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 the Minister of Health, Hon Andrew Little:

Health and Disability System Reform – Update on Plans for Implementation and First Three Years of the Reformed System

The following documents have been included in this release:

Title of paper: Health and Disability System Reform – Update on Plans for Implementation and First Three Years of the Reformed System (SWC-21-SUB-0163 refers)

Title of minute: Health and Disability System Reform – Update on Plans for Implementation and First Three Years of the Reformed System (SWC-21-MIN-0163 refers)

Title of minute: Report of the Cabinet Social Wellbeing Committee: Period Ended 29 October 2021 (CAB-21-MIN-0447)

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 code:

- Section 9(2)(f)(iv), to maintain the confidentiality of advice tendered by or to Ministers and officials.

~~[In Confidence]~~

Office of the Minister of Health

Social Wellbeing Committee

Health and Disability System Reform – Update on plans for implementation and first three years of the reformed system

Proposal

1 This paper provides advice on the anticipated characteristics of the reformed health system on the day new legislation comes into effect; the necessary transfer of functions between organisations to support implementation over the coming year; the priorities for the reformed system over its first three years; and the planned approach to managing outstanding and emergent risks through the transition period.

Relation to Government priorities

2 The Government's manifesto and the Speech from the Throne committed to undertaking a long-term programme of reform to build a stronger public health system that delivers for all, drawing on the recommendations of the independent Health and Disability System Review.

Executive summary

3 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. Work is now well underway in the Transition Unit, Ministry of Health and with other key agencies to take forward design and development and achieve critical early milestones.

4 There has been significant progress in relation to policy and legislative design, early establishment of interim entities, appointment of the interim boards, stakeholder engagement, and transition preparedness. My assessment is that the programme remains on track to deliver the key milestone for implementation of the reforms by July 2022.

5 Day 1 for the reformed system is intended to be 1 July 2022, when the legislation will formally establish Health New Zealand and the Māori Health Authority and disestablish district health boards (DHBs) and Te Hiringa Hauora/Health Promotion Agency, with functions from those agencies shifting predominantly to Health NZ. On this day, the new entities will assume their full range of statutory functions and will have developed initial or interim versions of key processes and artefacts, such as an interim New Zealand Health Plan, ready for approval by their incoming boards. Day 1 will need to ensure continuity of care and service, while signalling early the opportunities resulting from reforms.

6 The pathway to Day 1 will require the interim agencies, legally established by Order in Council on 1 September 2021, to design and build the operating model for the new system and put in place the key leadership positions and critical functions required. Over the coming eight months, the interim entities will need to build and test their capability, processes and ways of working to be ready to discharge their operational functions come July 2022. This will necessarily include planning, shadow arrangements and live operation of certain functions to ensure readiness.

7 To support the interim agencies, it will be necessary for specific operational and delivery-focused functions of the Ministry of Health to be transferred to the interim agencies during the period to July 2022, to allow greater time for preparation. I also expect there to be a significant opportunity in transferring some functions quickly after leadership is in place, so that interim agencies are able to advance actions to improve outcomes for people and build and demonstrate their leadership role to the health sector sooner.

8 The conditions and sequencing for the transfer of such functions will consider the risks and opportunities of each, including assurance that the interim agency is ready to receive functions and has appropriate leadership and processes in place to deliver. I recommend that decisions on the timing and process for specific transfers be delegated to the Minister of Health, in consultation with the group of Ministers for 'Tier 2' decisions previously agreed [SWC-21-MIN-0080][1].

9 Beyond Day 1, the critical period for development, refinement and consolidation of the new system operating model will be over the first two years. Early next year in the lead up to Budget 2022, I anticipate setting an interim two-year Government Policy Statement and agreeing an interim two-year New Zealand Health Plan to set priorities and expectations, s9(2)(f)(iv) The third year (FY2024/25) will mark the first 'full' year of operation of the model agreed by Cabinet, and will include a full New Zealand Health Plan which sets costed forward plans for the system.

10 As previously advised, there are a range of systemic and programme risks associated with reforms of this scale. The nature and likelihood of programme risks remains unchanged. The approach to implementation is designed to mitigate risks so far as possible; however, the significant challenge of the timetable for reform remains, and should risks materialise in a way that affects the timetable to July 2022, alternate pathways will be available to ensure that the direction of reform is maintained.

11 I suggest that Cabinet invite me to report quarterly on the progress of reforms and attendant risks over the coming months. While our COVID-19 response is continually evolving, I recommend that a checkpoint in December 2021 be used to fully test the implications of our approach to managing COVID-19 for the implementation of reforms. In addition to checkpoints on delivery in

[1] That is, the Prime Minister, Minister of Finance, Minister for the Public Service, Minister for Disability Issues, and the Associate Ministers of Health.

December 2021 and April 2022, I propose that Cabinet seek to take a formal decision in May 2022 on the commencement date of 1 July 2022 in advance of the legislation being passed, based on an assessment of readiness at the time.

Background

12 On 29 March 2021, Cabinet agreed to reform the health system to achieve a vision of pae ora/healthy futures for all New Zealanders. The first set of decisions included significant reforms to the system's structures and operating model: establishing Health New Zealand to replace the 20 district health boards, creating a new Māori Health Authority, a new Public Health Agency, and refocusing the role of the Ministry of Health [CAB-21-MIN-0092 refers].

13 On 2 June 2021, the Cabinet Social Wellbeing Committee noted the intention to proceed swiftly to implement the reforms, starting with a transitional phase of preparation, detailed functional design and wider stakeholder engagement over the period to late 2022. This phase would also include development of legislation required to implement the changes, with the expectation that this will come into effect on 1 July 2022.

14 The Committee also noted the number of outstanding policy decisions that are required, both to support drafting of the legislation and to confirm the policy settings, priorities and objectives for the new system. While some of these decisions will be matters for Cabinet, including those relating to future Budgets and investment, in relation to second-order policy matters the Committee agreed that a group of relevant Ministers should be delegated authority to make necessary decisions [SWC-21-MIN-0080 refers].

Structure of this paper

15 This paper:

15.1 summarises early progress with the design and implementation of the Government's reforms;

15.2 considers potential risks to this timetable and alternative approaches that may be employed to maintain the roadmap to the reformed system;

15.3 describes the intended characteristics of the reformed system which will be in place on the first day that the legislation comes into effect, including changes from the perspective of the workforce and people who use health services;

15.4 sets out proposals for how and when functions may be transferred to the interim agencies – interim Health New Zealand and the interim Māori Health Authority – to support preparation for the first day; and

15.5 outlines current thinking on the priority areas of development over the first three years which follow.

Update on progress to date

16 Delivery of the health reforms requires a broad and significant programme of work to design policy and operational settings, establish new entities and functions, and take initial steps towards fostering culture change across the system. The design of the Transition Unit's programme reflects this breadth. Across all areas there has been substantial progress in the early months since the announcement of the reforms, with a particular focus on partnership and engagement with the health workforce, wider sector, and Māori, Pacific peoples and disabled people.

17 The table below notes the critical areas of focus for the reform programme in the past quarter, summarises key activity to date and notes progress for each.

Milestone	Progress
Establishment of interim agencies (interim Health New Zealand and interim Māori Health Authority) [September 2021]	• The entities were formally established on 1 September via an Order in Council. • Interim boards (Section 11 committees) of agencies have been appointed by Cabinet, and announced. The boards have been inducted. • A recruitment process is underway to identify chief executives of the agencies, and interim CEs are expected to be identified shortly. • Letters of expectation have been developed for the interim entities and the Ministry of Health to communicate Ministerial requirements and expectations for their transition-related work priorities to July 2022. Letters will be issued formally shortly after appointment of interim chief executives. • Departmental agency agreements are under development to set the working relationship with the host agency (the Ministry of Health), to be finalised once interim chief executives are in place.
Introduction of the Health Reform Bill October 2021	• Cabinet agreement has been secured to outstanding policy decisions for inclusion in the legislation [SWC-21-MIN-0107; CAB-21-MIN-0345], and the Bill has been introduced [CPC-21-MIN-0024].

Milestone	Progress
	• Full provisions relating to the functions and powers of iwi-Māori partnership boards will not be included at introduction, but will be subject to further advice from the interim Māori Health Authority between now and March 2022.
Further development of the system operating model [Ongoing]	• The first "discovery" phase is underway to develop locality prototypes, with a request to DHBs and service providers to identify existing practice and learning to support development of the future model. Findings from this phase are anticipated in October 2021. Following the discovery phase, a selection process will be run with a view to present the recommended sites for the prototypes to the interim boards in November 2021 for approval, and set up the prototypes in early 2022. • Programmes have been established to develop the interim New Zealand Health Plan and New Zealand Health Charter. These will be taken forward in partnership with the interim agencies, and engagement is already underway with the workforce and wider stakeholders. • Work is ongoing to develop a commissioning framework to drive the approach to commissioning and decision-making by Health New Zealand and the Māori Health Authority in its allocation of funding. • A due diligence process is underway to understand the totality of contracts currently with DHBs and the Ministry of Health that will need to be transferred to Health New Zealand from 1 July 2022 via the Health Sector (Transfers) Act.
Engagement and communications [Ongoing]	• The Hauora Māori Steering Group, led initially by Tā Mason Durie, has continued to meet regularly to advise on the development of the Māori Health Authority and wider responsiveness of the system to Māori.

Milestone	Progress
	• A significant programme of engagement is underway with health system stakeholders, including a series of workshops with DHBs, Pacific health providers, disability sector representatives, unions, colleges and workforce representatives, amongst others. To date the Transition Unit has conducted more than 400 separate meetings and events, and formalised a number of working groups with the Ministry of Health, other agencies, and the health sector.
Transition and implementation of the system model [Ongoing]	• The Ministry of Health and Transition Unit have developed an indicative approach to and timeline for functions transfer (discussed further below). • The Transition Unit, DHB leadership and shared services agencies are in the process of preparing an approach to DHB and shared service agency transfers, and to personnel and asset transfers, including opportunities for early transfers ahead of Day 1. • Development of key artefacts to set system direction, including an interim Government Policy Statement, and governance and accountability frameworks, is underway.

18 My overall assessment is that the programme remains on track to deliver the reforms as envisaged by July 2022, but that time is tight. Design and development are well underway, with a particular focus on the early deliverables for the Health Reform Bill and the establishment of interim agencies.

19 Our approach to implementation is designed to mitigate system risks as far as possible. For example, the interim agencies are intended to both undertake detailed organisational design for the future entities and incrementally put in place arrangements for oversight and coordination across DHBs that foreshadow the functions of the permanent entities. This should smooth the transition pathway and reduce risk by beginning the shift towards cohesive national and regional arrangements in advance of July 2022. The features of the reforms designed to manage risks were outlined to Cabinet in previous advice [SWC-21-MIN-0080].

20 Notwithstanding these mitigations, there remain risks to delivery, in relation to which I have previously advised Cabinet [SWC-21-MIN-0080]. These include

systemic risks, including those arising from historic issues such as funding sufficiency, and programme risks which relate to the necessary pace of implementation. The recent COVID-19 situation adds to the context for these risks, although in my view the nature and likelihood of the risks remain broadly unchanged at this time. Risks are being managed actively.

Potential mitigations

21 1 July 2022 has been identified as Day 1 for the key structural aspects of these reforms for several reasons:

21.1 The health sector expect, and want, the transition to move at pace. Delaying the transition risks losing the momentum and good will that has been built for the reforms, and would extend a period of uncertainty for the health workforce and providers.

21.2 Alignment to financial years allows for a more straightforward transition of DHB finances and assets into Health NZ, and makes managing appropriations and accountability simpler.

21.3 It means there are not unnecessary planning processes for a portion of the financial year, and that the interim New Zealand Health Plan can serve as the plan for Health NZ and Māori Health Authority from 2022/23 without extending or refreshing DHB annual plans.

21.4 The health sector has had to operate more like a single system to support the COVID-19 response, particularly across the public health units, and delays to implementation of the new legislation risk regressing on the gains that have already been made.

It is therefore important that we 'go live' on 1 July if it is possible and safe to do so, as agreed by Cabinet [SWC-21-MIN-0080].

22 While our approach to reform should help to identify and manage risk, the scale of the reform programme is such that some element of risk will inevitably remain. In particular:

22.1 The timeline to pass legislation by July 2022 may become undeliverable, given the complexity of issues to be debated and likely volume of submissions to the Select Committee. Controversy over provisions in the Bill may mean that it cannot be passed and brought into effect in time.

22.2 The reformed system may be unprepared to 'go live' on 1 July 2022, for instance because the interim Health NZ and/or the Māori Health Authority have not developed sufficient infrastructure to deliver their core functions and manage day-to-day operations of the health system.

22.3 External pressures on the health system could make 'go live' on 1 July 2022 undesirable even if other pre-requisites are met, such as if the health system is under excessive strain due to outbreaks of COVID-19.

23 Our risk mitigation is focused on ensuring that these scenarios do not come to pass. However, it is prudent to consider how they would be managed in such a way as to maintain the direction of the Government's health reforms and avoid disruption. Options are set out below.

Inability to meet legislative timelines

24 We may be unable to meet planned timelines for legislation if:

24.1 the Bill is not ready for referral to Select Committee by end October 2021; or

24.2 debate over the substance of the Bill is sufficiently substantial that further time is needed to confirm the content of the Bill; or

24.3 if delays cause Select Committee meetings to go beyond March 2022, meaning that the Bill's passage is delayed such that Royal Assent cannot be achieved by June 2022.

25 Drafting of the Bill is complete, and approval for introduction is expected to be sought from Cabinet on 18 October. If approved, introduction may follow swiftly, enabling First Reading and referral to Committee before the end of October.

26 If the Bill were subject to a small delay to introduction to the House which may push referral to Select Committee into November 2021, I recommend in the first instance that the Select Committee process be curtailed, retaining the planned deadlines for the Bill's Third Reading and Royal Assent. This will ensure that the commencement date of 1 July 2022 can still be met.

27 s9(2)(f)(iv) [redacted]

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

[redacted]

[redacted]

Delays in readiness to establish new system

30 Interim agencies now have eight months to prepare for assuming leadership and delivery of our health system, including building an executive leadership team, preparing leadership and management structures aligned to the system operating model, and preparing key initial artefacts such as an interim New Zealand Health Plan and co-commissioning frameworks. Further detail of the expectations for these agencies in advance of July 2022 are set out below.

31 The scale of the requirements for these agencies mean that there is some risk that agencies are not prepared to assume system leadership on 1 July 2022. The measure of this risk will depend to some extent on timing of appointments to key positions in the interim entities (acting chief executives and subordinate roles) and their success once in role.

32 Mitigating this risk should primarily be driven by the way in which the interim agencies are established, the priorities and expectations they are given, and the plans for their expansion to take on operational functions. I have consulted on formal letters of expectation to each interim agency, and intend to issue these shortly to clarify requirements and critical deliverables to support delivery of the reformed system by July 2022. The letters will also confirm expectations regarding ongoing monitoring and accountability, to ensure visibility of progress and a route for the escalation of issues as they arise.

33 Where a risk is identified early – such as because interim entities are not meeting expected timelines to establish leadership or begin developing key artefacts – agencies have committed to alert Ministers early, and will at first instance provide greater, more targeted support to interim entities to ensure they meet these timelines.

34 If interim entities are persistently behind timelines to prepare for 1 July 2022, or if risks are identified late (e.g. due to factors that may not become apparent sooner), it may become prudent to delay 'go live' to manage this risk. Practically, this would entail a delay to the commencement of legislation and mean a continuation of existing structures (i.e. DHBs and interim agencies). It

s9(2)(f)(iv) In this case moreover there may also be considerations regarding the suitability of the leadership and governance arrangements for interim entities for them to succeed. The period for any such delay would need to be agreed based on the situation at the time, weighing the practicalities of commencing the new system mid-year.

Delays due to external pressures

35 While the risk that the system is not ready for Day 1 may be driven by legislative delay or internal factors in the interim agencies, it may also be the result of wider systemic risks that are sufficiently great to necessitate a delay to implementation. For instance, a sustained deterioration of the COVID-19 situation may give rise to additional risks to system stability that suggest a potential pause. This could include scenarios where continued community transmission of COVID-19 requires a substantial health system response, or where pressures from the community presence of COVID-19 seriously limits DHB capacity to prepare for transition.

36 It is my view, which has been informed by feedback from the sector, that the threshold to delay moving to the new structures needs to be exceptionally high, and only considered where there is evidence that moving too quickly poses more risk to health service delivery than staying in the current arrangements. The sector has articulated overwhelming support to move to new structures quickly, in order to enable them to get on with new ways of working, and to reduce the uncertainty that comes from being in a transition period.

37 I do not consider that Cabinet should adopt any one plan to respond to such situations, as the cause, duration and severity of any such events will determine the appropriate response. While a relatively time-bound external event might justify interventions s9(2)(f)(iv) more severe or ongoing pressures could make a longer delay desirable. Agencies have committed to providing regular updates to Ministers on any external factors or pressures likely to affect the health system's capacity to effect reforms, and are considering contingency arrangements for a diversity of possible scenarios.

Implications of delays to commencement

38 In any of the scenarios above, it may become necessary to delay commencement of the legislation beyond July 2022. As noted, if this were to occur, steps would be taken to ensure the continued direction of the reforms, and to put in place many of the practical arrangements of the new system, including central management and reporting through the interim Health New Zealand and new leadership roles. Although district health boards would continue to exist as Crown entities until they are disestablished by law, they would be required using existing powers to support the new national and regional structures to be embedded and to work collectively towards shared plans (including the interim New Zealand Health Plan).

39 For the majority of system settings, with a short delay to commencement it would be possible to formally establish the new system during the 2022/23 year. A mid-year implementation date should not have a significant impact on the transitional arrangements required for most statutory functions to shift to Health NZ and the Māori Health Authority. The transfer of staff and assets using the Health Sector (Transfers) Act 2003 will facilitate the legal move at any point required. Indeed, the commencement of the legislation which established district health boards took place during the financial year, on 1 January 2001.

40 There will be greater complexity with a mid-year commencement regarding financial functions, where the requirements of annual budgeting and accounting cycles pose additional practical challenges. To enable a shorter delay beyond July 2022 of three to six months, for example, it will be necessary to take a range of steps to manage risks to audit and reporting processes (including, for example, extending audit requirements to cover a period of more than 12 months). These steps will need to be considered in greater detail, should this scenario become more likely. They may allow for some greater optionality in determining the commencement date, based on the facts at the time, and not require a full 12 months' delay to 1 July 2023.

Monitoring risk and confirming 'go live' decisions

41 The Transition Unit will continue to strengthen a proactive risk management and transition oversight role over this financial year, aligned with the Ministry of Health's stewardship function. This will include regular reporting to the Ministerial Oversight Group on key risks, including progress against expected timelines for legislation and entity establishment. The Oversight Group will be advised early if the likelihood of risks occurring, or the implications of their occurrence, increases over the course of the transition period. To support this, the Transition Unit has established a Transition Assurance Group of senior officials, leaders from the health sector and independent advisors to review emerging and ongoing risks and issues and strengthen monitoring and reporting to Ministers.

42 I propose that Cabinet invite me to report quarterly on progress, to provide for a number of 'checkpoints' over the coming year to apprise activities underway and review the status of risks. This process is intended to support Cabinet to maintain an overview and to consider early interventions if necessary to ensure that delivery remains on course. These checkpoints may consider, for example, the progress of the interim agencies with their work programmes and their readiness to assume wider functions and accountabilities. I recommend two key checkpoints prior to 'go live':

42.1 At the end of December 2021, confirming that enabling legislation is on-track; and that a detailed plan for the transition of functions from the Ministry of Health and DHBs has been prepared and confirmed.

42.2 In April/May 2022, confirming that legislation has made sufficient progress towards Royal Assent; and that interim agencies have built sufficient capacity and capability to assume their roles in the future

health system on 1 July 2022. This checkpoint would result in a formal 'go/no-go' decision for Cabinet by mid-May 2022.

43 This final decision point could be supported by advice prepared by the Transition Unit, the Public Service Commission, Treasury and other agencies, based on previous examples of entity establishment, disestablishment and mergers. I have asked the Transition Unit to develop advice on how such an approach may be supported by quantifiable and qualitative information to enable Cabinet to reach a decision to proceed.

Day 1 of the reformed system

44 Our health reform programme will take a number of years to deliver: both to embed new structures and functions, and to make the changes to access and models of care that will lead to improved outcomes and equity for New Zealanders. I anticipate that it will require several years for the full benefits of reform to become evident. However, the most critical early milestone on the roadmap to transformation is when the new legislation is intended to come into effect: 1 July 2022.

45 This date will be "Day 1" for the reformed system. On this day [CAB-21-MIN-0092]:

45.1 district health boards and Te Hiringa Hauora/Health Promotion Agency will be formally disestablished;

45.2 Health NZ will be established as a Crown entity, and will legally hold the staff, assets and liabilities of current DHBs and their subsidiaries, including the public health units;

45.3 the relevant functions of Te Hiringa Hauora/Health Promotion Agency will shift to the Public Health Agency of the Ministry of Health and Health NZ;

45.4 the Māori Health Authority will be established;

45.5 Health NZ and the Māori Health Authority will assume their full range of statutory functions as agreed by Cabinet (noting that final decisions on the Māori Health Authority are still to be taken); and

45.6 the Public Health Agency will have been set up as a branded business unit within the Ministry of Health.

46 I anticipate that making these shifts on Day 1, supported by preparatory work prior and further evolution after, will enable the reforms without disrupting the day-to-day operations of the health system. Prior work with both DHBs and interim agencies will ensure readiness on both sides for functions to shift, including maintaining continuity of personnel and technology.

47 Taking a population health approach and delivering primary and community care through localities will be at the heart of the new system. On Day 1 there

will be some meaningful steps towards standing up this new approach, including population analytics to underpin the development of the interim New Zealand Health Plan, and standing up locality prototypes for 5 percent of the New Zealand population. The locality prototypes give the opportunity to put in place new co-commissioning arrangements between Health NZ and the Māori Health Authority. These prototypes will be designed to test locality models for diverse communities, including those with large Māori and Pacific populations; and both urban and rural areas.

48 In order to have a functioning system on Day 1, there are a number of structures, functions and machinery of government artefacts that will need to be in place, along with transfers of staff to their new employers. For each of these I would expect to see:

48.1 Structures: the structural settings will be in place for new entities to run our health system at national, regional and local levels, including regional divisions and teams within Health NZ that will stand up the delivery spine of the future distributed system. Not all elements will be place and some will be expected to be in interim form – for instance, I expect it will take some time for localities to be determined and established in all areas of New Zealand. Initial structural arrangements will need to account for the intended development over time.

48.2 Functions: entities will be performing the critical functions to carry out their core operations, including performance monitoring and improvement. For instance, I expect that Health NZ and the Māori Health Authority will prioritise the implementation of a transformative commissioning approach that seeks to address inequities and reorient primary and community care to improve access for vulnerable communities, such as Māori, Pacific and disabled people, and work with providers to strengthen service models.

48.3 People: staff will be transferred to their new employers and interim boards, executive arrangements and key leadership positions are in place, some of which will be interim or having acting arrangements. This will include ensuring appropriate diversity and representation in those positions from Day 1, including Māori and Pacific leadership. Not all positions will be appointed at Day 1: for other roles, recruitment strategies will have been developed to set the pathway to permanent appointments.

48.4 Machinery of government artefacts: the initial two-year Government Policy Statement and New Zealand Health Charter will have been developed, and significant progress will have been made towards an interim New Zealand Health Plan. These documents will be ready for board consideration on Day 1, ahead of formal Ministerial approval.

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

Governance and accountability arrangements will be in place flowing

from the Government Policy Statement, including requirements for necessary data and information for monitoring.

49 An outline view of the key characteristics of Day 1 is attached at **Appendix A**. This is based on the principle of paring back to those activities and settings that must be in place to keep the overall system running and safeguard operations, while at the same time moving the system to deliver more equitable outcomes and lift overall performance. It is based on a number of assumptions as to the internal design of the system, including matters that will need to be determined by the interim agencies once they are established such as the sub-national structures within Health NZ. As a result, I expect this view to continue to evolve over time.

50 While Day 1 marks the final legal structures taking effect, entities will still have some internal transitional arrangements for some time after Day 1. Temporary, interim, or transitional arrangements for a short period after legislation comes into effect are a feature of most reforms and will not negatively affect the time to realise benefits. In many cases, these temporary arrangements will be an improvement on the current state as variation in policies, models of care and decision-making frameworks will be reduced across geographic areas, and there will be greater clarity on overall accountabilities.

51 By Day 1, I expect there to be a clear picture of current performance across the health system to highlight variation and opportunities for performance improvement to guide priorities for early action and improvement.

Day 1 from the perspective of the health workforce

52 The characteristics of Day 1 summarised in Appendix A provide a system-level view of changes to structures and machinery. While much of this will be recognisable to those in the health workforce, the visibility of changes will be determined to a significant extent by the worker's position within their organisations and by the effectiveness of communications and change management strategies.

53 For frontline health workers, our primary intention is for Day 1 to provide as little disruption to core business as possible. This means that the basic elements of their jobs – where they work, the services they provide, to whom they report – are likely to be unchanged, and where any changes are planned (such as for the small proportion of staff where reporting lines may change to fit new Health NZ arrangements) these should be communicated well in advance of July 2022. For commissioning staff, workforce development to embed the new commissioning framework (including ways of working with providers, communities and iwi-Māori partnership boards) will be a key focus of activity ahead of Day 1.

54 For most staff, the most visible elements of change at Day 1 will be related to changes in system leadership and presentational matters such as the branding of new entities. In this context, the advent of the health system reforms provides an unprecedented opportunity to reset workforce culture and

move towards a one-system ethos – including by the communication and demonstration of cultural expectations from system leaders. Although our aim is to minimise practical changes on Day 1, we must seek to use this moment as a catalyst for changing culture and establishing the norms of the new organisations. I expect this to include:

54.1 targeted communications from the new leadership of Health NZ and the Māori Health Authority to the workforce, including roadshows in advance of Day 1 that aim to confirm management arrangements and set core principles and values for the new entities; and

54.2 widespread consultation on the draft New Zealand Health Charter as a vehicle to those express principles and values held by all health sector workers.

55 These approaches will balance ensuring staff feel continuity with signalling the opportunities – particularly early opportunities – to alleviate pressure on our health workforce and improve their experiences of working in health.

Day 1 from the perspective of people who use health services

56 The primary objectives of our health reforms are to improve health outcomes overall, and equity of outcomes and access for New Zealanders. Over time, I expect that all people who engage with the health system should begin to feel the benefits of reform – in terms of improved outcomes and experience, better access and availability of services and greater use of new technologies.

57 The core changes on Day 1 will be focused on the structures, organisations and machinery that will support the new system model. From the perspective of people who use health services and the wider public, whilst the fact of these changes may be noted through communications and media reporting, they are unlikely to be highly visible in relation to their day-to-day experience of the health system. However, there will be some early markers to signal the improvements in care people can expect over time, including live locality prototypes in some parts of the country, covering 5 percent of the population. These targeted opportunities will be supported by communications which signal the advantages of reforms, so that structural change is seen as a precursor to improved care – which is what will matter most to New Zealanders.

58 Moreover, in my view it will be important that the public experience and can expect the same availability and access to current health services on Day 1, to ensure no disruption to treatment. People should have confidence that they will be able to continue to see the same clinicians and have access at least to the same services as they had before. Over time, I expect that as the new entities develop new models of care and drive a culture of innovation, people will have a greater suite of options for how they access health services, including greater access to virtual options.

Transfer of functions ahead of Day 1

59 The period to 1 July 2022 will be a critical and intensive period of organisational design and preparation. At the end of this period, the permanent agencies should be ready to assume and operate their full range of statutory functions – accepting that their capacity and capabilities will strengthen over time and there may be interim arrangement in place on Day 1.

60 In order to be ready for Day 1, interim agencies will need to have designed and tested their core functions and processes. I have previously advised Cabinet of my expectation that functions will be transferred progressively from the Ministry of Health to the interim agencies over this period to support them to incrementally expand their remit and build towards their full set of responsibilities [SWC-21-MIN-0080].

61 Across the period to July 2022, I envisage that the maturity of the interim entities to take on live operational functions will develop progressively and we might expect to see three phases of development. These are not expected to be discrete, but instead overlap as the entities build towards inheriting their full range of functions:

61.1 Phase one: focused on establishing the new entities, furthering the detail of the operating model, and starting to build leadership, critical mass and capability to take on future operational functions. This might be expected to take two or three months from initial establishment in September.

61.2 Phase two: this phase will be focused on beginning the transfer of certain functions where there is the critical mass and leadership in key areas to take these on, and the business processes and governance to oversee live operations and take on accountability. I anticipate that the initial transfers may be possible early next year.

61.3 Phase three: it is expected that in this phase the interim entities will be operating close to full capacity in a number of areas and be ready for handover of remaining functions, and the focus will be on continuing to build longer term capability requirements and refining business and governance processes. I expect that phase three will be close to the legal establishment of the new entities.

62 The transfer of functions to interim agencies is not only a pre-requisite for effective preparation but is also an opportunity to take early steps towards the system's future leadership, culture and operating model. As the interim agencies develop their operating models and begin to appoint to national and regional leadership roles, I expect that they will begin to amass significant soft power within the health sector. Our strategy should be to harness that power to begin to lead delivery functions ahead of July 2022, where the interim agencies may be well placed to make early progress. Such an approach would also, moreover, help to address risks highlighted by the health sector regarding the loss of talent in key areas, by providing greater certainty around

the structures within Health NZ and the Māori Health Authority and the future leadership positions available.

63 It is my expectation that as functions are transferred into the interim entities, the formal accountability for those functions will transfer with them by default. However, in some cases, alternative arrangements may need to be in place for a short period to ensure sufficient continuity of a function, and can be addressed via relationship agreements between the entities.

64 For some functions, there will need to be a period where the interim entities have shadow arrangements and not formally receive the functions or accountability. The shadow period will be required in some cases to build capacity and capability in the new entities to execute the function at the scale required in the reformed system. In other cases, shadow arrangements will be used to redesign functions from how they are currently carried out today. For example, I expect there will be a transformed approach to performance monitoring in the future system where each of the national entities will have a role in monitoring system performance. The entities will need to design their future performance monitoring regimes in line with their respective roles over the coming eight months, without disruption to the monitoring and management of current system performance.

65 For the transfers to succeed, it will be important to ensure that both the "giving" environment and the "receiving" environments are well prepared. This should include, for example, advance clarity on the specific activities, resources and assets to transfer, any service contracts associated, and the delegation of any formal powers required for that function. It will also require that the interim agencies are ready to receive a function, including that for example:

65.1 that appropriate leadership and capability is in place for the function;

65.2 that any additional resources required to deliver the function have been identified;

65.3 that robust assurance and monitoring arrangements are in place to support accountability, which should transfer at the same time as the function itself.

66 While these factors are relevant to individual decisions on functions to be transferred, it will also be necessary to consider the sequencing of all relevant functions in the aggregate and ensuring a deliverable timetable. This should take into account other factors including the need to ensure that the agencies' primary purpose of design and development is not compromised.

Transfer of Ministry of Health functions

67 In line with this broad timeline, the Ministry of Health and Transition Unit have developed a proposed approach to shift key operational Ministry of Health functions to interim entities ahead of 1 July 2022. This approach emphasises moving early to shift enabling functions and functions vital to the future

operations of Health NZ and the Māori Health Authority, while the Ministry works to prepare more complex areas (such as those responsible for ongoing delivery, or where only some parts of functions will transfer) for Day 1. I have been assured that officials from all agencies will work together closely to ensure interim entities are set up to successfully receive functions, using tactics such as establishing 'beachhead' teams to provide functional leadership as agencies build their own capacity and capability, and establishing shadow or virtual teams to build and test capability prior to Day 1.

68 Transfers from the Ministry of Health will occur in three tranches:

68.1 Tranche 1 (February 2022): Focused on enabling functions – such as DHB performance and capital – which will make it easier to effect change, and which can be readily moved early.

68.2 s9(2)(f)(iv) [redacted]

69 The transfer of some Ministry functions involves significant complexity. This includes functions at the heart of our COVID-19 response (including COVID-19-specific functions and public health functions), disability services (on which Cabinet has received separate advice as part of its own reform programme) and screening services. I anticipate receiving advice on these areas in the near future, noting that transfers which may affect our COVID-19 response will be subject to ongoing evaluation over coming months to ensure any transfers occur safely.

70 In the interim, the Transition Unit and Ministry of Health have been working with DHB chairs to ensure that they are working to bring public health and COVID-related functions closer together, to both improve our COVID-19 response and begin to mirror future arrangements under Health NZ.

71 Between now and December, the Ministry of Health and Transition Unit will prepare a functional analysis of the functions to be shifted as part of different tranches for consideration, and associated implementation plans. To ensure that decisions can be taken rapidly over the coming months to support the transfer of functions, **I recommend that the Minister of Health be delegated authority to agree transfers from the Ministry to the interim agencies, in consultation with the group of Ministers established for 'Tier 2' decisions on health reform**[2] [SWC-21-MIN-0080 refers].

[2] Tier 2 Ministers consists of the Prime Minister, Minister of Finance, Minister for the Public Service, Minister for Disability Issues, Minister of Health, and Associate Ministers of Health (Hon Dr Ayesha Verrall, Hon Peeni Henare, Hon Aupito William Sio)

Transfer of DHB functions

72 While the transfer of functions from the Ministry of Health will occur in advance of Day 1, the transfer of most functions from DHBs will not be able to occur formally until Day 1, given their day-to-day statutory and operational responsibilities. At the same time, I expect that interim agencies will appoint key leadership positions, and grow their understanding of and influence over the system, from early in their establishment.

73 The Transition Unit, lead DHB chief executives and shared services agencies are working to identify areas where early transfers, or a role for interim agency leadership, would be appropriate. Shared services agencies may present sound opportunities for early transfer – particularly those providing some national services, such as the Technical Advisory Service's workforce responsibilities – to embed Health NZ and the Māori Health Authority system roles early. Functions from the Transition Unit such as those teams working on the NZ Health Plan, NZ Health Charter and locality prototypes are also likely to move early to new entities to grow capacity and capability.

Beyond Day 1: the three-year roadmap

74 The first three years of the new system following Day 1 will be the critical period to build, refine and consolidate new functions as the entities work towards their intended final state. This will be important for:

74.1 Health NZ, the Māori Health Authority and the Ministry of Health to adapt to new ways of working and reshape structures from today's health system (including DHB staff and structures, and current Ministry structures) to be fit for purpose for the future;

74.2 entities to develop and refine their approaches to partnership and joint working in their respective functions, including at regional and local-level, to act as a single system;

74.3 health agencies to have time to undertake detailed work to ensure quality planning, commissioning and strategy for our future health system, such as developing new tools, modelling and frameworks to manage hospital network demand, workforce pressures, and locality co-commissioning arrangements; and

74.4 designing and delivering key frontline initiatives in priority areas, as funded through Budget 2022 and future budget cycles.

75 The first two years in particular will be crucial to development. I expect that these will be supported by a two-year Government Policy Statement that sets priorities and requirements for the new system, and an interim two-year New Zealand Health Plan. Both of these should reflect the nascent state of the reformed system and the need to both refine functions, processes and ways of working, and to continue to improve service delivery and outcomes, with a particular focus on initial priority areas. The interim Health Plan should also act to signal the work programme for the production of the first full Plan.

76 The third year (FY2024/25) represents the first 'full' year of the future health system's operation. s9(2)(f)(iv) and setting expectations for the ongoing improvement in performance and operation of the system.

77 By the end of this three-year period, therefore, I expect that the system will closely resemble the destination of the system that has been designed. **Appendix B** sets out an indicative high-level roadmap for the three years. As with the Day 1 outline described above, this represents an outline of current planning. In particular, I would note that:

77.1 anticipated activities beyond FY2021/22 are largely subject to future Budget decisions, including funding for the ongoing sustainability of the future health system; and

77.2 I expect the interim and permanent boards and chief executives of Health NZ and the Māori Health Authority to have strong views on reform priorities; their leadership of reforms will be vital to success, and I recommend they be given a measure of flexibility to shift the focus of work beyond 1 July 2022 to align to their own views of organisational and system priorities (within parameters set by the Government Policy Statement and New Zealand Health Plan, and subject to Transition Unit stewardship during the transition period).

78 The first three years of the new health system, and the years that follow, will have the greatest impact on health outcomes for priority populations, including Māori, Pacific peoples, disabled people, rural communities, LGBTQI+ communities, migrant and refugee communities, women, those with long-term conditions, and seniors.

Impact analysis

Financial implications

79 Funding to deliver implementation and transition activities has been secured through Budget 21, and all the investments needed to deliver Day 1 will be fully funded from existing baselines or tagged contingencies. As planning for transition activities progresses – for example, as decisions are made about the sequence in which functions are created or moved between agencies – reprioritisations within existing Vote Health baselines may be required.

80 As previously noted by Cabinet, the implementation of health reforms will have financial implications for our health system, both in moving to the new system and in sustaining improved care. The scale of these financial implications will depend on investment priorities and sequencing. I am seeking transitional and ongoing funding for this through Budget 22. I have asked the Transition Unit to provide advice on the investments that would provide greatest value for money, and best achieve the agreed vision for these reforms. I expect these investment opportunities to be underpinned by

early content tied to the interim New Zealand Health Plan, to ensure that investment priorities reflect the intended direction of the reformed health system over its first two years of operation.

Legislative implications

81 The structural changes to the health system agreed by Cabinet require primary legislation. Cabinet has agreed to use the Pae Ora (Healthy Futures) Bill on legislative programme to do this, which has a priority 4 (to be referred to Select Committee in 2021).

Regulatory impact statement

82 The impact analysis requirements do not apply to this paper. A Supplementary Analysis Report was however prepared and attached to a previous Cabinet paper – Health and Disability System Reform: Implementation and Transitional Arrangement [SWC-21-SUB-0080], covering the structural changes to the health system agreed by Cabinet. The Treasury's Impact Analysis Team considered it met the quality assurance criteria.

Population implications

83 As previously advised, the new system operating model is expected to have significant benefits for populations who experience poorer health outcomes or could be better served by the health system, especially Māori, Pacific peoples, disabled people, rural communities, LGBTQI+ communities and people with lower socio-economic status. For example, we anticipate that:

83.1 the introduction of a Māori Health Authority and strengthened roles for iwi-Māori partnership boards will improve system responsiveness to Māori and so improve Māori health outcomes;

83.2 strengthened system expectations for equity-based performance (such as through the GPS and NZ Health Plan), including a nationally accountable body in Health NZ, will better ensure system performance for Māori, Pacific peoples, disabled people, rural communities, LGBTQI+ communities, people with lower socio-economic status, migrant and refugee communities, people with long-term conditions, women, and seniors;

83.3 strengthened commissioning approaches, designed to mitigate the 'postcode lottery' and ensure a balance of national consistency and local tailoring, and adoption of more consistent models of care and best practice, will improve the consistency and tailoring of care for Māori, Pacific peoples, disabled people, rural communities, LGBTQI+ communities, people with lower socio-economic status, migrant and refugee communities, people with long-term conditions, women, and seniors; and

83.4 the adoption of a locality model for primary and community-based care, and increased focus on early intervention and preventative care in the community, will improve access and system performance for Māori, Pacific peoples, disabled people, rural communities, people with lower socio-economic status, migrant and refugee communities, people with long-term conditions and seniors.

84 The phasing of implementation activity has been designed to realise benefits for these groups as early as possible. The new health system will also need to ensure that these groups have confidence in how their interactions with the health system will be planned, delivered and performance monitored.

Human rights

85 The proposals in this paper are consistent with, and advance the purposes of, the New Zealand Bill of Rights Act 1990 and the Human Rights Act 1993.

Consultation

86 The Ministry of Health, the Treasury and the Public Service Commission have been consulted. Their comments are reflected in this paper. The Department of Prime Minister and Cabinet has been informed.

Communications

87 The announcement of the new health and disability system operating model on 21 April 2021 covered key points made in this paper, including the timeframes to establish interim entities to for new legislation to take effect. The decisions and recommendations from this paper may feature in other public communications relating to the reform.

Proactive release

88 I intend to release this paper in accordance with the guidance in Cabinet Office Circular CO (18) 4.

Recommendations

The Minister of Health recommends that the Committee:

Previous decisions

1. **note** that in March 2021 Cabinet agreed to significant reforms to the system structures and operating model, including establishing Health New Zealand to replace the 20 current District Health Boards, creating a new Māori Health Authority, and refocusing the role of the Ministry of Health [CAB-21-MIN-0092 refers]

2. **note** that Cabinet authorised the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office for legislation to give effect to the agreed proposals [CAB-21-MIN-0092 refers]

3. **note** that Cabinet has received advice on the approach to managing system and programme risks to implementation of the health system reforms

Progress with implementation and risk management

4. **note** that significant progress has been made with the design, development and implementation of the health system reforms, and that these remain on track for critical milestones in July 2022

5. **note** that the approach to implementation is intended to manage system risks, however given the scale and timetable for change there will remain risks to delivery of the structural reforms in the timetable intended

6. **note** that these risks may result in scenarios where the Pae Ora (Healthy Futures) Bill is not able to be commenced by July 2022; the interim agencies are not sufficiently established to be able to give effect to their full range of functions; or where external events make a delay in implementation desirable.

7. **note** that in any of these scenarios, it may be necessary to adopt alternate pathways which maintain the direction of the reforms but delay legislative change

8. **note** that the Minister of Health will oversee risks with implementation and advise Cabinet on the need for any further mitigating actions

9. **invite** the Minister of Health to report to Cabinet quarterly on progress with implementation of the health reforms, with the next report due by December 2021

10. **agree** that Cabinet should undertake a formal checkpoint by May 2022 ahead of passage of the legislation to confirm that the structural reforms should proceed as intended on 1 July 2022

Day 1 for the reformed system

11. **note** that the system reforms are intended to come into effect on 1 July 2022 subject to legislation, and this will be Day 1 for the new system

12. **note** that on Day 1, I expect that:

    a. structural settings will be in place for new entities to run initial arrangements at national, regional and local levels as relevant, including regional divisions, leaders and teams and district offices within Health NZ

    b. entities will have and be performing the critical functions to carry out their core operations, including performance monitoring and improvement

    c. staff will transfer to their new employers, key leadership positions will be in place, some which will be interim or have acting arrangements, regional and local teams will be established, and interim national and regional boards will be in place, including consideration of appropriate representation such as Māori and Pacific leadership

d. the initial two-year Government Policy Statement will have been developed, the interim New Zealand Health Plan will be ready for consideration and approval by the incoming boards of Health New Zealand and the Māori Health Authority, and the initial NZ Health Charter will be subject to consultation

Transfer of functions ahead of Day 1

13. **note** that to support the intended system design on Day 1, it will be necessary for certain functions to be transferred from the Ministry of Health to the interim agencies in advance, allowing sufficient time for capability and capacity to be developed

14. **note** that decisions on when functions should be transferred should include consideration of the risks and opportunities of such transfers, including an assessment of readiness of both the Ministry (as the "sending" organisation) and the interim agency (as the "receiving" organisation)

15. **note** that the Ministry of Health anticipates transferring functions to interim agencies in three tranches, commencing in February 2022

16. **authorise** the Minister of Health, in consultation with the group of Ministers identified to support Tier 2 decisions on health reform, to make decisions on how and when to transfer relevant functions and accountabilities between the Ministry and the interim agencies over the coming period

Three-year roadmap

17. **note** that the full system model agreed by Cabinet is expected to come into effect from the start of the third year after Day 1, from FY 2024/25

18. **note** that the first two years of operation of the new system will therefore be critical to the development, refinement and consolidation of roles, functions and relationships between the system entities

19. **note** that the roadmap for the first three years of the reformed system will continue to evolve, and will require the input of the incoming boards and chief executives of the interim agencies to confirm plans.

Authorised for lodgement

Hon Andrew Little

Minister of Health

Appendix A

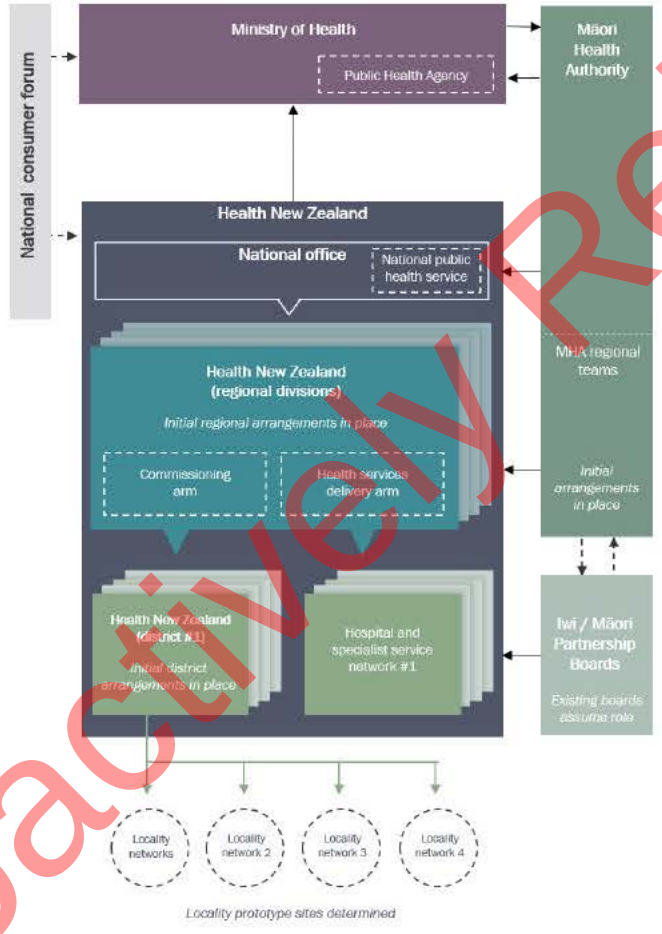
Key characteristics of the reformed health system on Day 1

Structures

- The **Ministry of Health** will adopt a new operating model for its refocused role
- **Health NZ** will be a Crown entity, with a core national office in place and DHBs disestablished
- Initial regional divisions of Health NZ will be established, based on the existing four regions
- Initial district offices of Health NZ will be confirmed, derived from and perhaps consolidating DHB boundaries
- Appropriations in place, along with internal HNZ allocations and delegations
- Early localities will be in place, based on prototype and early adopter sites (c.5-6 in total)
- The **Māori Health Authority** will be established, with a national office and initial regional teams that map to Health NZ arrangements
- Initial **iwi-Māori partnership boards** will be in place based on existing arrangements
- The **Public Health Agency** will be a distinct business unit of the Ministry of Health
- A **national consumer forum** will be in place to promote and embed community and consumer voice

Functions

- Health NZ and the Māori Health Authority will assume their **full range of statutory functions** – some functions may be delegated initially to other agencies or the Ministry of Health
- The Ministry will be the **lead monitor** and oversee a strengthened approach to monitoring of performance and outcomes
- Health NZ will lead **internal performance management and improvement** of services at all levels
- Health NZ the MHA will **commission and co-commission** health services at appropriate levels
- Health NZ and the MHA will have **critical corporate functions** in place: governance, business processes, IT, payroll – within Health NZ some may initially be adapted from DHB systems
- Health NZ and the MHA will have the **capability to understand health needs** for all populations and commission services to address inequities
- Health NZ and the MHA will **build capability to innovate and trial new approaches** for Māori, Pacific people, and other groups experiencing inequitable outcomes



People

- All existing DHB staff will transfer and become employees of Health NZ
- Health NZ will have an appointed Board, CEO and national-level executives in key posts; with a recruitment strategy for other posts
- The national public health service will be established, including employees transferred into Health NZ from the 12 PHUs. The Health Promotion Agency will be a subsidiary or business unit of Health NZ.
- Health NZ regional executives, key regional leadership roles and interim regional boards in place
- The Māori Health Authority will have a Board, CEO and national-level executives in key posts; with a recruitment strategy for other positions
- Initial MHA regional teams will be in place
- Existing members of iwi-Māori partnership boards will fulfil new functions until changes are made

Artefacts

- An initial two-year **Government Policy Statement** will be published to set system expectations
- This will be supported by transitional funding arrangemens for first two years (subject to agreement)
- Requirements for individual entities will be in place through **LoEs**, SOIs and SPEs as necessary
- The Ministry will also publish additional **system rules and regulations**, derived from the new Act, including a framework for delegations to agencies
- **National data and information requirements** for monitoring will be set in the GPS
- An interim **NZ Health Plan** will be ready for approval by the Health NZ and MHA Boards
- Health NZ will publish critical **initial guidance** to set the system approach: commissioning framework, performance management framework, digital plan
- Guidance will support initial locality plans, but these will not yet be developed
- An initial **NZ Health Charter** will be published, with plans for further consultation

Note: all artefacts will **reiterate the commitment to addressing inequities**

Appendix b withheld in full under section 9(2)(f)(iv)

Cabinet Social Wellbeing Committee

Minute of Decision

Health and Disability System Reform: Update on Implementation Plans and First Three Years of the Reformed System

Portfolio **Health**

On 27 October 2021, the Cabinet Social Wellbeing Committee (SWC):

Background

1 **noted** that in March 2021, Cabinet agreed to significant reforms to the health system structures and operating model, including establishing Health New Zealand to replace 20 District Health Boards, creating a new Māori Health Authority and refocusing the role of the Ministry of Health [CAB-21-MIN-0092];

2 **noted** that in June 2021, SWC noted the implementation approach for the health reforms and the associated programme risks, and authorised a group of Ministers to make Tier 2 policy decisions as required (Tier 2 Ministerial group) [SWC-21-MIN-0080];

Progress with implementation and risk management

3 **noted** that significant progress has been made with the design, development and implementation of the health system reforms, and that these remain on track for critical milestones in July 2022;

4 **noted** that the approach to implementation is intended to manage system risks, however given the scale and timetable for change there will remain risks to delivery of the structural reforms in the timetable intended;

5 s9(2)(f)(iv) [redacted]

6 **noted** that in any of the above scenarios, it may be necessary to adopt alternate pathways which maintain the direction of the reforms but delay legislative change;

7 **noted** that the Minister of Health will oversee risks with implementation and advise Cabinet on the need for any further mitigating actions;

8 **invited** the Minister of Health to report back to SWC quarterly on progress with implementation of the health reforms, with the next report due by December 2021;

9 **agreed** that Cabinet should undertake a formal checkpoint by May 2022 ahead of passage of the legislation to confirm that the structural reforms should proceed as intended on 1 July 2022;

Day 1 for the reformed system

10 **noted** that the system reforms are intended to come into effect on 1 July 2022 subject to legislation, and this will be Day 1 for the new system;

11 **noted** that on Day 1, it is expected that:

11.1 structural settings will be in place for new entities to run initial arrangements at national, regional and local levels as relevant, including regional divisions, leaders and teams and district offices within Health NZ;

11.2 entities will have and be performing the critical functions to carry out their core operations, including performance monitoring and improvement;

11.3 staff will transfer to their new employers, key leadership positions will be in place - some of which will be interim or have acting arrangements, regional and local teams will be established, and interim national and regional boards will be in place, including consideration of appropriate representation such as Māori and Pacific leadership;

11.4 the initial two-year Government Policy Statement will have been developed, the interim New Zealand Health Plan will be ready for consideration and approval by the incoming boards of Health New Zealand and the Māori Health Authority, and the initial NZ Health Charter will be subject to consultation;

Transfer of functions ahead of Day 1

12 **noted** that to support the intended system design on Day 1, it will be necessary for certain functions to be transferred from the Ministry of Health (the Ministry) to the interim agencies in advance, allowing sufficient time for capability and capacity to be developed;

13 **noted** that decisions on when functions should be transferred should include consideration of the risks and opportunities of such transfers, including an assessment of readiness of both the Ministry (as the "sending" organisation) and the interim agency (as the "receiving" organisation);

14 **noted** that the Ministry of Health anticipates transferring functions to interim agencies in three tranches, commencing in February 2022;

15 **authorised** the Minister of Health, in consultation with the Tier 2 Ministerial group, to make decisions on how and when to transfer relevant functions and accountabilities between the Ministry and the interim agencies over the coming period;

Three-year roadmap

16 **noted** that the full system model agreed by Cabinet is expected to come into effect from the start of the third year after Day 1, from Financial Year 2024/25;

17 **noted** that the first two years of operation of the new system will therefore be critical to the development, refinement and consolidation of roles, functions and relationships between the system entities;

18 **noted** that the roadmap for the first three years of the reformed system will continue to evolve and will require the input of the incoming boards and chief executives of the interim agencies to confirm plans.

Rachel Clarke
Committee Secretary

Present:
Rt Hon Jacinda Ardern
Hon Grant Robertson
Hon Kelvin Davis
Hon Dr Megan Woods
Hon Carmel Sepuloni (Chair)
Hon Andrew Little
Hon Poto Williams
Hon Kris Faafoi
Hon Peeni Henare
Hon Willie Jackson
Hon Jan Tinetti
Hon Dr Ayesha Verrall
Hon Meka Whaitiri
Hon Priyanca Radhakrishnan

Officials present from:
Office of the Prime Minister
Officials Committee for SWC

Cabinet

Minute of Decision

Report of the Cabinet Social Wellbeing Committee: Period Ended 29 October 2021

On 1 November 2021, Cabinet made the following decisions on the work of the Cabinet Social Wellbeing Committee for the period ended 29 October 2021:

[redacted]

SWC-21-MIN-0163	**Health and Disability System Reform: Update on Implementation Plans and First Three Years of the Reformed System** Portfolio: Health	CONFIRMED

[redacted]

[redacted]

Michael Webster
Secretary of the Cabinet