability System Reform: Legislative Proposals for release (SWC-21-SUB-0107)

Title of Minute: Health and Disability System Reform: Legislative Proposals for release (SWC-21-MIN-0107)

Title of Minute: Health and Disability System Reform: Legislative Proposals for release (CAB-21-MIN-0274)

Title of Paper: Pae Ora (Healthy Futures) Bill: Approval for Introduction for release (CPC-21-SUB-0024)

Title of Minute: Pae Ora (Healthy Futures) Bill: Approval for Introduction for release (CPC-21-SUB-0024)

Title of Minute: Pae Ora (Healthy Futures) Bill: Approval for Introduction for release (CAB-21-MIN-0417)

Title of Minute: Pae Ora (Healthy Futures) Bill: Approval for Introduction for release (CAB-21-MIN-0427)

Title of Paper: Health and Disability System Review: Further Policy Decisions for the Health Reform Bill for release (CAB-21-SUB-0378)

Title of Minute: Health and Disability System Review: Further Policy Decisions for the Health Reform Bill for release (CAB-21-MIN-0378)

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Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant section of the Act that would apply has been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction codes:

- 9(2)(f)(iv) protect the confidentiality of advice tendered by Ministers of the Crown and officials; and
- 9(2)(h) protect legal privilege.

~~[In Confidence]~~

Office of the Minister of Health

Social Wellbeing Committee

Health and Disability System Reform - Implementation and Transitional Arrangements

Proposal

1 This paper sets out the implementation approach for the health and disability system reforms and the strategy for managing risk during the transition to the new system operating model.

Relation to Government priorities

2 The Government's manifesto and the Speech from the Throne committed to undertaking a long-term programme of reform to build a stronger health and disability system that delivers for all, drawing on the recommendations of the independent Health and Disability System Review.

Executive summary

3 Cabinet has agreed to a bold and ambitious reform programme for our health system to improve the quality, consistency and equity of care for New Zealanders. It will take time for these reforms to have their full impact; but I intend to move quickly to get enabling settings in place – both to minimise disruption, and to ensure our system can get underway realising the benefits of reform. While it is ambitious, I expect that by 1 July 2022, subject to legislation, the core structures and functions of our future health system will be in place.

4 Implementation of these reforms will be grounded in the interests of those cared for by our health system, and those who work within it. We will focus on ensuring consistency of care and service; encouraging strong leadership which can shift entrenched cultures; and designing our future health system with New Zealanders wherever possible.

5 Over the coming year, our system will continue to perform much as it does today. The Ministry of Health and District Health Boards (DHBs) are rapidly standing up measures to sustain access to care and, importantly, the health response to COVID-19, while an interim Health NZ and interim Māori Health Authority come into being as departmental agencies to build the final forms of both entities and prepare for a new approach to system leadership. This preparation will facilitate a clean transition to our future way of working from 1 July 2022, while ensuring we do not just replicate our current health system under new banners.

6 Detailed planning is now underway to support the transition to the future health system. I envisage that initial implementation will take place in four broad phases:

6.1 Phase 1: Establishment (Now – September 2021). This will focus on finalising detailed design of the key aspects of our future health system and establishing interim agencies and Section 11 committees, and will culminate with the anticipated introduction of legislation to give effect to the reforms.

6.2 Phase 2: Preparation (September 2021 – March 2022). This will focus on readying entities – existing and new – for transition and preparing the operational settings to make sure the transition is seamless. This will coincide with Select Committee consideration of the reform Bill.

6.3 Phase 3: Transition (March 2022 – July 2022). This will focus on final preparations for transition, to ensure that our health system continues to perform from day 1.

6.4 Phase 4: Consolidation (July 2022 – Onwards). This will wind down the initial transition to new agencies, and focus on supporting those agencies to shape our health system towards the goals of reform.

7 Delivering a programme of this scale will naturally create a number of risks that will need to be monitored and managed. This includes risks to system stability and performance as a result of the implementation of the reforms, exacerbated by current pressures on the health system including clinical and financial variation, gaps in workforce supply and the delivery of the COVID-19 response and vaccination programme. It will be critical to plan to mitigate system risks and avoid disruption to core business and to the COVID-19 response through the way in which the implementation is designed, delivered and governed.

8 There will also be programme risks relating to the pace of implementation, in particular to the timetable for legislation to establish new entities by July 2022. Mitigations to this risk, including alternate approaches to legislation, are being considered to ensure that the reforms remain on track.

9 These reforms, delivered well, will improve our system's performance. But they will need to be followed by consequent improvements to access, models of care, ways of working, cultures, and system enablers (like workforce and digital infrastructure) to fully realise their potential. I anticipate that these wider benefits will take between three and five years to realise as new health agencies find their feet and gradually strengthen the services we have today.

10 I expect to come back to Cabinet for a range of further decisions over the coming months, including on policy and funding settings for our future health system, the design and form of the Māori Health Authority (subject to the progress of engagement with Māori), and to commence a legislative programme to allow reforms to proceed. s9(2)(f)(iv) [redacted]

Background

11 On 29 March 2021, Cabinet agreed to reform the health system to achieve a vision of pae ora/healthy futures for all New Zealanders. The first set of decisions made by Cabinet included significant reforms to the system's structures and operating model: establishing Health New Zealand to replace the 20 current DHBs, creating a new Māori Health Authority, and refocusing the role of the Ministry of Health [CAB-21-MIN-0092 refers].

12 Cabinet also noted initial thinking on the strategy for implementation of the reforms, and agreed to establish interim departmental agencies to take forward detailed design work and preparation for the new entities. Cabinet invited the Minister of Health to bring further advice in May 2021 on the approach to managing change during the implementation phase, including the transition for DHBs. This paper responds to that invitation.

Agreed priority outcomes for reform

13 Cabinet agreed that the vision for the reformed health system will be based on pae ora/healthy futures for all people: where people live longer in good health, have improved quality of life, and there is equity between all groups. To meet this overall objective, Cabinet further agreed that the priority outcomes for the reformed health system will be:

13.1 partnership: ensuring partnership with Māori in decisions at all levels of the system, and empowering consumers of care to design services that work for them

13.2 equity: tackling the gap in access and health outcomes between different populations and areas of New Zealand

13.3 sustainability: embedding population health as the driver of preventing and reducing health need, and promoting efficient and effective care

13.4 person and whānau-centred care: empowering all people to manage their own health and wellbeing, have meaningful control over the services they receive, and treating people, their carers and whānau as experts in care

13.5 excellence: ensuring consistent, high-quality care in all areas, and harnessing innovation, digital and new technologies to continuously improve services.

Health and disability system operating model

14 The design of the reformed system is centred on creating the right settings, incentives and cultures to achieve the priority outcomes above. The current structural design of the health system, as demonstrated by the Health and Disability System Review, has become overly complex and fragmented leading to variation, inconsistency, and inequity. The reforms agreed by Cabinet are intended to address these longstanding issues and create a

system that is more cohesive and collaborative and which is focused on the health needs of the whole population.

15 To achieve the Government's ambitions, Cabinet agreed to:

15.1 confirm the Ministry of Health's role as the chief steward of the health system and principal advisor to the Minister of Health

15.2 establish a new statutory entity, provisionally called the Māori Health Authority, to lead hauora Māori in the health system, to work with the Ministry of Health on strategy and policy relating to hauora Māori, and to work with Health New Zealand on operational matters

15.3 take forward a process with iwi and the Māori health sector to design proposals for the constitution of the Māori Health Authority as a new entity, to be presented to Cabinet for agreement

15.4 establish a new Crown agent, provisionally called Health New Zealand, that will be the lead operational organisation for the public health system, within the parameters set by the Minister in national strategies and policies

15.5 disestablish all DHBs and vest their assets and liabilities in Health New Zealand

15.6 note the Minister of Health's intention that the internal organisation of Health New Zealand will include four regional divisions with regional commissioning boards within Health New Zealand to commission primary and community health services, in collaboration with the Māori Health Authority; and hospital and specialist services consolidated into four regional networks, planned nationally by Health New Zealand and delivered through regional divisions to align with primary and community services

15.7 establish the Public Health Agency as a distinct, branded unit within the Ministry of Health, to lead on all public health and population health policy, strategy, regulatory, intelligence, surveillance and monitoring functions

15.8 establish a national public health service within Health New Zealand, which encompasses the 12 public health units and builds on the work led by Ministry of Health to provide more central coordination across public health units

15.9 disestablish Te Hiringa Hauora / Health Promotion Agency as a separate Crown entity and to transfer its relevant functions to the Public Health Agency of the Ministry of Health and Health New Zealand.

16 Cabinet also noted the intention to proceed at pace to implement the reforms, starting with a transitional phase of preparation, detailed functional design and wider stakeholder engagement over the period to late 2022. This phase would

also include development of necessary legislation to implement the changes. To support transition, Cabinet agreed to establish interim organisations to undertake detailed planning, functional design and consultation for both of Health New Zealand and the Māori Health Authority. Interim organisations are to be established as departmental agencies hosted by the Ministry of Health, and supported by Section 11 advisory committees under the New Zealand Public Health and Disability Act 2000.

17 In relation to disability support services, Cabinet noted that it will receive separate advice on reform proposals, including the future model and governance of these services, in September 2021. At that time, Cabinet will take decisions on the transformation of the disability support system, the machinery of government to support a transformed system and the scope of future work on the broader cross-government disability system. The transformed disability support system, wherever it is located, is expected to give effect to the principles that underpin the Enabling Good Lives approach.

Structure of this paper

18 This paper:

18.1 summarises the overall approach to implementation, including principles to guide decisions and the anticipated roles of key agencies to support delivery

18.2 outlines the timeline and key milestones, activities and priorities over the coming period, and identifies four phases that define the implementation programme; and

18.3 highlights the core system and programme risks facing the implementation programme, and how these will be monitored and mitigated.

Approach to implementation

19 These reforms are large and complex, both in the scale of organisations and workforce affected, and in the complexity of transformation. Around 80,000 people employed across the 20 District Health Boards, the Ministry of Health, shared services agencies and Te Hiringa Hauora / Health Promotion Agency will move to a new employer, and a further 145,000 people in the sector will be indirectly affected by new commissioning arrangements.

20 Some of the functions and features of the new system represent a significant departure from how functions are carried out today, and will require dedicated capability building, investment and transformation to achieve. As such, it will take several years to fully realise the expected benefits of reform.

21 The vision for our future health system has been generally well received, and there is momentum and enthusiasm for these reforms. At the same time, health sector leaders and our workforce have told me they want to move quickly with the change. Since the Review was announced in 2018, the sector

has been operating in a state of uncertainty; and both the sector and I want to bring an end to that uncertainty as quickly as possible.

22 I intend to move as swiftly as is safe and practical to deliver the structural changes that will enable our future health system – particularly establishing new entities, building national and regional layers of operational leadership, putting in place the machinery needed to support organisations, and developing key components of the future system such as localities, the New Zealand Health Charter and the New Zealand Health Plan. This will provide clarity and certainty to the sector, and will equip agencies to get on with improving system performance, equity, and care quality.

23 Once those changes are in place, new agencies and structures will be responsible for shaping what they inherit from our current system – services, contracts, workforce and ways of working – into the better performing health system which we are aiming for. This will be supported by new leadership arrangements which break down arbitrary district barriers, and which are focused on the changes which will make the biggest difference.

24 During initial phases of the implementation there will be dedicated effort and planning focused on realising early wins for the system. These early wins will be achieved by prioritising investment into areas where there will be demonstrable changes in improving access to health services and outcomes for underserved populations, including Māori, Pacific, disabled people, rural and socio-economically deprived communities, and demonstrable efficiency gains. Early benefits realisation will be critical to maintaining the enthusiasm and momentum through the sector and keep the vision of the reforms at the centre of the change.

Principles underpinning implementation

25 How we implement these reforms will have a huge impact on New Zealanders – both those working in the health system, and those who rely on the care it provides. In order to plan, prepare and deliver changes of this scale, we will need to harness the lessons from recent and current transformation programmes, including those relating to Oranga Tamariki and vocational education. These reforms have demonstrated the need to prioritise actions to change ways of working and invest in areas that will quickly result in tangible benefits for New Zealanders. They have also indicated the scale of the task of achieving and sustaining structural change.

26 Throughout the period of implementation and transition, I see three main objectives that will contribute to maintaining system performance:

26.1 Stakeholders have clarity on the transition pathway and expectations: what the changes mean for them, a shared understanding of what is possible in improving or maintaining financial performance and preventing deterioration without compromising clinical safety, and clarity on how we will get to the new operating model, including interim steps and ways of working.

26.2 Stabilise the sector through the change – minimising disruption, aligning current system levers, retaining a focus on performance and supporting organisations and people through change.

26.3 Shared ownership of reform and success is fostered across the system – stakeholders feel connected and responsible for the success of reforms and the smooth transition through change, and the opportunity of transition is used for the reorientation of the sector to a system-wide view of performance.

27 In order to achieve the above objectives, I expect that the following principles will underpin how agencies deliver reforms:

27.1 The principles of Te Tiriti o Waitangi govern how we design, communicate and implement reforms, particularly as regards changes that significantly affect Māori.

27.2 We communicate openly and honestly with New Zealanders about when change is happening, and how they will be affected.

27.3 We minimise the impact on our hard-working workforce, with as few moves, structural changes and pressures as possible – while acknowledging that some of these changes are needed to achieve the goals of reform.

27.4 We move quickly, where it is safe and practical to do so.

27.5 While recognising that meaningful change takes time, we retain momentum, seek early opportunities and avoid stagnation in existing structures and problems.

27.6 We harness what is best in the current system as functions shift to new organisations and we begin to align current entities towards the new operating model.

27.7 We involve New Zealanders in design where possible, and recognise their expertise in their own experiences of the health system.

27.8 We magnify the voices of communities which have been traditionally unheard or underserved by social services.

27.9 We seek to ensure minimal disruption or impact to the core business of the health system, including the COVID-19 response.

Roles and oversight during the transition

28 During the transition period, the Ministry of Health and DHBs will retain their statutory obligations under current legislation, unless explicitly delegated to a new entity using existing powers. This will create time and space for the interim Health NZ and the interim Māori Health Authority to prepare for 1 July 2022, without being immediately burdened with the pressures of sustaining

our health system; a key lesson learned from recent implementations, such as the Reform of Vocational Education.

29 I expect that some functions will be transferred from the Ministry of Health to interim agencies over the coming year. This will allow for interim agencies to incrementally expand their remit and build towards the full set of responsibilities which they will hold in future. The precise timetable for such transfers will be agreed with the Director-General of Health and the incoming Chief Executives of the interim agencies. I will emphasise to agencies that it must always be clear which agency is responsible for each part of our system.

30 In parallel, I also expect the interim agencies to take steps with DHBs to begin to mirror the future arrangements for common oversight and leadership. s9(2)(f)(iv) Although DHBs will retain their legal status and obligations until the new legislation is passed, this should allow for early progress with setting new norms for the system and smooth the transition to Health New Zealand.

31 Collaborative working between key agencies will be crucial to delivering the reform programme, and I note the commitment of the Ministry of Health, the Treasury and the Public Service Commission to work in an integrated way with the Transition Unit to support policy and operational design for the future system settings.

32 During this period, the Transition Unit will continue to lead the design of the future health system, will coordinate implementation activity, and will maintain a programme office that tracks reform progress against agreed planning. The Ministry of Health will remain my chief advisor on health system strategy and policy, system performance and settings, and will continue to lead existing priority programmes. The Ministry will also lead work to develop the future model for system stewardship and its strengthened role as agreed by Cabinet, and will support on wider implementation issues such as standing up the Public Health Agency and hosting the interim entities as departmental agencies. Over and above these roles, however, I expect all key agencies to work in partnership to design and deliver the Government's reforms within a compressed and challenging timetable.

33 While the Transition Unit will lead overall governance arrangements for the reform programme, I anticipate a shared work programme with key agencies that takes advantage of their knowledge and expertise. Arrangements are already in place to establish the Director of the Transition Unit and the Director-General of Health as joint sponsors for a combined work programme which will include in particular the substantial policy and legislative design which is required to confirm system settings. These arrangements will also include the Treasury, Public Service Commission and other agencies where appropriate to reinforce partnership.

34 Beyond this core oversight and governance for delivery of the reform programme, the Transition Unit will also establish a separate transition assurance group. This group will include wider representation from the health sector and workforce, with the purpose of providing independent assessment

of delivery plans and ongoing feedback on the practical and cultural challenges faced by health entities in preparing for and implementing change. Its input will support the Transition Unit to refine actions and mitigate risk during the transition, and inform advice and reports to Ministers and Cabinet.

How we will transition to a new system

35 Building on the Government's announcements to date, there are several key activities which need to occur for the reforms to succeed:

35.1 further strategy, policy and detailed design of the system operating model – such as governance arrangements, accountability structures, Ministerial powers, funding systems, enablers, and the form of the Māori Health Authority

35.2 new legislation to reflect new structures and accountabilities

35.3 establishment of new interim entities and development of necessary capacity and capability in those entities to taken on functions from other organisations where determined

35.4 implementing changes to secure and strengthen the Ministry of Health's role as the chief steward of the system, whilst ensuring that core business and priority programmes are not disrupted

35.5 development of interim and initial plans, frameworks and accountability documents, including the first Government Policy Statement and NZ Health Plan; and

35.6 the roll out of locality prototypes, which will be the first localities and locality networks in the future system.

36 These activities will progress in four broad phases which will be carried out in partnership between the key agencies and new interim entities, when established:

36.1 Phase 1: Establishment (Now – September 2021). The Establishment phase will focus on finalising detailed design of the key aspects of our future health system, in partnership with New Zealanders where possible within the timescales. This will include establishment of interim agencies and Section 11 committees, and culminate with the anticipated introduction of legislation to give effect to the reforms.

36.2 Phase 2: Preparation (September 2021 – March 2022). The Preparation phase will focus on readying entities – existing and new – for a transition and preparing the operational settings to make sure the transition is seamless while driving towards the change we want to see. This will coincide with Select Committee consideration of the reform Bill.

36.3 Phase 3: Transition (March 2022 – July 2022). The Transition phase will focus on final preparations for transition, to ensure that our health system continues to perform from Day 1.

36.4 Phase 4: Consolidation (July 2022 – Onwards). The Consolidation phase will wind down the transition to new agencies, and focus on supporting those agencies to shape our health system towards the goals of reform.

37 **Annex A** attaches a timeline of key milestones across these four phases. Together these set out the intended critical path towards implementation of the major system reforms announced to date. A description of the components and objectives of each these phases follows below.

Ministerial committees during transition

38 In March Cabinet noted my intention to establish committees pursuant to section 11 of the New Zealand Public Health and Disability Act 2000 to advise Ministers on the establishment of the interim entities and their transition to the new system. I intend to establish two committees – one focused on the work of interim Health NZ and the other focused on the interim Māori Health Authority. Appointments to these committees will be effective from 1 September 2021.

39 Each committee will have eight members and will cover a range of the necessary skills to assist me with overseeing the establishment of these entities. The members of the committee for interim Health NZ will have commercial expertise, expertise in Māori health, expertise in Pacific health, expertise in the health of disabled communities, expertise in management of clinical services, clinical risk and service performance, experience in managing or governing large operational organisations or systems, and knowledge of the New Zealand health system. The members of the committee for the interim Māori Health Authority will have expertise in te ao Māori and hauora Māori, significant governance expertise, commercial expertise, expertise in commissioning, management of clinical services and service performance, and knowledge of the New Zealand health system. These committees will have the same skill-mix I intend for the permanent Boards of Health NZ and the Māori Health Authority once established.

40 To ensure that the interim Māori Health Authority committee embodies the intended purpose of the Authority, and is able to meaningfully advance the Authority's agendas of tino rangatiratanga and partnership between Māori and the Crown, I intend that Māori lead the process to shortlist interim committee members. Sir Mason Durie will lead a Steering Group within the Transition Unit, made up of experts in hauora Māori and Māori governance, to develop a shortlist of appointees for me to consider. The process for selecting members for each committee and timelines are outlined in **Annexes B and C**.

Phase One: Establishment (May – September 2021)

41 The focus of the Establishment phase will be:

41.1 confirming key policy and design choices for settings beyond the system structure, including on funding and investment, locality design, consumer voice, workforce, data, digital and capital management

41.2 starting to engage with people, including the health sector, in key areas for detailed design; including the design of the Māori Health Authority, the design of localities, the New Zealand Health Plan, the Health Charter, and how we give effect to consumer voice in our future health system

41.3 identifying key leaders for interim Health NZ and the Māori Health Authority – particularly members of advisory committees and Chief Executives – and establishing those interim entities with clear Ministerial requirements for their priorities; and

41.4 preparing enabling legislation for introduction in September 2021.

Confirming key policy settings and priorities

42 There is a series of further key decisions to make about various strategic, policy and design settings for our future health system. Some of these are significant – such as the function, role and organisational form of the Māori Health Authority and future funding models and settings. Further specification is set out from paragraph 94 onwards. I will bring significant decisions back to Cabinet for agreement, following further design work and engagement with stakeholders.

Engagement

43 Engagement will be a substantial feature of the Establishment phase. The approach to engagement will include both general communications and targeted activities, tailored in the early stages towards both supporting key policy decisions and encouraging involvement in system design. This will be supported and expanded in later phases, for instance as part of Select Committee consideration of the Bill.

44 One of the most effective strategies for monitoring and mitigating the risks outlined above will be to have sector leaders own and drive change. The Transition Unit is already working with the portfolio leads DHB chief executives, and existing sector forums (such as the Chief Information Officers, General Managers Funding and Planning, Chief Financial Officers, and Chief Medical Officers) to identify areas in the work programme where they can contribute. This will include a combination of:

44.1 providing some dedicated time from nominated senior staff to work with the Transition Unit on particular areas where we know technical expertise and experience will be required, such as consideration of merging information systems and financials across the DHBs, developing commissioning frameworks and operational design of hospital networks

44.2 supporting and in some cases driving the sector engagement on components of the interim NZ Health Plan and NZ Health Charter, and other go-early initiatives like locality prototypes

44.3 using their networks across the sector to disseminate communications and coordinate input (e.g. from clinical senates and leadership groups)

44.4 identifying areas which could serve as quick wins for efficiencies (e.g. alignment of procurement functions) and benefits realisation, and streamlining the move to regional leadership roles by working at a regional level in a more deliberate and formal way; and

44.5 acting as advocates for the change, particularly those who have regular contact with frontline staff, and with support from the Transition Unit and the Ministry, providing opportunities for staff to be involved in designing the future as a way to manage flight-risk of key personnel.

45 Initial engagement will also focus on working with Māori on the design of the Māori Health Authority, to ensure it both contributes to a single, joined-up health system, and has mandate from Māori to be a force for tino rangatiratanga. This detail is required to complete drafting of necessary legislation ahead of introducing a Bill.

46 This first phase will develop plans for early engagement on other key features of the future system, in anticipation of broader involvement of stakeholders and the public to follow, led from the Transition Unit, Ministry and other interim agencies as they are established. This will include work to design the approach to the New Zealand Health Plan, the New Zealand Health Charter, the design of locality networks, and mechanisms for embedding consumer voice in the system. All of these features need to be well underway at 1 July 2022 for the future system to succeed. Engagement on these areas offers a major opportunity for broad involvement of the health workforce, unions (in particular on the Health Charter), and consumers of services.

Redesign of the Ministry of Health

47 The refocused and strengthened role for the Ministry of Health that was agreed by Cabinet will require significant change to the structure and functions of the Ministry. Although the Ministry's future role as the chief system steward and lead advisor to Government builds from its current responsibilities, I expect the need for substantial capacity and capability-building to fulfil this role in the context of the future system, in particular given the need to monitor an organisation of the size and scale of Health New Zealand.

48 Planning is already underway within the Ministry for a redesign of its functions and a change programme to support staff in order to be prepared to assume a broader and more empowered role in overseeing system performance and outcomes from July 2022. This will include the development of a new approach to accountability and monitoring arrangements, subject to approval

by Minsters, and encompass the production of the first Government Policy Statement in early 2022 which will set initial priorities for the reformed system.

Preparing to establish interim agencies

49 Work is already underway to inform the process for appointing chief executives to the interim agencies. The appointments will be made by the Public Service Commissioner under the Public Service Act. Similarly, the interim agencies will be established under the Public Service Act by order-in-council.

50 Work is also underway on the Section 11 advisory committees agreed by Cabinet which are intended to support the development and governance of those agencies. Annexes B and C describe my intended approach to identifying and appointing individuals to the advisory committees. The approach in relation to the interim Māori Health Authority will be developed in partnership with Māori, including through a Steering Group led by Sir Mason Durie.

51 In parallel, a priority for the Establishment phase will be to determine the initial areas of focus for the interim agencies, in order to set Ministerial expectations. I anticipate developing initial requirements and draft work plans for the interim agencies that will clarify their obligations, note planning assumptions and provide proposals for immediate activities, to inform the agencies' own decision-making. Although it will be for the agencies' leadership to determine their precise priorities, this will be aimed to support rapid progress in organisational design and development over the months to follow.

Phase Two: Preparation (September 2021 – March 2022)

52 The focus of the Preparation phase will be:

52.1 progressing from detailed policy design into operational design of our future health system, so that we have an understanding of how new mechanisms – such as planning, commissioning and service delivery – are working to meet our goals for the health system (this will continue engagement with New Zealanders, and draw on the detailed work done during the Establishment phase). This will lead to the design of the detailed operating model for Health New Zealand and the Māori Health Authority

52.2 undertaking the redesign of the Ministry of Health's critical functions to fulfil the strengthened role of chief system steward agreed by Cabinet, and taking initial steps to build capacity and skills in key areas

52.3 transitioning key functions from existing health agencies, particularly the Ministry of Health, into interim Health NZ and the interim Māori Health Authority as appropriate, to support preparation for our future health system – and beginning to grow nascent functions within the interim agencies where required

52.4 developing the initial Government Policy Statement, to provide clear directions, requirements and priorities for the future system to coincide with the establishment of new entities

52.5 developing a unifying leadership layer for our current system, to support existing functions to work together better and start to get ready for the shift to new entities and ways of working (e.g. ensuring national and regional connections between similar functions in different DHBs)

52.6 supporting the Bill through the legislative process; and

52.7 delivering Budget 21 initiatives to prepare for reforms, including locality prototypes and capability-building initiatives.

Establishment of interim agencies

53 A reflection from the lessons of major public service reforms is that the need to ensure that new organisations have time to design and develop their model and are not too swiftly taken up with the pressures of undertaking their full functions. It is important that both Health NZ and the Māori Health Authority have time and bandwidth to prepare before they take responsibility for day-to-day running of the health system.

54 Between the planned establishment of interim entities in September 2021 and their assumption of full powers and responsibilities in July 2022, I expect that the two organisations will work with DHBs and others in the system to focus on:

54.1 establishing key leadership roles, including a national and regional leadership structure aligned to reform goals under which existing DHB frontline services can 'slot in'

54.2 considering the organisational design needed to sustain the reformed health system

54.3 preparing for transition, particularly ensuring seamless service delivery and mitigating risks

54.4 starting to build new functions, such as enabling functions for localities and national planning functions for hospital and specialist services

54.5 beginning to migrate functions, mainly out of the Ministry of Health, which are not closely linked to day-to-day system delivery and so can be tackled early

54.6 work to develop the critical operational documents of the future system, such as a national commissioning framework and performance management approach, within any expectations and parameters set by Ministers such as national outcomes; and

54.7 finalising internal budgets and plans to be operational from 1 July 2022.

55 As previously agreed, the interim Health NZ and Māori Health Authority entities will be established as departmental agencies hosted by the Ministry of Health. They will be supported by advisory committees established under section 11 of the New Zealand Public Health and Disability Act 2000. I anticipate appointing members to these committees in August 2021, and the Public Service Commissioner appointing chief executives in the same timeframe. The interim entities would be established from September 2021. For continuity, the advisory committees will be appointed with a view to them potentially becoming the boards of the final entities from July 2022.

56 The approach to transferring functions from the Ministry of Health is currently being co-developed by the Ministry and Transition Unit, to ensure a balance between reform and maintaining current system performance. This is accompanied by a Ministry-managed change programme, to support staff and ensure a safe and smooth transition.

57 As the interim entities are stood up, they may begin to take on some functions from the Ministry or DHBs to prepare for their future roles. Where there is a transfer of functions and staff, mechanisms such as a memorandum of understanding will be used to help clarify roles, accountabilities and points of contact. It will be essential that there is clear, single accountability for the practical discharge of those functions at all times. Where a formal transfer of functions is not possible or desirable prior to July 2022 (for example, where this may pose an unacceptable risk to business as usual), I expect that pragmatic joint working arrangements will be put in place.

58 Officials will provide the Ministerial Group with advice on how and when functions and staff transfer, appropriate sequencing and phasing, interdependencies and requirements to support transfers to ensure there is minimal disruption to critical business as usual functions and the COVID-19 response. The risks to DHB services, workforce and financial performance, including employment relations, will be a particular focus. Officials are regularly updating me on performance and emerging risks, and will report to the Ministerial Group and Cabinet on significant areas.

59 In addition to these transferred functions, there will be some areas where new functions will need to be built – for example, national and regional structures for hospital planning and networking. Similarly, early Health NZ and Māori Health Authority teams will be needed to deliver key sector-facing and prototyping activities, such as on locality networks, the New Zealand Health Plan, and the Health Charter.

60 A key component of enabling the interim entities to sufficiently plan and set budgets for the following financial year is early planning advice, performance expectations and an indicative funding signal. Commencing planning, including the interim NZ Health Plan, and setting of internal budgets during this phase will enable the initial plan to be agreed and performance expectations formally set ahead of 1 July 2022.

Budget 21 initiatives

61 Funding has been provided in Budget 21 to progress implementation in the key 'go early' areas, beginning with $485m across the forecast period until 2024/25:

61.1 $242m for establishment of an interim MHA, an initial commissioning budget for the MHA to grow the range and spread of kaupapa Māori services accessible to local Māori communities, and initial funding to empower Iwi-Māori Partnership Boards to have greater influence

61.2 $46m to commence prototypes across five to six localities covering in total around 5% of the New Zealand population. This first phase of localities will provide early insights into the critical success factors and central support required to establish locality networks, as well as developing information systems and clinical governance processes to support provider connectivity

61.3 $181m for one-off change costs to fund the functions and staffing in Health New Zealand and the Transition Unit needed to design and deliver a health system which is equitable, Treaty-honouring, sustainable, person and whānau-centred and provides consistently high-quality care. This includes significantly strengthening functions and capabilities in the areas which will have the most impact for New Zealanders, such as data, digital, planning, commissioning and cultural responsiveness; and

61.4 $14m for in-role training programmes to build capability of key commissioner and data and digital roles in new entities and the system.

62 s9(2)(f)(iv) [redacted]

Phase Three: Transition (March 2022 – July 2022)

63 The focus of the Transition phase will be:

63.1 finalising the operational details of how responsibilities, powers and services will shift to Health NZ and the Māori Health Authority from 1 July 2022, with a focus on ensuring continuity of service

63.2 finalising new arrangements, structures and relationships between agencies, including key priority and direction-setting institutions like the first Government Policy Statement and an interim New Zealand Health Plan

63.3 planning agencies' forward work programmes to achieve change objectives from 1 July 2022

63.4 passing the necessary legislation ready for commencement; and

63.5 setting Health NZ and the Māori Health Authority budgets.

64 During this period, I expect the Transition Unit and Ministry to support the interim Health NZ and interim Māori Health Authority, and DHBs, to prepare services to operate in new ways and to support staff for the change of employers. The emphasis of this phase will be on preparing for a seamless 'day 1', with no disruption to service provision or the lived experiences of our workforce. This will include vigilant risk-management protocols and processes, and troubleshooting systems to manage emergent issues immediately before and after 1 July 2022.

Day 1 of the new system operating model

65 A core component of the consolidation phase will be the new entities developing full capacity across their range of functions and standing up longer-term organisational structures and design. By 1 July 2022, I expect the interim Health NZ and the interim Māori Health Authority to have established organisational structures, defined regional boundaries and have made key appointments to put leadership in place at the national and regional levels. I also expect to see phased recruitment strategies and longer term transformation and change management plans.

66 Establishing the interim entities will provide some lead in time for the new leadership and governors to establish demonstration projects, identify and progress areas for early efficiencies and benefits, and set in motion longer term transformation plans. However, there will be little time to prepare early areas of change as well as getting across issues within the current system and immediate areas of risk, particularly for significant in-flight projects which will transfer to Health NZ. The Ministry of Health and Transition Unit will need to support these entities as they stand up their final forms, and to provide sufficient induction to the interim boards and chief executives as they are appointed.

67 Across the system, the 1 July 2022 milestone will need to be preceded by focused effort to set in place interim plans and core accountability documents, such as the first Government Policy Statement and Statement of Intent documents, and new Crown Funding Agreements. s9(2)(f)(iv) [redacted]

Phase Four: Consolidation (July 2022 onwards)

68 The focus of the Consolidation phase will be:

68.1 adapting existing system structures to work together more cohesively in pursuit of system goals – for example, bringing together DHB-by-DHB teams which share functions into coherent national teams; and

68.2 embedding new ways of working to deliver on our system outcomes, such as shifting primary care networks to operate as localities, and developing the first full New Zealand Health Plan.

Managing transition and implementation risks

69 As would be expected for a reform of this scale, there are material risks that we will need to monitor and manage as we move to strengthen our health system:

69.1 s9(2)(f)(iv) [redacted]

69.2 Service delivery and / or clinical performance could be affected by changes to structures, or by secondary impacts on quality of life for our workforce.

69.3 Other government health priorities, including reform to mental health services and the COVID-19 response, could be affected by structural change or crowded out by a focus on reform.

69.4 The process of shifting staff between organisations, and interim uncertainty about roles for senior leaders, may result in staff attrition and the loss of talent.

69.5 Confused accountabilities during the transition period could harm system performance or cause delays to in-flight projects or initiatives where we want to maintain momentum.

69.6 Agencies could struggle to give effect to the reforms, particularly once initial structural changes are made, given the size and risk of inertia of Health NZ in particular.

69.7 Providers may be disrupted by changes to funding and commissioning approaches, which could weaken markets or disrupt care provision.

70 While some risks are the direct result of change, others reflect longer-term and underlying instability in the health system. Reform may exacerbate known issues such as variable financial and clinical performance if it leads to a loss of focus over the transition period, or a loss of critical staff to new interim structures in an unmanaged way. Existing issues are likely to complicate the context for reform: including capacity and staffing issues, competing priorities in relation to COVID-19 and the vaccination programme, and perceptions regarding public sector pay settlements.

Core approach to managing system risks

71 Our approach to implementation is designed to mitigate system risks as far as possible. For example, the establishment of interim agencies is intended to

both undertake detailed organisational design for the future entities and incrementally put in place arrangements for oversight and coordination across DHBs that foreshadow the functions of the permanent entities. This should smooth the transition pathway by beginning the shift towards cohesive national and regional arrangements in advance of July 2022, reducing the risk of a cliff-edge when the legislation comes into effect.

72 I expect to continuously monitor these risks throughout the implementation period, and receive regular reporting from the Transition Unit and Ministry of Health to ensure they are adequately managed. I anticipate that a range of tools will keep these risks manageable:

72.1 A proactive approach to communications, which will ensure that the health sector and communities are well-informed about progress towards change, remain motivated by the opportunities of reform, and are not surprised by changes which will impact them directly. This will be supported wherever possible by partnering with unions and other professional bodies to ensure staff are kept abreast of potential impacts on their employment.

72.2 A clear, simple approach to maintaining accountabilities and responsibilities during the transition period – with the Ministry of Health and DHBs retaining existing responsibilities until 1 July 2022, unless otherwise explicitly delegated under direction from the Minister of Health.

72.3 Clear expectations on DHB chairs and chief executives to sustain system performance, including financial performance, with ongoing, enhanced monitoring by the Ministry of Health throughout implementation. This includes regular guidance to chairs and chief executives on expectations for operational decision-making and planning during the transition period (including adjusted delegations to reflect these expectations).

72.4 Building new system functions, including national and regional leadership layers, within interim entities (particularly interim Health NZ) prior to 1 July 2022 to ensure that the future system can sustain service from 1 July, while being rapidly reconfigured to work in a more cohesive, effective way. This should be cognisant of the risk to current system performance from moving critical leadership and staff into new organisations; for instance, it may entail joint appointments so as to ensure an aligned focus on both business as usual and reform.

72.5 Making dedicated change support available to enable DHBs to prioritise the necessary skills and capacity to deliver transition plans for the transfer of functions to Health New Zealand.

72.6 Using existing legislation – such as the Health Sector (Transfers) Act – to simplify legal dimensions of moving assets and staff to new entities.

73 The preparatory and transitional phase of implementation inherently has the most risk to continuity of service provision and deterioration of financial and non-financial performance. I have defined the transitional phase as the first 18 months of implementation, or until approximately September 2022, when legislation would have been effective for approximately one quarter of the new financial year. It is during this phase that there will be significant transfer of functions and accountabilities across entities, and new leadership will need to rapidly get across the risks and issues of today while leading transformation.

74 For the majority of the transitional phase, the existing roles and accountability settings under the New Zealand Public Health and Disability Act 2000 will remain in effect until new legislation comes into effect, currently scheduled for 1 July 2022, unless functions or accountabilities are explicitly delegated to other entities under my direction. This means DHB Boards retain their existing leadership role and accountabilities under the existing Act, and will operate under the Ministry of Health's framework for managing and supporting DHBs until the new legislation comes into effect. In order to keep momentum in the system, DHB Boards and the Ministry of Health will be expected to take decisions to maintain business as usual activity and to protect the provision of health services. My expectations have been communicated to DHB Board Chairs and the Director-General of Health through Letters of Expectations administered on announcement of the new system operating model.

75 While the implementation plan sets out an approach and a timeline of activity during the transitional phase, there will inevitably be unforeseen risks or operational matters that will arise and need to be dealt with quickly, and in a way that supports the overall implementation plan. Therefore a set of principles have been developed to specifically guide the transitional phase:

75.1 s9(2)(f)(iv) [redacted]

75.3 There will be clear system accountabilities during the transition which will be transparent to the sector and Ministers.

75.4 Shifts of functions and staff will be streamlined and minimised where possible.

75.5 Communications will be consistent for and across sector actors.

75.6 Employers will be responsible for the change management of their employees, with support provided from the centre.

76 During the transitional phase a significant number of major collective agreements are due for renegotiation, some of which some are already underway. These include collective agreements for nurses, senior medical specialists, and allied health professionals. The terms on which these

collective agreements are negotiated will be inherited by Health NZ, and will affect the operations and costs of our future health system. Therefore, the risk profile of these negotiations and the enduring implications they will have on the future system is high.

77 As the current employers, DHBs will be required to manage these negotiations (through Technical Advisory Services (TAS)) and to take responsibility for ensuring that the approaches taken to bargaining reflect the Government's strategic priorities for employment relations. In order to minimise the implications for the future system, I have instructed DHBs to consult with the Director-General of Health early in each bargaining cycle to receive the Ministry's feedback on the key bargaining approaches and strategies. I have also instructed DHBs to seek approval for bargaining strategies, cost modelling and settlement proposals from the Health Employment Relations Governance Group, chaired by the Director-General of Health, before they are provided to unions.

Additional and reserve powers to mitigate system risks

78 My preference is that delivery of the reforms proceed on a collaborative basis and with mutual effort and consensus, aiming to foster the "one system" ethos that is at the heart of our proposals. This approach would rely on those actions above, together with the input and skills of those working in the health system, to plan, prepare and deliver change within entities' usual powers and prerogatives.

79 However, recognising the instability in the health system, I am prepared to take additional steps if required to ensure system continuity and performance, or mitigate risks, including:

79.1 issuing revised letters of expectations to ensure boards and chief executives are working to reform goals

79.2 s9(2)(f)(iv) [redacted]

79.3 shifting functions, responsibilities and/or delegations from DHBs to other agencies, including the Ministry of Health or interim entities (once established), subject to consideration of the practical and legal issues of such changes and a commitment to support our workforce through change.

80 These steps should prove useful in responding to transitional risks and clarifying directions and expectations. However, they would not in themselves change underlying split accountabilities of DHBs, which are subject to Ministerial directions but also responsible to their Board members, including a majority of elected members. As a result, nascent relationships between DHBs and interim agencies would rely on a more informal basis and may be hindered by multiple reporting lines. s9(2)(f)(iv) [redacted]

s9(2)(f)(iv)

s9(2)(f)(iv) [redacted]

87 I will keep the Ministerial Group updated regularly on the risks associated with reforms, including on whether any additional steps are necessary to mitigate such risks.

Implications for the COVID-19 response and vaccine programme

88 The roll out of the COVID-19 vaccine and ongoing COVID-19 response is one of Government's top priorities. Careful planning and consideration has been taken in the development of this implementation and transition plan to ensure the vaccine programme and response to COVID-19 is not at undue risk.

89 For front line staff, including those who are administering the vaccines, the transition to the new system operating model will not result in significant disruption to their day to day working environment or operations. Reporting lines for most front line staff will be consistent through the transition, and a key principle of the change is that most staff who move from DHBs to Health NZ will do so on their existing terms and conditions in an effort to minimise disruption. Similarly, most contracts with providers of primary and community services will be rolled over to cover at least the transition to the new structures.

90 At the point of new legislation coming into effect and DHBs being disestablished (expected to be 1 July 2022), it is my expectation that the majority of the general population would be vaccinated against COVID-19. Therefore it is my expectation that there will be a handover of the operation of the vaccination programme when it is at a less critical point, and there is more clarity about what the future business as usual regimes for COVID-19 vaccinations look like. The ongoing COVID-19 response and vaccination programme will remain in the Ministry of Health until Ministers have confidence that it is an appropriate time to transition any of these functions to other entities.

91 I have also considered how stability of the key leadership roles and necessary settings to maintain the elimination strategy and vaccine programme can be kept intact during the transition period. There are three core elements to this:

91.1 The scope of the Bill described in this paper will focus on establishing new entities, describing accountability settings, and Ministerial powers. Subsequent policy work, and any required legislation, will look at the extent of the Director-General's and Director of Public Health's powers and whether any amendments need to be made. Maintaining existing statutory provisions with respect to public health during the transition period will ensure there is clarity of health security response authority while there continues to be threat of further COVID-19 outbreaks and the vaccine roll out is underway.

91.2 The sequencing and timing of when functions will transfer between entities will be subject to health security assessment, in addition to the legislation agenda. That is, if it is unsafe to transfer functions due to critical issues or risks in the health sector (e.g. if there is an outbreak of COVID 19) the timing to move particular functions would be revisited.

91.3 Whilst we need to ensure the best expertise is used in the detailed design of the future system operating model and the transition to it, there will be careful consideration and steps taken to ensure capability and leadership in the system is maintained in core priority areas, such as the COVID-19 vaccination programme.

Programme risks

92 In addition to system risks, there are also risks associated with the timetable for the delivery of the necessary policy decisions, operational design and legislation. Implementing the reforms at pace will provide no room for slippage in key decisions, which will need to be mitigated through dedicated processes for inter-agency working and a robust programme management.

93 There are a number of policy decisions and choices which will develop the detail of the system model and determine what people receive and how they experience health services. I expect to bring further advice to Cabinet in the coming months on these topics, prioritising those which may impact on the legislation. An overview of these decisions is set out from paragraph 99.

94 The timetable for legislation is particularly challenging. In order to bring legislation into effect from July 2022 to formally establish the new entities, it will be necessary to introduce a Bill in September 2021 and therefore to have completed policy design in advance to inform instructions. I intend to bring further substantive policy matters requiring legislation to Cabinet by early July in order to meet this timeframe. However, I expect that this may not be possible in relation to detailed advice on the form and governance of the Māori Health Authority, given Cabinet's commitment to undertake the design of the Authority in partnership with iwi and the Māori health sector.

95 Partnership in the design of the Māori Health Authority is essential to deliver the right design to match the functions and aspirations for the entity. It is also a critical factor in building consensus which will support Parliamentary debate. Undertaking this engagement process in a meaningful, open and constructive way will require time, with the risk that we are unable to secure sufficient agreement to the legal form and functions of the Māori Health Authority to draft provisions in good time for introduction in September.

96 I have asked the Transition Unit to develop mitigations and options for dealing with a potential delay to confirmation of the core form and functions of the Māori Health Authority, and any other issues where they may be similar risks to securing agreement. The primary objective will be to maintain our commitment to implement the reforms from July 2022. However, it is possible that under some scenarios, the primary legislation may not be in place and alternative routes may need to be taken to deliver the core principles and

functions to this timeline. I shall monitor these risks and advise Cabinet accordingly.

97 Should the Bill not receive Royal Assent by May 2022, a related risk from delay is that the legislation would not be in place in time to cancel the next round of elections to DHB Boards. In my view, it may become prudent to avoid such a risk by legislating through a separate Bill to cancel these elections. This would remove any chance of the need for urgent legislation nearer to May 2022 if required; and would also provide legal certainty sooner for local government and for DHBs themselves. s9(2)(f)(iv)

98 As noted above, I do not propose to seek agreement to legislate now, through a separate Bill, to cancel DHB elections. However, I recommend that Cabinet note the case for such an approach in principle, and delegate the authority to issue drafting instructions to the Minister of Health so that this can be drafted and deployed urgently if required.

Major reform decisions to come

99 While Cabinet has agreed to the core structural framework of the future health system, there remain a number of policy decisions and choices which will develop the detail of the system model and determine what people receive and how they experience health services. These decisions will shape the legislation to set key duties and obligations, will underpin the requirements for agencies over the transition period, and will inform the funding, functions and outcomes of the reformed system.

100 I anticipate bringing further advice to Cabinet on relevant topics over the coming months. Key decisions include:

100.1 The function, role and design of the Māori Health Authority, including the governance and process of Board appointments. This work is subject to in-depth engagement with iwi and the Māori health sector, coordinated by a steering group led by Sir Mason Durie.

100.2 Appointments to the Section 11 Committees to be established to support the interim Health New Zealand and interim Māori Health Authority.

100.3 Detailed mapping of accountabilities, planning and funding cycles, and improved accountabilities for disadvantaged communities including Pacific communities: the roles of the Government Policy Statement, New Zealand Health Plan and other key documents in setting direction and supporting accountability, underpinned by a strengthened monitoring and stewardship model.

100.4 s9(2)(f)(iv)

s9(2)(f)(iv) [redacted]

100.6 The desired early priorities for the health system, as expressed in a future Government Policy Statement, for example requirements to improve access, reduce waiting times, expand service coverage or set minimum expectations in particular areas or for particular groups. There will be choices for Ministers on how and where to prioritise investment in improving the service offer to the public.

100.7 Early actions and priorities on other critical enablers that are necessary to give effect to the reforms and strengthen the resilience and sustainability of the health system. This may include decisions on system settings and investment in workforce development, digital services and infrastructure, system intelligence, capital asset.

101 Where decisions relate to matters that should be included in the legislation, these will be expedited to reduce risks to the drafting process. I expect to bring a paper on relevant topics by early July 2021. Subsequent decisions will follow to align with key implementation milestones, including the timetable for establishing interim agencies (by September 2021) and developing a Budget 2022 bid (by December 2021).

Financial implications

102 Funding to deliver core implementation and transition activities has been secured through Budget 21. As planning for transition activities progresses – for example, as decisions are made about the sequence in which functions are created or moved between agencies – reprioritisations within existing Vote Health baselines may be required.

103 s9(2)(f)(iv) [redacted]

105 s9(2)(f)(iv) [redacted]

Legislative implications

106 The structural changes to the health system agreed by Cabinet require primary legislation. Cabinet has agreed to use the Health Reform Bill on the legislative programme to do this. The broad approach is expected to be to repeal and replace the New Zealand Public Health and Disability Act 2000 to give effect to changes agreed by Cabinet and set out the purpose and functions of organisations and associated duties. The Bill will also need to carry through aspects of the NZPHD Act that are required in the new system but which are outside the reform programme.

107 As a minimum, the legislation will need to establish the new entities, set their core purpose, objectives, obligations and functions, and provide clear accountability and direction mechanisms. This will include key features such as the NZ Health Plan and Government Policy Statement, and new requirements relating to Te Tiriti o Waitangi obligations. There will be choices for Cabinet on how far to legislate in this Bill for related topics that extend beyond the core system architecture and include wider rights, statutory duties or functions that speak to the Government's broader aims and objectives of the reforms. These choices will be presented in a subsequent Cabinet paper, scheduled for late June 2021.

108 The Transition Unit has been working with the Ministry of Health on the design of implementing legislation, with input from the Public Service Commission and the Treasury. The implementation plan presented in this paper was developed around a critical path for new legislation, with the objective of new legislation coming into effect on 1 July 2022.

Impact Analysis

Regulatory Impact Statement

109 An Impact Statement is attached to this paper. The Impact Statement does not contain options relating to the design of the Māori Health Authority, which will be progressed in a subsequent Impact Statement following design work with Māori.

110 Treasury's Regulatory Impact Analysis Team has reviewed the Supplementary Analysis Report (SAR) "Health System Structural Change to

Support Reform Programme" produced by the Department of the Prime Minister and Cabinet. The review panel considers that it meets the Quality Assurance criteria.

111 The SAR provides a clear problem definition and intervention logic. It acknowledges that not all costs and benefits of the proposed change have been estimated, and provides informed estimates where these are possible.

112 The analysis within this SAR is on the first regulatory proposal decided as part of the wider health reform process. Subsequent regulatory decisions will be accompanied by separate regulatory impact analyses.

Population implications

113 The new system operating model is expected to have significant benefits for populations who experience poorer health outcomes, especially Māori, Pacific peoples, disabled people, rural communities and people with lower socio-economic status. The new health and disability system will need to ensure that disabled people have confidence in how both disability support services and their interactions with the broader health system will be planned, delivered and performance monitored. The phasing of implementation activity has been designed to realise benefits for these groups as early as possible.

114 As part of engagement activity planned between now and September 2022, we will proactively seek representation and voice from these communities to ensure their perspectives are reflected in the design of the future health system.

Human rights

115 The proposals in this paper are consistent with, and advance the purposes of, the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

116 The Ministry of Health, the Treasury and the Public Service Commission have been consulted. Their comments are reflected in this paper. The Department of Prime Minister and Cabinet has been informed.

Communications

117 The announcement of the new health and disability system operating model on 21 April 2021 covered key points made in this paper, including the timeframes to establish interim entities to for new legislation to take effect. The decisions and recommendations from this paper may feature in other public communications relating to the reform.

Proactive release

118 I intend to release this paper in accordance with the guidance in Cabinet Office Circular CO (18) 4.

Recommendations

The Minister of Health recommends that the Committee:

Previous decisions

1. **note** that in March 2021 Cabinet agreed to significant reforms to the health system's structures and operating model which included establishing Health New Zealand to replace the 20 current District Health Boards, creating a new Māori Health Authority, and refocusing the role of the Ministry of Health [CAB-21-MIN-0092 refers]

2. **note** that Cabinet authorised the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office for legislation to give effect to the agreed proposals [CAB-21-MIN-0092 refers]

3. **note** that Cabinet agreed to establish an interim Health NZ and an interim Māori Health Authority as departmental agencies hosted by the Ministry of Health, and that Cabinet agreed to allow the interim entities to manage assets and liabilities in accordance with section 24(2)b of the Public Service Act 2020 [CAB-21-MIN-0092 refers]

4. **note** that Cabinet invited the Minister of Health to report to Cabinet in May 2021 with further advice on the approach to managing change through the implementation phase, including on the transition for district health boards [CAB-21-MIN-0092 refers]

Implementation approach

5. **note** that the intention to proceed with implementation of the enabling structural changes at pace aims to manage uncertainty for the sector but also gives rise to risks

6. **note** that there are three main objectives for the sector and stabilising performance during the transition to new structures:

    6.1 Stakeholders have clarity on the transition pathway and expectations

    6.2 Stabilise the sector through the change

    6.3 Shared ownership of reform and success is fostered across the system

7. **note** that the delivery of reforms will require partnership and integrated working between the Transition Unit, Ministry of Health, Treasury, Public Service Commission and other key agencies on the policy, legislative and operational design

8. **note** there are four main phases of implementation:

    7.1 Phase 1: Establishment (Now – September 2021), focused on finalising detailed design of the key aspects of our future health system

7.2 Phase 2: Preparation (September 2021 – March 2022), focused on readying entities – existing and new – for a transition

7.3 Phase 3: Transition (March 2022 – July 2022), focused on final preparations for day 1 of new legislation coming into effect

7.4 Phase 4: Consolidation (July 2022 – Onwards), focused on winding down the transition to new agencies, and supporting those agencies to shape our health system towards the goals of reform.

9. **note** that the Ministry of Health and District Health Boards will retain their statutory obligations under current legislation, unless explicitly delegated to another entity using existing powers

10. **note** the expectation that some functions will be transferred from the Ministry of Health to the interim Health New Zealand and the interim Māori Health Authority over the coming year to support the interim agencies to incrementally expand their remit and build towards the full set of responsibilities which they will hold in future, subject to an approach and timetable to be agreed with the Director-General of Health and the incoming Chief Executives of the interim agencies

11. **note** that the interim Health New Zealand will also be expected to take steps with DHBs to begin to mirror the future arrangements for shared oversight and leadership, and this may include early appointments to regional roles

12. **note** that the Ministry of Health will undertake a programme of change to build capacity to carry out its refocused and strengthened role as the chief system steward, monitor and lead advisor to Government

13. **note** that the Minister of Health will set expectations for the interim agencies to inform their priorities and support rapid progress with operational design of the new system, in consultation with relevant parties

Ministerial committees

14. **note** that in March 2021, Cabinet:

8.1 **agreed** to establish an interim Health New Zealand and an interim Māori Health Authority as departmental agencies hosted by the Ministry of Health

8.2 **noted** my intention to establish committees to advise on the establishment of the interim entities and their transition to the new system [CAB-21-MIN-0092]

15. **note** that I intend to seek nominations for the interim Health New Zealand advisory committee from a wide range of sources, including ministerial and parliamentary colleagues, and the leaders of parliamentary parties

16. **note** that I intend to seek nominations for the interim Māori Health Authority advisory committee via a process to be designed and guided by a Māori steering group within the Transition Unit, led by Sir Mason Durie

17. **note** that the steering group process is expected to seek nominations from iwi Māori, the Māori health sector and a wide range of sources, including central government, the wider health sector, and ministerial and parliamentary colleagues

18. **note** that the appointment process for both advisory committees will be managed by the Transition Unit

19. **note** the Transition Unit has engaged a recruitment consultant to ensure an independent review of candidates and to carry out due diligence

20. **note** I expect to have a shortlist of candidates for each board, which I will discuss with colleagues, by early July

21. **note** appointments for both committees will be considered by APH in August and appointments complete by 1 September 2021

Identifying and managing risks

22. **note** that there will be risks associated with implementing a reform programme of this scale at pace

23. **note** that the design of the implementation approach is intended to address and mitigate system risks and avoid disruption to the core business of the health system and the COVID-19 response, in particular through the establishment of interim agencies

24. **note** that there will also be programme risks relating to the pace of implementation, including to the timetable for key decisions for the legislation to establish new entities by July 2022

25. s9(2)(f)(iv) [redacted]

27. **note** that the Minister of Health will monitor risks to system performance and implementation and consider mitigations, advised by the Transition Unit and the Ministry of Health, and will report to the Ministerial Group and Cabinet on significant areas

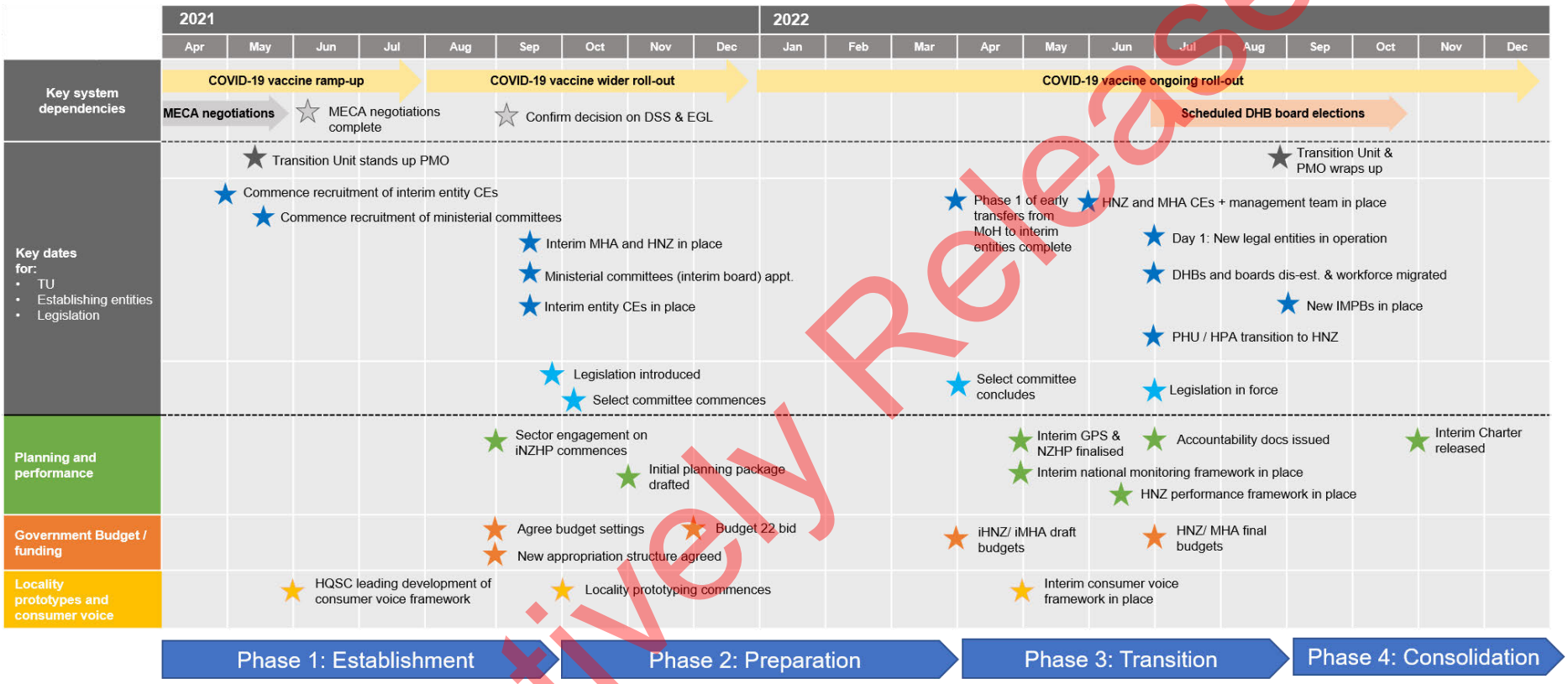
28. **invite** the Minister of Health to report back to Cabinet in August 2021 on early progress with implementation of the reforms.

Authorised for lodgement

Hon Andrew Little

Minister of Health

Annex A – Timeline of key milestones for implementation



Annex B – Ministerial committee to advise on the work of interim Health NZ

Background

1 On 29 March 2021, Cabinet [Cab-21-MIN-0092]:

1.1 **agreed** to establish an interim Health New Zealand as a departmental agency within the Ministry of Health, and

1.2 **noted** my intention to establish committees pursuant to section 11 of the New Zealand Public Health and Disability Act 2000 to advise Ministers on the establishment of the interim entities and their transition to the new system.

2 Alongside the appointment of advisory committee members, the Public Service Commissioner will appoint a chief executive to the departmental agency.

Analysis

3 The advisory committee will assist me in my oversight role relating to the interim entity. The committee will have a vital role in the success of the reform programme. They will help design the future system and new ways of working that will improve the health of all our communities. It is therefore essential that the members appointed are the best possible candidates.

Requirements for members

4 I intend to appoint eight members to the advisory committee who between them have commercial expertise, expertise in Māori health, expertise in Pacific health, expertise in disability, expertise in management of clinical services, clinical risk and service performance, experience in managing or governing large operational organisations or systems, and knowledge of the New Zealand health system. This is the same skill-mix I intend for the Health New Zealand board when the permanent organisation is established.

5 It is important to appoint highly capable members to the committee. They will have a key role in the detailed design of the reformed health system. Further, I intend that the advisory committee will form the interim board of the permanent entity, while permanent appointments are made.

Process for appointments

6 The Health Transition Unit in DPMC will manage the appointment process, working with the Ministry of Health. The Unit is appointing a recruitment consultant to provide an independent review of nominations, including due diligence reviews of candidates.

Nominations

7 I intend to seek nominations using networks from a wide range of organisations and individuals:

7.1 Central government: Public Service Commission, the Treasury, Te Puni Kōkiri, the Ministry for Pacific Peoples, the Ministry for Women, the Office of Ethnic Communities, and the Ministries of Health, Social Development, and Business, Innovation and Employment.

7.2 Health sector: DHB Board members, health Crown entities, Primary Health Organisations, provider bodies, health sector unions, health professional colleges, and health NGOs.

7.3 Political: I welcome nominations from ministerial colleagues, and will seek nominations from the government caucus. I also intend to write to the leaders of Parliamentary parties asking for nominations.

Review of nominations

8 The Transition Unit will receive nominations and refer them to the recruitment consultant who will prepare a long list for further consideration. Once the long-list is reviewed by the Transition Unit, the recruitment consultant will begin the due diligence process.

9 I expect to receive a short list of candidates by early July. I will discuss appointments with ministerial colleagues and the government caucus during July, with a view to bringing a paper to APH to finalise appointees in August 2021. Appointments will be made by 1 September 2021.

Terms of reference and fees

10 Terms of reference for the advisory committee are being developed and will be available to prospective appointees. Similarly, the fee structure is being determined based on the criteria set out in the Cabinet Office Fees Framework. I expect the fees for the advisory committee to be within the fees framework. However, given the size of the permanent entity, I anticipate an exception to the fees framework to ensure we can attract the right candidates.

Indicative timetable

Milestone	**Timeframe**
Nominations sought	June 2021
Long list prepared	June 2021
Short list prepared	July 2021
Discussion of proposed appointments with colleagues	July 2021 (during parliamentary recess)
APH consideration	August 2021
Appointments made	1 September

Annex C – Ministerial committee to advise on the work of interim Māori Health Authority

Background

1 On 29 March 2021, Cabinet [Cab-21-MIN-0092]:

1.1 **agreed** to establish an interim Māori Health Authority as a departmental agency within the Ministry of Health, and

1.2 **noted** my intention to establish committees pursuant to section 11 of the New Zealand Public Health and Disability Act 2000 to advise Ministers on the establishment of the interim entities and their transition to the new system.

2 Alongside the appointment of an advisory committee members, the Public Service Commissioner will appoint a chief executive to the departmental agency.

Analysis

3 The advisory committee will support me in my oversight role for the interim entity. The committee will have a vital role in the success of the reform programme. They will help design the future system and new ways of working that will improve the health of all our communities, and particularly that of Māori. They will also be a tangible demonstration how we give effect to tino rangatiratanga in the governance and running of the Māori Health Authority, and its influence on the rest of the system. It is therefore essential that the members appointed are the best possible candidates, and that they reflect the intended nature of the Māori Health Authority as a key vehicle for Māori leadership in the system.

Requirements for members

4 I intend to appoint up to eight members to the advisory committee who between them have expertise in te ao Māori and hauora Māori, significant governance expertise, commercial expertise, expertise in commissioning, management of clinical services and service performance, and knowledge of the New Zealand health system. This is the same skill-mix I intend for the Māori Health Authority board when the permanent organisation is established.

5 It is important to appoint highly capable members to the committee. They will have a key role in the detailed design of the reformed health system. Further, I intend that the advisory committee will form the interim board of the permanent entity, while permanent appointments are made.

Process for appointments

6 The Health Transition Unit in DPMC will manage the appointment process, working with the Ministry of Health.

Steering Group to oversee process

7 As part of fulfilling our manifesto commitment, I intend that Māori will have a strong role in shaping the organisational arrangements of the Māori Health Authority. This will include accountabilities to iwi and Māori. All advisory committee members will be appointed by me on the recommendation of Māori.

8 To this end, the Transition Unit is rapidly establishing a steering group, to be led by Sir Mason Durie and made up of a mix of respected and experienced senior Māori individuals. This group will determine and oversee a process to engage with iwi and Māori to identify potential candidates for the advisory committee from the perspective of Māori. The steering group will provide staged advice to the Transition Unit, to me and to the Associate Minister of Health (Māori Health) throughout the process, creating opportunities to discuss candidates with colleagues.

9 In parallel, the Transition Unit will receive nominations on potential candidates from a wide range of organisations and individuals. This will include central government agencies, the health sector and other appropriate channels, such as the Māori caucus.

10 The Transition Unit will support the steering group to identify and test candidates for the advisory committee. This will include ensuring appropriate diversity and skills mix across long- and short-listed candidates, and due diligence on candidates, with the assistance of a recruitment consultant.

11 The steering group will then work through a process to select and provide me with a short list of candidates by the beginning of July. I will discuss appointments with ministerial colleagues and the government caucus during July, with a view to bringing a paper to APH to finalise appointees in August 2021. Appointments will be made by 1 September 2021.

Enduring appointment process

12 The interim process outlined above will inform the process for appointments to the Māori Health Authority Board, once it is established in legislation. I anticipate incorporating input from Māori and lessons learned from the interim appointments process to structure a formal, enduring process to appoint future Board members in partnership with Māori.

Terms of reference and fees

11 Terms of reference for the advisory committee are being developed with the steering committee led by Sir Mason, and will be available to prospective appointees. Similarly, the fee structure is being determined based on the criteria set out in the Cabinet Office Fees Framework. I expect the fees for the advisory committee to be within the fees framework. However, given the responsibilities of the permanent entity, I anticipate an exception to the fees framework to ensure we can attract the right candidates.

Indicative timetable

Milestone	**Timeframe**
Steering group established	May 2021
Long list prepared	June 2021
Short list prepared	Early July 2021
Discussion of proposed appointments with colleagues	July 2021 (during parliamentary recess)
APH consideration	August 2021
Appointments made	1 September

Cabinet Social Wellbeing Committee

Minute of Decision

Health and Disability System Reform: Implementation and Transitional Arrangements

Portfolio **Health**

On 2 June 2021, the Cabinet Social Wellbeing Committee:

Background

1 **noted** that in March 2021, Cabinet:

1.1 agreed to significant reforms to the health system's structures and operating model which included establishing Health New Zealand to replace the 20 current District Health Boards, creating a new Māori Health Authority, and refocusing the role of the Ministry of Health;

1.2 authorised the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office for legislation to give effect to the agreed proposals;

1.3 agreed to establish an interim Health NZ and an interim Māori Health Authority as departmental agencies hosted by the Ministry of Health;

1.4 agreed to allow the interim entities to manage assets and liabilities in accordance with section 24(2)b of the Public Service Act 2020;

1.5 invited the Minister of Health to report to Cabinet in May 2021 with further advice on the approach to managing change through the implementation phase, including on the transition for district health boards;

[CAB-21-MIN-0092]

Implementation approach

2 **noted** that the intention to proceed with implementation of the enabling structural changes at pace aims to manage uncertainty for the sector but also gives rise to risks;

3 **noted** that there are three main objectives for the sector and stabilising performance during the transition to new structures:

3.1 Stakeholders have clarity on the transition pathway and expectations;

3.2 Stabilise the sector through the change;

3.3 Shared ownership of reform and success is fostered across the system;

4 **noted** that the delivery of reforms will require partnership and integrated working between the Transition Unit, Ministry of Health, Treasury, Public Service Commission and other key agencies on the policy, legislative and operational design;

5 **noted** there are four main phases of implementation:

5.1 Phase 1: Establishment (Now – September 2021), focused on finalising detailed design of the key aspects of our future health system;

5.2 Phase 2: Preparation (September 2021 – March 2022), focused on readying entities – existing and new – for a transition;

5.3 Phase 3: Transition (March 2022 – July 2022), focused on final preparations for day 1 of new legislation coming into effect;

5.4 Phase 4: Consolidation (July 2022 – Onwards), focused on winding down the transition to new agencies, and supporting those agencies to shape our health system towards the goals of reform;

6 **noted** that the Ministry of Health and District Health Boards will retain their statutory obligations under current legislation, unless explicitly delegated to another entity using existing powers;

7 **noted** the expectation that some functions will be transferred from the Ministry of Health to the interim Health New Zealand and the interim Māori Health Authority over the coming year to support the interim agencies to incrementally expand their remit and build towards the full set of responsibilities which they will hold in future, subject to an approach and timetable to be agreed with the Director-General of Health and the incoming Chief Executives of the interim agencies;

8 **noted** that the interim Health New Zealand will also be expected to take steps with DHBs to begin to mirror the future arrangements for shared oversight and leadership, and this may include early appointments to regional roles;

9 **noted** that the Ministry of Health will undertake a programme of change to build capacity to carry out its refocused and strengthened role as the chief system steward, monitor and lead advisor to Government;

10 **noted** that the Minister of Health will set expectations for the interim agencies to inform their priorities and support rapid progress with operational design of the new system, in consultation with relevant parties Ministerial committees;

11 **noted** that in March 2021, Cabinet:

11.1 agreed to establish an interim Health New Zealand and an interim Māori Health Authority as departmental agencies hosted by the Ministry of Health;

11.2 agreed to establish the Public Health Agency as a distinct branded unit within the Ministry of Health, and establish a public health service within Health New Zealand to provide more central coordination across public health units;

11.3 noted the intention to establish committees to advise on the establishment of the interim Health New Zealand and Māori Health Authority and their transition to the new system;

[CAB-21-MIN-0092]

12 **noted** that the Minister of Health intends to seek nominations for the interim Health New Zealand advisory committee from a wide range of sources, including ministerial and parliamentary colleagues, and the leaders of parliamentary parties;

13 **noted** that the Minister of Health intends to seek nominations for the interim Māori Health Authority advisory committee via a process to be designed and guided by a Māori steering group within the Transition Unit, led by Sir Mason Durie;

14 **noted** that the steering group process is expected to seek nominations from iwi Māori, the Māori health sector and a wide range of sources, including central government, the wider health sector, and ministerial and parliamentary colleagues;

15 **noted** that the appointment process for both advisory committees will be managed by the Transition Unit;

16 **noted** that the Transition Unit has engaged a recruitment consultant to ensure an independent review of candidates and to carry out due diligence;

17 **noted** that the Minister of Health expects to have a shortlist of candidates for each board, which he intends to discuss with colleagues, by early July;

18 **noted** that appointments for both committees will be considered by the Cabinet Appointments and Honours Committee in August 2021 and appointments completed by 1 September 2021;

Identifying and managing risks

19 **noted** that there will be risks associated with implementing a reform programme of this scale at pace;

20 **noted** that the design of the implementation approach is intended to address and mitigate system risks and avoid disruption to the core business of the health system and the COVID-19 response, in particular through the establishment of interim agencies;

21 **noted** that there will also be programme risks relating to the pace of implementation, including to the timetable for key decisions for the legislation to establish new entities by July 2022;

22 s9(2)(f)(iv) [redacted]

24 **noted** that the Minister of Health will monitor risks to system performance and implementation and consider mitigations, advised by the Transition Unit and the Ministry of Health, and will report to the Ministerial Group and Cabinet on significant areas;

25 **authorised** a group of Ministers consisting the Prime Minister, Minister of Finance, Minister for the Public Service, Minister for Disability Issues, Minister of Health, and Associate Ministers of Health (Hon Dr Ayesha Verrall, Hon Peeni Henare, Hon Aupito William Sio) to make Tier 2 policy decisions as required;

26 **invited** the Minister of Health to report back to Cabinet in August 2021 on early progress with implementation of the reforms.

Rachel Clarke
Committee Secretary

Present:
Rt Hon Jacinda Ardern
Hon Grant Robertson
Hon Dr Megan Woods
Hon Carmel Sepuloni (Chair)
Hon Andrew Little
Hon Kris Faafoi
Hon Jan Tinetti
Hon Dr Ayesha Verrall
Hon Aupito William Sio
Hon Priyanca Radhakrishnan

Officials present from:
Office of the Prime Minister
Office of the SWC Chair
Officials Committee for SWC

CAB-21-MIN-0206

Cabinet

Minute of Decision

Report of the Cabinet Social Wellbeing Committee: Period Ended 4 June 2021

On 8 June 2021, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 4 June 2021:

SWC-21-MIN-0080	**Health and Disability System Reform: Implementation and Transitional Arrangements** Portfolio: Health	CONFIRMED

[redacted]

Michael Webster
Secretary of the Cabinet

[In Confidence]

Office of the Minister of Health

Social Wellbeing Committee

Health and Disability System Reform – Legislating for the reforms

Proposal

1 This paper seeks the policy decisions required for the drafting of a Bill to give effect to the Government's announced reforms to the publicly-funded health system.

Relation to Government priorities

2 The Government's manifesto and the Speech from the Throne committed to undertaking a long-term programme of reform to build a stronger public health system that delivers for all, drawing on the recommendations of the independent Health and Disability System Review.

Executive summary

3 Cabinet has agreed to a bold and ambitious reform programme for our public health system to improve the quality, consistency and equity of care for New Zealanders. Delivering these reforms will require primary legislation to give effect to new system structures, accountabilities and arrangements. The Health Reform Bill on the 2021 Legislation Programme has already been identified as the vehicle for taking forward these changes in the coming year.

4 The degree of change to legislative arrangements is sufficient that I intend to repeal the New Zealand Public Health and Disability Act 2000 and replace it in its entirety, rather than amend the current Act. The timeframe for the initial reform is short – legislation establishing the new publicly-funded health organisations is intended to be introduced to the House in September this year, passed by May 2022 and in force on 1 July 2022. For that reason, it is important that the scope of the legislation is kept within reasonable limits, focusing on the elements needed for day 1 of the system. I anticipate further legislative reform as the Government continues to improve the health system.

5 The structural elements of the health system set out in the Bill will reflect previous Cabinet decisions. Health New Zealand will be established as a Crown entity, with its functions, objectives and governance arrangements set out in the Bill (see Appendix 1). The decision that the Public Health Agency will be a business unit of the Ministry of Health means no legislative provision is required for its establishment, nor for the public health service in Health NZ.

6 As directed by Cabinet, the Transition Unit is engaging with iwi and Māori representatives on the details of the Māori Health Authority, including via the

Steering Group led by Tā Mason Durie. It is important that this engagement is open and genuine, and it therefore cannot be rushed. This means final details for legislation will likely not be known when the Bill is introduced. I intend therefore to include draft provisions in the Bill as introduced and for these to be amended during the Select Committee's consideration of the Bill. This will require a specific instruction from the House when the Bill is referred to the Select Committee. While not ideal from a legislative standpoint, this approach is responsive to our Tiriti partnership commitments and retains the current timetable, and the draft provisions will be prepared with Māori stakeholders.

7 I intend the legislation to set out shared statutory goals and principles to frame the general requirements of relevant entities, in three ways:

7.1 specifying the obligations of organisations under Te Tiriti o Waitangi/ the Treaty of Waitangi and relevant principles for giving effect to these. Transition Unit officials are working with other agencies, and Māori stakeholders, on the formulation of this provision and the specific principles to follow. I will bring further advice to Cabinet on this matter;

7.2 creating a general duty on all publicly-owned health organisations to make best efforts to achieve specific common goals, in line with Cabinet's agreed priority outcomes; and

7.3 specifying principles to follow in giving effect to this duty, to which all publicly-owned health organisations must have regard.

8 Accountability arrangements will be based on the documents and processes outlined in my advice to Cabinet in March 2021. The Minister will be required from time to time to determine a New Zealand Health Strategy to set out the government's overall strategy for the publicly-funded health system, as is the case now. In addition, I consider strategies covering Māori Health and Pacific Health will be necessary, as well as the ability to make other strategies as needed. A Government Policy Statement (GPS), covering at least three financial years, will be required and will set the Government's requirements, expectations and investment, and drive accountabilities.

9 The GPS and health strategies will be given effect via the New Zealand Health Plan that sets out national service requirements, reporting frameworks, and the like, and which must be approved by the Minister. The Plan will be supplemented by a more detailed, web-based, planning environment, with modules covering specific elements of the health sector, which will not require formal Ministerial approval.

10 Monitoring against these strategies and plans, and intervention when appropriate, will be essential to the success of the reformed system. This will include: system-level monitoring to hold organisations to account and to support the stewardship role of the Ministry of Health; the monitoring roles of other agencies such as the Treasury, Te Puni Kōkiri and the Ministry for Pacific Peoples; and consistent internal monitoring by organisations to support improvement in performance at all levels. These functions will largely be empowered by the standard administrative machinery in the Crown Entities

Act and Public Finance Act. I intend to bring further proposals for consultation with Ministers on any additional powers for inclusion in the Bill.

11 Based on the recommendations in this paper and previous Cabinet decisions, I have instructed the Parliamentary Counsel Office to begin drafting, and will issue further instructions as further decisions are made. I seek Cabinet's approval to make further policy decisions required, in consultation with the group of relevant Ministers previously identified by Cabinet [SWC-21-MIN-0080 refers], and issue drafting instruction to give effect to them.

Background

12 On 29 March 2021, Cabinet agreed to reform the health system to achieve a vision of pae ora/healthy futures for all New Zealanders. The first set of decisions included significant reforms to the system's structures and operating model: establishing Health New Zealand to replace the 20 district health boards, creating a new Māori Health Authority, a new Public Health Agency, and refocusing the role of the Ministry of Health [CAB-21-MIN-0092 refers].

13 In relation to disability support services, Cabinet noted that it will receive separate advice on reform proposals, including the future model and governance of these services, in September 2021. That advice is expected to give full regard to ensuring that the future model and governance of disability support services are underpinned by the approaches and principles of Enabling Good Lives and current work on disability system transformation. It is important to note that this future advice and Cabinet decision does not reduce the obligation and expectation that the health system as a whole provides greater equity of access and outcomes for disabled people.

14 Cabinet also noted the requirement for legislation to implement many of these reforms, and my intention to progress this through the Health Reform Bill on the Government's legislative programme (which is a category 4 priority – referral to Select Committee this year). This paper provides further advice and seeks subsequent decisions to inform instructions for that Bill.

15 On 2 June 2021, the Cabinet Social Wellbeing Committee noted the intention to proceed swiftly to implement the reforms, starting with a transitional phase of preparation, detailed functional design and wider stakeholder engagement over the period to late 2022. This phase would also include development of necessary legislation to implement the changes, with the expectation that this will come into effect on 1 July 2022.

16 The Committee also noted the number of outstanding policy decisions that are required, both to support drafting of the legislation and to confirm the policy settings, priorities and objectives for the new system. While some of these decisions will be matters for Cabinet, including those relating to future Budgets and investment, in relation to second-order policy matters the Committee agreed that a group of relevant Ministers should be delegated authority to make necessary decisions [SWC-21-MIN-0080 refers].

Structure of this paper

17 This paper:

17.1 notes the overall strategy to legislating for the reforms, and the approach to and scope of the Health Reform Bill;

17.2 outlines the intended approach to legislating for the structural elements of the health system agreed by Cabinet – in particular to establish Health New Zealand and the Māori Health Authority;

17.3 proposes statutory purpose, goals and principles to reflect Government's priority outcomes for the health system;

17.4 describes how core system accountability documents should be legislated for; and

17.5 notes other areas that should be, or may be, reflected in the Bill, and how decisions will be taken.

Approach to legislation

18 The primary purpose of the Health Reform Bill is to give effect to the changes announced by the Government, and to put in place the new system structures and arrangements. Our wider reform programme, however, will take a number of years to deliver: both to embed new structures, and to make the changes to access and models of care that will lead to improved outcomes and equity for New Zealanders. In this context, the Health Reform Bill should be seen as the first of a series of legislative steps to drive and support the reform programme. I anticipate that further legislation will be required to deliver wider objectives in due course, subject to future advice.

19 We have committed in public to implementing the health system reforms in July 2022; this remains my intention. Finalising policy, drafting and passing a Bill within the next 12 months will be challenging. The overall strategy, therefore, should be focused on mitigating the policy and practical risks to this timeline, including:

19.1 expediting policy decisions so that there is clarity on the matters to be included in the legislation. Further detail is set out in this paper; where additional decisions are identified subsequently I propose that authority to determine the policy and issue drafting instructions be delegated to the Minister of Health, in consultation with relevant colleagues;

19.2 using sector and public communications and stakeholder engagement to build consensus around the reform proposals and involve the sector in the design of elements of the future system; and

19.3 managing our legislative strategy as far as possible to focus debate on the elements required for Day 1 of the reformed system.

20 A key element of this strategy should be to keep the primary legislation as simple and flexible as possible, and rely on secondary legislation, other direction-setting powers and guidance to specify detailed processes. This would be in accordance with modern practice and the Legislation Advisory Committee Guidelines.

Scope and focus of the Bill

21 As a minimum, the legislation will need to establish the new entities, set their core purpose, objectives, obligations and functions, and provide clear accountability and direction mechanisms. This will include key features such as the NZ Health Plan and Government Policy Statement, requirements relating to Te Tiriti o Waitangi/Treaty of Waitangi obligations and other principles that capture our vision and objectives. Proposals in these areas are discussed in this paper.

22 The health reforms are extensive and fundamentally change the overall structure of the health system. I have received advice on the New Zealand Public Health and Disability (NZPHD) Act 2000 and my view is that the changes needed to that Act are so extensive that it is necessary to repeal and replace the Act in its entirety.

23 In addition to establishing the current arrangements for district health boards, the NZPHD Act also contains wider provisions. These should be retained and carried into the new statute. They include, for example, the provisions that allow for 'bulk contracting' of services (section 88 notices), the provisions that establish other entities in the health system (Pharmac, the NZ Blood and Organ Service, etc.), powers of direction, and others.

24 This will result in a Bill that is has a relatively wide scope across health system institutions and requirements. In my view this is unavoidable, and in any event it would be practically and politically challenging to seek to limit the scope of the Bill unduly.

25 Notwithstanding the above, there are wider areas of the health regulatory framework that I believe we can, and should, seek to rule out of scope without undermining the integrity of the Bill. This should include making any significant amendments to the Health Act 1956 in relation to public health legislation (to avoid, for instance, debating changes to quarantine rules) or reforms to the Mental Health (Compulsory Assessment and Treatment) Act 1992. Such matters can be taken forward through subsequent legislation in later bills. We should also exclude any issues where legislation is being taken forward through another vehicle (e.g. regulation of therapeutic products).

26 I further recommend that this Bill does not seek to legislate for all potential changes to wider system structures and entities beyond those announced already, except where these are required as consequential matters. There is a range of options relating to other Crown entities (e.g. the NZ Blood and Organ Service, the Health Quality and Safety Commission) and agencies (e.g. Cancer Control Agency) and how they sit in the new system structure.

Although some options may require legislation, I do not believe we are in a position to seek policy agreement for inclusion in this Bill given the need for focus on the core requirements for Day 1. Moreover, my view is that adding further structural reforms would be highly challenging to deliver in parallel. I intend to replicate the existing provisions relating to the non-DHB health Crown entities in the new legislation.

Legislating for system structures

27 Cabinet has previously agreed to the overall system operating model, including the establishment of Health New Zealand, the Māori Health Authority and a Public Health Agency. This section sets out how I propose to legislate for these system structures and seeks some further decisions.

Health NZ

28 Health NZ will be established as a Crown entity under the Crown Entities Act 2004 and subject to the usual provisions of that Act. Health NZ will have up to eight board members appointed by the Minister of Health. It will be a large and complex organisation, having a workforce of approximately 80,000 staff working across New Zealand's public hospitals, community and primary care services, and the wider public health system. I also estimate it will oversee approximately $20 billion in annual operational expenditure and manage an estimated $24 billion in assets.

29 Cabinet has agreed to the core functions and governance of Health NZ, and these will be reflected in the objectives, functions and accountabilities which are described in the legislation. Appendix 1 to this paper outlines the expected objectives and functions of Health NZ that will be reflected in the legislation. These provisions, in addition to those which give effect to Cabinet's decisions regarding the Health NZ board and governance, will set the statutory foundations for the entity in the Bill.

30 Because of the size and coverage of Health New Zealand, it will need to establish sub-national (regional, district and local) administrative arrangements to drive population health improvement and plan services most effectively. Moreover, these arrangements will allow for a 'place-based' means of engaging with communities in determining priorities, aims and service design to meet the needs of New Zealanders at the appropriate level; and in particular support an effective approach to meeting Tiriti obligations to partner with Māori at all levels. There is a question as to whether and how to legislate to reflect or allow for these arrangements.

Regional arrangements

31 Cabinet has previously noted my intention that the internal organisation arrangements of Health New Zealand will include:

31.1 four regional divisions with regional commissioning boards within Health New Zealand, to be led by regional chief executives, to

commission primary and community health services, in partnership with the Māori Health Authority; and

31.2 hospital and specialist services consolidated into four regional networks, planned nationally by Health New Zealand in partnership with the Māori Health Authority and delivered through regional divisions to align with primary and community services [CAB-21-MIN-0092].

32 In keeping with the principle of enabling legislation that provides flexibility to the Health New Zealand Board and management, I do not intend to legislate for a precise configuration of regional divisions. However, given the importance of these arrangements to the intended model of Health NZ, and their role in overseeing the commissioning of primary and community services through localities and supporting community engagement, in particular for Māori, Pacific and disabled people, I recommend that the Bill require that Health NZ establish regional divisions for this purpose. I do not believe it is necessary to require similar regional arrangements for managing hospital networks, since these are a matter of service delivery and will be within Health NZ's general powers and functions.

33 It will be for Health NZ, in collaboration with the Māori Health Authority, to determine the design of regional or district arrangements in the longer term to fulfil its objectives and functions, and I expect that these may change over time as the system matures and iwi, hapū, whānau and consumers' preferences are reflected. However, if it is necessary to provide firmer expectations for the initial arrangements, I expect to use powers including the Government Policy Statement to do this rather than legislating.

Localities

34 The "locality approach" is a critical element of the health reforms. The concept of a locality is based on a desire to focus on population health improvement and achieving equity for priority groups, and that the most effective means of understanding the needs and goals of a population, of integrating the voice of communities and of designing services to reflect these, is by focusing on a shared notion of the place and populations that are being served. The locality therefore acts as both a right-sized local unit for engaging with iwi, hapū, communities and community leaders, and for planning, commissioning and delivering primary and community health services, including as a locus for social sector engagement.

35 While the reformed system will plan and deliver primary and community health services at the national, regional and local level, depending on the nature of the specific service, the majority of these services should be commissioned locally, as close to communities as possible. In this respect it is helpful to distinguish between:

35.1 localities, which are geographic areas that are determined to capture as far as possible distinct communities within practical boundaries. I anticipate that the future system will ultimately organise between 50 and 100 localities as the basis for planning and delivering primary and

community services and addressing broader determinants of health through a population health approach; and

35.2 provider networks, which are the coordinated set of health services that are commissioned to serve a specific locality or population. Provider networks will encourage integrated services, with common management arrangements, to enable people and whānau to access a coordinated range of primary healthcare services, no matter where they live.

36 Localities are a key part of the reform programme, and in my view legislation should require them, and articulate their function and purpose, but not constrain their potential form and nature or seek to set their boundaries. It will be for Health NZ, in partnership with the Māori Health Authority, to determine localities; and doing so will require careful consideration of the social and human factors that define a place, including iwi rohe, the need for alignment with other public services (for instance, the 15 public service regions), and the minimum size needed for viable and effective services, amongst other matters. The Bill should not seek to pre-judge these.

37 I believe the legislation should, however, place an obligation on Health NZ that it must determine a number of discrete localities for the purposes of arranging primary and community care services and involving communities in the design of those services, in partnership with the Māori Health Authority. It should further require that in so doing the whole of New Zealand is covered. This will ensure that all people are covered within a locality and mitigate the risk of gaps in coverage, while enabling new models of care and service arrangements to emerge to suit the needs and priorities of particular communities, including iwi, hapū and Māori communities and Pacific communities.

38 While localities should be based on geographic areas, provider networks may not always match these precisely. There may be provider networks that span multiple localities, or which focus on specific population groups within one or more localities. Health NZ may wish, for instance, to establish provider networks based on “communities of interest” or specific population groups (e.g. a Pacific provider network in South Auckland) that do not map precisely to standard geographies. Although this should be possible as a matter of service planning within Health NZ’s broad mandate and functions, legislation should enable rather than require such approaches. Moreover I do not believe it is necessary or desirable to legislate for provider networks themselves, of whatever form, to avoid reducing flexibility and innovation.

The Māori Health Authority and Iwi-Māori Partnership Boards

39 Cabinet has agreed to establish the Māori Health Authority to lead hauora Māori in the health system. Legislation will need to give effect to Cabinet’s decision to establish the Māori Health Authority as a statutory entity, including setting out the core purpose and functions of the entity and how it is constituted and governed. The Bill must also provide for the right range of tools and powers to ensure that Māori can exercise genuine control and

influence, including over strategies developed by the Ministry and plans developed by Health New Zealand, to ensure that the Authority can meet Cabinet's ambitions.

40 Cabinet recognised that it would be premature to take decisions on the form, governance and functions of the Māori Health Authority before there had been an opportunity to engage with Māori stakeholders and the Māori health sector. Final decisions on the design of the Māori Health Authority will need to strike a careful balance between providing for tino rangatiratanga and accountabilities to Government.

41 The Transition Unit is taking a two-stage approach to engaging with Māori stakeholders on proposals relating to the Māori Health Authority and Iwi/ Māori Partnership Boards. The first stage of engagement is focusing on the following elements that need to be confirmed, in at least general terms, for initial drafts of the Bill to be completed:

41.1 how the Māori Health Authority (and other organisations including Health NZ) should be held accountable to Māori;

41.2 the broad functions and relationships of the Māori Health Authority (e.g. its strategy, policy, planning, commissioning and monitoring); and

41.3 how iwi-Māori partnership boards should be sustained by the health system, how they are recognised in legislation, and how health agencies work with iwi rohe, particularly across regional lines.

42 The second stage of engagement will focus on further matters that are not required to be included in legislation, although they are relevant to how the system will operate in practice, including:

42.1 how direct commissioning by the Māori Health Authority, and co-commissioning between the Māori Health Authority and Health NZ, might work in practice (beyond legislative requirements); and

42.2 the roles of iwi and wider Māori communities in shaping the agenda of the Māori Health Authority, Health NZ and iwi-Māori partnership boards.

43 Open engagement is essential to demonstrating the Government's commitment to partnership in the design of the future system for Māori, and to ensuring that the system benefits from Māori expertise. I believe this engagement approach appropriately balances the need to establish the system quickly, while working in partnership with Māori to design the functions and governance of the Māori Health Authority. The timetable for engagement and progress with design cannot, and should not, be strictly controlled by Government. It is crucial, as good Tiriti partners, that engagement is done in good faith, and is not rushed.

44 A consequence, therefore, is that this process may not match the timetable for developing the Bill, with the likelihood that final recommendations will

not be able to be brought to Cabinet within a timeframe that would allow them to be included in the Bill at introduction. To maintain pace with implementation, we will need to take an alternative approach to legislate for these proposals.

45 Accordingly, my intention is that the Bill at introduction will include draft provisions relating to the Māori Health Authority and iwi-Māori partnership boards. This will allow for Cabinet to agree a complete Bill that provides proposals in these areas, drawing on the feedback from engagement with Māori to date. However, these provisions are unlikely to be the final position, and I expect them to be amended once the first stage of the engagement process concludes. I anticipate that this will be after introduction, when the Bill is being considered by the Select Committee. I intend to ask the Committee to actively consider these proposals and to signal that these are expected to be modified or replaced at the Government's request during the Committee process.

46 This approach is not without risk: any provisions, even draft, may be seen as pre-empting the outcome of engagement with Māori. Moreover, it may hinder the Committee's consideration of the Bill if it is understood that some elements may change but it is not clear which, how and when. However, I believe it is possible to manage these risks through a communications approach that clarifies the status of the provisions, provides reassurance on expectation of their revision, and updates on the progress of engagement, perhaps with a report to the Committee from Tā Mason Durie. I have also asked the Transition Unit to discuss, as far as practicable and when available, draft provisions with Māori stakeholders to ensure they reflect likely areas of agreement and early feedback from engagement hui.

47 I have considered alternatives to this approach, including to delay the introduction of the Bill while this engagement continues. However, these would likely postpone the commencement of the legislation in July 2022. Given Cabinet's commitment to provide certainty to the health sector, I am not minded to pursue a course that affects the timeline for legislation in this way.

48 I therefore seek Cabinet's authorisation to take in-principle policy decisions, in consultation with the group of Ministers previously agreed [SWC-21-MIN-0080], and to issue instructions to the Parliamentary Council Office relating to the Māori Health Authority and iwi-Māori partnership boards, drawing on the first stage of engagement with Māori stakeholders. I will bring final recommendations to Cabinet for approval later this year, and continue to advise on the progress with this engagement more generally.

Public health

49 Cabinet has agreed to establish the Public Health Agency as a distinct, branded unit within the Ministry of Health, and to establish a national public health service within Health NZ that brings together the 12 public health units, currently organised within DHBs, with the goal to strengthen a national approach to public health operations. Given both the Public Health Agency and national public health service will be internal divisions of the Ministry of

Health and Health NZ respectively, there is no express need to legislate to establish them.

50 However, I expect that the purpose and functions of Health NZ that are described in legislation will be drafted to include relevant public health functions; in addition to their anticipated responsibilities regarding partnership with the Māori Health Authority. I also anticipate that there will be a small number of other provisions and amendments to other legislation which would helpfully reinforce the prominence of the Public Health Agency, and the statutory powers of key system leadership roles such as the Director of Public Health. It will be important that such provisions do not inadvertently expand the scope of the Bill, as noted above. I have requested further advice on options and seek Cabinet's authorisation to make necessary decisions and issue drafting instructions for provisions that clarify public health structures and roles.

Statutory purpose, goals and principles

51 Cabinet has agreed that the vision for the reformed health system will be based on pae ora/healthy futures for all people: with the aims that people live longer in good health, have improved quality of life, and there is equity between all groups. The Health Reform Bill provides an important opportunity to enshrine this vision in statute and influence how organisations make decisions and discharge their functions towards this end.

52 I recommend that the overall purpose statement in the Bill should be kept brief and focused for maximum clarity, and elucidate Cabinet's decisions with regard to the scope of the reforms. Therefore I expect that the purpose would be to provide for the public funding and provision of health services and to establish publicly-owned health organisations to improve equity, promote and protect health, and achieve pae ora/healthy futures for all New Zealanders. System entities will then be responsible for achieving the purpose, and it will inform decisions made and functions undertaken.

53 Beyond this general statement, I believe it will be valuable to include more detailed goals and principles to guide decision-makers and give fuller description to the aims and objectives of the health system. This will be particularly important to achieve the reform's ambitions relating to equity and partnership with Māori, where general provisions in place for the last three decades have not led to significant improvements.

54 I recommend that the legislation take a layered approach, with provisions that reinforce the Government's vision in three ways:

54.1 specifying the obligations of organisations under the Te Tiriti o Waitangi/Treaty of Waitangi and relevant principles for giving effect to these;

54.2 creating a general duty on all publicly-owned health organisations to make best efforts to achieve specific common goals, in line with Cabinet's agreed priority outcomes; and

54.3 specifying principles to follow in giving effect to the above duty, to which all publicly-owned health organisations must have regard.

Te Tiriti o Waitangi/Treaty of Waitangi obligations

55 A key goal of the reform programme is delivering on the Crown's obligations to Māori under Te Tiriti o Waitangi/the Treaty of Waitangi. These obligations are well described in the Ministry of Health's *Whakamaua: Māori Health Action Plan 2020-2025,* which was developed with the voices of Māori as an integral part. The high-level outcomes as set out in Whakamaua are:

55.1 Iwi, hapū, whānau and Māori communities exercising their authority to improve their health and wellbeing;

55.2 The health and disability system is fair, sustainable and delivers more equitable outcomes for Māori;

55.3 The health and disability system addresses racism and discrimination in all its forms; and

55.4 The protection and elevation of mātauranga Māori throughout the health and disability system.

56 Cabinet has agreed that the legislation contain a statement giving effect to the principles identified by the Waitangi Tribunal in its Wai2575 Health Services and Outcomes Kaupapa Inquiry. To do so, I believe we should consider including the specific principles identified by the Tribunal explicitly, as a guide for organisational decision-making.

57 It will be important to get the expression of obligations to Māori, and principles supporting those obligations, right. I am conscious that the interpretation and understanding these obligations and concepts has evolved over time, and the legislation should allow for this natural process to continue. It may be prudent to provide for regulations to set specific requirements for entities to give effect to the principles above, so that a more flexible legal device can be employed and refined as necessary as the system matures. Officials are working through these issues with appropriate stakeholders, taking into account the Cabinet's wider work on legislating for Tiriti/Treaty obligations. I intend to bring further advice to Cabinet on this issue.

Shared goals for achieving health outcomes

58 I intend to provide for a general duty in legislation for publicly-owned health organisations to pursue explicit goals in the discharge of their functions and obligations. This duty will expand on the purpose of the legislation, and reflect the priority outcomes for reform agreed by Cabinet in March 2021:

58.1 partnership: ensuring partnership with Māori in decisions at all levels of the system, and empowering consumers of care to design services that work for them;

58.2 equity: tackling the gap in access and health outcomes between different populations and areas of New Zealand;

58.3 sustainability: embedding population health as the driver of preventing and reducing health need, and promoting efficient and effective care;

58.4 person and whānau-centred care: empowering all people to manage their own health and wellbeing, have meaningful choices about the services they receive, and treating people, their carers and whānau as experts in care; and

58.5 excellence: ensuring consistent, high-quality care in all areas, and harnessing innovation, digital and new technologies to continuously improve services.

59 All publicly-owned health organisations should be required to make their best efforts to achieve these overarching system goals in the exercise of their functions, including through their commissioning and contracting relationships. This would provide a common framework of outcomes to drive the system at the strategic level and align with the key areas of focus of the Government's agenda. Although the goals may have varying degrees of relevance in relation to different issues, and may create tensions in balancing their aims, they all represent concepts that should be pursued as a matter of course in good decision-making. The onus should be on organisations to demonstrate how they have sought to promote these goals, in line with their organisational functions and the resources available to them. I expect to develop guidance for health organisations to set out in more detail the expectations of each in pursuing these goals and to encourage consistency.

60 This general duty is intended to inform and influence decision-makers in the health system. In addition to serving as a strong direction of priority goals, it would carry some legal weight, to which organisations would be required to respond. However, it would not pre-determine decisions or constrain the authority of individual decision-makers, and these goals would not be legally enforceable on an individual level.

61 In my view, the requirements of such a general duty should include all health Crown Agents (that is, Health New Zealand, Pharmac, the New Zealand Blood and Organ Service, the Health Quality and Safety Commission). The legislation should also clarify that the requirements of this duty should include the Ministry of Health and departmental agencies. Although the Ministry and agencies would not usually be included in the definition of publicly-owned health organisations, these goals should be relevant across the system and would have greater resonance if applied to all decision-makers. I would also intend for the goals to influence the work of the independent Crown entities (the Health and Disability Commissioner or the Mental Health and Wellbeing Commission), though this would be subject to their agreement, rather than legislated, so as to not undermine their independence. Decisions on the inclusion of the Māori Health Authority will be taken pending a final recommendation on its legal form, following engagement with Māori.

62 I do not believe that this statutory duty should extend explicitly to include contracted providers of health services. This could present an unjustifiable legislative burden and may be ineffective, in particular for small organisations. However, to ensure that these goals remain constant throughout all levels of

the system, I intend to require Health NZ to stipulate these objectives, as well as Te Tiriti o Waitangi obligations, as standard provisions within all future contracts (including those made under the future equivalent to Section 88 provisions), and use these contractual levers to embed a consistent focus.

Principles to support goals and equity for all groups

63 Achieving equity is a Te Tiriti requirement and one of the key aims of the reformed system, and will be expressly included as one of the goals in the general duty above. The current New Zealand Public Health and Disability Act has provisions relating to improving equity, however these provisions are very general, and in any event inequity in access and health outcomes remains a significant issue.

64 Tackling inequity is not an issue that is amenable to a simple legislative solution. The causes of inequity are complex, and not limited to the health sector, and the solutions to them will be similarly complex and inter-sectoral. However, I believe this Bill provides an opportunity to set out a more expansive description of what we mean by equity and the sorts of considerations we want organisations to take account of when designing and delivering health services to achieve equity. The actions set out in the Bill allow Government to demonstrate its commitment to address long-standing inequities in health outcomes.

65 Accordingly, I propose that legislation include a set of key principles that should apply in relation to the general duty to pursue the goals set out above. As well as reinforcing the goals in the round, these principles should have a particular focus on equity. Organisations will be required to have regard to these in the discharge of their functions, to supplement their existing accountabilities and functions. These principles would, as above, be supported by guidance on their application to promote consistency.

66 I propose that the Bill include an obligation on organisations, in using the resources available to them to achieve best value for money, to have regard to the following principles:

66.1 ensure equitable health outcomes for all groups, taking into consideration gender, ethnicity, sexuality, condition, disability, place of residence, etc.;

66.2 improve, prevent, diagnose and treat both physical and mental health problems with equal regard;

66.3 provide all people with an equitable range and quality of services;

66.4 provide services that reflect people's views, wishes and beliefs; and

66.5 make decisions and provide services having regard to all of a person's circumstances, and ensure decisions are not based solely on a person's age, disability, etc.

67 This provision is intended to capture the critical areas in which inequity is most evident and longstanding: including inequity in access and outcomes based on ethnicity, disability and setting; inequity in the treatment of physical and mental health; and inequity in diagnosis and care for people with

disabilities. It would recognise that people with different levels of advantage require different approaches and resources to achieve equitable health outcomes. By requiring organisations to have regard to these matters, the legislation would encourage organisations to explicitly take them into account in the performance of their functions, and demonstrate how they have done so, reinforcing the need to consider population health and wider circumstances when making decisions. While this will not tackle biases alone, it should provide helpful statutory support.

68 These principles are not intended to bind individual decision-makers. The requirements should not conflict with clinical judgments on an individual level, and should be balanced against organisations' reasonable legal and financial constraints. However, they should set expectations that guide strategic decisions and improve processes and practices to support equity.

69 The matters noted above are intended to mirror the protections afforded by the UN Convention on the Rights of Disabled People, which was ratified in New Zealand in 2008 and sets out enduring responsibilities to people with disabilities that accord with the vision and aims of our health reforms. In particular, the list of matters reflects the rights in Article 25 of the Convention. I propose that the Bill make an explicit reference to this intention to link visibly to the Convention and augment this area of focus.

Accountability

70 There is a compelling and widely-accepted case for shifting to a more coherent health planning and accountability framework. The Health and Disability System Review found that planning requirements are spread across different legislation and accountability documents with no single nationwide framework that describes how things should work and who should do what. Priorities can be unclear, with multiple direction-setting documents. Planning can be disconnected from budgeting, and focused on the annual cycle and marginal new initiatives and spending, rather than on reshaping health care to reduce inequity, and lift outcomes and value. Te Tiriti o Waitangi principles and consumer voice are not routinely embedded into the determination of priorities or design of plans, with few mechanisms for the system to be accountable to people (including to Māori).

71 We need an approach to system-wide planning and accountability that is coherent, reflects system priorities and outcomes, and links long-term strategic direction with service, capacity planning and resourcing. This requires a clear, formal 'spine' of accountability documents that forms the system architecture for setting and monitoring objectives and directly connect budgets with organisational actions. Moreover, it also requires stronger mechanisms for capturing and embedding Tiriti/Treaty principles and obligations and ensuring that people, communities and iwi partners have meaningful opportunities to engage with and influence priorities.

Core accountability and planning arrangements

Health strategies

72 Current legislation requires two separate strategic documents for the health and disability system: a strategy for health services (the NZ Health Strategy) and strategy for disability support services (the NZ Disability Strategy). The legislative provision for a Disability Strategy will need to be considered as part of work on the September 2021 report back on the future model and governance of disability support services. The new requirements of the Public Service Act 2020 also require three-yearly Long-Term Insights Briefings (LTIB) setting out medium and long term trends, risks and opportunities, along with impartial analysis including policy options, developed independent of Ministers with requirements for public consultation.

73 Beyond these requirements, Governments regularly develop more specific health strategies and policy statements, for example for population groups (Māori, Pacific, disabled people, carers), services (mental health, maternity) or outcomes (person-centred care). These types of strategies have no statutory basis, unless expressly required through Letters of Expectation, and their traction within the health sector can be highly variable.

74 In March, Cabinet agreed that the Minister of Health would issue a Government Policy Statement (GPS) to set a multi-year national direction for the health system, including priorities and objectives for the health system. The advent of the GPS means a need to consider how this vehicle sits with existing (and future) health strategies.

75 It is possible that the GPS, under some approaches, could replace much of the purpose of a comprehensive NZ Health Strategy. Both could be long-term in outlook and identify strategic objectives and priorities; the GPS would then additionally be expected to translate these into more tangible expectations for the coming period. However, it is debatable whether the GPS, focusing as it will on the policy priorities of the Government of the day, would be the right vehicle to consider and address long-term issues and changes in the health system such as the gradual impact of demographic change.

76 There are options about whether to require any specific health strategies or policy statements in the legislation. Inevitably any such requirements could reduce flexibility to adopt different approaches, and indeed explicit requirements of this nature may give the appearance of being exclusive, to the detriment of other topics or groups. However, creating duties to publish certain strategies will ensure an enduring strategic focus on matters that should remain critical to long-term direction and provide a framework for accountability.

77 In my view, there is a case in the future for both a broad and overarching ‘NZ Health Strategy’ and more specific strategies and policy documents that are

developed by governments. I recommend legislating for a duty on the Minister of Health to publish four specific health strategies:

77.1 a New Zealand Health Strategy;

77.2 a national strategy for hauora Māori;

77.3 a national strategy for Pacific health; and

77.4 a national strategy for the health of disabled people.

78 Retaining the requirement for the Minister of Health to produce a NZ Health Strategy would reflect that this should continue to be a key document for overall direction-setting and long-term objectives. I anticipate that this strategy would only require updating infrequently (perhaps every five to ten years). Similarly, requiring a specific strategy for the health of disabled people (as distinct from disability support services) would reinforce the existing focus on this population and place this strategy within the context of the reformed health system. Issues relating to the strategy for disability support services will, as above, be considered in future advice.

79 Requiring two new strategies for Māori and Pacific health would reinforce the Government's commitment to equity and reflect the disproportionate gap in health outcomes for these populations. A hauora Māori strategy would moreover visibly reflect our underpinning Tiriti obligations. I am confident that the case for publishing and maintaining these strategies in their own right is sufficiently robust to warrant making them a legal requirement on the Minister of Health.

80 I expect that in practice most health strategies would be developed by the Ministry of Health, in partnership with the Māori Health Authority. The requirement for joint production should be reflected in the legislation, in the form of an obligation for the Minister to have regard to the advice of the Māori Health Authority. This should be supported by a duty to consult with Health New Zealand, other affected entities, and wider groups as the Minister deems appropriate. Publicly-owned health organisations will be required to give effect to these strategies in line with their functions, as guided where necessary by the GPS.

81 I do not recommend requiring any further national strategies in the legislation: to do so would risk creating a longer list of requirements that would limit the focus and priorities of future Governments. Instead, I recommend legislating for an enabling provision for the Minister to publish strategies or policy statements on any aspect or area of the health system, with the consultation of any affected entities in their development. This would be underpinned by a requirement for Health NZ and other health agencies to give effect to those strategies or statements once published. This additional legal weight would strengthen the basis of these strategies, and could be supplemented where necessary through Letters of Expectation or in specific actions highlighted in the GPS.

Government Policy Statement

82 The Government Policy Statement will be an integral part of the core accountability arrangements for the health system. It will set the Government's requirements and expectations over a multi-year period, which are then to be delivered through the development and implementation of the NZ Health Plan. It will specify national priorities for outcomes and services, and set the basis for monitoring and reporting on progress. Moreover, it will confirm the total funding available for the system over the same timeframe.

83 The publication of the GPS should be a legal duty on the Minister of Health. In practice, I anticipate that the GPS will be developed by the Ministry of Health, as the Minister's agent, with input from the Māori Health Authority, and will be subject to Cabinet approval. I expect that a draft GPS would be produced initially, which would be presented to Health NZ and the Māori Health Authority as the basis for developing or updating the NZ Health Plan. The two documents would then be refined in parallel, so that the priorities and requirements are mirrored and the final GPS is clearly embedded in the Plan. This process would be aligned with budget cycles so that both draft and final GPSs are able to set out available investment.

84 There is precedent for GPSs in legislation in other sectors, although they take different approaches. The legislation on the Housing and Urban Development GPS requires overall directions, priorities and expectations, with no reference to funding. The Transport GPS meanwhile has more specific requirements, particularly in relation to funding, reflecting in part the different nature of transport, with a hypothecated funding stream and a mix of investments.

85 Consistent with the approach towards enabling legislation rather than undue prescription as noted above, I believe there is value in a legislative approach that is closer to the HUD GPS, but that includes some additional elements that are important to supporting a more coherent planning and accountability framework that is connected with budgeting. In particular, the legislation should specify that the GPS will set out the funding level that the system will need to deliver within, and include the framework for regular monitoring of progress and reporting requirements.

86 The Bill should set out these requirements for the GPS. It should also include requirements for consultation, as Ministers deem appropriate. While the health strategies above should be a significant opportunity for consultation, as an accountability document that is linked to Government's priorities, the GPS would be more limited in this respect. All health entities would then be required to give effect to the GPS, with relevant requirements tracking through to the plans of individual organisations.

NZ Health Plan

87 The NZ Health Plan will be part of the core accountability arrangements that will respond to and translate the strategic direction, priorities, outcomes and policy requirements in the GPS into concrete, funded plans for health services and health system capacity. Moreover, the NZ Health Plan will set the principal system configuration, operational frameworks and national service specifications, which will then be implemented at all levels of the system. Its focus and duration will need to align with decisions on multi-year budgets for Vote Health, but I envisage it having at least a 10-year planning horizon.

88 The NZ Health Plan will be co-created by Health NZ and the Māori Health Authority, but I recommend that its scope cover the full publicly-funded health system and include all health Crown Entities (e.g. Pharmac, HQSC, New Zealand Blood and Organ Service) and other public sector organisations (e.g. Cancer Control Agency) to align all entities in a common direction and integrate delivery. Although the content of the plan will inevitably lean heavily towards the actions and responsibilities of Health NZ, this broader scope will ensure that expectations of other entities can be included, and their own accountabilities aligned.

89 Health NZ will be expected to coordinate the development of the Plan as the operational leader of the system, but should be required to consult with those organisations affected and co-develop content related to their functions and responsibilities, to ensure wider ownership of the plan. The plan would not include the Ministry of Health, whose priorities would be set by the Minister in the usual way; however the Ministry should be involved in the development of the NZ Health Plan as the Minister's agent to oversee progress and alignment with the GPS.

90 The timing of the NZ Health Plan will be aligned with Budget processes, and finalised alongside the Government Policy Statement. Funding information based on a multi-year budget will be circulated within the sector to inform planning, in a similar manner to the current funding signal, but in more detail.

91 I envisage that practically the NZ Health Plan will be modular in nature and split into parts: a statutory plan, which must be approved by the Minister of Health; and a series of detailed annexes or modules, which set out planning in much more detail, but are not formally approved by the Minister:

91.1 The statutory NZ Health Plan will set out the key national requirements, service specifications, models of care and enabling activities, to be delivered at all levels of the system. It will include the primary set of expectations that Health NZ and other health entities will be held accountable for delivering, aligning with the expectations set out in the GPS. This part of the NZ Health Plan will be linked to the Budget cycle, so will set out relevant budget information. It will also include the specific measures or indicators that will be tracked over time – reflecting the expectations set in the GPS. It will be signed off by the Health NZ and Māori Health Authority boards, as well as by other health entities (insofar as the plan relates to their functions). The Minister of Health will ultimately approve the statutory NZ Health Plan, to signal satisfaction that it adequately responds to the set of strategic

priorities, policy requirements and expectations set out in the GPS. The Ministry of Health, acting as the agent of the Minister of Health, will monitor the development and delivery of the NZ Health Plan by the relevant entities, with the support of central agencies, Te Puni Kōkiri and the Ministry for Pacific Peoples.

91.2 The second part of the NZ Health Plan will be a much more detailed, modular and dynamic website-based planning environment, including planning for specific services, localities, and enablers, and detailed technical analyses. It will contain a range of 'annexes' or 'modules', each covering a specific part of the health sector (primary and community, hospital and specialist services, mental health, public health), population group (Māori, Pacific people, disabled people) or enabler (facilities and equipment, digital, workforce). These annexes will not ordinarily be signed off by the Minister and their governance would depend on the topic. Health NZ would be the lead agency for maintaining and coordinating this 'planning environment'.

92 I anticipate that Health NZ will engage with the population groups noted above to ensure that the overall Plan and related annexes reflect the priorities of these communities. This would support accountability to those communities and demonstrate a commitment the outcomes that matter to consumers and their whānau.

93 There would also be annexes setting out more detailed information for each of the health Crown Entities, covering Crown Entities Act requirements for Statements of Intent and Statements of Performance Expectations and aligning with the directions and measures in the NZ Health Plan. My aim would be that the NZ Health Plan could be produced in such a way as to meet the requirements of the SOI and SPE for Health NZ (and potentially other publicly-owned health organisations) without requiring further documents, if future entities wished to do so.

94 The Bill should specify the requirements for the statutory element of the plan, including elements of intended content, including population health needs assessment, service and investment requirements for the different levels of the system, financial plans and key performance measures. I do not intend that the legislation should require the content of the second part. Where in practice some individual annexes require closer Ministerial involvement or approval, this should be provided for via other routes such as the GPS.

95 Cabinet has also noted the intention for Health NZ to develop a Māori Health Improvement Plan, to consolidate its priorities and obligations to Māori and form the basis for monitoring of outcomes and objectives, including by the Māori Health Authority. This plan should be clearly linked to the NZ Health Plan, and in effect will draw out and expand Health NZ's requirements in relation to Māori health. As such, I do not expect that the Māori Health Improvement Plan should require explicit provision in statute, but the relevant requirements would be included within the description of the content for the statutory NZ Health Plan. More detailed expectations of Health NZ in developing this plan and agreeing it with the Māori Health Authority would be

set out in the GPS, so that these can be updated over time to ensure a continuous and evolving focus on health improvement for Māori.

96 The Bill should also legislate to create a requirement for Health NZ and the Māori Health Authority to co-develop the NZ Health Plan. The practical and functional means for co-development are subject to ongoing engagement, but my expectation is this should be a joint responsibility, with dual ownership acting as a powerful incentive for agreement. Where issues arise or elements of the plan cannot be agreed by the respective boards, I anticipate that there may be a need for the Ministry of Health to have a supporting mediation role as the system steward, and that ultimately the Minister may be required to broker resolution. However, I do not foresee that this should be necessary, and clearly any such steps would be undesirable. I shall provide further advice on this matter as part of future decisions on the role of the Māori Health Authority.

97 Should government priorities change over the lifespan of the NZ Health Plan, for instance in response to events such as a pandemic, the Minister of the day could re-issue the GPS or an addendum to it as a supplementary tool, depending on the significance and nature of the change. Any such changes should be published to support transparency. Health NZ and the Māori Health Authority would subsequently be required to issue an addendum to the NZ Health Plan that responds to the new priorities (unless the nature of the change was so substantial as to require the plan be revised in its totality). Such changes may also require additional funding or amendments to existing budget plans and to other planning documents. Health NZ would be able to update the annexes/modules, and indeed would be expected to do so over time in line with evolving practice and ongoing review of performance, but would require Ministerial approval for any changes to the statutory plan or other identified areas.

Locality plans

98 Locality plans will be multi-year commissioning plans setting out how each locality will address the needs and priorities of their resident populations. They will be a crucial element of the future system, and the means through which the majority of services that people access are planned and monitored. They will also be a significant focal point of local partnership: with Māori, Pacific and other populations, and with wider social sector organisations.

99 In relation to planning for primary and community health services, locality plans will have a dual focus:

99.1 Locality plans will need to reflect the requirements of the NZ Health Plan, and flow directly from the expectations set in the statutory plan and its annexes. They will cover the current and future state, key interventions to improve population health, outcomes and equity, services to be delivered, provider network arrangements, and funding levels and flows.

99.2 Beyond national requirements, locality plans will critically create space for communities to identify priorities and issues that matter to them, and develop innovative ways to meet goals. Increasingly, I expect that this will inform service design – for example, planning for remote or visiting services, or combinations of services or approaches that suit the needs of a particular community.

100 Initially, national service requirements are likely to be relatively fixed, with correspondingly less flexibility in locality arrangements. Over time, as new arrangements bed in, I anticipate a greater degree of flexibility. This process should expand towards a wider focus on population health and wellbeing that addresses the broader needs of communities, providing a platform for the locality plan to harness the input of social sector partners and integrate service planning and delivery.

101 Given that choices at a locality level will play a critical role in addressing inequities and transforming health outcomes, I believe that legislation should recognise the importance of locality-level service planning. These, like the localities they cover, are integral elements of the system model agreed by Cabinet. I propose that the following requirements be included in the Bill:

101.1 An obligation that Health NZ must prepare a plan for each locality, which must be jointly developed and agreed with the appropriate iwi-Māori partnership board or other vehicle for local Māori voice (subject to engagement on the functions of such boards).

101.2 An obligation that each locality plan must:

i. set out the priority health outcomes, equity targets and services for the locality, for at least the next three years;

ii. meet the requirements of the NZ Health Plan that are relevant to that locality; and

iii. involve social sector agencies and other entities that contribute to population health and wellbeing.

101.3 A provision to be clear that the locality plan may also include priorities and plans relating to other social services that contribute to health and wellbeing, where agreed by the relevant agency.

101.4 An obligation on Health NZ to demonstrate the involvement of communities and priority populations, including iwi, hapū, Māori and Pacific communities and disabled people, in determining priorities for the locality plans.

101.5 An obligation for each plan to be jointly developed and agreed with the appropriate iwi-Māori partnership board or other vehicle for local Māori voice (subject to engagement on the functions of such boards).

102 One of the principles of the locality approach is to respond to the needs of local communities. Ensuring that the health system is accountable locally, as well as through national requirements and monitoring, is important to fostering trust and maintaining the legitimacy of the locality model. Public reporting is a key means of such accountability, through which Health NZ should account for the outcomes achieved and progress against priorities and outcomes. In addition to national avenues for reporting, which are discussed below, I believe that Health NZ should be under a duty to report on the delivery of locality plans, at least annually, to the local populations within that place. The precise format of such communications may vary and would be developed through guidance on best practice.

103 I expect that Health NZ, together with the Māori Health Authority, will develop guidance to support the development of locality plans that embed the requirements and principles of the NZ Health Plan. I also anticipate that locality planning would be overseen by Health NZ's relevant regional commissioning division; this would ensure oversight and alignment between localities within a region, and consistent application of national requirements. I expect the Māori Health Authority would also agree these plans and have regional representation alongside Health NZ to support this. These regional arrangements would also be the main route for escalation of any issues arising in the development and agreement of locality plans (for instance, resolving disputes between parties). I do not however, believe that these oversight arrangements require specific legislation; and indeed it will be a matter for Health NZ and the Māori Health Authority to design the most effective model.

Monitoring and reporting

Monitoring

104 Monitoring against the priorities and plans above will be essential to tracking progress, supporting continuous improvement, identifying and addressing potential risks, and promoting the accountability of entities to the Minister, Parliament and the public. It will also support setting and confirming future direction and performance expectations. These varied responsibilities will require a detailed framework, with clearly defined roles, which should include:

104.1 **System monitoring**: national-level monitoring across the health system, to monitor Te Tiriti obligations, system outcomes and priorities and entities' performance and operations, and to hold individual entities to account in line with their own objectives. This will underpin stewardship by the Ministry of Health, which will remain the monitoring department for health system organisations. It will also include roles for the Māori Health Authority, in particular in respect to its monitoring of the Māori Health Improvement Plan prepared by Health NZ; and for other public sector monitors such as the Treasury, Te Puni Kōkiri, Te Arawhiti and the Ministry for Pacific Peoples.

104.2 **Consistent internal monitoring:** an aligned approach to monitoring performance and outcomes at different levels within the health system.

This will be an operational responsibility for Health NZ in particular, to develop the management framework that enables the oversight of regional, locality and provider performance.

104.3 **Improvement:** supporting a learning environment where the health system is able to identify and disseminate best practice, and support continuous improvement in quality across all services. Monitoring within Health NZ should provide the basis for routine benchmarking of services and outcomes as the foundation for a more effective system-wide approach to improvement.

104.4 **Public reporting:** clear expectations for public reporting of performance information. As well as the statutory reporting to the Minister and Parliament, this should include live performance information.

105 The monitoring framework will largely rely on existing powers in the Crown Entities Act and internal administrative arrangements, so will not require detailed legislation. However, its design and practice will be crucial to how the system is overseen and held to account. I intend to discuss the framework with the group of relevant Ministers later this year.

106 Active and informed monitoring for the purposes of improvement, performance oversight and management requires a regular flow of information. The availability and quality of information at present is highly variable and has significant gaps in major service areas; these reforms provide an opportunity to address these over time both through new systems and mechanisms for sharing information.

107 I expect to set a schedule of data and information requirements that Health NZ and other entities would be mandated to provide to the Ministry of Health (and therefore be made available to other agencies), using the existing power in the Crown Entities Act. This schedule would be attached to the Government Policy Statement, so that it ties clearly to the Government's priorities and demonstrates how these will be monitored. The detail of this schedule will be developed by the Ministry of Health and the Transition Unit, together with other agencies, over the coming months. I expect it will include a mixture of quantitative and qualitative information, including service, financial, and outcomes data, experiential measures and consumer views.

Reporting against objectives

108 I intend the existing organisational reporting requirements for Crown Entities to remain – all entities will continue to be expected to report annually against their Statements of Intent or an equivalent vehicle. This should include explicit reference to entities' Te Tiriti obligations and requirements within the NZ Health Plan, which may comprise the large majority or all of the entity's requirements (as in the case of Health NZ), or may be one part of a broader set of objectives (as in the case of the Health Quality and Safety Commission).

109 For legislation, in addition to annual organisational reporting, there will be a need for more strategic and system-wide reporting on the performance of the system as a whole. This will provide a more coherent and comprehensive report on progress against the New Zealand Health Plan, and support transparency to Parliament and the public on the delivery of the Government's priorities and health outcomes. This report should be led by the Ministry of Health as part of its stewardship role, with involvement from the Māori Health Authority. There would of course also be regular engagement between the Ministry and sector agencies on performance, operations and the delivery of objectives, as part of routine in-year monitoring and reporting.

110 I recommend, therefore, that the Director-General of Health have a statutory duty to prepare an annual report on the performance of the health system, including their perspective as system steward on the sector's progress with delivering the New Zealand Health Plan and achieving health strategies. Like the annual report on the state of public health, this report would be published and tabled in the House. It would supersede the existing requirement in the NZPHD Act on the Minister to report annually on progress in implementing the NZ Health Strategy. Additionally, the Director-General would retain the separate statutory requirement (which sits in the Health Act 1956) to publish a report on the current state of public health. In practice these reports or elements of them may be aligned or consolidated.

Intervention powers

111 The core processes and artefacts described above are intended to set and enable monitoring of the delivery of priorities and underpin accountability in the health system. When the health system is working well, these routine, regular processes, together with a strengthened approach to regular monitoring and oversight, should track progress, identify risk and ensure transparent reporting for outcomes.

112 However, when specific risks or issues are identified, or there is worsening system performance, intervention may be necessary. Responding in such situations requires a carefully-tuned set of soft and hard levers which are both practical (so that they can be used with relative ease) and proportionate (so that they can be tailored to the matter at hand).

113 The starting point for such levers should be relational and reflect the importance of aligned leadership and values across the health system. This includes the soft power of the Minister and Director-General of Health, for example, to convene system leaders, and facilitate and broker solutions to shared problems. Experience has shown that these non-statutory avenues can have a marked success (as demonstrated by coordination of the COVID-19 response), and I expect these to continue to be the default for responding to issues and avoiding escalation wherever possible.

114 Harder, statutory powers are will needed as part of an escalation pathway that identifies steps to be taken and matches the appropriate responses to the risks and circumstances. This pathway should aim to set thresholds for when certain steps may be triggered, to provide clarity to the health system and

help to remove barriers to the use of harder levers where the situation requires them.

115 There is a suite of Ministerial powers under existing legislation which can be used to respond and intervene in the health system. These can be broadly categorised between:

115.1 powers that derive from the Crown Entities Act 2004 and which would therefore apply to Health NZ as a Crown Agent (and potentially also to the Māori Health Authority); and

115.2 powers that derive from the New Zealand Public Health and Disability Act 2000, which should be carried into the new system (with any necessary modifications to ensure fit with the new model), including the direction-making powers. There are some redundant powers, such as the inquiry powers, which were superseded by the Inquiries Act 2013.

116 Moreover, the Director-General of Health also holds specific powers in relation to their statutory role, although these are primarily rooted on public health legislation. As the monitor of the health system, the Director-General exercises significant soft power and leverage over the health system, but has few statutory powers that can be exercised independently to support the exercise of system stewardship.

117 The Bill will need to provide for necessary powers for Ministers and the Director-General to support a broader intervention framework and pathway for escalation. I intend to bring proposals for consultation with relevant Ministers, subject to detailed development work by officials, and recommend that the Minister of Health be authorised to make policy decisions to enable drafting instructions.

Other matters requiring legislation

Consumer voice

118 Embedding the voice of consumers into the day-to-day operations of the future health system is necessary for a system that is going to improve the quality and consistency of care for New Zealanders. Practice in involving consumers in the design of health services is currently sporadic, and must improve.

119 To ensure that the voices of consumers are widely heard by our future health system, I propose to embed some fundamental principles and expectations for how this should happen in legislation. This will both establish new institutions that help magnify the perspectives of New Zealanders, and set clear benchmarks for what good looks like.

120 In particular, I intend that the Bill include:

120.1 a duty on all health agencies to consult and engage with consumers in line with their roles and responsibilities; and

120.2 a power for the Minister of Health to approve a national set of expectations for how consumer voice is gathered and used, with a statutory requirement for health system organisations to give effect to the expectations and report on them.

121 To give effect to this change I am also considering adding to the Health Quality and Safety Commission's statutory objectives:

121.1 to reflect an expanded role in supporting health system organisations to embed consumer and community voice effectively – this would enable the Commission to take steps to become a "centre of excellence" and provide guidance and resources to system entities to support engagement; and

121.2 to require that the Commission support the establishment of a national consumer forum that will act as an umbrella organisation to aggregate consumer voices, support consumer groups and amplify the voices of consumers.

122 These new mechanisms, including national expectations and a consumer forum, will require careful design to meaningfully reflect the diversity of New Zealand's communities and to ensure fit with the new balance of functions and roles in the new operating model. I anticipate that there will be a need for a parallel entity to the national consumer forum to fulfil a similar role for the perspectives of whānau and hapū Māori, which should be designed with input from the Māori Health Authority and iwi-Māori partnership boards. There may also be a case to consider a similar approach for Pacific people.

123 Likewise, the boundaries of the HQSC's role as a centre of excellence for the wider health system and the facilitator of the national consumer forum will require consideration of the extent to which the forum ought to be (and be seen to be) independent from government, specifically in its ability to collect the data necessary to monitor consumer engagement. It will also require consideration of the future resource implications for HQSC.

Transitional provisions

124 The new legislation will require transitional provisions to ensure the business of the health system can continue unimpeded throughout the change. The precise provisions required will become clear as legislation is drafted and decisions made, including by the interim Health New Zealand and Māori Health Authority. I will keep Cabinet informed of any significant provisions likely to be required.

Other policy issues

125 While Cabinet has agreed to the main structural framework of the future health system, there remain a number of policy decisions that will develop the detail of the system model and settings. I anticipate bringing further advice to Cabinet on relevant topics over the coming months, including:

125.1 The function, role and design of the Māori Health Authority, including the governance and process of Board appointments. This work is subject to in-depth engagement with iwi and the Māori health sector, including through the steering group led by Tā Mason Durie.

125.2 The funding model and future funding track for the health system, to ensure sufficient quantum and certainty to enable effective system and service planning, including near-term costs of change and future investment choices to promote sustainability.

125.3 The desired early priorities for the health system, as expressed in a future Government Policy Statement, for example requirements to improve access, reduce waiting times, expand service coverage or set minimum expectations in particular areas or for particular groups such as Māori, Pacific and disabled people. There will be choices for Ministers on how and where to prioritise investment in improving the service offer to the public.

125.4 Early actions and priorities on other critical enablers that are necessary to give effect to the reforms and strengthen the resilience and sustainability of the health system. This may include decisions on system settings and investment in workforce development, digital services and infrastructure, system intelligence, capital asset.

126 Many of these decisions will not require legislation, but relate to the practical operation of functions, processes and relationships that are needed to implement the reformed system. Where legislation is necessary, there will be choices about how and when to do so, with options to deliver in future Bills as part of the medium-term reform objectives.

127 In addition to advice in these planned areas and those matters described in this paper, I expect that the process of drafting the Bill will identify additional policy questions that require rapid resolution. In order to meet the requirements of the compressed timetable for development, I recommend that authority to issue drafting instructions be delegated to the Minister of Health in relation to any such topics that arise, subject to engagement with colleagues.

Disability support services

128 Cabinet has noted that it will receive separate advice on reform proposals regarding disability support services, including the future model and governance of these services, in September 2021. It is likely that some options relating to the future model will require legislation to give effect to them, subject to ongoing policy development. Given the timetable for the Health Reform Bill, I expect that any legislative requirements would require a separate Bill to be taken forward.

Impact analysis

Financial implications

129 Funding to deliver implementation and transition activities has been secured through Budget 21. As planning for transition activities progresses – for example, as decisions are made about the sequence in which functions are created or moved between agencies – reprioritisations within existing Vote Health baselines may be required.

130 s9(2)(f)(iv)

Legislative implications

132 The structural changes to the health system agreed by Cabinet require primary legislation. Cabinet has agreed to use the Health Reform Bill on legislative programme to do this, which has a priority 4 (to be referred to Select Committee in 2021). This paper sets out the intended requirements for that Bill.

Regulatory impact statement

133 The impact analysis requirements apply to this paper. A Supplementary Analysis Report was prepared and attached to a previous Cabinet paper – Health and Disability System Reform: Implementation and Transitional Arrangement [SWC-21-SUB-0080]. The Treasury's Impact Analysis Team considered it met the quality assurance criteria. That analysis covered the structural changes agreed by Cabinet. Further impact analysis will be required for future decisions, in particular decisions relating to the establishment of the Māori Health Authority.

Population implications

134 The new system operating model is expected to have significant benefits for populations who experience poorer health outcomes, especially Māori, Pacific peoples, disabled people, rural communities, LGBTQI+ and people with lower socio-economic status. The phasing of implementation activity has been designed to realise benefits for these groups as early as possible. The new health system will also need to ensure that these groups have confidence in how their interactions with the health system will be planned, delivered and performance monitored.

135 As part of engagement activity, we will proactively seek representation and voice from these communities to ensure their perspectives are reflected in the design of the future health system.

Human rights

136 The proposals in this paper are consistent with, and advance the purposes of, the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

137 The Ministry of Health, the Treasury and the Public Service Commission have been consulted. Their comments are reflected in this paper. The Department of Prime Minister and Cabinet has been informed.

Communications

138 The announcement of the new health and disability system operating model on 21 April 2021 covered key points made in this paper, including the timeframes to establish interim entities to for new legislation to take effect. The decisions and recommendations from this paper may feature in other public communications relating to the reform.

Proactive release

139 I intend to release this paper in accordance with the guidance in Cabinet Office Circular CO (18) 4.

Recommendations

The Minister of Health recommends that the Committee:

Previous decisions

1. **note** that in March 2021 Cabinet agreed to significant reforms to the system structures and operating model, including establishing Health New Zealand to replace the 20 current District Health Boards, creating a new Māori Health Authority, and refocusing the role of the Ministry of Health [CAB-21-MIN-0092 refers]

2. **note** that Cabinet authorised the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office for legislation to give effect to the agreed proposals [CAB-21-MIN-0092 refers]

Approach to legislation

3. **note** that the announced health reforms require significant changes to primary legislation, and the timetable for implementation requires a concerted effort to secure policy decisions, drafting and passage of the new legislation by July 2022

4. **note** my intention that the forthcoming Health Reform Bill should be considered the first of a series of legislative steps, subject to future agreement, to give effect to the Government's broad reform agenda

5. **note** my intention that the Bill should focus on the core requirements for the reformed health system on its first day

6. **note** my intention to repeal and replace the New Zealand Public Health and Disability Act 2000 in its entirety, replicating provisions as appropriate

7. **agree** that wider health regulatory frameworks outside the NZPHD Act 2000, including the Health Act 1956 and Mental Health Act 1992, should be out of scope for this Bill

Health New Zealand

8. **note** that the sub-national administrative arrangements of Health New Zealand will be confirmed through the implementation work led by the interim entities and the Transition Unit

9. **agree** that the legislation provide for the key intended features and expectations in line with Cabinet's previous decisions, including:

    a. an obligation on Health NZ that it must, together with the Māori Health Authority, determine a number of regional divisions for the purposes of commissioning primary and community services and ensuring community engagement, in particular for Māori, Pacific and disabled people

    b. an obligation on Health NZ that it must, together with the Māori Health Authority, determine a number of discrete localities for arranging the delivery of primary and community care services; and that these arrangements must cover all New Zealanders

Māori Health Authority

10. **note** that decisions on the form, governance and functions of the Māori Health Authority have not been made, as engagement with Māori stakeholders is ongoing

11. **note** that the Transition Unit is leading an engagement process with Māori stakeholders, focusing initially on proposals that need to be reflected in legislation

12. **note** ongoing engagement with Māori stakeholders is expected to mean that final Cabinet decisions relating to the legislation for the Māori Health Authority and iwi/Māori partnership boards cannot be made in time for introduction of the Bill in September 2021, and an alternative approach is required

13. **agree** that draft provisions in relation to hauora Māori should be included in the Bill at introduction for completeness, based on feedback from engagement with Māori stakeholders to that point, but the status of these and the expectation that they will be amended should be made clear

14. **authorise** the Minister of Health to make in-principle policy decisions, in consultation with relevant Ministers, and issue initial drafting instructions in relation to the Māori Health Authority, iwi-Māori partnership boards and hauora Māori

Public health

15. **note** that legislation is not required to give direct effect to Cabinet's decisions to establish the Public Health Agency and national public health service, as they will be business units within the Ministry of Health and Health New Zealand respectively; however, it may be prudent to legislate to confirm these arrangements and ensure their prominence

Statutory purpose, goals and principles

16. **agree** that the overall purpose of the Bill should be to provide for the public funding and provision of health services, and establish publicly-owned health organisations in order to protect, promote and improve health and achieve pae ora/healthy futures for all New Zealanders

17. **note** that the legislation will include provisions relating to obligations under Te Tiriti o Waitangi/the Treaty of Waitangi and principles based on those identified by the Waitangi Tribunal

18. **note** that officials are working through the details of these principles and how to give legal effect to the obligations, and I will provide further advice to Cabinet

19. **agree** that the Bill include a general duty on publicly-funded health organisations to undertake best efforts to achieve the priority goals agreed by Cabinet, within each organisation's functions and the funding made available

20. **agree** that this general duty should be supported by specific principles to which organisations must have regard in giving effect to their obligations to promote equity, including:

    a. to ensure equitable health outcomes for all groups, taking into consideration gender, ethnicity, sexuality, condition, disability, place of residence.;

    b. to improve, prevent, diagnose and treat both physical and mental health problems with equal regard;

    c. to provide all people with an equitable range and quality of services;

    d. to provide services that accord with people's views, wishes and beliefs; and

    e. to make decisions and provide services having regard to all of a person's circumstances, and ensure decisions are not based solely on a person's age, disability, etc.

21. **note** that the above principles are intended in particular to reflect the obligations of health entities to consider the matters that drive inequity, in particular for Māori, Pacific and disabled people

22. **agree** that the above provision should make explicit reference to its intention to reflect the concepts within the UN Convention on the Rights of People with Disabilities

Accountability framework

23. **note** in March Cabinet agreed to the following components of the future health accountability and intervention framework (CAB-21-Min-0092):

    a. a Government Policy Statement to set a multi-year national direction;

    b. a national Pacific Health Strategy;

    c. a New Zealand Health Plan that sets out a long-term health service view, defines national service requirements and specifications, and forms the basis for wider planning including for capital, digital, and workforce needs; and

    d. standard monitoring and accountability arrangements as per the Crown Entities Act, alongside some more finely grained intervention powers

24. **agree** to retain the existing requirement for the Minister of Health to determine a New Zealand Health Strategy

25. **agree** to require the Minister of Health to determine a national strategy for hauora Māori

26. **agree** to require the Minister of Health to determine a national strategy for Pacific health

27. **agree** to require the Minister of Health to determine a national strategy for the health of disabled people

28. **agree** to enable the Minister of Health to determine health strategies and policy statements on any other aspect of the health system, require that relevant entities be consulted in their development, and require that publicly-owned health organiations must be give effect to these

29. **note** that the legislation will require that the Government Policy Statement set out system directions, priorities, objectives including measures, expectations, funding and a framework for regular monitoring of progress and reporting requirements

30. **note** that the legislation will require a statutory New Zealand Health Plan, which will set national service requirements, specifications and key activities to deliver the Government Policy Statement and relevant strategies; and that this Plan will be led by Health New Zealand in partnership with the Māori Health Authority, and relate to the whole publicly-funded health system

31. **agree** that the legislation require Health New Zealand to prepare locality plans for each locality, which must be jointly developed with the appropriate iwi-Māori partnership board or other vehicle for local Māori voice (subject to engagement on the functions of such boards)

32. **agree** that the legislation require that each locality plan must:

    a. set out priority health outcomes, equity targets and services for the locality, for at least the next three years

    b. reflect the requirements of the NZ Health Plan that are relevant to that locality

    c. involve social sector agencies and other entities that contribute to population health and wellbeing

33. **agree** that the legislation require Health New Zealand to report at least annually on the delivery of locality plans to local populations within each locality

34. **agree** that the legislation require Health New Zealand to demonstrate the involvement of communities and priority popilations, including Māori and Pacific communities, in the development of locality plans

Monitoring, reporting and intervention

35. **note** the monitoring and reporting framework for Health New Zealand will largely rely on existing powers in the Crown Entities Act 2004 and New Zealand Public Health and Disability Act 2000

36. **agree** that the Director-General of Health have a statutory duty to prepare an annual report on the performance of the public health system and progress with delivering the New Zealand Health Plan

Other matters

37. **agree** that the legislation should make provision for embedding consumer voice in the system, including:

    a. a duty on all health agencies to consult and engage with consumers in line with their roles and responsibilities;

    b. a power for the Minister of Health to approve a set of expectations that specify requirements on organisations in giving effect to the above duty

38. **note** the intention to add to the objectives and functions of the Health Quality and Safety Commission to enable it to be a centre of excellence for the health system on consumer voice, and for it to establish and support a national consumer forum as an umbrella organisation to aggregate consumer voices and amplify the voices of consumers

39. **note** that the approach to a national consumer forum will need to consider how to appropriately represent voices from different communities, and there may be a case for separate approach to represent the voice of Māori communities, whānau and hapū, and Pacific people

40. **note** that, subject to future Cabinet decisions, any agreed reforms to disability support services that require legislation would necessitate a separate Bill to be taken forward

Authorisations

41. **authorise** the Minister of Health, in consultation with the group of relevant Ministers, to make decisions on the statutory intervention powers of Ministers and the Director-General of Health to be included in the Bill

42. **authorise** the Minister of Health, in consultation with the group of relevant Ministers, to make decisions on provisions that clarify public health structures and roles

43. **note** that the group of relevant Ministers referred to above relates to those agreed to be delegated authority for second-order policy decisions [SWC-21-MIN-0080 refers]

44. **authorise** the Minster of Health to issue drafting instructions on other policy matters that arise in developing the Bill, including provisions from the New Zealand Public Health and Disability Act 2000 to be retained, and consequential amendments to other legislation, such as the Health Sector (Transfers) Act 1993

45. **authorise** the Minister of Health to issue drafting instructions to give effect to the above proposals.

Authorised for lodgement

Hon Andrew Little

Minister of Health

Cabinet Social Wellbeing Committee

Minute of Decision

Health and Disability System Reform: Legislative Proposals

Portfolio **Health**

On 7 July 2021, the Cabinet Social Wellbeing Committee:

Background

1 **noted** that in March 2021, Cabinet:

1.1 agreed to significant reforms to the health system structures and operating model, including establishing Health New Zealand to replace 20 District Health Boards, creating a new Māori Health Authority, and refocusing the Ministry of Health's role;

1.2 invited the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office to give effect to the decisions;

[CAB-21-MIN-0092]

2 **noted** that the Health Sector Reform Bill (the Bill) has a category 4 priority on the 2021 Legislation Programme (to be referred to Select Committee in 2021);

3 **noted** that in June 2021, SWC noted the implementation approach and transitional arrangements for the Health and Disability System Reform, and authorised a group of Ministers consisting of the Prime Minister, Minister of Finance, Minister for the Public Service, Minister for Disability Issues, Minister of Health, and Associate Ministers of Health (Hon Dr Ayesha Verrall, Hon Peeni Henare, Hon Aupito William Sio) to make Tier 2 policy decisions as required (Tier 2 Ministerial Group) [SWC-21-MIN-0080];

Approach to Legislation

4 **noted** that the announced health reforms require significant changes to primary legislation, and the timetable for implementation requires a concerted effort to secure policy decisions, drafting and passage of the new legislation by July 2022;

5 **noted** the Minister of Health's intention that the forthcoming Bill should be considered the first of a series of legislative steps, subject to future agreement, to give effect to the broad reform agenda;

6 **noted** the Minister of Health's intention that the Bill should focus on the core requirements for the reformed health system on its first day;

7 **noted** the Minister of Health's intention to repeal and replace the New Zealand Public Health and Disability Act 2000 (NZPHD Act) in its entirety, replicating provisions as appropriate;

8 **agreed** that wider health regulatory frameworks outside the NZPHD Act, including the Health Act 1956 and Mental Health Act 1992, should be out of scope for this Bill;

Health New Zealand

9 **noted** that the sub-national administrative arrangements of Health New Zealand will be confirmed through the implementation work led by the interim entities and the Transition Unit;

10 **agreed** that the legislation provide for the key intended features and expectations in line with Cabinet's previous decisions outlined in paragraph 1 above, including:

10.1 an obligation on Health NZ that it must, together with the Māori Health Authority, determine a number of regional divisions for the purposes of commissioning primary and community services and ensuring community engagement, in particular for Māori, Pacific and disabled people;

10.2 an obligation on Health NZ that it must, together with the Māori Health Authority, determine a number of discrete localities for arranging the delivery of primary and community care services, and that these arrangements must cover all New Zealanders;

Māori Health Authority

11 **noted** that decisions on the form, governance and functions of the Māori Health Authority have not been made, as engagement with Māori stakeholders is ongoing;

12 **noted** that the Transition Unit is leading an engagement process with Māori stakeholders, focusing initially on proposals that need to be reflected in legislation;

13 **noted** that ongoing engagement with Māori stakeholders is expected to mean that final Cabinet decisions relating to the legislation for the Māori Health Authority and iwi/Māori partnership boards cannot be made in time for introduction of the Bill in September 2021, and an alternative approach is required;

14 **agreed** that draft provisions in relation to hauora Māori should be included in the Bill at introduction for completeness, based on feedback from engagement with Māori stakeholders to that point, but the status of these and the expectation that they will be amended should be made clear;

15 **authorised** the Minister of Health to make in-principle policy decisions, in consultation with relevant Ministers, and issue initial drafting instructions to Parliamentary Counsel Office in relation to the Māori Health Authority, iwi-Māori partnership boards and hauora Māori;

Public Health

16 **noted** that legislation is not required to give direct effect to Cabinet's decisions to establish the Public Health Agency and national public health service, as these will be business units within the Ministry of Health and Health New Zealand respectively, however, it may be prudent to legislate to confirm these arrangements and ensure their prominence;

Statutory Purpose, goals and Principles

17 **agreed** that the overall purpose of the Bill should be to provide for the public funding and provision of health services, and establish publicly-owned health organisations in order to protect, promote and improve health and achieve pae ora/healthy futures for all New Zealanders;

18 **noted** that the Bill will include provisions relating to obligations under Te Tiriti o Waitangi/ the Treaty of Waitangi and principles based on those identified by the Waitangi Tribunal;

19 **noted** that the Minister of Health intends to provide further advice to Cabinet on the above principles and how to give legal effect to the obligations once officials have worked through the details;

20 **agreed** that the Bill include a general duty on publicly-funded health organisations to undertake best efforts to achieve the priority goals agreed by Cabinet, within each organisation's functions and the funding made available;

21 **agreed** that the above general duty should be supported by specific principles to which organisations must have regard in giving effect to their obligations to promote equity, including:

21.1 to ensure equitable health outcomes for all groups, taking into consideration gender, ethnicity, sexuality, condition, disability, place of residence;

21.2 to improve, prevent, diagnose and treat both physical and mental health problems with equal regard;

21.3 to provide all people with an equitable range and quality of services, regardless of personal circumstances;

21.4 to provide services that accord with people's views, wishes, and beliefs;

21.5 to make decisions and provide services having regard to all of a person's circumstances, and ensure decisions are not based solely on a person's age, disability, etc.;

22 **noted** that the above principles are intended in particular to reflect the obligations of health entities to consider the matters that drive inequity, in particular for Māori, Pacific and disabled people;

23 **agreed** that the above provision should make explicit reference to its intention to reflect the concepts within the United Nations Convention on the Rights of People with Disabilities;

Accountability Framework

24 **noted** that in March 2021, Cabinet agreed to the following components of the future health accountability and intervention framework:

24.1 a Government Policy Statement to set a multi-year national direction;

24.2 a national Pacific Health Strategy;

24.3 a New Zealand Health Plan that sets out a long-term health service view, defines national service requirements and specifications, and forms the basis for wider planning including for capital, digital, and workforce needs;

24.4 standard monitoring and accountability arrangements as per the Crown Entities Act 2004, alongside some more finely grained intervention powers;

[CAB-21-MIN-0092]

25 **agreed** to retain the existing requirement for the Minister of Health to determine a New Zealand Health Strategy;

26 **agreed** to require the Minister of Health to determine a national strategy for hauora Māori;

27 **agreed** to require the Minister of Health to determine a national strategy for Pacific health;

28 **agreed** to require the Minister of Health to determine a national strategy for the health of disabled people;

29 **agreed** to enable the Minister of Health to determine health strategies and policy statements on any other aspect of the health system, require that relevant entities be consulted in their development, and require that publicly-owned health organisations must give effect to these;

30 **noted** that the Bill will require that the Government Policy Statement set out system directions, priorities, objectives including measures, expectations, funding and a framework for regular monitoring of progress and reporting requirements;

31 **noted** that:

31.1 the Bill will require a statutory New Zealand Health Plan, which will set national service requirements, specifications and key activities to deliver the Government Policy Statement and relevant strategies;

31.2 this Plan will be led by Health New Zealand in partnership with the Māori Health Authority, and relate to the whole publicly-funded health system;

32 **agreed** that the Bill require Health New Zealand to prepare locality plans for each locality, which must be jointly developed with the appropriate iwi-Māori partnership board or other vehicle for local Māori voice (subject to engagement on the functions of such boards);

33 **agreed** that the Bill require that each locality plan must:

33.1 set out priority health outcomes, equity targets and services for the locality, for at least the next three years;

33.2 reflect the requirements of the NZ Health Plan that are relevant to that locality;

33.3 involve social sector agencies and other entities that contribute to population health and wellbeing;

34 **agreed** that the Bill require Health New Zealand to report at least annually on the delivery of locality plans to local populations within each locality;

35 **agreed** that the Bill require Health New Zealand to demonstrate the involvement of communities and priority populations, including Māori and Pacific communities, in the development of locality plans;

Monitoring, reporting and intervention

36 **noted** that the monitoring and reporting framework for Health New Zealand will largely rely on existing powers in the Crown Entities Act 2004 and NZPHD Act;

37 **agreed** that the Director-General of Health have a statutory duty to prepare an annual report on the performance of the public health system and progress with delivering the New Zealand Health Plan;

Other matters

38 **agreed** that the Bill should make provision for embedding consumer voice in the system, including:

38.1 a duty on all health agencies to consult and engage with consumers in line with their roles and responsibilities;

38.2 a power for the Minister of Health to approve a set of expectations that specify requirements on organisations in giving effect to the above duty;

39 **noted** the intention to add to the objectives and functions of the Health Quality and Safety Commission to enable it to be a centre of excellence for the health system on consumer voice, and for it to establish and support a national consumer forum as an umbrella organisation to aggregate and amplify consumer voices;

40 **noted** that the approach to a national consumer forum will need to consider how to appropriately represent voices from different communities, and there may be a case for separate approach to represent the voice of Māori communities, whānau and hapū, and Pacific people;

41 **noted** that, subject to future Cabinet decisions, any agreed reforms to disability support services that require legislation would necessitate a separate bill to be taken forward;

Authorisations

42 **authorised** the Minister of Health, in consultation with relevant Ministers, to make decisions on the statutory intervention powers of Ministers and the Director-General of Health to be included in the Bill;

43 **authorised** the Minister of Health, in consultation with the Tier 2 Ministerial group, to make decisions on provisions that clarify public health structures and roles;

44 **authorised** the Minster of Health to issue drafting instructions to the Parliamentary Counsel Office:

44.1 to give effect to the above decisions;

44.2 on other policy matters that arise in developing the Bill, including provisions from the New Zealand Public Health and Disability Act 2000 to be retained, and consequential amendments to other legislation, such as the Health Sector (Transfers) Act 1993.

Jenny Vickers
Committee Secretary

Present:
Rt Hon Jacinda Ardern
Hon Grant Robertson
Hon Kelvin Davis
Hon Dr Megan Woods
Hon Chris Hipkins
Hon Carmel Sepuloni (Chair)
Hon Andrew Little
Hon David Parker
Hon Poto Williams
Hon Damien O'Connor
Hon Kris Faafoi
Hon Peeni Henare
Hon Jan Tinetti
Hon Dr Ayesha Verrall
Hon Aupito William Sio
Hon Meka Whaitiri
Hon Priyanca Radhakrishnan

Officials present from:
Office of the Prime Minister
Officials Committee for SWC

CAB-21-MIN-0274

Cabinet

Minute of Decision

Report of the Cabinet Social Wellbeing Committee: Period Ended 9 July 2021

On 12 July 2021, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 9 July 2021:

[redacted]

SWC-21-MIN-0107	**Health and Disability System Reform: Legislative Proposals** Portfolio: Health	CONFIRMED

[redacted]

Michael Webster
Secretary of the Cabinet

[IN CONFIDENCE]

Office of the Minister for Health

Cabinet

Pae Ora (Healthy Futures) Bill: approval for introduction

Proposal

1 This paper seeks approval for the introduction of the Pae Ora (Healthy Futures) Bill 2021 (the Bill), which provides for the public funding and provision of health services and establishes publicly-owned health organisations to improve equity, promote and protect health, and achieve pae ora/healthy futures for all New Zealanders.

Background

2 The Government's manifesto and the Speech from the Throne committed to undertaking a long-term programme of reform to build a stronger health and disability system that delivers for all, drawing on the recommendations of the Health and Disability System Review.

3 The proposed reforms fundamentally change the structure of the health system, making it necessary to repeal and replace the New Zealand Public Health and Disability Act 2000 in its entirety, as agreed by Cabinet [CAB-20-MIN-0269 refers].

Establishing new health system entities

4 On 29 March 2021, Cabinet agreed to establish new health system entities to give effect its reform agenda [CAB-21-MIN-0092 refers].

Health New Zealand

5 The Bill disestablishes the 20 district health boards and transfers all DHB assets and liabilities to Health New Zealand. It will be a Crown agent under the Crown Entities Act 2004.

6 Health New Zealand will lead system operations, planning, commissioning, and delivery of health services. This will include owning and operating public hospitals, specialist and community services, as well as commissioning primary and community health services at national, regional and local levels. Health New Zealand will be responsible for monitoring the delivery and performance of services.

7 The Bill requires Health New Zealand to establish localities for the purpose of commissioning primary and community health services and engaging with communities at the appropriate level. Decisions relating to the planning and

commissioning of services are required to be made jointly with the Māori Health Authority.

Māori Health Authority

8 The Bill establishes the Māori Health Authority to drive improvement in hauora Māori. The Authority will be a statutory entity governed by a board. While established by the Bill, it will be subject to parts of the Crown Entities Act for its accountability to the Crown. This includes retaining the powers to require information, review operations and direct the entity to give effect to government policy for the purposes of improving equity of access and outcomes for Māori. Its accountability to Māori will be set out in the Bill and includes a requirement for the Authority to engage with Māori, use that engagement to inform its functions, and report back to Māori on how it has done so. In addition, a key part of these arrangements is the Hauora Māori Advisory Committee (described further below).

9 The key functions of the Authority will be:

9.1 policy and strategy – advice will generally be given through the Ministry of Health, but the Authority will have an explicit power to advise Ministers independently of the Ministry;

9.2 co-commissioning services with Health New Zealand - including jointly working with Health New Zealand to determine national plans and significant service agreements;

9.3 commissioning kaupapa Māori services, and other services aimed specifically at Māori; and

9.4 monitoring the performance of the health system for Māori, including the performance of Health New Zealand against its agreed objectives for hauora Māori.

10 The Bill requires the Minister of Health to establish a Hauora Māori Advisory Committee for the purposes of advising on the exercise of Ministerial powers in relation to the Māori Health Authority. This would include powers such as to make appointments to the board of the Authority, to issue letters of expectation, or to direct the Authority to give effect to government policy. The Minister is required by the Bill to consult this committee before exercising relevant powers.

Iwi-Māori partnership boards

11 The Bill formally recognises iwi-Māori partnership boards in legislation for the first time, to act as vehicles for Māori to exercise tino rangatiratanga and mana motuhake with respect to local planning and decision-making. The Bill lists boards in a schedule which can be altered by Order in Council, on the advice of the Māori Health Authority to the Minister.

12 At the local level, the boards are expected to engage with whānau and hapū, monitor the delivery of health services, and evaluate hauora Māori. They will

have a role in determining local priorities and locality plans with Health New Zealand. The precise nature of this role, and the boards' other functions and powers, will be determined following further work led by the interim Māori Health Authority and subsequent proposals to Ministers. The Bill will not provide for all these matters on introduction, but will be amended by Government following decisions by Cabinet based on the interim Authority's advice. I expect these decisions to be taken by Cabinet in time for amendments to be proposed during the Select Committee process. I will make this intention clear at the time the Bill is introduced.

13 The Māori Health Authority will have a duty to take reasonable steps to ensure each iwi-Māori partnership board has capacity and capability to perform its functions. Additionally, the Māori Health Authority must engage with boards on priorities for kaupapa Māori and other innovative services to support Māori health, so that its national role is informed by the local knowledge held by the boards.

Reform of existing health structures and roles

14 As agreed by Cabinet, the Ministry of Health will be strengthened so that it will remain chief steward of the health system, and be refocused on strategy, policy, regulation, and monitoring.

15 The Public Health Agency is established as a business unit within the Ministry of Health, through an amendment to the Health Act 1956. Te Hiringa Hauora/ Health Promotion Agency is disestablished, with the majority of its operational functions transferred to Health New Zealand, and its policy functions, including alcohol functions and associated levy, placed with the Public Health Agency.

16 Pharmac, the New Zealand Blood and Organ Service, and the Health Quality and Safety Commission will continue to exercise their current functions, subject to the accountability and monitoring requirements in the Bill as set out below. Minor amendments have been made to the functions of the Health Quality and Safety Commission to reflect its new role in supporting consumer and community voice in the reformed system; but no other substantive changes are made to the functions of these entities.

17 The Bill requires the Minister to establish an expert advisory committee on public health. It also strengthens the powers and prominence of the Director of Public Health as a system leader through consequential amendments to the Health Act 1956.

18 The Bill replicates a number of provisions from the New Zealand Public Health and Disability Act 2000 to provide for good running of the health system, including:

18.1 powers to enter into funding agreements and issue notices setting terms and conditions of payment;

18.2 continuation of the New Zealand Disability Strategy and the National Ethics Advisory Committee; and

18.3 certain regulation-making powers.

Providing for strategic, accountability, and monitoring documents

19 The Bill provides for a number of key health system strategic, accountability, and monitoring documents:

19.1 the Government Policy Statement. This is the key requirement from which the rest of the accountability framework cascades. The GPS will set out the government's overall direction, priorities, funding and objectives for the health system, to which health entities must give effect. It must be issued by the Minister at intervals no longer than three years, and may be reissued at any time;

19.2 national health strategies to be determined by the Minister. The New Zealand Health Strategy will provide a framework for the overall medium to long-term direction of the health sector. The Bill also requires the Minister to determine strategies for the health system's response to the health needs of Māori, Pacific people, and disabled people;

19.3 the New Zealand Health Plan. This will set the operational direction for the system and is to be jointly prepared by Health New Zealand and the Māori Health Authority before approval by the Minister. The Health Plan must give effect to the Government Policy Statement;

19.4 locality plans, which will assess health needs at the local level and set out plans for the provision of health services. These plans are to be jointly agreed by Health New Zealand and the Māori Health Authority, with the role of iwi-Māori partnerships to be confirmed through further engagement work;

19.5 the New Zealand Health Charter, issued by the Minister of Health to provide for common values, principles, and behaviours for people within the health system; and

19.6 the Code of Consumer Participation, to be developed by the Health Quality and Safety Commission and issued by the Minister, to support community and consumer participation in the health system and enable the consumer voice to be heard at all levels.

20 The Bill ensures that the current New Zealand Disability Strategy determined under the New Zealand Public Health and Disability Act will remain in force. The new disability health strategy provided for in the Bill will align with existing strategies and international obligations, and will be designed in partnership with disabled people, with a focus on equity of access to all parts of the health system and equitable health and wellbeing outcomes for disabled people. It will include reporting and monitoring on progress with disabled people and

cover all parts of the health system. Further policy work on the future relationship between the New Zealand Disability Strategy and the disability health strategy is underway.

Recognising te Tiriti o Waitangi/The Treaty of Waitangi

21 The Bill gives effect to the principles identified by the Waitangi Tribunal in its Health Services and Outcomes Inquiry (Wai 2575). The relevant provisions are referenced through a descriptive clause setting out the provisions that give effect to the Crown's obligations: for example, the Māori Health Authority is an explicit mechanism to promote equity.

22 This descriptive provision is accompanied by a second clause which sets out principles to guide decision-makers, incorporating the concepts of the Treaty/ Tiriti principles identified by the Tribunal. This places Treaty-informed decision-making at the heart of the system by ensuring that decisions made by health system actors will be genuinely informed by the principles of te Tiriti o Waitangi, and that the legislation will support system-wide accountability for Māori health outcomes.

Outstanding matters for agreement

23 Cabinet has previously agreed that the Bill should include a single set of 'health system principles' to ensure that all actions and decisions in the system are aligned with both the key objectives of the reforms, and the core concepts articulated by the Waitangi Tribunal in its Health Services and Outcomes Kaupapa Inquiry (Wai 2575). These statutory principles are intended to wrap around the specific provisions of the Bill to inform the exercise of all functions or decision-making processes, including those that are not fully prescribed.

24 I now seek Cabinet's final agreement on specific aspects of these principles:

24.1 the application and legal weighting for the principles; and

24.2 the specific reference to "opportunities for Māori to exercise decision-making authority on matters of importance to Māori".

25 Both of these issues are likely to attract specific comment and debate during the Parliamentary process. Further recommendations are described below.

Application of the health system principles

26 Cabinet has previously agreed that the statutory principles in the Bill should apply to all health entities under the legislation – that is, Health New Zealand, the Māori Health Authority, the Health Quality and Safety Commission, Pharmac and the NZ Blood and Organ Service. Additionally, there is a question as to their relevant and application to both the Minister and Ministry of Health in the exercise of their functions.

27 **In relation to the Ministry of Health, I recommend that these principles apply on the same basis as to the health entities**. The principles reflect concepts and considerations that should be an inherent part of the Ministry's role as system steward and lead advisor to Ministers. I do not wish to create the impression of a gap or difference in the principles as they apply to the Ministry, and propose the Bill is explicit in including the Ministry.

28 In relation to the role of the Minister of Health, this is more finely balanced. Although the principles should be considered by the Minister in relation to exercise of his/her functions in a similar way to health entities, the Minister has a much broader role and range of statutory powers. There is a risk that applying the principles to all of the Minister's functions might constrain the ability to use intervention powers when needed in extremis. This may only be in very rare cases where the Minister needs to weigh the requirement to act in the public interest against the interests of specific groups. However, if the application of the principles leads to reluctance or delay in using those powers, this could have unintended consequences. In any event, the Minister is required to seek the input, and in some respects the agreement, of the Hauora Māori Advisory Committee in exercising powers in relation to the Māori Health Authority.

29 Although I am open in principle to extending this provision to the Minister, I believe it is important to be clearer about the nature of any risks here. For this reason, **I do not propose extending the principles to the Minister of Health at this time**, but will retain an open mind pending submissions to the Select Committee on this matter and further work to assess the implications.

Legal weighting for the health system principles

30 The weighting assigned to the principles will define the impact they will have on the actions of health entities under the legislation and the litigation risk associated. Decision-makers must be expected to turn their mind to concepts that are essential for partnership with Māori and the provision of equity, and for the principles must truly inform and influence decision-making. A meaningful weighting is essential, while also playing an important part in shifting the system towards key reform objectives.

31 The possibility of future legal challenges based on the principles is an inherent part of their effectiveness, and such decisions can lead to better processes and outcomes. However, because the Courts operate a bipartite, adversarial process, they are often not well-placed to make complex social trade-offs (such as for resource allocation or service planning). As such, frequent Court interventions may undermine the certainty and integrity of the legislative framework and the wider system.

32 This indicates a need to balance ensuring that the principles are as strong as possible to achieve the intended effect, while not placing duties on entities that are impossible to meet or risking unintended consequences. Having considered these matters, **I recommend that the Bill provide that the health entities and the Ministry of Health "must be guided by" the principles**.

33 "Must be guided by" is relatively novel legal weighting. I intend that it is likely to require substantive weight be given to the principles – such that entities must act on the principles in discharging their functions (not merely consider or have regard to them). When considering the principles against other legitimate factors, it may be the case that those other factors legally carry a greater weight and therefore the entity may have cause to deviate from them. This might be the case, for instance, if they are clear limitations or where the statute specifies it such as the requirement to "give effect to" the Government Policy Statement. This provides some flexibility to respond to the reality of delivering a health system and inevitable trade-offs, but ensures that the principles cannot be disregarded.

34 There is recent precedent for this legal weighting, in particular in legislation that is related to health. For example, the Health Practitioners Competence Assurance Act 2003 requires that regulatory authorities must be guided by certain principles in requiring qualifications. The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 and Human Assisted Reproductive Technology Act 2004 similarly provide that decision-makers must be guided by specified principles.

35 s9(2)(h)

36 In my view, this risk is proportionate and justifiable to provide that most closely matches our intentions and affords the principles a sufficient degree of influence.

37 I have considered a number of potential legal weightings for the principles, including more commonly-used structures such as "have regard to". "Have regard to" means the principles are 'mandatory relevant considerations': in exercising their functions, decision-makers must turn their mind to the principles and give them due weight, but may decide that no weight is to be given in particular circumstances. Only decisions that are clearly unreasonable or based on an error of fact may be overturned, and the court cannot substitute its own decision for that of the entity.

38 This would provide greater control and discretion for health entities, whilst encouraging processes that highlight the relevance of the principles. However, in my view it is too weak a requirement and creates at least the risk of entities routinely disregarding the principles on grounds that may be legally reasonable but which undermine the spirit and aims of the reforms.

39 I have also considered stronger potential weightings, including duties to "act consistently with" or "recognise and provide for" the principles. While these have their merits in terms of creating clear requirements for the principles to drive decision-making, in my view they are inappropriately restrictive on

entities and pose too great a legal risk. A key factor in this judgment is that several of the principles represent broad and aspirational outcomes for the whole system, so that such more substantive weightings could place obligations on some entities that it is difficult for them to meet.

40 As such, I recommend the Bill include a "be guided by" weighting on introduction. **I further recommend that this weighting be clarified in the Bill in two clear ways**:

40.1 that entities must be guided by the principles as far as reasonably practicable, having regard to all the circumstances, including any resource constraints; and

40.2 that entities must be guided by the principles to the extent applicable to each entity and its functions.

41 Neither of these is intended to unduly constrain the application of the principles. Both aim to reflect the natural and proportionate limits on entities' ability to be guided by the principles, in line with their statutory functions and resourcing. I believe it is important to be clear about these matters to give some security to decision-makers on the expectations placed upon them.

Opportunities for Māori to exercise decision-making authority

42 The draft principles clause provided to Cabinet on 20 September proposed that entities would have regard to a principle that "*the health system should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori*".

43 This reference is important in demonstrating the Crown's commitment to incorporating Tiriti principles of partnership and rangatiratanga in the health system. While these principles are primarily recognised in more specific provisions of the Bill (such as the establishment and functions of the Māori Health Authority and iwi-Māori partnership boards), a wider obligation to engage Māori in decision-making is an important part of providing for this at all levels of the system.

44 The phrase 'decision-making authority' is intended to provide for the possibility that some functions or decisions in the health system (outside those prescribed in specific provisions) may warrant joint or delegated decision-making. A good example of this might be the choice of specific target outcomes for a particular service contract. Within the bounds of the New Zealand Health Plan and locality plan and commissioning frameworks, a commissioning agency might make joint decisions with an iwi-Māori partnership board or specific iwi/Māori health entity about those outcomes that relate particularly to Māori, or might delegate authority to make those decisions.

45 At the same time, joint or delegated decision-making will not always be required to achieve Treaty consistency. Entities will need to exercise judgment about the nature and extent of the opportunities they need to

provide under this principle, and that judgment will need to be informed by good faith engagement with Māori. As with the other principles, this judgment involves a level of ambiguity and legal risk, but I consider that risk is both necessary and justified in a reform programme aimed at significantly improving partnership with Māori.

46 **I propose to mitigate the potential for ambiguity without compromising on our objectives by amending this principle** to read:

> *the health system should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori, and for that purpose, have regard to both —*
>
> *(i) the strength or nature of Māori interest in the matter; and*
>
> *(ii) the interests of other health consumers or the Crown in the matter:*

47 I consider the text in (ii) provides clarity that the nature of engagement required for a particular matter (consultation, collaboration, co-design, joint-decision-making or delegation) needs to take into account both the Māori interest in exercising tino rangatiratanga in relation to that matter and the interests of other health consumers or the Crown.

s9(2)(f)(iv)

[redacted]

s9(2)(f)(iv)

s9(2)(f)(iv)

Likely areas of interest at Select Committee

55 Extensive engagement on the shape of the reforms has been undertaken, with a particular focus on partnering with Māori in the design of the provisions relating to hauora Māori. The reform proposals have been generally well received by the broader health sector.

56 The Tiriti/Treaty provisions, mandate of the Māori Health Authority, and role of iwi-Māori partnership boards will drive improved outcomes for hauora Māori and centre te Tiriti at the core of the health system. The Bill aims to strike a balance between providing for tino rangatiratanga and mana motuhake and ensuring a cohesive public health system. Some stakeholders may feel that the hauora Māori provisions go too far, while others may want them to go further.

57 The Bill provides for meaningful community engagement through the use of locality networks and iwi-Māori partnership boards; however some stakeholders may be concerned that disestablishing district health boards will result in reduced community input into local health services. Moreover, the absence of detailed provisions relating to iwi-Māori partnership boards' functions at introduction will need to be carefully communicated to manage the risk of negative reaction, and to point towards decisions to be made based on the advice of the interim Māori Health Authority.

58 I also expect that the committee will have a wide interest in the practical and procedural expectations that underpin the provisions in the Bill, including for instance:

58.1 how the proposed cascade of strategy, planning and accountability documents will work together to improve how the system operates and is monitored;

58.2 the future role of the Ministry of Health;

58.3 how the reformed health system is expected to operate at regional and locality levels; and

58.4 how the transition to the future system will be managed for DHB staff and others transferring around entities.

Impact analysis

59 A Regulatory Impact Assessment has been prepared and was submitted to Cabinet with the paper Health and Disability System Review: Further Policy Decisions [CBC-21-SUB-0095 refers].

Compliance

60 The Bill complies with:

60.1 the principles of the Treaty of Waitangi;

60.2 the rights and freedoms contained in the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993;

60.3 the disclosure statement requirements;

60.4 the principles and guidelines set out in the Privacy Act 2020;

60.5 relevant international standards and obligations; and

60.6 the Legislation Guidelines (2018 edition) maintained by the Legislation Design and Advisory Committee.

Consultation

61 The Treasury, Te Puni Kōkiri, the Public Service Commission, Te Arawhiti, the Ministry of Justice, the Ministry of Health and the Ministry of Social Development have been consulted on this paper.

Binding on the Crown

62 This Bill would bind the Crown.

Creating new agencies or amending law relating to existing agencies

63 Health New Zealand will be a Crown entity. The Māori Health Authority will be a statutory entity, to which parts of the Crown Entities Act will apply. The Official Information Act 1982 and the Ombudsmen Act 1975 will also apply to the Māori Health Authority.

Allocation of decision-making powers

64 The Bill does not allocate decision-making powers between the executive, tribunals and courts.

Associated regulations

65 Regulations will not be required to bring the Bill into operation.

Other instruments

66 The Bill does not contain any provisions empowering the making of deemed regulations.

Definition of Minister/department

67 The Bill does not amend the definition of a Minister or Department.

Commencement of legislation

68 The Bill is expected to come into force on 1 July 2022.

Parliamentary stages

69 The Bill should be introduced into Parliament on 19 October following Cabinet approval, and be enacted by 1 July 2022.

70 I propose that the Bill be referred to a temporary committee, established for the purposes of cross-party consideration of the Bill.

Proactive release

71 I propose proactively releasing this Cabinet paper with appropriate redactions.

Recommendations

The Minister for Health recommends that the Committee:

1 **note** that the Pae Ora (Healthy Futures) Bill holds a category 4 priority on the 2021 Legislation Programme

2 **note** that the Bill provides for the public funding and provision of health services and establishes publicly-owned health organisations to improve equity, promote and protect health, and achieve pae ora/healthy futures for all New Zealanders

3 **note** that officials from the Transition Unit, the Ministry of Social Development, the Office for Disability Issues and the Ministry of Health will undertake further policy work and make recommendations to the Minister of Health and Minister for Disability Issues concerning:

3.1 the relationship between the New Zealand disability strategy and the Disability health strategy; and

3.2 the implications for the Bill of Cabinet's decisions on Disability System Transformation, including the decision to establish a Ministry for Disabled People

4 **agree** the Bill provide for general decision-making principles which should apply to all health entities under the Act and to the Ministry of Health

5 **agree** that the principles should not apply explicitly to the Minister of Health, but to consider whether there is case to extend them in light of submissions to Select Committee

6 **note** that the legal weighting attached to the principles will have a significant influence on the actions of health entities under the legislation and the litigation risk associated

7 **agree** that health entities and the Ministry of Health must be guided by the principles in the exercise of their functions

8 **agree** one of the principles should be that the health system should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori, and for that purpose, have regard to both:

8.1 the strength or nature of Māori interest in the matter; and

8.2 the interests of other health consumers or the Crown in the matter

9 s9(2)(f)(iv) [redacted]

10 **approve** the Pae Ora (Healthy Futures) Bill for introduction, subject to the final approval of the government caucus and sufficient support in the House of Representatives

11 **agree** that the Bill be introduced on 19 October 2021

12 **agree** that the government propose that the Bill be:

12.1 referred to a temporary committee, established for the purposes of cross-party consideration of the Bill;

12.2 enacted by 1 July 2022.

Authorised for lodgement

Hon Andrew Little

Minister of Health

CPC-21-MIN-0024
Revised

Cabinet Priorities Committee

Minute of Decision

Pae Ora (Healthy Futures) Bill: Approval for Introduction

Portfolio **Health**

On 19 October 2021, the Cabinet Priorities Committee, having been authorised by Cabinet to have Power to Act [CAB-21-MIN-0417]:

1 **noted** that the Pae Ora (Healthy Futures) Bill (the Bill) holds a category 4 priority on the 2021 Legislation Programme (to be referred to a select committee);

2 **noted** that the Bill provides for the public funding and provision of health services and establishes publicly-owned health organisations to improve equity, promote and protect health, and achieve pae ora/healthy futures for all New Zealanders;

3 **noted** that officials from the Transition Unit, the Ministry of Social Development, the Office for Disability Issues, and the Ministry of Health will undertake further policy work and make recommendations to the Minister of Health and the Minister for Disability Issues concerning:

3.1 the relationship between the New Zealand disability strategy and the disability health strategy; and

3.2 the implications for the Bill of Cabinet's decisions on Disability System Transformation, including the decision to establish a Ministry for Disabled People;

4 **agreed** that the Bill provide for general decision-making principles which should apply to all health entities under the Crown Entities Act 2004 and to the Ministry of Health;

5 **agreed** that the principles should not apply explicitly to the Minister of Health, but consider whether there is a case to extend them in light of submissions to Select Committee;

6 **noted** that the legal weighting attached to the principles will have a significant influence on the actions of health entities under the legislation and the litigation risk associated;

7 **agreed** that health entities and the Ministry of Health must be guided by the principles in the exercise of their functions;

8 **agreed** one of the principles should be that the health system should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori, and for that purpose, have regard to both:

8.1 the strength or nature of Māori interest in the matter; and

8.2 the interests of other health consumers and the Crown in the matter;

9 s9(2)(f)(iv) [redacted]

10 **approved** for introduction the Pae Ora (Healthy Futures) Bill [PCO 23441], subject to the work referred to in paragraph 9, the final approval of the government caucus, and sufficient support in the House of Representatives;

11 **agreed** that the Bill be introduced on 20 October 2021;

12 **agreed** that the government propose that the Bill be:

12.1 referred to a temporary committee, established for the purposes of cross-party consideration of the Bill;

12.2 enacted by 1 July 2022.

Jenny Vickers
Committee Secretary

Present:
Rt Hon Jacinda Ardern (Chair)
Hon Grant Robertson (Deputy Chair)
Hon Kelvin Davis
Hon Dr Megan Woods
Hon Chris Hipkins
Hon Carmel Sepuloni
Hon Andrew Little
Hon David Parker
Hon Nanaia Mahuta
Hon Poto Williams
Hon Damien O'Connor
Hon Stuart Nash
Hon Kiri Allan

Officials present from:
Office of the Prime Minister
Officials Committee for CPC
Crown Law

CAB-21-MIN-0417

Cabinet

Minute of Decision

Pae Ora (Healthy Futures) Bill: Approval for Introduction

Portfolio **Health**

On 18 October 2021, Cabinet:

1 **referred** the submission *Pae Ora (Healthy Futures) Bill: Approval for Introduction* [CAB-21-SUB-0417] to the Cabinet Priorities Committee (CPC) on 19 October 2021 for further consideration;

2 **authorised** CPC to have Power to Act to take decisions on the submission.

Michael Webster
Secretary of the Cabinet

CAB-21-MIN-0427

Cabinet

Minute of Decision

Report of the Cabinet Priorities Committee: Period Ended 22 October 2021

On 26 October 2021, Cabinet made the following decisions on the work of the Cabinet Priorities Committee for the period ended 22 October 2021.

[redacted]

CPC-21-MIN-0024	**Pae Ora (Healthy Futures) Bill: Approval for Introduction** Portfolio: Health	CONFIRMED

[redacted]

Michael Webster
Secretary of the Cabinet

~~[In Confidence]~~

Office of the Minister of Health

Social Wellbeing Committee

Health and Disability System Review – further policy decisions for the Health Reform Bill

Proposal

1 This paper seeks agreement to further legislative proposals for inclusion in the Health Reform Bill which will give effect to the reformed health system.

Relation to Government priorities

2 The Government's Manifesto and the Speech from the Throne committed to undertaking a long-term programme of reform to build a stronger health and disability system that delivers for all, drawing on the recommendations of the Health and Disability System Review.

Executive summary

3 Cabinet has previously considered and agreed to specific proposals to legislate for the Government's health reforms, including in relation to the internal structures of Health New Zealand and key governance and accountability arrangements such as the Government Policy Statement and New Zealand Health Plan.

4 My previous advice anticipated at least four further policy areas for Cabinet to consider before a Bill is finalised, which are the subject of this paper:

4.1 the approach to legislating for Te Tiriti o Waitangi obligations;

4.2 the role, functions, form and accountabilities of the Māori Health Authority, and the constitution of iwi-Māori partnership boards;

4.3 statutory intervention powers; and

4.4 provisions to give effect to public health structures and roles in the reformed system.

Te Tiriti o Waitangi provisions

5 Cabinet has previously agreed that the legislation place obligations on health sector entities by including a Tiriti o Waitangi clause that gives effect to the principles identified by the Waitangi Tribunal in its Wai2575 Health Services and Outcomes Kaupapa Inquiry [CAB-20-MIN-0092].

6 I propose to give effect to this decision through two sections of the legislation. First, a descriptive clause that sets out the provisions of the Bill that give effect to the Crown's obligations under Te Tiriti o Waitangi, such as those relating to the

establishment of the Māori Health Authority. Second, a clause setting out decision-making principles to guide health entities in the new system, incorporating the concepts of Te Tiriti o Waitangi principles identified by the Tribunal.

7 In my view, reflecting Te Tiriti in this way will have two benefits. The descriptive clause will highlight the specific provisions of the legislation that give effect to the Tiriti relationship, while incorporating the concepts of the principles within the general decision-making guidance will put Te Tiriti o Waitangi-informed decision-making at the heart of the reformed health system.

Māori Health Authority and iwi-Māori partnership boards

8 Cabinet has previously agreed that the Māori Health Authority will have policy, strategy, planning, commissioning, co-commissioning, and monitoring roles, and that its design would be undertaken through engagement with Māori. The Transition Unit has consulted and partnered with Māori stakeholders and the Māori health sector in the design of system settings for hauora Māori, including for the Māori Health Authority and iwi-Māori partnership boards.

9 I recommend that the Authority's policy and strategy roles focus on matters relevant to hauora Māori, and that it be required to co-develop and give effect to the New Zealand Health Plan. The Authority should be able to independently advise the Minister of Health, be responsible for commissioning kaupapa Māori and other services tailored to Māori, and co-commission all other health services with Health New Zealand. I intend a dispute resolution mechanism to resolve issues that may arise through these responsibilities.

10 A bespoke entity form will be required to achieve this range of functions and to balance accountabilities to Ministers with those to Māori. I recommend that the Authority be established in the Health Reform Bill as a statutory entity, but not a Crown entity. It should be governed by a board and subject to elements of the Crown Entities Act 2004, but with some modifications. Significantly, I propose the establishment of a standing statutory advisory committee, the Māori Health Advisory Committee, and codifying a requirement for the Minister to seek the advice of the committee when exercising key powers.

11 I also propose statutory mechanisms to require the Authority to consider, act on, and report back on Māori aspirations and needs to inform how it delivers its functions, with provisions to reinforce reporting accountabilities for the Authority to Māori, similar to those to the Minister of Health. This approach will provide a balance to the powers of Ministers, by ensuring that the Authority employs its operational autonomy to give effect to Māori aspirations and needs, while remaining aligned with other health entities and structures.

12 Iwi-Māori partnership boards are a part of the current health landscape, and have existed for more than twenty years as partners to district health boards. While some have developed mature and active relationships with their DHB with influences on planning and commissioning, the partnership boards have no formal role and are not recognised in legislation, meaning that their impact can be highly variable.

13 In the future system, Cabinet has agreed that iwi-Māori partnership boards will have a stronger role in shaping locality priorities and plans, as the key Tiriti partner to Health New Zealand. Iwi groups, hapori and mātā waka in their areas must have the opportunity to participate. The boards will have a role in agreeing local priorities and locality plans with Health New Zealand and the Māori Health Authority, and the relevant annual locality report by Health New Zealand. Moreover, I expect iwi-Māori partnership boards will engage with whānau and hapū, assess and evaluate hauora Māori in their localities, engage with the Authority on their priorities for kaupapa Māori innovation, and report to Māori in their areas on their activities and the state of Māori health and wellbeing locally.

14 At this stage, I do not propose to legislate to prescribe a composition or a full range of statutory powers and functions for the boards – the boards are Māori bodies and it is up to Māori, working through the Māori Health Authority, to determine the detailed form and activities. However, it is appropriate in this paper to express my expectation of what those functions and powers might be. Legislation will, however, need to recognise the iwi-Māori partnership boards in order to provide for them. To do so while maintaining flexibility, I propose that each board be listed in a Schedule to the Bill, amendable by notice from the Minister of Health and subject to the advice of the Māori Health Authority. I also intend that the Māori Health Authority be required to offer support to the boards to carry out their functions and develop their capability. This support may be administrative, analytical or financial, and will be primarily provided by the Māori Health Authority, reflecting the partnership between the boards and the Authority. Health New Zealand will also have a key role in supporting and maintaining the boards and ensuring positive relationships.

Statutory intervention powers

15 Most of the statutory intervention powers required for the Minister of Health and the Director-General of Health will derive from the Crown Entities Act. The Act will apply to Health New Zealand as a Crown agent, and I recommend that certain powers also apply to the Māori Health Authority, although to be exercised in consultation with the Māori Health Advisory Committee.

16 Further, I intend to carry over powers from the New Zealand Public Health and Disability Act 2000 relating to entering into funding agreements, replacing an entity's board with a commissioner and the power for the Minister of Finance to require information. I also propose certain new powers in the Bill to provide for intermediate steps as part of a transparent escalation pathway, including allowing for the Minister to appoint Crown observers and require an improvement plan, and providing that the Director-General may require information from an entity.

Public health structures and roles

17 To ensure the Public Health Agency can exercise all necessary functions and strengthen its leadership of the national public health system, I intend the Bill to amend the Health Act 1956 to require the establishment the Agency as a business unit of the Ministry of Health. I also intend it to require the establishment of a permanent Public Health Advisory Committee and make small changes to strengthen the powers and prominence of the Director of Public Health as a system leader.

18 Beyond the matters referred to in this paper, I expect that further matters may arise in respect of the legislation requiring urgent decision. I anticipate that all such decisions should be made by the Minister of Health, in consultation with relevant Ministers, within the scope of Cabinet's existing authorisation.

19 Subject to Cabinet's agreement, the Transition Unit will continue to work to develop the Bill at pace, with the intention of supporting consideration of the Bill by Cabinet Legislation Committee by the end of September 2021. However, given the current COVID-19 situation and implications for Cabinet and Parliamentary timetables, it may not be possible to meet these planned timelines. The Transition Unit has prepared a number of contingencies, including to manage to a short delay to introduction, and I will advise Cabinet in due course should alternative steps be necessary.

Background

20 On 29 March 2021, Cabinet agreed to reform the health system to achieve a vision of pae ora/healthy futures for all New Zealanders [CAB-21-MIN-0092 refers]. Cabinet subsequently considered and agreed to specific proposals to legislate for the health reforms [SWC-21-MIN-0107 refers].

21 Cabinet's previous decisions on the Health Reform Bill anticipated that there would be further matters to confirm in advance of introduction. These include:

21.1 the approach to legislating for Te Tiriti o Waitangi obligations;

21.2 the role, functions, form and accountabilities of the Māori Health Authority, and the constitution of iwi-Māori partnership boards;

21.3 statutory intervention powers; and

21.4 provisions to give effect to public health structures and roles in the reformed system.

22 This paper seeks Cabinet's agreement on the outstanding matters listed above in order that the Bill can be prepared for approval and introduction.

Te Tiriti o Waitangi provisions

23 Cabinet has agreed that the legislation place obligations on health sector entities by including a Tiriti o Waitangi clause that gives effect to the principles identified by the Waitangi Tribunal in its Wai2575 Health Services and Outcomes Kaupapa Inquiry [CAB-20-MIN-0092]. These principles specifically relate to tino rangatiratanga, partnership, active protection, options and equity.

24 The Government's health reforms are intended to achieve equity for Māori. The principles of Te Tiriti o Waitangi will guide decision-making across the system. The Māori Health Authority is an expression of the Crown's obligations under Te Tiriti, but it is a part of the whole system which, in all its working parts, must contribute to achieving equity. The policy objective of including Tiriti references in the legislation is, consistent with the desire for more contemporary approaches on this point, to be clear cut about the intention of the provisions, and to ensure

that decision-makers within the system take them into account and implement them appropriately.

25 Generally speaking, legislation with Te Tiriti o Waitangi provisions expresses these in one of two ways: a general operative clause which expresses an obligation in respect of the manner in which legislation is to be administered, and a descriptive form, which outlines specific mechanisms by which Te Tiriti is recognised in the legislation. The two forms reflect different policy choices. The general form aims to ensure delegated decision-making has due regard to the Tiriti principles. The descriptive form highlights the specific mechanisms established by Government to give effect to Tiriti principles.

26 I have carefully considered these issues, including through engagement with Māori while designing new system features. In my view, the legislation should be clear that the provisions relating to, for example, the Māori Health Authority, are intended to address the Government's Tiriti obligations. At the same time, most decisions within the health system that impact on hauora Māori will continue to be made at an operational level, rather than by Ministers, and it is important for those decisions to be informed by the Tiriti relationship.

27 There is a large number and variety of decisions made in the health system every day, at different levels. Overall prioritisation and resource allocation will be made through the new mechanisms in the legislation – in particular the New Zealand Health Plan, on which the Māori Health Authority and Health New Zealand must agree. Iwi-Māori partnership boards will have a critical role in the process for settling locality plans for primary and community care to ensure the plans reflect local needs and priorities..

28 Given the variety of decisions and the need for system integrity, and the upfront effort in the planning framework to make tough trade-offs, I consider that individual decisions in the system should be informed by Treaty obligations, but do not consider that every decision should be widely or unpredictably subject to judicial interpretation or review on that basis.

29 With this in mind, **I consider Cabinet's intent is best given effect through a third approach**:

29.1 **A descriptive Tiriti o Waitangi provision** which recognises and reflects how the legislation provides for Māori interests and rights under Te Tiriti o Waitangi. This would include the establishment of the Māori Health Authority, the provisions relating to iwi-Māori partnership boards, and relevant requirements relating to consultation on all entities, for example.

29.2 **A separate provision setting out decision-making principles to which all health entities in the Act would be required to have regard in pursuing their functions**. This provision would adopt the concepts of the Te Tiriti principles identified by the Tribunal within a suite of decision-making principles for the health system overall, also incorporating the key system priorities and equity principles previously agreed by Cabinet. This approach is more fully described in **Annex One**.

30 In my view, it would be far simpler and more powerful to legislate for one set of statutory principles rather than having competing principles whose relative standing may be unclear. There is significant conceptual overlap and a number of individual principles (e.g. partnership, equity) that occur more than once. s9(2)(h)

31 For example, as one of the principles I anticipate that decision-makers would be required to have regard to the need to ensure equity, which might then be described to include addressing equity of access, quality and health outcomes between different populations in, and different regions of New Zealand, with particular focus on addressing the disparity in health outcomes for Māori. This is more fully explained in **Annex One**. Because the statutory principles are intended to influence operational decision-making in the health system, I do not intend that they would explicitly apply to the Minister or Ministry of Health. However, both would continue to be bound by the Crown's obligations under Te Tiriti o Waitangi.

32 This approach is novel and I consider it has the greatest potential to achieve equity for Māori by employing a blend of general and descriptive provisions. **Annex One, Appendix C** includes an outline of intended drafting of principles, which has been developed by the Transition Unit following initial input from the Crown Law Office, Te Arawhiti, Te Puni Kōkiri, and the Ministry of Justice. Any issues with final drafting will be addressed with Ministers prior to or as part of the Cabinet paper seeking introduction of the legislation.

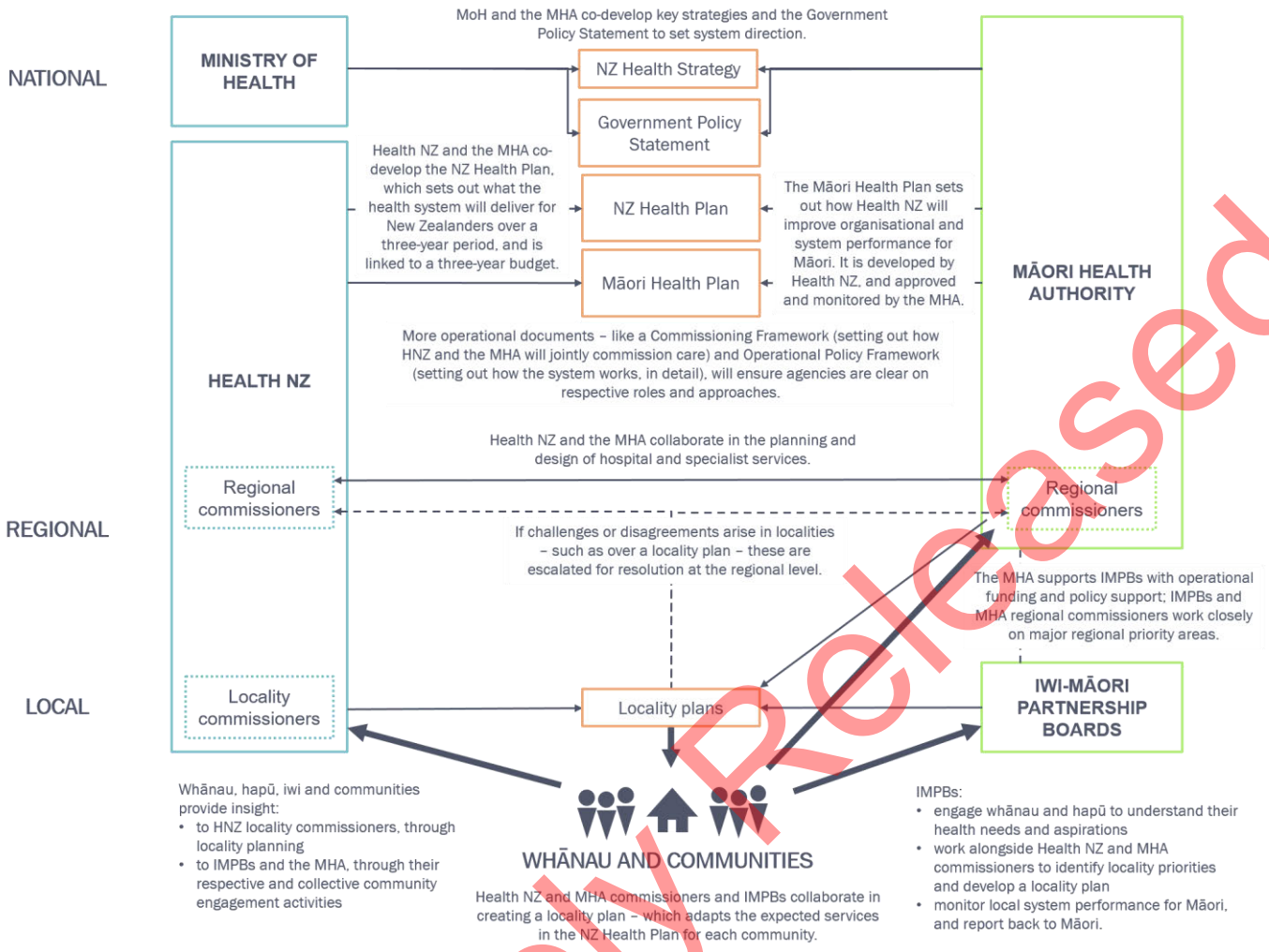
33 Moreover, the legislative provisions will need to be supplemented with operational policy frameworks and resources, such as protocols and best-practice guidance to assist all levels of the new system to support the Crown in meeting its obligations.

34 s9(2)(h)

Legislating for institutions to support hauora Māori

35 A key measure of success for the Government's health reform programme will be the ability to demonstrate system-wide improvements for hauora Māori and shared accountability for these gains across the system. All entities will need to take action to support the Crown in meeting its obligations under Te Tiriti o Waitangi and to strengthen Māori health equity and outcomes.

36 Central to our approach are the establishment of the Māori Health Authority and positioning iwi-Māori partnership boards to play a greater role in shaping national, regional and local planning for hauora Māori [CAB-21-MIN-0092 refers]. The broad structures and relationships envisaged in the operating model for hauora Māori, based on previous Cabinet decisions and the fuller proposals set out in this paper, are illustrated in the diagram below.



37 Cabinet agreed that the design of the Māori Health Authority would be undertaken through engagement with Māori. The Transition Unit has consulted and partnered with Māori stakeholders and the Māori health sector in the design of future system settings for hauora Māori, including those for the Māori Health Authority and iwi-Māori partnership boards. This has included:

37.1 establishing a Steering Group chaired by Tā Mason Durie, one of the roles of which has been to provide advice on accountabilities of the Māori Health Authority to Māori in the future health system. This advice has informed the proposals in this paper;

37.2 engaging with Māori through 30 hui across New Zealand to seek input on the reforms, and further decisions to come on approaches to the Māori Health Authority and iwi-Māori partnership boards; and

37.3 considering insights from the Ministry of Health's Hui Whakaoranga series, which has also engaged with Māori nationwide.

38 Cabinet authorised the Minister of Health to make in-principle decisions on the Māori Health Authority, iwi-Māori partnership boards, and hauora Māori in consultation with relevant Ministers [SWC-21-MIN-0107 refers]. This authorisation reflected the concern that there might be insufficient time to design these features in partnership, and the need to engage openly and fairly and not

rush engagement to suit the Crown's timetable. This anticipated introducing indicative provisions, and asking the Health Committee to pay particular attention to them in its consideration of the Bill.

39 In practice, this risk has not arisen and the Steering Group led by Tā Mason Durie has worked highly effectively to inform the accountability features of the Māori Health Authority.

40 Engagement with Māori to date has indicated a cautious optimism for the reforms, including the proposed approach to the respective roles and functions of the Māori Health Authority and iwi-Māori partnership boards. These engagements have emphasised a desire for the Māori Health Authority to have mana and real power, and to act as a vehicle for enabling rangatiratanga and mana motuhake.

The Māori Health Authority

41 Based on the decisions to date, the Māori Health Authority (the Authority) will be tasked with driving hauora Māori improvement in the new system, both through its own actions and through monitoring of the system as a whole. It will be one of the key mechanisms through which Te Tiriti o Waitangi principles will be embedded in the system, and will hold dual accountabilities which drive decisions about its functions and form:

41.1 the Authority should be accountable to whānau, hapū, iwi and hapori Māori, to represent and embed their voice, aspirations and needs throughout the system and support partnership at all levels; and

41.2 the Authority should be accountable to Ministers, reflecting its position in the public service, the health system, and its funding by the Crown.

Functions of the Māori Health Authority

42 Cabinet has previously agreed that the Authority will have policy, strategy, operational planning, commissioning, co-commissioning, and monitoring roles [CAB-21-MIN-0092 refers]. **To give effect to these roles, after consultation with relevant Ministers, I recommend that**:

42.1 the Authority's policy and strategy roles focus on matters relevant to hauora Māori. This should include the Māori Health Strategy as a major focus, and the New Zealand Health Strategy, other strategies, frameworks and plans that relate to or impact on hauora Māori. I expect that this should recognise the Government's current hauora Māori strategies and plans, including He Korowai Oranga: the Māori Health Strategy 2014, and Whakamaua: the Māori Health Action Plan 2020-2025, as the starting point;

42.2 the Authority be able to independently advise the Minister of Health, but generally provide advice in partnership with the Ministry of Health;

42.3 the Authority be responsible for commissioning kaupapa Māori services, other innovative services tailored for Māori, and Māori provider and workforce development;

42.4 the Authority act as a co-commissioner of primary and community-based care alongside Health New Zealand. This means that the Māori Health Authority and Health New Zealand will work in partnership to identify health needs and plan, contract for, manage and monitor health services. In relation to hospital and specialist services, which are not directly commissioned but are managed and provided by Health New Zealand, this will include partnering with Health New Zealand in planning and monitoring of these services. It will further include the joint development of, and responsibility for, plans (including the NZ Health Plan and locality plans), operational mechanisms (such as commissioning and performance frameworks) and all health services commissioned and delivered by the health system; and

42.5 as such, the Authority be required to give effect to the NZ Health Plan. Once developed and agreed in partnership with Health New Zealand (and approved by the Minister of Health), the NZ Health Plan will determine the services and enablers the health system will deliver and will determine funding to deliver those services and enablers.

43 To give effect to these roles and powers, the Authority will hold a significant budget. It is appropriate therefore that accountability requirements, including annual reporting and issuing a statement of intent and statement of performance expectations, equivalent to those required of Health New Zealand, also apply to the Authority. This is discussed further below.

44 The commissioning and co-commissioning roles of the Māori Health Authority are among its more novel and significant functions. These roles go beyond the Health and Disability System Review proposals to include wider functions:

44.1 Direct commissioning powers (i.e. not necessarily in partnership with Health New Zealand) in relation to innovative Māori-focused services and kaupapa Māori services. This is intended to stimulate new Māori approaches to hauora Māori challenges and opportunities; over time, those initiatives which prove successful would become part of the general health system.

44.2 Co-commissioning powers over the full range of health services commissioned by our health system. This means that the Māori Health Authority and Health New Zealand will jointly develop major plans, such as the NZ Health Plan and the plan for each locality, and that they will also make joint decisions on the planning, funding, contracting and monitoring of services. This extends to both primary and community-based care, and hospital and specialist services, and provider and workforce development.

Legal form of the Māori Health Authority

45 Given the mix of policy and strategy, commissioning and co-commissioning, monitoring, and the dual accountability functions the Authority will have, it will require an entity form that is bespoke and unlike existing health system organisations.

46 It will be important for the Authority to have a clear mandate to hear and understand the views, aspirations and needs of Māori, act on them through its activities, and to be accountable to Māori for its performance. Key to this is the Authority's work and relationship with iwi-Māori partnership boards, which provide local context and insights on priorities and system performance on the ground. At the same time, it will be necessary for the Authority to work in partnership and alignment with other entities in the system, particularly with respect to developing, agreeing and delivering on key plans with Health New Zealand.

47 The absence of this alignment could lead to fraught co-commissioning and deadlock, wherein the Authority seeks to co-commission services which are outside the policy direction provided to Health New Zealand by the Minister. Disagreements requiring Ministerial intervention could be much more likely.

48 I have considered options for establishing the Authority under the Crown Entities Act (as either a Crown agent, an independent Crown entity, or an autonomous Crown entity). In my view, none of these is an ideal fit for the unique nature of the Authority. Both the autonomous and independent Crown entity models confer a level of distance from Government, however in so doing both would create risks for an entity which is a commissioner and co-commissioner of health services and which must operate in common frameworks with its partners. The Crown agent model meanwhile, whilst more closely aligned to Government policy, suggests a much smaller role for Māori priorities and aspirations than is intended by the Authority's design. Although this model is flexible and could accommodate requirements for accountability to Māori, in my view it would risk the appearance of the Authority being established as too heavily weighted in favour of Government.

49 There would be some advantages to using a standard form such as a Crown agent, which would be well understood by Parliament and which would reflect the Authority's accountabilities to Ministers. However, these advantages would be outweighed by significant presentational and practical disadvantages. Moreover, such a form would undermine the cautious support from Māori based on engagement to date.

50 Given this consideration, **I recommend that the Authority be established in the Bill as a statutory entity, with mechanisms from the Crown Entities Act referenced as part of its organisational form, but would not be a Crown entity**. This would be clear that the Authority is a unique statutory organisation, with a form that reflects its intended role and purpose and is not established under the Crown Entities Act. This would be similar in some respects to the approach taken to legislating to establish Te Mātāwai by Te Ture mō Te Reo Māori/the Māori Language Act 2016, which is an independent statutory entity with bespoke Māori governance arrangements. However, given the nature and role of the Māori Health Authority, I believe it requires a novel approach.

51 In my view, this approach would offer freedom to the Authority to give effect to the aspirations and needs of Māori, for example, through incorporating hauora Māori aspirations and needs into system strategies and plans, the advice it provides to the Minister, and how services are planned, funded and managed. At the same time, it would allow it to maintain alignment and partnership working

with other health entities by providing for a common system architecture to be applied.

52 This approach would also allow for sensible practical and administrative provisions under the Crown Entities Act to be applied, to avoid undue complexity and recognise the Authority as part of the wider public service. These may include provisions such as in relation to behaviour and integrity, and the role, duties and accountabilities of the board. **I recommend that the precise administrative provisions of the Crown Entities Act to be applied to the Authority are agreed by the Minister of Health in consultation with the Minister for the Public Service**. I also expect the Official Information Act 1982 and Ombudsman Act 1975 to apply to the Authority similarly as part of its public service responsibilities.

53 In relation to the Ministerial powers under the Crown Entities Act and how these would apply to the Authority, the sections below set out my proposals for directive and intervention powers. In addition, I recommend that the Authority be bound to wider duties in relation to accountability to Māori, as outlined below.

Accountability to Māori

54 A distinguishing feature of the Authority is its accountability to Māori. **I propose statutory mechanisms to require the Authority to consider, act on and in accordance with, and report back on Māori aspirations and needs, to inform how it delivers its functions.**

55 I propose that this requirement also extends to engagement with Māori organisations, including iwi-Māori partnership boards, iwi authorities, rūnanga and trust boards, Māori health providers and professionals' organisations, and representatives of whānau and hapū as appropriate. This approach was recommended by the Steering Group as a means of ensuring accountability to Māori.

56 While this obligation will apply generally to all of the Authority's functions and be deliberately flexible (i.e. without specifics of form and frequency of engagement set in legislation), **I further recommend legislating for specific areas where the Authority should be required to have regard to the needs and aspirations of Māori:**

56.1 Co-developing and signing off the New Zealand Health Strategy, and other health strategies (such as the Māori Health Strategy), and the NZ Health Plan.

56.2 Preparing the Authority's statement of intent, and other performance documents such as an annual statement of performance expectations (recognising that in time these requirements are intended to be given effect to by the NZ Health Plan).

56.3 Developing expectations for Health New Zealand to strengthen organisational performance for Māori.

57 Collectively, these provisions are intended to provide for clear reporting accountability to Māori, parallel to those the Authority has to the Minister of

Health. They would also support Te Tiriti obligations by demonstrating how the legislation will reinforce principles of tino rangatiratanga and partnership through the duties on the Authority. This approach also provides a balance to Ministerial directive powers, by ensuring that the Authority employs its operational autonomy to give effect to Māori aspirations and needs, while remaining aligned with other health entities and structures. This element was highlighted as key to the Authority's success by the Steering Group.

Governance arrangements

58 A broad strategic and operational remit, and accountability to Māori, means the Authority will be in a unique position compared to other entities in the health system. This will require the Authority to blend the interests and priorities of Māori and the Crown across a range of functional areas and partner with other system entities in undertaking many of its functions; remaining anchored in hauora Māori aspirations and needs while recognising that it does not have the mandate from iwi to be Te Tiriti o Waitangi partner to the Crown.

59 The Authority should be led by a board to help it navigate this balance and have robust governance mechanisms in place. Additionally, however, I propose that the usual role of the Minister in appointing members to this board be complemented by a process which ensures Māori advice and influence over appointments (and removals).

60 **I propose therefore that legislation require a standing statutory advisory committee for hauora Māori.** The committee – the Māori Health Advisory Committee – would be similar in nature to a current Section 11 committee under the New Zealand Public Health and Disability Act 2000, established under the new legislation. It would provide an avenue to engage with Māori on the Authority's board appointments and other matters at the discretion of the Minister. This may, for example, include advice on board appointments in relation to Health New Zealand.

61 I further recommend that the legislation require the Minister to seek the advice of the committee in relation to the exercise of the powers to appoint or remove board members. This would provide a legal mechanism to ensure consultation and ongoing Māori influence over the composition of the board, to strengthen the confidence of Māori in the arrangements. Moreover, the establishment of the committee would also provide the opportunity to balance the responsible Minister's powers in other respects, as discussed below.

Responsiveness to government policy

62 A primary feature which distinguishes different kinds of statutory entities is the extent to which the entity is responsive to direction on government policy and/or exercises a degree of independence.

63 The decisions already made as to the character and role of the Māori Health Authority mean it will, in practice, give ongoing effect to government policy in in most instances. In developing the NZ Health Plan with Health New Zealand, the Authority will be expected to give independent advice and input which reflects the needs, aspirations and priorities of Māori; but once approved by the Minister, the

NZ Health Plan will bind both the Authority and Health New Zealand to a shared approach. The same would apply, for example, to the NZ Health Strategy (or other strategies) once agreed with the Ministry of Health.

64 Although these requirements will practically bind the Māori Health Authority to government policy in some ways, there will remain significant operational freedom to give effect to government policies in a manner consistent with Māori aspirations – for example, in how the NZ Health Strategy and NZ Health Plan are co-developed by the Authority; in the advice provided to the Minister about strategy and policy; and in how services are planned, funded and managed (both in partnership with Health New Zealand and the Ministry of Health, and by the Authority alone).

65 Beyond these broad requirements, there is a question as to whether and how to apply the existing powers of Ministers to direct an entity to give effect to government policy. These powers apply to Crown agents (and will therefore apply to Health New Zealand) and may be thought of as part of the suite of intervention powers available to Ministers to direct entities on specific matters related to their functions (which are noted in further detail in the section later in this paper). Consistent with the approach above of incorporating elements of the Crown Entities Act but not establishing the Authority as a Crown agent, I believe that a modified version of these powers which better describes the Authority's shared accountabilities should apply.

66 I consider that it is right that the Minister of Health should have some power to direct the Māori Health Authority to give effect to government policy, at least to the extent that such powers mitigate against system risks. For example, directions may be required to resolve disputes or to manage practical issues that arise from the co-commissioning relationship with Health New Zealand to avoid disrupting services. For the Māori Health Authority to be a recipient of significant government funding to be used for strategic and service-level commissioning, moreover, it is desirable that it be bound to follow government policy in how it spends that money.

67 However, the Māori Health Authority is intended to work differently from other health entities to achieve health equity for Māori. The Authority will need to balance accountabilities to both Māori and the Crown, and ought to have operational flexibility to adopt approaches which meet Māori needs, aspirations and priorities. It will be important for the Authority to have a clear mandate to hear and understand the views, aspirations and needs of Māori, act on them through its activities, and be accountable to Māori for its performance. Some fetter on the powers of the Minister of Health to direct the organisation are therefore appropriate, to ensure Māori needs and aspirations shape the approach taken by the Authority.

68 **I therefore recommend that the Minister's powers to direct the Authority be limited in two ways**:

68.1 First, **by providing that directions may only require the Māori Health Authority to give effect to government policy for the purpose of improving equity of access to and outcomes of publicly-funded health services for Māori.** This means that the Authority would only need

to respond to Ministerial directives to extent they have that effect, and could not be directed to adopt policies which do not improve equity of access or outcomes for Māori.

68.2 Second, **by requiring that the Minister consult the Māori Health Advisory Committee before exercising this power**. This would require the engagement of the standing advisory committee and provide an avenue for discussion before these powers are deployed. Moreover, it would allow the committee itself to be able to raise issues to the Minister that may require direction.

69 I believe that this approach will balance the requirements of accountability to Ministers, as a commissioner and a budget-holder, with those to Māori. Together with the statutory obligations for engagement and accountability to Māori as above, these provisions are intended to provide a model that weighs and applies these responsibilities effectively. I do not propose that this approach would apply to any whole-of-government directions required to meet statutory obligations as a publicly-funded entity (under Section 107 of the Crown Entities Act).

Monitoring powers of the Māori Health Authority

70 The Authority will have a monitoring function [CAB-21-MIN-0092 refers] aimed at ensuring that other system entities (particularly Health New Zealand) and the system as a whole are driving better care and outcomes for Māori.

71 The detailed design of the Authority's monitoring function needs to take into account and complement the Ministry of Health's responsibility for monitoring the system and its performance as a whole. In particular, the Ministry will be responsible as the system steward for monitoring the performance of health entities including the Māori Health Authority; the Authority cannot monitor its own service delivery. To balance its roles, **I propose that the Authority have two monitoring roles**:

71.1 **First, as a partner to the Ministry of Health in relation to monitoring the whole system's performance on hauora Māori**. The two entities would work in partnership to undertake whole-of-system monitoring, with both contributing to advice to Ministers on hauora Māori system performance.

71.2 **Second, as a monitor of Health New Zealand's delivery against the Māori Health Plan.** This plan will be an agreement between the Authority and Health New Zealand as to the steps Health New Zealand will take to improve hauora Māori and achieve Māori health equity. This role will empower the Authority to monitor Health New Zealand's performance as a commissioner of health services, using any and all system data and information as appropriate, including from the Authority's own networks and iwi-Māori partnership boards.

72 In relation to the first of these, the Ministry of Health's role as overall monitor and system steward will be complemented by the Authority's specific focus on hauora Māori and its role as a co-commissioner of services with Health New Zealand. Any overlap with the statutory role of Te Puni Kōkiri (which has a broad

monitoring remit) can be managed through practical arrangements between the entities and a memorandum of understanding if necessary.

73 To support transparent sharing of data and information to underpin joint monitoring, **I recommend that the Māori Health Authority have access to all data and information held or accessed by Health New Zealand,** limited only by appropriate controls for data governance, security and privacy. **I also recommend that the Director-General of Health be required to provide such information to the Māori Health Authority as it reasonably requests for this function**. This would reflect the proposed powers of the Director-General to require information from Health New Zealand, as set out in the section on intervention powers below.

Disputes arising between Health New Zealand and the Māori Health Authority

74 While I anticipate Health New Zealand and the Authority will work closely together and serious disputes will be few, they may arise. In the event of a serious dispute between Health New Zealand and the Authority, **I propose that a resolution mechanism be set out in the Bill as follows**:

74.1 Either party may raise a dispute with the other, setting out the areas of dispute.

74.2 Both parties must then use their best endeavours to resolve the dispute.

74.3 If the dispute is not resolved within 20 working days, they must refer the dispute to the Minister of Health, but may agree to refer the dispute to the Minister sooner than that.

75 This process will encourage the two entities to work together to resolve disagreements and compromise, as neither organisation will wish to involve the Minister unnecessarily. This approach will, however, allow for genuine serious concerns about system priorities to be referred to and resolved by the Minister, where appropriate.

Iwi-Māori partnership boards

76 Cabinet has previously agreed that iwi-Māori partnership boards should have a strengthened role in the reformed system, to be empowered and enabled to act as Tiriti partners to Health New Zealand at the local level.

77 At present, iwi-Māori partnership boards are non-government Māori organisations, established by Māori to work with DHBs. They are not new: most have been operating for 20 years, and some have advanced to hold mature and active relationships with DHBs that inform the planning and commissioning of health services in their district.

78 However, the current partnership boards are not reflected in existing legislation, and are not supported to engage with Māori communities to identify local health concerns and aspirations in the planning and commissioning process. They have no formal levers to influence health commissioners, and therefore have had a variable impact on decision-making. To achieve the role intended, it will be

necessary not only to provide for them in statute, but also to ensure they have access to sufficient support and funding.

Role of the boards and relationship with the Māori Health Authority

79 As signalled previously [CAB-21-MIN-0092 refers], in the new system iwi-Māori partnership boards are intended to:

79.1 exercise tino rangatiratanga as the tangata whenua partner in planning around health priorities and services at the locality level, within their rohe or coverage area;

79.2 ensure the voices of whānau Māori are elevated and made visible within the health system; and

79.3 embed mātauranga Māori within locality plans, which then influences and informs national planning.

80 The Māori Health Authority will be dedicated to Māori health equity and outcomes, but will be a predominantly national and regional body and will not be expected to have a significant presence in each community across New Zealand. While the Authority will have strong analytical capability to monitor health outcomes and equity across New Zealand, it will not be sufficiently embedded within local communities to understand the practical needs and issues they experience with local health services – such as limited service availability, lack of service options (e.g. after-hours access). This understanding cannot be obtained from a centralised intelligence function – it requires a local mechanism.

81 To this extent, the role of iwi-Māori partnership boards is essential to the Māori Health Authority exercising its functions. The boards will provide access to local intelligence and Māori voice that will support the Authority in driving the system as a whole to achieve equity.

82 While the individual boards and the Māori Health Authority will be separate entities, they will co-exist and be expected to form enduring partnerships to drive health equity for Māori across the system. Their relationship should be two-way:

82.1 The Māori Health Authority will provide system leadership and support to the boards to enable them to carry out their role locally and to build their capability. This might include providing mātauranga Māori strategic analysis, other health intelligence support (through a unique Māori lens), and research and insight into exemplar models of best practice for kaupapa Māori services from elsewhere in the country, for instance.

82.2 I also expect that the Authority, alongside Health New Zealand, will put in place strong relationship management processes with the boards at national and regional levels, for example by establishing forums or networks to bring together representation from boards at those levels. This would allow the iwi-Māori partnership boards to elevate their local intelligence and analysis of Māori voices to the Authority and Health New Zealand, to inform those entities' functions and activities.

83 The Māori Health Authority will also act to ensure that boards continue to reflect and be representative of all Māori in their geographic areas, and will have a critical role in brokering and resolving issues that may arise in their partnership with Health New Zealand. These are described further below.

84 These relationships will develop over time as the new system consolidates and the boards mature into their role. The development of boards' functions, powers and capabilities will evolve gradually, in line with the timetable for localities themselves to be established by Health New Zealand and for initial locality plans to be agreed. The Māori Health Authority will have a role in supporting the development of functions and powers of iwi-Māori partnership boards in accordance with the expectations set out in this paper. I therefore recommend that the Māori Health Authority lead a process for finalising the detailed powers and functions of the boards. I will report to Cabinet to confirm these arrangements. On 1 July 2022, there will only be formal locality arrangements in place in a small number of prototype areas in New Zealand, with plans to scale up localities over the following three to four years.

Constitution and functions of boards

85 The fundamental purpose of iwi-Māori partnership boards is to create a local Tiriti o Waitangi partnership between Health New Zealand commissioners and iwi and hapori Māori, and to ensure that Māori aspirations and needs are reflected in locality planning – alongside the aspirations and needs of the wider community.

86 Engagement with Māori has highlighted the importance of Māori being able to determine how boards are organised. This includes the extent to which mana whenua, mātā waka, and hauora Māori expertise are included on each board. Several iwi-Māori partnership boards have indicated a desire to consolidate along the lines of iwi rohe in future. Given this, and that the ability to organise themselves is inherent to tino rangatiratanga, the Bill will not require a specific form or prescribe a full range of functions of boards. These matters will be determined in a process lead by the Māori Health Authority.

87 **Based on consultation, my expectation is the iwi-Māori partnership boards will have functions along the following lines**:

87.1 engaging with whānau and hapū, and share the resulting insights and perspectives with Health NZ, the Māori Health Authority and others. This would ensure that the boards' views reflect local priorities and insights, and would act to magnify the perspectives of Māori within localities;

87.2 assessing and evaluating the current state of hauora Māori in their locality or localities; and to identify local priorities for improving hauora Māori;

87.3 s9(2)(f)(iv) [redacted]

87.4 monitoring the performance of the health system in their locality or localities, including against the locality plan;

87.5 engaging with the Māori Health Authority to support its national stewardship of hauora Māori and its priorities for kaupapa Māori investment and innovation. This would support a 'ground up' approach to oversight and investment decisions by the Authority; and

87.6 reporting on their own activities to whānau and hapori Māori, and other relevant partners. This would recognise a measure of accountability of the boards to Māori in each locality.

88 The expression of expected statutory functions above should indicate a visible and consistent set of roles for iwi-Māori partnership boards. While I do not believe it would be right for the Crown to define all (including non-statutory) functions for a non-government entity, there is significant merit in clarifying a shared view on those functions which are common to all boards, and ensuring that they are recognised by other entities within the health system.

89 In order to identify boards clearly and to provide for sufficient flexibility over time, **I propose that the Bill require the Minister to identify iwi-Māori partnership boards in a Schedule**, amendable by Order in Council. I expect that this Schedule would initially identify the existing boards, based on those currently constituted to support DHBs and operating along district boundaries. This draws on the bodies which will 'start out' as the boards, and gives appropriate mana to these entities in the current system.

90 To support the boards to operate practically and effectively with other health system entities, in addition to the provisions above **I propose three minimum requirements be necessary in the legislation**:

90.1 That iwi-Māori partnership board geographic boundaries must be mutually exclusive – no two boards may have the same area within their boundary.

90.2 That the iwi-Māori partnership board must give all recognised iwi groups within its geographic boundary the opportunity to nominate a member to the board (noting some may choose not to be represented).

90.3 That each iwi-Māori partnership board must include or invite representation for hapori (including mātā waka) and appropriate hauora Māori expertise, in a form appropriate for each board. It is assumed that such representation should be sufficiently senior to be able to advocate effectively for these groups, and that members will have broad experience and understanding of the health system and local health needs.

91 To provide assurance that these requirements are met, **the Minister must seek the advice of the Māori Health Authority in making this Schedule.** The Authority will, by virtue of its relationship with the boards described above and its wider intelligence from other Māori groups, be well placed to confirm that the composition of each board is meaningful and representative of all Māori, and that boards are able to assume their role and the powers that follow.

92 As system settings embed over time, the existing boards may wish to vary their membership at their discretion (subject to the minimum requirements outlined above), and to re-negotiate their boundaries – including merging, de-merging, or shifting boundaries – by mutual agreement. Where changes are agreed between relevant boards that need amendment to the Schedule, these should be confirmed by way of written notice to the Minister of Health and the Authority. **I do not propose that the Minister be able to make any amendment to the Schedule other than on the advice of the Māori Health Authority**.

93 This approach allows for maximum flexibility for Māori to constitute the boards in the manner they deem most appropriate, and to adjust boundaries and approaches over time, while ensuring legal certainty, and mitigating risks relating to uncertainty of boundaries in the exercise of statutory powers.

Powers of iwi-Māori partnership boards

94 As noted above, I do not intend that the Bill, at this stage, should seek to prescribe the functions of iwi-Māori partnership boards, which should be further worked through by the Māori Health Authority against the expectations expressed in this paper.

95 I believe that it is important that boards can exercise their own powers, rather than relying on obligations being placed on other entities to facilitate their role. This was a point emphasised by the Steering Group.

96 Iwi-Māori partnership boards' most significant impact should be at the locality level, and through the planning and prioritisation process that determines local health services. The process of locality planning will weave together national and local expectations, and will be expected to reflect community perspectives and preferences, including those of Māori.

97 Health New Zealand will be required by the Bill to make a locality plan for each locality. I expect that locality plans will be developed in partnership with iwi-Māori partnership boards, and indeed with other communities and groups at the locality level. The plans will be formally approved by Health New Zealand and the Māori Health Authority together; I expect that this will take place at the regional level of both entities, where it will be possible for an overview to be taken across multiple localities to ensure alignment and consistency.

98 s9(2)(f)(iv) [redacted]

s9(2)(f)(iv) [redacted]

[redacted]

[redacted]

101 s9(2)(f)(iv) [redacted] I believe it is further necessary to provide for duties on the boards' partners to facilitate the intended role. Specifically**, I recommend that the Bill provide for:**

101.1 **a duty on Health New Zealand and the Māori Health Authority to provide all reasonable information to iwi-Māori partnership boards** to support them to monitor the performance of the health system in their relevant locality or localities; and

101.2 **a duty on the Māori Health Authority to engage with boards in determining its priorities for kaupapa Māori services**.

s9(2)(f)(iv) [redacted]

[redacted]

[redacted]

[redacted]

105 s9(2)(f)(iv) [redacted]

[redacted]

Support for boards to exercise their functions

107 To deliver on their functions, iwi-Māori partnership boards will need resourcing and support beyond simply paying board members. This support could include secretariat functions, providing data analysis and policy advice, undertaking their own consultation and research, and support to influence locality planning (e.g. to provide Health New Zealand and Māori Health Authority commissioners with clear articulations of iwi, hapū, whānau and hapori expectations).

108 In the course of engaging with current iwi-Māori partnership boards, it was highlighted that some boards already have infrastructure in place (for example, from the relevant iwi health organisation) which can meet their needs. Requiring these boards to draw support from health system entities would mark a step backwards from mana motuhake. At the same time, other boards highlighted that significant capability growth will be needed to fulfil the proposed new roles.

109 Therefore, **I propose a statutory requirement on the Māori Health Authority to offer support to iwi-Māori partnership boards**. The Māori Health Authority should be responsible for supporting boards to build and develop their capabilities to fulfil their role in the local system – the nature of their support may be administrative, analytical or financial, for example. Health New Zealand should also have an important role in relation to developing and maintaining positive relationships with the boards, which allows them to operate as intended. I propose that the legislative requirement should be deliberately flexible in how support is provided, so that arrangements can be agreed with each iwi-Māori partnership board.

110 This means that the appropriate approach would be negotiated between each iwi-Māori partnership board and the Authority. As boards become acclimatised to their new functions, they have the opportunity to take increasingly autonomous approaches. This aligns with the advice provided by the Steering Group.

Statutory intervention powers

111 Cabinet authorised the Minister of Health, in consultation with relevant Ministers, to make decisions on statutory intervention powers for the Minister and Director-General of Health [SWC-21-MIN-0107 refers]. This section outlines the decisions I have made under that delegation.

Powers derived from the Crown Entities Act 2004

112 Most of the statutory intervention powers required will derive from the Crown Entities Act 2004, which provides appropriate powers for responsible Ministers to influence the activity of Crown entities. **As a Crown agent, all of these powers will apply to Health New Zealand.** In relation to the Māori Health Authority, although it is not a Crown entity as proposed above, I recommend that certain powers should apply as noted below.

113 There are four broad categories of power under the Crown Entities Act, in addition to the power to appoint and dismiss board members.

Powers relating to an entity's accountability documents

114 The responsible Minister may issue a letter of expectations, setting out requirements for the entity. A Crown entity must then prepare a statement of intent, setting out its strategic intentions for at least the next four years, and a statement of performance expectations for a single financial year, setting out its intended outputs for that year. Each of these must be presented to the responsible Minister and tabled in the House.

115 In the reformed health system, the Government Policy Statement is expected to fulfil the role of the letter of expectations in time, and the NZ Health Plan will have significant crossover with the statements of intent and performance expectations. I anticipate that over time, the content of the latter two will be incorporated into the Health Plan, rather than being separate documents.

116 The responsible Minister may require amendments to a Crown entity's draft statement of intent or draft statement of performance expectations. This is a broad power, since these two documents set out a high-level view of all of the entity's proposed activities. **I intend that this power be held in respect of the Māori Health Authority, but subject to the requirement to consult the Māori Health Advisory Committee proposed above.**

The power to require information

117 A Crown entity must provide its Minister any information relating to its operations and performance that the Minister requests. The entity may decline where it would be a breach of a natural person's privacy, but only if that consideration is not outweighed by the Minister's need for the information. **Given the role, functions and expected budget of the Authority, I intend this power be held in respect of the Māori Health Authority.**

The power to review the operations of a Crown entity

118 A responsible Minister may review the operations and performance of a Crown entity at any time. Before doing so, the Minister must consult the entity on the scope of the review and consider submissions from it. **I intend this power to be held in respect of the Māori Health Authority.**

The power to direct a Crown agent to give effect to government policy

119 The power of direction in the Crown Entities Act provides that the responsible Minister may direct a Crown agent to give effect to a government policy that relates to the entity's functions and objectives. The limits are that such a direction may not relate to a statutorily independent function, nor require a particular act or a particular result in relation to a particular person. For example, the Minister could not direct Health New Zealand to enter into a contract with a particular supplier, or to provide treatment to a particular person. As discussed in paragraphs 61-68 above, **I intend this power to be held in respect of the Māori Health Authority, subject to the qualifications proposed to focus any such directions on Māori health equity and to consult with the advisory committee before using the power.**

Powers continued from the New Zealand Public Health and Disability Act 2000

120 There are powers in the New Zealand Public Health and Disability Act 2000 that **I intend to carry over into the Bill and apply to both Health New Zealand and the Māori Health Authority**:

120.1 **Entering into funding agreements and issuing notices**. Section 10 of the Act provides that the Minister or Ministry may enter into a funding agreement, and may set conditions on the funding. In the future system, the NZ Health Plan will fulfil these functions. However, it is worth retaining this power in reserve, for instance for any funding provided outside of the regular planning cycle.

120.2 **Replacing a board with a commissioner**. Section 31 of the Act provides that, where the Minister is seriously dissatisfied with a DHB board's performance, they may dismiss the board and replace it with a commissioner and up to three deputy commissioners. I intend to retain this power for Health New Zealand for use in extremis. In relation to the Māori Health Authority, I recommend that the Minister of Health be able to exercise this power, but that any appointment must be made with the agreement of the Māori Health Advisory Committee, given the implications of such a step for the balance of accountabilities.

120.3 **Power for Minister of Finance to require information**. Section 44 of the Act provides that the Minister of Finance may require a DHB to provide financial and economic statements, including financial and economic forecasts relating to the DHB and/or any of its subsidiaries. This is a slightly broader power than the Crown Entities Act provision (which does not include forecasts) and should be retained.

Additional provisions for inclusion in the Health Reform Bill

121 Cabinet has already agreed that the system will need finely-grained intervention powers. The proposals so far provide most of these. However, in practice, some of the existing powers have been rarely exercised. In order that we are able to implement a graded escalation path for the system, **I recommend four additional or amended provisions**:

121.1 **Power for the Minister to appoint Crown observers.** I intend that the new legislation provide that the Minister has the power to appoint a Crown observer to the Health New Zealand board, and to significant internal meetings that the Minister specifies. This is similar to the power to appoint Crown monitors, but extended to lower level meetings. The extension is intended to allow visibility of significant internal processes, such as regional commissioning boards, which could potentially be controlling several billion dollars of public money. Similar to the power above to appoint commissioners, I recommend that in relation to the Māori Health Authority the Minister of Health be able to exercise this power, but that any appointment must be made with the agreement of the Māori Health Advisory Committee.

121.2 **Power for the Minister to require improvement plan(s)**. This power would allow the Minister to respond to an identified area of underperformance by empowering the Minister to require a formal improvement plan. The plan may specify particular elements and timeframes. This is similar to the existing power in the Education Act 1989. This power would be exercised for the Māori Health Authority only in consultation with the Māori Health Advisory Committee.

121.3 **Power for the Director-General to obtain information.** In order to support the Director-General in performing their monitoring role, I propose that the Bill provide that the Director-General may require any information from a statutory health entity that relates to its operations or performance. This is the equivalent of the Minister's power under the Crown Entities Act. I recommend this apply equally to Health New Zealand and the Māori Health Authority.

121.4 **Specify skills, attributes, and experience required for board members.** It is now routine for legislation establishing an entity to set requirements for board members, to ensure the board is suitably qualified, with the appropriate range of skills, knowledge and experience. I intend that the Bill provide that at a minimum the Health New Zealand board should have expertise in te ao Māori, health, public sector governance and government processes, and financial management.

Public health structures and roles

122 Cabinet also authorised the Minister of Health, in consultation with the Tier 2 Ministerial group to make decisions on legislative provisions regarding public health structures and roles [SWC-21-MIN-0107 refers]. This section summarises my intentions following that consultation.

123 Cabinet has agreed that the Public Health Agency will be a business unit of the Ministry of Health. With that decision, the need for specific statutory provisions is limited. That said, I propose provisions that would put the Public Health Agency on a firm statutory footing, and strengthen the Agency's leadership of the national public health effort, and ensure that robust public health advice is provided to the Minister and Director-General:

123.1 **Require that the Minister appoint a permanent Public Health Advisory Committee**. This would require a committee to be established for the purposes of providing independent advice to the Minister on public health, including health protection and promotion.

123.2 **Require the establishment of the Public Health Agency** as a business unit of the Ministry of Health. At present the Health Act 1956 requires the Ministry to have a public health group, to advise the Director-General on public health. I intend to amend these provisions to establish the Public Health Agency, with the broader functions of leading public health across the system, and advising the Director-General on public health, and personal health, regulatory issues, and strategic issues relating to public health.

123.3 **Amend provisions relating to the Director of Public Health and medical officers of health**. I propose to make small changes to strengthen the powers and prominence of the statutory Director of Public Health as a system leader. This will include that the Director-General may exercise the power to appoint or remove medical officers of health on the advice of the Director of Public Health. Additionally, the Director of Public Health will automatically have the powers of a medical officer of health, able to exercise them for any health district, as long as they are a public health medical practitioner. I also propose a minor amendment to clarify that medical officers of health, who are designated by the Director-General rather than it being part of an employment relationship, can be removed from that office by the Director-General.

124 These provisions are intended to strengthen the basis for the new public health system settings in legislation. Work is ongoing in relation to the detailed design of the core elements (specifically, the Public Health Agency and the national public health service in Health New Zealand) and the future allocation of functions between these, including in relation to the COVID-19 response. Further decisions will need to be made for how the entities operate individually and collectively to give effect to a cohesive public health model.

Impact analysis

Financial implications

125 Funding to deliver core implementation and transition activities has been secured through Budget 21. As planning for transition activities progresses – for example, as decisions are made about the sequence in which functions are created or moved between agencies – reprioritisations within existing Vote Health baselines may be required.

126 s9(2)(f)(iv) [redacted]

127 s9(2)(f)(iv) [redacted]

Legislative implications

128 The structural changes to the health system agreed by Cabinet require primary legislation. Cabinet has agreed to use the Health Reform Bill on the legislative programme to do this. This paper sets out some of the intended requirements for that Bill.

Regulatory impact statement

129 The Impact Analysis requirements apply to this paper. An earlier Supplementary Analysis Report was prepared to inform decisions about the broader structural reform of the health system, but excluded consideration of hauora Māori options, due to the engagement process underway at the time. A Regulatory Impact Statement has been prepared and accompanies this paper.

130 The Statement has been quality assured by a panel with representatives from the Department of the Prime Minister and Cabinet and the Ministry of Health. The Panel gave a QA statement as follows:

> "The Panel considers that the RIA Meets the Quality Assurance Criteria".
>
> "The Panel noted that it was difficult to develop a full regulatory impact assessment for a machinery of government issue, in this case for choosing between different organisational forms for the Māori Health Authority. This is because it is not possible or practical to distinguish between the overall costs and benefits of creating a Māori Health Authority (which has already been decided by Cabinet), and those associated with the question of organisational form. This is a similar situation faced in producing other RIAs of a comparable nature, such as for Taumata Arowai, the Criminal Case Review Commission, the role of the Reserve Bank Governor on its Board, and the Independent Mental Health and Wellbeing Commission.
>
> "In this case, the decision to form the Māori Health Authority has already been made, and the remaining decision (and the focus of the RIA) is its organisational form.
>
> "The RIA clearly outlines the benefits that could be gained in Māori health status and equity through the effective functioning of the Māori Health Authority. The approach taken is robust, and based on available evidence.

"The Multi-Criteria Analysis teases out the trade-offs and nuances between the different choices of organisational form, and allows a clear choice to be made.

"There has been considerable general consultation and engagement on these issues, and the advice of an expert panel, on these matters. The Select Committee process will provide the opportunity for further detailed stakeholder input".

Population implications

131 The new system operating model is expected to have significant benefits for populations who experience poorer health outcomes and/or unwarranted variation in the healthcare available to them. This includes Māori, Pacific peoples, disabled people, rural communities, LGBTQI+ and people with lower socio-economic status. The phasing of implementation activity has been designed to realise benefits for these groups as early as possible. The new health system will also need to ensure that disabled people have confidence in how their interactions with the health system will be planned, delivered and performance monitored. This includes coordinating and aligning efforts undertaken through health system reform and disability support system transformation, which the Minister of Disability Issues and I are overseeing and on which we will present recommendations to Cabinet in October.

132 As part of engagement activity, we will proactively seek representation and voice from these communities to ensure their perspectives are reflected in the design of the future health system.

133 The implications for hauora Māori are particularly significant. The proposed function, powers, accountabilities and form of the Māori Health Authority supports a focus on hauora Māori aspirations and needs, and that it is well-placed to partner with other health and social sector entities to influence, inform and agree strategies, policy, plans and operations. The proposed functions for iwi-Māori partnership boards provide for iwi and Māori to exercise tino rangatiratanga with respect to local planning and decision-making.

Human Rights

134 The proposals in this paper are consistent with, and advance the purposes of, the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

135 The Ministry of Health, the Treasury, the Public Service Commission, Te Arawhiti, the Ministry of Justice and Crown Law have been consulted. Their comments are reflected in this paper. The Department of Prime Minister and Cabinet has been informed.

Communications

136 The announcement of the new health and disability system operating model on 21 April 2021 covered the Government's key objectives and reforms as further described in this paper. I do not intend to communicate the decisions and

recommendations from this paper specifically, but anticipate further public announcements to support introduction of the legislation.

Proactive Release

137 I intend to release this paper in accordance with the guidance in Cabinet Office Circular CO (18) 4.

Recommendations

The Minister of Health recommends that the Committee:

1. **note** that Cabinet has agreed that a Health Reform Bill should be introduced as the vehicle for implementing the Government's health reforms

2. **note** that Cabinet has previously made a number of decisions relating to the provisions of the Health Reform Bill, including in relation to the functions and structures of Health New Zealand and core accountability arrangements including the Government Policy Statement [CAB-21-MIN-0092 refers]

Te Tiriti o Waitangi

3. **note** Cabinet has previously:

    3.1. **agreed** that implementing legislation place obligations on health sector entities in respect of Te Tiriti o Waitangi by including a Tiriti clause following the standard modern form, that incorporates the principles identified by the Waitangi Tribunal in its Hauora inquiry [CAB-21-MIN-0092 refers]

    3.2. **noted** my intention to provide further advice to Cabinet on the above principles and how to give legal effect to the obligations once officials have worked through the details [SWC-21-MIN-0107 refers]

4. **agree** that the legislation should contain a descriptive Tiriti o Waitangi clause, setting out how particular provisions in the legislation give effect to the Government's obligations under Te Tiriti

5. **agree** that the concepts of the principles identified by the Waitangi Tribunal in the Hauora Inquiry should be incorporated into a general set of decision-making principles to which health entities established or continued by the Act must have regard in carrying out their functions

6. **note** that the above will incorporate Cabinet's previous decisions regarding legislating for the objectives and associated principles of reform [SWC-21-MIN-0107] into a single set of statutory principles for decision-makers

Māori Health Authority

7. **note** that Cabinet has previously agreed:

    7.1. to establish the Māori Health Authority as a new statutory entity, to lead hauora Māori in the health system, to work with the Ministry of Health on

strategy and policy relating to hauora Māori, and to work with Health New Zealand on operational matters;

7.2. that the Māori Health Authority should be independent of other health system organisations, and constituted in a way that gives effect to rangatiratanga and embeds the principle of partnership between Māori and the Crown;

7.3. agreed that the Transition Unit should take forward a process with iwi and the Māori health sector to design proposals for the constitution of the Māori Health Authority as a new entity, to be presented to Cabinet for agreement [CAB-MIN-21-0092 refers]

8. **note** Cabinet has previously authorised the Minister of Health to make in-principle decisions, in consultation with relevant Ministers and issue drafting instructions for indicative provisions that would be included in legislation for introduction, and revised in Committee, so as not to pre-empt or rush that engagement [SWC-21-MIN-0107 refers]

9. **note** that the engagement referred to above has included:

9.1. establishing a Steering Group chaired by Tā Mason Durie, one of the roles of which has been to provide advice on accountabilities of the Māori Health Authority to Māori in the future health system. This advice has informed the proposals in this paper;

9.2. engaging with Māori through 30 hui across New Zealand to seek input on the reforms, and further decisions to come on approaches to the Māori Health Authority and iwi-Māori partnership boards; and

9.3. considering insights from the Ministry of Health's Hui Whakaoranga series, which has also engaged with Māori nationwide

10. **note** that the Steering Group and Ministers have reached agreement on provisions relating to the Māori Health Authority and iwi-Māori partnership boards, and that it is proposed that the hauora Māori provisions will therefore represent a considered policy position rather than being merely indicative

Roles and functions of the Māori Health Authority

11. **note** that the Māori Health Authority will have dual accountabilities to Ministers, as a part of the public service and in line with its funding by the Crown, and to Māori, to give effect to and support partnership at all levels; and that these accountabilities shape proposals on the Authority's functions and form

12. **agree** that the roles and functions of the Māori Health Authority should be:

12.1. policy and strategy functions which focus on matters relevant to hauora Māori,

12.2. advising the Minister of Health on matters relating to its functions;

12.3. commissioning kaupapa Māori services, other innovative services tailored for Māori, and Māori provider and workforce development;

12.4. co-commissioning all general health services (including both primary and community-based care, and hospital and specialist services) with Health New Zealand, including joint development and responsibility for plans (including the New Zealand Health Plan); and

12.5. holding a significant budget as a commissioner of health services, with consequent accountability requirements including annual reporting and issuing a statement of intent and statement of performance expectations, equivalent to those required of Health New Zealand

13. **agree** the Māori Health Authority will be required to co-develop and give effect to the New Zealand Health Plan once approved by the Minister of Health

Legal form of the Māori Health Authority

14. **agree** that the Māori Health Authority be a statutory entity established under the Bill

15. **agree** that the Māori Health Authority will not be a Crown entity, but that it will be subject to specified provisions of the Crown Entities Act 2004 as amended

16. **note** that the Minister of Health, in consultation with the Minister for Public Service, will determine which administrative provisions of the Crown Entities Act should apply to the Māori Health Authority, with any necessary modification

Establishment of the Māori Health Advisory Committee and use of Ministerial powers

17. **agree** that the Bill require the Minister of Health to establish the Māori Health Advisory Committee to provide advice on the exercise of powers relevant to hauora Māori in the health system

18. **agree** that the Bill require consultation with the Māori Health Advisory Committee in relation to the use of Ministerial powers as specified in recommendations 20, 24, 42, 45 and 47

19. **agree** that the Minister of Health will:

19.1. appoint the board members of the Māori Health Authority;

19.2. be the responsible Minister for the purposes of the Authority's statement of intent and statement of performance expectations; and

19.3. have other powers in relation to the Authority as described in recommendations 24 and 41-47 below

20. **agree** the Minister may only exercise the powers in recommendations 19.1 and 19.2 in consultation with the Māori Health Advisory Committee

Accountability to Māori

21. **agree** the Māori Health Authority will be required to consider, act on, and report back on Māori aspirations and needs, in the exercise of its general functions

22. **agree** the Māori Health Authority will be specifically required to have regard to Māori views and aspirations in carrying out the following functions:

    22.1. co-developing the New Zealand Health Plan and relevant health strategies;

    22.2. preparing statements of intent and performance documents;

    22.3. developing expectations for Health New Zealand to strengthen its performance for Māori

23. **note** the provisions in recommendations 21-22 are considered particularly important by the Steering Group chaired by Tā Mason Durie.

Responsiveness to government policy

24. **agree** that the Minister of Health be empowered to direct the Authority to give effect to government policy, subject to the requirements that:

    24.1. directions must require that policy be given effect only insofar as it relates to improving equity of access and health outcomes for Māori, consistent with the Authority's functions and objectives;

    24.2. the Minister of Health must consult the Māori Health Advisory Committee before using this power

Monitoring roles of the Māori Health Authority

25. **agree** the Māori Health Authority will have dual monitoring functions as follows:

    25.1. partnering with the Director-General of Health to monitor the performance of the whole health system in relation to hauora Māori; and

    25.2. monitoring the performance of Health New Zealand against the Māori Health Plan which is agreed between Health New Zealand and the Authority

26. **agree** that the Māori Health Authority should have all reasonable access to data and information held by Health New Zealand in order to support its monitoring role, except where limited by data governance, security and privacy considerations

27. **agree** the Director-General be required to provide information as reasonably requested by the Māori Health Authority to carry out its monitoring functions

Resolution of disputes between the Māori Health Authority and Health New Zealand

28. **agree** that in the event of a dispute between Health New Zealand and the Māori Health Authority about any function they must carry out jointly, the following procedure will apply:

    28.1. either party may notify the other of the matters in dispute;

    28.2. the parties will have 20 working days to resolve a notified dispute; and

    28.3. if they are unable to resolve a dispute, they must notify the Minister after 20 working days or sooner by mutual agreement, who will determine a process to resolve the dispute

Iwi-Māori partnership boards

29. **note** that Cabinet has previously agreed that iwi-Māori partnership boards should have a strengthened role in determining priorities and giving effect to Te Tiriti o Waitangi partnership at the local level of the health system

30. **note** that, while the iwi-Māori partnership boards will be owned and organised by Māori rather than the Crown, and the Bill should not prescribe their form or full range of statutory functions, they require a statutory existence in order to confer the powers intended

31. **agree** that the Minister of Health should be required to identify named iwi-Māori partnership boards in a Schedule to the Bill, amendable by Order in Council

32. **agree** the Māori Health Authority lead a process for finalising the detailed powers and functions of the boards which I will report to Cabinet on, s9(2)(f)(iv)

33. **agree** that in order to identify iwi-Māori partnership boards in this Schedule, the Minister of Health seek the advice of the Māori Health Authority to ensure that the following requirements are met:

    33.1. iwi-Māori partnership board geographic boundaries must be mutually exclusive – no two boards may have the same area included within their boundary;

    33.2. iwi-Māori partnership boards must give all recognised iwi groups within its geographic boundary the opportunity to nominate a member to the board (noting some may choose not to be represented);

    33.3. each iwi-Māori partnership board must include or invite representation for hapori (including mātā waka) and hauora Māori expertise, in a form appropriate for each board

34. **agree** that the Schedule will provide initially for the existing iwi-Māori partnership boards, that have been constituted as partners to DHBs, to be identified as the starting basis for the new system

35. **agree** that the Minister of Health may only make amendments to the Schedule in future on the advice of the Māori Health Authority

36. **agree** that in order to support boards to fulfil their roles effectively, the legislation further provide:

    36.1. duties on Health New Zealand and the Māori Health Authority to provide all reasonable information to the boards to support them to monitor the performance of the health system in their locality; and

    36.2. a duty on the Māori Health Authority to engage with boards in relation to determining its priorities for kaupapa Māori investment and innovation

37. s9(2)(f)(iv) [redacted]

38. **agree** the Māori Health Authority will be required to offer support to iwi-Māori partnership boards to carry out their functions, and that this support may be administrative, analytical or financial

Statutory intervention powers

39. **note** Cabinet previously authorised the Minister of Health to make decisions in consultation with relevant Ministers on statutory intervention powers for the Minister and Director-General, and provisions clarifying public health structures and roles [SWC-21-MIN-0107 refers]

40. **note** the Crown Entities Act 2004 provides a significant proportion of all the intervention powers required in relation to Health New Zealand as a Crown agent

41. **agree** to provide that certain equivalent powers to those under the Crown Entities Act 2004 be held in respect of the Māori Health Authority:

    41.1. powers to issue letters of expectations and require amendments to statements of intent and statements of performance expectations;

    41.2. a power to require information from the entity;

    41.3. a power to review the operations of the entity

42. **agree** that the powers in recommendation 41.1 only be applied in respect of the Māori Health Authority in consultation with the Māori Health Advisory Committee

43. **note** my intention to carry over and apply to both Health New Zealand and the Māori Health Authority certain powers from the New Zealand Public Health and Disability Act 2000 to:

    43.1. enter into funding agreements and issuing notices;

    43.2. replace a board member with a commissioner; and

    43.3. provide a power for the Minister of Finance to require information including financial forecasts

44. **note** my intention to also carry over the power from the New Zealand Public Health and Disability Act for the Minister to enter into Crown Funding Agreements

45. **agree** that the Minister of Health may determine the exercise of the power in recommendation 43.2, but that any appointment must be made with the agreement of the Māori Health Advisory Committee.

46. **note** my intention to include the following provisions in the new health system legislation in respect of Health New Zealand and the Māori Health Authority:

    46.1. the power for the Minister to appoint Crown observers to the new entity boards or any significant internal meeting;

    46.2. the power for the Minister to require an improvement plan;

    46.3. the power for Director-General to require any information about a health entity's operations or performance; and

    46.4. specify the boards of Health New Zealand and the Māori Health Authority should have expertise in te ao Māori, health, public sector governance and government processes, and financial management

47. **agree** that the Minister of Health may determine the exercise of the power in recommendation 46.1, but that any appointment must be made with the agreement of the Māori Health Advisory Committee.

48. **agree** that the powers in recommendation 46.2 only be applied in respect of the Māori Health Authority in consultation with the Māori Health Advisory Committee

Public health structures and roles

49. **note** my intention to include the following statutory provisions to support the Cabinet's intended public health arrangements:

    49.1. require the Minister to establish a public health advisory committee for the purposes of providing independent advice on public health;

    49.2. amend the Health Act 1956 to require the Ministry of Health to have the Public Health Agency as a business unit;

    49.3. allow the Director-General to appoint medical officers of health on the advice of the Director of Public Health, and clarify that the Director-General may remove the designation of a person as a medical officer of health; and

    49.4. give the Director of Public Health the functions of a medical officer of health, provided they are a public health medical practitioner.

Authorised for lodgement

Hon Andrew Little

Minister of Health

CAB-21-MIN-0378

Cabinet

Minute of Decision

Health and Disability System Review: Further Policy Decisions for the Health Reform Bill

Portfolio **Health**

On 20 September 2021, following reference from the Cabinet Business Committee, Cabinet:

Background

1 **noted** that Cabinet has agreed that a Health Reform Bill should be introduced as the vehicle for implementing the government's health reforms;

2 **noted** that Cabinet has previously made a number of decisions relating to the provisions of the Health Reform Bill, including in relation to the functions and structures of Health New Zealand and core accountability arrangements including the Government Policy Statement [CAB-21-MIN-0092];

Te Tiriti o Waitangi

3 **noted** Cabinet has previously:

3.1 agreed that implementing legislation place obligations on health sector entities in respect of Te Tiriti o Waitangi by including a Tiriti clause following the standard modern form, that incorporates the principles identified by the Waitangi Tribunal in its Hauora inquiry [CAB-21-MIN-0092];

3.2 noted that the Minister of Health intends to provide further advice to Cabinet on the above principles and how to give legal effect to the obligations once officials have worked through the details [SWC-21-MIN-0107];

4 **agreed** that the legislation should contain a descriptive Tiriti o Waitangi clause, setting out how particular provisions in the legislation give effect to the government's obligations under Te Tiriti;

5 **agreed** that the concepts of the principles identified by the Waitangi Tribunal in the Hauora Inquiry should be incorporated into a general set of decision-making principles to which health entities established or continued by the Act must have regard in carrying out their functions;

6 **noted** that the above will incorporate Cabinet's previous decisions regarding legislating for the objectives and associated principles of reform [SWC-21-MIN-0107] into a single set of statutory principles for decision-makers;

Māori Health Authority

7 **noted** that Cabinet has previously agreed:

7.1 to establish the Māori Health Authority as a new statutory entity, to lead hauora Māori in the health system, to work with the Ministry of Health on strategy and policy relating to hauora Māori, and to work with Health New Zealand on operational matters;

7.2 that the Māori Health Authority should be independent of other health system organisations, and constituted in a way that gives effect to rangatiratanga and embeds the principle of partnership between Māori and the Crown;

7.3 agreed that the Transition Unit should take forward a process with iwi and the Māori health sector to design proposals for the constitution of the Māori Health Authority as a new entity, to be presented to Cabinet for agreement;

[CAB-MIN-21-0092]

8 **noted** that the Cabinet Social Wellbeing Committee has previously authorised the Minister of Health to make in-principle decisions, in consultation with relevant Ministers and issue drafting instructions for indicative provisions that would be included in legislation for introduction, and revised in Committee, so as not to pre-empt or rush that engagement [SWC-21-MIN-0107];

9 **noted** that the engagement referred to above has included:

9.1 establishing a Steering Group chaired by Tā Mason Durie, one of the roles of which has been to provide advice on accountabilities of the Māori Health Authority to Māori in the future health system. This advice has informed the proposals in the paper under CAB-21-SUB-0378;

9.2 engaging with Māori through 30 hui across New Zealand to seek input on the reforms, and further decisions to come on approaches to the Māori Health Authority and iwi-Māori partnership boards;

9.3 considering insights from the Ministry of Health's Hui Whakaoranga series, which has also engaged with Māori nationwide;

10 **noted** that the Steering Group and Ministers have reached agreement on provisions relating to the Māori Health Authority and iwi-Māori partnership boards, and that it is proposed that the hauora Māori provisions will therefore represent a considered policy position rather than being merely indicative;

Roles and functions of the Māori Health Authority

11 **noted** that the Māori Health Authority will have dual accountabilities to Ministers, as a part of the public service and in line with its funding by the Crown, and to Māori, to give effect to and support partnership at all levels; and that these accountabilities shape proposals on the Authority's functions and form;

12 **agreed** that the roles and functions of the Māori Health Authority should be:

12.1 policy and strategy functions which focus on matters relevant to hauora Māori;

12.2 advising the Minister of Health on matters relating to its functions;

12.3 commissioning kaupapa Māori services, other innovative services tailored for Māori, and Māori provider and workforce development;

12.4 co-commissioning all general health services (including both primary and community-based care, and hospital and specialist services) with Health New Zealand, including joint development and responsibility for plans (including the New Zealand Health Plan);

12.5 holding a significant budget as a commissioner of health services, with consequent accountability requirements, including annual reporting and issuing a statement of intent and statement of performance expectations, equivalent to those required of Health New Zealand;

13 **agreed** that the Māori Health Authority will be required to co-develop and give effect to the New Zealand Health Plan once approved by the Minister of Health;

Legal form of the Māori Health Authority

14 **agreed** that the Māori Health Authority be a statutory entity established under the Bill;

15 **agreed** that the Māori Health Authority will not be a Crown entity, but that it will be subject to specified provisions of the Crown Entities Act 2004 as amended;

16 **noted** that the Minister of Health, in consultation with the Minister for Public Service, will determine which administrative provisions of the Crown Entities Act should apply to the Māori Health Authority, with any necessary modification;

Establishment of the Māori Health Advisory Committee and use of Ministerial powers

17 **agreed** that the Bill require the Minister of Health to establish the Māori Health Advisory Committee (the Committee) to provide advice on the exercise of powers relevant to hauora Māori in the health system;

18 **agreed** that the Bill require consultation with the committee in relation to the use of Ministerial powers as specified in paragraphs 19, 24, 42, 45, 47 and 48;

19 **agreed** that the Minister of Health will:

19.1 appoint the board members of the Māori Health Authority;

19.2 be the responsible Minister for the purposes of the Authority's statement of intent and statement of performance expectations;

19.3 have other powers in relation to the Authority as described in paragraphs 24 and 41-48 below;

20 **agreed** the Minister may only exercise the powers in paragraphs 19.1 and 19.2 in consultation with the Māori Health Advisory Committee;

Accountability to Māori

21 **agreed** that the Māori Health Authority will be required to consider, act on, and report back on Māori aspirations and needs, in the exercise of its general functions;

22 **agreed** the Māori Health Authority will be specifically required to have regard to Māori views and aspirations in carrying out the following functions:

22.1 co-developing the New Zealand Health Plan and relevant health strategies;

22.2 preparing statements of intent and performance documents;

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23 **noted** the provisions in paragraphs 21-22 are considered particularly important by the Steering Group chaired by Tā Mason Durie;

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24 **agreed** that the Minister of Health be empowered to direct the Authority to give effect to government policy, subject to the requirements that:

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28.2 the parties will have 20 working days to resolve a notified dispute;

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Iwi-Māori partnership boards

29 **noted** that Cabinet has previously agreed that iwi-Māori partnership boards should have a strengthened role in determining priorities and giving effect to Te Tiriti o Waitangi partnership at the local level of the health system;

30 **noted** that, while the iwi-Māori partnership boards will be owned and organised by Māori rather than the Crown, and the Bill should not prescribe their form or full range of statutory functions, they require a statutory existence in order to confer the powers intended;

31 **agreed** that the Minister of Health should be required to identify named iwi-Māori partnership boards in a Schedule to the Bill, amendable by Order in Council;

32 **agreed** that the Māori Health Authority lead a process for finalising the detailed powers and functions of the boards which the Minister of Health will report to Cabinet on, s9(2)(f)(iv)

[redacted]

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33.1 iwi-Māori partnership board geographic boundaries must be mutually exclusive – no two boards may have the same area included within their boundary;

33.2 iwi-Māori partnership boards must give all recognised iwi groups within its geographic boundary the opportunity to nominate a member to the board (noting some may choose not to be represented);

33.3 each iwi-Māori partnership board must include or invite representation for hapori (including mātā waka) and hauora Māori expertise, in a form appropriate for each board;

34 **agreed** that the Schedule will provide initially for the existing iwi-Māori partnership boards, that have been constituted as partners to DHBs, to be identified as the starting basis for the new system;

35 **agreed** that the Minister of Health may only make amendments to the Schedule in future on the advice of the Māori Health Authority;

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36.1 duties on Health New Zealand and the Māori Health Authority to provide all reasonable information to the boards to support them to monitor the performance of the health system in their locality;

36.2 a duty on the Māori Health Authority to engage with boards in relation to determining its priorities for kaupapa Māori investment and innovation;

37 s9(2)(f)(iv) [redacted]

38 **agreed** that the Māori Health Authority will be required to offer support to iwi-Māori partnership boards to carry out their functions, and that this support may be administrative, analytical or financial;

Statutory intervention powers

39 **noted** that the Cabinet Social Wellbeing Committee previously authorised the Minister of Health to make decisions in consultation with relevant Ministers on statutory intervention powers for the Minister and Director-General, and provisions clarifying public health structures and roles [SWC-21-MIN-0107];

40 **noted** that the Crown Entities Act 2004 provides a significant proportion of all the intervention powers required in relation to Health New Zealand as a Crown agent;

41 **agreed** to provide that certain equivalent powers to those under the Crown Entities Act 2004 be held in respect of the Māori Health Authority:

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42 **agreed** that the powers in paragraph 41.1 only be applied in respect of the Māori Health Authority following consultation with the Māori Health Advisory Committee;

43 **noted** that the Minister of Health intends to carry over and apply to both Health New Zealand and the Māori Health Authority certain powers from the New Zealand Public Health and Disability Act 2000 to:

43.1 enter into funding agreements and issuing notices;

43.2 replace a board with a commissioner;

43.3 provide a power for the Minister of Finance to require information including financial forecasts;

44 **noted** that the Minister of Health intends to also carry over the power from the New Zealand Public Health and Disability Act for the Minister to enter into Crown Funding Agreements;

45 **agreed** that the Minister of Health may determine the exercise of the power referred to in paragraph 43.2 in respect of the Māori Health Authority, but that an appointment must be made with the agreement of the Māori Health Advisory Committee;

46 **noted** that the Minister of Health intends to include the following provisions in the new health system legislation in respect of Health New Zealand and the Māori Health Authority:

46.1 the power for the Minister to appoint Crown observers to the new entity boards or any significant internal meeting;

46.2 the power for the Minister to require an improvement plan;

46.3 the power for Director-General to require any information about a health entity's operations or performance;

46.4 specify that the boards of Health New Zealand and the Māori Health Authority should have expertise in Te Ao Māori, health, public sector governance and government processes, and financial management;

47 **agreed** that Minister of Health may determine the exercise of the power referred to in paragraph 46.1 in respect of the Māori Health Authority, but that any appointment must be made with the agreement of the Māori Health Advisory Committee;

48 **agreed** that the powers in paragraph 46.2 only be applied in respect of the Māori Health Authority following consultation with the Māori Health Advisory Committee;

Public health structures and roles

49 **noted** that the Minister of Health intends to include the following statutory provisions to support the Cabinet's intended public health arrangements:

49.1 require the Minister to establish a public health advisory committee for the purposes of providing independent advice on public health;

49.2 amend the Health Act 1956 to require the Ministry of Health to have the Public Health Agency as a business unit;

49.3 allow the Director-General to appoint medical officers of health on the advice of the Director of Public Health, and clarify that the Director-General may remove the designation of a person as a medical officer of health;

49.4 give the Director of Public Health the functions of a medical officer of health, provided they are a public health medical practitioner.

Michael Webster
Secretary of the Cabinet