



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

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

HEALTH REFORM: CHOICES TO EXPAND THE PUBLIC OFFER

To Hon Andrew Little, Minister of Health

Date	29/10/2021	Priority	Routine
Deadline	11/11/2021	Briefing Number	DPMC-2021/22-671

Purpose

This briefing unpacks how people will experience the health system differently as a result of health reforms, and outlines the range of choices for expanding the 'public offer' of our health system both immediately through reforms and over time.

Recommendations

- a. **Note** that we expect reforms announced to date, and the flow on impacts of the future system planned to be funded through Budget 22 (such as localities and comprehensive primary care teams) to have significant, positive impacts on how New Zealanders experience the health system, and on the perceived public offer of the health system.
- b. **Indicate** whether you would like the Transition Unit to work with the Ministry of Health, Ministry of Business, Innovation and Employment, and Immigration NZ on options to extend eligibility for public healthcare to illegal migrants and overstayers, and people on work visas of under 2 years. **Yes / No**
- c. **Agree** that in the future health system the Service Coverage Schedule will be replaced by higher-level expectations set by the Government Policy Statement and the NZ Health Plan, and supported by commissioning schedules developed by Health NZ and the Māori Health Authority which set out expectations for the balance of national consistency and local flexibility in commissioning care. **Yes / No**
- d. **Note** that final decisions on enrolment settings will take around 18 months to implement once made, and should be timed to align with advice on locality design, funding flows, and Budget 24 decisions.

e. **Agree** to retain enrolment as a feature of the future health system, as a tool to direct both clinical and provider accountability for people's care, and as a tool to direct funding. **Yes / No**

f. s9(2)(f)(iv) [Redacted] **Yes / No**

g. **Agree** in principle that in the future system, enrolment should have features of both: **Yes / No**

- i. connecting people to provider networks, particularly for accountability for population health outcomes within localities
- ii. connecting people to individual providers, particularly for individual accountabilities for specific care needs tied to that provider.

h. s9(2)(f)(iv) [Redacted] **Yes / No**

Stephen McKernan

pp.
 Stephen McKernan
 Director
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29 / 10 / 2021

Hon Andrew Little
 Minister of Health

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Contact for telephone discussion if required:

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Minister's office comments:

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

Proactively Released

HEALTH REFORM: CHOICES TO EXPAND THE PUBLIC OFFER

Context

1. Our advice on health reforms to date has primarily focused on the changes to institutions and settings that are required to make the health system fairer, easier to access, more equitable and consistent. As we have discussed with you previously, an early focus on institutional settings is vital to set our system up for success. However, changes in how people experience the health system are what will ultimately gauge the success of reforms.
2. The purpose of this paper is twofold:
 - a. To describe what these changes mean for people, and how they will experience and interact with the system differently over time as a result of policy choices and investments made to date, and those anticipated through Budget 22.
 - b. To identify the choices yet available to government to expand the scope of the 'public offer' through the reforms, in the short and longer term.

What is the 'public offer'?

3. These reforms are squarely focused on ensuring that all New Zealanders – particularly Māori, Pacific peoples and disabled people – get the same access to, quality of and outcomes from healthcare as other New Zealanders. The 'public offer' of the health system defines those expectations, acting as the offer of the health system to its citizens and residents. This includes the range of care which people can expect to have access to, the circumstances in which they can expect to receive care, the quality of care to be provided, and any conditions which might attach to that care (e.g. co-payments).
4. The shape of the public offer is defined, broadly, by four key factors. Each of these elements presents choices to change or expand the offer to more people, more services, or with fewer conditions:
 - a. Eligibility – who is entitled to receive public healthcare?
 - b. Availability – which services are publicly funded?
 - c. Service coverage – how much of these publicly-funded services are expected to be available, with what level of access and conditions?
 - d. Enrolment – how do people access their public health system entitlements, including how do funding and accountabilities attach to people's care?
5. Transformation of the health system is intended to improve how the offer is delivered and experienced by people, with a particular improvement in the unjustifiable variation between groups. As we outline below, aspects of the reforms already adopted and others being progressed through Budget 22 will offer significant improvement in the

quality and consistency of services which are part of the public offer. However, in aggregate these reforms will not make the overall offer any more generous – that would require further policy decisions in relation to the four factors above.

6. This paper considers three of the factors above: eligibility, service coverage and enrolment. It seeks your early steers on potential opportunities in each to inform the next stage of our development work.
7. The paper does not at this stage consider the question of which services are funded by our public health system, and which are not. Through your proposed Budget 22 package you have already signalled priority areas for early investment here, including in the expansion of comprehensive primary care teams and the shift to a locality model.
8. Over time, there will be opportunities to consider further expansions, either by reducing co-payments to access various services (e.g. making GP care more affordable), by expanding the range of services which are funded (e.g. to include adult dental) or by extending more intensive services for groups the health system under-delivers for. However, on the basis that these items are not included in your Budget 22 package, we expect that any such shifts would need to be funded through Budget 24, and so are better addressed at that time. If you would like advice on the comparative merits of different future areas for investment, we can provide you with it.
9. Most of these areas involve significant policy and operational complexity, so this paper seeks your in-principle agreement to general shifts in system settings, subject to further work to be undertaken to develop fulsome models and approaches. We anticipate that making most of the changes explored in this paper will take between 18 months and two years. Many of these options would also impact system funding, so would need to be progressed from Budget 24 onwards.

How will people experience the health system differently?

10. As part of the reform proposals [CAB-21-MIN-0092 refers] and subsequent advice, a number of decisions have already been made that will fundamentally change the way that people experience and interact with the future health system. In effect, these form a baseline of improvements that would be expected from the reformed system.
11. All New Zealanders will experience improvements in care over time as a result of these reforms, particularly in settings which are relatively universal. However, the approach to implementation will prioritise those who are currently underserved by the health system – particularly Māori, Pacific peoples and disabled people. This means that we will focus on addressing inequities of access, care quality and outcomes for these communities, including through targeted initiatives and reforms.
12. These shifts will not all be realised on Day 1, and concerted investment over time will be needed to sustain improvements in care, access and outcomes. However, we anticipate that good progress will have been made in the following areas by 2025.

From a fragmented, localised model of hospital management – to a nationally planned and regionally managed hospital network

13. In our future health system, Health NZ will be the single nationwide provider of hospital and specialist services. This fully networked system will allow national planning and

regional management of services, and will make a significant difference to how people experience hospital and specialist care:

- a. A system where resource allocation and improvement activity is informed by benchmarking and analysis will reduce variation and improve universality of access to care. This means more people will get the care they need, faster – reducing waiting lists and improving the range of care available over time.
- b. By bringing together experts from across the system to identify innovation and roll out the best models of care and approaches, the care people receive will be more likely to reflect best practice resulting in better, more consistent health outcomes.
- c. Improving the consistency of care nationwide will reduce inequity and lift performance where there are currently major differences in intervention rates or speeds.
- d. A better configured and more coherent hospital and specialist system will make it easier to grow funding for primary and community settings over time. While this won't be visible to most people, the opportunities which it creates to expand primary and community-based care, and keep people well for longer, will be.
- e. Improved digital tools will ensure expertise can be better shared nationwide, resulting in more timely access to specialist care and expertise, and reduced incidence of errors or delays resulting from a lack of local expertise.

From localised interactions with individual providers, to a community-oriented system grounded in primary care teams

14. The implementation of a locality approach, including the establishment of comprehensive primary care teams and provider networks that serve localities [DPMC-2021/22-102 refers], is about embedding a population health focus to improve people's health outcomes. There are a number of ways that people will experience the system differently as a result:
 - a. Māori and Pacific people will have better access to care close to home that reflects their cultures, needs and aspirations. Kaupapa Māori and Pacific services will be available in more localities, across a wider range of health and wellbeing services, and with greater capacity than is the case today.
 - b. Comprehensive primary care teams will enable people to access broader primary care services more efficiently, and over time more affordably, by integrating previously disparate services into a single team. This means people will need to re-explain themselves less, will feel more valued by the health system, and will receive care which is more timely and integrated – leading to better outcomes. These benefits will be particularly experienced by Māori and Pacific peoples and rural communities.
 - c. Provider networks will join up services around specific conditions and stages of the life course where multiple providers should be brought together to deliver the best possible care to people (such as families with babies, people with chronic illnesses, youth, or those requiring support for mental health and addiction). This will mean people can get more coordinated access to health and broader social care when they need it.

- d. Facilitated by iwi-Māori partnership boards, Māori will be much better able to influence the health priorities that are most important to their communities. This will make care more effective, more enfranchising, and more aligned to Tiriti o Waitangi principles.
- e. Commissioners from Health NZ and the Māori Health Authority will facilitate engagement with each local community on their health priorities, so that all people have the opportunity to influence the commissioning of services for their locality. This means that services are more likely to meet people's needs, and reflect their expectations and lived experiences (e.g. by providing whānau-centred services, rather than purely individualised care).

Strengthened consumer voice

- 15. You previously agreed to develop a national consumer voice framework that will promote, embed and strengthen diverse consumer voices in our future health system [DPMC-2020/21-781 refers]. This framework will improve how people are heard in the health system, and make services more responsive to their needs:
 - a. A national set of expectations underpinned by Tiriti o Waitangi principles for how consumer voices are gathered and used, and statutory requirements for health agencies to give effect to these expectations will mean people will be involved more often in health, and when they are involved, will feel more like they've been heard based on real changes to services and models of care.
 - b. A national consumer forum that will facilitate access for health agencies to a diverse range of community and consumer groups, including those that are less-often heard, as a pathway to improve equity of outcomes for minority populations. This will elevate community voices, and advocate for consumer voices to be prioritised and heard.
 - c. A streamlined, consistent and transparent national feedback and complaints pathway in Health NZ will ensure consumer feedback and complaints can be used for continuous improvement across the system meaning consumers are less likely to encounter the same issues over and over again.
- 16. The above improvements to the public offer are not conditional on further changes to settings, but are already achievable through components of the reforms and your proposed Budget 22 package. As above, these improvements do not necessarily expand the aggregate public offer in their own right, but instead will iron out inequity and variation within different groups' experience of that offer.
- 17. Below, we explore in more detail other aspects of the public offer which offer opportunities for greater improvement and expansion over time.

Eligibility

- 18. The Health and Disability Services Eligibility Direction 2011 sets out who is eligible for publicly funded (i.e. free or subsidised) health and disability services. The entire list is outlined in Annex 1, and includes all New Zealand residents and citizens. We also have reciprocal health agreements with Australia (for acute conditions) and the UK (for acute

conditions that began, or deteriorated in New Zealand) which allow people from these nations to receive care here.

19. Some services are free regardless of eligibility status. This includes Well Child/Tamariki Ora, vaccinations listed on the New Zealand immunisation schedule, services that are required as a result of an emergency, services required under certain legislation (e.g. Alcoholism and Drug Addiction Act 1966), and services related to a suspected or confirmed infectious disease, including COVID-19. However, those who are ineligible for care generally cannot receive subsidised general practice access, and are required to fund the costs of hospital and specialist care themselves.
20. While most people in New Zealand are covered by our health system, some notable groups are not covered (other than those subject to reciprocal arrangements):
 - a. illegal migrants and visa overstayers
 - b. those on work visas with a duration under 2 years
 - c. international students and working holiday visa holders
 - d. tourists.
21. Some of these groups, such as fee-paying student visa holders, and some working holiday visa holders, are required to hold comprehensive medical insurance prior to entering the country.
22. For the most part, our eligibility settings are working well and aligned to international practice. Most people living and working in New Zealand are eligible to access free or subsidised health care when they need it. However, there are two areas where you may want to consider changes to eligibility over time: for those on short-duration work visas, and long-term illegal migrants and overstayers.

Short-term work visas

23. Those on work visas for under two years are often relatively vulnerable migrants. To qualify for such visas, they are either earning below the median wage of \$27 per hour, or are on a fixed-term employment contract for under two years. People in this category are often from jurisdictions with relatively low wages and may face financial, language and cultural barriers to accessing healthcare.
24. International practice typically involves those on work visas either receiving cover, or being required to hold comprehensive insurance to cover health costs. This ensures that people on work visas – including short-term work visas – can access care without leaving the health system carrying bad debts.

Illegal migrants and visa overstayers

25. Immigration New Zealand put the total number of overstayers at 13,895 in 2017, with the national groups most represented being Tongan (18% of the total), Samoan (11%), Chinese (11%), Indian (9%) and Malaysian (6%). While disincentives to visa overstaying may be effective, some overstayers have now been living in NZ for significant periods of time and are well integrated in our communities, and have not been discouraged by low access to healthcare.

26. Other countries do not typically extend health system eligibility to illegal migrants or visa overstayers, on the basis that entitlement to access care should not follow illegal migration. We have previously provided amnesty to well-settled visa overstayers, with the last such amnesty occurring in 2000.

Implications and approaches

27. While we have little evidence of the scale of the problem due to relatively limited data collected on non-eligible populations who access care), people in both groups are unlikely to have comprehensive insurance and are likely to avoid non-urgent healthcare (and potentially urgent healthcare) because of a lack of affordable cover. This results in poor health outcomes for affected communities – and the costs of this are likely to be borne by the New Zealand health system over time in any case, as when more acute or specialist care is needed, people in these groups are unlikely to be able to afford the costs of care.
28. Previous DHB OIA releases have signalled bad debts from ineligible patients are approximately \$14 million annually across Auckland, Counties Manukau, Canterbury, Northland and Waitemata DHBs. We anticipate that our health system likely spends more on care for long-term visa overstayers and illegal migrants by virtue of their ineligibility for care, due to delayed access to preventative care and the likelihood of non-payment.
29. Notwithstanding the equity and financial case, the principled and practical dimensions of extending eligibility to one or both of these groups are complex, and would require cross-agency work, noting that:
- a. there are principled issues with offering some people who are in New Zealand illegally greater health cover than some people who are in New Zealand legally
 - b. it is desirable not to encourage illegal migration or visa overstaying, and a lack of access to funded care contributes to that disincentive – and it would be vital to avoid any incentive for people to come to New Zealand specifically to receive care (e.g. by overstaying a tourist visa), which is already a problem for some DHBs today
 - c. there are broader economic and immigration implications of changes to work visa settings – for example, a requirement to carry insurance could dampen migration or add to costs on businesses looking to use short-term migration to meet labour needs
 - d. levers within economic or immigration agencies' purviews may be better at achieving some of these goals (e.g. extending a further amnesty to illegal migrants and visa overstayers, or requiring employers to fund the costs of care for those on short-term work visas).
30. We seek your views on whether you would like us to explore options to expand eligibility for these groups, working with the Ministry of Health, Ministry of Business, Innovation and Employment and Immigration NZ.

Service coverage

31. Addressing national inconsistency in the level, quality, and availability of care is a significant driver of the reform programme. Service coverage is an essential element of this, and is an area where today's system is not working well.
32. Generally speaking, 'service coverage' sets out the range of publicly funded services that people can expect to be available, and the circumstances in which those services will be available. This is dictated in practice both by the formal agreements as to what services should be provided, and by factors such as workforce, provider capacity, funding, and geography.
33. The Service Coverage Schedule (SCS) is the mechanism used in the current system to set national expectations for service coverage. It is a schedule to the Crown Funding Agreements applicable to each DHB, and allows the Minister to explicitly agree national expectations of levels of service coverage for which DHBs are held accountable. The SCS effectively serves two purposes: first as a mechanism for DHB consistency and accountability, and second as a summary of the care which is provided by the health system.
34. In theory, the SCS should ensure national consistency in care by setting out the services which the health system is required to provide, to whom, and at what cost and level of service. In practice, the SCS has not achieved that purpose due to:
 - a. inadequate levers in place to hold DHBs to account when they do not meet the requirements set out in the SCS, meaning that its expectations are not always met
 - b. barriers to service coverage such as insufficient funding or workforce not being reflected in the SCS, resulting in it inaccurately representing the services available nationwide (e.g. where high waitlists inhibit real access)
 - c. contracts not always reflecting the full scope of the SCS, meaning that while there is a theoretical entitlement to access care, contracted providers may not deliver it.

Holding agencies accountable for service coverage

35. The new operating model agreed to by Cabinet means that the need for a detailed SCS set by Ministers as an accountability tool is less compelling. Indeed, the reformed system will address a number of the issues outlined above:
 - a. National consistency in care will be significantly easier to achieve with Health NZ assuming the roles and responsibilities of the 20 former DHBs.
 - b. Oversight at a national level of what services are provided, and their availability and cost, will allow Health NZ and the Māori Health Authority to build a comprehensive picture of national variation that can then be addressed.
 - c. Similarly, more consistent commissioning practice should combat differences between service coverage expectations and contracts.
36. Moreover, the current SCS is a hybrid of general government policies regarding access, higher-level expectations, and detailed service specifications. It is not clear that this

model fits well in the future system, where the reforms intend to draw a clearer line between government policy requirements (as reflected in the Government Policy Statement) and service planning and delivery (through the NZ Health Plan and other frameworks and specifications developed by Health NZ and the Māori Health Authority).

37. Accordingly, we consider that the reformed system requires a more nuanced approach to service coverage that reflects the roles and accountabilities of different entities:
- a. The Minister of Health can use the Government Policy Statement to set national expectations about the scope and character of service coverage.
 - b. Health NZ and the Māori Health Authority would then have responsibility for setting more detailed service specifications, informed by government priorities and drawing on relevant clinical expertise and evidence.
38. In keeping with its primary role as an accountability mechanism, the GPS will be the vehicle for setting Ministerial expectations and requirements regarding access to health services. Given the nature of the GPS, we expect that these directions would for the most part generally be broad in scope, for instance setting high-level priorities that are then given effect to through the NZ Health Plan.
39. However, there is also a case for the GPS to set more specific expectations in certain areas. This could include:
- a. directions on the expansion of services to meet specific public promises or initiatives, such as the rollout of a new service or profession. In this case, the GPS may set more detailed requirements and metrics which would affect the public offer in the round;
 - b. universal service outcomes and expectations – such as expectations for minimum accessibility of certain kinds of care – which can drive organisational performance;
 - c. national policy or rules on aspects of service coverage or access that should remain decisions for Ministers – most obviously in relation to co-payments.
40. To give effect to the above, our view is that the GPS is likely to need to contain some description on expectations for service coverage, perhaps in an annex to the main document. This might include some minimum expectations for access and conditions (e.g. co-payments) as well as any priorities for improvement (which would be expected to be highlighted in the GPS itself).

Public communication and consistency

41. Beyond the higher-level expectations in the GPS, it will continue to be desirable to have more detailed specifications for the services expected to be delivered by the health system for other purposes, and in at least some areas:
- a. To ensure that Health NZ and the Māori Health Authority have shared expectations, both between agencies and within them, about the services which should be nationally consistent across localities and regions (to avoid exacerbating a postcode lottery).

- b. To ensure clarity on service levels and conditions for specific services which are more entitlement-based than needs based. For example, access to gender-affirming treatment and fertility treatments are policy decisions, given the importance of access to specific care to particular populations or in certain circumstances – and it will be important that agencies and New Zealanders alike have clear information about what care they can access in such circumstances.
42. Annexes to the NZ Health Plan may at times set out detailed specifications for particular services, where those services are matters of policy (e.g. as above, or where manifesto or Budget commitments result in the creation or expansion of specific services which will need to meet particular coverage or access expectations). However, in general, this level of detail would not be articulated routinely by the Health Plan – though general guides as to expected consistency of care would be.
43. For maintaining internal and cross-agency consistency, we would expect commissioning teams within Health NZ and the Māori Health Authority to develop frameworks or specifications to ensure an appropriate balance of local flexibility and national consistency, agreed between the organisations and made publically available as appropriate to ensure public visibility. This combination of measures would replace much of the technical detail of today's Service Coverage Schedule.
44. We therefore recommend that you agree that in future the Service Coverage Schedule will instead be replaced by a set of broader accountability expectations in the GPS and NZ Health Plan, supported by Health NZ and Māori Health Authority frameworks or schedules which set shared, cross-agency expectations for the parameters of local flexibility and national consistency in service provision
45. We expect to work through the development of the first GPS and interim NZ Health Plan to ensure that service coverage expectations are appropriately reflected in these future structures and artefacts, and in other more operational artefacts created by interim agencies. We will also provide you with advice as part of risk management approaches for the transition on how this should be managed through the period through to the first full NZ Health Plan in 2024, to ensure service expectations are maintained as DHBs are consolidated into Health NZ.

Enrolment

46. The final option to expand the public offer is how we manage enrolment. As noted in previous advice [DPMC-2020/21-1168 refers], people are enrolled with both a provider and a PHO under current system settings. Enrolment is a multi-faceted tool which serves a range of purposes:
- a. Funding: enrolment determines the eligible population for subsidised primary care, and the associated quantum of capitated funding required for each provider or PHO. Capitated funding, under current settings, only flows to general practices based on their enrolled populations. Enrolment therefore significantly impacts the operations and business models of general practices.
- b. Clinical accountability: enrolment identifies a clinician or group of clinicians responsible for a patient's primary care, including following up results, making referrals, and having oversight of patient needs.

- c. Provider accountability: enrolment formalises a provider's role in coordinating care for the enrolled population, and establishes a provider's responsibilities to be proactive with care (e.g. health promotion activities, regular screening, and immunisation) for a defined population, allowing a degree of system tracking and assurance.
47. For providers and clinicians, all these aspects are important features of enrolment, as they determine their funding received and the population for whom they are held to account for performance. For the general population, enrolment is mainly experienced as a designation of your 'usual' practice or clinician, which also fixes where you can receive subsidised primary care. In this way, enrolment can affect the care people have real access to.
48. As a system lever, enrolment is part of the picture for how we build localities which are more responsive to community need, and do a better job of spreading innovation and minimising undue variation in service performance and models of care. Alongside other funding and accountability levers, sound enrolment settings contribute to a system which is people-centred, and drives providers to collaborate to improve access and health outcomes.
49. Given its value as both an accountability and funding tool (including as a premise of capitation), the Transition Unit supports the continued use of enrolment in the future system. However, there are choices for how enrolment settings could be adjusted to address the weaknesses of the current system:
- a. At present, 6% of the total population are currently not enrolled with a PHO, and therefore miss out on subsidised primary care that they are entitled to. This is an even greater issue for Māori, as 16% of the eligible Māori population (or 139,500 people) are not enrolled for subsidised healthcare, representing 45% of the total unenrolled population. Māori are more likely than non-Māori to have unmet need, and to experience cost barriers to accessing care.
- b. Practices can choose whether or not to accept new enrolees, which is intended to avoid practices taking on more patients than they can handle. However, in some areas of New Zealand this has resulted in all, or almost all, practices 'closing books' to new enrolees. People who move to these areas or who wish to change providers may be unable to access subsidised care if no-one will accept their enrolment.
- c. Enrolment can pose a more general barrier to consumer choice and access, as it limits the settings in which people can access subsidised care. This can disadvantage people or make care inaccessible in a range of circumstances, such as where people can't get timely appointments with their enrolled provider (and so have to pay out-of-pocket to see another provider), or where people need to access care while away from their usual practice (including where, for example, they work in a different place to where they live).
- d. Enrolment settings are not configured to drive collaboration and shared accountability for population health outcomes, or to improve outreach and access for populations underserved by the health system. In particular, the intersection between funding architecture and enrolment settings does not create strong

incentives for providers to work together to reach marginalised communities, particularly where they are unenrolled or rarely proactively access care.

50. People who are unenrolled not only lose access to subsidised primary care, which can mean they don't access care, but are also less likely to be caught by proactive outreach to receive vaccinations, screening and other services. Being unenrolled may also result in increased, unnecessary use of emergency services to address primary health needs. Unenrolled populations also don't fall into the accountability catchment for any provider or network, meaning that no provider is responsible for ensuring they get improved access.
51. Further details on these challenges, and current settings, is set out at Annex 2.
52. In the future health system, the introduction of localities and comprehensive primary care teams offers opportunities to manage enrolment differently. In particular, there is scope to explore three main choices, which we explore in more detail below:
 - a. Should enrolment be default (opt-in) or active (opt-out)?
 - b. Who should people enrol with in the future system?
 - c. Should people be able to access subsidised care from any primary care provider, as long as they are enrolled somewhere?
53. In relation to all of these choices, we note that changes to enrolment settings are likely to take some time (around 18 months at minimum) to implement, and would ideally be timed to coincide with decisions on the future of the PHO Services Agreement, which is tied to current enrolment settings. Should you wish to progress any of the options below, we will work with the Ministry of Health, Health NZ and Māori Health Authority to progress advice and present final decisions to you to allow any changes in line with that timeline.

Choice A – should enrolment be opt in or opt out?

54. The current enrolment system is opt-in, requiring individuals to actively register with a PHO to be enrolled, typically through general practice. This creates a barrier to accessing publicly funded healthcare as it relies on individual initiative, and a measure of administration.
55. The current opt in enrolment mechanism has created unnecessary barriers to people being able to access entitlements to subsidised primary care. An opt out model similar to that used for KiwiSaver (i.e. if you aren't already enrolled, you are automatically enrolled with a nearby provider, and have to take steps to opt out of enrolment), would ensure that all people that want to be able to access care are able to do so at the subsidised rate, and would nominate a provider to be accountable for proactive care such as immunisations, screening, and health promotion activities. This aligns to our desired incentives and shifts in practice for primary and community-based care.
56. These inequities make opt out enrolment intuitively appealing. However, implementing a default enrolment scheme would be complex:
 - a. It would increase the cost of state-funded primary care (due to the increase in capitation payments based on enrolment volumes), but would not automatically

lead to better health outcomes for recently enrolled people unless accompanied by increased outreach and access.

- b. To ensure that health outcomes for populations underserved by the health system improve, we would need mechanisms to ensure that providers with default-registered patients take appropriate steps to reach out to them and ensure their access to care, and to avoid paying capitation payments to providers where care was not being delivered (e.g. a requirement that capitation only follow first contact, or a greater role for fees-for-service in provider funding).
- c. In some areas, default enrolment might also require that we mandate providers to take new enrolees, as in some areas all providers have 'closed books', and do not currently take new enrolees. This would ensure access for those currently denied the opportunity to enrol locally, but could decrease care access for the wider population in such areas.

57. Notwithstanding that complexity, we consider that an opt-out model is more equitable, and would better ensure access to care for some of our most marginalised and vulnerable communities. Even ensuring a point of accountability for proactive and no-cost care offerings, such as vaccinations, screening and health promotion would be beneficial, though ideally such a change would result in better outreach to currently unenrolled New Zealanders. However, this change would have costs which would need to be funded from Budget 24 onwards.

58. s9(2)(f)(iv)
[Redacted text]

Choice B – who do people enrol with in the new system?

- 59. Enrolment settings will inevitably need to be adjusted for the future system given that Health NZ will not be obliged to contract with PHOs to purchase primary care services. While this isn't a critical decision for Day 1 (July 2022) as locality prototypes can be implemented within existing system settings, decisions about who people will enrol with in the future system will need to be made within the next 12 months to align with work on our future primary and community operating model (including implications for the relationship with PHOs), and funding models for primary and community-based care.
- 60. The establishment of localities, provider networks and comprehensive primary care teams offers opportunities to allow enrolment above the level of individual providers, such as enrolment with a provider network. In such a case, accountability for a person's care would be lifted to be shared across a group of different providers, which is in line with the intended goals of reform. Similarly, it would allow for a measure of cost and risk sharing which may drive and aid service integration – supporting the localities model. This is not mutually exclusive with elements of enrolment, such as specific clinical accountabilities, remaining with individual providers.
- 61. In general, we consider that it is advantageous for people to have a clear connection to a 'usual' provider and clear clinical lines of responsibility, but that some measure of accountability (and to at least some extent, funding) should be shared across the full

range of providers responsible for people's care, not only general practice. This recognises that responding to people's health needs – particularly where their needs are complex – requires both individual clinical responsibility and contribution from a range of different people and providers. There are many ways to embed this blend of accountabilities, including funding models, commissioning approaches, and enrolment settings. Shifting towards this approach will be vital to genuine sharing of accountability and responsibility for locality populations across providers.

62. We therefore consider that while the current model of enrolment with a single provider only is sustainable, the future model of enrolment should also include enrolment with a provider network. Such an approach could support a more integrated care environment, and strengthened incentives on providers. In particular, we recommend that you agree in principle that future enrolment settings include elements of:
- a. connecting people to provider networks, particularly for accountability for population health outcomes within localities; and
 - b. connecting people to individual providers, particularly for individual accountabilities for specific care needs tied to that provider.
63. There are significant intersections between these settings and funding flows and locality design, neither of which have been finalised for the future system. To ensure the alignment of advice and system settings, we will provide you with final advice on a preferred approach alongside advice on those settings – but expect that this will either result in a 'single provider' enrolment approach, or enrolment with a provider network.

Choice C – should people be able to receive subsidised care from any primary care provider?

64. Restricting access to primary general practice care to the provider that you enrol with is an inefficient way of distributing appointment capacity, and limits people's ability to access necessary care. It can act as a barrier to accessing care in a range of contexts, including where practices are unable to offer timely appointments; where people live and work in different places; or where people happen to be in a different locality when they need care. However, it makes for an administratively simple system, minimising transfers between providers or 'compensation' for seeing another practice's patients.
65. The introduction of provider networks as part of the locality approach provides an opportunity to reimagine how care should be accessed by people to make the best use of the resources within the network, or even nationally.
66. There are a number of ways that enrolment could be expanded to allow access to subsidised care at more than one provider of general practice services, including:
- a. as noted above, shifting to a model where elements of enrolment are with a network of providers, instead of just a single provider – which could include an entitlement to access subsidised care
 - b. voucher systems (i.e. provider A gives a voucher to their patient to access care from provider B when they can't offer them a timely appointment)

- c. formally establishing reimbursement mechanisms that ensure people can access subsidised care from any primary care provider within their provider network, or nationwide.
67. There are significant operational complexities involved in making these kind of adjustments to enrolment settings, particularly when it involves transferring funding between providers so that funding follows the patient. Any options that affect provider co-payment charges and clawbacks of funding would require negotiation with the sector, and investment in the administration of reimbursement mechanisms – and would have implications for Budget 24 and outyears.
68. s9(2)(f)(iv) [Redacted]

Next steps

69. The Ministry of Health and Transition Unit are developing Budget 22 initiatives to support the implementation of system reforms that provide greater national consistency in care access and outcomes, and seek to expand access to a number of existing services. Any approved investments through Budget 22 will therefore result in expansion of the public offer in the future health system.
70. Based on your indication of whether any of the areas discussed above should be developed further, the Transition Unit will work with the Ministry of Health, Health NZ and the Māori Health Authority to ensure that these areas are added to each entity's forward work programme and, where options have financial implications, inform options for investment in Budget 24.

Annexes	
Annex A	People eligible for publicly funded health care
Annex B	Current enrolment settings

ANNEX A

People eligible for publicly funded health care

The Health and Disability Services Eligibility Direction 2011 sets out who is eligible for publicly funded health care in New Zealand. These groups of people are:

- New Zealand citizen or resident
- An Australian citizen or permanent resident who's lived, or intends to live, in New Zealand for at least a consecutive 2 years
- A work visa holder who's eligible to be here for two years or more
- Under 17 with an eligible guardian or parent
- An interim visa holder who was eligible immediately before they became the holder of the interim visa
- A New Zealand Aid Programme student receiving Official Development Assistance funding (and their partners)
- A commonwealth scholarship student
- Foreign language teaching assistants funded by the Ministry of Education's Foreign Language Teaching Assistantship Scheme
- A refugee or protected person, or in the process of applying or appealing for refugee or protection status
- A victim of people trafficking
- Prison inmates or people on remand (unless services are not available through the prison health services)
- People who have or suspected to have an infectious and/or quarantine disease

ANNEX B

Current enrolment settings

How does enrolment operate today?

People enrol with a provider of First Level Services (a general practice) and that provider's associated PHO in order to gain access to subsidised doctors' visits and prescriptions.

Enrolment is voluntary but formal – people can only access the benefits of subsidised care through the provider that they enrol with. Even if people access First Level Services from another provider within the same PHO, they will not be eligible for subsidised care.

People are free to change the provider that they enrol with as often as they like, however, this is not reflected in funding for providers until the next capitation pay cycle. Some providers choose to charge new enrollees the higher unenrolled price until their capitation funding is adjusted.

If a person doesn't have contact with their provider after three years, or they go to prison, they are automatically de-enrolled.

Enrolment statistics

- 94% of the total New Zealand population are enrolled in a PHO
 - 84% Māori
 - 99% Pacific people
 - 95% Other
- Approximately 139,500 Māori are not enrolled in a PHO, which represents 45% of the total unenrolled population
- PHO enrolment tends to decrease as deprivation increases, and those aged 15-44 tend to have lower enrolment rates

Dep.	% enrolled
1-2	99%
3-4	92%
5-6	89%
7-8	88%
9-10	87%

Age	% enrolled
0-4	98%
5-14	98%
15-24	88%
25-44	90%
45-64	95%
65+	98%

Reasons for not enrolling

There are a number of reasons for people not enrolling with a provider / PHO:

- No perceived need for health care (people are automatically de-enrolled if no contact after 3 years)

- Use other services for health need, such as Emergency Department or Urgent Care
- In prison
- Prefer not to engage
- Cost barriers (even subsidised care can be too expensive)
- Housing vulnerability – lack of address can be a barrier to enrolment
- Willing but not able due to providers not having enough capacity (11% of GPs had closed books in 2018)
- System disincentives (i.e. providers actively or passively avoiding enrolling patients with perceived high health need)
- Transience (i.e. when shift cities you may put off enrolling with a provider until you have a need for health services).

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