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.

Key to redaction codes:

- section 9(2)(a), to protect the privacy of individuals;
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Briefing

HEALTH REFORM: STRATEGY AND APPROACH TO LEGISLATION

To Hon Andrew Little (Minister of Health)			
Date	14/05/2021	**Priority**	High
Deadline	17/05/2021	**Briefing Number**	DPMC-2020/21-956

Purpose

This paper seeks your agreement to the Transition Unit's recommended approach to legislating for the health system reforms. It sets out a number of considerations including the strategy for and scope of legislation, and the timetable for development. You are not being asked to agree to any particular legislative provisions at this stage.

Recommendations

a. **Agree** that health reform legislation should seek to be enabling, rather than unduly prescriptive, to provide for flexible and enduring legislation. **YES / NO**

b. **Note** that we anticipate that the broad approach should be to repeal and replace the New Zealand Public Health and Disability Act 2000 to give effect to changes agreed by Cabinet, given the scale of the reforms and the impact on existing legislation.

c. **Note** that while the focus will be on the changes agreed by Cabinet, the Bill will have a relatively wide scope given the need to carry over aspects of the 2000 Act, and it is likely to be difficult to meaningfully limit the scope of legislation, given the breadth of the reforms and interest in them.

d. **Agree** that substantive change to health legislation other than the New Zealand Public Health and Disability Act 2000 will be outside of the scope of the Bill, and that changes to other primary legislation will be limited to minor and necessary consequential changes. **YES / NO**

e. **Note** that the timetable for development of the Bill for introduction in September is challenging, and we have confirmed with Parliamentary Counsel Office that they are willing to accept drafting instructions iteratively as decisions are made.

f. **Note** that the timeframes for getting agreement with Māori on the form, functions and governance of the Māori Health Authority for inclusion in the legislation are ambitious, and based on when agreement is reached, in order to deliver the current timetable you may need to take an alternative approach to legislating for these decisions and the scope of implementation by 1 July 2022.

g. **Indicate** whether you wish to consider developing a separate Bill to ensure that provisions to cancel DHB Board elections can be given effect by May 2022, to guard against the risk of delay to the implementation of reforms. **YES / NO**

Stephen McKernan **Director, Transition Unit**	Hon Andrew Little **Minister of Health**
…../…../….	…../…../….

Hon Peeni Henare **Associate Minister of Health**
…../…../….

Contact for telephone discussion if required:

Name	Position	Telephone	1st contact
Simon Medcalf	Health Team Lead, Transition Unit	s9(2)(a)	✓
Stephen McKernan	Director, Transition Unit	s9(2)(a)	

Minister's office comments:

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

HEALTH REFORM: STRATEGY AND APPROACH TO LEGISLATION

Purpose

1. This paper seeks your agreement to the Transition Unit's recommended approach to legislating for the health system reforms. You are not being asked to agree to any particular legislative provisions at this stage.

Background

2. As you are aware, the structural changes to the health system agreed by Cabinet will require primary legislation. Cabinet has agreed to use the Health Reform Bill on the legislative programme to do this. The Transition Unit has been working with the Ministry of Health on the design of implementing legislation. Drafting instructions will be issued by the Ministry's legal team on your behalf.

3. To support issuing initial drafting instructions there are a number of matters to confirm with you with respect to the overall strategy for and approach to legislation. In addition, as set out below, there are several areas requiring detailed policy decisions, including Cabinet agreement, to confirm the content of the Bill. We anticipate that this will be the first of a series of papers as legislation develops.

4. Our objective remains to have delivered the necessary legislation to allow the reforms to the health system to come into effect on 1 July 2022, as per your announcements. This gives a tight timeframe for seeking further policy decisions, drafting legislation and supporting Parliamentary passage. The timeframe is achievable but will require focused effort, increased policy and legal capacity, and cross-agency input. A number of our recommendations on approach below are informed by the need for pace to meet this timetable and mitigation of risks that may arise.

Overall strategy

5. Finalising policy, drafting and passing a Bill within the next 12 months that reforms statutory organisations will be challenging. Our overall strategy, therefore, should be focused on mitigating the policy and practical risks to support delivery within this timeline, including:

   a. Expediting policy decisions over the coming two months so that there is clarity on the matters to be included in the legislation, over and above Cabinet's decisions to date. Further detail on anticipated decisions is set out below; we anticipate the need for a further Cabinet paper on such policy issues by the end of June.

   b. Using sector and public communications and stakeholder engagement to build consensus around the reform proposals and involve the sector in the design of elements, to improve the context in which reforms are debated.

   c. Managing our legislative strategy as far as possible to focus and streamline Parliamentary debate, as discussed below.

6. We recommend that a key element of this strategy should be to keep the primary legislation as simple and flexible as possible, and rely on secondary legislation, other direction-setting powers and guidance to specify detailed processes or requirements. This approach accords with modern practice and the Legislation Advisory Committee's Guidelines, and would follow the existing approach in the New Zealand Public Health and Disability Act 2000 and previous health legislation.

7. As a minimum, the legislation will need to establish the new entities, set their core purpose, objectives, obligations and functions, their inter-relationships, and provide clear accountability and direction mechanisms. This will include key features such as the NZ Health Plan and Government Policy Statement, and new requirements relating to Te Tiriti o Waitangi obligations. It will also need to bring across those aspects of the NZPHD Act that are not part of the reform agenda, but that are needed as ongoing elements of the health system. There will be choices for Ministers on how far to legislate in this Bill for related topics that extend beyond the new system architecture and include wider rights, statutory duties or functions that speak to the Government's broader aims and objectives of the reforms. This is discussed below.

8. We are not yet clear on the extent to which new secondary legislation will be required from July 2022. It is possible that some new regulations will be required, for example in relation to accountability and reporting arrangements. Moreover, there is some existing secondary legislation that should be retained and remade under the new Act: for example the Health and Disability (Archives) Regulations 2001 set out how health information is to be retained and archived. There are also some Orders, applying to DHBs, that will need to be revoked and remade, in particular the protected quality assurance notices. We are discussing these with the Ministry and will provide advice where needed in due course.

9. It is likely that members of Parliament and submitters will want to specify some elements of the reformed system more precisely, or amend other elements of existing legislation that are not changed by the reform programme. For example, the Health Act 1956 provisions specifying the public health functions of the Ministry of Health were added during the passage of legislation disestablishing the Public Health Commission. Our approach to such issues will be guided by the ongoing policy work and engagement on the new system arrangements. We will seek to identify such issues early and consider our approach to each.

10. A core element of our legislative strategy will also be the approach taken to communications and engagement through policy work and planning for implementation. A number of areas of engagement are expected to impact on the legislation, whether directly or indirectly, and will need to be managed with this mind. More broadly, however, our wider approach to communications will help to build consensus in the health sector and public, and create a more positive environment for the Bill to be debated. Close engagement with sector leaders should also support us to identify potential risks or areas of challenge.

Scope of legislation

11. A key decision which affects management of the Bill is the scope of the legislation. The health reforms are extensive and fundamentally change the overall design of the health system. We have examined the NZPHD Act and our view is that the changes needed

to that Act to give effect to the reforms would be so extensive that it is likely to be necessary to repeal and replace the Act.

12. That said, the NZPHD Act also contains provisions that are outside the core structural reforms and these should be carried into the new statute. We are not currently seeking policy decisions on these. They include, for example, the provisions that allow for 'bulk contracting' of services (known as section 88 notices), the provisions that establish other entities in the health system (Pharmac, the NZ Blood and Organ Service, etc.), the provisions that govern the conduct of inquiries in the health system, and others. The Bill will need to include these types of provisions as well as those that establish the new structures (particularly Health NZ), new requirements (e.g. the Health Charter), and new ways of working (e.g. the new Te Tiriti o Waitangi provisions) and other matters agreed by Cabinet to date (and decisions yet to come).

13. It will be necessary for the scope of the Bill to allow for all these matters. This mean that the communication strategy and processes to support the Bill through the parliamentary process will need be to be able to respond to interest in these wider issues.

14. Moreover, there will be choices for Ministers on how far to legislate in this Bill for other topics that extend beyond the basic system architecture and include, for example, requirements to promote equity, individual rights, and other statutory duties or functions. Many of these are planned to be the topic of subsequent briefings (e.g. duties on equity and disability rights), and we would not suggest ruling these in or out at this stage.

15. We have considered whether it would be possible to scope the Bill more narrowly. A more narrowly scoped Bill may support quicker drafting and ease debate by reducing the breadth of the legislation. However, a narrowly scoped Bill would need to be one that amends rather than repeals the NZPHD Act and this does not seem feasible given the new direction of the health system and how it needs to be expressed in legislation. In addition, a narrower Bill may miss opportunities to legislate for related topics that support the reform agenda. s9(2)(g)(i) [redacted]

16. Notwithstanding the above, there are wider areas of the health regulatory framework that we believe we can, and should, seek to rule out of scope without undermining the integrity of the Bill. This should include making any significant amendments to the Health Act 1956 in relation to public health legislation (to avoid, for instance, debating changes to quarantine rules), aside from consequential amendments needed to reflect new structures. It should also include matters where legislation is being taken forward through another vehicle (e.g. regulation of therapeutic products).

Name of the Bill

17. The name of the Bill and eventual Act will need to be carefully considered. We have referred to the 'Health Reform Bill' thus far, in the legislation programme and Cabinet material. However, the new Act will need a more descriptive name, reflecting its purpose. The name of legislation is an issue that can easily distract from its substance,

so it is important to get right. We are considering options and will provide you with more advice closer to introduction.

Timetable for legislation, policy decisions and approach to drafting

18. As noted above, our aim is to legislate to allow for the legislation to come into effect on 1 July 2022, as you have announced. This will require a very rapid process to develop the Bill, and actions to smooth Parliamentary debate. The key milestones are set out in the table below.

Initial instructions to PCO	Late May 2021
Discussion with PCO and further drafting instructions	May-June and ongoing
Cabinet paper(s) on required further policy decisions	End June 2021
First draft of Bill	Mid-July 2021
Review draft, revise and further instructions	July-August 2021
Explanatory note, RIS and Departmental Disclosure Statement	August 2021
LEG approval (and SWC if policy approval required)	Mid-September 2021
Introduction	Late September 2021
Health Committee consideration	October 2021 – March 2022
Remaining House stages and Royal Assent	April 2022
Commencement	1 July 2022

19. This timescale gives little room for slippage and is especially compressed in the early stages to develop and introduce the Bill. It is also contingent on Committee consideration not being elongated or raising significant issues. Nonetheless, this timetable is achievable, provided that a Bill can be introduced in September as planned.

20. The need for pace means we intend to take an iterative approach to instructing PCO, to ensure drafting is not delayed while further policy decisions are taken. That means we will issue drafting instructions to PCO in advance of the full range of decisions, and issue supplementary instructions as Ministerial or Cabinet decisions are made. This will require a clear plan to identify which further decisions are required, and when these are anticipated; as well as confidence that decisions will not be delayed. We are liaising with PCO to agree this approach.

21. There will be a number of further decisions to be made about the content of legislation. Many of these will be routine and managed between officials, but some will require a Ministerial or Cabinet decision. A clear decision-making framework and delegations will be important to support pace. These topics include:

a. Decisions on the detail of structures or functions already agreed by Cabinet – such as the accountability framework and role of Iwi-Māori Partnership Boards. In particular this will include decisions on the form and governance of the Māori Health Authority, following engagement with Māori (as noted in the section below).

b. Decisions on any changes to functions and entities that were not within the initial set of Cabinet decisions, but may or may not be needed consequential to the design of the future system (e.g. research and innovation functions; the role of other agencies such as the NZ Blood and Organ Service).

c. Decisions on other strategic policy objectives that affect what the health system delivers and how it works, such as in relation to individual access to services or roles for workforce development, if legislation is the best way of achieving aims.

22. **Annex A** sets out a schedule of anticipated policy issues that we are working through. Some of these issues may need to be reflected in the Bill, subject to further Ministerial or Cabinet decisions. These are to be the subject of further advice over the coming weeks; some of the initial areas raised in discussions with legal advisors are noted below.

Managing risks to the timetable for legislation

23. The timetable above represents our central plan for delivery of the legislation to enable implementation of the reforms from July 2022 – and we expect to work towards this plan to secure necessary policy decisions and prepare legislation. However, there is a risk that some critical policy decisions may not be able to be confirmed in line with this timetable; specifically those relating to the Māori Health Authority.

24. Following your announcements on health reform, work is underway to design the form, governance and functions of the Māori Health Authority in collaboration with Māori, in accordance with the Government's manifesto commitment. A separate briefing is provided alongside this paper which provides you with advice on our planned approach to this engagement.

25. Legislation will need to give effect to Cabinet's decision to establish the Māori Health Authority as a statutory entity, including setting out the core purpose and functions of the entity and how it is constituted and governed. The Bill must also have the right range of tools and powers to ensure that Māori can exercise genuine control and influence, including over plans developed by Health New Zealand, to ensure that the Authority can meet Cabinet's ambitions.

26. The process of engagement with Māori on the design of the Authority is essential to building support for the proposal, and will in time help manage risks to Parliamentary passage. However, the likely time required for engagement poses a risk to the timetable for the Bill. Even a rapid process may be expected to take several months to involve Māori stakeholders appropriately, meaning that engagement may not be complete until later this year. This would mean a potential for some legislative elements to be unknown by the scheduled introduction time.

27. We intend to mitigate this risk by asking participants to finalise views relating to the organisational form of the Authority and its relationship with Health New Zealand – the

key elements requiring legislation – in mid-July. That timing would allow content to be drafted in advance of introduction, with wider (non-legislative topics) to be considered subsequently in the engagement process. However, this does not provide much time for debate on essential topics; and we may not be able to control the process to meet these deadlines without risking alienating participants.

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

29. A first option would be **to introduce partial legislation and for the House to instruct the Select Committee to consult on the Māori Health Authority provisions at a later stage once Cabinet decisions have been made**. This option would rely on Cabinet decisions being made relatively close to when the Bill has been referred to Select Committee, and the approval of the Chair of the Committee and the House to consult on these provisions. Referring a partial Bill to Select Committee could be manageable provided that Government was clear about the nature and timing of the expected provisions to follow, and managed this with the Committee (for instance, by providing an initial report from Tā Mason Durie along with officials' advice). A rationale based on the desire for meaningful engagement may help the case. However, this may be poorly received and hinder debate on the Bill.

30. A consequence of this option would be to increase the likelihood that the Committee seek to extend the report back date beyond six months to support public consultation on the new provisions. The chance of such an extension would naturally grow the longer the period before these provisions could be shared. This in turn would delay the date of Royal Assent, pushing this closer to the implementation date in July 2022.

31. Although a short period between Royal Assent and commencement may be manageable for the majority of the provisions in the Bill, there is a particular issue in relation to the provisions to cancel the next round of DHB Board elections. In order to give sufficient notice to cancel these elections, the legislative provision must have been enacted by May 2022. There is therefore a risk that any extension to the Select Committee consideration (or indeed another part of the process) would not leave time to meet this statutory deadline.

32. If it eventuates, this risk would have a material impact on the reform programme. It could, however, be avoided by developing a short, separate, standalone Bill to cancel the elections in 2022. This could be passed rapidly to ensure that this provision was in effect in good time. Legislating sooner would also have the benefit of providing legal certainty to local government and provides a material early step in implementing the reform programme. There is a precedent for this type of bill in the Act that cancelled the Waikato DHB elections in 2019.

33. A separate Bill could include solely this one provision; s9(2)(f)(iv) [redacted]

34. A decision does not need to be taken immediately – if limited only to cancelling DHB elections, this could be progressed later this year and held for now as a fallback option. However, if you were minded to take forward, there would be benefit in doing so sooner, perhaps to coincide with establishment of the interim agencies and support wider messaging around the progress with reform. We would welcome your views on this.

35. A second option would be **to delay introduction of the Bill** to ensure a more complete product. This would tackle the risk of presenting a partial or incomplete Bill, but would of course impact the timing of legislation. Given the little room for manoeuvre in the timetable, this would risk the ability to stand up the new system from July 2022 and may require changing our approach to implementation (e.g. to run the interim agencies for longer).

36. A third option would be to **push provisions relating to the Māori Health Authority to a separate, subsequent piece of legislation.** This would create a more focused vehicle for the provisions, which could be developed in greater time and ensure sufficient engagement with iwi and the Māori health sector as well as more focused debate in Parliament. However, it would be very legally challenging to administer, given the inter-connectedness of the entities and the need to refer to each other in the legislation. It would mean that consideration of the Health New Zealand provisions, for example, could not include a full understanding of the relationships with the Māori Health Authority. Moreover, it would mean that the Authority would not be established in law until after July 2022.

37. Both the second and third options would likely mean that at least one of the key new entities would not be established in July 2022, with likely alternative dates of 1 January 2023 or 1 July 2023. Although this would not accord with your announcements, if necessary such a delay could be mitigated by adapting our implementation approach to provide the interim agencies with additional functions so that they mirror the anticipated form of the final entities. The cancellation of DHB elections and further actions to change accountability arrangements of DHBs to a common system-wide leadership would also likely be necessary.

38. Additionally, we have considered whether an **exposure draft process** may help to manage this risk. However, our view, and that of PCO, is that there is unlikely to be sufficient time in the window for developing the legislation to include an additional consultation on a draft Bill. Moreover, given the sensitivities of the topic and the risk of Government being seen to force its view for the Māori Health Authority, even draft legislation may be perceived as pre-empting partnership rather than supporting discussion. We also note that the sector has already been extensively consulted on the reform process through the Simpson Review and we judge that there may be little appetite for engagement on an exposure draft and then again at Select Committee.

39. Clearly, none of the above options is desirable. We recommend progressing with the engagement process with a clear request to prioritise matters requiring legislation, and using Ministers' interactions seek to underline the importance of progress in these areas. We will keep this under review and advise further as required.

Other significant elements of legislation to consider

Te Tiriti O Waitangi

40. Cabinet has agreed to a Te Tiriti statement reflecting the principles identified by the Waitangi Tribunal in its Hauora Inquiry. The actual statement will need to be carefully worked out in cooperation with Te Arawhiti and the Ministry of Justice, both of whom have already made approaches to the Transition Unit. We anticipate advice being prepared in alignment with the timing of detail work on the legislative elements of the Māori Health Authority.

41. It will be important that, as well as the statement, the provisions of the legislation contain specific powers and functions that will allow Māori to make and influence decisions. This will be particularly important with respect to the role of the Māori Health Authority. There are elements already agreed, such as the joint sign-off of significant plans and strategies, but there will almost certainly be elements emerging from the co-design of the authority to be reflected in legislation.

Accountability arrangements and use of existing machinery

42. Cabinet has agreed that Health New Zealand will be established as a Crown Agent. Health New Zealand however is different in its scale and scope from all other Crown Entities (and indeed from any other organisation in New Zealand) and work is underway with central agencies to examine what amendments or additions to the intervention and direction powers in the Crown Entities Act 2004 will be required. You will be advised separately on these issues. For example, it may be desirable to include specified direction powers, as in the current New Zealand Public Health and Disability Act, which provides a specific power for the Minister to direct DHBs on who is eligible for funded services. We also anticipate additional accountability requirements.

43. There will also be questions relating to the relevance and application of some existing powers. For instance, the existing power to install a Crown Monitor on the Board of a DHB derives from a context in which most board members are elected. In the context of a wholly-appointed Health New Zealand board with easier levers for the Minister to replace members, it is not obvious that the same provision is necessary. We shall provide further advice on these matters shortly.

44. The Māori Health Authority may or may not be set up as a Crown entity, pending engagement and further advice. The Ministerial relationship and what Ministerial powers might be effective and proportionate will be considered further as part of the design work for the Authority.

Health NZ regions and operating model

45. We will also need to determine the extent to which the sub-national operating model of Health New Zealand (regional divisions, district offices and locality networks) is reflected in the legislation.

46. Given our overall focus on simplicity, we recommend that these sub-national arrangements are not legislated for specifically, but are set up as administrative divisions of Health New Zealand and confirmed through implementation work with the interim agencies. It is possible that the number and form of regions, districts and

localities will change over time, as new arrangements are made and consumer's preferences reflected. Legislating for boundaries risks inhibiting the flexibility of the new system to respond to need and preferences over time.

47. However, there may be some benefit to more general statutory references to regional and locality arrangements, to set principles, expectations and accountability or transparency requirements for Health New Zealand but without fixing or pre-judging the precise form. For example, we may wish to require Health New Zealand to establish regional divisions (and localities) for the purpose of commissioning primary and community services, and set requirements in relation to engaging local communities, but without specifying what these must look like. We will provide you with further advice.

Next steps

48. Subject to any early steers, we intend to issue initial drafting instructions to PCO within the coming week.

49. We will seek further decisions from you as required.

Consultation

50. We have discussed the proposed legislative strategy, and this paper, with the Ministry of Health, the Public Service Commission, the Treasury and the Parliamentary Counsel Office. Agencies are committed to supporting the legislation and mindful of the acute pressures on time and resource.

Communications

51. We do not intend to release this paper or any comment on legislation until the Bill is introduced.

Attachments:	
Attachment A:	Schedule of policy decisions and issues for possible inclusion in the Bill

Annex A – Schedule of major issues that are likely to require further Ministerial or Cabinet decisions for inclusion in the draft Health Reform Bill for introduction

Issues where further ministerial and/or Cabinet decisions may be required	Comment
Māori Health Authority	Further Cabinet decisions will be required on the form, functions and governance of the Māori Health Authority, following engagement with Māori. Once the details of the Māori Health Authority are agreed, further consideration may be required of the powers and tools available to Māori to make and influence decisions.
Key accountability documents	Cabinet has already agreed to the key elements of the accountability arrangements for the transformed system, including: • that the Minister of Health will issue a Government Policy Statement (GPS) to set a multi-year direction, including priorities for the health system, in line with the New Zealand Health Strategy; • Health New Zealand will be required to give effect to the GPS (and other policy as directed), and subject to the standard monitoring arrangements in the Crown Entities Act 2004; and • Health New Zealand and the Māori Health Authority will be required to agree a New Zealand Health Plan that sets out a long-term health service view and forms the basis for capital, digital and workforce planning. We anticipate further policy decisions on matters of detail will be required, including about: • the purpose of, and requirements for, the GPS and Health Strategy, and ultimately whether both are required to meet the Bill's objectives; • how the key documents work together in practice, including whether the Health Plan can cover other requirements such as Statement of Intent; • specific requirements (e.g. consultation requirements) that need to be included in legislation; and • dispute resolution mechanisms for the documents and plans that require joint sign-off.

Monitoring and Ministerial and other intervention powers	Cabinet has also agreed that the Minister of Health will have more finely-grained intervention powers, including the powers to: • replace one or members of the Health New Zealand board; • appoint observers to any Health New Zealand-operated or contracted service; and • require specified improvement actions of Health New Zealand. We anticipate further, and more narrowly defined, powers in legislation, over and above powers available in existing legislation (such as the Crown Entities Act and Public Finance Act). We are also considering the role of other Ministers, and information access provisions, among other matters. From the monitoring perspective we are mindful that Ministers and their agents will need visibility over more than simply the consolidated Health NZ performance. There will need to be arrangements to understand, for example, individual hospital performance.
Equity and individual rights	Cabinet has already agreed to include a provision in the Bill to give effect to the health system's obligations under Te Tiriti o Waitangi, which we anticipate will include specific provisions regarding equity for Māori. There are a number of other matters related to equity for other groups which pose options to strengthen the legislation in line with Government's reform agenda, for example: • Disability rights – in particular how to give effect to obligations under the United Nations Convention on the Rights of People with Disabilities • "Parity of esteem" for mental and physical health – i.e. principles regarding equal access to treatment • More specific requirements on equity for all groups – such as duties which set out expectations to inform decision-making in the system and matters to take into account
Consumer voice	In your March 2021 Cabinet paper, you signalled you would bring further proposals to Cabinet regarding embedding consumer voice more explicitly and consistently in the future system. You signalled these proposals might include: • strengthening the Health Quality and Safety Commission as the centre of excellence for consumer engagement; • establishing a national consumer forum to act as the umbrella organisation for consumer and patient voice;

	• underlining expectations for consumer engagement in legislation and incorporating them into monitoring and review frameworks; and • implementing proactive engagement mechanisms to ensure the voice of disadvantaged and minority populations influences service design and delivery. We are preparing advice on these matters for you. We anticipate further policy decisions to determine the legislative provisions needed to embed core requirements on consumer voice, and to establish any new bodies (such as a consumer forum). This may also need to include any formal mechanisms for regional and provider voice in the system given that there will no longer be locally-elected representation. Experience is that this type of mechanism is likely to be important for supporting the transition from DHBs to Health NZ.
Statutory obligations	The legislation will include statutory obligations (such as operating principles) for how the organisations covered by the legislation will discharge their duties and functions. Some of these may be general in nature, or specific in relation to certain tasks or processes (such as engaging people and organisations on the development of key accountability documents). We will be guided by precedent in existing legislation, such as the Taumata Arowai- the Water Services Regulator Act 2020.
Health New Zealand sub-national operating model and locality network design	Cabinet has noted your intention for Health New Zealand's internal organisation arrangements. Further decisions will be required to determine the extent to which the sub-national operating model of Health New Zealand (regional divisions, district offices and locality networks) is reflected in the Bill. Given the Bill's purpose is to be flexible and enabling, there would be risk with being too specific about requirements for the sub-national operating model. However, we may wish to include in the Bill a requirement that HNZ must have regional and locality networks, and to establish principles and expectations on HNZ for establishing these.
Health New Zealand governance	Cabinet has agreed the core expectations for governance of Health NZ and you have previously received advice on the expected skill set and experience of Board members. There may be some further issues to confirm, for example relating to the role of observers in Board meetings.

Funding and financial powers	There is substantial further policy work to determine the financial and funding arrangements for the future system, and the expectations regarding the future funding path. Some of these elements may require legislative provisions.
Reporting requirements	We anticipate further decisions will be required relating to bespoke requirements to be included in the Bill. We are working through these issues with the Treasury and the Public Service Commission and will provide you with advice in the coming weeks.
Public health	Provisions to reflect the establishment of a national public health service in Health New Zealand are likely to be required, with consequential amendments to the Health Act 1956. Further policy work on the design of new public health arrangements will identify any policy decisions required beyond Cabinet's initial agreements.
Disability	Cabinet has noted that the reform of disability support services (DSS) is subject to a separate process which is expected to provide recommendations to Cabinet in September. The health reform Bill will need to be clear on the responsibilities of entities in relation to disability – for example to set functions for Health NZ relating to health services for disabled people. As part of this we will also need to consider how to manage the interdependency with the parallel reform work for DSS in the context of this Bill.
Transition	We anticipate that many of the practical transitions to move functions, assets and resources between entities can be undertaken using existing powers in the Health Transfers Act 1993. However, implementation planning may identify additional provisions that are necessary to smooth the transition.