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 System Reform Briefings

The following documents have been included in this release:

Title of paper: Health Reform Strategy and Approach to Legislation

Title of paper: Health Reforms: Implementation and Transition Cabinet Paper

Title of paper: Health Reforms: Planning and Accountability Framework

Title of paper: Health Reforms: Implementation of a Consumer Voice Framework

Title of paper: Health Reforms: Legislation Cabinet Paper Summary and Talking Points

Title of paper: Health Reform: Legislation and Transition Update

Title of paper: Health Reforms: Legislating for Public Health Structures

Title of paper: Health Reforms: Legislating Intervention Powers and Obligations Relating to Health New Zealand

Title of paper: Health Reforms: Final Decisions for Legislation

Title of paper: Health Reforms: Implementation Cabinet Paper Summary and Talking Points

Title of paper: Confirming Hauora Māori System Settings

Title of paper: Health Reforms: Employment Relations Settings

Title of paper: Further Policy Decisions for the Health Reform Bill: Cabinet Paper Summary and Talking Points

Title of paper: Health Reforms: Development of the NZ Health Charter and Associated Legislative Provisions

Title of paper: Health Reforms: Independent Alcohol Advice and Research Function and Levy

Title of paper: Health Reforms: Remaining Transitional and Consequential Provisions for Decision

Title of paper: Joint Te Kawa Mataaho/ Health Transition Unit Report: Māori Health Authority – Proposed Application of Crown Entities Act 2004 and Public Service Act 2020

Title of paper: Health Reforms: Draft Cabinet Paper to Approve Bill for Introduction and Health System Principles

Title of paper: Pae Ora (Healthy Futures) Bill: Approval for Introduction at Cabinet

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Aide-Mémoire

FURTHER POLICY DECISIONS FOR THE HEALTH REFORM BILL: CABINET PAPER SUMMARY AND TALKING POINTS

To	Hon Andrew Little, Minister of Health	**Report No**	DPMC-2021/22-223
From	Stephen McKernan, Director, Health Transition Unit	**Date**	25/08/2021

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Purpose

1. This aide-mémoire provides you with a two-page summary of the draft Cabinet paper on the further policy decisions for the Health Reform Bill, and additional talking points to support Ministerial consultation. Talking points will be updated as necessary following consultation to support further discussion at the Cabinet Social Wellbeing Committee.

Summary talking points

2. Cabinet has agreed to most of the substantive policy decisions required for the legislation to implement the health and disability system reforms. There are further policy decisions on four key areas to be confirmed before the Bill is finalised for introduction.

Te Tiriti o Waitangi provisions

3. The health reforms are intended to achieve equity for Māori and put the principles of the Treaty of Waitangi at the heart of our system. Including provisions in legislation reflecting the principles will ensure that decision-makers within the system take them into account appropriately.

4. The proposed approach to achieve this involves two parts:

   a. a Te Tiriti o Waitangi clause including a descriptive provision setting out provisions that recognise or give effect to Te Tiriti o Waitangi principles. That is the standard approach used for recent legislation, such as that establishing the Mental Health and Wellbeing Commission, and Taumata Arowai; and

   b. a separate section setting out principles to guide decision-makers. That section will be framed around the concepts of the Hauora Inquiry principles, but incorporate broader, more generally applicable content.

5. Not specifically referencing the principles identified by the Tribunal raises the potential for Māori and other stakeholders to perceive the proposed provision as being too weak. But, by

integrating the principles identified by the Tribunal into the overall decision-making principles, we reinforce Te Tiriti o Waitangi at the heart of the new health system.

6. By doing it this way, there is no individually enforceable right established, but decisions will still be subject to judicial review. That's a reasonable trade-off for the benefits that I expect genuinely Treaty-informed decision making to have for our objective to achieve equitable outcomes for Māori.

Māori Health Authority and Iwi-Māori Partnership Boards

7. Achieving equity of health outcomes for Māori is central to our approach to health reform. The establishment of a Māori Health Authority and positioning iwi-Māori partnership boards to play a greater role in locality planning is central to our approach to achieving Māori health equity.

8. The Transition Unit in DPMC has consulted widely and partnered with Māori stakeholders and the Māori health sector. That has included a Steering Group chaired by Tā Mason Durie, 30 hui across New Zealand specifically to seek input on the reforms. The Unit has also considered insights from the Ministry of Health's Hui Whakaoranga series which has engaged with Māori nationwide.

Māori Health Authority

9. Through those hui and other engagement, Māori have indicated a cautious optimism for the reforms. Māori have expressed 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.

10. The key functions of the Authority will be:

    a. policy and strategy, including working with the Ministry of Health on preparing the New Zealand Health Strategy, Māori Health Strategy and other national strategies. It will generally give its advice through the Ministry, but it will have an explicit power to advise Ministers independently of the Ministry;

    b. co-commissioning services with Health New Zealand, including jointly working with Health New Zealand to determine national plans, including the New Zealand Health Plan and significant service agreements;

    c. commissioning kaupapa Māori services, and other innovative services to support Māori health improvement; and

    d. monitoring the performance of the health system for Māori.

11. A bespoke entity form – unlike existing health system organisations – is required for the Māori Health Authority. The Bill will establish the Authority as a statutory entity, rather than a Crown entity. But because it is expected to have a substantial budget, there need to be mechanisms for accountability for that budget so key mechanisms from the Crown Entities Act will apply. For example, the Authority will have to prepare a statement of intent, and an annual report.

12. As well as accountability to the Crown, the Authority needs mechanisms to facilitate accountability to Māori. The legislation will provide for a Māori Health Advisory Committee, appointed by the Minister. The Minister will be required to seek the advice of the Committee in the exercise of key powers, such as issuing letters of expectation to the Māori Health Authority. It will also provide a ready avenue to engage with Māori on the Authority's board

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appointments. This would ensure that the voice of Māori is embedded in this process as a balance to Ministerial direction.

13. As well as this, legislation will reinforce accountability to Māori by legislating for specific areas where the Authority will be required to have regard to the needs and aspirations of Māori, for example when developing the New Zealand Health Plan. This will reinforce clear accountabilities to Māori while providing the Authority flexibility and autonomy. It will also ensure it remains aligned with other health entities and structures.

14. While the Ministry of Health will retain its role as formal monitor and steward of the system as a whole, the Māori Health Authority will have a significant monitoring function. The Authority's role should be two-fold:

    a. as a co-monitor, with the Ministry of Health, of the health system in relation to hauora Māori; and

    b. as a monitor of Health NZ's performance against the Māori Health Plan, which will be the agreed priorities and activities of Health NZ to improve hauora Māori.

15. While I anticipate Health NZ 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 NZ and the Authority, there will be a resolution process that amounts to the Authority and Health New Zealand having 20 days to reach agreement, or the Minister will determine how the dispute is resolved.

Iwi-Māori Partnership Boards

16. Iwi-Māori partnership boards will remain independent Māori organisations, operating predominantly at the locality level of the health system. The new system will significantly strengthen the role of these boards at the locality level in priority-setting, strategy and planning. They will approve locality plans and reports on them, and agree locality priorities.

17. It will be necessary to recognise partnership boards in statute in order to provide them with statutory powers. The Bill will list boards in a schedule, based on the current set of boards. As the new system beds in, it is likely boards will want to re-negotiate boundaries. The legislation will allow the schedule to be altered by Order in Council, following mutual agreement between affected boards and notice to the Minister.

18. 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. It also ensures legal certainty, and mitigates risks relating to uncertainty of boundaries in the exercise of statutory powers.

Statutory intervention powers

19. Most of the statutory intervention powers required will derive from the Crown Entities Act 2004, which provides an extensive set of powers for the responsible Minister to influence the activity of Crown entities. The Act applies to Health NZ as it is a Crown agent. The unique structure of the Māori Health Authority means that certain powers will need to be carried over and applied to the Authority. The Authority will for example, be required to completed a statement of intent and annual report.

20. Some powers from the Health and Disability Act New Zealand should also be carried over into the new legislation. These powers are sufficiently flexible to achieve almost all of the types of intervention above, and therefore meet Cabinet's aims for finely-grained powers.

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21. However, in practice some of these powers are rarely exercised and have been seen as disproportionate. I consider it would be desirable to provide for some additional, more explicit provisions enabling intermediate steps and a more transparent escalation pathway. This includes new powers to require improvement plans, for instance.

22. Recognising the unique status of the Māori Health Authority, I propose that certain of these powers only be exercised by the Minister having consulted with, or sought agreement from, the Māori health advisory committee. This will ensure that the use of intervention powers follows the blended accountability arrangements within the Authority's form.

Public health structures and roles

23. 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. I intend minor provisions to put it on a sound statutory footing. I intend amendments to require the Agency to be established as a business unit of the Ministry and strengthening the powers of the Director of Public Health to lead the system. I also intend to establish a permanent public health advisory committee.

Recommendations

24. It is recommended that you note the contents of this aide-mémoire.

pp.

From Stephen McKernan

Director, Health Transition Unit

NOTED
To Hon Andrew Little Minister of Health
Date: / /

Appendix A: Two-page summary of Cabinet paper

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APPENDIX A

Summary of paper: Further policy decisions for the Health Reform Bill

1. 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. Cabinet has previously considered and agreed to specific proposals to legislate for the 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.

2. There are four further policy areas for Cabinet to consider before a Bill is finalised for introduction:

   - the approach to legislating for Te Tiriti o Waitangi obligations;
   - the role, functions, form and accountabilities of the Māori Health Authority, and the constitution of iwi-Māori partnership boards;
   - statutory intervention powers; and
   - provisions to give effect to public health structures and roles in the reformed system.

Te Tiriti o Waitangi provisions

3. Cabinet has previously agreed that the legislation will include a descriptive Treaty of Waitangi provision giving effect to the principles identified by the Waitangi Tribunal in its Hauora Inquiry. 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, such as those relating to the establishment of the Māori Health Authority. Second, a clause setting out decision-making principles to guide government agencies, incorporating the concepts of the Treaty/Tiriti principles identified by the Tribunal.

4. This approach, which does not specifically reference the Hauora Inquiry principles, may be seen as too weak by Māori. However, incorporating the concepts of the principles within the general decision-making guidance, puts Treaty-informed decision-making at the heart of the reformed health system. Legal advice is that this approach may increase the risk of judicial review litigation with respect to how the principles are taken into account. I consider this to be an appropriate trade-off for the benefits that Te Tiriti-informed decision making is expected to have in promoting equity of health outcomes for Māori.

Māori Health Authority and Iwi-Māori Partnership Boards

5. Cabinet has previously agreed that the Authority will have policy, strategy, operational planning, commissioning, co-commissioning, and monitoring roles, and 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 Authority and iwi-Māori partnership boards.

6. The Authority's policy and strategy roles will focus on matters relevant to hauora Māori and it will be required to give effect to the NZ Health Plan. The Authority will also have the prerogative to put up advice independently to the Minister of Health, be responsible for commissioning kaupapa Māori and other services tailored to Māori and co-commissioning

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all health services commissioned by Health NZ. I intend a dispute resolution mechanism to resolve disputes between the Authority and Health NZ to be included in the Bill. To enable the monitoring function of the Authority and avoid duplication, I propose the Authority's monitoring function be two-fold: as a co-monitor of the health system in relation to hauora Māori and as a monitor of Health NZ's commissioning and organisational performance in its capacity as co-commissioner (the main vehicle being the Māori Health Plan).

7. I propose statutory mechanisms requiring 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 clear reporting accountabilities to Māori, parallel to those of the Authority to the Minister of Health. This approach provides a balance to the Minister's powers of direction, 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.

8. A bespoke entity form will be required to achieve this. I recommend that the Authority be established in the Health Reform Bill as a statutory entity, governed by a board, not generally subject to the Crown Entities Act, but with key mechanisms from that Act referenced as part of its organisation form. Further, I propose the establishment of a standing statutory advisory committee, Māori Health Advisory Committee, and codifying a requirement for the Minister to seek the advice of the committee when exercising key powers.

9. Iwi-Māori partnership boards (IMPBs) will have stronger rights in shaping locality priorities than their current iterations do in influencing DHB commissioning. They will cover discrete areas, which will not overlap, and all iwi groups, hapori and mātā waka in their areas must have the opportunity to participate. I expect IMPBs will engage with whānau and hapū, assess and evaluate hauora Māori in their localities, engage with the Authority on priorities for kaupapa Māori investment innovation and report to Māori in their areas on their activities and the state of Māori Health within their areas. I do not propose to legislate for functions – the IMPBs are Māori bodies and it is up to Māori to determine the detail of their activities.

10. Legislation will need to recognise IMPBs in order to provide for their intended powers. To provide IMPBs with the necessary powers while maintaining flexibility for Māori to constitute the boards in the manner they deem most appropriate, including IMPB boundaries, I propose that IMPBs be listed in a schedule to the Bill, amendable by notice from the Minister of Health. I propose that these boards have powers to agree on local priorities and jointly approve locality plans with Health New Zealand commissioners, and to approve Health New Zealand's annual locality report for their localities. I intend that Health New Zealand and the Authority to be required to offer support to IMPBs to carry out their functions, and that this support may be administrative, analytical or financial, including an obligation to provide information, and for the Māori Health Authority to engage with IMPBs on priorities for kaupapa Māori and other innovative service to support Māori Health.

Statutory intervention powers

11. 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 NZ as a Crown agent, and I recommend the powers relating to the requiring information from the entity, reviewing the operations of an entity and directing an entity to give effect to government policy also apply to the Authority. Further, I intend to carry over powers from the New Zealand Public Health and Disability Act 2000 relating to entering into funding agreements and issuing notices, replacing an entity's board with a commissioner and the power for the Minister of Finance to require information and that these apply to both Health NZ and the Authority.

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12. I also propose certain new powers to provide for intermediate steps as part of a transparent escalation pathway, allowing for the Minister to appoint Crown observers and require an improvement plan, provide that the Director-General may require information from an entity, and specify that boards should have expertise in Te Ao Māori, health, public sector governance and government processes, and financial management.

Public health structures and roles

13. To ensure the Public Health Agency can exercise all necessary functions and strengthen its leadership of the national public health effort, I intend the Bill to amend the Health Act 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, including providing the Director-General with the power to appoint or remove medical officers of health on the advice of the Director of Public Health.

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