DEPARTMENT OF THE PRIME MINISTER AND CABINET
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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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Briefing

HEALTH REFORMS: LEGISLATING INTERVENTION POWERS AND OBLIGATIONS RELATING TO HEALTH NEW ZEALAND

To	Hon Andrew Little, Minister of Health; cc Hon Peeni Henare, Associate Minister of Health	**Report No**	DPMC-2021/22-60
From	Stephen McKernan, Director Health and Disability Review Transition Unit	**Date**	29 July 2021

Purpose

This note provides you with options and proposals for legislating in the Health Reform Bill for "more finely-grained" intervention powers to support monitoring and performance improvement for Health New Zealand. It also provides advice on miscellaneous legislative controls on the entity.

Recommendations

It is recommended that you:

1. **Note** Cabinet agreed the Minister of Health would, in addition to the usual powers relating to Crown entities, have more finely grained intervention powers, including the powers to:
   1.1. replace one or more members of the Health New Zealand Board;
   1.2. appoint a Crown observer to any Health New Zealand operated or funded service;
   1.3. require specified improvement actions of Health New Zealand.
2. **Agree** to carry over from the New Zealand Public Health and Disability Act 2000 the following provisions: **YES/NO**
   2.1. powers relating to funding agreements and payment notices;
   2.2. the power to appoint commissioners to replace boards;
   2.3. the Minister of Finance's power to require information;
   2.4. the requirement for Ministerial approval of delegation policies.
3. **Agree** to include in the Health Reform Bill provisions: **YES/NO**

3.1. allowing the Minister to appoint Crown Observers to the Health New Zealand Board and significant internal processes;

3.2. allowing the Minister to require Health New Zealand to prepare and implement an improvement plan;

3.3. for the Director-General of Health to require information;

3.4. specifying some attributes required in Health NZ Board members.

4. **Note** that we have considered other options for statutory powers but do not recommend including these in the Bill:

4.1. requiring the Director-General of Health to routinely attend Health New Zealand board meetings;

4.2. requiring Health New Zealand and the Māori Health Authority to sign a memorandum of understanding;

4.3. requiring the Health New Zealand board to have certain committees;

4.4. requiring access to information sources.

5. **Indicate** if you wish to discuss and consider further any of the options identified in (4) above. **YES / NO**

6. **Note** further work will be undertaken by the Transition Unit, Ministry of Health, Public Service Commission, and the Treasury to develop a robust monitoring and intervention framework, with further advice to be provided to you later this year.

Stephen McKernan Director **Health Transition Unit**	Hon Minister Andrew Little **Minister of Health**
29 / 07 / 2021	…../…../….

Contact for telephone discussion if required:

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Minister's office comments:

- ☐ Noted
- ☐ Seen
- ☐ Approved
- ☐ Needs change
- ☐ Withdrawn
- ☐ Not seen by Minister
- ☐ Overtaken by events
- ☐ Referred to

LEGISLATING FOR INTERVENTION POWERS

Background

1. Cabinet has agreed that in addition to the standard monitoring and accountability arrangements for Crown Entities the Minister of Health will have more finely grained intervention powers, including the powers to:

   i. replace one or more members of the Health New Zealand board;

   ii. appoint observers to any Health New Zealand-operated or contracted service; and

   iii. require specified improvement actions of Health New Zealand.

   (CAB-21-SUB0092)

2. This paper briefly describes the standard statutory intervention powers which would apply to Health New Zealand as a Crown Agent, and recommends some additions. It also outlines options that have been considered but are not recommended for primary legislation – either they can be given effect by other means, or are unnecessary.

3. We will provide advice on the entirety of the intervention framework, showing how statutory and non-statutory levers will work together, later this year, following further work with the Ministry of Health, Treasury and the Public Service Commission. In the event that the work on the intervention framework requires further legislative provisions, this timeframe will allow them to be made in Select Committee or the Committee of the Whole.

Powers from the Crown Entities Act

4. 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 a Crown Agent, such as Health New Zealand. For example, the Minister may replace Health New Zealand's board members at will (except the ex-officio MHA Chair). There are four broad categories of power, aside from the power to appoint and dismiss members:

Powers relating to an entity's accountability documents

5. A Crown Entity must 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.

6. The responsible Minister may require amendments to a Crown Entity's draft Statement of Intent or draft Statement of Performance Expectations. This is a very broad power. The two documents set out a high-level view of everything the entity is going to do.

7. In the reformed health system, the New Zealand Health Plan will have significant crossover with the statements of intent and performance expectations. We anticipate that over time, the content of the latter two will be incorporated into the Health Plan, rather than being separate documents. However, these are likely to remain important in the early years where the interim Health Plan is not fully formed.

The power to require information

8. 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.

The power to review the operations of a Crown entity

9. This power is set out in section 132 of the Crown Entities Act, which provides that 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.

The power to direct a Crown Agent to give effect to government policy

10. The power of direction in the Crown Entities Act is very broad. The responsible Minister may direct a Crown Agent to give effect to a government policy that relates to the entities functions and objectives. This power can be used very specifically, for instance to require particular actions. It can also require a Crown Agent to take on a new function (and has been used in this way for example in response to national emergencies). 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.

11. Collectively, the powers above are in theory sufficiently flexible to achieve almost all of the types of intervention above, and therefore meet Cabinet's aims for "finely-grained" powers. However, in practice, some have been rarely exercised and have been seen as disproportionate. We consider therefore, while there is significant breadth in those powers, it would be desirable to provide for some additional, more explicit provisions to provide intermediate steps as part of a transparent escalation pathway. These would provide greater clarity about the steps envisaged and may therefore improve the ease with which powers are employed in practice.

Powers from New Zealand Public Health and Disability Act

12. There are four existing powers in the New Zealand Public Health and Disability Act 2000 that we recommend carrying over:

    i. **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 Government Policy Statement and New Zealand Health Plan are expected to fulfil these functions by setting the budget and funding agreements. However, it is worth retaining this power in reserve – the Crown may wish to fund an organisation other than a health Crown entity, or may wish to fund outside the usual cycle. Section 88 of the Act allows the Crown or a DHB to issue notices setting out terms and conditions for payment for a service and binds the payees as if they had signed a contract.

    ii. **Replacing a Board with a Commissioner.** Section 31 of the Act provides that, where the Minister is seriously dissatisfied with a board's performance, they may dismiss the board and replace it with a commissioner and up to three deputy commissioners. Such commissioners hold office until the next election. We recommend retaining this power for

use in extremis. Health New Zealand will be a Crown Agent without elected members, so the Minister will be able to dismiss members at will, including the entire board if they see fit. However, appointing replacement members is likely to take some time, so a commissioner could be appointed more quickly if necessary to fill the governance gap.

iii. **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. This is a slightly broader power than the Crown Entities Act provision (which does not include forecasts), and should be retained.

iv. **Ministerial approval of delegation framework**. Delegation is essential for any Crown Entity to carry out its business. It is not uncommon to specify that some power may not be delegated, where the power is judged to be properly exercised only at a particular level. For example, a health practitioner regulatory authority may not delegate its power to suspend a practitioner in advance of a misconduct hearing. We have considered whether there should be powers the board may not delegate, but have not identified any at this stage. However, the requirement for ministerial approval of a delegation framework will ensure oversight of the approach to delegation, and give some ministerial assurance over internal decision-making structures. Moreover, this would be consistent with this approval over other health Crown Entities (e.g. Pharmac), to whom this provision would continue to apply.

13. There are extensive rules for the conduct of board meetings and other business set out in the New Zealand Public Health and Disability Act schedules. We do not recommend we reproduce them in the new legislation. They were necessary in a context of largely elected DHB boards, with mixed experience, which were thought to require more guidance than it is expected the new entities will require. The elements of the schedules that should be retained, such as restrictions on borrowing, are already provided for by the Crown Entities Act.

Options recommended for inclusion in the Health Reform Bill

14. **Power for Minister to appoint Crown observers.** We recommend that the Minister have 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 in the 2000 Act to appoint Crown monitors, but extended to lower-level meetings. The extension is intended to allow visibility of significant internal processes, such as board subcommittees, national executive meetings, and regional commissioning boards, which could potentially be controlling several billion dollars of government money.

15. We do not propose that this power should extend to include contracted services. Our view, and that of colleagues from Treasury and the Public Service Commission, is that this would likely would constitute an unreasonable overreach, and if Ministerial observers were to become common at the service-level would risk creating an environment of dull compliance rather than innovation.

16. **Power for Minister to require improvement plan**. This power will allow the Minister to respond to an identified area of underperformance. We recommend the power is to require an improvement plan, with such elements, and on such a timeframe, as the Minister may require. This is similar to the existing power in the Education Act 1989.

17. While the intent of this proposal could be effected using the power to direct under the Crown Entities Act, a direction is a formal mechanism that must be published in the Gazette and

tabled in Parliament and requires a degree of specificity that may not be appropriate or even possible. Typically, directions are used to set detailed operational parameters, such as in the case of the Eligibility Direction, which has 34 clauses setting out in precise detail the persons eligible for publicly-funded health services. This level of specificity is unlikely to be possible for the proposed improvement plans. For example, if there is a persistent service failure in a Health New Zealand service, a solution will need to be developed rather than imposed, and the purpose of the plan may in part be to analyse the situation.

18. **Power for Director-General to obtain information**. The Crown Entities Act provides that a Minister may delegate their power to require information to the monitoring department. We recommend that the new legislation provide that the Director-General may exercise such a power in his or her own right.

19. This power will support the Ministry's role as system steward and monitor of the new entities, and of the health system overall. We do not anticipate it being frequently used, as the ministerial power is not frequently used now – in part because the existence of the power persuades DHBs to provide information on request that could otherwise be compelled. Moreover, most information should be covered by the schedule of routine reporting that Health New Zealand will be required to follow through the Government Policy Statement. However, the recommended power would be used, for example, to undertake deeper reviews into system risks or issues for the purpose of determining whether an improvement plan should be required, and to ensure that escalation to the Minister's attention is warranted.

20. **Specify skills, attributes, and experience required for board members.** It is routine for legislation establishing an entity to set requirements for board members, to ensure the board would be suitably qualified, with the appropriate range of skills, knowledge and experience. At a minimum, we consider it will be necessary for any board to have expertise in Te Ao Māori, health, public sector governance and government processes, and financial management.

21. We do not consider it necessary to specify further. The Crown Entities Act provides that the Minister may only appoint people who, in the Minister's opinion, have the appropriate skills, knowledge and experience to assist the relevant entity to achieve its objectives and fulfil its functions. It further provides that in making appointments the Minister must take into account the desirability of promoting diversity in the membership of entities.

22. In practical terms, as with the appointments to the advisory committee for the interim Health New Zealand, we expect there will be a reasonably robust set of criteria that specify further than this. However, there is no need to specify so narrowly in primary legislation, and not doing so provides a degree of flexibility if required. It also avoids the need to define attributes in a way that satisfies legal drafting requirements.

Other options considered

23. We have also considered a number of additional options for statutory intervention powers, including existing powers that relate to DHBs under the 2000 Act. We do not recommend including these in the Health Reform Bill, for the reasons set out below. However, should you wish to consider these further, we would be happy to provide more advice.

24. **Director-General of Health to routinely attend Health New Zealand board meetings**. This provision was proposed as a mitigation of the risk that the Ministry would have poor information and thus not be able to provide good support to the Minister. After further consideration, we do not recommend proceeding with this proposal. We are concerned that

that mandated attendance could undermine trust and risk pushing significant conversations to other forums. If attendance were required in response to any particular future issue, the power to insert a Crown observer could be used to make the Director-General an observer. Moreover, the information gathering powers proposed above would allow routine acquisition of board papers.

25. **Require Health New Zealand and the Māori Health Authority to sign a memorandum of understanding**. We have considered whether there should be a statutory requirement for the Māori Health Authority and Health New Zealand to sign a memorandum of understanding (MoU). It will be a key requirement for the success of the new system that they work together smoothly, and the incentives on them to do so are strong, as such cooperation will also be a key element of the individual organisations' success. However, we do not believe it is necessary to compel such a MoU, and indeed the entities may choose to adopt other arrangements to confirm their partnership. The New Zealand Health Plan will provide one vehicle (amongst others) for any agreements that would form part of a memorandum of understanding.

26. **Require the Health New Zealand board to have certain committees**. District health boards were required under the 2000 Act to have particular committees, with a view to managing any tensions they experienced in their dual role as funder and provider, and to seek community input. The current provisions also reflect the status of DHBs as dually accountable to the public and the Minister of Health. The board of Health New Zealand will not have the same mixed accountability and will be able to establish committees as it sees fit, and delegate powers to them where appropriate.

27. We do not consider it necessary to retain this power to specify board committees. If a situation were to arise where such a direction were desirable, it would be possible to use Crown Entities Act powers to make this direction. It would also be likely that the prior power to require an improvement plan may have be deployed in relation to the same issue.

28. **Access to information sources**. This option was considered to ensure access to information without difficulty. At present, even with the information gathering powers, it can be difficult to get particular information from DHBs. In the new system, this is expected to be less difficult with no longer having 20 DHBs to negotiate with. The proposed ability of the Director-General to exercise an information gathering power will also help. If necessary, requirements for access to data sources could be set through direction under the Crown Entities Act. We therefore do not consider it necessary to include specifics in primary legislation.

Improving performance in practice

29. The powers in legislation are important, but a relatively small part of the overall picture. Improved performance will come from a proportionate and transparent monitoring and intervention framework, of which formal interventions are a small part.

30. Many of the most effective interventions within the health system will be relational, reflecting the fact that the system comprises a number of leaders of organisations whose motivations should be well-aligned. 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). It has been general practice to use such soft levers for day-to-day oversight and preserve the essential relationships on which the system is based. We expect this to continue to be the default for responding to issues and avoiding escalation wherever possible.

31. The use of harder, statutory powers should therefore not be seen as the starting point, but in the context of a clear escalation pathway which 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. We will bring advice on a wider intervention framework and pathway with the Ministerial Group later this year, subject to detailed development work by the Ministry of Health, Transition Unit, Public Service Commission and the Treasury.

Next steps

32. Subject to your agreement, we will instruct Parliamentary Counsel to include the powers above in the draft Health Reform Bill. We will advise Cabinet on the inclusion of these powers through the approval process for the Bill in September.

33. Agencies are working to develop an accountability framework that will support a robust and considered approach to monitoring and intervention, including a clear escalation pathway. We will prove further advice later this year.