



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 Review - Proposals for Reform

The following documents have been included in this release:

Title of paper: Health and Disability System Review - Proposals for Reform
(SWC-21-SUB-0092 refers)

Title of minute: Health and Disability System Review - Proposals for Reform
(CAB-21-MIN-0092 refers)

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Section 9(2)(g)(i) to protect the free and frank expression of opinions by or between or to Ministers of the Crown

~~[IN CONFIDENCE]~~

Office of the Minister of Health

Social Wellbeing Committee

Health and Disability System Review – proposals for reform

Proposal

- 1 This paper sets out foundational proposals for reform of the health system in New Zealand, in response to the Health and Disability System Review.

Relation to government priorities

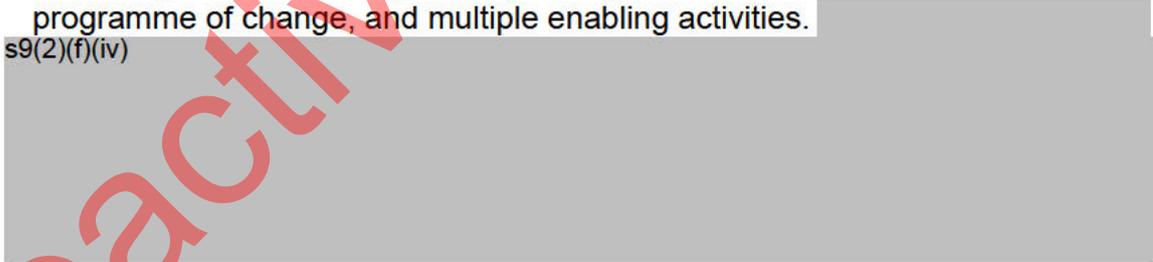
- 2 The Government's Manifesto and the Speech from the Throne committed to undertaking a long-term programme of reform to build a stronger health and disability system that delivers for all, drawing on the recommendations of the Health and Disability System Review.

Executive summary

- 3 This is anticipated to be the first of a series of papers that seek Cabinet agreement to the necessary design, service requirements and enabling framework for the reform of the health system. It sets out my proposals for the foundational elements of the future system – the organisational structures and their functions – and seeks agreement to the broad vision for change and high-level timetable for implementation.
- 4 On 14 December 2020 Cabinet noted its previous agreement to the case for change to the system and invited the Minister of Health to bring forward recommendations for system reform and a plan for implementation, for consideration in March 2021 [CAB-20-MIN-0519].
- 5 The case for change in the New Zealand health system is clear. Reviews over past decades have reached similar conclusions: the public health and disability system performs well overall against most international comparisons, but has significant issues in delivering equity. Outcomes for Māori and Pacific peoples, disabled people and other groups are persistently worse than those for the general population. The system does not operate in partnership or meet the Crown's Te Tiriti o Waitangi obligations, as found in the WAI2575 claim. The Health and Disability System Review (the Review) made similar findings, also highlighting fragmentation and a lack of cohesion across the system's many actors, leading to unwarranted variation in performance and a failure to innovate or to scale new practice. Moreover, the system faces significant financial pressures, mounting deficits, and challenges to long-term affordability.
- 6 Our vision should be to build a system that achieves pae ora/healthy futures for all New Zealanders, and which works collectively and cohesively around a shared set of values and culture. There is an unprecedented opportunity

through these reforms to tackle these longstanding issues and deliver a health system that is more equitable and sustainable for future generations, that embeds partnership with the people it serves, that promotes person and whānau-centred care, and that strives for excellence.

- 7 Delivering this vision will require change to many aspects of the current system. However, the critical foundational layer for reform is the design of the system operating model: how core functions are allocated and discharged, where decision rights are located, and how system entities work together.
- 8 Creating a clearer, more effective design of functions starts at the national level. The principal elements of a system designed to deliver real change are:
 - 8.1 The Ministry of Health should be strengthened in its role as the steward of the health system, leading on strategy and policy.
 - 8.2 Health New Zealand should be established as the operational lead for health services, undertaking planning and commissioning, monitoring performance, and driving innovation.
 - 8.3 The Māori Health Authority should be established to drive a focus on hauora Māori in the system, working jointly with the Ministry and Health NZ to agree strategies, plans and priorities.
 - 8.4 The Public Health Agency and national public health service should be established to focus on strengthening health protection and health promotion and to improve public health knowledge, research and intelligence.
- 9 Planning, commissioning and delivery functions for health services, which are currently delivered by the 20 existing district health boards (DHBs), should be consolidated into a single entity, Health NZ. To deliver its core operational functions, Health NZ would be split into two distinct but aligned arms for commissioning primary and community services, and providing hospital and specialist services. Hospital and specialist services will be planned nationally by Health NZ to improve the allocation of resources across the country; and will be managed through regional networks. Primary and community services should be commissioned closer to communities and delivered through new locality networks of providers, which integrate core systems and processes and incentivise a focus on shared outcomes which are agreed by and for the people they serve.
- 10 The Māori Health Authority must drive and monitor Māori health, but it must be a decision-maker too, consistent with the Crown's Te Tiriti o Waitangi obligations, and should therefore also have a significant commissioning role. It should be a lead commissioner of kaupapa Māori services, focusing on expanding and developing provision of services targeted at Māori communities. It should also act as a co-commissioner for other health services, working jointly with Health NZ to ensure that hauora Māori is prioritised.

- 11 Giving effect to this model requires a simpler, more coherent and coordinated structure of organisations, which is clearly led and accountable for achieving national objectives. The current status of district health boards as individual Crown entities, with significant operational independence, inhibits this future state and risks perpetuating fragmentation and misalignment. In the future, Health NZ should be a single Crown agent and have sub-national groupings that are internal divisions rather than separate entities. These divisions would hold both the regional commissioning and service delivery arms. Health NZ will hold public assets including hospitals and equipment and employ public sector workers and health professionals. DHBs would be disestablished and their functions, assets, liabilities and staff transferred to Health NZ.
- 12 Within the Health NZ regional divisions, regional chief executives will be responsible for determining the best approach to commissioning, based on a 'hub and spoke' model. This is expected to include regions establishing a number of district-level offices which are located closer to communities, and which each include locality commissioning teams that will have responsibility for particular defined areas. The Māori Health Authority will also have regional teams, co-located with Health NZ and embedded in regional governance arrangements to ensure partnership and agreement to plans.
- 13 Partnership with Māori and the integration of Māori voice into planning and priorities will be an essential feature of the new system. This will involve a strong role for iwi-Māori partnership boards to agree locality priorities and plans that best meet the needs and aspirations of Māori communities, and to influence regionally through their relationship with the Māori Health Authority. Partnership and engagement with Pacific peoples, other communities and consumers of health services in governance, prioritisation, planning and commissioning will also be essential to achieve equity of outcomes.
- 14 Delivering reform to the system operating model will require a wide programme of change, and multiple enabling activities.  s9(2)(f)(iv)
- 15 We are now embarking on an ambitious programme of change. The initial decisions in this paper lay out a blueprint for the future of the health system, but much remains to be done to develop the necessary detail and the underpinning frameworks and processes that will make the system a reality. Cabinet's decisions on these first-order elements will create an opportunity for a collaborative approach to designing this detail with stakeholders.
- 16 Early progress in implementation will be important to lay the foundations and build momentum. Moreover, it is essential to provide the health sector with clarity on the direction and destination of reform and not delay the decisions required. During the transition, district health boards should be expected to operate as now with minimal disruption to services. However, steps can be

taken ahead of legislation to establish interim entities (for Health NZ and the Māori Health Authority) and to put in place advisory committees that support the next phase of design and preparation. Subject to Budget 2021 decisions, early investments can also be made to prototype new models for locality networks and build learning for wider adoption, and to expand Māori health provision.

Decisions for Cabinet

- 17 The table below summarises the key decisions related to health system reform that have been made by Cabinet to date, those which are included in this paper, and those which will be subject to future advice.

<p><i>Cabinet decisions to date</i></p> <ul style="list-style-type: none">• Agreed to the case for change in the health and disability system, as set out in the report of the Health and Disability System Review, and to the general direction of reform proposed by the Review.• Agreed to establish a Transition Unit in the Department of the Prime Minister and Cabinet to oversee work to develop reform proposals.• Noted the Minister of Health's initial view that high-level system design should broadly follow the Review's recommendations, but with questions to be resolved about the detail of the functions of the new entities, and where reforms could go further to achieve goals.• Noted the Minister of Health's intention to establish Health New Zealand, the Māori Health Authority, and a Public Health Agency, subject to further detailed proposals being brought.• Invited the Minister of Health to bring proposals for reform of the health system to Cabinet in March 2021.
<p><i>Cabinet decisions in this paper</i></p> <ul style="list-style-type: none">• Agree to a vision for a reformed health system, based on the outcomes to be achieved for people and the key shifts required in the system.• Agree to the core foundational elements of the future health system operating model, and to specify the allocation of key functions across health entities.• Agree to the future role and functions of the Ministry of Health, the Māori Health Authority and Health New Zealand, including the accountabilities, powers and relationships between them.• Agree to the future role and functions of a national public health service, including how the service is delivered through the health organisations.

- Agree to the necessary, consequential implications for other existing health system entities, including district health boards.
- Agree to the pathway for implementation, including legislation and change management to deliver reforms at pace.
- Note wider issues and enabling activity that will be needed to achieve reform, which will be the subject of future advice.

Cabinet decisions anticipated in subsequent papers

- Agree to detailed proposals for managing the transition to the reformed system, including mitigating risks to performance and preparing the health sector for change.

s9(2)(f)(iv)

Structure of this paper

- 18 This paper is split into five parts:
- 18.1 Part A recaps the context for reform and the case for change.
 - 18.2 Part B describes a vision for the future system and the key changes that people will experience.
 - 18.3 Part C proposes a new system operating model to deliver the necessary change and defines roles and functions for organisations.
 - 18.4 Part D describes how the proposed new system model will reinforce a focus on shared outcomes and accountability.
 - 18.5 Part E sets out the pathway to reform, including critical enabling activity and the roadmap to implementation.

PART A: CONTEXT

The case for change

- 19 When looked at as a whole, the New Zealand public health system performs well by a number of international standards. New Zealand life expectancy is comparable to similar countries, and expenditure is generally lower. New Zealand's response to the COVID-19 pandemic has been amongst the most successful globally in eliminating and reducing the impact of the novel coronavirus. However, as successive reviews have concluded, this aggregate performance masks persistent failings for some population groups.
- 20 Cabinet has previously agreed the case for change in the health and disability system [CAB-20-MIN-0269 refers]. In summary, we can identify a number of critical issues with the current system that must and can only be addressed through reform:
 - 20.1 The public health system does not meet the Crown's obligations to Māori. Māori involvement in decision-making is highly variable, Māori outcomes lag well behind other groups, and Māori involvement in service design and delivery has stalled. Iwi relationship boards do not routinely have decision rights over district health board priorities, strategies and plans.
 - 20.2 Overall system performance conceals significant underperformance and inequity, particularly for Māori and Pacific peoples. Life expectancy at birth for Māori and Pacific peoples is significantly lower than for other groups. Nearly half of Māori women do not have a lead maternity caregiver in the first trimester of their pregnancy – 17% less than non-Māori. One-third of Pacific peoples report not seeing their primary care practitioner when needed. Disabled people also face inequitable outcomes, with only 50 percent rating their health as good, compared to 89 percent of the non-disabled population.
 - 20.3 The system has become complex and unnecessarily fragmented, with unclear roles, responsibilities and boundaries. Incentives tend towards a focus on individual organisational performance, rather than on the good of the system as a whole. There is significant duplication of activity and insufficient cooperation and collaboration. This has led to a lack of clear accountability and a narrow entity view rather than a collective "whole system" ethos. It has also led to unwarranted variation: unplanned hospitalisations in the highest area are almost 50% more than in the lowest; and there are nearly three times as many cataract surgeries performed in the DHB with highest volume than in the lowest.
 - 20.4 The public do not have a consistent say in the operation of the system. DHBs were intended to provide a community voice through elected members, public meetings, and consultation on strategic planning, yet this has not resulted in meaningful involvement or community engagement.

- 20.5 Partly as a result, services are too often built around the interests of providers, and not around what consumers value and need. Improvements in service design and adoption of new technologies have been sluggish, resulting in little shift of services from hospital to community environments, despite this having been government policy for more than 20 years. Virtual consultations only became common during the height of the COVID-19 pandemic; and since the lowering of alert levels, have retrenched again.
- 20.6 The system does not routinely take a population health approach. A significant proportion of deaths are potentially preventable; paying more attention to the wider determinants of health, addressing risk factors and intervening early has the potential to save lives and address equity. Māori develop diabetes up to ten years younger than non-Māori, yet they are less likely to receive screening and monitoring. Inter-sectoral activity outside the health sector is the exception rather than the rule.
- 20.7 Funding has not increased in line with increasing costs and rising demand. Affordability is an ongoing challenge when set against multiple other funding priorities. Risks to financial sustainability are further heightened by high variation in cost control and financial management, leading in part to combined DHB deficits of nearly a billion dollars. Funding arrangements provide little local discretion for innovation and are unpredictable, making long-term planning difficult. Low funding for digital infrastructure, for example, has resulted in a significant technology deficit that contributes to wider system issues.

The Health and Disability System Review

- 21 In the context of the multiple challenges above, the Health and Disability System Review was commissioned in 2018 to identify reforms. The Review recommended structural change to support clearer lines of accountability and greater national coherence, and to align planning, funding and management arrangements across the system. It outlined a proposed public health and disability sector that would have:
- 21.1 the Ministry of Health as chief steward with responsibility for policy, strategy, legislation, long-term system outcomes and monitoring, building population health capacity and leading the Budget process;
 - 21.2 a new organisation, Health New Zealand, to provide national leadership of health service delivery, both clinical and financial;
 - 21.3 a Māori Health Authority to provide policy and strategy advice on Māori health and to commission Māori provider and workforce development, and to support Health New Zealand and DHBs with the commissioning of Māori health services;
 - 21.4 a reduction in the number of DHBs from 20 to between 8 and 12, over a five-year period, with strengthened accountability for improving

equitable outcomes in their own populations and greater contribution to the efficiency and effectiveness of the nationwide system;

- 21.5 a much greater focus on Māori health, achieved by updating relevant clauses in legislation, strengthening DHB-iwi partnerships, requiring DHBs to improve equity of Māori health outcomes in their strategic and locality plans, and ensuring funding formulas better reflect unmet need.
- 22 This paper provides advice to Cabinet on the proposed Government response to the Review, insofar as its recommendations relate to the foundational system structures and the overall operating model within the scope of this paper. Subsequent advice will set out a proposed response to other recommendations.
- 23 The paper notes the findings and recommendations of the Review where relevant in its analysis and proposals. The recommendations of the Review have significantly informed the work of the Transition Unit, and the overall model put forward in this paper draws heavily on the Review's direction and its aims. Many of the recommendations in this advice directly deliver those of the Review. In other cases, where the Review's position left greater space for development, it has provided a framework which has served as a starting point to lead thinking. Where the proposals in this advice deviate from those of the Review, for instance in relation to the function of the Māori Health Authority, the rationale is described.

Disability support services

- 24 The Review made a number of recommendations relating to services and support for disabled people, including a mix of improvements associated with disability support services and to health services.
- 25 The Ministry of Health and Ministry of Social Development are leading work on system transformation for disability support services in partnership with the disability sector. This work programme is based on the vision and principles of the Enabling Good Lives approach, which is currently being trialled in three areas of New Zealand.
- 26 Improving access to health services and outcomes for disabled people are critical aspects of our reforms and embedded in the proposals set out in this paper. However, there has been an on-going discussion for some years on what good governance of the disability support system looks like, and a growing acceptance, based on demonstrated performance, that the principles underpinning Enabling Good Lives can improve the lives of the disability community materially and psychologically.
- 27 It is clear that a governance model that takes disability support services out of a health framework is a desired outcome. This is not to say that this would remove the health element of disability services, but rather acknowledges that support for disabled people also encompasses other social services such as housing, education, employment, and the Accident Compensation Corporation. While disability support services are critical to the wellbeing of

disabled people, disabled people are also important users within the wider health system. Even if the governance of disability support sits outside of health system, disabled people will continue to be high users of the health system, and health reforms will need to be guided by this.

- 28 The Minister for Disability Issues and I have sought advice from Officials on what alternative models for disability governance. This advice is due by September this year and will be informed by the Machinery of Government review. Once we have received this advice, we will return to Cabinet on next steps. Throughout this process we will actively engage with the disability community on any future governance models to ensure the full range of disability perspectives is accurately represented in advice to Ministers.

PART B: A VISION FOR THE FUTURE HEALTH SYSTEM

- 29 The public health system is one of New Zealand's principal assets, our largest employer, and a source of human capital that drives population health, wellbeing and economic growth. There is a significant opportunity for Cabinet to agree substantial and unprecedented reforms which chart a course towards a more equitable and sustainable future.
- 30 First and foremost, our vision should be for a health system that meaningfully achieves **pae ora/healthy futures** for all: where people live longer in good health, have improved quality of life, and where there is equity between all groups.
- 31 A reformed health system which achieves pae ora must focus on delivering a number of priority outcomes. The most important improvements in outcomes which we should prioritise through this reform programme include:
- 31.1 **Equity**: tackling the gap in access and health outcomes between different populations and areas of New Zealand, with a particular focus on outcomes for Māori, Pacific peoples, and disabled people.
 - 31.2 **Sustainability**: embedding population health as the driver of preventing and reducing health need, and promoting efficient and effective care.
 - 31.3 **Person and whānau-centred care**: empowering all people to manage their own health and wellbeing, have meaningful control over the services they receive, and treating people, their carers and whānau as experts in care.
 - 31.4 **Partnership**: ensuring partnership with Māori in leading the design and delivery of services at all levels of the system, and empowering all consumers of care to design services which work for them.

- 31.5 **Excellence:** ensuring consistent, high-quality care in all areas, and harnessing clinical leadership, innovation, digital and new technologies to continuously improve services.
- 32 In order to achieve progress toward these outcomes substantial change will be needed to the way that the health system is designed, operated, and overseen. The current, fragmented system is no longer fit for purpose. In its place, a new system must focus on collaboration and cohesion, and on the interests of the population above the interests of any one organisation. That system must be simple, avoid duplication, have clear accountabilities and be easy for people to understand and navigate.
- 33 Looking to the future, I see five key system shifts that will be required, amongst many other reforms and improvements:
- 33.1 **The health system will reinforce Te Tiriti o Waitangi principles and obligations.** This will ensure that, for Māori, there is effective and meaningful leadership and partnership at all levels of the system. Māori voice will be firmly embedded and jointly responsible for the way that organisations set priorities, design and commission services, and monitor outcomes. This will ensure a clear focus on Māori health needs and an emphasis on achieving rangatiratanga and mana motuhake, which sees kaupapa Māori services and options more widely available for Māori communities embedded as a core part of integrated service arrangements.
- 33.2 **All people will be able to access a comprehensive range of support in their local communities to help them stay well.** There will be a greater range of local services available in all areas, designed around the holistic needs of communities and which work together to improve population health. People and whānau will be empowered to better manage their own health and wellbeing, and remain independent and connected, through information, advice, community support and targeted services. People will know what is available and how to find local services. Services will reach out to support people at different stages in their lives, and when people need them, they will be delivered to fit individuals' needs and preferences, share information appropriately and connect seamlessly to other health and wider government services.
- 33.3 **When people need emergency or specialist healthcare this will be accessible and high quality for all.** People will know which specialist health services are available in their area, and which they may need to travel to another area for. Services will be planned to ensure equitable access based on population health needs. When people need services in an emergency or for specialist treatment, they will be delivered consistently, based on the best evidence, and adapted to fit patient needs. Hospitals and specialist services will work cohesively across New Zealand to ensure that the needs of the whole population are met equitably, and to share best practice.

- 33.4 **Digital services will mean that many more people will get the care they need in their homes and local communities.** Everyone will be able to access virtual primary care, diagnostic and some specialist services, wherever they live, and services will adapt to be more preventative and personalised, enabled by technology. Technologies that improve care will be identified rapidly so the health system is quicker to adopt and roll out proven technologies at scale. Health organisations will work together to share information, intelligence and best practice, helping each other to continuously improve care and patient experience. Digital technology will be a key feature of the system and will enable clinicians to work more efficiently and at the top of their scope, and will better support multi-disciplinary working.
- 33.5 **Health and care workers will be valued and well-trained for the future health system.** All workers will champion and espouse a set of shared values, to bind professional groups together and guide a focus on the health and wellbeing of the population and the system as a whole. Long-term planning will ensure sufficient workers for the future, with greater emphasis on the skills required to improve equity and meet the challenge of an ageing population. Organisations will not compete for workers, but will share an understanding of where and how skills need to be deployed for the benefit of the whole system.
- 34 These shifts point to a significant rebalancing in the health system: away from a reliance on hospital and inpatient services and towards greater investment in and access to primary and community services. With this rebalancing comes another crucial change of focus: away from a system that treats illness and focuses on what people cannot do, and towards a system which reduces need, promotes wellness and recognises people as leading their own care.
- 35 Delivering these system shifts will together amount to a significant change in the way that people interact with health services and the health system. There will be a stronger emphasis on promoting self-care and self-management of health conditions, arming people with the advice and support they need to stay independent. We should expect far greater public understanding of the range of health services available in every community and how to access them. The system will identify and target those who may be at greatest risk of developing needs with early interventions, rather than responding after those needs have become apparent. The ways in which people access services will be simpler and more equitable, with greater innovation and choice for digital options bringing some services closer to homes than ever before. Information will be shared so that people do not have to repeat personal details multiple times; and services and professionals will reshape how and when they deliver to fit around people's lives and not expect people to act in their convenience.
- 36 Achieving this vision will require an ambitious reform programme. 

s9(2)(f)(iv)

PART C: A NEW SYSTEM OPERATING MODEL FOR HEALTH

- 37 This part outlines my proposals for the overall shape of a reformed health system. As noted above, these proposals do not consider disability support services, which are subject to parallel development work. In common with the Health and Disability System Review, I have begun the approach to reform by considering the functions and roles of the various entities that together comprise the health system.
- 38 The system operating model – the way the system functions and roles are allocated, and that structures and organisations are designed – is the critical foundational layer. Together, the design of functions and organisations set the context in which all publicly-funded health services operate and provide the apparatus to shape people’s experience of care. These system structures do not, on their own, improve equity, quality or access; but the operating model creates the settings and incentives to drive change, and informs the environment, ethos and culture of the system.

Key functions of the health system

- 39 My approach to system design begins from a view of the functions required by the system in the future – reflecting the maxim that “form follows function”.
- 40 The health system requires numerous functions to be fulfilled simultaneously. At a high-level, these include:
- 40.1 policy and strategy functions (including legislation), to set direction for the system and provide ongoing policy development and support for Government priorities;
 - 40.2 regulatory and quasi-regulatory functions, through which a clear set of rules is enshrined in law and described in guidance to ensure the health system provides equitable access to safe and effective services and treatments, delivers value for money, protects public health, and supports system actors to innovate;
 - 40.3 funding functions, including securing and managing appropriations through the Budget process, determining the allocation of funding to health organisations, and setting the financial framework through which investment may be targeted and incentivised to particular ends;
 - 40.4 planning and commissioning functions, which provide a formal methodology to the planning, design, contracting and review of health services and technologies at all levels of the system, translating priorities and policy direction into the right mix and design of services to meet the needs of populations;
 - 40.5 service delivery functions, through which contracted services are provided to consumers and whānau;

- 40.6 monitoring and oversight functions, including system-wide oversight and population health outcomes (stewardship), organisational oversight and performance (governance), service oversight and monitoring of delivery (including as part of commissioning), and how accountability works coherently;
- 40.7 improvement and innovation functions, including approaches to improving existing services and functions by identifying issues with equity, access and quality; ensuring appropriate oversight and putting in place support and targeted interventions; and investing in research and development to test new models, harness new technologies and support rapid adoption and dissemination.
- 41 These functions can all be identified in the current health system. However, as the Review argued, these functions are not always allocated to organisations in a strategic or logical manner. Some overlap or duplicate; others are split across multiple entities. Over time, a complex mix of national, regional and local constructs have further complicated the model. My objective is to develop a simpler, more cohesive and more coherent allocation of functions across organisations in the future.

Overview of the proposed system model

- 42 This section describes my proposals for a reformed system operating model, starting with cross-system national roles and functions and then considering roles for planning and delivery of health services and the necessary sub-national (regional, district and locality-level) roles to build a full picture. The overall model is shown in a diagram at **Annex A**.

National roles and functions

Role of the Minister of Health

- 43 The Minister of Health should continue to have overall responsibility to Parliament and the public for the health of the New Zealand population and the performance of and outcomes achieved by the publicly-funded health system. The Minister will set national priorities and expectations for health system organisations in line with the direction of the Government of the day, and will oversee accountability for these through the boards and leadership of individual organisations. In so doing, the Minister of Health should also support Cabinet to play its role in agreeing overall strategy and policy direction, Vote Health and budgetary requirements, and legislation and regulatory matters.
- 44 The separation of operational and clinical decision-making from political oversight should remain a core feature of the future system. This means that, as now, the Minister of Health should not be involved in routine decisions relating to how individual services are managed and provided within the system. Maintaining these operational functions at arm's length from the Minister of Health is critical to the effective running of the system.

Role of the Ministry of Health

- 45 The Ministry of Health should **be strengthened in its continuing role as the chief steward of the health and disability system**. In line with the Review recommendations, the Ministry will be the primary source of strategy and policy functions for the system: it will manage the interface with Ministers, develop national policy direction and health strategy, and secure and monitor Vote Health funding. It will set and review the key parameters and settings within which the system operates, including legislative and regulatory settings and the ongoing design of the system model.
- 46 The Ministry's strategic and policy role should encompass development of national direction and priorities for both the system as a whole and for specific components (in conjunction with the Māori Health Authority, as noted below). For instance, subject to future Ministerial agreement, the Ministry may set direction for population groups or services (e.g. disability, mental health), in consultation with the affected groups, or for enablers such as workforce strategy which affect investment decisions and wider priorities, and require inter-agency negotiation (e.g. on immigration policy). This strategic role should therefore extend outside the health system, reflecting the wider drivers and impacts of population health and the Ministry's position as a Department of State to lead cross-government working.
- 47 To underpin this strategic role, it will be critical to strengthen the Ministry's approach to system stewardship. This is a significant system lever through which the Minister of Health, with the Ministry acting as their agent, will receive regular reports on the performance of the system, population health and service outcomes, and the actions underway to deliver objectives. The Ministry will manage a continuous process of review and oversight across the system as a whole, and support the formal accountability of organisations to the Minister. Moreover, the Ministry should safeguard and facilitate a suite of statutory intervention powers for the Minister of Health to conduct more specific and ad hoc reviews or investigations or take other steps in response to particular issues (described further in Part D of this paper).
- 48 The Ministry will no longer be a significant commissioner of services. The Ministry may commission some national interventions in line with its strategic role (e.g. national campaigns). However, the commissioning of frontline health services should sit within the operational parts of the system (i.e. predominantly Health NZ, and the Māori Health Authority). Similarly, I expect that responsibility for current shared and supporting services commissioned by the Ministry (e.g. billing systems) will be transferred to Health NZ.
- 49 This will amount to a significant refocusing of the role of the Ministry, and the success of the reforms over the medium term will depend upon the effectiveness with which their functions are discharged. This will require steps to build capacity in the Ministry and to develop new levers and processes to support it to be an empowered and confident steward and the sole holder of the system-wide view. Subject to Cabinet's agreement, further work will be taken forward to design the necessary approach.

Establishment of the Māori Health Authority

- 50 Despite some gains in health equity, Māori continue to lag behind in all key health status indicators. While this requires action from all health system actors, the scale of the challenge means that **I believe there is a clear case to create a new entity, provisionally called the Māori Health Authority, to drive improvement in hauora Māori in the health system.** We committed to establishing the Māori Health Authority in our Manifesto.
- 51 The Māori Health Authority should have a broad strategic remit to lead the system's focus on Māori, drive improvement in health outcomes for Māori, and jointly lead the management of Crown-Māori partnerships across the system with the Ministry. Whilst the Ministry would continue to have the role as chief steward of the system and hold critical strategy, policy, legislative and funding functions, insofar as these relate to Māori the Māori Health Authority should have a co-leadership role, as recommended by the Review. In this role, alongside the Ministry, this would mean that the Māori Health Authority should be expected to be accountable for the development and approval of national strategy and policy for Māori, for setting and monitoring system-wide outcomes, and for providing relevant advice to Ministers.
- 52 Similarly, turning to national service planning, in relation to hauora Māori it will also be critical that there is clear and meaningful Māori leadership and involvement. My expectation is that the Māori Health Authority should have a co-lead role in relation to national planning and in designing the key operating mechanisms that the system will use. This would require the Māori Health Authority to jointly agree national plans and operational frameworks (e.g. the commissioning framework), with clear approval rights including an ability to exercise a veto in sign-off. Having such an approval mandate would ensure the Māori Health Authority is engaged early and constructively, and that critical operations are aligned with a clear hauora Māori vision, embed Māori priorities and mātauranga Māori systems, and enable mechanisms that give life to local Māori leadership in the health system.
- 53 **I propose that the Māori Health Authority should be a new statutory entity.** It should be separate to other health system organisations, have an independent voice, and be able to exercise its role with the necessary powers and controls to ensure a system-wide response for hauora Māori. Moreover, it should be constituted in legislation in a way that gives effect to rangatiratanga and embeds the principle of partnership between Māori and the Crown. I expect this to include, for example, an appropriate partnering process, agreed and then undertaken with iwi and the Māori health sector, to identify directors for the Māori Health Authority board. I recommend that following Cabinet's agreement to establishing the Māori Health Authority as a new entity, further work is undertaken to jointly design the most appropriate arrangements with Māori stakeholders.
- 54 Beyond these core strategic national functions, there is a key question regarding the Māori Health Authority's role in relation to planning and commissioning of health services. This is considered later in this paper.

Establishment of Health New Zealand

- 55 As recommended by the Review, **I propose that there should be a new entity, provisionally called Health New Zealand, to lead system operations, planning, commissioning and the delivery of health services.**
- 56 I anticipate that Health New Zealand's operational functions and authority will be broad. It will be a significant system leader, responsible for driving improvements in service delivery and outcomes at all levels, in line with the Ministry's strategy and national policy direction. Health NZ should lead on national planning for services and enablers, including developing the New Zealand Health Plan, setting core standards, requirements and specifications for all services, and defining expectations for high-quality commissioning of services throughout the system (in conjunction with the Māori Health Authority).
- 57 Clinical governance at all levels will be vital to ensuring that both commissioning and service delivery functions are efficient, effective, and evidence-based. Health NZ should provide clinical leadership to the system and facilitate clinical networks, and have a key role in fostering an innovation culture within the system. It should also provide system-wide supporting infrastructure and back office functions such as a contract management system and national data and digital functions, taking on roles of current shared services agencies.
- 58 Health NZ should be ultimately accountable to the Minister of Health for delivery of health services and the outcomes achieved. Health NZ will have a high level of delegated authority to manage the day-to-day operations of the health system, but with strong accountability and reporting mechanisms. Contentious issues relating to national service configuration, investment or performance will continue to require Ministerial involvement and decisions, while Health NZ should have clear decision rights provided it acts in line with its funding agreement, accountability documents and policies to achieve strong system performance.
- 59 The Review's goal of achieving separation of functions is challenging in relation to policy roles, where there is significant scope for duplication and the risk of organisations being created in an oppositional rather than collaborative manner. To mitigate this, I propose that Health NZ's accountability to the Minister of Health is routinely facilitated via the Ministry's stewardship function. Moreover, the policy relationship to the Minister should be through the Ministry, seeking input from Health NZ and working collaboratively to provide a coherent and aligned voice. Health NZ would not maintain a substantial policy function of its own, except insofar as it is necessary to partner with the Ministry and Māori Health Authority on strategy and policy development, and to translate this direction into operational plans. This would not preclude the Minister from having a direct channel to Health NZ on policy matters (for example, to engage clinical leaders), but would mitigate the risk of parallel functions being developed.

- 60 **I propose that Health NZ should be a Crown entity**, with its board appointed by the Minister of Health. Given the system size, the reach and impact on the lives on New Zealanders, and the commercial size and complexity of the system, it will be critical to appoint high-calibre directors that reflect the population of New Zealand, supported by accountability levers and mechanisms such as consumer advisory boards and clinical senates. It will be important for the board to include strong representation of population groups that face the most significant health inequities, including Māori and Pacific peoples. Moreover, to ensure alignment and focus on Māori health outcomes, I recommend that the Chair of the Māori Health Authority be appointed as a director of the Health NZ board, with the ability to delegate the appointment to the Deputy Chair.
- 61 In my view, it is appropriate that Health NZ be a Crown entity in recognition of the need to separate operational decision-making in the health service from the immediate oversight of Ministers and provide the right authority. However, Health NZ will occupy a unique role and its status must respond to the lessons of the past and afford greater ability for Ministers to intervene when required.
- 62 I propose therefore that Health NZ should be required to give effect to Government policy and act under the directions of the Minister of Health, including sharing information with the Ministry of Health to ensure visibility of performance. The Minister of Health should have specific powers to set national objectives, approve system-level plans and closely monitor Health NZ performance, including appointing Crown Monitors to the Board and observers to any Health NZ-run or contracted services. The Minister should also have more finely grained intervention powers, including the power to require specific improvement actions, undertake investigations and, ultimately, to replace or remove Board members. These powers will be provided for in the legislation that creates the new entity.

Establishment of the Public Health Agency

- 63 The reformed health system should also include a renewed focus on public health, as per our Manifesto commitment. Public health, by its nature, is inherently focused on the prevention of disease and presents one of the largest opportunities to address inequities and reduce the future health burden of the population. A strengthened public health response is therefore critical to realising many of the goals of these reforms, and will be fundamental to embedding a population health approach across the health system. The response to COVID-19, moreover, has shown that there is a need to continue efforts to create a more robust health protection function by strengthening national coordination across the public health units.
- 64 Strengthening our public health response will require expert advice, enhanced policy, strategy and intelligence, and robust and coordinated operations which work cohesively with wider health services. Achieving this will require clear leadership and leverage and share capability and expertise across the system. My recommendations have been developed with this in mind.

- 65 **Firstly, I recommend establishing the Public Health Agency as a branded unit inside the Ministry of Health** to lead on public health policy, strategy, regulatory, surveillance and monitoring functions. The Public Health Agency will have a leadership role across the sector for public health knowledge, research and intelligence. This will include supporting the development of population health needs assessment, research priorities for the sector and surveillance activity. The agency will be responsible for monitoring environmental threats to public health and will develop advice on the appropriate system response to risks. It will also support the health system to improve environmentally sustainable practice. It will not be a delivery or commissioning agent; instead it will work with the Māori Health Authority and Health NZ, who will be responsible for the broader delivery of the public health vision.
- 66 Strengthened surveillance and monitoring will be a necessary component of the Public Health Agency. The Institute of Environmental Science and Research (ESR) currently conducts a large component of surveillance activity for the sector, which the experience of COVID-19 has shown to be critical to understanding and ensuring the health of our population. I have asked the Transition Unit, working with the Ministry of Health, to consider options to enhance surveillance activity and provide further advice, including on the appropriate location of these services within government structures.
- 67 **To strengthen public health service operations, I recommend establishing a national public health service, located within Health NZ.** The national public health service will encompass the 12 public health units, moving towards a more centralised public health operations function. This will build on the work currently underway in the Ministry of Health to provide more central coordination as a part of the COVID-19 response, and will align operations firmly within Health NZ so that public health functions are planned and discharged alongside other health services. The national public health service will, alongside the Māori Health Authority, determine and evaluate public health programmes, such as screening, immunisation programmes and Well Child Tamariki Ora, based on specifications provided by the Public Health Agency. Service design and evaluation capability will be required within the national public health service to drive a continuous improvement approach within public health programmes and enable learning where impact or effectiveness could be improved. These skills form a critical part of the commissioning cycle and will be necessary capabilities for both Health NZ and the Māori Health Authority to embed effective co-commissioning arrangements of public health programmes.
- 68 As the chief steward for the system and the department of state, the Ministry of Health will retain the Director-General role and its associated statutory powers, including the appointment of Health Protection Officers and Medical Officers of Health. The Director of Public Health will continue as a statutory role inside the Ministry of Health and will have a key leadership role in both the Public Health Agency and the national public health service within Health NZ, including providing professional support and oversight for the Medical

Officers of Health. Health Protection Officers and Medical Officers of Health will be located within Health NZ.

- 69 The Public Health Agency within the Ministry and the national public health service within Health NZ will need to work closely to ensure policy and strategy is informed by operations, and operational activities reflect system priorities. Shared leadership from the Director of Public Health will help to bridge these functions. Annex B illustrates an example where the enhanced public health unit and national public health service work within the system to deliver a new health priority, in this example, a bowel screening programme.
- 70 A core component of public health operations is health promotion. Health promotion will continue to be delivered nationally, regionally and locally in the future system, as appropriate to the nature of the activity and the specific community it targets. Health NZ and the Māori Health Authority will need access to health promotion design and delivery expertise at a national level to deliver activities through their services and networks.
- 71 Te Hiringa Hauora/Health Promotion Agency has developed expertise in national health promotion and holds a critical mass of this capability for the system. The capability and culture that Te Hiringa Hauora/Health Promotion Agency has fostered will need to be maintained and become accessible to both Health NZ and the Māori Health Authority. However, in my view we should avoid unnecessary complexity and duplication in these functions and seek to consolidate expertise. For this reason, **I propose that Te Hiringa Hauora/Health Promotion Agency should be disestablished as a Crown entity, and its core delivery functions transferred and housed as a unit or subsidiary of Health NZ.** This would allow the future unit to retain skills and capability to deliver on national programmes, for example the design and delivery of health promotion campaigns for Māori and Pacific communities. It should operate as a shared service for Health NZ and the Māori Health Authority, with its resources available to both entities. Any relevant research and oversight functions should transfer to the Public Health Agency to support the role described above.
- 72 The response to COVID-19 has demonstrated the value of expert advice for Ministers regarding public health. **It is my intention to establish an expert advisory committee on public health**, which will be supported by the Public Health Agency within the Ministry of Health. The Ministry is developing advice about the form and membership of this Committee, which will be provided to Cabinet in due course.

Relationships between national organisations

- 73 The proposals above aim to clarify national roles, establish cohesive system-wide leadership and avoid creating areas of uncertainty and potential conflict. Giving effect to this system model will require steps to ensure collaborative working arrangements and positive behaviours between the Ministry, Health NZ and the Māori Health Authority. Roles should be designed to be aligned and complementary, limiting areas of duplication and with clear protocols for managing day-to-day issues.

- 74 Much of the detailed design of how these organisations will turn their roles into practice will need to be agreed in the next phase of development as entities are established in interim form, subject to Cabinet's decisions. This will include the design of the arrangements through which the Minister of Health sets objectives for organisations (appropriate to their form and desired level of independence) and the Ministry manages accountability through its stewardship role. It should also include processes for sharing information and intelligence between organisations to support oversight, and for resolving any disputes that may arise as a result of organisations jointly agreeing plans. Initial thinking on some of the practical processes for aligning functions is set out in Part D of this paper.

Other national health organisations

- 75 There is a wide range of additional national health organisations in the current system, each with a defined set of functions. Reforming the health system and creating new entities mean that all organisations will sit in a new system-wide context, and it will be important to clarify their position and any desirable or consequential changes.
- 76 Some organisations should be expected to be largely unaffected by this programme of reform. For example, the Accident Compensation Corporation will continue with its current mandate and focus. In other cases, there may be a case for expanding or augmenting existing roles, for instance in relation to the Health Quality and Safety Commission. An overview of currently proposed changes and implications for health organisations is at **Annex B**.

Planning and commissioning of health services

- 77 Planning and commissioning functions are key roles of the health system, through which priorities and strategic direction are translated into plans for the design, allocation and delivery of services, and are then contracted from individual service providers. Enshrining the most effective arrangements is a fundamental challenge for the system operating model, which goes beyond the high-level functions of organisations noted in the previous section.

Health services for Māori

- 78 To achieve meaningful change for Māori from a health system which has not historically served them well, we need a better functioning system which ensures that hauora Māori and Māori health equity are front and centre in the operations of every level of our system: from the Ministry of Health to hospitals, localities, kaupapa Māori providers, iwi and Māori communities. This will require that clear outcomes and expectations for Māori are set nationally and embedded into the objectives and accountabilities of Health NZ, so that all health services are designed and delivered in support of equity and in line with Te Tiriti o Waitangi obligations.
- 79 Whilst the creation of the Māori Health Authority should bring a new focus and priority to hauora Māori across the system, it cannot on its own represent the voice of Māori at all levels and ensure this is embedded in system and service

design. In particular, there will be practical constraints on the ability of the Māori Health Authority as a national organisation to effectively represent Māori in all localities. Moreover, the Māori Health Authority will need to build relationships and should not assume it speaks on behalf of iwi.

80 Therefore, **at the local level I see a critical role for empowered iwi-Māori partnership boards to reflect the voice of Māori and act as a Tiriti partner to Health NZ and the Māori Health Authority.** The iwi-Māori partnership boards bring the direct aspirations of iwi and Māori communities and give effect to rangatiratanga through priority setting and decision-making roles.

81 At present, there are 20 existing iwi-Māori partnership boards, but their role, scope, composition and decision rights vary. They are self-governed and designed by and for iwi; they are not Crown agents. There is a significant opportunity to design the future system to build in Māori leadership and decision making around priorities and system/service design to support their local communities.

82 In my view, iwi-Māori partnership boards should jointly agree priorities and strategic plans for local services, together with Health NZ and the Māori Health Authority. The partnership boards should also advise and shape regional strategies, through the conduit of the Māori Health Authority.

83 There is also a question as to the extent of the Māori Health Authority's direct or indirect role in the commissioning of services, over and above its other system-wide roles.

84 This issue was a contentious area for the Review – which recommended in its principal view that the Māori Health Authority would not have a significant commissioning function (aside from some smaller elements such as programmes for Māori workforce development), but which also included an “alternative view” presented by the Māori expert advisory group that would see the Māori Health Authority operating as an independent entity and taking a much wider direct commissioning role.

85 In my view, the Review's principal recommendation did not go far enough to provide the basis for real change for Māori. A more effective model, in the context of a strong new Health NZ, is for the Māori Health Authority to have a range of commissioning and co-commissioning functions that would more firmly and decisively embed it in decision-making.

86 In relation to Māori services (including kaupapa Māori services and other services designed for Māori communities), **I propose that the Māori Health Authority should be a lead commissioning agency.** The Māori Health Authority should set, with Health NZ, the priority outcomes, commissioning frameworks and service plans for services at a national and regional level, to ensure they deliver better for Māori. This would be informed by relationships with iwi-Māori partnership boards. The Māori Health Authority should then commission kaupapa Māori services and other services targeted at Māori communities, whether directly or jointly. Where Health NZ commissions services for Māori, it will do this in conjunction with the Māori Health Authority.

- 87 As part of this commissioning function, the Māori Health Authority would also lead on nationwide Māori provider development and the expansion of kaupapa Māori services, as well as having a strong mandate to encourage and invest in innovation in delivery of local services and new service models to meet Māori health need.
- 88 In relation to other health services (i.e. those designed for other populations), **I recommend that, where these have a significant impact on Māori health outcomes, the Māori Health Authority should be a co-commissioner.** This would include, for instance, primary health services, and population health screening and immunisation programmes. Whilst Health NZ will lead on operational matters relating to general health service commissioning, this responsibility should clearly entail delivery of improved health outcomes and equity for Māori, and the Māori Health Authority would influence and agree these intended outcomes, set service expectations and initiatives to reduce bias, undertake monitoring, engage with iwi/Māori, and approve final plans and resource allocation. This would be more aligned with the Review's alternative recommendation.
- 89 In discharging its commissioning and co-commissioning roles, a key issue will be to design incentives and remedies for the Māori Health Authority to be sufficiently empowered. For instance, should commissioning of services fail to deliver intended outcomes for Māori or address inequity, it may be necessary for the Māori Health Authority to have an escalation pathway for resolution that could ultimately reach to the Ministry or Minister of Health.
- 90 Discharging the roles of a commissioner, co-commissioner and strategic system monitor will afford the Māori Health Authority an unprecedented position in relation to hauora Māori. As work progresses to design and establish the new organisation, subject to Cabinet's agreement, it will be crucial to work with Māori stakeholders to develop the detail of functions and appropriate, effective governance arrangements.

Health services for Pacific peoples

- 91 Pacific people suffer health disparities commensurate with those experienced by Māori, and an approach which prioritises improving equity must therefore ensure a focus on Pacific health within all health organisations.
- 92 Our Pacific communities continue to face broad, persistent inequities across most determinants of health and wellbeing like housing, mental health, child and youth outcomes, long-term conditions, and infectious diseases. Moreover, Pacific communities face entrenched socioeconomic inequality (73% of Pacific people in Counties Manukau DHB live in decile 9 and 10) and Pacific are now overrepresented in most health indicators monitored by the Ministry of Health (for example, diabetes, mental health conditions, obesity and cancer mortality) despite increased mainstream service delivery. This reflects a health and disability system that has continued to lag when it comes to meeting Pacific needs and aspirations.

- 93 The scale of this challenge is significant, and to achieve meaningful change and progress the Ministry of Health, as chief steward of the reformed health and disability system, will need to have a Pacific-led capability that has the resources and skills to chart a better future for Pacific communities. To this end, I expect the Ministry of Health will establish a high performance Pacific policy capability that has:
- 93.1 senior Pacific leadership which will advise Ministers on all aspects of Pacific health and disability policy, and provide leadership and support accountability across the health and disability system for Pacific outcomes
 - 93.2 deep cultural skills and community relationships to ensure the needs of our diverse Pacific communities are reflected across the health and disability system
 - 93.3 expertise in systems strategy, insights, and workforce development to provide ownership for the development of future Pacific health and workforce strategies and policies.
- 94 **I recommend that the Ministry of Health develop a new strategy for Pacific health**, aligned with the future whole-system strategy, as the basis for the strategic direction and objectives of the system. **I further recommend that Health NZ would then take lead operational responsibility for work to improve the health and wellbeing of Pacific peoples**, with a dedicated focus at national, regional and local levels.
- 95 Health NZ should deliver this focus through a variety of mechanisms that work together to increase investment in Pacific health and embed the voice of Pacific peoples in planning, commissioning and delivery. This should include undertaking a Pacific people's needs assessment; developing a commissioning plan to address identified needs; establishing an expert group; developing partnerships with Pacific nations; and developing dedicated capability in commissioning services for Pacific peoples.

Hospital and specialist services

- 96 At present, the planning of hospital and specialist services takes place through DHBs, which also fulfil the delivery function as a hospital provider. As this is based around a DHB's geographic area, it results in multiple plans across New Zealand which are developed around individual hospitals, with variable collaboration between areas and a suboptimal allocation of resources. Because the DHB has responsibilities as both planner and provider, it can also create a disincentive to shifting demand out of hospitals, leading to a continued increase in spending on hospitals (and consequent financial deficits), often at the expense of developing community alternatives.
- 97 In keeping with the Review's recommendation of greater cohesion in these services across New Zealand, I am convinced that there is a strong case for moving towards a model of "networked" health services, through which

resources are planned and allocated more efficiently across the country and delivery is managed collectively to promote quality and consistency of care.

- 98 A more nationally-coordinated approach to hospitals and specialist services requires a centralised approach to planning. My view, therefore, is **that Health NZ should be responsible for national planning of hospital and specialist services**, to ensure consistent networked models are developed and to allocate specialisms effectively. A national hospital plan would be expected to set detailed requirements for access, thresholds for treatment, common service specifications, standards and models of care, and expectations on cost, to be applied and monitored in all regional networks.
- 99 The Review sees a national health plan as presenting a detailed view of the clinical role of all public hospitals – this would be consistent. In parallel, Health NZ should also specify national health services, i.e. those which need only be contracted and provided once for the country, such as genetics and transplant, and so would not naturally fit at any other level in the system.
- 100 Day-to-day operational planning and management of hospital and specialist services should then take place within a network of services, at a level appropriate to the specific service. A networked approach will manage the services for a regional population that includes a number of hospitals, specialist and community services that operate cohesively around a planned area (based on current patient flows).
- 101 This approach to hospital and specialist services – ‘nationally planned, regionally managed’ – would allow for decisions on the precise configuration of services within a network to be made closer to communities and in the context of their local needs and circumstances. Moreover, given the complexity and size of many of these services, each hospital or service in a network would require its own local management, reporting to the regional network and in turn to the national leadership of Health NZ.

Primary and community services

- 102 Primary and community services account for the large majority of all patient and whānau interactions with the health service. Together, these services are essential for keeping people well and independent, ensuring they remain connected to their communities, and avoiding unnecessary use of emergency, acute and specialist health services.
- 103 Unlike hospital and specialist services which by their nature lend themselves towards a more consistent model, in relation to primary and community services there should be a strong emphasis on flexibility to determine the appropriate mix for the needs and preferences of local communities. Whilst some services could or should look the same in different places, localities are inherently different and the most effective services are often those designed with people and communities, based on population health principles. The way that these services are commissioned should reflect this local character and be based on achieving the outcomes that matter to the people they serve.

- 104 **My view is that Health NZ should have the primary role in the planning and commissioning of primary and community services, alongside the Māori Health Authority**, and that this should occur at the national, regional and local levels as appropriate to the particular service. As the Review recommends, this would provide a strong basis for evolving and integrating services to meet local needs, with a single commissioner across a network of collectively-engaged providers, and a shared set of local outcomes and incentives that are designed with communities.
- 105 Some elements of service planning and commissioning would be undertaken nationally by Health NZ – including procurement of national services (such as the national telehealth service) and development of national standards, service requirements, funding arrangements, or service guarantees for core services that New Zealanders would expect to be consistent across all areas. These core elements should be built into the New Zealand Health Plan. Commissioners would then design these into locality services, alongside other local and regional priorities. However, for the majority of these services, commissioning should take place as close to the community as possible to ensure that the needs and aspirations of local populations drive the approach.
- 106 In keeping with the Review’s recommendations, **I strongly support the principle of a “locality network” approach to the provision of primary and community services**. Establishing networks of service providers creates a major opportunity to drive integration of care models and service delivery around local people, and to expand investment and growth in the workforce as the system realigns towards communities. The locality network also offers a platform to implement a population health approach, drive innovation and ensure that services are planned for all local people, delivered seamlessly, and that providers are incentivised to work collectively towards shared objectives.
- 107 A locality network of providers should be more than a virtual concept. To be most effective, I believe there is a good case for adopting a purposeful approach to integration between locality providers and establishing shared systems, practices and management for networks. Locality networks should, as the default, embed integrated systems and share back office functions, including IT systems and routine data sharing. They should work towards shared outcomes and objectives, reinforced through a common network contract and incentivised through new funding arrangements.
- 108 Locality networks will require a collective management function. This would then provide the platform for integrated day-to-day working, for example to collate data from network providers to assist with monitoring progress, provide day-to-day remedial support for the network, facilitate or drive integration between providers, and act as a convenor for wider social service integration. In the absence of such a role to convene, manage and facilitate the network, it is likely that they will be less effective and have fewer practical levers to align services. This may be particularly relevant for highly urbanised localities with multiple networks, or where there are clusters of small localities that may be better supported by a single management layer.

- 109 Whilst having a clear focus on local communities' health needs, locality networks should also be subject to common priorities, standards, processes and models that are defined nationally. This will be essential to improving equity in access and outcomes between areas, embedding evidence-based care, and in reducing unnecessary duplication. It will also provide consistency for services that are not location-specific (e.g. virtual care) and support delivery of core infrastructure elements such as information standards.

The structure of regional and local organisations and functions

- 110 A critical question for the overall design of the health system is the autonomy and structure of sub-national health organisations, and to whom they should be accountable. At present, DHBs are Crown entities and therefore have a level of independence, reporting to their own boards (whose membership includes appointments made by the Minister). The Minister can direct DHBs to give effect to government policy and has statutory powers to intervene, as well as levers to influence DHBs (including setting and monitoring annual expectations through the Ministry). However, these levers have tended to have limited impact and, in some cases, have been rarely used.
- 111 In my view, there will continue to be a role for sub-national health decision-making through bodies that operate at levels closer to the regions and communities of New Zealand. As described above, effective commissioning requires the engagement and involvement of local communities and the right capabilities at a level to achieve this – a task that becomes more challenging for a more remote national agency.
- 112 However, I do not believe that we should maintain the status quo of various quasi-independent entities operating in their own geographies, with limited mechanisms to coordinate and innovate between them. Arguably, the current status of relative autonomy has contributed to the systemic challenges and lack of innovation described by the Review. In particular, the lack of robust collective accountability has contributed to fragmentation, misalignment of decision-making, and postcode variation in access and outcomes (e.g. waiting times for cancer). It is also partly the cause of financial deficits and the challenges experienced by the Ministry in gaining traction with these.
- 113 Maintaining any degree of legal separation between Health NZ and sub-national health organisations, therefore, is highly likely to maintain and compound these existing challenges. It is unlikely that these can be bridged by direction-setting and oversight levers alone whilst the sub-national organisations are partially or largely independently governed. Moreover, the continuation of separate sub-national organisations is likely to perpetuate the fragmented culture of the system and work against a “one system” ethos.
- 114 **I recommend, therefore, that the future system replace district health boards with a single Crown entity and sub-national groupings that are internal divisions of Health NZ.**
- 115 Determining the most appropriate number and form of sub-national health structures within Health NZ requires balancing a number of factors: the

operational levers and control required at the national level; the degree of consolidation and visible change from the status quo; the alignment between commissioning arrangements for different services; and the proximity to local communities to support engagement in local service planning.

- 116 The current health system is broadly structured around two levels for decision-making and commissioning: national decisions (including those made by the Ministry) and district-level decisions (made by DHBs). Whilst there is a “regional” dimension at present, this relates principally to shared services and does not have any legal entity or funding. As the Review indicated, there are two key issues with these arrangements. Firstly, over time the distribution of national and district-level decisions has lost its logic, with many decisions that could be made nationally being taken at district-level (and vice versa). Secondly, the definition of ‘district’ further erodes this logic, because there is such variation in the size of DHBs (with the largest by population being over 30 times the size of the smallest) that it naturally leads to inconsistency.
- 117 The Review also found that the current number of DHBs was spreading the talent for governance, leadership, commissioning, performance improvement and clinical services management thinly across the sector. The number of DHBs also contributes to duplication of activity, resulting in increased costs and hindering agreement on major changes and innovation including hospital configuration. In my view, a reduction in the number of the organisations at this level is required to address these concerns.
- 118 The Review proposed a consolidation to 8-12 DHBs, which would largely retain their existing status but would be subject to greater oversight from Health NZ and would be required to deliver consistent national plans. Whilst there would be benefits from consolidation, in my view this does not go far enough to provide the platform for change in the health system and risks replicating the same problems of accountability, fragmentation and stymied innovation witnessed at present. Moreover, this number suggests a geographic split that is neither sufficiently “regional” to oversee a major care pathway or service network, nor is sufficiently “local” to involve communities.
- 119 Tackling these issues requires establishing a more coherent multi-level approach to planning, commissioning and decision-making, and a realignment of where decision rights sit.
- 120 Below the national level, **I propose that there should be two distinct ‘arms’ of Health NZ holding key functions at a regional level: one holding responsibility for commissioning primary and community services, and one managing the delivery of Health NZ services in that region.** These arms should have separate internal management lines within Health NZ, both reporting to the national executive. They would be configured to provide appropriate focus and accountability in each arm relevant to the function, reflecting that these services are structured and respond differently to incentives (for example, primary health services represent a much more plural market of independent providers, whilst there is substantially less competition in relation to public hospitals), and would be integrated through management and governance.

- 121 **I recommend that these two arms should be co-located in four regional divisions, established as part of Health NZ.** These new regional divisions would replace the existing functions of DHBs, which would be disestablished. In effect, this would split the current DHB functions of the system: into a regional hospital and specialist arm accountable for delivering high-quality services efficiently and equitably, and a regional primary and community arm, responsible for improving population health outcomes and equity. These arms are described further below.
- 122 There are also a number of shared services agencies in the current system, which are owned by DHBs and provide essential collective functions such as service planning, information, analytical and IT services, provider audit, and procurement. In keeping with the wider approach to reform, **I propose that the functions provided by these shared services transfer to Health NZ,** with future decisions on the precise model (including whether distinct agencies or subsidiaries are maintained and how they support regional divisions) to be made by Health NZ.
- 123 Whilst decisions on the precise internal operating model for Health NZ should be a matter for confirmation by its future board, it is right that Government sets out clear expectations for how the structure and decision rights are to be organised. This both provides greater clarity on the anticipated model, and supports those working in the system to understand the practical consequences of reform. I intend, subject to Cabinet's agreement on the proposals, to reinforce these recommendations through expectations set for the future Health NZ.

The regional health service delivery arm

- 124 I anticipate that each of the four Health NZ regional divisions will include a regional delivery arm that manages a service network.
- 125 The health services network should comprise the range of services provided by Health NZ. Whilst there are some patient flows outside of regions, often for highly specialist services, the vast majority of services (97%) are delivered to patients within their own region. A regional network should therefore encompass the range of services for a regional population, at the right level to support integrated operational management. Given the population size and patient flows, **in my view the strongest case is for New Zealand to have four regional health service networks,** each of which is able to provide a comprehensive range of services for that region.
- 126 Within a regional network, there would be a number of hospitals, secondary care centres and community-based services. This would incorporate multiple hospitals in its natural catchment, including at least one major tertiary hospital centre per region. It would also recognise that many community services are provided either in hospital settings or by specialist staff in community settings (for instance, district nursing, community mental health teams, and dental therapy services). Bringing these services into a regional networked approach will help to ensure alignment of planning across a care pathway and support better allocation of resources and investment over time.

- 127 Governance of regional health service delivery within Health NZ will be through a regional executive board, including a regional director of health services and chaired by Health NZ national leadership. This internal governance board could have external appointees as deemed necessary and should be expected to include the regional commissioning arm to support integration and shared planning. It will also provide a locus, within the regional division, for overseeing collaborative working between the delivery and commissioning arms of Health NZ.

The regional commissioning arm

- 128 I also anticipate that the four Health NZ regional divisions will include a regional arm that is responsible for the commissioning of all primary and community health services.
- 129 The regional commissioning arms would act under national planning requirements, standards, specifications and guidance, and would be accountable to the national leadership of Health NZ for performance. However, they would have significant levers to design health services for their communities and would be incentivised to promote population health and improve equity and outcomes.
- 130 A small number of regional commissioners would necessarily mean that each would be a larger entity than most current DHBs, with a wider span of control. Whilst there is a risk of dislocation from some of its communities, this should be tackled through the organisational structure and ways of working (e.g. requirements for consultation and community engagement). In practice, **I would expect regional commissioning to operate in a “hub and spoke” model, with each region establishing several district offices that are located closer to communities**, so that:
- 130.1 the Health NZ regional division would take a regional approach to analytics, whole-system monitoring, contract management, and integration of planning for primary, community and hospital services, and develop a critical core of commissioning capability;
 - 130.2 the Health NZ district offices (which could be named “population health and wellbeing networks” to reinforce their primary role) would lead commissioning of primary and community services, hold relationships with providers and monitor network performance and outcomes. They would work with a broader range of social sector agencies and providers to promote a focus on population wellbeing. The regional division would be responsible for determining its district offices to provide them with the right skills, scale, and span of population; and
 - 130.3 the regional and district offices would then define the localities in their area as the basis for the planning and commissioning of primary and community services through locality networks of providers. These boundaries should be set in ways that make sense for communities; this may mean localities could be aligned with council boundaries, iwi

rohe, natural borders, or for particular population groups (e.g. a Pacific health network).

- 131 **I propose that the regional commissioning arm of Health New Zealand will be organised into four regional commissioning boards, each led by a regional chief executive.** This would align with the number of regions for health service delivery, which would be drawn on the same boundaries and established to promote joint working between the two arms and align commissioning and delivery plans across a region. In particular, these arrangements should recognise that there can be a blurred boundary between primary and secondary health services, and that our objective to shift services towards community settings will change this boundary over time. This will require a mutual and collective approach to planning and delivery across a care pathway, for example for mental health services. The co-location of these arms within Health NZ regional divisions provides the basis and incentives for such an integrated approach.
- 132 The appointment of regional chief executives and commissioning boards will be made by the chief executive of Health NZ and approved by the Health NZ board. Appointment of regional boards may also be subject to approval by the Minister of Health. I envisage the board will be co-chaired by Health NZ and the Māori Health Authority. Membership would include senior executives of Health NZ, external appointees, and may include relevant social sector agencies.
- 133 Health NZ regional chief executives will then establish a number of district offices within each region, as above, as the “front door” for commissioning of primary and community services and engagement with local populations. For instance, each region may have 4/5 district offices depending on their circumstances, which in many cases will initially cover a geographic area similar to existing DHBs. It will be for Health NZ regional chief executives, in conjunction with the Māori Health Authority, to determine the appropriate arrangements.
- 134 The district offices will focus on population health and wellbeing and therefore naturally be a significant locus of partnership with wider government services, including mapping to the 15 government service regions. Health NZ regional chief executives should design and implement these arrangements to promote integration with the social sector and ensure commissioning is responsive to communities with multiple needs who receive support from a range of services, and to the particular challenges faced by rural communities.
- 135 Locality commissioning teams will undertake population health assessments and develop strategic commissioning plans for their areas, supported by regional and national capability in Health NZ. Locality commissioning teams will put in place a range of effective models to engage and involve communities in the development and monitoring of these plans over time. The Health NZ regional chief executive will be responsible for assuring the quality of local engagement. Local commissioning would occur in accordance with national standards, and national service agreements.

- 136 I consider that this locality commissioner function can be built out of existing planning and funding teams in DHBs, albeit with wider responsibilities (including some services currently commissioned by the Ministry of Health) and a requirement for a more localised focus than in some existing cases.
- 137 In my view, it also follows that the locality commissioner should also have responsibility for ensuring that there is a robust and effective shared management function for the network. This could be in the form of a discrete organising entity for the locality network, such as a lead provider or a separate organisation providing management services for the network – akin to aspects of current Primary Health Organisations (PHOs), albeit with a wider focus. Alternatively, the function could be delivered by the commissioner itself. The most effective model is likely to be dependent on the local circumstances. In some places, there may be an existing PHO or Māori health entity which is able to adapt to provide coordination for a locality network; in others, it will be necessary for the commissioner to carry this out. Health NZ should have responsibility for ensuring that the right approach is designed locally.

The Māori Health Authority's regional role

- 138 To support its role and mirror Health NZ below the national level, the Māori Health Authority will have regional leads to partner with Health NZ in decision-making related to Māori. The Māori Health Authority should have approval rights for all relevant strategies and plans at the regional and locality level, including primary, community and hospital services. It should act as a conduit to represent the advice and direction of iwi in regional decision-making, with whom it will need to develop and maintain strong relationships.
- 139 I do not expect that the Māori Health Authority would replicate Health NZ's arrangements and have locality-based teams; instead, it would operate at the regional level where locality plans will be signed off. The Māori Health Authority's regional teams may be co-located with the Health NZ regional division, and would co-chair regional commissioning boards.

PART D: DELIVERY OF OUTCOMES THROUGH THE NEW SYSTEM MODEL

- 140 How the system acts collectively to focus around shared objectives, monitor progress, intervene where necessary and hold itself to account is critical to the effective delivery of a new approach.
- 141 The sections below outline my initial expectations for how these functions will dovetail, which will be subject to development work and design with the health sector and new entities. Further illustrations and scenarios which build on this description are included at **Annex C**. These include worked examples that indicate how the future system would deliver national priorities; respond to poor performance; manage a pandemic; and drive and adopt innovation.

Embedding shared outcomes in planning and delivery

- 142 A core set of national outcomes and priorities should be embedded in planning, commissioning and monitoring at all levels of the system. At present, while the values underpinning our health system are generally clear and shared, it is often insufficiently explicit where organisations should be focusing their efforts – particularly at the regional, district and local level. Tools such as annual plans, annual reports and letters of expectations which should sharpen shared objectives are not used to their fullest and can be limited by both their scope and timeframe.
- 143 The system operating model proposed in this paper lays the foundations for a clearer “line of sight” which focuses the system on common outcomes and objectives and reinforces the delivery of these at all levels.
- 144 This should start from the New Zealand Health Strategy (and subsidiary strategies) which are developed and revised by the Minister of Health, with the assistance of the Ministry and the Māori Health Authority, to set the direction for the system. These will be key strategic documents that provide for a medium to long-term view of overarching aims and direction.
- 145 Since strategies of this nature may only be developed infrequently and not specific enough to drive accountability, it will be necessary to embed a robust process which translates strategic direction into tangible national priorities and objectives that reflect the agenda of the Government. **I propose that to fulfil this role, the Minister of Health should agree a Government Policy Statement which sets multi-year requirements for the health system, supported by measurable goals.** This Policy Statement should align with the Budget cycle and provide a clear basis on which Health NZ (with the Māori Health Authority) can develop costed plans for services, built around a common set of priorities. It should draw on Māori and consumer voice and, as below, provide the framework for regular monitoring of progress.
- 146 **I recommend that the New Zealand Health Plan be the key vehicle for turning strategic priorities and policy requirements into concrete, funded plans for health services.** This will set the operational direction for the system, define planning assumptions and service and financial requirements, and be the basis for commissioning of services at all levels, with a particular emphasis on achieving equity. It should encompass both hospital and specialist services that are planned nationally, and also national standards and expectations for primary and community services. It should align service and financial planning for the health system, mirroring the national priorities in the Government Policy Statement and demonstrating how these will be achieved. Health NZ will lead development, partnering with the Māori Health Authority. The Minister of Health will sign off the plan, with advice from the Ministry.
- 147 At the regional, district and locality levels, I expect there will be a need for sub-national service plans. For instance, I expect there to be a strong case for strategic multi-year commissioning plans for localities which act as

the blueprint for integrated primary and community services, in line with the priorities agreed with local communities.

Monitoring, improvement and intervention

- 148 Effective, timely and responsive monitoring will be essential to ensuring the functioning of the health system and the performance of organisations individually and collectively. It is also fundamental to enabling a culture of continuous improvement.
- 149 At the system-level, the Ministry will monitor and report to the Minister of Health on agreed national health outcomes and system objectives, including for clinical and financial performance. This will include monitoring organisational performance of national health entities in line with individual letters of expectation, on behalf of the Minister. The Māori Health Authority will partner with the Ministry to monitor outcomes and objectives for Māori.
- 150 Making this national monitoring role more effective will require both new levers for the Ministry of Health, and investment to build its resources and capacity. The approach to a Government Policy Statement noted above should form the basis for the NZ Health Plan which underpins the formal, regular accountability process between the Chair of Health NZ and the Minister of Health, drawing on shared clinical and financial data and intelligence and measurable indicators of progress. This process would be led by the Ministry of Health and include advice from the Treasury.
- 151 The advent of Health NZ as a single national organisation will provide unprecedented opportunity to reduce variation within the system, lift performance, standardise processes and support improvement. Health NZ will monitor the operational performance of the publicly-funded health system, including in-depth clinical and financial outcomes which are aligned with national priorities and objectives. It will design and implement a multi-layer monitoring and improvement framework to cover its functions at all levels. This should include the performance of nationally-commissioned services, hospital networks, regional divisions and locality networks.
- 152 The role of the Health Quality and Safety Commission will also be crucial to monitoring quality of care. This should include an enhanced focus on patient-reported outcomes and experience of care, providing analysis and insight to support other national organisations to conduct their functions. The Commission will also convene cross-system sharing of intelligence to help identify and respond to issues with quality.
- 153 Beyond regular monitoring and accountability, it will be crucial that there is a robust and rapid escalation pathway to respond to specific issues, wherever they are identified in the system. This should involve both voluntary and mandatory improvement processes, with the former being accessible, no-fault and proactive; and the latter being more reactive, targeted and increasingly prescribed. This pathway should include clear roles for organisations, with the aim of responding appropriately and collaboratively.

- 154 As part of the escalation pathway, the Ministry will advise on and facilitate the Minister's use of intervention powers as necessary. Although there is a suite of powers currently available to the Minister of Health, they can be inflexible and ineffective within the existing system. The establishment of a single Health NZ entity provides a significant opportunity to design powers that are better targeted, and easier to deploy. For example, this should include powers to direct specified actions in response to concerns that are identified through the strengthened formal accountability process with the Minister. Further work on the range and scope of such powers will be taken forward to inform necessary legislation.

Embedding the consumer voice in the system

- 155 Prioritising the consumer voice is a key enabler of people and whānau-centred care. Whilst there is a range of mechanisms currently employed across the system to capture consumer voice – including through DHB consumer councils, Māori advisory boards, elected board members and obligations for public consultation – these are highly variable, and can be insufficient to meaningfully engage and represent the views of people. In my view, we should embed consumer voice more explicitly and consistently in the future; moving beyond a norm of 'consultation' to one in which there is more active engagement and involvement.
- 156 The creation of the Māori Health Authority and empowerment of iwi-Māori partnership boards should be expected to entrench Māori voice in decision-making at all levels of the system. The ongoing role of the Health and Disability Commissioner will also be crucial to ensure a focus on consumer rights and mediation of complaints for all groups. Nonetheless, further steps will be needed – not least to ensure the obligations of the UN Convention on the Rights of Persons with Disabilities. Whilst I intend to bring further proposals on this topic to Cabinet, these might include:
- 156.1 Strengthening the Health Quality and Safety Commission as the centre of excellence for consumer engagement to build capacity and support in the use of evidence-based models.
 - 156.2 Establishing a national consumer forum to act as the umbrella organisation for consumer and patient voice, bringing together multiple existing local groups and non-governmental organisations. This might be supported by national forums for individual groups, such as for Pacific peoples and disabled people.
 - 156.3 Underlining expectations for consumer engagement in legislation, and incorporating them into monitoring and review frameworks. This should seek to assure the quality and effectiveness of engagement undertaken by Health NZ and the Māori Health Authority.
 - 156.4 Implementing proactive engagement mechanisms to ensure the voice of disadvantaged and minority populations influences service design and delivery. This would include, among others: disabled people, Pacific peoples, those with mental health issues, young people, refugees and migrants, and the rainbow community.

PART E: IMPLEMENTING THE NEW SYSTEM MODEL

- 157 Giving effect to the necessary reforms to implement the functions and roles described above will require a tightly-managed and well-executed programme of change. Early progress will be essential to build momentum, and drive the reality and the benefits of change for the health sector. However, a programme of this scale should be expected to take a number of years to implement in full and realise all the benefits and gain in outcomes desired.
- 158 This part sets out a plan for implementation of the reformed system operating model. It describes some of the key enabling activity and practical actions which are required, and provides a timetable and roadmap for reform.
- 159 The plan set out below will be developed further subject to Cabinet's decisions. Subsequent advice will include detailed descriptions of the key enabling work and investment necessary, in addition to plans to manage transitional arrangements as the system builds towards reform.

Critical enabling activities

Funding and financial flows

- 160 The health system is under significant financial pressure. The Treasury's long-term health projections show that, as in all comparable countries, health funding will continue to increase as a percentage of GDP due to a combination of an ageing population, rising demand for healthcare and new technologies as incomes grow, and lower labour productivity. This poses a critical affordability challenge for Government.
- 161 In the short term, growing DHB deficits, which now total more than one billion dollars, represent a pressing issue to financial sustainability and a drag on system performance. It will be critical to put in place short-term actions and reforms to address the deficits and deliver a more efficient and equitable system, including to improve cost control and reduce variation in financial performance. However, even with well designed and implemented health reform, more funding will be needed to meet the anticipated growth in demand and inflationary pressures, and to tackle inequity.

s9(2)(f)(iv)

162 s9(2)(f)(iv)

s9(2)(f)(iv)

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164

Workforce development

165 If we are to ensure that New Zealanders can access quality care, we need to have the right people in the right place at the right time to deliver and partner in that care. The health workforce employs around 245,000 people; 11% of our national workforce. It is capable, skilled and committed, but faces challenges to its sustainability.

166 These system reforms will aim to do two main things:

166.1 increase the Government's role in shaping the health workforce of today and the future, recognising that the overwhelming majority are either employed by or funded by Government; and

166.2 increase the volume and skills of people produced by our workforce pipelines, so that we train enough of the right people to meet the growing needs of New Zealanders for healthcare, reflecting the diversity of the populations they serve and the strategic move towards primary and community services.

167 **I recommend that an early part of this work should be to develop a New Zealand Health Charter**, as proposed by the Review. The concept of a NZ Health Charter provides a major opportunity to engage health and care workers as part of "one system" and to secure their place in the reforms. The Charter will articulate shared values, standards, expectations and ways of working, to act as a common foundation across disciplines and locations that captures the core motivations of the workforce. It would aim to ensure cross-disciplinary teams can deliver quality care together, and improve mobility and collaboration between professions. It should become a central element of how the future system sees itself, and the underlying principles of those who work in it.

168 s9(2)(f)(iv)

Data and digital infrastructure

169 Data and digital infrastructure and capability will be essential to enhance system sustainability, enable better and more equitable outcomes for all New Zealanders, and deliver the new system model. A digital-first approach to health services, designed appropriately, can help improve equity of access and enable person and whānau-centred care. Virtual models of care such as telehealth enable consumers to access safe and effective services from wherever is most convenient for them – as we have seen first-hand during the COVID-19 pandemic response. Moreover, investment in digital systems and technology improves day-to-day practice and decision-making, and enables integration of data to improve consumer experience.

170 In New Zealand, a sustained underinvestment in data and digital, and a lack of strategic focus, has created huge variation in data and digital capabilities, and an overall low digital maturity. Challenges of access to digital services for some groups perpetuates inequity. While there are some exemplars, many parts of the health system remain unable to deliver digital services and the prevalence of end-of-life systems presents a clear vulnerability for health system delivery. This is in part because it has proved difficult to scale digital models that have been piloted and shown to be successful.

171 To counter this in the future, incentives must be built into the health system to encourage uptake of digital care models. This includes using contracting mechanisms, commissioning frameworks, funding models, and other levers to promote adoption, innovation and continuous improvement. I expect the new system operating model will require:

171.1 A coherent and ambitious system-level digital strategy, underpinned by increased and more strategic investment in critical systems and infrastructure, and steps to incentivise digitisation and new models of care linked to national service planning. I anticipate the Ministry of Health, the Māori Health Authority and Health NZ will work together to define this, building upon and consolidating existing digital strategies and frameworks.

171.2 Strong digital capability must be built into Health NZ, including digital expertise on the Board and Executive. The digital and data function within Health NZ must be enabled to make fast progress, and be well integrated with the Ministry of Health and the Māori Health Authority.

171.3 A substantial improvement in the scope, quality and management of the data which the system relies upon to understand and influence performance. I see a case for developing a single set of national data requirements to encompass the information needs for shared national outcomes and priorities, which are transparent and available for benchmarking between areas. This should also tackle key gaps in data, such as in relation to primary and community services.

171.4 Enhanced digital leadership, capacity and literacy in the workforce, together with more effective levers to ensure that national requirements are adhered to, and that innovation is identified, harnessed and spread.

172 s9(2)(f)(iv)

A large grey rectangular redaction box covers the text for item 172. The text 's9(2)(f)(iv)' is visible at the top left of the redaction.

Facilities and equipment

173 Facilities and equipment need to be maintained, updated and replaced to ensure that they are fit-for-purpose and adaptive to future models of care and needs. The Government has already supported the development of the first phase of the National Asset Management Plan and the establishment of the Health Infrastructure Unit as a business unit within the Ministry of Health. However, significant investment is required due to the age and condition of the current estate, combined with the demands generated by a growing and ageing population and the need to integrate with national service, digital and workforce plans.

- 174 The strengthened approach to national hospital planning through the NZ Health Plan, and the integration of hospitals into Health NZ, will enable improved planning, supply chain, procurement and asset management. A national service planning view should drive capital savings resulting from more efficient allocation of expensive clinical space, treatment and diagnostic equipment, greater standardisation, and a more robust consideration of the trade-offs between operational and capital investment.

s9(2)(f)(iv)

Legislation

- 175 Subject to Cabinet's agreement to the recommendations in this paper, changes to the system operating model will require legislation to restructure the publicly-owned health and disability system. This will include provisions to establish new entities and disestablish others, and clarify responsibilities across the system.

176 s9(2)(g)(i)

- 177 **I anticipate that the Bill should include a Treaty of Waitangi clause following the standard modern form.** That is, a provision that states that the Act contains provisions intended to give effect to relevant principles of the Treaty of Waitangi. This approach follows recent legislation such as the Taumata Arowai – the Water Services Regulator Act 2020 and Mental Health and Wellbeing Commission Act 2020. I anticipate including the principles identified by the Waitangi Tribunal in its Hauora inquiry.

The roadmap to reform

- 178 The complexity, scale and ambition of these reforms requires significant work ahead to prepare the system for change, transition effectively, and build new entities and relationships. The new system operating model will take some time to fully bed down, and the outcomes may not be fully realised for several years. However, there is an opportunity to set up interim structures quickly to deliver early benefits, accelerate implementation of the reforms as a whole and manage the risks of change. There is also a significant opportunity to use the implementation as a vehicle for engaging the health sector – and the wider public – on the rationale and ambition for change, and to develop momentum and enthusiasm.

- 179 My proposed approach to implementation seeks to balance a need for early progress which sets a compelling and confident direction, with the longer-term focus required to achieving lasting cultural change. **In broad terms, I see the implementation roadmap as having two major phases.**
- 180 **The initial preparatory and transitional phase, over the coming 18 months**, will include the establishment of new entities and early work to design functions and operating frameworks and test new approaches, ahead of legislation being passed to give effect to the new model. This phase will entail intensive engagement with sector stakeholders. A Budget 2021 bid has been submitted to support this phase; with proposals focused on prototyping the locality approach, expanding Māori health provision, and setting up new entities.
- 181 I expect this first phase to be punctuated by the legislation coming into force in July 2022 to formally establish new entities and disestablish DHBs. This phase will continue until later next year as organisations build capacity and staffing and assume their full range of functions. I also see this phase as an opportunity to commence work on establishing the future culture and ethos of the system – for instance by consulting widely on the NZ Health Charter. Further proposals on initial stakeholder involvement are noted below.
- 182 This phase will require close oversight and change management processes to support the transition in the Ministry of Health and district health boards, to empower nascent organisations to assume their roles and to manage the risk to health system performance. I expect these changes to be managed in accordance with contemporary principles of change management, with high quality engagement and consultation with relevant workforces and their representatives. As interim entities are established and the finer design of new functions and relationships continues, it will be necessary for strong governance to be in place across the breadth of the reform programme. I have instructed the Transition Unit to provide further advice on programme arrangements as part of subsequent advice on the transition.
- 183 **The expansion and development phase, over the following two to three years**, will see new entities become more mature, undertake and iterate strategic planning and refine the practical operations of the new system model. This phase will see the progressive full rollout of new delivery arrangements (including locality networks), and the ongoing improvement of systems and processes. It is also likely to demonstrate some of the earlier benefits of reform, in terms of outcomes for the system and people. Oversight will be mainstreamed through the Ministry's strengthened stewardship role, together with the relevant roles of the Māori Health Authority and Health NZ.
- 184 The above roadmap proposes a significant amount of change over a compressed timetable, aiming to have new organisations in place and operating fully by later next year. Whilst this is not without risk to the health system, I am convinced that it is the right approach to deliver change sooner and to provide certainty for those who work in the sector, and the public.

- 185 I have considered an alternative track for reform, which would stage individual elements over a longer timeframe. This approach might, for instance, commence with establishment of the Māori Health Authority, the national public health service and steps to establish informal regional service networks across existing DHBs as a precursor to more substantial change. There is of course some merit to a slower pace which allowed each step to be embedded in its own time.
- 186 However, in my view such a cautious approach would not meet either Government's ambition for reform, or the expectations of the health sector and the public for real and proximal change. It would not necessarily reduce risks to the system; conversely, by delaying clarity on the future model and allowing sub-optimal arrangements to continue for longer, it may add further disruption and mask under-performance. The challenges to the health system are so great that undue delay should not be an option. I am also conscious that, nearly three years after the Review was commissioned by Government, the system should wait no longer for change. Finally on this point, further delay to meaningful and broad spectrum change means a continuation of inequitable service provision and people continuing to denied the care that they need.
- 187 It follows that a core principle across both phases must be to conduct the implementation in a way that mitigates potential risks to business as usual in health services – including the ongoing COVID-19 response. This will be especially important during the first phase, where early implementation activity will coincide with the expected rollout of the vaccination programme.
- 188 Cabinet has previously agreed to the establishment of a Ministerial advisory committee, under section 11 of the New Zealand Public Health and Disability Act 2000, to advise Ministers on the design of the health and disability system reforms [CAB-20-MIN-0269 refers]. Given the need for ongoing Ministerial oversight across such a broad implementation programme, **I recommend that the terms of this committee be refocused towards providing advice to support implementation.** This would include advising Ministers on risks to successful delivery and appropriate mitigations. Subject to agreement, I intend to bring a revised terms of reference to Cabinet in due course.
- 189 The high-level timeline at **Annex D** illustrates the key milestones in the first phase of implementation. This assumes dates for the passage of legislation and Cabinet's agreement to proposals for interim entities, as described below.

Stakeholder engagement and involvement

- 190 Critical throughout the implementation will be the approach taken to engagement, involvement, and active measures to foster support and input within the health sector, wider stakeholders, patients and the public. A core element of our approach to change therefore should be to develop the detail on system processes and frameworks in an open and collaborative manner – working with stakeholders to co-design where possible.

- 191 In my view, there is an enthusiasm on the part of the health sector to embrace change and an expectation to be involved in its execution. We should meet this desire with a commitment to work closely in the next phase.
- 192 Following announcement of the foundational proposals in this paper, I recommend a structured programme of engagement with the health sector and wider stakeholders. This programme would have two primary aims:
- 192.1 to communicate the Government's vision and explain the implications of the reforms to the system, with a particular focus on assuring health professionals of the scale and pace of change, and how the transition will be managed to reduce impact on core business. This should seek to build support for the Government's approach and identify system leaders who can act as change agents to help socialise reform;
- 192.2 to invite stakeholders to support the design the next layers of detail for how the reformed system will work, to harness their expertise and build consensus.
- 193 Our approach should be clear on the issues which can be influenced and those which are fixed; while Cabinet will have decided on some of the base components of the operating model, there will be substantial elements of detail to develop, including for instance: how the Māori Health Authority works in practical partnership with other health organisations to drive hauora Māori; how iwi-Māori partnership boards are developed and embedded into system planning; how locality networks can be built from existing providers and formed with the right incentives and supporting infrastructure.
- 194 There will also be specific opportunities to engage the sector, workforce and the public on elements of the reform programme. In particular, I see the opportunity to develop options for the governance arrangements for the Māori Health Authority as an important symbol of partnership in design. The development of the NZ Health Charter, moreover, will also be an important vehicle for involving workforce groups that could be accelerated to begin during the transitional phase.

Establishment of interim entities

- 195 Until legislative changes are passed, the Ministry of Health and DHBs formally retain all existing statutory functions, powers and accountabilities. However, there is an opportunity to establish interim entities in advance of legislation to enable set up and commencement of new functions.
- 196 **I recommend establishing an interim Health New Zealand and an interim Māori Health Authority as two separate departmental agencies.** Departmental agencies require Orders in Council to establish within a host agency, which retains responsibility for pay and other corporate functions. The departmental agencies should be established at an appropriate time following the introduction of legislation into the house to enable progress with early implementation activities.

197 This approach would enable progress of early implementation activities whilst maintaining existing statutory accountabilities in advance of the anticipated 'go-live' in July 2022. The departmental agencies would have a clear legal status with an Acting Chief Executive accountable to the Minister; they can also have and manage assets and liabilities; and can have staff.

198 **I recommend that both agencies be established with the Ministry of Health as the host organisation.** This would align with existing capabilities, support sharing of necessary operational functions, and ensure the least disruption to business as usual, including the COVID-19 response.

199 **I propose that Ministerial committees be appointed for each interim agency under section 11 of the New Zealand Public Health and Disability Act 2000.** The members of the section 11 committees would advise Ministers on the establishment and governance of the interim entities; with a requirement that Acting Chief Executives work closely with the committees to oversee the transition. My intention would be to appoint these members such that they could transition to becoming the first formal Health NZ Board, subject to legislation.

s9(2)(f)(iv)

200 Whilst the Ministry of Health will retain its statutory functions and current accountabilities, including the monitoring of DHB performance and management of some national contracts during this transition period, some functions and staff can be gradually transferred to the interim entities over the transition period. This will enable interim entities to commence early implementation activities and enable a smooth transition once legislation has been passed. This will need careful planning over 2021, taking into consideration the key priorities and enablers of each organisation.

201 The transition will also pose issues as to the timing and scope of the necessary restructure of the Ministry of Health to reflect its new role in the health system. I recommend that this does not commence in practice until early 2022 to avoid any risk of disruption of the current Covid-19 response.

Managing performance during the transition

202 Given the inevitable uncertainty associated with any reform, maintaining a strong focus on financial and operational performance across the system will be crucial as implementation commences. Existing functions will remain with current organisations until new legislation comes into effect – meaning that the Ministry of Health and district health boards will need to both prepare for and begin to enact change, and also to maintain the good running of health services.

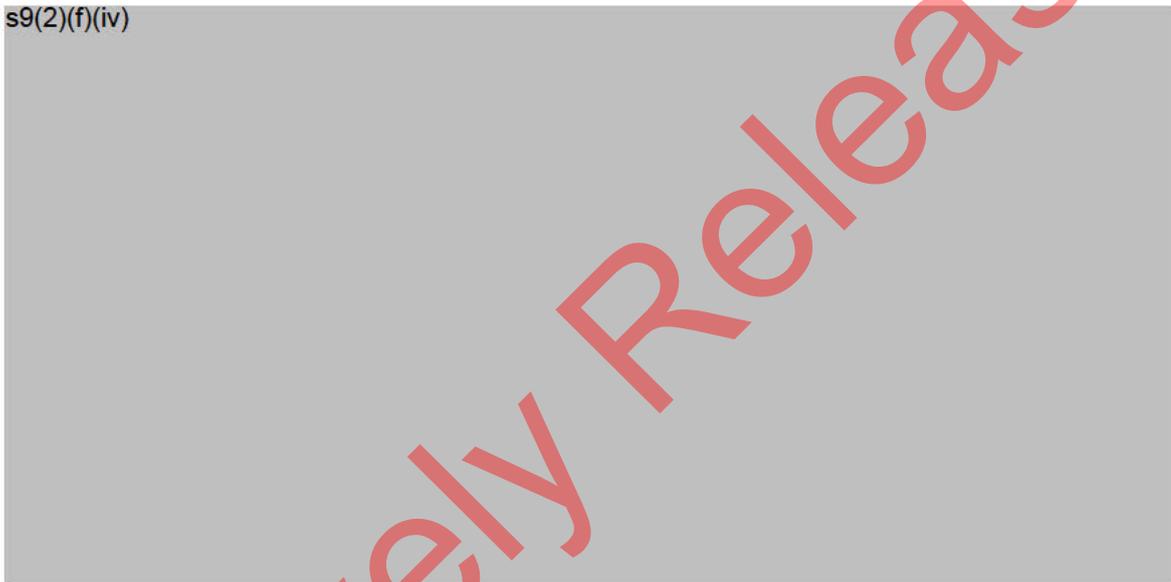
203 The Ministry of Health will retain overall accountability of DHBs during the transition period. However, the new interim entities will need to deliver early

implementation activities to demonstrate how the reformed system will work, which may include delivering projects that cut across several DHBs. The Ministry of Health and the interim entities will need to work together to partner, transfer or delegate functions as required to enable this.

- 204 It will be important that DHBs make decisions that align with the future model and ways of working. This includes consideration of the impact of long-term commitments such as major IT investments, key appointments, or significant services changes which impact on other DHBs. As implementation progresses, there is a risk that DHBs could make decisions that conflict with the reform process or system performance. Ongoing communications, involving key staff in design, and secondments of key staff to the interim organisations will be important mitigations of this risk.

205 s9(2)(f)(iv)

206



Timeframe for subsequent advice

- 207 Subject to Cabinet's agreement to the recommendations in this paper, it will be necessary to bring further advice on the range of matters required to design and implement the reformed system. Many of these are central to delivering the outcomes and system shifts for people as described above; others are essential enablers of change.

208 s9(2)(f)(iv)

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s9(2)(f)(iv)

211

Impact analysis

Benefits

212 The key rationale for health reform is to improve equity and health outcomes for patients and whānau. The core purpose of the system operating model is to provide the platform for aligned and integrated decision-making based on a population health approach, which allocates resources more fairly, tackles under-performance, and invests in innovation.

213 The proposed reforms are further expected to deliver a significant improvement in efficiency, productivity and financial performance over the medium term. The establishment of a single Health NZ creates an opportunity to consolidate and align critical system levers and accountabilities inside one organisation, tackling the current dispersal and duplication of these. Merging 20 district health boards, with different management structures and clinical quality frameworks, into a unified Health NZ presents a range of opportunities to improve cost control and manage demand more effectively:

213.1 central management and methodologies will help identify and tackle unwarranted variation wherever it occurs in the system, and promote clear accountability for under-performance;

213.2 decisions on adopting innovation and improvements in practice – such as new models of care – can be made once and readily spread nationwide; and

213.3 resources and expertise can be easily accessed and shared across regional and service boundaries.

- 214 Many of the key factors which drive cost variation in the health system, and which are presently split across district health boards, will be integrated within Health NZ: including responsibilities for asset utilisation, workforce planning and deployment, procurement and supply chain management, capital investment, and back office functions. There are also significant benefits to patients, and cost savings, from more consistent clinical services. For example, there is currently substantial variation in unplanned readmission rates, unplanned hospitalisation rates and lengths of stay. If performance of the higher-admission hospitals could be brought to the lower quartile, we estimate that it would lead to about 11,000 fewer hospitalisations every year.
- 215 The structure of Health NZ will also present new opportunities to improve allocative efficiency, in particular through the prioritisation of investment in primary and community services and new digital models which reduce health need, promote wellbeing and support virtual care. Over time, the development of better primary and community care, including community alternatives to hospital-based care, is expected to reduce pressure on the acute sector, allowing for further reinvestment. For example, many diabetes-related admissions could be prevented with better blood-glucose control associated with better primary care. Health NZ will be able to divert funds to support better primary and in-home diabetes management, and will reap the benefit of savings in hospital costs. As Māori experience significantly higher rates of admission, addressing these issues will also be a strong contributor to achieving equity.

Financial implications

- 216 Funding is required to make the proposed changes effective, and deliver a system that supports better and more equitable health outcomes. There will be significant cost implications in expanding services, addressing access barriers to services (including innovative delivery models), and reducing financial barriers to address longstanding health disparities and to shift costs away from hospital settings. There will be choices about scale and pace, and about how far to expand access and provision of services through the public system, but this investment will be key to the success of the reforms. I intend to bring a fuller assessment and proposals in a subsequent Cabinet paper.

Regulatory impact statement

- 217 There is no Regulatory Impact Statement accompanying this Cabinet paper. The Department of Prime Minister and Cabinet and the Treasury Regulatory Impact Analysis Team have agreed the timing and nature of a supplementary analysis report (SAR). This SAR will be provided alongside the Cabinet paper and RIA on transitional arrangements in the health system reform in May 2021.

Population implications

- 218 The proposals in this paper are expected to have significant benefits for disadvantaged populations, especially Māori and Pacific peoples and disabled people, and are not expected to negatively affect any population groups. The establishment of a Māori Health Authority, and strengthened iwi/Māori partnership boards, in particular, are expected to increase Māori access to services, and improve health outcomes.
- 219 Ethnic communities, including refugee communities, also have specific health needs, face unique barriers to accessing services and suffer inequities in our current health system. Gaps in data, analysis and the lack of cultural competency in some areas of the system will need to be considered as this work progresses to ensure better outcomes for this growing population.
- 220 One in four New Zealanders experience or live with a physical, sensory, learning, mental health or other impairment, with a large proportion of these people being over the age of 65. Many disabled people will be high users of the health system and experience disproportionately poorer outcomes and greater barriers to accessing health care than non-disabled people. The New Zealand Health Survey 2019/20 found around 21.5 percent of disabled people reported not visiting a GP due to cost, compared to 12.7 percent of non-disabled adults. Disabled people have a strong interest in ensuring the future health system works for them, addresses health inequities and improves health outcomes.
- 221 One in ten New Zealanders is a carer for a loved one with a disability, health condition, illness or injury. Individual, family, whānau and aiga carers are a specific population group that interact regularly with the health system, and in a different manner to those for whom they care. Carers are an integral part of the regulated and non-regulated health workforce and the broader health ecosystem, and the Government have committed to improving the wellbeing of carers through the Mahi Aroha – Carers' Strategy Action Plan. Part of the engagement over improving disability support services will be engagement with the disabled community and carers.

Human rights

- 222 The proposals in this paper are consistent with the rights and freedoms listed in the New Zealand Bill of Rights Act 1990 and Human Rights Act 1993. Nothing in the proposals affects an individual's right to life and security of person, including the right to refuse medical treatment. The proposal to remove elected district health board members does not engage any of the democratic and civil rights enumerated in sections 12-18 of the Bill of Rights Act: section 12 applies only to Parliamentary elections.
- 223 The proposals relating to the Māori Health Authority and iwi/Māori Partnership Boards are expected to address the systemic disadvantage of Māori found by the Waitangi Tribunal and accepted by the Crown. To the extent that they do so, they address long-standing discrimination, giving effect to section 19 of the New Zealand Bill of Rights Act, which also provides that action taken to

assist disadvantaged groups does not constitute unlawful discrimination. The proposals will require legislation to give them effect: such legislation will be the subject of a detailed examination by the Ministry of Justice for compatibility with the Human Rights Act 1993 and New Zealand Bill of Rights Act 1990 before it is introduced the House.

Consultation

224 The Ministries of Health, Justice, Education and Social Development, the Treasury, the Public Service Commission, the Department of Corrections, Oranga Tamariki, Te Puni Kōkiri, NZ Police, the Accident Compensation Corporation, the Parliamentary Counsel Office, the Joint Venture for Family Violence and Sexual Violence, and the Department of the Prime Minister and Cabinet have had the opportunity to review this advice. Their comments are reflected in this paper where possible. The Minister for the Public Service has indicated that he is comfortable with the machinery of government proposals in this paper going to the Social Wellbeing Committee for consideration.

Communications

225 Subject to Cabinet's agreement and further planning, I intend to make a public announcement as to the future direction for the health system in the coming weeks. This announcement will serve as the first step in a much wider programme of communications and engagement, with the aims of selling the Government's vision and proposed changes to the operating model, and creating the space for involvement in the development to follow.

Proactive release

226 I intend to release this paper in accordance with the guidance in Cabinet Office Circular CO (18) 4, at a time following the public announcement noted above.

Recommendations

The Minister of Health recommends that the Committee:

1. **note** that in June 2020, Cabinet accepted the case for change and general direction set out in the final report of the Health and Disability System Review, and agreed to establish a Transition Unit within the Department of the Prime Minister and Cabinet to advise on the Government's response, with a Ministerial Group to oversee the response to the review [CAB-20-MIN-0269]
2. **note** that in December 2020 Cabinet:
 - 2.1. **noted** the Minister of Health's initial view that high-level system design should broadly follow the Review's recommendations, but there were significant questions to be resolved about the detail of the functions of the new entities and relationships between them, and where recommendations could go further to achieve the goals of the reform

- 2.2. **noted**, subject to detailed reform proposals being brought, the Minister's intention to establish: a Māori Health Authority; Health New Zealand; and a public health agency
- 2.3. **invited** the Minister to bring detailed reform proposals to SWC in March 2021 [CAB-20-MIN-0519]
3. **note** the proposals in this paper respond to the independent Health and Disability System Review Report, giving effect to the general direction of reform outlined in the Review report, and going further in a number of areas
4. **note** the proposals for reform and their implementation are not expected to compromise the core business of health services, or the response to COVID-19, and the current operations and staffing of district health boards should continue during the transition with minimal disruption to services

Disability support services

5. **note** that Cabinet will receive separate advice on reform proposals relating to disability support services, the implementation of which shall be aligned with health system reform
6. **note** that the Minister of Health and Minister for Disability Issues will bring advice on the future model and governance of disability support services in September 2021

Reformed health system

7. **agree** that the vision for the reformed health system will be based on pae ora/healthy futures for all people: where people live longer in good health, have improved quality of life, and there is equity between all groups
8. **agree** the priority outcomes for the reformed health system will be:
 - 8.1. partnership: ensuring partnership with Māori in decisions at all levels of the system, and empowering consumers of care to design services which work for them
 - 8.2. equity: tackling the gap in access and health outcomes between different populations and areas of New Zealand
 - 8.3. sustainability: embedding population health as the driver of preventing and reducing health need, and promoting efficient and effective care
 - 8.4. person and whānau-centred care: empowering all people to manage their own health and wellbeing, have meaningful control over the services they receive, and treating people, their carers and whānau as experts in care

- 8.5. excellence: ensuring consistent, high-quality care in all areas, and harnessing innovation, digital and new technologies to continuously improve services
9. **confirm** the Ministry of Health's role as the chief steward of the health system and principal advisor to the Minister of Health
10. **agree** that the Minister of Health will issue a Government Policy Statement to set a multi-year national direction, including priorities and objectives for the health system, in line with the New Zealand Health Strategy
11. **agree** that the Ministry of Health will provide stewardship of Pacific health and disability through a dedicated Pacific-led policy capability that will:
 - 11.1. advise Ministers, including the Minister for Pacific Peoples, on all aspects of Pacific health and disability policy
 - 11.2. partner with the health and disability system, the Māori Health Authority, Pacific providers, the Ministry of Pacific Peoples and other government agencies to eliminate Pacific health inequities across the system
 - 11.3. provide monitoring and support accountability for the system's performance in respect of Pacific health outcomes, to achieve the Pacific Aotearoa Lalanga Fou goals
 - 11.4. manage the development of a national Pacific health strategy, that will also focus on developing a strong Pacific health workforce.
12. **agree** that the Minister of Health will lead the development of a New Zealand Health Charter for the health system that will set out common values and principles to guide organisations and health and care workers

Health New Zealand

13. **agree** to establish a new Crown entity, provisionally called Health New Zealand, that will be the lead operational organisation for the public health system, within the parameters set by the Minister in national strategies and policies
14. **agree** that the Minister of Health will appoint all members to the Health New Zealand board
15. **agree** that all district health boards will be disestablished and their assets and liabilities vested in Health New Zealand
16. **note** that I intend that the internal organisation arrangements of Health New Zealand will include:

- 16.1. four regional divisions with regional commissioning boards within Health New Zealand, to be led by regional chief executives, to commission primary and community health services, in collaboration with the Māori Health Authority; and
- 16.2. hospital and specialist services consolidated into four regional networks, planned nationally by Health New Zealand and delivered through regional divisions to align with primary and community services.
17. **agree** Health New Zealand will be a Crown Agent, responsible to the Minister of Health, required to give effect to the Government Policy Statement (and other government policy as directed), and subject to the standard monitoring and accountability arrangements in the Crown Entities Act 2004
18. **agree** that in addition to the above powers, the Minister of Health will have more finely grained intervention powers, including the powers to:
 - 18.1. replace one or more members of the Health New Zealand board
 - 18.2. appoint observers to any Health New Zealand-operated or contracted service
 - 18.3. require specified improvement actions of Health New Zealand
19. **note** that the Health New Zealand Board will appoint a chief executive, subject to the agreement of the Public Service Commissioner on terms and conditions
20. **agree** Health New Zealand will be responsible for the planning and commissioning of health services to achieve national outcomes and objectives
21. **agree** Health New Zealand will have a duty to ensure that iwi/Māori partnership boards, representative of iwi in the areas covered by the board, exist and can contribute to the development of significant service plans, and co-design and jointly approve locality plans
22. **agree** Health New Zealand will own and operate public hospitals on behalf of the Crown
23. **agree** Health New Zealand will be required to publish at regular intervals, once agreed with the Minister, a New Zealand Health Plan, that responds to the direction and priorities set in the New Zealand Health Strategy and Government Policy Statement and sets out a long-term health service view and forms the basis for capital, digital, and workforce planning
24. **agree** that Health New Zealand will take lead operational responsibility to deliver equitable health outcomes for Pacific peoples, including to:
 - 24.1. lead the development and implementation of a national Pacific health plan that delivers the outcomes set out in the Pacific health strategy

- 24.2. partner across the broader system to ensure delivery of Pacific health services are holistic and address all aspects of wellbeing
 - 24.3. report to the Ministry of Health on how service delivery is eliminating Pacific health inequalities, who will share reporting with the Lalanga Fou Chief Executive Grouping.
25. **agree** that relevant operational functions of the Ministry of Health will be transferred to Health New Zealand
 26. **note** my intention to require Health New Zealand to agree arrangements for locality-based provision of primary and community services, initially through regional chief executives for the relevant region.

Māori Health Authority

27. **agree** to establish a new statutory entity, provisionally called the Māori Health Authority, to lead hauora Māori in the health system, to work with the Ministry of Health on strategy and policy relating to hauora Māori, and to work with Health New Zealand on operational matters
28. **agree** that the Māori Health Authority should be independent of other health system organisations, and constituted in a way that gives effect to rangatiratanga and embeds the principle of partnership between Māori and the Crown
29. **agree** that the Transition Unit should take forward a process with iwi and the Māori health sector to design proposals for the constitution of the Māori Health Authority as a new entity, to be presented to Cabinet for agreement
30. **agree** the Chair of the Māori Health Authority will be appointed to the Health New Zealand Board, and may delegate the appointment to the Deputy Chair
31. **agree** the Māori Health Authority will be a lead commissioner of kaupapa Māori health services and other services targeted for Māori
32. **agree in principle** that, subject to the process of design with Māori health sector on the constitution of the Māori Health Authority, the authority will:
 - 32.1. act as a co-commissioner for other health services accessed by Māori, working jointly with Health New Zealand to approve commissioning plans and priorities
 - 32.2. jointly develop national and regional strategies and service plans with Health New Zealand and will need to co-sign or approve before such plans or strategies come into effect
 - 32.3. support iwi/Māori partnership boards to participate in service planning, and work to develop capability in the Boards for that purpose

Public health

33. **note** that the Government's Manifesto commitment included the creation of a public health agency that will more closely link the public health units
34. **agree** to establish the Public Health Agency as a distinct, branded unit within the Ministry of Health, to lead on all public health and population health policy, strategy, regulatory, intelligence, surveillance and monitoring functions
35. **agree** to establish a national public health service within Health New Zealand, which encompasses the 12 public health units and builds on the work led by Ministry of Health to provide more central coordination across public health units
36. **note** that the Director of Public Health will be based in the Public Health Agency within the Ministry of Health, and will provide direct leadership to the national public health service in Health New Zealand
37. **agree** that the Public Health Agency will develop technical specifications for public health programmes, and that Health New Zealand, together with the Māori Health Authority, will determine and commission services to deliver on these
38. **agree** to disestablish Te Hiringa Hauora/Health Promotion Agency as a separate Crown entity and to transfer its relevant functions to the Public Health Agency of the Ministry of Health and Health New Zealand
39. **note** that the Ministry of Health is developing advice on an Expert Advisory Committee for Public Health, which will be provided to Cabinet in due course
40. **note** that enhanced surveillance is critical to a strengthened public health system, and the Transition Unit, working with the Ministry of Health, will provide further advice on options to enhance the surveillance function, including on the appropriate location of these services within government structures

Implementation and interim arrangements

41. **note** that the approach to implementation will balance the health system's need for clarity and demonstrable early progress with a longer-term commitment to achieving lasting cultural change
42. **note** the intention to proceed to implement the reforms at pace, starting with a transitional phase of preparation, detailed functional design and wider stakeholder engagement over the period to late 2022
43. **note** that I have considered proposals for a more gradual approach to implementation but consider that the benefits of early clarity for the sector and risks of delay mean that this is not appropriate
44. **agree** to refocus the role of the Ministerial advisory committee, previously agreed by Cabinet [CAB-20-MIN-0269], to provide advice to Ministers in relation to the implementation of reforms

45. **agree** to establish interim organisations to undertake detailed planning, organisational design work, and consultation, especially with Māori
46. **agree** to establish an interim Health New Zealand as a departmental agency within the Ministry of Health
47. **agree** to allow the interim Health New Zealand to manage assets and liabilities in accordance with section 24(2)b of the Public Service Act 2020
48. **agree** to establish an interim Māori Health Authority as a departmental agency hosted by the Ministry of Health
49. **agree** to allow the interim Māori Health Authority to manage assets and liabilities in accordance with section 24(2)b of the Public Service Act 2020
50. **note** my intention to establish committees pursuant to section 11 of the New Zealand Public Health and Disability Act 2000 to advise Ministers on the establishment of the interim entities and their transition to the new system
51. **note** that staff and funding may be transferred from the Ministry of Health or district health boards to the interim entities as agreed by the relevant parties

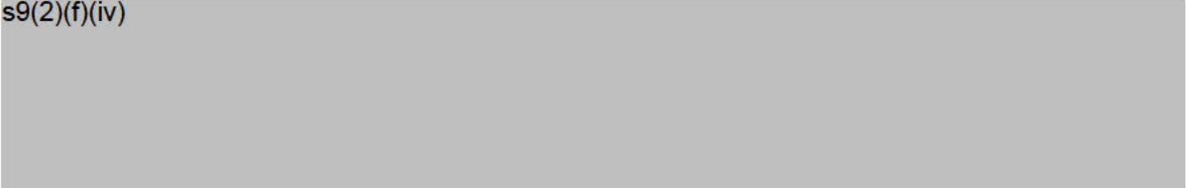
Implementing legislation

52. **note** that many of the above decisions will require legislation, 
s9(2)(g)(i) 

53. **agree** that implementing legislation place obligations on health sector entities in respect of the Treaty of Waitangi by including a Treaty of Waitangi clause following the standard modern form, that gives effect to the principles identified by the Waitangi Tribunal in its Hauora inquiry
54. **authorise** the Minister of Health to issue drafting instructions for legislation giving effect to the above recommendations

Funding

55. **note** that a bid has been submitted for Budget 2021 to provide necessary funding to progress with implementation of proposals in the coming year
56. **note** that recommendations relating to interim arrangements are subject to funding being agreed through Budget 2021 for health reform
57. **agree** to establish a funding framework for health that provides greater budget certainty for the health system and the Crown

58. s9(2)(f)(iv) 

59. s9(2)(f)(iv)

Next steps and reports to Cabinet

60. s9(2)(f)(iv)

61.

62.

62.1. s9(2)(f)(iv)

62.2.

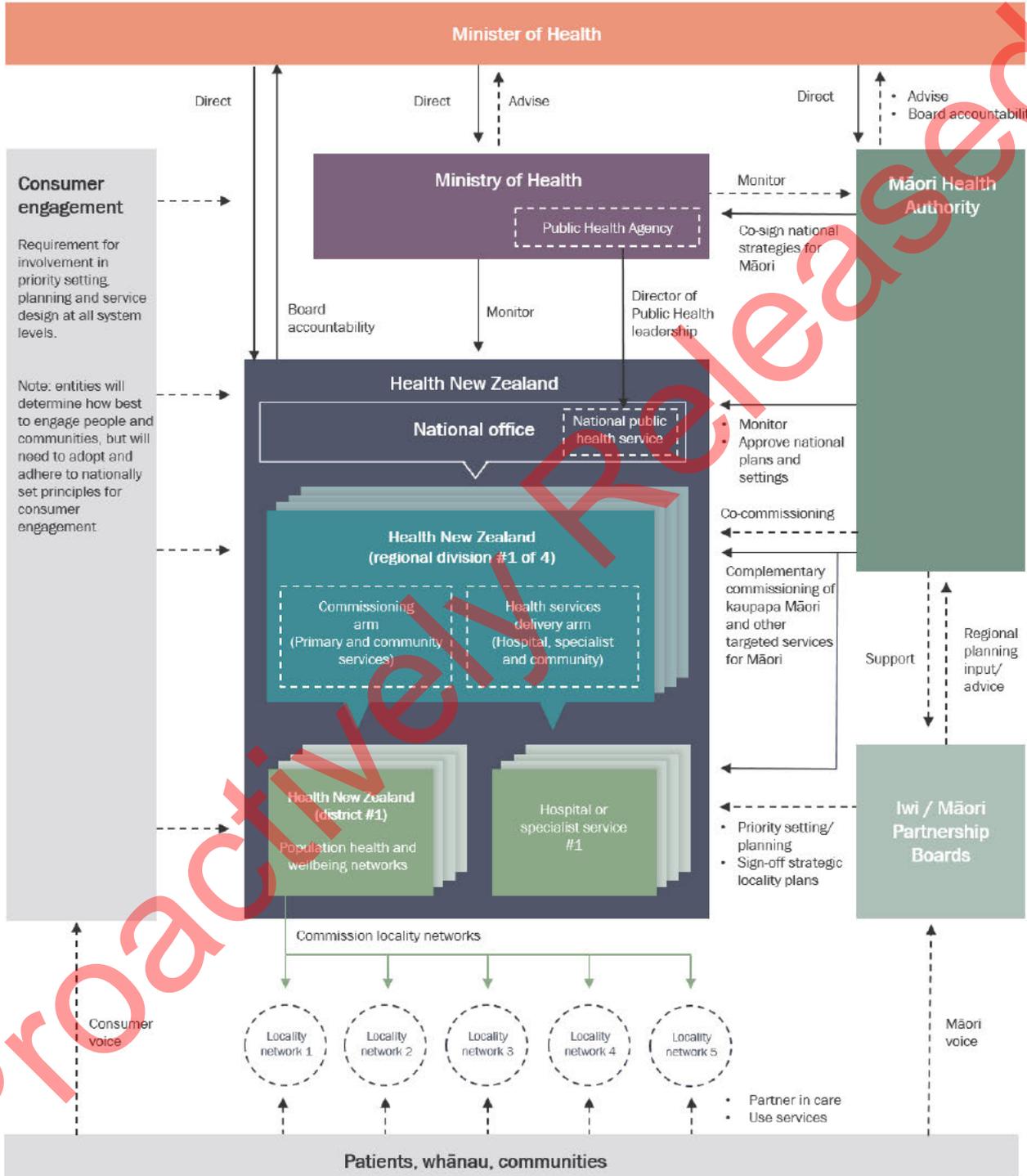
62.3.

Authorised for lodgement

Hon Andrew Little

Minister of Health

Illustration of proposed health system operating model



Overview of structure, primary functions, accountability, and powers of key national entities in the future system

<i>Entity</i>	<i>Structure (legal form)</i>	<i>Primary functions</i>	<i>Accountabilities</i>
Ministry of Health	Department	<ul style="list-style-type: none"> • Chief steward of the health and disability system, and the Minister’s agent • Lead entity for setting strategy, policy and regulation for the health and disability sector, including: <ul style="list-style-type: none"> • long-term strategy, policy, legislation and strategic funding and investment across the system, • high-level policy frameworks for services/groups to inform delivery, and • regulatory stewardship • Continues to set and monitor overall system outcomes and objectives – including monitoring system performance (clinical, financial, equity etc.) and that of Crown entities 	<ul style="list-style-type: none"> • Accountable to the Minister of Health for overall performance of the health system • Accountable to the Minister of Health under the Public Finance Act for financial management, and advising the Minister of Health on efficiency and effectiveness of spending for the Ministry, MHA and Health NZ

Proactively Released

Entity	Structure (legal form)	Primary functions	Accountabilities
Māori Health Authority (MHA)	Statutory entity	<ul style="list-style-type: none"> • Drives system focus on hauora Māori, lead strategy and policy for hauora Māori, alongside the Ministry • Sets expectations and monitors performance of the system with respect to Māori health and health inequities • Partners with Health NZ to develop and agree the NZ Health Plan and other national strategies, plans and operational frameworks • Commissions kaupapa Māori services and other services targeted at Māori populations, and supports innovation and provider and workforce development • Fosters growth in kaupapa Māori services and care models for Māori communities • Co-commissions other health services with Health NZ • Provides analytical, clinical, and intelligence capability to support Iwi/Māori Partnership Boards • Co-designs and delivers health promotion activity with Health NZ 	<ul style="list-style-type: none"> • MHA Board is accountable to the Minister for advice, strategy and reporting on hauora Māori (although the Ministry will perform monitoring activities and information requests on behalf of the Minister) • Accountable to Māori / Iwi through mechanisms to be determined in consultation with Māori • MHA monitors Health NZ (and others) with respect to Māori health • Accountable to the Minister for making best use of the MHA appropriation

Entity	Structure (legal form)	Primary functions	Accountabilities
Health New Zealand	Crown entity	<ul style="list-style-type: none"> • Lead operational entity for the health system • Responsible for the planning, commissioning and delivery of health services, including hospital and specialist service delivery and primary and community services commissioning • Sets and delivers on national expectations for service design and access, monitors and reports on performance and intervenes to improve quality and outcomes • Employer of all current DHB and shared service agency-employed staff • Responsible for maintaining appropriate clinical leadership of service design, development and delivery, including facilitation of clinical networks • Responsible for delivering system-wide supporting infrastructure including workforce development, asset management, contract management systems and national data and digital functions • Working with MHA on identified priority areas for co-commissioning • Responsible with MHA for engaging with social sector agencies, iwi, communities, and local authorities to improve population health through intersectoral action 	<ul style="list-style-type: none"> • Health NZ Board is accountable to the Minister of Health for delivery of the NZ Health Plan and the performance of Health NZ, including but not limited to: <ul style="list-style-type: none"> • planning and performance of hospital networks and specialist services • leading and delivering on pro-equity imperatives • improving commissioning and integration of primary and community services • improving data and intelligence systems that meet the needs of the health system and consumers • managing service demand and expenditure within annual appropriations • engaging with consumers, communities and iwi on health needs, priorities, and system responsiveness • development and retention of the workforce • managing national health system assets

Entity	Structure (legal form)	Primary functions	Accountabilities
		<ul style="list-style-type: none">• Delivers national public health service, through public health units located in Health NZ regional divisions, and designs and delivers national health promotion campaigns with the MHA• Delivers health promotion activity via regional divisions, districts and locality networks	<ul style="list-style-type: none">• Service quality, including patient experience, safety, outcomes, clinical standards, and cultural responsiveness• Accountable to MHA for delivering on jointly agreed strategies, plans and co-commissioning arrangements• Provides shared service to the MHA on design and delivery of national health promotion programmes <p>Note that the Ministry will perform monitoring activities and information requests on behalf of the Minister.</p>

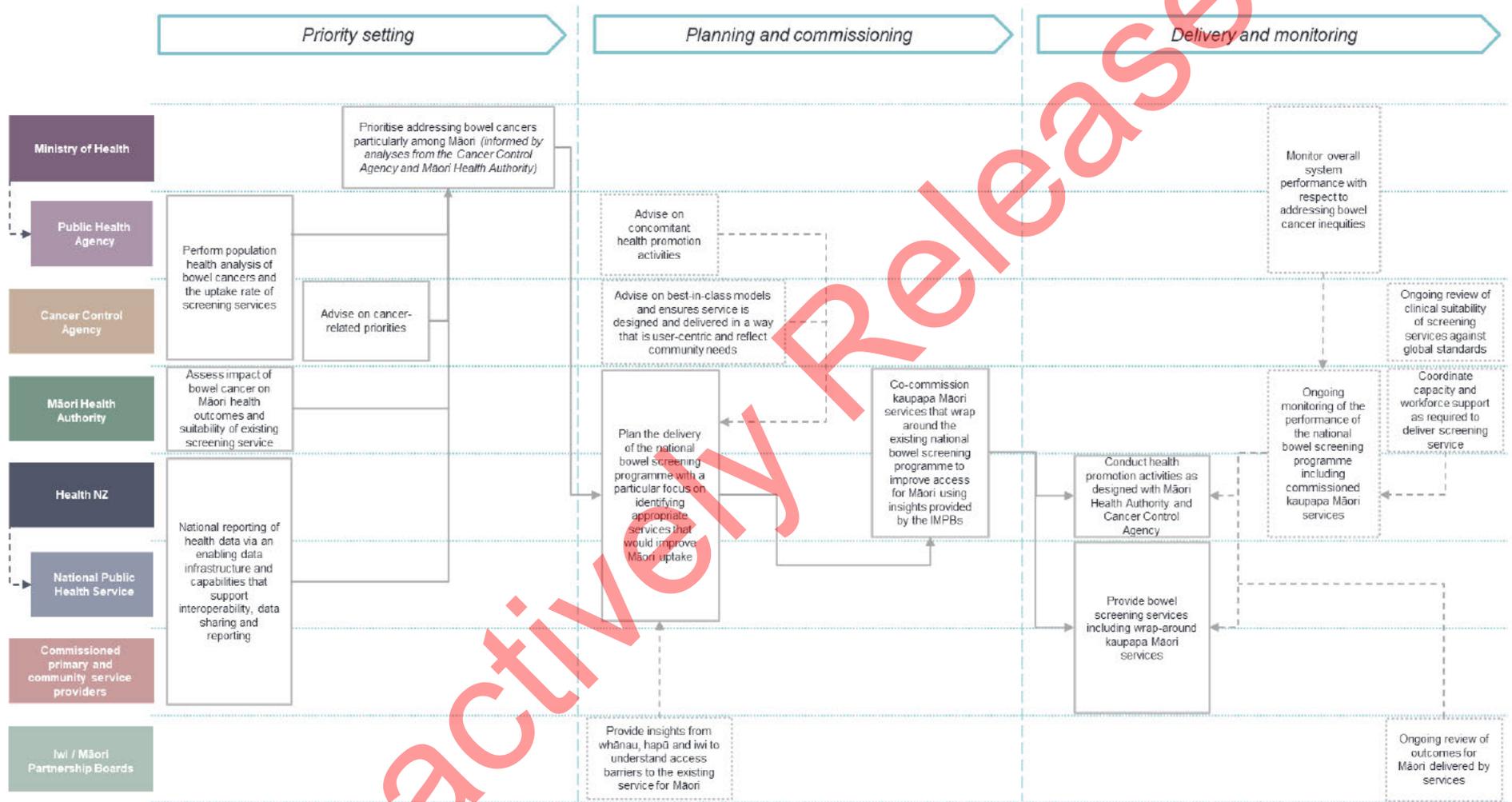
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Illustrative scenarios for the proposed system operating model

The purpose of the following four diagrams is to demonstrate how the proposed system operating model would function in a given scenario, and how the response would be improved compared to the current system.

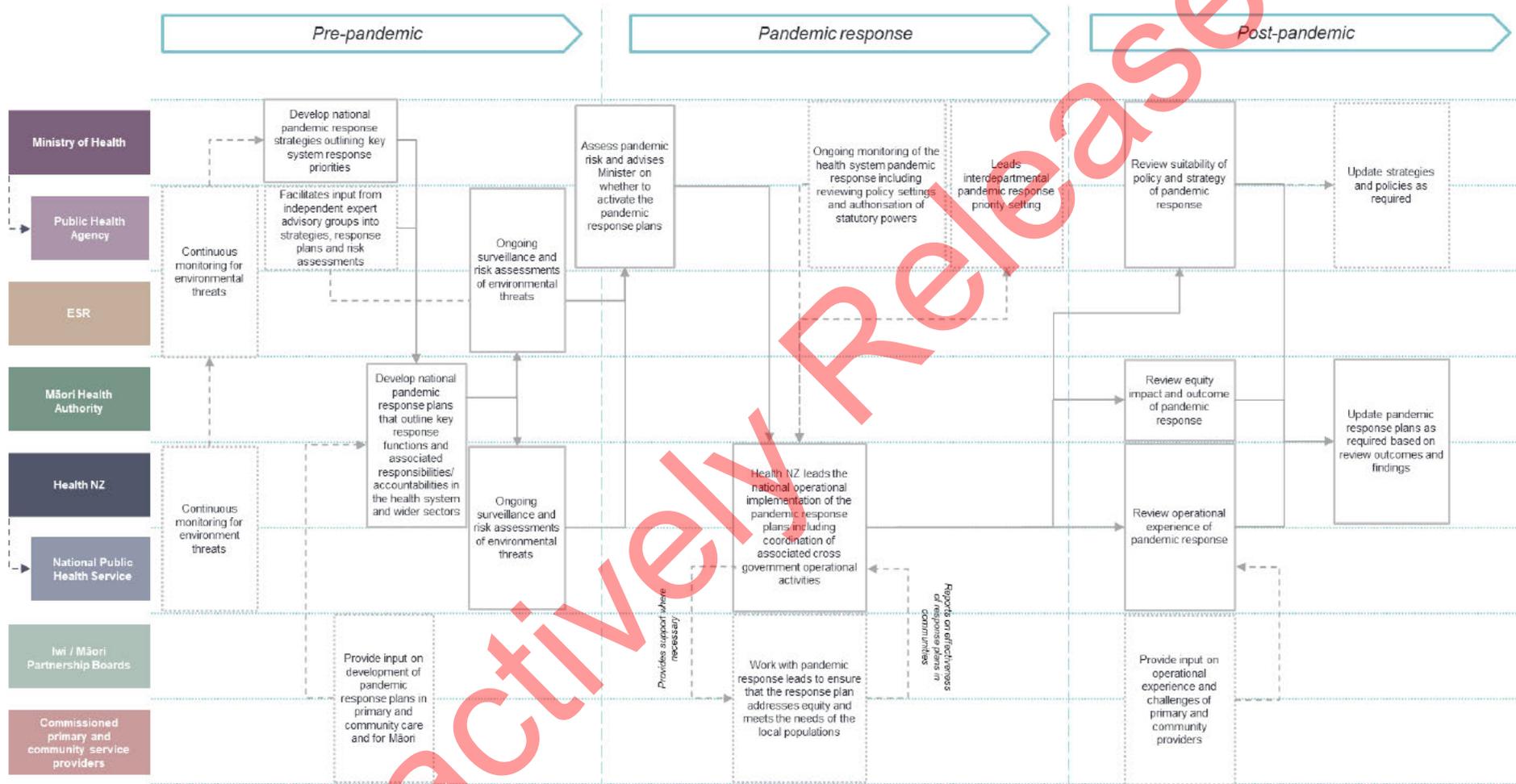
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Scenario 1: How the system delivers a new health priority (using expansion of bowel screening as an example)



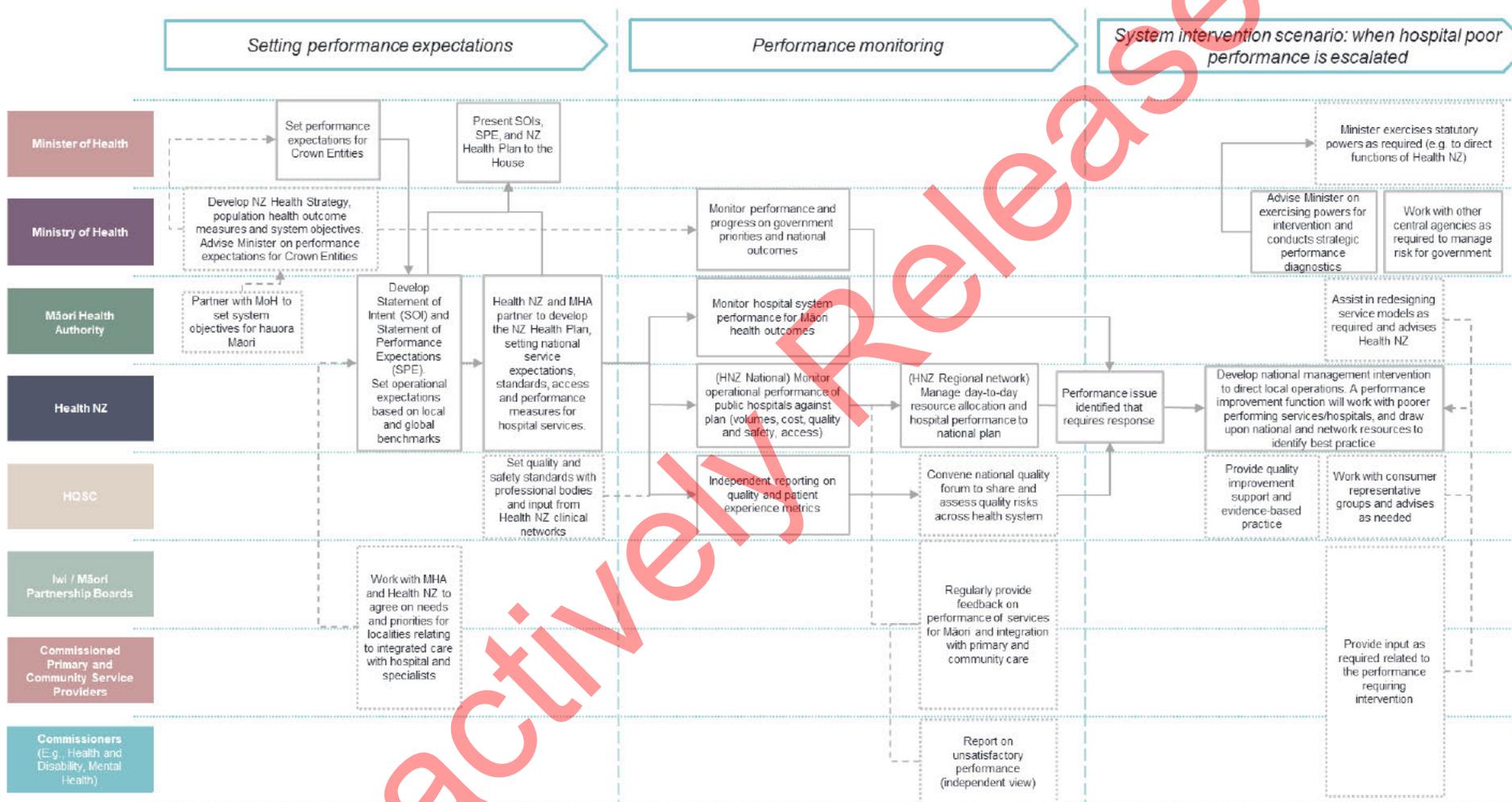
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Scenario 2: How the system prepares for and manages emergency response (using a pandemic as an example)



Proactively Released

Scenario 3: How the system monitors and manages performance of health services (using hospital performance as an example)



Proactively Released

Scenario 4: How the system supports and adopts innovation (using a new community care model as an example)



Proactively Released

Overview of key changes to roles in the current system

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
<p>Ministry of Health (MoH)</p>	<p>The Ministry of Health seeks to improve, promote and protect the health and wellbeing of New Zealanders through:</p> <ul style="list-style-type: none"> • stewardship of New Zealand's health and disability system • advising the Minister of Health, and government, on health and disability issues • monitoring overall system performance (including DHBs and other health entities) • directly purchasing a range of national health and disability support services • providing health sector information and payment services • working jointly with other agencies to promote health and wellbeing, for instance through the Joint Venture on Family Violence and Sexual Violence 	<ul style="list-style-type: none"> • Chief steward of the health and disability system, and the Minister's agent • Lead entity for setting strategy, policy and regulation for the health and disability sector, including: <ul style="list-style-type: none"> • long-term strategy, policy, legislation and strategic funding and investment across the system, • high-level policy frameworks for services/groups to inform delivery, and • regulatory stewardship • Continues to set and monitor overall system outcomes and objectives including monitoring system performance (clinical, financial, equity etc.) and that of Crown entities • Chief Executive of the Ministry of Health is the Director-General of Health, with existing statutory powers • Provides public health and population health policy, strategy, regulatory, surveillance and monitoring functions through the Public Health Agency (as a branded unit of the Ministry). 	<ul style="list-style-type: none"> • The Ministry's commissioning (purchasing) and operational functions will transfer to Health NZ • Some functions, such as strategy and policy, will be conducted in partnership with the MHA insofar as they relate to Māori health and equity of outcomes • No proposed changes relating to Ministry leadership of COVID-19 response and vaccination programme

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
Māori Health Authority (MHA)	This entity does not exist in the current system.	<ul style="list-style-type: none"> • Drives system focus on hauora Māori, leads strategy and policy for hauora Māori • Monitors performance of the system with respect to Māori health and health inequities • Partners with Health NZ to develop and agree the NZ Health Plan and other national plans and frameworks • Provides analytical, clinical and commissioning capability to support Iwi Māori Partnership Boards • Commissions kaupapa Māori services and other services targeted at Māori populations, and supports provider development and innovation • Co-commissions other health services with Health NZ 	<ul style="list-style-type: none"> • New entity established • Some functions will be shared with Health NZ and the Ministry as they relate to Māori health and equity of outcomes • Relationship agreements will exist between key system players to govern roles, responsibilities and accountability mechanisms
Health New Zealand	This entity does not exist in the current system.	<ul style="list-style-type: none"> • Lead operational entity for the health system • Responsible for the planning, commissioning and delivery of health services including hospital and specialist service delivery, primary and community services commissioning, and health promotion • Sets national expectations for service design and access, monitors performance and intervenes to improve quality and outcomes 	<ul style="list-style-type: none"> • New entity established • Commissioning functions performed by the Ministry in the current system will be transferred to Health NZ • Planning, commissioning and delivery functions performed by DHBs in the current system will be transferred to Health NZ

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
		<ul style="list-style-type: none"> • Employer of all current DHB and shared service agency-employed staff • Delivers national public health services, encompassing the 12 public health units in a centralised public health operations function 	<ul style="list-style-type: none"> • Some functions will be shared with the Māori Health Authority as they relate to Māori health and equity of outcomes
District Health Boards (DHBs)	The 20 DHBs implement the health policies of the Government and operate as separate semi-autonomous Crown entities. They plan and fund the provision of health services in their districts, including funding PHOs to provide essential primary health care services to their populations. They own and fund public hospitals and manage their own capital assets.	These entities do not exist in the future system – roles, functions and assets transfer to Health NZ	<ul style="list-style-type: none"> • DHBs disestablished • Their functions will be transferred to Health NZ national, regional, and district offices, who will become the employer of all currently DHB-employed staff • Delegations will sit at the different office levels of Health NZ depending on the best place for decision-making
Primary Health Organisations (PHOs)	PHOs provide primary health care services either directly or through contracted providers, primarily general practices. These services are designed to improve and maintain the health of the enrolled population. PHOs also ensure that services are provided in the community to restore people's health when they are unwell.	<ul style="list-style-type: none"> • Depending on local circumstances, Health NZ locality commissioners may decide to contract with some existing PHOs to manage and coordinate a locality network of service providers • GP teams may choose to continue to contract their services to Health NZ through an existing PHO 	<ul style="list-style-type: none"> • There will no longer be a requirement to use PHOs as a payment agent for primary care services • Entities with PHO agreements may have a reduced or expanded scope of work as determined by the locality commissioner. Their scope may change, for example to become a network coordinator for the locality, a GP support service, or a service delivery entity

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
Iwi-Māori Partnership Boards (IMPBs)	<p>Current legislation requires DHBs to have processes that enable Māori to participate in strategies for Māori health improvement. There are currently 20 Iwi Relationship Boards that act as advisors to DHBs, with varying roles, scope and composition. These boards have limited formal mechanisms to hold system players to account for performance and equity.</p>	<ul style="list-style-type: none"> • Formal network of IMPBs established as Te Tiriti partners at locality level to future Health NZ locality commissioners (note – IMPBs may serve more than one locality) • Works with Health NZ locality commissioners and MHA to jointly agree priorities and strategic plans, and influence service arrangements • Provides local data/insights to HNZ and the MHA to support service planning, delivery and monitoring of outcomes for Māori 	<ul style="list-style-type: none"> • Strengthened role for IMPBs • The number and member appointment process will be provided in future advice, subject to engagement with iwi and the Māori health sector • Additional guidance and support for IMPBs will be provided by the MHA (over and above HNZ relationship)
Shared services agencies	<p>Shared services agencies (including Health Alliance, Health Source, Health Share, Central TAS, Northern Region Alliance, South Island Alliance and Health Partnerships) support DHBs to pool their resources to better deliver common support services, including: health services and funding planning; information, analytical and IT services; provider audit; and procurement.</p>	<p>These entities do not exist in the future system – roles and functions transferred to Health NZ</p>	<ul style="list-style-type: none"> • Shared services agencies will no longer exist as separate entities owned by DHBs • Their functions will be transferred to Health NZ (national and regional offices) • All shared services agency staff will be employed by Health NZ

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
Non-government organisations (NGOs) and private providers	NGOs and private providers include a wide range of entities that provide flexible, responsive and innovative frontline service delivery. Diverse services are offered in primary care, mental health, personal health and disability support services, including kaupapa Māori services and Pacific health services.	<ul style="list-style-type: none"> Continue to provide health and support services as required 	<ul style="list-style-type: none"> Greater integration when working with other providers in locality networks Commissioned by Health NZ and the MHA instead of the Ministry of Health and DHBs Enhance use of digital health to increase responsiveness to patients and whānau
Public Health Units (PHUs)	The 12 PHUs focus on environmental health (including drinking water safety), communicable disease control, tobacco and alcohol control, health promotion programmes, health status assessment and surveillance and public health capacity development.	<ul style="list-style-type: none"> No change to role proposed, but will be joined up as a national public health service within Health NZ 	<ul style="list-style-type: none"> Role and functions shift from DHBs to Health NZ as part of the national public health service
Expert Advisory Committee on Public Health	This entity does not exist in the current system.	<ul style="list-style-type: none"> Expert independent advisor on public health issues (details to be confirmed) 	<ul style="list-style-type: none"> Subject to further advice

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
Health Promotion Agency	The Health Promotion Agency leads and delivers innovative, high-quality and cost-effective programmes that promote health; wellbeing and healthy lifestyles; disease prevention; and illness and injury prevention.	This entity does not exist in the future system – roles and functions transferred to the Ministry and Health NZ, subject to future advice	<ul style="list-style-type: none"> • Determination and delivery of national health promotion campaigns transfers to Health NZ, as a shared service for both Health NZ and the Māori Health Authority • Research and oversight functions transfer to the Public Health Agency within the Ministry of Health
Institute of Environmental Science and Research (ESR)	ESR is a New Zealand Crown Research Institute. Its purpose is to deliver scientific and research services to the public health, food safety, security and justice systems, and the environmental sector to improve the safety of, and contribute to the economic, environmental and social well-being of people and communities in New Zealand.	<ul style="list-style-type: none"> • No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> • There may be some changes in how ESR works with the new entities in the future system, and future advice on enhancing surveillance functions will follow
Te Aho o Te Kahu (the Cancer Control Agency)	Te Aho o Te Kahu is a departmental agency hosted by the Ministry of Health. The purpose of Te Aho o Te Kahu is to provide strong central leadership and oversight of cancer control.	<ul style="list-style-type: none"> • No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> • There may be some changes in how Te Aho o Te Kahu works with the new entities in the future system

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
Health Quality and Safety Commission (HQSC)	HQSC leads and coordinates work across the health and disability sector to monitor and improve the quality and safety of health and disability support services (including public, private and ACC-funded services). They advise the Minister of Health on improving the quality and safety of services and determine and report quality and safety indicators (such as serious and sentinel events). They also have a range of functions relating to mortality, including appointing and supporting mortality review committees.	<ul style="list-style-type: none"> • Maintains existing functions, but with expanded role to improve capacity to act as champion for quality improvement in the system • Expected to include increased focus on consumer voice and empowerment, and facilitation of national consumer forums • Also expected to increase capacity to provide, broker and facilitate evidence-based improvement support for health services 	<ul style="list-style-type: none"> • Expansion in scope and capacity to drive quality improvement and consumer voice • Further advice to consider effective relationship with the Ministry, Health NZ and MHA for monitoring of system-wide quality, identification of issues and appropriate coordination of rapid responses will follow
Health and Disability Commissioner	The Health and Disability Commissioner ensures that the rights of consumers are upheld and encourages service providers to improve performance. This includes making sure that consumer complaints are resolved in a fair, timely and effective way. The Commissioner also funds a national advocacy service to help with complaints.	<ul style="list-style-type: none"> • No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> • New relationships with Health NZ and MHA on the remediation of complaints and coordination of insight and intelligence for system monitoring

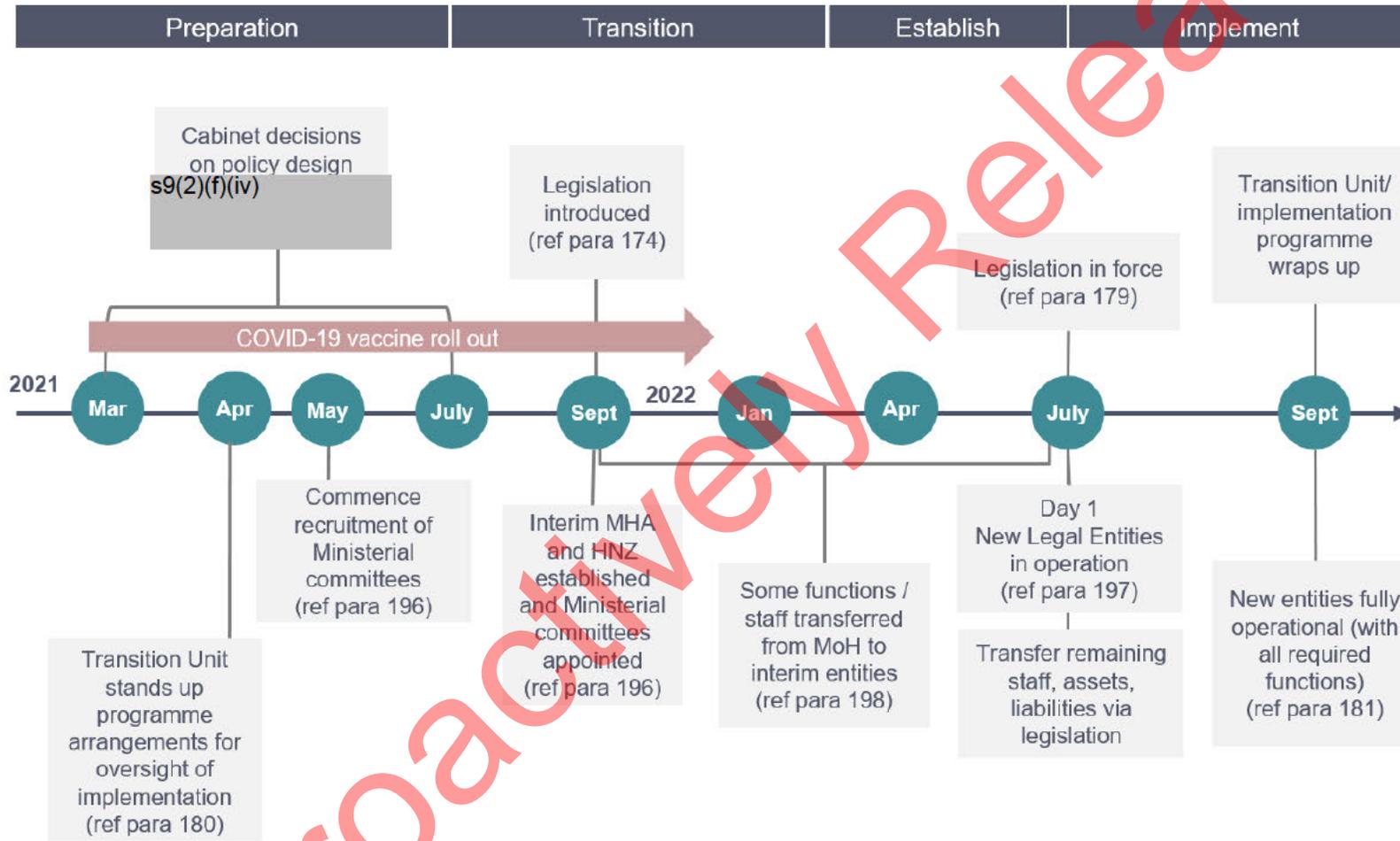
Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
Accident Compensation Corporation (ACC)	ACC provides no-fault personal injury cover for New Zealand residents and visitors. ACC can provide financial support for medical treatment, rehabilitation, loss of income and other ongoing costs. ACC purchases services directly from health and disability providers, and purchases acute health services through the Public Health Acute Service Agreement.	<ul style="list-style-type: none"> No changes in role currently proposed, noting parallel work on the future of disability support services which may impact ACC's future functions 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed Future advice will consider co-commissioning arrangements with ACC
Pharmaceutical Management Agency (PHARMAC)	PHARMAC manages the Pharmaceutical Schedule that outlines which medicines, therapeutic medical devices and related products are publicly funded; who can prescribe them to enable them to be funded; and who can access them.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice. The function and operation of PHARMAC is subject to a parallel review which has been established by Government Stronger collaboration with Health NZ on specific functions such as health technology assessments could be progressed in the future system, subject to the PHARMAC review 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed
New Zealand Medicines and Medical Devices Safety Authority (Medsafe)	Medsafe is a business unit of the Ministry and is the authority responsible for the regulation of therapeutic products in New Zealand.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
Health Research Council of New Zealand	The Health Research Council advises Ministers on priorities for health research and health research policy; initiates and supports health research; negotiates and administers health research funding; fosters health research workforce development; and promotes and disseminates health research findings.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed
New Zealand Blood Service (NZ Blood)	NZ Blood ensures the supply of safe blood products. It provides an integrated national blood transfusion process, from the collection of blood from volunteer donors to the provision of blood products within the hospital environment. In November 2020 NZ Blood began coordinating the organ donation function, taking over from a unit within Auckland DHB.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed
Mental Health and Wellbeing Commission	The Mental Health and Wellbeing Commission provides independent scrutiny of the Government's progress in improving NZ's mental health and wellbeing and promotes collaboration between entities that contribute to mental health and wellbeing.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
Health Infrastructure Unit	The Ministry of Health's Health Infrastructure Unit oversees and leads health capital projects for the sector. The HIU was established to provide stronger oversight, assurance and standardised project delivery across a national portfolio of DHB-owned and operated infrastructure.	<ul style="list-style-type: none"> Business unit function will transfer to Health NZ. The role will evolve as the organisational operating model for Health NZ is developed 	<ul style="list-style-type: none"> Health Infrastructure Unit will transfer to Health NZ
Capital Investment Committee	The Committee provides advice to the Minister of Health, the Minister of Finance and the Ministry on capital investment and infrastructure in the public health sector. This includes working with DHBs to review their business case proposals, providing advice on prioritisation of capital investment and delivery of a National Asset Management Plan, along with any other matters that the Ministers may refer to it.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed Secretariat and support functions for the Committee will transfer to Health NZ

Entity	Role in the current system	Proposed role in the future health and disability system	Proposed change
National Ambulance Sector Office (NASO)	NASO provides strategic and operational advice and commissions emergency ambulance services (road and air) so that critically unwell and injured New Zealand residents can access timely, high quality clinical care, saving lives and reducing long-term disability. NASO is jointly funded by the Ministry and ACC and reports to both agencies.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed
Medical colleges	Medical colleges set education and quality standards for their relevant professions, including approving the curricula required by the tertiary education sector to educate medical professionals.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed
Responsible authorities (e.g., Medical Council of New Zealand, Dental Council, Midwifery Council)	Responsible authorities regulate their relevant professions in discharge of statutory authority under the Health Practitioners Competence Assurance Act 2003.	<ul style="list-style-type: none"> No change in role currently proposed, subject to future advice 	<ul style="list-style-type: none"> No change in role currently proposed, however new relationships and system processes with Health NZ and the MHA will need to be developed

Indicative high-level implementation timeline





Cabinet

Minute of Decision

This document contains information for the New Zealand Cabinet. It must be treated in confidence and handled in accordance with any security classification, or other endorsement. The information can only be released, including under the Official Information Act 1982, by persons with the appropriate authority.

Health and Disability System Review: Proposals for Reform

Portfolio Health

On 29 March 2021, following reference from the Cabinet Social Wellbeing Committee (SWC), Cabinet:

Background

- 1 **noted** that in June 2020, Cabinet accepted the case for change and general direction set out in the final report of the Health and Disability System Review, and agreed to establish a Transition Unit within the Department of the Prime Minister and Cabinet to advise on the government's response, with a Ministerial Group to oversee the response to the review [CAB-20-MIN-0269];
- 2 **noted** that in December 2020 Cabinet:
 - 2.1 noted the Minister of Health's initial view that high-level system design should broadly follow the Review's recommendations, but there were significant questions to be resolved about the detail of the functions of the new entities and relationships between them, and where recommendations could go further to achieve the goals of the reform;
 - 2.2 noted, subject to detailed reform proposals being brought, the Minister's intention to establish: a Māori Health Authority; Health New Zealand; and a public health agency;
 - 2.3 invited the Minister to bring detailed reform proposals to SWC in March 2021 [CAB-20-MIN-0519];
- 3 **noted** the proposals in the paper attached to CAB-21-SUB-0092 respond to the independent Health and Disability System Review Report, giving effect to the general direction of reform outlined in the Review report, and going further in a number of areas;
- 4 **noted** that the proposals for reform and their implementation are not expected to compromise the core business of health services, or the response to COVID-19, and the current operations and staffing of district health boards should continue during the transition with minimal disruption to services;

Disability support services

- 5 **noted** that Cabinet will receive separate advice on reform proposals relating to disability support services, the implementation of which shall be aligned with health system reform

- 6 **noted** that the Minister of Health and Minister for Disability Issues will bring advice on the future model and governance of disability support services to Cabinet in September 2021;

Reformed health system

- 7 **agreed** that the vision for the reformed health system will be based on pae ora/healthy futures for all people: where people live longer in good health, have improved quality of life, and there is equity between all groups;
- 8 **agreed** that the priority outcomes for the reformed health system will be:
- 8.1 partnership: ensuring partnership with Māori in decisions at all levels of the system, and empowering consumers of care to design services which work for them;
 - 8.2 equity: tackling the gap in access and health outcomes between different populations and areas of New Zealand;
 - 8.3 sustainability: embedding population health as the driver of preventing and reducing health need, and promoting efficient and effective care;
 - 8.4 person and whānau-centred care: empowering all people to manage their own health and wellbeing, have meaningful control over the services they receive, and treating people, their carers and whānau as experts in care;
 - 8.5 excellence: ensuring consistent, high-quality care in all areas, and harnessing innovation, digital and new technologies to continuously improve services;
- 9 **confirmed** the Ministry of Health's role as the chief steward of the health system and principal advisor to the Minister of Health;
- 10 **agreed** that the Minister of Health will issue a Government Policy Statement to set a multi-year national direction, including priorities and objectives for the health system, in line with the New Zealand Health Strategy;
- 11 **agreed** that the Ministry of Health will provide stewardship of Pacific health and disability through a dedicated Pacific-led policy capability that will:
- 11.1 advise Ministers, including the Minister for Pacific Peoples, on all aspects of Pacific health and disability policy;
 - 11.2 partner with the health and disability system, the Māori Health Authority, Pacific providers, the Ministry for Pacific Peoples and other government agencies to eliminate Pacific health inequities across the system;
 - 11.3 provide monitoring and support accountability for the system's performance in respect of Pacific health outcomes, to achieve the Pacific Aotearoa Lalanga Fou goals;
 - 11.4 manage the development of a national Pacific health strategy, that will also focus on developing a strong Pacific health workforce;
- 12 **agreed** that the Minister of Health will lead the development of a New Zealand Health Charter for the health system that will set out common values and principles to guide organisations and health and care workers;

Health New Zealand

- 13 **agreed** to establish a new Crown entity, provisionally called Health New Zealand, that will be the lead operational organisation for the public health system, within the parameters set by the Minister in national strategies and policies;
- 14 **agreed** that the Minister of Health will appoint all members to the Health New Zealand board;
- 15 **agreed** that all district health boards will be disestablished and their assets and liabilities vested in Health New Zealand;
- 16 **noted** that the Minister of Health intends that the internal organisation arrangements of Health New Zealand will include:
- 16.1 four regional divisions with regional commissioning boards within Health New Zealand, to be led by regional chief executives, to commission primary and community health services, in collaboration with the Māori Health Authority; and
- 16.2 hospital and specialist services consolidated into four regional networks, planned nationally by Health New Zealand and delivered through regional divisions to align with primary and community services;
- 17 **agreed** that Health New Zealand will be a Crown Agent, responsible to the Minister of Health, required to give effect to the Government Policy Statement (and other government policy as directed), and subject to the standard monitoring and accountability arrangements in the Crown Entities Act 2004;
- 18 **agreed** that in addition to the above powers, the Minister of Health will have more finely grained intervention powers, including the powers to:
- 18.1 replace one or more members of the Health New Zealand board;
- 18.2 appoint observers to any Health New Zealand-operated or contracted service;
- 18.3 require specified improvement actions of Health New Zealand;
- 19 **noted** that the Health New Zealand Board will appoint a chief executive, subject to the agreement of the Public Service Commissioner on terms and conditions
- 20 **agreed** that Health New Zealand will be responsible for the planning and commissioning of health services to achieve national outcomes and objectives;
- 21 **agreed** that Health New Zealand will have a duty to ensure that iwi/Māori partnership boards, representative of iwi in the areas covered by the board, exist and can contribute to the development of significant service plans, and co-design and jointly approve locality plans;
- 22 **agreed** that Health New Zealand will own and operate public hospitals on behalf of the Crown;
- 23 **agreed** that Health New Zealand will be required to publish at regular intervals, once agreed with the Minister, a New Zealand Health Plan, that responds to the direction and priorities set in the New Zealand Health Strategy and Government Policy Statement and sets out a long-term health service view and forms the basis for capital, digital, and workforce planning;

- 24 **agreed** that Health New Zealand will take lead operational responsibility to deliver equitable health outcomes for Pacific peoples, including to:
- 24.1 lead the development and implementation of a national Pacific health plan that delivers the outcomes set out in the Pacific health strategy;
 - 24.2 partner across the broader system to ensure delivery of Pacific health services are holistic and address all aspects of wellbeing;
 - 24.3 report to the Ministry of Health on how service delivery is eliminating Pacific health inequalities, who will share reporting with the Lalanga Fou Chief Executive Grouping;
- 25 **agreed** that relevant operational functions of the Ministry of Health will be transferred to Health New Zealand;
- 26 **noted** the intention of the Minister of Health to require Health New Zealand to agree arrangements for locality-based provision of primary and community services, initially through regional chief executives for the relevant region;

Māori Health Authority

- 27 **agreed** to establish a new statutory entity, provisionally called the Māori Health Authority, to lead hauora Māori in the health system, to work with the Ministry of Health on strategy and policy relating to hauora Māori, and to work with Health New Zealand on operational matters;
- 28 **agreed** that the Māori Health Authority should be independent of other health system organisations, and constituted in a way that gives effect to rangatiratanga and embeds the principle of partnership between Māori and the Crown;
- 29 **agreed** that the Transition Unit should take forward a process with iwi and the Māori health sector to design proposals for the constitution of the Māori Health Authority as a new entity, to be presented to Cabinet for agreement;
- 30 **agreed** the Chair of the Māori Health Authority will be appointed to the Health New Zealand Board, and may delegate the appointment to the Deputy Chair;
- 31 **agreed** that the Māori Health Authority will be a lead commissioner of kaupapa Māori health services and other services targeted for Māori;
- 32 **agreed in principle, subject to** the process of design with Māori health sector on the constitution of the Māori Health Authority, that the authority will:
- 32.1 act as a co-commissioner for other health services accessed by Māori, working jointly with Health New Zealand to approve commissioning plans and priorities;
 - 32.2 jointly develop national and regional strategies and service plans with Health New Zealand and will need to co-sign or approve before such plans or strategies come into effect;
 - 32.3 support iwi/Māori partnership boards to participate in service planning, and work to develop capability in the Boards for that purpose;

Public health

- 33 **noted** that the government's manifesto commitment included the creation of a public health agency that will more closely link the public health units;
- 34 **agreed** to establish the Public Health Agency as a distinct, branded unit within the Ministry of Health, to lead on all public health and population health policy, strategy, regulatory, intelligence, surveillance and monitoring functions;
- 35 **agreed** to establish a national public health service within Health New Zealand, which encompasses the 12 public health units and builds on the work led by Ministry of Health to provide more central coordination across public health units;
- 36 **noted** that the Director of Public Health will be based in the Public Health Agency within the Ministry of Health, and will provide direct leadership to the national public health service in Health New Zealand;
- 37 **agreed** that the Public Health Agency will develop technical specifications for public health programmes, and that Health New Zealand, together with the Māori Health Authority, will determine and commission services to deliver on these;
- 38 **agreed** to disestablish Te Hiringa Hauora/Health Promotion Agency as a separate Crown entity and to transfer its relevant functions to the Public Health Agency of the Ministry of Health and Health New Zealand;
- 39 **noted** that the Ministry of Health is developing advice on an Expert Advisory Committee for Public Health, which will be provided to Cabinet in due course;
- 40 **noted** that enhanced surveillance is critical to a strengthened public health system, and the Transition Unit, working with the Ministry of Health, will provide further advice on options to enhance the surveillance function, including on the appropriate location of these services within government structures;

Implementation and interim arrangements

- 41 **noted** that the approach to implementation will balance the health system's need for clarity and demonstrable early progress with a longer-term commitment to achieving lasting cultural change;
- 42 **noted** the intention to proceed to implement the reforms at pace, starting with a transitional phase of preparation, detailed functional design and wider stakeholder engagement over the period to late 2022;
- 43 **noted** that the Minister of Health has considered proposals for a more gradual approach to implementation but considers that the benefits of early clarity for the sector and risks of delay mean that this is not appropriate;
- 44 **agreed** to refocus the role of the Ministerial advisory committee, previously agreed by Cabinet [CAB-20-MIN-0269], to provide advice to Ministers in relation to the implementation of reforms;
- 45 **agreed** to establish interim organisations to undertake detailed planning, organisational design work, and consultation, especially with Māori;
- 46 **agreed** to establish an interim Health New Zealand as a departmental agency within the Ministry of Health;

- 47 **agreed** to allow the interim Health New Zealand to manage assets and liabilities in accordance with section 24(2)b of the Public Service Act 2020;
- 48 **agreed** to establish an interim Māori Health Authority as a departmental agency hosted by the Ministry of Health;
- 49 **agreed** to allow the interim Māori Health Authority to manage assets and liabilities in accordance with section 24(2)b of the Public Service Act 2020;
- 50 **noted** the intention of the Minister of Health to establish committees pursuant to section 11 of the New Zealand Public Health and Disability Act 2000 to advise Ministers on the establishment of the interim entities and their transition to the new system;
- 51 **noted** that staff and funding may be transferred from the Ministry of Health or district health boards to the interim entities as agreed by the relevant parties;

Implementing legislation

- 52 **noted** that many of the above decisions will require legislation, s9(2)(g)(i) [redacted]
- 53 **agreed** that implementing legislation place obligations on health sector entities in respect of the Treaty of Waitangi by including a Treaty of Waitangi clause following the standard modern form, that gives effect to the principles identified by the Waitangi Tribunal in its Hauora inquiry;
- 54 **authorised** the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office for legislation to give effect to the above proposals;

Funding

- 55 **noted** that a bid has been submitted for Budget 2021 to provide necessary funding to progress with implementation of proposals in the coming year;
- 56 **noted** that the proposals relating to interim arrangements are subject to funding being agreed through Budget 2021 for health reform;
- 57 **agreed** to establish a funding framework for health that provides greater budget certainty for the health system and the Crown;

s9(2)(f)(iv)

Next steps and reports to Cabinet

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

61

s9(2)(f)(iv)

62



Michael Webster
Secretary of the Cabinet

Proactively Released