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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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.

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Briefing

CONFIRMING HAUORA MĀORI SYSTEM SETTINGS

To: Health Reforms Ministerial Oversight Group			
Date	19/08/2021	**Priority**	High
Deadline	27/08/2021	**Briefing Number**	DPMC-2021/22-192

Purpose

This briefing provides you with advice on the future system settings for our hauora Māori system, including recommendations around the roles and form of the Māori Health Authority and Iwi-Māori Partnership Boards.

Recommendations

a. **Note** that given decisions made to date on the roles and features of the Māori Health Authority, and on the wider health system operating model, there are significant advantages to establishing the Māori Health Authority in a form which is responsive to government policy and direction while also enabling Māori to exercise rangatiratanga and mana motuhake, to achieve wellbeing for whānau, hapu, iwi and hāpori Māori.

b. **Note** that the underlying rationale for a Māori Health Authority is to address inequities in Māori health access and outcomes, to embed Te Tiriti o Waitangi partnership across the health system, and to bring a sharper focus and emphasis on health system settings, responsiveness and accountability which have not been sufficiently delivered on by previous reforms.

c. **Agree** that the Health Reform Bill legislate for Te Tiriti in two ways:

i. a standalone Treaty clause that summarises the provisions giving effect to Tiriti elements; and **Yes / No**

ii. embedding the Tiriti principles identified by the Waitangi Tribunal in the core statutory principles which will apply to all entities in the Bill. **Yes / No**

Māori Health Authority

d.	**Agree** that the Health Reform Bill will confirm the roles of the Māori Health Authority as set out at [20].	**Yes / No**
e.	**Agree** that further features of the Māori Health Authority set out at [21] will be confirmed through the Health Reform Bill where required.	**Yes / No**
f.	**Agree** that the Māori Health Authority be established by the Health Reform Bill as a statutory entity not subject to the Crown Entities Act 2004, with mixed features resembling those of Crown agents and autonomous Crown entities under the Crown Entities Act.	**Yes / No**
g.	**Agree** that the Māori Health Authority have statutory obligations to engage with whānau, hapū, iwi and hapori Māori, and key hauora Māori stakeholders; and to report back to these groups and the Minister of Health on actions taken as a result of that engagement.	**Yes / No**
h.	**Agree** that the Māori Health Authority have statutory obligations to have regard to the needs and aspirations of Māori when undertaking key functions.	**Yes / No**
i.	**Agree** that the Māori Health Authority have a board appointed by the Minister of Health.	**Yes / No**
j.	**Agree** that the Health Reform Bill require the Minister of Health to establish a standing statutory Māori Health advisory group, comprised by Māori, to provide advice to the Minister on matters relating to hauora Māori.	**Yes / No**
k.	**Agree** that the Bill should require the Minister of Health to consult with this advisory group in exercising Ministerial powers regarding board appointments and letters of expectation.	**Yes / No**
l.	**Agree** that the Minister of Health should have the power to direct the Māori Health Authority to give effect to government policy, for the purposes of improving equity of access and equity of outcomes for Māori, and subject to a requirement to engage with the advisory group at recommendation [j].	**Yes / No**
m.	**Agree** that the Māori Health Authority's monitoring role be two-faceted; with one explicitly tied to its co-commissioning role and powers, focused on the performance of Health NZ; and the second a co-monitoring function in partnership with the Ministry of Health in monitoring the wider health system's performance for Māori.	**Yes / No**

Iwi-Māori Partnership Board design

n.	**Agree** to the roles for Iwi-Māori Partnership Boards set out at [73].	**Yes / No**

o.	**Agree** that Health NZ and the Māori Health Authority have statutory obligations to provide support to Iwi-Māori Partnership Boards for secretariat functions, and analytical and planning support; but also have the power to delegate and fund these supports to be delivered directly by IMPBs, at the agreement of Health NZ, the Māori Health Authority and affected Iwi-Māori Partnership Boards.	**Yes / No**
p.	**Agree** that Iwi-Māori Partnership Boards be formed at the discretion of Māori, including at a minimum an invitation to representation to all iwi within the Iwi-Māori Partnership Board's relevant area.	**Yes / No**
q.	**Agree** that the Health Reform Bill require Iwi-Māori Partnership Boards to include or invite representation for hapori Māori.	**Yes / No**
r.	**Agree** that Iwi-Māori Partnership Boards will be constituted at first instance with reference to the Boards which currently exist, tied to district boundaries, with the ability for Boards to reorganise (including merging, de-merging and shifting boundaries) based on mutual agreement between affected Iwi-Māori Partnership Boards.	**Yes / No**
s.	**Agree** to impose a requirement on Health NZ and the Māori Health Authority to recognise boundaries agreed by Iwi-Māori Partnership Boards when setting regional boundaries, and to ensure insofar as is possible that locality boundaries align to current Iwi-Māori Partnership Board boundaries.	**Yes / No**
t.	**Forward** this briefing to the Minister for the Public Service.	**Yes / No**

Stephen McKernan Director **Health Transition Unit**	Rt Hon Jacinda Ardern Prime Minister
18/08/2021	…../…../….

Hon Grant Robertson Minister of Finance	Hon Andrew Little Minister of Health
...../...../....	
Hon Peeni Henare Associate Minister of Health	Hon Carmel Sepuloni Minister for Disability Issues
...../...../....	...../...../....

Contact for telephone discussion if required:

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CONFIRMING HAUORA MĀORI SYSTEM SETTINGS

Context

1. Cabinet has made a series of decisions on aspects of our future health system which are intended to achieve equity for Māori, and put Tiriti o Waitangi partnership at the heart of our system.

2. Central to these decisions is the establishment of a Māori Health Authority and positioning Iwi-Māori Partnership Boards to play a greater role in locality planning (CAB-21-MIN-0092). However, key decisions on the role, functions, form and accountabilities of the Māori Health Authority, and the constitution of Iwi-Māori Partnership Boards, are required to finalise and introduce a Health Reform Bill in September.

3. Since April, 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. We have:

    a. established 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

    b. engaged with Māori through over 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

    c. considered insights from the Ministry of Health's Hui Whakaoranga series, which has also engaged with Māori nationwide.

4. Engagements with Māori indicate 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, to act as a vehicle for enabling rangatiratanga and mana motuhake, and to have significant influence in shaping the health system's approach and response to Māori health needs.

5. The Steering Group has provided advice to the Transition Unit on options for the Māori Health Authority and Health NZ's accountabilities to Māori. That advice informed a briefing to the Minister of Health and Associate Minister of Health (Māori Health) on 6 August, which was co-signed by Tā Mason Durie and sought decisions on key aspects of the hauora Māori system. This briefing reflects the decisions made by the Minister of Health in response to that advice.

The case for reforming our hauora Māori system

6. When Cabinet agreed in March to reform the health and disability system (CAB-21-MIN-0092), it did so in response to endemic, critical issues with our current health system – including that New Zealand's public health system does not meet the Crown's obligations to Māori, and that the overall performance of our health system

conceals significant underperformance and inequity, particularly for Māori and Pacific peoples. These aspirations are not new, but successive reforms have failed to make sufficient progress towards equity of care, access and outcomes for Māori among other population groups.

7. The Health and Disability System Review's Final Report, released in March 2020, made a case to establish a Māori Health Authority to meaningfully improve outcomes for hauora Māori. The report presented two views on how this might be achieved – either through a policy, strategy and monitoring agency, or through such an agency with additional commissioning powers (i.e. the ability to plan and contract services).

8. In previous reforms (both large and small), a range of approaches have been taken in an attempt to assure Māori health equity – from representation on boards or in executive roles, to the establishment of separate Māori teams or supplementary commissioners. Today's DHBs similarly take a diversity of approaches, including appointing Māori board members, establishing advisory Iwi-Māori Partnership Boards to seek Māori input on key strategic and policy decisions, and variable investment in kaupapa Māori providers to better reach into Māori whānau and communities. These measures have been insufficient for a range of reasons, including because:

   a. the institutional 'weight' of large organisations makes achieving transformational improvement difficult for a small number of Māori-oriented actors inside them

   b. the compounding effects of strategy, policy-making, planning, commissioning and monitoring mean that without clear Māori input and steer at each level, divergence from equity-focused approaches can easily occur

   c. insufficient resourcing and prioritisation decisions which have meant funding and resources have not been directed to Māori

   d. insufficient recognition has been given to tino rangatiratanga and mana motuhake – key aspects of the government's Tiriti o Waitangi obligations – relegating Māori voices outside of the public health system to advisory roles.

9. The approach proposed for the future hauora Māori system, including through decisions taken to date, is intended to approach health equity and Te Tiriti o Waitangi differently, by:

   a. establishing a Māori Health Authority with a broad mandate and role, including the ability to lead policy and strategy for hauora Māori in partnership with the Ministry of Health; to commission and co-commission services in partnership with Health NZ with span across the whole health system; and to monitor system performance for Māori

   b. leveraging the role of the Authority to sharpen the obligations and accountabilities on other health entities – particularly Health NZ – to improve outcomes for Māori, using levers such as the Māori Health Plan and the Māori Health Authority's commissioning powers

   c. giving bite to Iwi-Māori Partnership Boards by giving them influence over locality priorities, so that Health NZ's approach to locality commissioning is more sharply responsive to the voice and needs of local Māori communities.

10. The Māori Health Plan is a particularly critical lever to improve whole-of-system performance for Māori over time. It will be an agreement between the Authority and

Health New Zealand as to the steps Health NZ will take to improve Māori health equity, and will specify how Health New Zealand intends to design services, employ resources and train its workforce to improve equity and health outcomes. As discussed further below, it will form a key part of Health NZ's accountabilities to the Authority for Health NZ's role in the hauora Māori system.

11. We expect that this approach will materially improve Māori health equity and outcomes over time, by embedding Te Tiriti o Waitangi across the health system and health entities. The Māori Health Authority and Iwi-Māori Partnership Boards will bring a different level of Māori leadership and influence to the system, working alongside Health NZ to expand the range of services targeted at Māori needs (e.g. kaupapa Māori services) and ensure that the wider range of health services provided and commissioned by our system (which many Māori will continue to access) are more responsive to Māori needs and aspirations. In practice, this looks like:

    a. primary and community-based care networks prioritising better access, care models, clinical pathways and support for those whānau who have not been well served by the health system to date

    b. community care networks anchoring their models to the strengths of kaupapa Māori providers, rather than using them as a 'last resort' referral point

    c. services working harder to recognise and incorporate te ao Māori ways of working and models of care

    d. stronger connections between kaupapa Māori providers and 'mainstream' or universal services, recognising that Māori providers will have a different and greater reach into and relationship with Māori households and communities

    e. deliberately investing in a collective, joined-up response to serving Māori whānau and communities

    f. identifying successful care models and collaborations, and driving their adoption across the country

    g. identifying sub-standing practice and holding providers and commissioners to account for service and system improvement

    h. fostering new whānau-centric approaches to tackle local and community challenges.

12. In designing the proposed approach to the hauora Māori system, we have sought to adopt options which balance:

    a. the ability of the Authority to deliver on its core functions, including its delivery of policy and strategy advice alongside the Ministry of Health, the direct commissioning of kaupapa Māori and Māori-centred services, and the joint planning and co-commissioning of wider health services in partnership with Health NZ

    b. connection to other parts of the health system, including a constructive commissioning relationship with Health NZ (while pushing for meaningful equity for Māori), and a shared responsibility for delivering on improved outcomes for hauora Māori

    c. giving effect to tino rangatiratanga and mana motuhake.

13. To that, the various features of this system are intended to be considered part of an overall package, with respective roles and responsibilities in balancing kawanatanga, partnership, and rangatiratanga.

Te Tiriti o Waitangi

14. One of the most vital mechanisms to achieve equitable health outcomes for Māori, and to meet the Crown's obligations to Māori, is to embed Tiriti o Waitangi partnership across the health system. The obligation to do so will fall on all agencies, not just the Māori Health Authority.

15. There are two general forms of Treaty clause, with their own advantages and disadvantages. The traditional form, which requires that decision-makers give effect to the Treaty, is powerful, but it can be unclear how decision-makers give effect to it in practice. There is also the risk of unexpected implications emerging from legal action. The descriptive form that is more common today sets out the provisions of an Act that give effect to the Crown's Treaty obligations. This has the advantage of clarity for decision-makers about their obligations, however it doesn't allow for the evolution of the application of the principles over time, and can limit Treaty considerations to the narrowly defined legislative provisions.

16. The planning architecture of the reformed system has been designed in collaboration with Māori. This has been an open and good faith process, which has reached an agreed conclusion. It is important that Treaty provisions do not undercut that agreed position. Equally, it is important to ensure that the Crown continues that good faith approach by providing that decisions made by health system actors will be genuinely informed by the Treaty principles, and that the legislation supports rather than limits this.

17. We propose therefore a hybrid approach that gives effect to Tiriti o Waitangi obligations and principles in two ways:

    a. By summarising the provisions giving effect to Te Tiriti o Waitangi elements in a standalone Treaty clause, similar to those in the Mental Health and Wellbeing Commission Act 2020; and the Taumata Arowai – the Water Services Regulator Act 2020.

    b. By including a set of decision-making principles to which public entities within the health system must have regard. This list would include Te Tiriti o Waitangi principles identified by the Tribunal. This would seek to include the principles of tino rangatiratanga, partnership, active protection, options and equity – and apply them broadly to all decisions made by entities under the Bill.

18. These responsibilities will extend beyond the Māori Health Authority and to all other health entities to deliver on Te Tiriti o Waitangi principles. The legislative provisions for Te Tiriti o Waitangi 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.

The Māori Health Authority

Roles and functions

19. The Māori Health Authority will hold dual accountabilities to the Crown and to Māori. Its form and structure will influence how it balances those accountabilities, and the ways in which they manifest.

20. Cabinet has already made several fundamental decisions about the features, roles and structures of the Māori Health Authority (CAB-21-MIN-0092). We intend to give effect to these settings through provisions in the Health Reform Bill. In particular, it has agreed that the Māori Health Authority will have policy and strategy, operational planning, commissioning, and co-commissioning, and monitoring roles (with the Authority's commissioning roles having been agreed in-principle).

21. In advice to you, we have further confirmed a series of other settings which we propose to effect through the Bill:

    a. The Māori Health Authority's policy and strategy roles will focus on matters relevant to hauora Māori, including the New Zealand Health Strategy, Māori Health Strategy, and other associated strategies, frameworks and plans. It will have the prerogative to put up advice independently to the Minister of Health but will generally exercise this function by providing advice in partnership with the Ministry of Health.

    b. The Authority will have commissioning responsibility over novel kaupapa Māori services, other innovative services tailored for Māori, and Māori provider and workforce development.

    c. It will act as a co-commissioner of all health services (including both primary and community-based care, and hospital and specialist services) alongside Health NZ. This means that the Māori Health Authority and Health NZ will work in partnership to identify health needs and plan, contract for, fund, manage and monitor health services.

    d. This includes the joint development 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.

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

    f. Disputes between Health NZ and the Māori Health Authority (or between Health NZ and IMPBs) as to commissioning sign-offs – such as on the New Zealand Health Plan, locality plans, or a commissioning framework – which cannot be resolved relationally will escalate from the locality, to the regional, to the national, to the board layer. Any disputes unresolved between the boards will go to the Minister of Health for a decision; we anticipate that the Minister of Health would use letters of expectation to set clear expectations for the (rare) circumstances in which such escalation would be acceptable.

    g. The Authority will be subject to the NZ Health Plan, which it will jointly develop and sign off with Health NZ, for the Minister of Health's agreement. Once agreed, 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. This requirement to be bound to the NZ Health Plan will also extend to any associated funding agreements.

h. The Māori Health Authority will undertake annual reporting, including issuing a statement of intent, equivalent to that required of Health NZ (with precise mechanisms varying depending on organisational form).

22. The dual commissioning and co-commissioning role of the Māori Health Authority is among its more novel and significant functions. This role goes beyond the views expressed as to the Māori Health Authority's role in the Health and Disability System Review to include wider functions:

a. Sole commissioning powers 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 mainstream health system, opening up funding for new investments.

b. Co-commissioning powers over the full range of health services commissioned by our health system. This means that the Māori Health Authority and Health NZ will jointly sign off 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.

23. The Māori Health Authority's co-commissioning powers are deliberately wide-ranging and significant, allowing the Authority to play an active role in ensuring that outcomes for Māori are achieved through the care our system commissions. The two organisations will be expected to produce a commissioning framework, updated periodically, which outlines how they will co-commission in close partnership – recognising that in practice, the Authority will have greater capacity constraints than Health NZ. At the locality level (e.g. for locality planning), the Māori Health Authority will act with regard to recommendations from the relevant Iwi-Māori Partnership Board, to preserve and support mana motuhake.

24. This model offers significant advantages in practice. By ensuring the Authority is involved in all key decisions about commissioning and management of health services, it has scope to shape practice and make decisions alongside Health NZ across the health system. This allows the Māori Health Authority to focus in on areas of greatest need or value add as these shift over time; while building a strong partnership relationship with Health NZ to lift overall system performance (both through the Māori Health Plan and softer, relational measures such as shared best practice in commissioning). Where required to achieve change, the Authority and Health NZ can take steps such as re-planning where or how certain kinds of services are delivered; proactively managing the performance of providers; or adopting different funding approaches to incentivise improvements to Māori health outcomes.

25. For example, if performance of a particular service (e.g. national maternity services) or in a particular locality (e.g. Porirua) were to be failing to achieve expected progress in Māori health outcomes, the Authority would work with Health NZ to diagnose potential issues and causes, and identify steps to improve performance. If performance stubbornly failed to improve, Health NZ and the Authority might agree for the Māori Health Authority to take a more active role – such as by managing improvements or changes in services with contracted providers, or by adopting a

wholly different commissioning approach (e.g. commissioning care through a hauora Māori provider cluster, or investing in provider development to encourage new approaches and disrupt static provider markets).

26. In recommending this approach, we considered the narrower roles proposed by the Health and Disability System Review for the Māori Health Authority – including either a pure policy, strategy and monitoring agency, or an agency with limited commissioning powers over kaupapa Māori services. However, our evaluation was that these options:

    a. offered insufficient levers to the Māori Health Authority to achieve change in the wider health system where system performance for Māori is insufficient

    b. tend to fragment the health system, isolating hauora Māori – including kaupapa Māori services – from the mainstream health system, which cuts against the desire for greater service integration and does not match the reality of care, where Māori often access a blend of kaupapa Māori and mainstream services.

Relationship between the Crown and Māori Health Authority

27. Both Māori and the government have very significant and very broad ambitions for the Māori Health Authority. Māori we engaged with were clear that they wanted the Authority to operate differently to status quo agencies, to resource and support Māori to tackle Māori health equity, and to both invest in kaupapa Māori services and influence and shape the full range of health services which our system plans, commissions and delivers. We also expect the Authority to champion and drive improvements in Māori health equity and outcomes, and to partner sustainably with Health NZ to ensure a united front in improving our health system.

28. The system operating model which Cabinet has already agreed to (CAB-21-MIN-0092) makes the Māori Health Authority a full partner alongside Health NZ in co-commissioning all health services, and alongside the Ministry of Health in providing policy and strategy advice on hauora Māori – as well as commissioning innovative kaupapa Māori and Māori-focused services. This role has a fundamentally Crown character, as it focuses on the planning, commissioning and delivery of services for our public health system, including the anticipated management of significant Crown funds.

29. At the same time, the rationale for the Authority's existence is to take a different approach to Māori health equity and outcomes, to bring a unique Māori lens to the system, and to drive tino rangatiratanga and mana motuhake in improving hauora Māori. We have therefore sought to design a statutory entity with many features of the public service, which has accountabilities to Ministers for its overall direction, performance and use of public funds, and which also has accountabilities to Māori to listen and deliver on the needs, aspirations and priorities of tangata whenua.

30. We explore in more detail below how the proposed approach to the Māori Health Authority gives effect to this unique character, including through the Māori Health Authority's:

    a. legal form

    b. accountability to Māori

    c. governance arrangements

d. responsiveness to government policy

e. monitoring roles.

Legal form

31. Cabinet has already agreed that the Māori Health Authority will be a new statutory entity, independent of other health system organisations, constituted in a way that gives effect to rangatiratanga and embeds the principle of partnership between Māori and the Crown. This will require an entity which is bespoke and unlike any existing health entity.

32. Given that the Māori Health Authority is intended to operate in partnership between Māori and the Crown, and give effect to rangatiratanga and mana motuhake, we do not consider a traditional Crown entity model to be appropriate.

33. We have considered options for establishing the Authority in the model of the Crown Entities Act. 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 would be outweighed by significant presentational and practical disadvantages. Both in appearance and fundamental character, a Crown agent suggests a much smaller role for Māori priorities and aspirations than is intended by the Authority's design. Moreover, such a form would risk undermining the cautious support of Māori based on our engagement to date.

34. We therefore recommend pursuing a different, more novel approach to statutory form that balances the Authority's intended accountabilities to Ministers and Māori. This would provide that the Māori Health Authority be a statutory entity, which is not generally subject to the Crown Entities Act, but which has key mechanisms from that Act incorporated into its organisational form. This would be clear that the Authority is not a traditional form of Crown entity, but is a unique statutory organisation that reflects its intended role and purpose – similar to the approach taken to legislating to establish Te Mātāwai by Te Ture mō Te Reo Māori / the Māori Language Act 2016.

35. 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 system entities by providing for a common system architecture to be applied through the use of Crown Entities Act mechanisms.

36. The legislation should apply elements of the Crown Entities Act that reflect the Authority's accountabilities to Ministers as a commissioner and co-commissioner of health services and a budget-holder. These mechanisms would include general administrative requirements such as the role, duties and accountabilities of the board, and support necessary accountability through reporting requirements, including requirements for statements of intent and statements of performance expectations.

37. In addition, the Authority should be bound to wider duties in relation to Māori accountabilities as outlined below. We will seek legal advice and input from the Parliamentary Counsel Office on how best to achieve this.

Accountability to Māori

38. A unique, distinguishing feature of the Authority relates to its accountability to Māori. We recommend using statutory mechanisms to require the Authority to consider, act on and report back on whānau, hapū, iwi and hapori (communities) Māori aspirations and needs, which would inform how it delivers its functions.

39. This should also extend to a specific requirement to engage with Māori organisations including Iwi-Māori Partnership Boards; iwi authorities, rūnanga and trust boards; Māori health professionals' organisations; providers; and representatives of whānau and hapū. This approach has been recommended by the Steering Group.

40. While we intend that these obligations would be deliberately flexible (i.e. without specifics set by legislation), they would be underpinned by a requirement to undertake engagement, and to report back to whānau, hapū, iwi, hapori, the organisations or groups above, and the Minister on actions taken based on that engagement. This would create clear reporting accountabilities to Māori parallel to those to the Minister of Health. If you wish, some or all of these obligations could also be extended to Health NZ.

41. In addition to these general duties to engage, we recommend also legislating for specific areas where the Authority should be required to have regard to the needs and aspirations of Māori, as identified through the above engagement:

    a. Co-developing and signing off the NZ Health Strategy, other health strategies and the NZ Health Plan (before they are put to the Minister of Health for approval).

    b. Preparing a statement of intent and other applicable performance documents (e.g. an annual statement of performance expectations).

    c. Developing expectations on Health NZ to strengthen organisational performance for Māori (such as through a Māori Health Plan).

    d. Giving effect to government policy and the Authority's statutory purposes, including in approving strategies, plans and frameworks which affect the Authority's activities.

Governance arrangements

42. We strongly recommend that the permanent Māori Health Authority have a stand-alone board. A board will be best placed to blend the interests and priorities of Māori and the Crown, and to represent a diversity of Māori perspectives on the Authority's mission. It will also allow for Māori governance of the Authority, and for the involvement of Māori in the appointment of organisational leadership.

43. A board would require a permanent mechanism for appointment and removal. Under the Crown Entities Act 2004, the responsible Minister appoints and removes board members of Crown agents or autonomous Crown entities unless otherwise provided by enabling legislation. Although we do not intend the Authority to be established under the Crown Entities Act, we consider that the Minister of Health is best placed to hold this role for the Māori Health Authority to ensure the Authority's performance and delivery to government expectations (e.g. in relation to the NZ Health Plan, and in the management of co-commissioning arrangements with Health NZ).

44. Given the Māori Health Authority's character, we further recommend statutory requirements to consult with Māori in the exercise of the power of appointment. While this could be achieved through a broad statutory obligation to consult with Māori when exercising powers relating to boards, such an approach would create workload and pressure on Ministers to design a robust approach whenever board appointments are required, which could risk becoming both inflexible and insufficient consultative.

45. We therefore recommend establishing a permanent version of the Steering Group currently chaired by Tā Mason Durie, which would provide advice on appointments to the Māori Health Authority board, and would also (as described below) act to support the exercise of other Ministerial powers.

46. The establishment of a standing statutory advisory committee advising the Minister of Health – similar in nature to the Steering Group or a section 11 committee – would provide a ready avenue to engage with Māori on Māori Health Authority board appointments and letters of expectation, which are likely to occur periodically. A body of this nature would make it more likely that the Authority can readily respond to both Māori and government aspirations and would support the Minister of Health to shape a single, coherent set of priorities for the organisation.

47. We therefore recommend that a permanent Māori advisory group be established through the Health Reform Bill, to provide advice on board appointments (and removals) to the Māori Health Authority and on the letter of expectations for the Māori Health Authority. We also recommend that this extends to board appointments and removals and the letter of expectations for the board of Health NZ, given the desire to ensure that all agencies contribute to improving access and outcomes for Māori. This body would have statutory rights of consultation prior to the Minister exercising the above powers.

48. If an advisory group were to be a feature of the future health system, we recommend leaving the establishment and composition of such a group to Ministerial discretion, so that Ministers can work with Māori to determine the most appropriate way to convene such a body, which might evolve over time.

s9(2)(g)(i) [redacted]

[redacted]

[redacted]

52. s9(2)(g)(i) [redacted]

Responsiveness to government policy

53. A primary feature which distinguishes different kinds of statutory entities from each other is the extent to which the entity is responsive to direction on government policy and/or exercises a degree of independence. Typically entities will either:

    a. 'give effect to' government policy where directed by the Minister, including in this instance through the Government Policy Statement, or

    b. 'have regard to' government policy, meaning it must take into account directions from the Minister of Health when making decisions, but might not comply with them as stated.

54. The decisions already made as to the character and role of the Māori Health Authority mean it will, in practice, give effect to government policy in an ongoing manner in most instances. In developing the NZ Health Plan with Health NZ, the Authority will be expected to give independent advice and input which reflects the needs, aspirations and priorities of Māori; but once signed off, the Health Plan must bind both the Authority and Health NZ 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.

55. Although these requirements will practically bind the Māori Health Authority to government policy in some ways (e.g. as expressed through the NZ Health Plan), 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 NZ, and by the Authority alone).

56. 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. Consistent with our approach above to incorporating elements of the Crown Entities Act but to not establishing the Authority as a Crown agent, we believe that there should be a modified version of these powers which better describes the Authority's shared accountabilities.

57. We consider that it is right that the Minister 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 a series of risks:

    a. Co-commissioning would be fraught if the Māori Health Authority and Health NZ were to approach the relationship with different direction (i.e. where the Māori Health Authority could set aside government policy) – for example, the Māori Health Authority could seek to co-commission services which Health NZ was precluded from co-commissioning, leading to deadlock.

    b. Disagreements in the commissioning relationship would be much more likely under other scenarios, and much more likely to escalate to the Minister of

Health, as Health NZ and the Māori Health Authority diverge in direction despite shared plans and frameworks (though we consider a degree of divergence in priorities during the development of plans a feature of a healthy system).

c. For the Māori Health Authority to be a recipient of significant government funding to be used for service commissioning, it is desirable that it be bound to follow government policy in how it spends that money, and governments will be able to use funding agreements to that effect regardless of the fundamental statutory settings.

58. However, the Māori Health Authority is intended to work differently to other health agencies to deliver improvements in health equity and outcomes 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.

59. We therefore recommend that the Minister's powers to direct the Authority be limited in two ways:

a. First, by providing that directions may only require the Māori Health Authority to give effect to government policy for the purposes of improving equity of access and equity of outcomes for Māori. This means that the Authority would only need to respond to ministerial directives to that effect, and could not be directed to adopt policies which do not improve equity of access or outcomes for Māori.

b. Second, by requiring that the Minister seek the advice of the Māori health advisory committee in the exercise of 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.

60. We believe that this approach will balance the requirements of accountability to Ministers, as a commissioner of health services and a budget-holder, with those to Māori. Together with the statutory obligations of engagement and accountability to Māori as above, these provisions are intended to provide a model that weighs and applies these responsibilities effectively. This element was highlighted as key to the Authority's success by the Steering Group.

Alternative approaches

61. We also considered other models for the Māori Health Authority's form which were more independent. If you wished to adopt a more independent model – for example, where the Authority was not required to give effect to government policy – modifications to the fundamental operating model would be required to make that greater autonomy meaningful. For example:

a. the NZ Health Plan would need to incorporate greater freedom for the Authority to direct funding where it chooses, including to identify priorities for investment not captured by the Health Plan (noting that this may result in comparatively decreased coverage or investment in government priority areas)

b. a more neutral dispute resolution system would be required to preserve the Authority's autonomy, which might include binding arbitration or mediation, which would likely result in some fundamentally political decisions (e.g. about the relative prioritisation of different services) being outside ministerial control or direction

c. governments would need to resist the temptation to over-specify in funding agreements for the Māori Health Authority, to maintain that degree of autonomy over time.

62. Our view is that these concessions in the wider operating model would undermine some of its strengths – including that of a NZ Health Plan which provides certainty as to what the health system will deliver, and of a high-trust co-commissioning relationship between Health NZ and the Māori Health Authority – without delivering significant benefits beyond those offered by the preferred model. This would likely undermine the proposed system role of the Authority, and limit its funding and influence over time.

Monitoring functions

63. One of the Māori Health Authority's key roles as outlined in previous Cabinet decisions is its monitoring function, which is intended to ensure that other health agencies – particularly Health NZ – are also driving the health system to deliver better care and outcomes for Māori.

64. In the future system operating model, the Ministry will retain a role as a formal monitor and steward of the system. This will include collecting and analysing data and information on Māori health equity and improvements in system performance to benefit Māori, and analysing the organisational performance of both Health NZ and the Māori Health Authority. We do not consider that this role needs to be duplicated by the Māori Health Authority; however, we intend to include requirements in the Bill that the Ministry of Health must work jointly with the Māori Health Authority in evaluating the performance of Health NZ for Māori.

65. The unique lens that the Māori Health Authority will bring to monitoring is as a co-commissioner. Unlike the Ministry of Health, the Authority will have a close view of how commissioning occurs in practice, including the details of how Health NZ plans, funds, contracts, manages and evaluates services nationwide.

66. Given this lens and the levers available, we recommend that the Māori Health Authority's monitoring function be two-fold:

a. First, as a co-monitor of the health system in relation to hauora Māori, alongside the Ministry of Health. In this role, the Authority would partner with the Ministry of Health to add insight from its capacity as co-commissioner, and analytical capability and insight (with a Māori lens) to the Ministry of Health's monitoring functions. The two agencies would undertake a whole-of-system monitoring in partnership, with both contributing to advice to Ministers of system performance for Māori.

b. Second, as a monitor of Health NZ's performance against the Māori Health Plan – which will ensure continuous improvement by Health NZ in delivering on Māori health equity.

67. In relation to the first of these, the Ministry of Health will retain its role as a formal monitor and steward of the system as a whole. The Authority, moreover, will bring a unique lens to monitoring of hauora Māori as a co-commissioner with Health NZ. This will complement the Ministry's role as system steward, supplementing detail of how Health NZ plans, funds, contracts, manages and evaluates services nationwide. This dimension of this monitoring function will also overlap to some extent with the statutory role of Te Puni Kōkiri. The agencies involved would seek a memorandum of understanding or similar agreement to clarify practice in any areas where monitoring functions overlap.

Iwi-Māori Partnership Boards

68. As signalled in previous Cabinet papers (CAB-21-MIN-0092), Iwi-Māori Partnership Boards (IMPBs) are Māori bodies intended to:

a. 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

b. ensure the voices of whānau Māori are elevated and made visible within the health system

c. embed mātauranga Māori within locality plans, which then influence national planning.

69. IMPBs will be independent Māori organisations without government character which operate predominantly at the locality level of the health system. They will be closely involved in locality priority-setting, strategy and planning; locality plans will be agreed between Health NZ commissioners and Iwi-Māori Partnership Boards to proceed to implementation. Where the two disagree, disputes will be escalated to Health NZ and the Māori Health Authority at the regional level.

70. There are three major outstanding decisions relating to Iwi-Māori Partnership Boards:

a. The extent of their roles in localities.

b. How their functions are supported and resourced (e.g. secretariat and policy functions).

c. Their composition and constitution.

Roles

71. As agreed in previous advice, Iwi-Māori Partnership Boards are intended to have much greater involvement in shaping locality priorities than their current iterations do in influencing DHB commissioning. At present, generic requirements on DHBs to engage with Māori have resulted in inconsistent involvement of whānau and hapū Māori, and mana whenua in decision-making, making the case for stronger levers to drive partnership between Health NZ and Māori in locality planning and commissioning.

72. In engagement with Māori (including the Steering Group), it was emphasised that Iwi-Māori Partnership Boards ought to have their own mana and powers, rather than relying on obligations on Health NZ.

73. To deliver on these purposes, IMPBs could play several complementary core roles to be outlined in the Health Reform Bill:

    a. Engage with whānau and hapū, and share resulting insights and perspectives with Health NZ, the Māori Health Authority and others. This would ensure that IMPBs' views reflect local priorities and insights, and would act to magnify the perspectives of Māori within localities.

    b. Assess and evaluate the current state of hauora Māori in their locality or localities.

    c. Agree locality priorities with Health NZ locality commissioners – working with locality commissioners to negotiate strategic Māori health outcomes and priorities, service-level priorities, unique or significant local issues, and broader observations on wellbeing and social determinants of health in the locality. Locality commissioners would be required by the Bill to engage with IMPBs.

    d. Engage on and review locality plans developed by Health NZ locality commissioners, and approve these according to a statutory power.

    e. Engage with the Māori Health Authority on wider priorities for kaupapa Māori investment and innovation. This would support a 'ground up' approach to investment by the Authority, which will not have a significant presence in localities.

    f. Monitor the performance of the health system in their locality or localities against the locality plan.

    g. Produce an annual report of activities (or equivalent) for whānau and hapori Māori, and other partners. This ensures a measure of accountability of IMPBs to Māori in each locality.

74. In light of the approach proposed to the Māori Health Authority above, we recommend that the locality layer of the system be where tino rangatiratanga and mana motuhake are most emphasised. This is fitting, as it is where mana whenua are best placed to directly influence the care made available in their communities. To that end, we recommend you include all the core roles of Iwi-Māori Partnership Boards above in the Health Reform Bill.

75. Beyond these roles, there are further functions which some or all Iwi-Māori Partnership Boards may grow over time, or may take on in some areas. These could include inter-sectoral collaboration (e.g. with other social sector agencies), communications (e.g. health promotion), data sovereignty, training and education, crisis or risk management, innovation, provider capability- and market-building, and workforce development.

76. We do not recommend that these roles be prescribed by the Bill – as they are unlikely to be part of how IMPBs operate in all localities, and some involve a measure of complexity (e.g. how data sovereignty is managed nationally, regionally and locally across entities). However, we recommend that the Bill be inclusive in permitting further roles for IMPBs where agreed by the IMPB, Health NZ and the Māori Health Authority – which may include on an individualised basis by IMPB, as maturity and

capability develop. This will require that today's IMPBs develop significantly in some cases over the coming year, evolving and building capability in response to these new roles.

77. Based on discussions to date with IMPBs, there are already three regional 'aggregate' bodies which bring together the interests of relevant IMPBs in a region. We anticipate that as IMPBs embed, IMPBs will collaborate regionally to inform and influence the practice of Health NZ regional commissioners; and likely nationally to provide advice and steer to the Māori Health Authority. We do not plan to legislate for these functions, but rather to let them evolve over time.

Support for functions

78. To deliver on the above roles – including the fundamental role of working on locality plans – Iwi-Māori Partnership Boards will need a measure of resourcing and support in addition to funding the membership of the Board. This support includes secretariat functions, the provision of data analysis and policy advice, and support to influence locality planning (e.g. to provide Health NZ and Māori Health Authority commissioners with clear articulations of iwi, hapū, whānau and hapori expectations).

79. It was originally proposed that this support would be provided by health agencies. Health NZ would provide more functional support (e.g. secretariat and basic analytical support), while the Māori Health Authority would provide additional Māori-oriented subject-matter support (e.g. in understanding population health outcomes in a locality through a Māori lens), including support with policy advice and drafting in locality planning.

80. In the course of engaging with today's IMPBs, they highlighted that in some instances current IMPBs already have infrastructure supporting them (e.g. from iwi health organisations) which can meet these needs. In such circumstances, requiring IMPBs to draw this support only from health agencies would represent a step backwards away from mana motuhake for these Boards. At the same time, other IMPBs highlighted that significant capability growth will be needed to fulfil the proposed new roles; not all are ready now to take on all of these functions themselves.

81. Health NZ and the Māori Health Authority will need to offer support to at least some Iwi-Māori Partnership Boards initially, and we recommend imposing a statutory requirement on those agencies to do so. However, we recommend permitting statutory flexibility in how this support is provided to be negotiated with each Iwi-Māori Partnership Board, whereby IMPBs can either be supported by Health NZ and the Māori Health Authority, or receive funding directly to provide support functions themselves. The appropriate approach would be negotiated between each IMPB, Health NZ and the Māori Health Authority, applying a scaling approach so that IMPBs can grow capability and take increasingly autonomous approaches over time, as they acclimate to their new functions. This approach aligns with advice provided by the Steering Group.

Composition and constitution

82. We have considered and discussed with Māori a range of options for the composition and identification of Iwi-Māori Partnership Boards. Membership and skill-sets of the current partnership boards is variable, and in many cases reflects the perceived importance and influence of the partnership boards through current DHB relationships. Often these boards are predominantly advisory in nature, and very focused on the DHB agenda. Today's partnership boards have also suffered from

limited resources and support to develop and drive a strategic agenda focused on local Māori community needs, beyond simple response to DHB prompts.

83. s9(2)(f)(iv)

Approach to the legislative process

89. We propose to include provisions covering all of the above elements in the Health Reform Bill to be introduced to the House to ensure the Bill's completeness.

90. While we have not had the opportunity to widely test the details of the approach in each area (e.g. governance models, organisational form), based on our engagement to date we are confident that including the elements above will improve the comprehensibility of the Bill and the integrity of the Select Committee process, and ensure Māori can see where their voice has been considered and reflected in the approach proposed to the hauora Māori system.

91. There are also further policy areas where decisions will be needed on the hauora Māori system, but which will not require legislation and so need not be confirmed for the Bill's introduction. We will explore these with you in subsequent advice.

Risks

s9(2)(g)(i) [redacted]

[redacted]

Operating model and dispute resolution

93. As previously agreed by Cabinet (CAB-21-MIN-0092) and highlighted above, the operating model grants Health NZ and the Māori Health Authority joint development and approval of significant system plans and frameworks. This will include the New Zealand Health Plan, but also relevant national, regional, and local service plans.

94. While we anticipate the two entities 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 Māori Health Authority, we propose a resolution mechanism be set out in the Bill as follows. Either party may raise a dispute with the other, setting out the areas of dispute. Both parties must then use their best endeavours to resolve the dispute. If the dispute is not resolved within 20 working days, they must refer the dispute to the Minister. The Minister must then determine a process to resolve the dispute.

95. The process above will encourage the Māori Health Authority and Health NZ to work together to resolve disagreements and compromise – neither will wish to involve the Minister unnecessarily. It will however, allow genuine serious choices about system priorities to be referred to and resolved by the Minister where appropriate. The process reflects other health system dispute procedures, particularly that for a dispute about a DHB plan in the New Zealand Public Health and Disability Act. The proposed structural approaches in this paper increase the likelihood that this process will work well and will be enduring.

Consultation

96. As noted above, this advice incorporates the views of the Steering Group in its advice to the Transition Unit, and the outcomes of wider engagement with Māori. Advice provided to the Minister of Health and the Associate Minister of Health, which is to the same effect as this advice, was co-signed by Tā Mason Durie in his capacity as chair of the Steering Group. However, these specific proposals have not been widely socialised with Māori.

97. The Public Services Commission, the Treasury, the Ministry of Health and Te Puni Kōkiri have been consulted on this advice.

Next steps

98. Subject to your agreement and preferred approach, we will provide the Minister of Health with a revised draft Cabinet paper to confirm settings with Cabinet ahead of introduction of the Bill.