DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of Hon Andrew Little, Minister of Health:

Health and Disability System Review – policy decisions for Pae Ora (Healthy Futures) Bill Departmental Report

The following documents have been included in this release:

Title of paper: Health and Disability System Review – policy decisions for Pae Ora (Healthy Futures) Bill Departmental Report (SWC-22-SUB-0006 refers)

Title of minute: Health and Disability System Review: Policy Decisions for Pae Ora (Healthy Futures) Bill Departmental Report (CAB-22-MIN-0021.01 refers)

Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant section of the Act that would apply has been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

Key to redaction code:

Section 9(2)(h), to maintain legal professional privilege

~~[In Confidence]~~

Office of the Minister of Health

Cabinet

Health and Disability System Review – policy decisions for Pae Ora (Healthy Futures) Bill Departmental Report

Proposal

1 This paper:

1.1 provides a summary of public submissions on the Pae Ora (Healthy Futures) Bill, which is currently being considered by the Pae Ora Legislation Committee; and

1.2 seeks agreement to a number of changes to the Bill that would be presented to the Committee in the departmental report on 14 February 2022.

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 Public submissions on the Pae Ora (Healthy Futures) Bill closed on 9 December 2021, with a total of 4,663 submissions received. Substantive submissions were largely in favour of the intent of the reforms, and a number of consistent themes were raised, many of which indicate potential amendments to the Bill. While I anticipate other minor changes not discussed, this paper covers the potential changes that require Cabinet decisions, specifically relating to the accountability of the Māori Health Authority and the role of iwi-Māori partnership boards.

Te Tiriti o Waitangi and health system principles

4 In particular, submissions and feedback during engagement with Māori have expressed concern that the Bill does not include an operative Tiriti o Waitangi clause. I do not recommend changing the novel approach Cabinet has taken to legislating for the Crown's Tiriti obligations and intend to undertake specific public communications on this issue when the Bill is reported back to the House by the Committee. This would form part of a broader communications strategy to raise awareness and help address any information gaps or misunderstandings about the hauora Māori settings in the Bill more generally.

5 The Cabinet Priorities Committee with Power to Act had previously agreed that the health system principles in the Bill would not apply to the Minister, but would consider whether there is a case to extend them in light of submissions [CPC-21-

MIN-0024 refers]. This was highlighted by a number of submitters, concerned that this does not reflect true partnership. As a result, I now recommend that the principles explicitly apply to the Minister.

Hauora Māori

6 Many submissions sought greater independence for the Māori Health Authority or called for more direct accountability to Māori, noting that the Hauora Māori Advisory Committee is not appointed by or representative of Māori. I agree that we should take an approach that strengthens the relationship between Māori and the Hauora Māori Advisory Committee, while ensuring that doing this does not undermine the Māori health leadership and stewardship role of the Māori Health Authority. It is also important that the relationship between the Minister, the Hauora Māori Advisory Committee and the Māori Health Authority appropriately reflects both accountabilities to Māori and the Minister's accountability to Parliament.

7 To strengthen its role in providing a Māori perspective on the exercise of key accountability functions, I propose the Hauora Māori Advisory Committee be appointed based on nominations from iwi-Māori partnership boards and other hauora Māori organisations. This would ensure that this committee is appointed by and for Māori, and reinforce partnership in key accountability functions in the new system.

8 Recognising the proposed new composition of this Committee, I recommend that the Minister of Health be required to consult with this Committee in exercising the particular statutory powers specified in the Bill, including in making appointments to the board of the Māori Health Authority. I have reflected on the current Bill's provisions in relation to the exercise by the Minister of other powers concerning the Māori Health Authority which require agreement between the Minister and the Hauora Māori Advisory Committee (i.e. powers to appoint a commissioner to replace the board, and to appoint a Crown observer). In my view, requiring agreement in these instances is inconsistent with the Minister's accountability to Parliament, and these powers should be subject to consultation only. This would entail a revision to previous Cabinet decisions.

9 Separately, I also propose to require the Minister of Health to consult the Minister for Māori Development and/or the Minister for Māori Crown Relations: Te Arawhiti when determining disputes between entities under the legislation.

10 In September, Cabinet noted my expectation that the Bill would need to provide specific functions for iwi-Māori partnership boards [CAB-21-MIN-0378 refers]. Engagement has confirmed a strong desire for Māori to play a meaningful role in the planning and design of local health services. To enable this, and to reflect the intended role of iwi-Māori partnership boards as a local vehicle for Māori to exercise tino rangatiratanga, I propose that the list of functions noted to Cabinet in September, including agreeing to priority outcomes within locality plans, is included in the departmental report. I have also recommended associated amendments to the locality provisions of the Bill to better connect iwi-Māori partnership boards to the locality planning process.

11 I also propose a clear and transparent statutory process for recognising iwi-Māori partnership boards in the Bill. This would involve the Māori Health Authority undertaking a recognition process using principles set out in the legislation, to advise the Minister of Health who would then recommend inclusion of those boards in a Schedule to the Act via an Order in Council. The process would ensure iwi-Māori partnership boards are truly representative of Māori within their area while providing Māori with the flexibility to take a tikanga-based approach to organising within their communities.

Intervention powers

12 Although not the subject of public submissions on the Bill, I have considered further the range of statutory powers available to Ministers to intervene where required in the health system. In addition to those existing and new powers previously noted by Cabinet [CAB-MIN-21-0378 refers], I recommend the addition of a further provision to the Bill to enable the Minister of Health to appoint a Crown Manager to act in place of the board of Health New Zealand for specified functions. This would allow Ministers to respond to dynamic and volatile situations in the Health system with greater direct influence, while allowing the board to remain in place and continue with their other responsibilities.

Statutory post-legislative review

13 As previously advised to Cabinet, I expect there will be a need for future legislation, following the Pae Ora Bill, to deal with related health regulatory matters that are not addressed in this Bill. This will be subject to future advice and Cabinet decisions. Additionally, to support ongoing review of the legislation in the medium-term, I recommend that the Bill include a provision to require a post-legislative review of the Act at least every five years. Such a review would provide an opportunity to consider how effectively the legislation has supported the aims of the reforms, including for instance in relation to te Tiriti obligations, the functions of entities and accountabilities to the Crown and to Māori.

Background

14 On 19 October 2021, Cabinet approved the Pae Ora (Healthy Futures) Bill for introduction, subject to the final approval of the government caucus and sufficient support in the House of Representatives [CPC-21-MIN-0024 refers].

15 The Bill is a key component in the reform of New Zealand's Health system, enabling fundamental change by:

15.1 establishing new health system entities (including Health New Zealand, the Māori Health Authority, and iwi-Māori partnership boards);

15.2 reforming existing structures and roles (such as a strengthened role for the Ministry of Health and the establishment of the Public Health Agency within the Ministry);

15.3 providing a new accountability framework for the system, including strategic and service planning documents and monitoring mechanisms, a New Zealand Health Charter to set common values and behaviours, and a Code of Consumer Participation.

15.4 providing for the Crown's intention to give effect to the principles of te Tiriti o Waitangi at all levels of the system.

16 The Bill was introduced to the House on 20 October 2021 and referred to the Pae Ora Legislation Committee following its first reading on 27 October. Written submissions opened on 28 October 2022 and closed on 9 December 2021. The Committee is due to complete oral hearings by 2 February 2022. The Committee is scheduled to report the Bill back to the House by 27 April 2022 and has requested that officials provide the Departmental Report by 14 February 2022.

Overview and key themes of public submissions

17 The Committee has received a total of 4,663 public submissions on the Bill. The vast majority were single issue or single sentence submissions from individuals opposed to reform. There were about 150 from organisations and a similar number of substantive individual submissions. A narrative summary of the key themes raised in submissions is attached at Appendix A.

18 The substantive submissions were largely in support of the overall intent of reform.

19 Opposing submissions raised opinions that have been expressed before, and I and other Ministers routinely address, for example:

19.1 The Māori Health Authority is separatist.

19.2 The new system will privilege Māori – health services should be based on need, not ethnicity.

19.3 Reform should not be undertaken during a pandemic.

20 Of the submitters in favour, but who recommended changes, the substantial issues raised were not new. Many submitters restricted themselves to matters of detail; the substantial issues were focused on the hauora Māori elements of the legislation and are discussed below.

Approach to legislating for Tiriti o Waitangi obligations

Existing provisions

21 In September, Cabinet adopted a novel approach to legislating for the Crown's Treaty obligations [CAB-21-MIN-0378 refers], by providing both:

21.1 **a set of specific provisions that aim to reflect Treaty obligations** in particular functions or processes (such as the role and functions of the Māori Health Authority) – these provisions are summarised in a **descriptive clause,** which places them in the context of the Crown's intention to give effect to Tiriti principles; and

21.2 a more comprehensive and flexible **requirement that health entities must be guided by a set of health system principles,** which aim to reflect key outcomes and behaviours contemplated by the WAI 2575

principles – any decision by health entities under the Act could be judicially reviewed against these principles.

22 This sought to respond to the strengths and weaknesses of previous approaches to Treaty provisions, where general operative clauses have not provided sufficient certainty or direction to decision makers[1], or where descriptive approaches alone have not been able to anticipate all of the instances where actions and decisions need to reflect Treaty principles.

23 By combining these two elements, the Bill seeks to provide practical recognition in specific processes (such as the co-production of the New Zealand Health Plan by Health New Zealand and the Māori Health Authority), and the flexibility and comprehensiveness of a principles-based obligation to cover situations where decision-making is not prescribed or is more discretionary (such as in the co-commissioning of health services by Health New Zealand and the Māori Health Authority). It also allows the Bill to include a single, coherent set of 'system principles' to achieve all of the desired system shifts we have previously identified (including meeting Treaty obligations and achieving equity for Māori).

24 This approach reflects the idea that the form and nature of Treaty clauses should be tailored to the particular context in which they will be used (i.e., the authority or activities being exercised or regulated under legislation).

25 In addition, and despite the approach taken above, a significant number of submissions from Māori and feedback during recent engagement by the interim Māori Health Authority express concern that the Bill does not include a general operative clause or a legal obligation based on specific Treaty principles. In some cases, this is considered inconsistent with the inclusion of an operative Treaty clause in the Natural and Built Environments Bill[2].

26 I also note that a number of recent court decisions may be contributing to a view that the fastest way to advance the Crown-Māori relationship is through the courts.

Proposed approach

27 The submissions have not raised any substantive issues that were not previously considered in my advice on the approach to the Treaty in the Bill, but do reinforce the importance of the Tiriti clause to Māori. On balance, I do not consider that a general operative clause will improve either certainty or outcomes for Māori in the system. While such clauses may still be relevant in other contexts (such as for environmental regulation, where devolved decisions about resource use and environmental effects are made within a comprehensive judicial fabric), I consider they are less valuable in a health context, where choices about need and entitlement to public services are often more subjective and dependent on wider fiscal policy.

[1] General operative clauses impose broad obligations on statutory actors in terms of **how** functions and powers are exercised, such as in section 4 of the Conservation Act, which requires that "*This Act shall be so interpreted and administered as to give effect to the principles of the Treaty of Waitangi*"

[2] Clause 6 of the exposure draft provides that "All persons exercising and performing functions and duties under this Act must give effect to the principles of te Tiriti o Waitangi".

28 In the Pae Ora context, it is simpler and more powerful to legislate for one set of guiding statutory principles rather than having competing sets of principles whose relative standing may be unclear. The core concepts of te Tiriti principles are captured in the health principles and reinforced by the descriptive Treaty clause. This combination will provide for accountability through the courts to an appropriate extent having regard to relative institutional competence.

29 Adding an operative clause to the current approach would likely create significant uncertainty by requiring Health entities to consider and weigh different sets of principles: the Treaty principles on one hand, and the health system principles on the other (which already aim to reflect outcomes and behaviours consistent with the Treaty principles in a health context). With a substantive legal weighting (such as 'give effect to'), it would also increase the likelihood of the Court substituting its own decision for that of Health New Zealand or the Māori Health Authority on specific choices about service design or delivery.

30 I remain of the view that, having established Health New Zealand and the Māori Health Authority to make better choices on such matters, the system needs to support those organisations to do so, and I do not think a clause that promotes merits-based appeals to the courts will achieve this.

31 At the same time as approving the general approach to the Treaty provisions, Cabinet also:

31.1 **authorised** the Minister of Health, in consultation with the Attorney-General, Hon Kiri Allan, and Crown Law, to give consideration to how to give effect to the principle of rangatiratanga in the Bill [CPC-21-MIN-0024 refers].

32 As requested, the Attorney-General, Hon Kiri Allan and I have further considered how the Bill could refer to and gives effect to rangatiratanga. In the context of the approach to the Treaty outlined above, the Bill strikes a careful balance between kāwanatanga and rangatiratanga. Although jurisprudence on Treaty clauses is inevitably maturing, and Government will have at some point to consider how kāwanatanga and rangatiratanga are explicitly and appropriately reflected in legislation, I am not convinced that an explicit reference to rangatiratanga in the legislation would have a material impact on decisions made under the Bill, while at the same time it could create undue risk in how the Bill would be interpreted by the Courts. On balance, I do not propose changing the current drafting as a result.

33 While I am confident that the novel approach Cabinet has adopted to the Treaty is fitting for the Pae Ora context, I expect views on this issue to continue to evolve over time. I anticipate that this would be amongst the matters than may be considered directly in a post-legislative review of the Act in the future, as proposed at paragraphs 86-87 below.

Specific public communications

34 Given what seems to be significant misconceptions about what the health system principles will deliver in relation to Te Tiriti and hauora Māori more generally, I intend to undertake specific public communications on this issue when the Bill is

reported back to the House by the Committee. Such communications are likely to emphasise that:

34.1 approaches to Treaty provisions should not be one-size-fits-all, but reflect the particular context in which they apply

34.2 in the Pae Ora Bill, the Crown has sought to take a very practical and clear approach to Treaty obligations by providing for the Māori voice at all levels of the system;

34.3 it is the combined effect of those specific provisions (such as the role of the Māori Health Authority) **and** the health system principles that provide for the Crown's Treaty obligations;

34.4 the system principles aim to reflect the outcomes and behaviours that are required by the Treaty principles in the health context, and, like for an operative Treaty clause, all decisions made by health entities under the Act can be judicially reviewed against those principles.

35 These points will form part of a broader communications strategy on the hauora Māori aspects of the Bill more generally, which will be designed to raise awareness and help address any information gaps or misunderstandings about these settings.

Applicability of the health system principles to the Minister of Health

36 In October when approving the Bill for introduction, the Cabinet Priorities Committee with Power to Act agreed that the health system principles should not apply explicitly to the Minister of Health, but would consider whether there is a case to extend them in light of submissions to the Pae Ora Legislation Committee [CPC-21-MIN-0024 refers].

37 Submitters expressed a view that the principles should apply to the Minister in exercising their powers under the Bill. There was a strong perception from Māori that by not having the principles apply to the Minister, the Crown is exempting itself from true partnership.

38 As drafted, the Bill already incorporates elements of the principles that specifically relate to where the Minister exercises powers under the Bill. As an example, when issuing the Government Policy Statement (GPS) there are specific requirements on the Minister such as consulting with the Māori Health Authority and having regard to their views. The Minister also cannot issue a GPS that does not include the government's priorities in relation to Māori – specifically, priorities for improving health outcomes for Māori and engaging with Māori. In practice, any Minister would consider the principles when exercising their powers under the Bill because they reflect the purpose of the Bill and the health system reforms.

39 s9(2)(h) [redacted]

40 s9(2)(h) [redacted]

[redacted]

[redacted]

Accountability of the Māori Health Authority

43 In September, Cabinet also made specific decisions about the institutional accountability of the Māori Health Authority [CAB-21-MIN-0378 refers]. We have attempted to balance the Authority's accountability to both Parliament and Māori by applying the fundamental mechanisms of the Crown Entities Act 2004, and providing for the appointment of a Hauora Māori Advisory Committee to advise on the exercise of those mechanisms.

44 The Hauora Māori Advisory Committee has a much narrower role than the Māori Health Authority itself, and has been designed to provide a mechanism for partnership with Māori in the exercise of key Ministerial functions and powers. Accordingly, the Bill currently requires that the Minister of Health:

44.1 **consult** the Hauora Māori Advisory Committee:

a) on specific appointments to the board of the Māori Health Authority and removals;

b) when issuing directions or letters of expectation to the Authority; and

c) when engaging with the Authority's proposed Statements of Intent or Performance Expectations; and

44.2 **obtain the agreement of** the Hauora Māori Advisory Committee when exercising powers to:

a) replacing the board of the Authority with a Commissioner; or

b) appointing a Crown observer.

45 A number of submitters sought greater independence for the Māori Health Authority or more direct accountability to Māori. These submitters tended to question how Treaty-consistent it is for the Minister to retain the determinative role in appointments to the Māori Health Authority board, or whether the Hauora Māori Advisory Committee can achieve its purpose of representing Māori in these processes when its members are appointed by a Minister of the Crown. Significant, specific proposals put forward include:

45.1 replacing the Hauora Māori Advisory Committee with a broader 'taumata' determined directly by Māori;

45.2 strengthening the influence of the Hauora Māori Advisory Committee over appointments; or

45.3 allowing Māori Health Authority board appointments to be made (at least partly) by 'selection' clusters of iwi and Māori interest groups around the country, as is the case for Te Mātāwai.

46 I do not consider that a large number of people involved in a permanent taumata will necessarily improve accountability, and I consider that it could limit the timely exercise of these functions. Nor do I consider that an agency with the significant and varied functions and statutory roles of the Māori Health Authority, for which the Minister is accountable to Parliament, should have its members appointed via a joint decision-making process, as this would be inconsistent with the Minister's responsibility to Parliament which only the Minister can discharge.

47 However, I do accept that an entity as significant as the Māori Health Authority should have a more partnership-based approach to its fundamental accountability settings. For this reason, I propose that we provide a mechanism for iwi-Māori partnership boards and health specific Māori organisations to appoint the members of the Hauora Māori Advisory Committee.

48 This would ensure that an entity appointed by Māori and for Māori is involved in the key accountability functions discussed above, leaving no doubt as to our intention to give effect to Tiriti partnership at the highest level of the system. As discussed below, the Māori Health Authority will undertake a formal recognition process of iwi-Māori partnership boards. Recognised IMPBs will provide a strong building block for this appointment process.

49 I propose that:

49.1 There will be a maximum of eight seats on the Committee, with six appointable by iwi-Māori partnership boards and two appointable by relevant hauora Māori/pan-Māori leadership organisations;

49.2 Members of the Committee are appointed once they are notified to the Minister of Health in writing by all of the Chairs of recognised iwi-Māori partnership boards; and

49.3 Where no appointment is made (or where fewer than six are made by the collective chairs), the Minister can choose to appoint someone to that seat or leave it open.

50 Iwi-Māori partnership boards will be recognised by a statutory process following enactment of the Bill. In order to allow time for this process, the Bill would provide that appointments to the Committee can only be made from two years after enactment. This would align with other implementation phases in the reforms and ensure the Committee is in place at year three.

51 In the interim phase, the Bill would provide for the Minister to appoint an interim Committee to consult on Ministerial decisions as required, following appropriate consultation and engagement including with the Minister for Māori Development and the Minister for Māori Crown Relations: Te Arawhiti.

52 In light of this change to the appointment of members of the Committee, I no longer consider it necessary for the Minister to obtain the agreement of the Committee on the exercise of the specific powers referred to in paragraph 44.2 above. I recommend that this be amended so that the Minister is required to consult with the Committee, in line with the approach to other powers.

53 It will be critical that the Minister has an open and respectful relationship with the Advisory Committee, and that there is transparency to Māori and the wider public over the advice received and the Minister's ultimate responsibility for decision-making. I therefore recommend a further provision in the Bill: that the Minister be required to set out where he or she has not followed the advice of the Hauora Māori Advisory Committee in exercising a relevant power, whether in whole or in part. The Minister is required to balance many matters when making decisions of this sort, and may not be able to always follow the advice of the Committee (or any other source of advice). Being clear on when this occurs should support more open decision-making and reduce grounds for concern that the Minister's consultation with the Committee is merely perfunctory.

54 If agreed, public communications on this could be part of the broader communications strategy noted above. I consider this approach to go some way to addressing accountability concerns raised by many submitters.

55 Given the limited time in which to make this change, I propose that officials put forward the specific approach in the Departmental Report, and report to me on the Select Committee's consideration of this issue. I would then proactively communicate the approach to the public when the Bill is reported back to the House in late April.

56 Should there be substantial concern amongst Māori about the approach, we would still be able to change the approach via Supplementary Order Paper.

Dispute resolution process

57 A number of submissions raised concerns with the dispute resolution process where Health New Zealand and the Māori Health Authority cannot agree on a matter on which they are required to work together. I anticipate an internal escalation process, whereby disagreements between the MHA and Health NZ are escalated first to the regional level (if they occur at the local level, for instance in relation to locality plans), and then the national level, before a dispute is raised formally with the Minister. In practice, I expect very few disputes to arise that necessitate the full pathway of escalation.

58 Where disputes do arise, current drafting provides that if their chief executives are unable to resolve the dispute between themselves, it must be referred to the Minister of Health. The Minister may determine the dispute or a process to resolve the dispute, the outcomes of which the parties must comply with. This process will be extended to include decisions made with IMPBs about the agreement of locality plans, if Cabinet confirms this as a function of IMPBs.

59 Some submitters have challenged the appropriateness of the Minister making final decisions on disputes unilaterally, and the risk that this may undermine partnership and Treaty principles. I recognise the risk here and accordingly I have directed officials to recommend that the Minister be required to consult the Minister for Māori Development and/or the Minister for Māori Crown Relations: Te Arawhiti before determining a dispute. This would work to provide a form of check on the Minister's powers and allay some of the concerns expressed by submitters, while maintaining a clear final arbiter to ensure the smooth operation of the system and incentivise collaboration between Health New Zealand and the Māori Health Authority (and the iwi-Māori partnership boards).

Iwi-Māori partnership boards: powers and functions

60 In September, Cabinet noted my expectation that the Pae Ora Bill would need to specifically provide for IMPBs to perform the following functions:

60.1 engaging with whānau and hapū about local health needs, and sharing the resulting insights and perspectives with Health New Zealand, the Māori Health Authority, and others;

60.2 assessing and evaluating the current state of hauora Māori in their locality or localities, and determining priorities for improving hauora Māori;

60.3 agreeing local priorities and locality plans with Health New Zealand and the Māori Health Authority (these plans will highlight local health priorities, and set out the localised approach to health service provision, taking into account community preferences for service design and delivery);

60.4 monitoring the performance of the health system in their localities, including against the locality plan;

60.5 engaging with the Māori Health Authority to support its stewardship of hauora Māori and its priorities for kaupapa Māori investment and innovation; and

60.6 reporting on their activities to whānau and hapori Māori, and other relevant partners [CAB-21-MIN-0378 refers].

61 If changes to the appointment process for the Hauora Māori Advisory Committee are agreed, the role of IMPBs in this process will need to be added to their list of functions.

62 At the same time, Cabinet asked the interim Māori Health Authority Board to lead an engagement process that would test and refine these functions for us to consider before including them in the Bill. The Board undertook comprehensive engagement on this issue between mid-November and late December, convening hui with a wide range of iwi/Māori participants (including Māori health providers) orientated around the existing Māori Relationship Board areas.

63 This engagement has confirmed a profound desire by Māori to play a more meaningful role in the planning and design of local health services. In particular, the engagement highlighted:

63.1 the importance Māori communities are placing on IMPBs as a complement to the Māori Health Authority, which, by nature and function, cannot provide a meaningful expression of rangatiratanga at the local level;

63.2 the way IMPBs provide an important counterpoint to concerns about 'centralisation' – this mechanism is a critical aspect of the distributed nature of the new system; and

63.3 the breadth and depth of expertise that is 'ready to go' in Māori communities in relation to these functions (several hui highlighted well developed views about local service preferences and priorities).

64 If anything, engagement has suggested a desire for a deeper role in some areas, such as direct commissioning by IMPBs, engagement with social sector agencies to discuss the wider determinants of health, and involvement in workforce development.

65 Delegation of commissioning functions is already possible under the Bill, but would depend significantly on the circumstances and capabilities present in a particular area. Similarly, engagement with the wider social sector and workforce development will be key functions of the Māori Health Authority at a national and regional level, and I expect IMPB views on these, and wider issues such as hospital and specialist service priorities, to be articulated through their relationship with the Authority. For these reasons, I do not propose to expand the functions in response to these points. The proposed list of functions is not limiting, meaning IMPBs would be able to undertake additional activities according to local preferences and requirements (for example, engaging with social sector agencies). A more expansive list of functions would likely become an exclusive list and limiting the potential for innovation by IMPBs.

66 However, put simply, this engagement and submissions from Māori confirm that the functions I discussed in September represent the 'minimum' level of local Māori participation necessary to secure a good level of support within the Māori

community for the Pae Ora Bill, and I strongly recommend Cabinet approve them for proposal in the Departmental Report.

Associated amendments to locality provisions

67 The above engagement and submissions have also highlighted a small number of instances where changes to the Bill are necessary to meet the intentions of the reforms by connecting IMPBs and the locality planning process to the wider system. I have agreed officials should recommend changes to the Bill to ensure:

67.1 Health New Zealand and the Māori Health Authority consult both established IMPBs and relevant Māori organisations[3] when determining localities. IMPBs are interested in the scale and geographical coverage of localities as this will impact their ability to adequately understand and represent Māori views and aspirations and feed into locality planning processes in those areas;

67.2 Health New Zealand and the Māori Health Authority have regard to the priorities and preferences expressed in approved locality plans when drafting subsequent versions of the New Zealand Health Plan (to ensure that the local perspective informs national and regional service planning and therefore commissioning);

67.3 IMPBs are engaged in the preparation of locality plans (to enable a genuinely collaborative process for determining local priorities and preferences); and

67.4 agreeing locality plans are within the scope of the dispute resolution process in the Bill (albeit driven by an expectation of consensus in the first instance).

Iwi-Māori partnership boards: constitution and representation

68 Engagement has also highlighted the importance of IMPBs being able to represent the views of the entire Māori community in their proposed areas, including mātāwaka and other entities that play a significant role in health services, such as Urban Māori Authorities (where relevant) or Māori Health Providers. The existing Māori Relationship Boards that work with DHBs do not consistently provide for this perspective.

69 The current Bill provisions name existing Boards in a schedule, providing them with IMPB functions and powers for the purpose of the legislation at enactment. This approach assumed that key parties to the existing boards would be able to develop a 'representative' structure prior to the Bill coming into force.

70 Several prospective boards are making good progress on establishment plans, with iwi/hapū representatives from existing boards leading the conversation, supported by the Transition Unit and the Ministry of Health. However, many are yet to specifically engage the full Māori community in their proposed area, and a

[3] 'Relevant Māori organisations' are defined for the purpose of Māori Health Authority engagement with Māori as 'Māori organisations that the Māori Health Authority considers relevant for the purpose of the engagement (clause 20 of the Pae Ora (Healthy Futures) Bill).

number are unlikely to have meaningfully engaged and resolved representation issues in time for them to be directly established in the Bill.

71 For this reason, I consider it important to provide space for a Māori-led, tikanga-based process for determining the constitution and governance structures of IMPBs. At the same time, I am mindful that the Crown is obliged to actively protect the interests of all Māori in having their views represented, and of the need for certainty under the legislation about who is exercising the functions of IMPBs in particular areas.

An amended process for confirming iwi-Māori partnership boards

72 As such, I propose a clear and transparent statutory process, whereby:

72.1 prospective IMPBs will make establishment proposals (after 1 July 2022) to the Māori Health Authority setting out what engagement they have undertaken, how they will be constituted and governed, and how they will continue to represent Māori in their areas;

72.2 the Māori Health Authority will assess these proposals against statutory principles that aim to provide for some essential features of IMPBs while leaving flexibility for a tikanga-based approach; and

72.3 when satisfied with proposals, the Māori Health Authority will recommend to the Minister that an IMPB be established; and

72.4 the Minister of Health must then recommend that the entity be added to a Schedule of the legislation by Order in Council (the same process would be used for subsequent variations, as anticipated in the current Bill).

73 I recommend that the principles against which proposals are assessed should ensure that:

73.1 the person or group making the proposal has taken all reasonable steps to engage with relevant Māori communities and groups, including all relevant iwi, mātāwaka, Urban Māori Authorities, and Māori health providers;

73.2 the constitution and governance arrangements for the IMPB will ensure:

a) the IMPB will be engaged with and can represent the views of Māori communities and groups in the area about hauora Māori;

b) Māori communities and groups in the proposed area will be able to hold the IMPB accountable; and

c) the IMPB has the capacity and capability to fulfil its functions.

73.3 the area proposed for coverage by an IMPB will best allow the IMPB to efficiently fulfil its purpose and functions (the Bill will still provide that there may only be one IMPB for any area).

74 If the Māori Health Authority no longer considers that an IMPB meets these requirements, the Bill will allow for the Authority to recommend to the Minister

that the IMPB be removed from the Schedule. The Minister would then have the discretion to recommend this occur by Order in Council.

75 These principles aim to ensure representativeness for IMPBs while leaving flexibility and discretion for Māori to adopt a tikanga-based approach to the constitution of the boards in local areas. I consider this broadly consistent with the approach being taken to Māori representation in the governance and accountability arrangements for Water Service Entities in Three Waters Reform, and that being explored for joint committees on combined plans under Resource Management reform.

76 It is important to note that I do not expect boards to include individual representatives of all relevant Māori communities, groups, or entities. Rather, the essential feature is that the constitution and governance arrangements allow them to understand and represent all relevant views. This will ensure the boards do not become unwieldy and minimise conflict of interest risk for Māori providers. The 'area' principle is necessary because IMPBs cannot operate at such a small scale that their role in the system becomes impossible to sustain.

77 Inevitably, such a process creates the possibility that the Māori Health Authority's decisions will be judicially reviewed – in some places, no representation approach will please everybody. However, I consider the possibility of such review to be a fundamental part of the Authority's accountability to Māori, and I consider that the flexibility of the above approach will allow the Māori Health Authority to hold constructive conversations with Māori communities on these matters.

78 The interim Māori Health Authority (and formal Māori Health Authority once established) will support prospective boards to develop their establishment plans, including by providing operational guidance about meeting the above principles (many of the boards may be ready to submit their proposals soon after 1 July).

79 If an IMPB is not established in an area after the two-year period, or if there is a gap in the future, the wider obligations to engage with Māori contained in the Bill will still apply to decisions impacting Māori in that area. This includes the obligation on the Māori Health Authority to engage with Māori more broadly, and the engagement requirements contained in the principles that apply to both the Māori Health Authority and Health New Zealand at the locality level. This will ensure that partnership requirements are fulfilled in the absence of a confirmed IMPB, if that is necessary for a period.

Communicating this approach

80 These amendments may be the focus of some debate at Select Committee, but would not be made public until the Bill is reported back to the House at the end of April. I intend to emphasise these proposals in the broader public communications about Treaty/Māori aspects of the Bill at this time.

Intervention powers

81 Although it was not raised in submissions, I have further considered the intervention powers available to Ministers. Cabinet has previously noted the

statutory intervention framework which provides for a range of powers that enable an escalation pathway, allowing Ministers to appoint a Crown Observer alongside a board or executive, appoint a Commissioner in place of the board, require a Performance Improvement Plan, or direct the entity (under the Crown Entities Act 2004) [CAB-21-MIN-0378 refers]. The Hauora Māori Advisory Committee must be consulted on the exercise of these powers where they relate to the Māori Health Authority.

82 These statutory powers, together with wider non-statutory levers, provide a robust escalation pathway that will allow Ministers significant additional flexibility for responding to system issues. However, they may be less well suited to respond to a dynamic and volatile situation in the system, where additional Ministerial control may be warranted for a period of time, but which do not justify the replacement of the entire board. To respond to risks to the Crown in these circumstances, it may be prudent for Ministers to be able to exercise greater involvement in board-level decision-making, beyond that which would be achievable through a Crown Observer or via non-statutory means.

83 I therefore propose the addition of a further power to enable the Minister of Health to appoint a Crown Manager to act in place of the board of Health New Zealand in relation to specified functions. The functions specified could be broad (e.g. financial management) or more narrowly defined (e.g. a specific purchasing decision) and would be in place for a defined period of time. This would not require any change to appointments to the board, and their other functions would continue unaffected.

84 These powers already exist in in the tertiary education sector (historically for all polytechnics and now for Te Pūkenga, the national polytechnic), in the schooling sector (where it is called a Limited Statutory Manager), in the infrastructure sector where it manages risk in Special Purpose Vehicles, and in local government where it can be used to intervene in local authorities.[4]

85 As with other statutory intervention powers, it is not my intention that these would be used regularly; and ideally, there would not be case to deploy a Crown Manager at all. Non-statutory and relationship-based approaches should continue to be the default to responding to risk and issues in the system. However, this addition would provide the Minister of the day with a further option that is not currently available and would be an effective backstop if required. It allows for a flexible, direct course of action that would allow the board to remain in place and continue with other duties.

86 I do not propose that these additional powers extend to the Māori Health Authority, but that they relate only to the board of Health New Zealand. In my view, the Ministerial appointment of a Crown Manager over the Māori Health Authority would not be in keeping with the balance of accountabilities to the Crown and to Māori, and is likely to be considered Ministerial over-reach. This would also appear to contradict the other steps in this paper to strengthen accountability to Māori across the system. Moreover, I expect Health New Zealand to hold the significant majority of the total health budget, and such

[4] Sections 180 and 334 of the Education and Training Act 2020, section 258D of the Local Government Act 2002, and s 126 of the Infrastructure Funding and Financing Act 2020 refer.

powers should be proportionate to where system risks are more likely to be encountered.

87 Introducing these additional powers at this stage of the Bill process may provoke questions on whether Government is seeking to change the relationship of the Minister with the Health New Zealand. I would note the intention to use the powers only where essential, and reflect on the prudence of ensuring sufficient ability to intervene in the context of creating the largest public entity in New Zealand history.

Post-legislative review

88 As previously advised to Cabinet, I expect that following the Pae Ora Bill there will be a need for further legislation in the near future to address other regulatory and legislative matters that are relevant to our health reforms but which are not included in this Bill. Moreover, in a complex and dynamic environment like the health system, it is likely that further legislative changes will be identified through experience and the implementation of reform. Any subsequent Bills will be subject to Cabinet approval in due course.

89 In order to ensure that the legislation in the Pae Ora Bill remains relevant, appropriate and effective in supporting the health reforms over time, it will be necessary to undertake regular reviews. I recommend that the Bill be reviewed at least every five years, and that a provision be included in the Bill to require the Minister to undertake this. This would be line with similar provisions in other legislation, including the Intelligence and Security Act 2017. This timeframe would allow for a comprehensive review after a few years' operation of the reformed system, to allow new entities, systems and processes to bed in sufficiently. This would provide an opportunity to review the mechanisms of the Bill which are intended to give effect to te Tiriti obligations and principles, hauora Māori settings, and other key provisions.

Impact analysis

Financial implications

90 There are no financial implications arising from this paper. An operational budget for the Māori Health Authority was approved in Budget 21 and the role of the MHA discussed in paragraphs 57 above can be performed within that budget.

91 Some funding for the basic meeting and secretariat costs for iwi-Māori partnership boards was also provided in Budget 21, while a separate bid was submitted for Budget 22 to fund the policy, data, and engagement capabilities IMPBs will need to perform the specific functions referenced in Cabinet decisions in September [CAB-21-MIN-0378 refers].

Legislative implications

92 Should Cabinet approve the recommendations in this report, changes to the Bill will be proposed in the Departmental Report on the Pae Ora Bill, currently before the Pae Ora Legislation Select Committee. The Committee is due to report the Bill back to the House by 27 April 2022.

Regulatory impact statement

93 Treasury's Regulatory Impact Analysis team has determined that these changes to the Pae Ora (Healthy Futures) Bill are exempt from the requirement to provide a Regulatory Impact Statement on the grounds that they have no or only minor impacts on businesses, individuals, and not-for-profit entities.

Population implications

94 The changes proposed in this paper are expected to marginally enhance the significant positive implications for hauora Māori discussed in Cabinet policy decisions on Health and Disability reform in September 2021 [CAB-21-MIN-0378 refers.

Human Rights

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

Consultation

96 The Ministry of Health, the Treasury, the Public Service Commission, Te Arawhiti, Te Puni Kōkiri, and Crown Law have been consulted on this paper. Their comments are reflected in this paper. The Department of Prime Minister and Cabinet has been informed.

Communications

97 The announcement of the new health and disability system operating model on 21 April 2021 covered the Government's key objectives and reforms as further described in this paper. As noted in paragraphs 34-35 above, I am developing a communications strategy on the hauora Māori settings in the Pae Ora Bill to raise public awareness and help to address any information gaps or misunderstandings about this aspect of the reforms.

Proactive Release

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

Recommendations

The Minister of Health recommends that the Committee:

1. **note** the narrative summary of public submissions on the Pae Ora Bill attached to this paper;

2. **note** that a communications strategy is being developed to address public concern regarding hauora Māori settings in the Pae Ora Bill, including Cabinet's novel approach to Te Tiriti o Waitangi;

3. **note** that when approving the Bill for introduction, the Cabinet Priorities Committee with Power to Act agreed that the health system principles should not

apply explicitly to the Minister of Health, but would consider whether there is a case to extend them in light of submissions to the Pae Ora Legislation Committee [CPC-21-MIN-0024 refers];

4. **note** that public submissions have called for the Minister of Health to be guided by the health system principles;

5. **agree** that officials recommend in the departmental report to the Pae Ora Legislation Committee that the health system principles explicitly apply to the Minister of Health;

6. **note** that supportive public submissions on the Pae Ora Bill have called for the Māori Health Authority to have more direct accountability to Māori and that this can be achieved by providing a mechanism for Māori to appoint the Hauora Māori Advisory Committee;

7. **agree** that officials recommend in the departmental report to the Pae Ora Legislation Committee that the process for appointments to the Hauora Māori Advisory Committee in the Pae Ora Bill be amended to provide that:

    7.1. There will be a maximum of eight seats on the Committee, with six appointable by iwi-Māori partnership boards and two appointable by relevant hauora Māori/pan Māori leadership organisations;

    7.2. Members of the Committee are appointed once they are notified to the Minister of Health in writing by all of the Chairs of recognised iwi-Māori partnership boards; and

    7.3. Where no appointment is made (or where fewer than eight are made by the collective chairs), the Minister of Health can choose to appoint someone to that seat or leave it open

8. **agree** to rescind Cabinet's decisions at paragraphs 45 and 47 in CAB-21-MIN-0378 and that officials recommend in the departmental report to the Pae Ora Legislation Committee that the Minister of Health consult the Hauora Māori Advisory Committee on the exercise of all key accountability functions;

9. **agree** that officials recommend in the departmental report to the Pae Ora Legislation Committee that the Minister be required to publish where he or she has determined to not follow the advice of the Hauora Māori Advisory Committee in exercising a relevant power;

10. **note** that I have directed officials to recommend in the departmental report to the Pae Ora Legislation Committee that the Minister of Health be required to consult the Minister for Māori Development and/or the Minister for Māori Crown Relations: Te Arawhiti before determining a dispute;

11. **note** that the interim Māori Health Authority has undertaken engagement with Māori on the powers and functions of iwi-Māori partnership boards, and this has confirmed a strong desire for Māori to play a meaningful role in the planning and design of local health services;

12. **agree** that officials recommend in the departmental report to the Pae Ora Legislation Committee that the functions of iwi-Māori partnership boards replicate those noted in CAB-21-MIN-0378, specifically:

    12.1. engaging with whānau and hapū about local health needs, and sharing the resulting insights and perspectives with Health New Zealand, the Māori Health Authority, and others;

    12.2. assessing and evaluating the current state of hauora Māori in their locality or localities, and determining priorities for improving hauora Māori;

    12.3. agreeing local priorities and locality plans with Health New Zealand- and the Māori Health Authority (these plans will highlight local health priorities, and set out the localised approach to health service provision, taking into account community preferences for service design and delivery);

    12.4. monitoring the performance of the health system in their localities, including against the locality plan;

    12.5. engaging with the Māori Health Authority to support its stewardship of hauora Māori and its priorities for kaupapa Māori investment and innovation; and

    12.6. reporting on their activities to whānau and hapori Māori, and other relevant partners.

13. **agree** that officials recommend in the departmental report to the Pae Ora Legislation Committee that iwi-Māori partnership boards, where recognised in the Schedule to the Act, also have a function to appoint members of the Hauora Māori Advisory Committee;

14. **note** that officials will recommend amendments to the locality provisions in the Pae Ora Bill to better connect iwi-Māori partnership boards and the locality planning process to the wider system in the departmental report to the Pae Ora Legislation Committee;

15. **agree** that officials recommend a tikanga-based process to recognise iwi-Māori partnership boards against a set of representativeness principles in the departmental report to the Pae Ora Legislation Committee;

16. **note** that this process will be led by the Māori Health Authority, on whose advice the Minister will recommend the inclusion of iwi-Māori partnership boards in a Schedule to the Act;

17. **note** that an iwi-Māori partnership board may be removed from the Schedule to the Act via the same process, subject to the advice of the Māori Health Authority;

18. **agree** that officials recommend in the departmental report to the Pae Ora Legislation Committee that the Bill include the power for the Minister of Health to appoint a Crown Manager to act in place of the board of Health New Zealand in relation to specified functions;

19. **agree** that that officials recommend in the departmental report to the Pae Ora Legislation Committee that the Bill include a provision to require a review of the legislation at least every five years.

Authorised for lodgement

Hon Andrew Little

Minister of Health

Cabinet

Minute of Decision

Health and Disability System Review: Policy Decisions for Pae Ora (Healthy Futures) Bill Departmental Report

Portfolio **Health**

On 14 February 2022, following reference from the Cabinet Social Wellbeing Committee, Cabinet:

1 **noted** the summary of public submissions on the Pae Ora (Healthy Futures) Bill (the Bill), attached to the paper under SWC-22-SUB-0006;

2 **noted** that a communications strategy is being developed to address public concern regarding hauora Māori settings in the Bill, including Cabinet's novel approach to Te Tiriti o Waitangi;

Health system principles

3 **noted** that on 19 October 2021, when approving the Bill for introduction, the Cabinet Priorities Committee agreed that the health system principles should not apply explicitly to the Minister of Health, but would consider whether there is a case to extend them in light of submissions to the Pae Ora Legislation Committee [CPC-21-MIN-0024];

4 **noted** that public submissions have called for the Minister of Health to be guided by the health system principles;

5 **agreed** that officials recommend in the departmental report to the Pae Ora Legislation Committee (the departmental report) that the health system principles explicitly apply to the Minister of Health;

Hauora Māori Advisory Committee

6 **noted** that supportive public submissions on the Bill have called for the Māori Health Authority to have more direct accountability to Māori, and that this can be achieved by providing a mechanism for Māori to appoint the Hauora Māori Advisory Committee;

7 **agreed** that officials recommend in the departmental report that the process for appointments to the Hauora Māori Advisory Committee in the Bill be amended to provide that:

7.1 there will be a maximum of eight seats on the Committee, with six appointable by iwi-Māori partnership boards and two appointable by relevant hauora Māori/pan Māori leadership organisations;

7.2 members of the Committee are appointed once they are notified to the Minister of Health in writing by all of the Chairs of recognised iwi-Māori partnership boards or relevant hauora Māori/pan Māori leadership organisations;

7.3 where no appointment is made (or where fewer than six are made by the collective chairs), the Minister of Health can choose to appoint someone to that seat or leave it open;

Minister of Health's exercise of power

8 **noted** that in September 2021, Cabinet agreed that the Minister of Health may determine the exercise of power:

8.1 to replace a board with a Commissioner in respect of the Māori Health Authority, but that an appointment must be made with the agreement of the Māori Health Advisory Committee;

8.2 to appoint Crown observers to the new entity boards or any significant internal meeting in respect of the Māori Health Authority, but that appointments must be made with the agreement of the Māori Health Advisory Committee;

[CAB-21-MIN-0378]

9 **rescinded** the decisions in paragraph 8 above, and instead **agreed** that officials recommend in the departmental report that the Minister of Health consult the Hauora Māori Advisory Committee on the exercise of all key accountability functions;

10 **agreed** that officials recommend in the departmental report that the Minister be required to publish where they have determined to not follow the advice of the Hauora Māori Advisory Committee in exercising a relevant power;

11 **noted** that the Minister of Health has directed officials to recommend in the departmental report that the Minister of Health be required to consult the Minister for Māori Development and/or the Minister for Māori Crown Relations: Te Arawhiti before determining a dispute;

Iwi-Māori partnership boards

12 **noted** that:

12.1 in September 2021, Cabinet agreed that the Māori Health Authority lead a process for finalising the detailed powers and functions of the boards which the Minister of Health will report to Cabinet on, and noted the functions expected to be considered [CAB-21-MIN-0378];

12.2 the interim Māori Health Authority has undertaken engagement with Māori on the powers and functions of iwi-Māori partnership boards, and this has confirmed a strong desire for Māori to play a meaningful role in the planning and design of local health services;

13 **agreed** that officials recommend in the departmental report that the functions of iwi-Māori partnership boards replicate those noted in CAB-21-MIN-0378, specifically:

13.1 engaging with whānau and hapū about local health needs, and sharing the resulting insights and perspectives with Health New Zealand, the Māori Health Authority, and others;

13.2 assessing and evaluating the current state of hauora Māori in their locality or localities, and determining priorities for improving hauora Māori;

13.3 agreeing local priorities and locality plans with Health New Zealand and the Māori Health Authority (these plans will highlight local health priorities, and set out the localised approach to health service provision, taking into account community preferences for service design and delivery);

13.4 monitoring the performance of the health system in their localities, including against the locality plan;

13.5 engaging with the Māori Health Authority to support its stewardship of hauora Māori and its priorities for kaupapa Māori investment and innovation;

13.6 reporting on their activities to whānau and hapori Māori, and other relevant partners;

14 **agreed** that officials recommend in the departmental report that iwi-Māori partnership boards, where recognised in the Schedule to the Act, also have a function to appoint members of the Hauora Māori Advisory Committee;

15 **noted** that officials will recommend amendments to the locality provisions in the Bill to better connect iwi-Māori partnership boards and the locality planning process to the wider system in the departmental report;

16 **agreed** that officials recommend a tikanga-based process to recognise iwi-Māori partnership boards against a set of representativeness principles in the departmental report;

17 **noted** that the above process will be led by the Māori Health Authority, on whose advice the Minister of Health will recommend the inclusion of iwi-Māori partnership boards in a Schedule to the Act;

18 **noted** that an iwi-Māori partnership board may be removed from the Schedule to the Act via the same process, subject to the advice of the Māori Health Authority;

Other matters

19 **agreed** that officials recommend in the departmental report that the Bill include the power for the Minister of Health to appoint a Crown Manager to act in place of the board of Health New Zealand in relation to specified functions;

20 **agreed** that officials recommend in the departmental report that the Bill include a provision to require a review of the legislation at least every five years.

Michael Webster
Secretary of the Cabinet

Secretary's Note: *This minute replaces SWC-22-MIN-0006. Cabinet agreed to the rescinding decision in paragraph 9 and add paragraph 10.*