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

Proactive Release

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

Health and Disability System Reform Briefings October 2021 to January 2022

The following documents have been included in this release:

Title of paper: Health Reforms: Realising the Digital Shift for the Health System

Title of paper: Development of the Interim Government Policy Statement for the Reformed Health and Disability System

Title of paper: Further advice on the Interim Government Policy Statement - Priorities for Inclusion

Title of paper: Health Reform: Choices to Expand the Public Offer

Title of paper: Health Reforms: Public Health Transformation

Title of paper: Health Reforms: Addressing Workforce Supply and Demand

Title of paper: Localities: Setting a Narrative, and Updating on Rollout and Prototypes

Title of paper: Further Advice on the Interim Government Policy Statement – High Level Approach to Priorities

Title of paper: Monitoring Arrangements for the New Health System

Title of paper: Restructure of Vote Health Appropriations to Support Health Reforms

Title of paper: Health Reform – Progress Update and Assurance Framework

Title of paper: Update on the Pae Ora Bill: Select Committee Progress and Further Policy Decisions

Title of paper: Pae Ora Bill: Key Policy Decisions for Recommendation in the Departmental Report

Title of paper: Allocation of Commissioning Budgets Across Future Health Entities

Title of paper: Health Reform: Transfer of Functions from Ministry of Health to New Entities

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- section 9(2)(a), to protect the privacy of individuals;
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- section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion.

~~IN CONFIDENCE~~

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Briefing

ALLOCATION OF COMMISSIONING BUDGETS ACROSS FUTURE HEALTH ENTITIES

To: Ministerial Oversight Group, Health System Reform			
Date	25/01/2022	**Priority**	Medium
Deadline	1/02/2022	**Briefing Number**	DPMC-2021/22-1220

Purpose

This briefing:

a. responds to Cabinet's direction for further advice on the allocation of commissioning budgets across Health NZ and the Māori Health Authority in the future health system; and

b. seeks the Ministerial Oversight Group's direction and comment on a preferred approach to be tested with the interim Health NZ and Māori Health Authority boards, before referring to Cabinet for final decisions.

Recommendations

a. **Note** that Cabinet has previously agreed that in the future health system, Health NZ and the Māori Health Authority will co-commission health services in partnership, with the Māori Health Authority having further authority to directly commission kaupapa Māori services, as well as other innovative services tailored for Māori and Māori provider and workforce development [CAB-21-MIN-0092 refers].

b. **Note** that Cabinet has also agreed to the Māori Health Authority holding a significant budget as a commissioner of health services, with consequent accountability requirements, including annual reporting and issuing a statement of intent and statement of performance expectations, equivalent to those required of Health NZ [CAB-21-MIN-0378 refers].

c. **Note** that Cabinet has agreed in principle, subject to confirmation with the interim Māori Health Authority board and advice on the overall implementation approach, that in addition to funding provided through Budget 2021 and any potential funding provided through Budget 2022, the Māori Health Authority will be responsible for managing funding and reporting against a hauora Māori appropriation containing:

i. Ministry of Health non-departmental funding currently managed by its Māori Health Directorate, for example, Māori Provider Development Scheme funding;

ii. District Health Board-funded kaupapa Māori services; and

iii. non-departmental Vote Health funding currently administered by the Ministry which has a Māori component (for example, mental health and workforce development) [SWC-21-MIN-0157 refers];

d. **Note** that officials favour a balanced approach, aligned with government decisions to date on the core system operating model, to ensure joint accountability for Māori health outcomes and provide a strong starting point for the Māori Health Authority's influence, without compromising the 'one system' approach intended through reform;

e. **Agree**, subject to any further advice from the boards of the interim Māori Health Authority and Health NZ, to officials' recommendation that the Māori Health Authority's direct commissioning budget (funded through a Hauora Māori appropriation) consist of:

i. new funding allocated through Budgets 21 and 22 for Māori-specific services; and

ii. non-departmental funding managed by the Ministry of Health's Māori Health Directorate (such as the Māori Provider Development Scheme).

Rt Hon Jacinda Ardern	Hon Grant Robertson	Hon Andrew Little
Agree / Disagree	**Agree / Disagree**	**Agree / Disagree**
Hon Carmel Sepuloni	Hon Peeni Henare	
Agree / Disagree	**Agree / Disagree**	

f. **Agree**, subject to any further advice from the boards of the interim Māori Health Authority and Health NZ, to officials' recommendation that the Māori Health Authority hold funding for services co-commissioned to Māori providers (other than where Māori providers subscribe to demand-driven, nationally consistent contracts), with Health NZ holding all remaining funding for co-commissioned services, with funding to shift between the agencies over time as the proportion of funding allocated to Māori providers changes;

Rt Hon Jacinda Ardern	Hon Grant Robertson	Hon Andrew Little
Agree / Disagree	**Agree / Disagree**	**Agree / Disagree**
Hon Carmel Sepuloni	Hon Peeni Henare	
Agree / Disagree	**Agree / Disagree**	

g. **Note** that the recommended approach at (f) above would require a change to the planned approach to appropriations for health services, such that core appropriations for the funding of health services would be shared by Health NZ and the Māori Health Authority, in addition to the Hauora Māori appropriation allocated only to the Māori Health Authority;

h. **Note** that if you accept officials' recommendation at (f) above, a further submission to Cabinet will be required to modify Cabinet's previous in-principle agreement as to appropriations;

i. **Note** that subject to your agreement, we will engage with the interim Māori Health Authority and Health NZ boards and provide you with further advice as required based on their comments on the preferred approach.

 Stephen McKernan Director **Health Transition Unit**	Rt Hon Jacinda Ardern Prime Minister
20/01/21	…../…../….
Hon Grant Robertson Minister of Finance	Hon Andrew Little Minister of Health
…../…../….	…../…../….
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ALLOCATION OF COMMISSIONING BUDGETS ACROSS FUTURE HEALTH ENTITIES

Context

1. As part of further decisions on the Pae Ora (Healthy Futures) Bill [CAB-21-MIN-0378 refers], Cabinet has specifically agreed that the roles and functions of the Māori Health Authority should include:

    i. commissioning kaupapa Māori services, other innovative services tailored for Māori and Māori provider and workforce development;

    ii. co-commissioning all general health services (including both primary and community-based care and hospital and specialist services) with Health New Zealand, including joint development and responsibility for plans (including the New Zealand Health Plan); and

    iii. holding a significant budget as a commissioner of health services, with consequent accountability requirements, including annual reporting and issuing a statement of intent and statement of performance expectations, equivalent to those required of Health New Zealand.

2. As part of decisions on national-level budget and funding settings, Cabinet agreed in principle that Vote Health will be condensed into a smaller set of around ten appropriations [SWC-21-MIN-0157 refers], including separate appropriations for:

    i. primary and community, public and population health services;

    ii. hospital and specialist services; and

    iii. Hauora Māori, with financial accountability and reporting sitting with the Māori Health Authority.

3. Cabinet also agreed in principle, subject to confirmation with the interim Māori Health Authority Board and advice on the overall implementation approach, that in addition to funding provided through Budget 2021 and any potential funding provided through Budget 2022, the Māori Health Authority will be responsible for managing funding and reporting against a hauora Māori appropriation containing:

    i. Ministry of Health non-departmental funding currently managed by its Māori Services Directorate (for example, Māori Provider Development Scheme funding);

    ii. District Health Board-funded kaupapa Māori services; and

    iii. non-departmental Vote Health non-devolved funding currently administered by the Ministry which has a Māori component (for example, mental health and workforce development).

4. Cabinet authorised the Minister of Finance and the relevant appropriation Minister to finalise the new Vote Health appropriation structure and establish new appropriations, as required, as well as to reallocate existing funding within the new appropriation structure, which will take effect from 1 July 2022.

5. This advice seeks to confirm an approach to operationalising Cabinet's in-principle agreement with Ministers, ahead of testing with the boards of the interim Māori Health Authority and Health NZ, and then confirmation by joint Ministers and/or Cabinet.

How direct commissioning and co-commissioning work in practice

6. In the future health system, Health NZ and the Māori Health Authority will be responsible for commissioning and managing the health services delivered to New Zealanders in partnership. This commissioning activity will occur in one of two ways:

    a. General health services will be co-commissioned by the Māori Health Authority and Health NZ, meaning that the two agencies agree how the services are to be planned, contracted, managed and monitored. At the heart of these arrangements are jointly developed and agreed plans – including the NZ Health Plan and locality plans – with day-to-day commissioning activity typically being led by one agency or the other (most commonly Health NZ).

    b. Some services will be directly commissioned by the Authority, meaning that Health NZ does not have control over how that commissioning occurs – though the Authority will still do so in line with the overall approach outlined by the NZ Health Plan for the system and the locality plan for each locality.

7. Co-commissioning of all general health services is at the heart of the new system operating model. To that end, it has been agreed that both agencies will have significant accountability requirements, including annual reporting and issuing a statement of intent and statement of performance expectations – while recognising that as a statutory (rather than Crown) entity, the Māori Health Authority will also have unique accountabilities to Māori for its performance [CAB-21-MIN-0378 refers].

8. Commissioning in this context refers to the process from planning services through to contracting, service design, management, delivery, monitoring and evaluation – with co-commissioning representing that agencies will work in partnership to agree how services will be commissioned, and in the planning of how services will come together to deliver on New Zealanders' expectations for the health system. In practice, Health NZ will bear the greater burden of this co-commissioning activity, particularly in administration and day-to-day management, given its greater capacity and resources in relation to contracting, market-building and funding systems, though the Māori Health Authority will be resourced to be able to take a leadership role in some areas of co-commissioning depending on its prioritisation and focus.

9. As a result, on a day-to-day basis the agencies will have agreements – including a co-commissioning framework – specifying how involved the Māori Health Authority will be in various aspects of commissioning, ranging across:

    a. active leadership, taking on most of the work in the commissioning process, such as in relation to certain primary and community care services delivered by kaupapa Māori providers, or in areas of historic underperformance where intervention is needed;

    b. full partnership with the agencies working in tandem, for example in the development of the New Zealand Health Plan and key national contracts (e.g. the future equivalents of the PHO Services Agreement);

c. involvement in setting strategic direction and signing off end products, such as in the design and agreement of key national contracts and service specifications; and

d. a requirement to be kept informed (e.g. about the impacts of a new initiative that are not specifically focused on Māori, or day-to-day contracting activity not directly tied to hauora Māori)

10. In the event of any disputes arising between the Māori Health Authority and Health NZ in relation to their co-commissioning functions, there are established dispute resolution mechanisms in the Pae Ora Bill to ensure services are not disrupted.

11. In addition to influence over co-commissioning, the Māori Health Authority's direct commissioning powers are a critical lever to ensure that our health system is able to innovate and test novel approaches and models of care in delivering improved access and health outcomes for Māori. Direct commissioning decisions will be made by the Māori Health Authority but will still be aligned to the NZ Health Plan and locality plans as agreed between agencies, with learnings and emergent best practice from innovative Māori services flowing into the wider system.

Advice

Decisions on budget allocations are tightly linked to commissioning arrangements – as co-commissioning otherwise provides the levers for the Māori Health Authority and Health NZ to balance influence over services.

12. The commissioning arrangements articulated above create a fundamental distinction between two kinds of funding for health services in the future system: between those general services that are co-commissioned (and where responsibility for spending money, regardless of which agency's budget it is in, is broadly shared between the Authority and Health NZ) and specific services that are directly commissioned by the Authority.

13. As is noted above, co-commissioning arrangements are intended to avoid a strict dichotomy where influence always follows funding. We anticipate that regardless of where funding for services sits, both agencies will shape how services are planned, designed and monitored. For that reason, funding decisions ought to be considered in the context of the co-commissioning arrangements between agencies, which will have significant influence on how services are delivered. This means that the major implications of decisions about funding allocations will be in:

a. Shaping to some extent the relative influence of the two agencies over how services are commissioned, subject to the influence of commissioning arrangements.

b. Influencing the relationship and dynamics between the Authority and Health NZ. More 'arms-length' funding agreements may drive a less integrated commissioning relationship between the agencies but may relatively strengthen the Māori Health Authority's influence over commissioning activities.

c. The perception of the Māori Health Authority by Māori, the health sector and the wider community. Wielding a larger budget is more likely to meet the expectations of Māori, and other clinical and community groups, for the Māori Health Authority's apparent influence.

d. Determining the agency or agencies that are formally accountable for Vote Health management and obligations under the Public Finance Act and could also be the basis for other accountabilities.

14. As a consequence, there are two dimensions to how funding is allocated:

a. How to delineate services directly commissioned by the Māori Health Authority (for which they should hold funding and over which they have full commissioning authority) from those which are co-commissioned (where funding could be held by either agency with shared commissioning authority).

b. How funding should be allocated between the two agencies within the funding dedicated for co-commissioned services, representing the overwhelming majority of Vote Health.

15. The core operating model has been envisioned based on a one-system ethos and the premise of shared influence and accountability for outcomes, particularly regarding equity of access and outcomes for Māori. Decisions on direct and co-commissioning budget-holding responsibilities should, therefore, take a balanced approach that is consistent with the overarching intent of reform to design services that meet the needs of localities while ensuring that Health NZ can be held meaningfully accountable for system performance for Māori.

16. We analyse below options in answer to these questions and in each respect set out a preferred option. In considering options, we have considered the extent to which each option:

a. impacts on the likely overall quality of care delivered to people, weighted by the extent to which health inequities are addressed

b. is consistent with Government decisions to date, including the core system operating model

c. strengthens the influence of the Māori Health Authority and its ability to hold Health NZ accountable

d. is simple to administer in terms of funding, commissioning and activity, as well as administrative operations

e. ensures access for Māori (and other) providers to a sufficient level of services and funding and commissioning by Māori, where possible

f. drives constructive commissioning activity between the Māori Health Authority and Health NZ, avoiding perverse incentives or relationship disruption

g. impacts on workforce capacity and capability and is deliverable within these constraints.

Delineating directly commissioned and co-commissioned services

17. As highlighted above, the majority of services in the future health system will be co-commissioned, to ensure the voices of Māori and other population groups are equitably represented in how services are planned and commissioned. Services directly commissioned by the Māori Health Authority are intended to complement co-commissioned services, which will serve both Māori and the wider population.

18. We consider that Cabinet has already made clear decisions about the kinds of services which should be directly commissioned by the Authority in future – in particular, those which deliver fully kaupapa Māori services (e.g. rongoā Māori) and those which are designed to introduce novel or innovative approaches to improving services for Māori. This leaves open the question of which services, contracts and funding should comprise the Authority's direct commissioning budget at Day 1.

19. To that end, we considered a range of options to determine the Authority's initial direct commissioning budget – ranging from the Authority receiving only new money through Budgets 21 and 22 as direct commissioning funding, through to transferring all funding for kaupapa Māori providers and services to the Authority as direct commissioning funding. We consider that only one option is feasible within the parameters already set by reforms: that the Māori Health Authority's direct commissioning budget should be comprised (as of Day 1) of:

    a. new funding allocated through Budgets 21 and 22 for Māori-specific services; and

    b. non-departmental funding managed by the Ministry of Health's Māori Health Directorate (such as the Māori Provider Development Scheme).

20. This option ensures that the Māori Health Authority will receive an appropriation and budget for direct commissioning from Day 1, including both established contracts (which could be redirected, replaced or refocused) and new, uncommitted funding. This will allow it to fulfil its promise as an innovator in kaupapa Māori commissioning and service provision and to push the boundaries of best practice in primary and community care. It is well aligned to the operating model, is implementable, and strengthens the influence of the Authority.

21. In evaluating how best to give effect to Cabinet's in-principle agreement, we thoroughly explored how the Authority might be funded through a single Hauora Māori appropriation as anticipated by Cabinet. However, on further analysis, we found approaches other than that above relatively unworkable, including those which most explicitly gave effect to Cabinet's agreement:

    a. Given how contracts to Māori providers are currently configured across the Ministry of Health and DHBs, it is impractical to split these into different 'types' of contract based on service type. This is due to the diversity of different kinds of Māori providers (ranging from fully kaupapa Māori services, to whānau-centred delivery models, to traditional Western delivery models run by Māori providers) and the similar diversity of services they are contracted to provide. As a result, wider DHB or Ministry contracts with Māori providers need to be either included or excluded from the Authority's direct commissioning budget in aggregate.

    b. Allocating all contracts currently given to Māori providers to the Authority's direct commissioning budget (within the Hauora Māori appropriation) would be challenging. While shared locality planning would still govern the commissioning of this funding, it would mean the Authority directly commissions services that may also be intended to meet the needs of non-Māori, which may not meet the needs or expectations of other underserved population groups. It would also create significant complexity in appropriation arrangements and raise uncertainty where co-commissioning arrangements result in contracts with Māori providers.

22. Given these factors, we consider this preferred approach to be the best way to give effect to the intent of Cabinet's in-principle agreement, alongside the further recommended

options detailed below. We therefore seek your agreement to the preferred option, subject to consultation with the interim boards.

Allocating funding for co-commissioned services

23. As noted above, in the context of co-commissioning arrangements which agency holds funding does not necessarily determine who decides how that funding is spent – but perceptions, relationships and administration could be affected by where funding sits.

24. We consider there to be two workable options for the allocation of funding for co-commissioned services:

    a. *Option 1:* The Māori Health Authority holds the budget for co-commissioned services contracted to Māori providers (with some exceptions detailed below), and Health NZ holds residual funding for co-commissioned services, with joint planning through co-commissioning arrangements.

    b. *Option 2:* Health NZ holds the full budget for co-commissioned services, with joint planning through co-commissioning arrangements.

25. We recommend Option 1 – and detail the relative merits and challenges of the proposals below.

Option 1: Māori Health Authority holds co-commissioned funding for Māori providers

26. This option emphasises making it as easy as possible for the Māori Health Authority to adopt more innovative, holistic commissioning approaches for Māori providers, ensuring that they can take new approaches to lift access and equity of outcomes for Māori – and best ensures that the Authority receives an overall budget commensurate with its transformative potential.

27. Under this approach, on Day 1 all funding to Māori providers under current DHB and Ministry of Health contracts would transfer to the Māori Health Authority, to be co-commissioned in partnership with Health NZ in line with the NZ Health Plan and locality plans. Over time, as Māori providers take on contracts to deliver co-commissioned services, the funding associated would move across to the Māori Health Authority to allow for cross-service commissioning in line with best practice for kaupapa Māori care. We illustrate this approach below:

Direct commissioning (MHA)	Co-commissioning (MHA-led)	Co-commissioning (joint)	Co-commissioning (HNZ-led)
MHA leads commissioning activity for Māori-centred services designed to drive innovation and new models of care for Māori. The MHA keeps Health NZ informed and connected to ensure complementary delivery and sharing of emergent best practice. At Day 1, this funding comes from Budget 21 and 22 funding to the MHA for service provision, and from funding from the Ministry of Health's Māori Health Directorate.	MHA leads commissioning activity for Māori providers within the parameters set by the NZ Health Plan and locality plans, through aggregated, cross-service contracts where possible, but using co-commissioning approaches to involve Health NZ in planning, design, management and monitoring. At Day 1, the MHA receives funding for all Māori providers. Where Māori providers take on new services from non-Māori providers (e.g. after a contract is re-tendered), funding can be transferred between agencies within appropriations.	Agencies jointly plan and sign-off key national and local planning documents, including the NZ Health Plan and locality plans, and key national agreements with wide-reaching implications (e.g. national pharmacy agreements). At Day 1 and beyond, this funding sits with Health NZ – even where Māori providers access this funding – to maintain national contract consistency, and to manage the complexities of demand-driven funding.	Health NZ leads commissioning day-to-day for services commissioned to non-Māori providers within the parameters set by the NZ Health Plan and locality plans, with locality- or population-level oversight by the MHA. At Day 1, this funding includes all other funding for service provision not in the former three categories.
Funding held by MHA in Hauora Māori appropriation	*Funding held by MHA in various appropriations, shared with Health NZ*	*Funding held by Health NZ in various appropriations*	

28. We consider that this option will be best received by Māori and would put the Authority in a strong position to employ this funding to lift the health system's performance for Māori. We consider this option will best ensure parity in the relative influence of the Authority and Health NZ. It will also ensure the Authority is empowered in practice (as well as in theory) to lead in the co-commissioning of services for Māori and to disrupt traditional commissioning and contracting approaches which have not delivered equity. This option is also most consistent with Cabinet's previous in-principle agreement, as the funding streams identified in that decision would be held by the Authority.

29. We propose that there would be one major exception to funding for Māori providers flowing automatically to the Māori Health Authority: funding allocated by the two agencies to demand-driven, nationally consistent contracts (e.g. national contracts for GP services, maternity services, pharmacy and aged residential care). Where contracts are fixed and funding is demand-driven, passing funding responsibility to the Authority may create a liability where demand exceeds the Authority's associated budget, and would be complex in practice. These contracts are also unlikely to offer options for transforming the model for services delivery, as providers who subscribe to consistent, national agreements will all need to work within the same broad contractual and service design parameters.

30. This does not preclude agencies agreeing that some proportion of funding traditionally allocated to such contracts should be spent differently – for example, in adopting new whānau-centred approaches targeted based on need, rather than using demand-driven formulae. In such instances, funding for those services would transfer to the Authority where allocated to Māori providers. We anticipate testing this caveat specifically with interim boards.

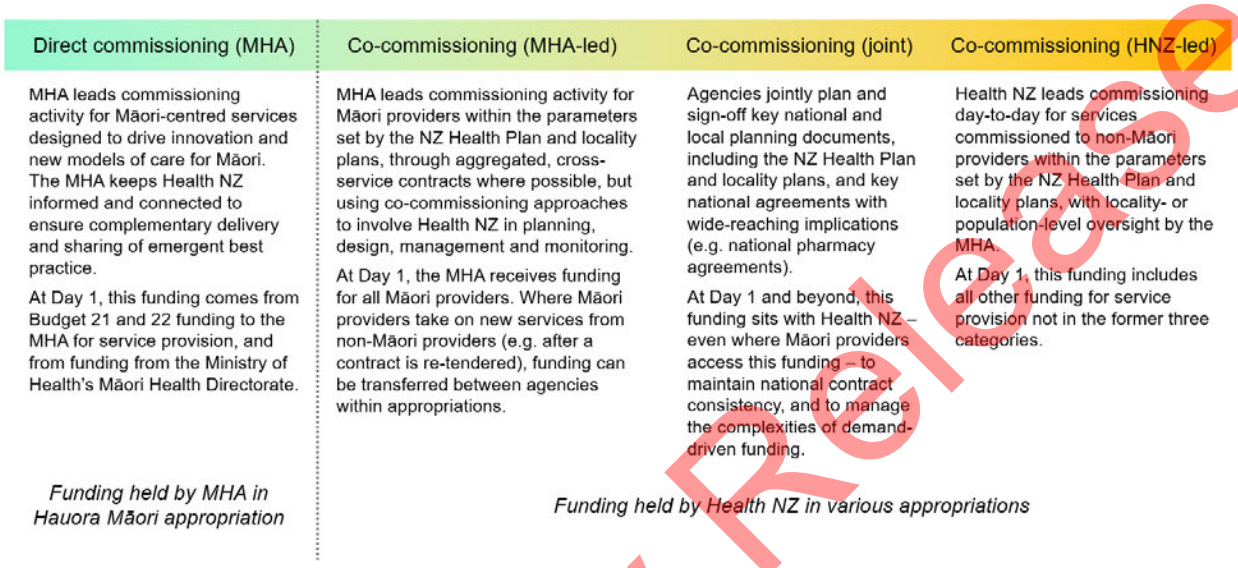
31. To make such transfers manageable in practice, it would be necessary for this funding to be held by both agencies in shared appropriations along the lines of those previously agreed by Cabinet (e.g. for primary and community care), separated into two tranches based on the allocation of agency funding. These tranches would be initially allocated as noted above for FY2022/23, and agencies would report through usual reporting on spend against appropriations on how funding has been ultimately allocated between agencies (noting that some shifts in funding across the two tranches would be expected in the course of each financial year as contracts and funding are recommissioned from non-Māori to Māori providers, and vice versa, with commensurate implications for which agency holds funding). This would avoid the need to shift funding between appropriations as a result of commissioning decisions. This is a change from Cabinet's previous in-principle decision, which had anticipated the Māori Health Authority only having a single appropriation not shared with Health NZ; but we consider this approach aligned to the intent of that in-principle agreement.

32. We note that this option has some potential disadvantages – in particular, it is comparatively administratively complex, as funding would need to move between agencies depending on what kind of provider holds contracts, rather than following services. There is also some residual risk that this might lessen Health NZ's accountability for the performance of the health system for Māori, as both funding and the co-commissioning lead for Māori providers will be held by the Authority; or that this model may discourage Health NZ from contracting to Māori providers in some instances (as such decisions would require Health NZ to transfer that funding to the Authority). We consider these risks to be manageable subject to intended system monitoring, particularly to ensure that funding continues to flow between the agencies over time, in recognition of healthy changes in commissioning approaches between different types of providers.

33. We note that this would require an update to Cabinet given the modification of Cabinet's in-principle agreement around appropriation architecture.

Option 2: Health NZ holds all co-commissioned funding

34. The alternative to the above, preferred option is to have Health NZ hold all funding for co-commissioned services, with the Māori Health Authority retaining a lead co-commissioning role for Māori providers – but with funding for those services and providers remaining with Health NZ. We illustrate this approach below:



35. The primary advantage of this approach is simplicity because all funding for co-commissioned services sits with Health NZ, meaning no transfers are required between agencies, providers always receive funding from the same source, and Vote management is made more straightforward. This approach also avoids the above risks relating to potential perverse incentives on Health NZ or a shift in perceived accountability for hauora Māori.

36. However, this approach results in the Authority having a relatively small commissioning budget compared to Health NZ – well below what may be the expectations of Māori to have the Authority's budget reflect the proportion of the population identifying as Māori. We consider that this would, at least to some extent, undermine the perceived mana of the Authority and is likely to be seen as insufficiently transformative by Māori. It may also mean that the Authority finds it harder to influence how co-commissioning occurs in relation to key services, resulting in a lack of innovation in service design and commissioning approach to shift Māori health outcomes. We also note that this option is not aligned with Cabinet's in-principle agreement, which anticipated a larger budget-holding for the Authority. For that reason, this option is not recommended.

37. For the above reasons, we recommend that you adopt Option 1, subject to consultation with the interim boards.

Implications and risks

38. If you adopt the recommended options noted above, minor modifications will be required to Cabinet's in-principle agreements in relation to budget-holding – as the Māori Health Authority will not hold all funding within its own Hauora Māori appropriation as anticipated. Further Cabinet consideration of the approach would therefore be required.

39. Regardless of the option adopted, we anticipate that commissioning arrangements in the future health system will evolve over time as agencies:

    a. develop and confirm fundamental documents such as their commissioning framework

    b. undertake the first full process to develop an NZ Health Plan and locality plans

    c. test the theory of co-commissioning approaches in practice, taking a relatively agile approach to address any emergent challenges, risks or issues.

40. We therefore recommend that Ministers continue to monitor how commissioning and funding relationships work in practice as the system transitions and embeds, noting that further modifications to this model could be made if issues arise.

Consultation

41. We have consulted with the Treasury and the Ministry of Health on this paper.

Next steps

42. Subject to your agreement to the preferred approaches outlined above, we recommend providing this advice to the boards of Health NZ and the Māori Health Authority for their comment and consideration.

43. We will then provide a further update to the Minister of Finance, Minister of Health and Associate Minister of Health with any further considerations or advice resulting from discussion with the boards. Following that advice, we will provide those Ministers with a draft Cabinet paper or oral item for Cabinet, depending on your preferences, to update Cabinet on the planned approach and any deviation from their previous in-principle agreement.