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

HEALTH REFORMS: LEGISLATION CABINET PAPER SUMMARY AND TALKING POINTS

To	Hon Andrew Little, Minister of Health	**Report No**	DPMC-2020/21-1161
From	Stephen McKernan, Director, Health Transition Unit	**Date**	23/06/2021

Purpose

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

Summary talking points

2. Approach and timetable for legislation:

a. The purpose of the Health Reform Bill is to give effect to the core changes announced by Government. Our wider reform programme, however, will take a number of years to deliver: both to embed new structures, and to make the changes to access and models of care that will lead to improved outcomes and equity for New Zealanders. The Health Reform Bill should be seen as the first of a series of legislative steps to drive and support the reform programme.

b. We have committed in public to implementing the health system reforms in July 2022; this remains my intention. Finalising policy, drafting and passing a Bill within the next 12 months will be challenging. Meeting this timeline will mean:

i. focusing the Bill as far as possible on the core system settings required for Day 1, and leaving discretionary matters or those which come into effect later for subsequent legislation;

ii. keeping the legislation as simple and flexible as possible, and relying on regulations, other direction-setting powers and guidance to specify detailed processes;

iii. managing the scope of the Bill as far as possible to avoid opening up unnecessary debates on wider regulatory frameworks;

iv. ensuring rapid policy decisions can be made to support drafting of the Bill; and

v. using sector and public communications and wider stakeholder engagement to build consensus and involve the sector in the design of the legislation.

c. I intend to repeal the New Zealand Public Health and Disability Act 2000 (which provides for DHBs and the existing system) and replace in its entirety, rather than amend the current Act. Although this will entail a relatively broad scope, I do not intend that this Bill should extend more widely to include other regulatory frameworks such as those for public health or mental health.

3. **Legislating for future health system structures:**

Health NZ

a. The Bill will establish Health NZ as a Crown entity under the Crown Entities Act 2004 and subject to the usual provisions of that Act. Cabinet has agreed to the core functions and governance of Health NZ, and these will be reflected in the objectives, functions and accountabilities which are described in the legislation.

b. Because of the size of Health NZ, it will need to establish sub-national (regional, district and local) administrative arrangements to drive population health, plan and commission services most effectively, and engage with communities. In keeping with the principle of keeping legislation enabling in order to provide flexibility to the Health NZ Board and management, I do not intend to legislate for a precise configuration of these arrangements. However, I propose to:

i. require Health NZ to establish regional divisions for the purposes of commissioning primary and community health services, and for ensuring the involvement of communities in planning services;

ii. require Health NZ to determine a number of localities for the purposes of arranging the delivery of primary and community health services; and ensure that the whole population is covered by such arrangements; and

iii. require that Health NZ make these decisions jointly with the Māori Health Authority, to ensure their insight on boundaries is reflected and allow for alignment with the MHA's own internal model.

Māori Health Authority

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

d. Open engagement is essential to demonstrating the Government's commitment to partnership in the design of the future system for Māori, and to ensuring that the system benefits from Māori expertise. It is crucial that engagement is done in good faith, and is not rushed.

e. This means final details for legislation will likely not be known when the Bill is introduced. I intend therefore to include draft provisions in the Bill as introduced and for these to be amended during the select committee's consideration of the Bill. This will require a specific instruction from the House when the Bill is referred to the Select Committee.

While not ideal, this approach retains the current timetable, and the draft provisions will be prepared with Māori stakeholders.

Public health

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

g. Given both the Public Health Agency and national public health service will be internal divisions of the Ministry of Health and Health NZ respectively, there is no express need to legislate for their establishment. The purpose and functions of Health NZ that are described in legislation will be drafted to include relevant public health functions; in addition to their anticipated responsibilities regarding joint working with the Māori Health Authority.

4. Statutory objectives and principles

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

b. I believe it will be valuable to include detailed objectives and principles in the Bill to guide decision-makers and give fuller description to the aims of the health system. This will be particularly important to achieve the reform's goals relating to equity and partnership with Māori, where general provisions in place for the last three decades have not led to significant improvements. I recommend that the legislation reinforce the Government's vision in three ways:

   i. specifying the obligations of organisations under Te Tiriti o Waitangi / the Treaty of Waitangi and relevant principles for giving effect to these. Cabinet has already agreed to such a provision, and work is underway in consultation with relevant agencies to determine how best to express these obligations;

   ii. creating a general duty on all publicly-owned health organisations to make best efforts to achieve common objectives, in line with Cabinet's agreed priority outcomes. This would specify the five outcomes agreed (partnership, equity, person and whānau-centred care, sustainability, excellence); and

   iii. specifying principles to follow in giving effect to this duty, to which all publicly-owned health organisations must have regard. These would capture the critical areas in which inequity is most evident and longstanding: including inequity in access and outcomes based on age, ethnicity, disability and setting; inequity in the treatment of physical and mental health; and inequity in diagnosis and care for people with disabilities. These are not intended to bind individual decision-makers or conflict with clinical judgment, but would supplement organisations' existing accountabilities and functions.

5. Accountability and direction-setting:

a. The Bill should support a new approach to system-wide planning and accountability that is coherent, reflects system priorities and outcomes, and links long-term strategic

direction with service and capacity planning. This requires a clear, formal 'spine' of accountability documents that forms the system architecture for setting and monitoring objectives and directly connect budgets with organisational actions.

Health strategies

b. Current legislation requires two separate strategic documents for the health and disability system: a NZ Health Strategy and a NZ Disability Strategy. The legislative provision for a Disability Strategy will need to be considered as part of the September 2021 report on the future model and governance of disability support services.

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

d. I recommend legislating for a duty on the Minister of Health to publish three specific health strategies in the future:

   i. An overarching New Zealand Health Strategy;

   ii. a national strategy for hauora Māori; and

   iii. a national strategy for Pacific health. These latter two new requirements would reinforce the Government's commitment to equity and reflect the disproportionate gap in health outcomes for these populations.

e. I also recommend legislating for an enabling provision for the Minister to publish strategies on any aspect or area of the health system, with the consultation of any affected entities in their development. This would be underpinned by a requirement for Health NZ and other health agencies to give effect to those strategies once published.

Government Policy Statement

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

g. The Bill should set out these core requirements for the GPS. It should also include requirements for consultation, as Ministers deem appropriate. All health entities would then be required to give effect to the GPS, with relevant requirements tracking through to the plans of individual organisations.

New Zealand Health Plan

h. The NZ Health Plan will be part of the core accountability arrangements that will respond to and translate the strategic direction, priorities and requirements in the GPS into concrete, funded plans for health services and health system capacity. The Plan will set the core system configuration, operational frameworks and national service specifications, which will then be implemented at all levels of the system. I envisage it having at least a 10-year planning horizon.

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

   i. The Bill will require the statutory NZ Health Plan will set out the key national requirements, service specifications, models of care and enabling activities, to be delivered at all levels of the system. This will be approved by the Minister of Health to signal satisfaction that it adequately responds to the set of strategic priorities, policy requirements and expectations set out in the GPS.

   ii. The second part of the NZ Health Plan will be a much more detailed, modular and dynamic website-based planning environment, including planning for specific services, localities, and enablers, and detailed technical analyses. It will contain a range of 'annexes' or 'modules', each covering a specific part of the health sector. These annexes will not ordinarily be signed off by the Minister.

Locality plans

j. Locality plans will be multi-year commissioning plans setting out how each locality will meet national requirements and the needs and priorities of their resident populations. They will be a crucial element of the future system, and the means through which the majority of services which people access are planned and monitored.

k. I recommend that the Bill require Health NZ to develop a plan for each locality. The locality plan must set out priority health outcomes for the next three years, including how both the requirements of the NZ Health Plan and other matters determined locally will be met. The Bill should also require that iwi-Māori partnership boards jointly develop the plans with Health NZ.

l. In practice, I expect that locality plans will be formally agreed by Health NZ regional divisions, together with the Māori Health Authority's regional leads. This would allow for oversight across multiple localities to ensure alignment. The Bill would not need to specify these arrangements.

6. Other matters and decisions to come for the legislation:

a. There is a number of other topics that I expect to be included in the legislation, some of which will be subject to separate decisions:

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

   ii. Roles and powers relating to monitoring and intervention in the health system, including powers of Ministers and the Director-General of Health. This will be subject to separate advice.

   iii. A framework for ensuring consumer voice in the system. I propose that the Bill provide for duties to engage and involve communities in priorities and service design, and underpins this with regulations that set key requirements.

b. I also expect that other issues will arise in the course of drafting legislation that will require urgent decisions. I propose that these decisions be delegated to the Minister of Health.

Recommendations

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

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

From Stephen McKernan
Director, Health Transition Unit

Appendix A: Two-page summary of Cabinet paper

APPENDIX A

Summary paper: Legislating for the health reforms

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

2 The Health Reform Bill will give effect to the core changes announced by Government. Our wider reform programme, however, will take a number of years to deliver: both to embed new structures, and to make the changes to access and models of care that will lead to improved outcomes and equity for New Zealanders. In this context, this Bill should be seen as the first of a series of legislative steps to drive and support the reform programme.

3 We have committed in public to implementing the health system reforms in July 2022. Finalising policy, drafting and passing a Bill within the next 12 months will be challenging. The overall strategy, therefore, is focused on delivering to this timeline:

3.1 focusing the Bill as far as possible on the core system settings required for Day 1, and leaving discretionary matters or those which come into effect later for subsequent legislation;

3.2 ensuring rapid policy decisions can be made to support drafting of the Bill; and

3.3 using sector and public communications and wider stakeholder engagement to build consensus and involve the sector in the design of the legislation.

4 The degree of change to legislative arrangements is sufficient that I intend to repeal the New Zealand Public Health and Disability Act 2000 and replace in its entirety, rather than amend the current Act. Although this will entail a relatively broad scope, I do not intend that this Bill should extend more widely to include other regulatory frameworks such as those for public health or mental health.

5 As a minimum, the Bill will need to establish the new entities, set their core purpose, objectives, obligations and functions, and provide clear accountability and direction mechanisms. This will include key features such as the NZ Health Plan and Government Policy Statement, and requirements relating to Te Tiriti o Waitangi / Treaty of Waitangi obligations and other principles which capture our vision and objectives.

6 The structural elements of the health system in the Bill will reflect previous Cabinet decisions. Health New Zealand will be established as a Crown entity, with its functions, objectives and governance arrangements set out in the Bill. The decision that the Public Health Agency will be a business unit of the Ministry of Health means no legislative provision is expressly required for its establishment, nor for the public health service in Health NZ; however I intend for the Bill to set requirements to embed these decisions.

7 As directed by Cabinet, the Transition Unit is engaging with iwi and Māori representatives on the details of the Māori Health Authority, including via the Steering Group led by Tā Mason Durie. It is important that this engagement is open and genuine, and it therefore cannot be rushed. This means final details for legislation will likely not be known when the Bill is introduced. I intend therefore to include draft provisions in the Bill as introduced and for these to be amended during the select committee's consideration of the Bill. This will require a specific instruction from the House when the

Bill is referred to the Select Committee. While not ideal, this approach retains the current timetable, and the draft provisions will be prepared with Māori stakeholders.

8 The Bill provides an important opportunity to set out the common obligations, objectives and principles of health system entities, to frame the general requirements. I propose to do this in three ways:

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

8.2 creating a general duty on all publicly-owned health organisations to make best efforts to achieve specific common objectives, in line with Cabinet's agreed priority outcomes (those are: partnership, equity, person and whānau-centred care, sustainability and excellence); and

8.3 specifying principles to follow in giving effect to this duty, to which all publicly-owned health organisations must have regard. This would include principles relating to the key factors affecting equity between groups, including those based on ethnicity, age and condition or disability.

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

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

11 Monitoring against these strategies and plans, and intervention when appropriate, will be essential to the success of the reformed system. This will include: system level monitoring to hold organisations to account and to support the stewardship role of the Ministry of Health, and the monitoring roles of other agencies, such as the Treasury and Te Puni Kōkiri; and consistent internal monitoring by organisations to support improvement and enable oversight of performance at all levels. Public reporting will be an essential element of accountability. These functions will largely be empowered by the standard administrative machinery in the Crown Entities Act and Public Finance Act. I intend to bring further proposals to the Ministerial Group on Health Reform in order to make decisions on any additional powers for inclusion in the Bill.

12 Based on the recommendations in this paper, and previous Cabinet decisions, I have instructed the Parliamentary Counsel Office to begin drafting, and will issue further instructions as further decisions are made. The draft Cabinet paper seeks approval to make further policy decisions required, in consultation with relevant Ministers, and issue drafting instruction to give effect to them.