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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- section 9(2)(f)(iv), to maintain the confidentiality of advice tendered by or to Ministers and officials;
- section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion; and
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Briefing

HEALTH REFORMS: PLANNING AND ACCOUNTABILITY FRAMEWORK

To: Hon Andrew Little, Minister of Health			
Date	1/06/2021	**Priority**	Routine
Deadline	4/06/2021	**Briefing Number**	DPMC-2020/21-1046

Purpose

This briefing seeks your agreement to the key elements of the future health planning and accountability framework. It focuses in particular on those elements which will need to be included in legislation in the initial Health Reform Bill. It also covers our initial thinking on interim arrangements for the first two years, and indicates where further policy work will be needed to develop wider roles and processes to put the approach into practice.

Executive summary

Overview of proposed planning and accountability framework

The proposed key elements of the future planning and accountability framework, building on Cabinet's decisions to date, are:

- Direction, priority and expectation-setting for health services and capacity planning via a multi-year **Government Policy Statement**, with a medium to long-term focus linked to multi-year budgets. We expect there will continue to be national strategies for various parts of the health system (e.g. He Korowai Oranga) which will feed into the Government Policy Statement (GPS), but recommend in general using legislation to enable strategies (and to require the system to give effect to them) rather than mandating specific health strategies. However, you may wish to require a small number of strategies, and preserve the requirement for an overarching NZ Health Strategy.
- A **New Zealand Health Plan** as a service and capacity plan that responds to the GPS, covers all health Crown Entities and is linked to multi-year budgets. Service planning at a locality level will be via locality plans, which are also required in legislation and must be co-designed and agreed with iwi-Māori partnership boards (subject to the outcome of ongoing engagement with Māori).
- **Mechanisms to embed the MHA's role into the system** and enable it to undertake its co-stewardship, commissioning and co-commissioning roles effectively. This will include:
  - co-creation and sign off by the MHA board of the NZ Health Plan and any national strategies that have a significant impact or opportunity for Māori,

- a Māori Health Improvement Plan which sets out how Health New Zealand (Health NZ) will partner with Māori to improve Māori health outcomes – this would need to be signed off by the board of the MHA.

- **Statements of Intent** (SOI) **and Statements of Performance Expectation** (SPE) for all health Crown Entities as per existing Crown Entity requirements. We would expect the directions and measures in the agency SOIs and SPEs to align with the directions and measures in the NZ Health Plan; and for Health NZ and the MHA we would aim for SOIs and SPEs to be captured within the Plan and not require additional documents.

Recommendations

Previous decisions on the health accountability and intervention framework

1. **Note** in March Cabinet agreed to the following core components of the future health accountability and intervention framework (CAB-21-Min-0092):
   - a Government Policy Statement to set a multi-year national direction;
   - a national Pacific Health Strategy;
   - a New Zealand Health Plan that sets out a long-term health service view and forms the basis for capital, digital, and workforce planning; and
   - standard monitoring and accountability arrangements as per the Crown Entities Act, alongside some more finely grained intervention powers

Choices regarding the health accountability framework

2. **Note** there are choices about the detail of the future accountability health framework including:
   - whether to have legislative requirements to produce specific strategies e.g. a New Zealand Health Strategy, Māori Health Strategy, a Pacific Health Strategy;
   - the nature of the Government Policy Statement;
   - whether to legislate for a Māori Health Improvement Plan; and
   - whether to legislate for locality plans.
3. **Note** that the details of the Māori Health Authority's role, functions and accountabilities are being designed in partnership with Māori and will need to be reflected in the final planning and accountabillity framework
4. **Agree** that legislation should in general enable rather than mandate specific health strategies **YES/NO**

5. **Agree** that the responsibility for producing health strategies will sit with the Director-General of Health, with a requirement to work jointly with the Māori Health Authority **YES/NO**

6. **Agree** that health entities must give effect to any health strategies developed by the Ministry and Māori Health Authority where they are endorsed by the Minister of Health **YES/NO**

7. **Indicate** whether you wish to

   a. preserve the requirement for a standalone New Zealand Health Strategy, **YES/NO**

   b. require a Māori health strategy, **YES/NO**

   c. require a Pacific health strategy, and/or **YES/NO**

   d. require any other specified strategies to be developed **YES/NO**

8. **Agree** that the Government Policy Statement set system direction, priorities, outcomes, expectations, funding, and a framework for regular monitoring of progress and reporting requirements **YES/NO**

9. **Agree** that, subject to the outcome of engagement with Māori, there should be a Māori Health Improvement Plan that has a clear set of expectations and actions for how Health New Zealand will partner with Māori to improve Māori health outcomes, and that will be signed off by the Māori Health Authority Board **YES/NO**

10. **Agree** that subject to the outcome of engagement with Māori, the Māori Health Improvement Plan will not be included explicitly in legislation **YES/NO**

11. **Agree** that locality plans should be reflected in the legislation to recognise their importance to decision-making on local services; with a duty on Health New Zealand to co-design these and agree them with iwi-Māori partnership boards (subject to the outcome of ongoing engagement with Māori) **YES/NO**

12. **Note** that we will reflect your decisions in an upcoming Cabinet Paper on outstanding policy decisions for legislation and drafting instructions for legislation to be issued to PCO

Transitional arrangements

13. **Note** that we expect an interim GPS and interim NZ Health Plan to be developed and agreed by July 2022 to set initial priorities for the reformed health system

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

15. **Note** the full planning and accountability framework outlined will not be in place until the first full New Zealand Health Plan in 2024/25

Stephen McKernan Director **Health Transition Unit**	Hon Minister Andrew Little **Minister of Health**
1 / 06 / 2021	…../…../….

Contact for telephone discussion if required:

Name	Position	Telephone	1st contact
Stephen McKernan	Director, Health Transition Unit	s9(2)(a)	
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Minister's office comments:

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

PLANNING AND ACCOUNTABILITY FRAMEWORK

Purpose

1. Decisions on the planning and accountability framework and intervention powers for the future health system operating model are needed for legislation. In March Cabinet agreed some components of this, including a Government Policy Statement (GPS), a New Zealand Health Plan, and standard monitoring and accountability arrangements as per the Crown Entities Act, alongside some more finely-grained intervention powers (CAB-21-Min-0092).

2. This briefing seeks your agreement to the key elements of the future health planning and accountability framework and includes an outline of how it might work in practice. Over the next few months, further policy work will be needed to flesh out the arrangements and develop the core roles and processes which will drive the approach. Decisions will also be needed on budget and fiscal management settings for Vote Health, including links with planning and mechanisms for funding certainty; the Transition Unit is working with the Treasury and the Ministry of Health on this.

Case for change

We recommend shifting to a more coherent multi-year health planning and accountability framework

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

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

Choices about the role of health strategies and the Government Policy Statement

5. This and the following section set out key high-level choices for the planning and accountability framework, and how these should be reflected in legislation. This section covers the role of health strategies and the GPS in setting direction, priorities and expectations. The next section covers the NZ Health Plan and other service and organisational plans. Appendices A to E shows a diagram, table and cycle of the proposed planning and accountability framework.

There is a question about the relationship between health strategies and the Government Policy Statement

6. 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 work on the September 2021 report back on the future model and governance of disability support services. The new requirements of the Public Services Act 2020 also require three-yearly Long-Term Insights Briefings (LTIB) setting out medium and long term trends, risks and opportunities, along with impartial analysis including policy options, developed independent of Ministers with requirements around public consultation.

7. In March Cabinet also agreed that the Minister of Health would issue a GPS to set a multi-year national direction for the health system, including priorities and objectives for the health system. The advent of the GPS means a need to consider how this vehicle sits with existing (and future) health strategies, not least because the requirement for a GPS will need to be included in the Health Reform Bill.

8. There are choices as to the level of detail of the GPS and the depth of its focus (this is set out further in the next section below). However, there is also a choice as to the relationship between the GPS and the statutory and non-statutory health strategies. While the GPS is the primary document that sets parameters and expectations for the NZ Health Plan, we would expect Government to continue to want to develop national health strategies in the future, which would help set and inform the direction in the GPS, and supplement it over time. For example, the publication of the GPS is unlikely to mean that Ministers would not wish in the future to set a Māori health strategy, or a Pacific health strategy.

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

10. There is therefore a choice as to the relationship between the NZ Health Strategy and the GPS; and how this relationship is legislated for:

    a) A more fulsome approach to the GPS could replace much or all of the NZ Health Strategy requirement, by including a longer-term direction and broader strategic focus. The GPS would use this as context for setting more specific expectations for the health system in the coming period. It would recognise the need for alignment between the long-term direction and shorter-term deliverables. However, it could become unwieldy to develop and large elements of strategic direction may not merit updating as regularly as every three years. Moreover, it would suggest a type of document that should be subject to broader consultation, which may not fit with the need for pace to align with planning and budget cycles.

    b) A more clearly delineated role would see the GPS focused more on Government priorities in the coming three years, including strategic context for those choices but without a detailed analysis and overview in the long-term. A separate NZ Health Strategy could be developed less frequently (for example, every five years) and take a more consultative approach, building on the LTIB requirement. The GPS would be agreed by Government to deliver its agenda and could be subject to more limited

consultation. This would ensure a place for both elements; but with the need to manage the risk of misalignment over time.

11. Under either option, there would continue to be a case for Government agreeing more specific health strategies, for example for population groups (Māori, Pacific, disabled people), services (mental health, maternity) or outcomes (person-centred care). It is unlikely that the GPS would be well-suited to setting detailed direction on more specific areas of policy, which may be better achieved through bespoke national strategies. However, at present these types of strategies have no statutory basis, unless expressly required through Ministerial directions, and as a result can have limited traction within the health sector.

12. In our view, there is likely to be a case in the future for both a broad 'NZ Health Strategy' and more specific strategies and policy documents which are developed by Governments on a regular basis. However, it is not certain that there will always be a case for a separate, standalone NZ Health Strategy; and indeed future Governments may wish to employ the GPS as a means of strategic direction-setting as well as shorter-term accountability. We should be careful not to limit the discretion of Government to use a GPS in this way.

13. There is an option to require specific strategies in the legislation – including the NZ Health Strategy as now, and perhaps national strategies for Māori and Pacific health. Inevitably requiring these may reduce some flexibility in the future to adopt different approaches, and any explicit requirements may give the appearance of the exclusion of others. We should therefore be confident of the ongoing need and rationale for any required strategies.

14. More broadly, we believe there is merit in reflecting the wider range of strategies that may be produced and affording these additional legal weight. National strategies on various topics will continue to be developed during the political cycle (i.e. in between iterations of the GPS) and allow for Government to evolve its strategic direction over time. A general requirement for Health New Zealand and other health agencies to give effect to these strategies when they are endorsed by the Minister would strengthen their basis, and could be supplemented where necessary through directions (as now) or in specific actions highlighted in the GPS.

15. We therefore recommend using legislation to enable health strategies, and to require that they are given effect to when endorsed by the Minister. In most cases, we would not recommend legislating explicitly to require specific individual strategies. This would preserve flexibility about the scope and approach to producing such strategies and help avoid duplication in legislative requirements with the GPS and LTIBs. It would also allow for a clear duty in relation to the partnership between the Ministry and the Māori Health Authority (MHA) that applies to all such strategies.

16. However, you may wish to specify a requirement for some national strategies explicitly, including a NZ Health Strategy, Māori and Pacific health strategies (or indeed others). This is not legally necessary, since such strategies could be developed at any time and would have the intended legal force by virtue of the general provisions proposed. However, it could provide a clear statement of priorities and baseline requirements; although at the risk of suggesting an exclusion of others (for example, mental health and rural populations) and creating list that becomes the focus of lobbying.

17. Below is our initial proposal on what legislation would cover in relation to health strategies:

Initial proposals on legislative provisions for health strategies

- [The Director-General must develop and publish a NZ Health Strategy, and strategies relating to the improvement of Māori health and Pacific health.]

- the Director-General may develop and publish a health strategy covering any area of the health system
- where the Director-General develops a health strategy, s/he must do so jointly with the Māori Health Authority where the MHA wants to be involved
- Health NZ and other health Crown Entities must give effect to any health strategy the Director-General publishes under this provision where it is endorsed by the Minister of Health

Do you agree that legislation will enable health strategies? And the Director-General of Health must develop the strategies with the MHA where the MHA wants to be involved? Do you wish to require any specific national health strategies?

There is a choice about the nature and level of detail for the Government Policy Statement

18. 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.

19. Legislation requiring GPSs in other sectors take different approaches; the Transport GPS is much more prescriptive than the Housing and Urban Development GPS. The legislation on the HUD GPS requires overall directions, priorities and expectations, with no reference to funding. The Transport GPS has some very specific requirements, particularly in relation to funding, for example, for the first six financial years it needs to set out likely revenue, expenditure targets and allowable reasons for varying from those targets. In part this reflects the different nature of transport, with a hypothecated funding stream and a very different mix of investments to health.

20. Although there is some precedent for a GPS in relation to transport and housing, neither of those sectors is comparable to the health system in terms of scale, outcomes or operating model. In our view, therefore, the GPS for the health system will need to be designed for the specific requirements and settings of the future health system.

21. Consistent with our approach towards enabling legislation enabling rather than undue prescription (refer DPMC-2020/21-956), we think there is value in a legislative approach that is closer to the HUD GPS, but that includes some additional elements that are important to supporting a more coherent planning and accountability framework that is connected with budgeting. In particular, we think the legislation needs to specify that the GPS will set out the funding level that the system will need to deliver within and include the framework for regular monitoring of progress and reporting requirements. We propose to include content requirements for the GPS in legislation along the lines in the box below.

Initial proposals on legislative provisions for content for GPS

Content requirements:

- Government's overall direction for the health system which must include a medium to long-term outlook
- Government's priorities and objectives for the health system, including the outcomes the Government wants to achieve
- Government's priorities for improvements in health outcomes for Māori, Pacific, disabled, rural and other vulnerable populations
- Government's expectations in relation to Māori interests, partnering with Māori and protections for Māori interests and aspirations

- s9(2)(f)(iv) [redacted]
- A framework and measures for regular monitoring of progress, including minimum reporting requirements and roles and responsibilities across entities
- Other matters the Government considers relevant

Consultation requirements:

- The Minister will need to consult all health agencies covered by the GPS, and any organisations and individuals that the Minister considers appropriate when preparing or reviewing a GPS

Effect of GPS:

- All health entities must give effect to the GPS in undertaking their functions, including developing any plans

Do you agree with a GPS made by the Minister that has a medium to long-term outlook and sets out directions, priorities, objectives including outcomes, funding, and a monitoring and reporting framework?

The New Zealand Health Plan and other service and organisational plans

The New Zealand Health Plan will be a multi-year funded service and capacity plan, replacing current annual plans

22. The NZ Health Plan will be part of the core accountability arrangements that will respond to and translate the strategic direction, priorities, outcomes and policy requirements in the GPS into concrete, funded plans for health services and health system capacity. s9(2)(f)(iv) [redacted]

23. The NZ Health Plan will be co-created by Health NZ and the MHA, but we recommend that its scope cover the full publicly-funded health system and include all health Crown Entities (e.g. Pharmac, HQSC, New Zealand Blood and Organ Service) and other public sector organisations (e.g. Cancer Control Agency) to align all entities in a common direction and integrate delivery. It would not include the Ministry of Health, whose priorities would be set by the Minister in the usual way; however the Ministry should be involved in the development of the NZ Health Plan to oversee progress and alignment with the GPS.

24. Although the content of the plan will inevitably lean heavily towards the actions and responsibilities of Health NZ, this broader scope will ensure that expectations of other entities can be included, and their own accountabilities aligned. Health NZ will be expected to coordinate the development of the NZ Health Plan as the operational leader of the system.

25. We envisage that the NZ Health Plan will be modular in nature and split into parts (see illustrative diagram in Appendix D):

    - The 'core' NZ Health Plan will contain the key system shifts and significant service and enabler directions and changes, including significant regional and locality changes. It will include the key set of expectations that Health NZ, the MHA and other health entities will be held accountable for delivering, aligning with the expectations set out in the GPS. s9(2)(f)(iv) [redacted]

s9(2)(f)(iv)

[redacted]

26. A comprehensive NZ Health Plan will need to consider the impact and interdependency of wider public services and agencies which influence population health outcomes. Although the NZ Health Plan will not be an accountability document for entities outside of the core health delivery system, it should identify opportunities and actions to align inter-sectoral activity and we would expect the scope of this to mature over time. We envisage that agencies who have clear current and potential future impacts on the health system and health outcomes (such as ACC and other social sector agencies), will be engaged in the development of the Plan and relevant modules.

27. In practice, we expect the development of the GPS and NZ Health Plan to operate in tandem. Government would develop a draft GPS that set its expectations, as the basis for development of the NZ Health Plan. However, it is likely that the development of detailed plans will highlight issues and trade-offs that may not have been foreseen. This may in turn require changes to the GPS, or the NZ Health Plan, or both. This should be iterative, so that the final GPS and NZ Health Plan emerge together and are aligned when both are agreed and published. This will help avoid discrepancies or contradictions between the two, and the necessary negotiations should build ownership of the suite of documents.

28. We propose to include content requirements for the NZ Health Plan in legislation along the lines in the box below.

Initial proposals on legislative provisions for content for the NZ Health Plan

Content requirements

Health NZ and the Māori Health Authority must develop a NZ Health Plan with specific detail covering at least the next [three] financial years. It must include:

- A population health needs assessment

- Significant service and investment changes to meet prioritised needs and outcomes
- How relevant agencies will deliver on priority service shifts and changes, including how they will commission services at all levels with a particular emphasis on achieving equity for Māori, Pacific, disabled, rural and other vulnerable populations
- How agencies will cater for Māori interests, partner with Māori and protect Māori interests and aspirations in order to improve Māori outcomes
- Key services and activities to be delivered, and associated investments to enhance system capability and capacity
- Key performance measures and reporting framework covering health outcomes, efficiency, effectiveness, equity and sustainability
- Financial plans broken down by division and services
- How agencies will give effect to the purpose and principles of the Act, including how they will involve and engage with communities at all levels of the system

Consultation requirements:

- Health NZ will need to consult all other health entities covered by the NZ Health Plan and the Ministry of Health in developing the Plan
- Health NZ and MHA must consult persons and representative groups of persons they consider appropriate/have an interest in developing the Plan

29. Should government priorities change over the lifespan of the NZ Health Plan, the Minister of the day could re-issue the GPS or issue a new Letter of Expectations, depending on the significance and nature of the change. Health NZ and the MHA would subsequently be required to issue an addendum to the NZ Health Plan that responds to the new priorities (unless the nature of the change was so substantial as to require the plan be revised in its totality).

30. The NZ Health Plan would become a multi-year accountability vehicle, so there would not be a need for separate annual plans acting as accountability documents, as is in the current system. However, entities would need to prepare budgets and commissioning plans (where they are a commissioner) on an annual basis for internal purposes.

Do you agree with our thinking on the scope of the NZ Health Plan *(i.e. all Vote Health spending except the Ministry of Health)?* ***Do you agree with the modular approach?***

A Māori Health Improvement Plan will specify how Health NZ will improve Māori access and outcomes, but we don't recommend legislating for it at present

31. To embed and entrench a pro-equity approach and avoid the risk that improving Māori health outcomes is largely left to the MHA, we expect that Health NZ would develop a Māori Health Improvement Plan (subject to ongoing engagement with Māori). This would be an organisational document rather than a service planning document: it would set out a clear set of expectations and actions for how it will partner with Māori to improve Māori health outcomes, for example by building te ao Māori capability at senior leadership level of Health NZ, or an organisational priority to change the commissioning framework for maternity services to reflect kaupapa Māori principles. It would sit alongside the actions in the NZ Health Plan to improve services. We would expect this to be co-created by Health NZ and the MHA, and signed off by both boards.

32. As with our approach to strategies above, we do not recommend legislating for an explicit Māori Health Improvement Plan, to provide flexibility around what form it might take. There will already be requirements in the new legislation for entities to improve Māori health outcomes and partner with Māori, including via the objectives and functions of entities, and content requirements for the GPS and the New Zealand Health Plan. This gives sufficient

power to ensure that such a plan is developed, subject to the views of future entities on content and approach.

33. Not including this as a specific requirement in legislation risks the perception that Health NZ's role in improving Māori health outcomes is not being given sufficient focus and attention in the legislation. If Ministers did wish to legislate for a Māori Health Improvement Plan, one approach would be to include a duty to undertake the function rather than specifying it needed to be a separate plan, to provide flexibility around the exact form of this document. Respecting the ongoing engagement with Māori on the role and functions of the MHA and accountability to Māori, we may expect to return to this issue in the coming months and will provide further advice.

At a local level, the key accountability document for service delivery will be locality plans

34. Locality plans will be multi-year commissioning plans setting out how each locality will meet national, regional and locality expectations and meet the needs 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, delivered and monitored. They will also be the most significant enabler of local partnership with Māori and other populations in determining priorities, and of reflecting community voice.

35. Locality plans will need to reflect the requirements of the NZ Health Plan, and flow directly from the expectations set in the 'core' plan and its annexes. They will cover current and future state, key interventions to achieve desired shifts in population health and wellbeing outcomes and equity, services to be delivered, network arrangements, and funding levels and flows. Beyond these national requirements, locality plans will critically create space to agree and address priorities and issues identified by communities themselves.

36. Cabinet agreed in March that locality plans will be developed by locality commissioning teams in Health NZ, working in partnership with Iwi-Māori partnership boards to obtain those boards' agreement to priorities and plans. Locality plans will also need to ensure wider community involvement in their development, and demonstrate how this voice has been embedded and acted upon. As explained in your March Cabinet Paper, locality plans would then be signed off at a regional level by the Health NZ regional commissioning board, together with the MHA, to ensure alignment with each other and to the NZ Health Plan, and to address issues that are better tackled across multiple localities (e.g. elements of workforce planning and resource allocation).

37. Given choices at a locality level around service delivery and design will play a critical role in addressing inequities and transforming health outcomes, we think legislation should recognise the importance of locality-level service planning. These, like the localities they cover, are integral elements of the future system model agreed by Cabinet. Consistent with our approach of making legislation enabling and avoiding over-specifying elements which reduces room for manoeuvre, we propose not defining what "localities" are in precise detail, or fixing the content of locality plans. However, legislation will need to set out roles and responsibilities; in particular the IMPBs' role in agreeing locality plans and the MHA's role in signing them off (subject to confirmation following engagement with Māori).

38. Below is our initial proposal on the legislative requirements for locality plans.

Initial proposals on legislative provisions for locality plans

Health NZ must determine a number of localities for the purposes of arranging delivery of health services to local communities, subject to the advice of the Māori Health Authority.

Health NZ must develop plans for each of these localities. These locality plans must:

- Set out priority health outcomes and services for the locality, for at least the next three years
- Reflect the requirements of the NZ Health Plan which are relevant to that locality
- Demonstrate the involvement of consumers and communities in their locality in the development of the plan and agreement of its priorities
- Involve social sector agencies and other entities which contribute to population health and wellbeing

Health NZ must obtain the agreement of relevant Iwi-Māori Partnership Boards, and of the Māori Health Authority, to locality plans.

Health NZ must consult persons and representative groups of persons they consider appropriate/have an interest in developing locality plans.

39. The Transition Unit will provide advice on the MHA and IMPBs' roles as our engagement with Māori on the MHA progresses.

Monitoring, reporting and intervention powers

40. The core processes described above are intended to work to set priorities and underpin accountability in the health system. When the health system is working well, these regular processes, together with a strengthened approach to monitoring and oversight, should support the Ministry and Minister to track progress, identify risk and ensure transparent reporting for outcomes.

41. However, when specific risks or issues are identified, or there is worsening system performance, the regular accountability arrangements may not be sufficient and it may be necessary to take additional steps to intervene in the system. Responding to such situations required a carefully-tuned set of soft and hard levers, including legal powers which are both practicable (so that they can be used with relative ease) and proportionate (so that they can be tailored to the matter at hand).

42. It will be important to develop a coherent framework for how the health system will be monitored, and how and when interventions of various types, both hard and soft, may be deployed by the Ministry and the Minister to respond to issues. Policy work is underway between the Transition Unit, Ministry of Health, Treasury and Public Service Commission to develop such a framework; we anticipate bringing further advice in due course.

43. There will also be a number of legislative requirements to underpin monitoring, reporting and interventions in the Health Reform Bill, building on the arrangements already in place through the Crown Entities Act and NZ Public Health and Disability Act. Further advice on the legislative requirements will be set out in a draft Cabinet paper to be provided to you next week.

Transitional arrangements

44. The sections above describe how we expect the planning and accountability framework to operate in the final state. We expect that it will take time to work towards this final state, as the system transitions and refines its new functions, and expands initial versions of the NZ Health Plan to incrementally increase scope and depth. In our view, the first two years of the new system (i.e. 2022/23 and 2023/24) should be seen as transitional and an opportunity to develop, test and improve initial arrangements.

45. We are currently working through what the transition period looks like until 2024/25. We expect an interim NZ Health Plan to be signed off after final HNZ and MHA entities are established in July 2022. We think there is value in having a budget settlement for Vote Health longer than one year alongside this Plan to provide stability and certainty of funding

s9(2)(f)(iv)

46. The first 'full' NZ Health Plan, therefore, would come into effect in the 2024/25 financial year, building from the two-year interim plan. This three-year timeframe for development would begin immediately after July 2022, reflecting the need to develop a series of inputs that will inform national service and enabler planning – including a nationwide Health Needs Assessment (HNA), and tools to inform the national planning of hospital and specialist services. The diagram in Appendix E shows high-level indicative timings across the coming years for planning and budgets.

Next steps

47. We will include an overview of the planning and accountability framework in our upcoming Cabinet paper on legislation and plan to include your decisions from this paper in drafting instructions to PCO. This Cabinet paper will also set out proposals for related powers for monitoring, reporting and interventions to bring the accountability framework into force. We will continue to engage with the Ministry of Health, the Public Services Commission, the Treasury and the Office of the Auditor-General of the planning and accountability framework, and broader reporting, monitoring and intervention arrangements.

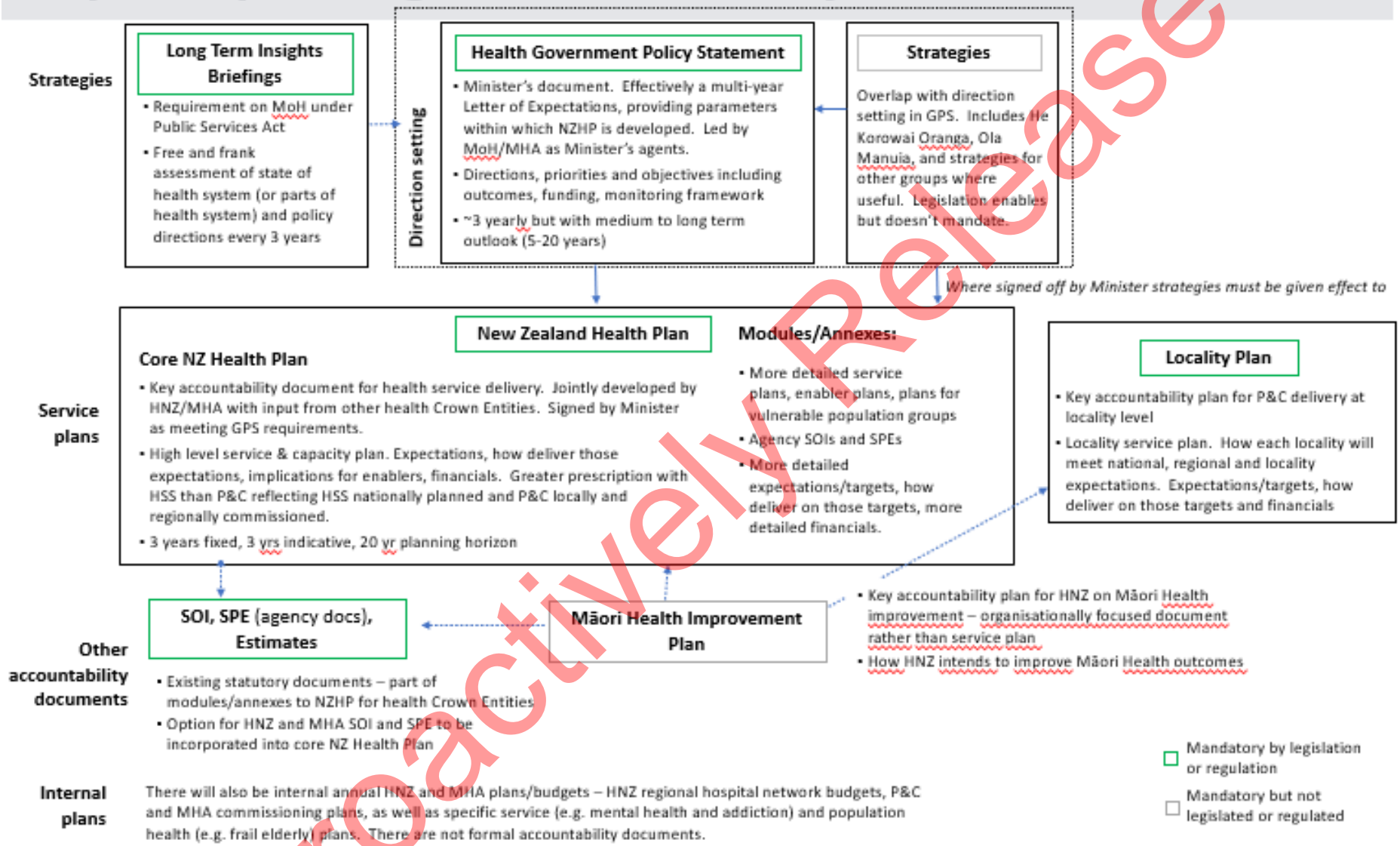
48. s9(2)(f)(iv)

Appendixes	
Appendix A	Diagram of Health Planning and Accountability Framework
Appendix B	Table of Health Planning and Accountability Framework
Appendix C	Withheld in full under section 9(2)(f)(iv) of the Act
Appendix D	Illustrative content of the NZ Health Plan
Appendix E	Withheld in full under section 9(2)(f)(iv) of the Act

APPENDIX A

~~IN CONFIDENCE~~

Proposed planning and accountability framework



APPENDIX B

IN CONFIDENCE

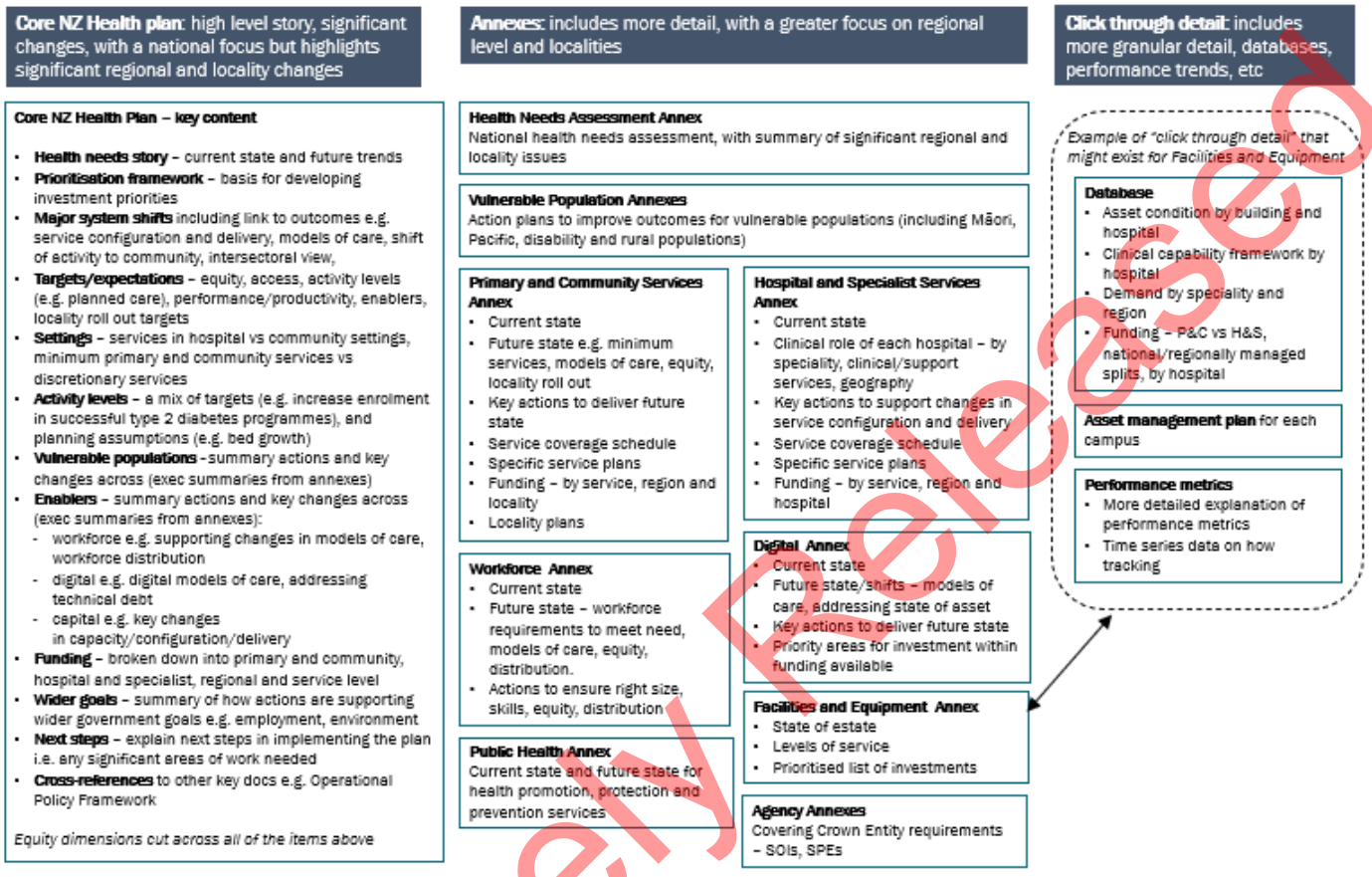
Roles, purpose and legislative implications for key accountability documents in future system

Document	Who makes it?	What purpose?	Timeframe?	With whom?	Accountabilities?	Reporting?	Legislation
Long Term Insights Briefing (Public Services Act)	DG Health	Independent stewardship document Promote public debate	Every 3 yrs	Expect co-creation with MHA where significant impacts or opportunities for Māori Public consultation process	Accountability to public and Parliament	n/a	Already in legislation
Health Strategies	DG Health and MHA Option to be endorsed by Minister	Set system direction	As needed	Expect co-creation with MHA where significant impacts or opportunities for Māori Expect public consultation process	Health entities must give effect to it where endorsed by Minister	n/a	Enabling provision in legislation
Government Policy Statement (new requirement in future system)	Minister, supported by MoH & MHA as agents Cabinet agrees as part of Budget process. Draft GPS signed off by MoF.	Government's directions, requirements and expectations for the health system over a multi-year period	~ every 3 yrs to align with multi-yr settlement	Consult affected health agencies	Govt's accountability to Parliament Health entities required to give effect to it Performance framework provides basis for monitoring health entities	GPS sets out performance framework against which system & agency performance monitored	Include in legislation
Statement of Intent (Crown Entities Act)	Individual Crown Entities	Strategic intentions	3 yrly covering 4 yrs	Minister (and therefore MoH) engaged as per existing Crown Entities Act requirements	Accountability to Crown and Parliament	Annual report	Already in legislation
Māori Heath Improvement Plan (to be determined as part of MHA design)	HNZ with MHA, MHA signs off	~~Organisational document~~ Clear expectations and actions for how Health NZ will partner with Māori to improve Māori health outcomes	As agreed with MHA. Initially might be yearly with 3 yr time horizon	IMPBs consulted MoH engaged as steward and monitor Minister consulted	Part of HNZ accountability to Māori	MHA monitors progress	Not included in legislation
Core New Zealand Health Plan (new requirement in future system, remove need for Annual Plans)	HNZ and MHA Minister signs off as consistent with GPS	Service and capacity plan covering all Vote Health spending (except MoH and Independent Crown Entities e.g. Mental Health and Wellbeing Commission) Give effect to GPS	~3 years fixed, 3 years indictive to align with multi-yr settlement. 20 year planning horizon	Other health entities (they sign off their "parts") MoH engaged as steward and monitor Developed in consultation with sector & stakeholders Minister consulted in development	Accountability to Crown and Parliament	Schedule of reporting included in NHZP (will need to meet expectations in GPS) Expect real time/dynamic reporting Regular reporting to Board & Monitor Annual report	Include in legislation
Locality plans (new requirement)	HNZ and IMPBs, regional HNZ and MHA sign off	Service plan for localities	~3 years	Iwi, whānau and community; providers; other social sector agencies	Accountability to iwi, whānau and community; and Crown	Expect real time/dynamic reporting	Include in legislation
Statement of Performance Expectations	Individual Crown Entities	Ex ante output reporting – how performance will be assessed	Annually	Minister (& therefore MoH) engaged as per existing Crown Entities Act requirements	Accountability to Crown and Parliament	Annual report	Already in legislation
Annual report	Individual entities	Reporting against SOI and SPE	Annually		Accountability to Crown and Parliament	Already in legislation, add requirement to report against NZHP	

Direction setting | Service and/or capacity plan | Annual financial and non-financial performance expectations | Reporting

APPENDIX D

The following diagram illustrates the type of content in each part of the NZ Heath Plan, and the relationship between each of the parts.



s9(2)(f)(iv)

Each annex will follow a planning cycle that best suits the context. For example, given fast-paced change in the digital environment, digital planning will incorporate a shorter planning timeframe than longer-term cycles such as major capital projects planning. In another example, the Hospital and Specialist Services funding annex could follow an annual cycle, and act as Health NZ's annual operational internal budget and plan. We envisage that the annexes will be hosted on a website that provides the ability to 'click through' from the 'core' plan to each of the detailed 'annex' plans, analyses, databases and performance metrics, available to the public to provide enhanced public transparency regarding the health system's performance.