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 February – June 2022

The following documents have been included in this release:

Title of paper: Policy Decisions for Pae Ora Bill Departmental Report: Talking Points

Title of paper: Health Reforms: Quality Functions in the Future System

Title of paper: Progress on Health System Functions Transfer

Title of paper: Health Reforms: Policy Critical Path to Day 1

Title of paper: Health Reforms: Key Policy Decisions and Delegation

Title of paper: Implementing the Intervention Framework for the Reformed Health System

Title of paper: Health Research in the Future System

Title of paper: Progress Update on Public Health Transformation Programme

Title of paper: Pae Ora Legislation Committee Report

Title of paper: Supplementary Order Paper for Pae Ora (Healthy Futures) Bill

Title of paper: Update on the Transfer of Functions from Ministry of Health to New Entities

Title of paper: Appendices to the Interim Government Policy Statement

Title of paper: Health Reforms: Role of Localities in the Reformed System

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Briefing

HEALTH REFORMS: KEY POLICY DECISIONS AND DELEGATION

To Hon Andrew Little, Minister of Health; Hon Peeni Henare, Associate Minister of Health			
Date	11/03/2022	**Priority**	Routine
Deadline	15/03/2022	**Briefing Number**	DPMC-2021/22-1621

Purpose

This paper sets out the key policy decisions required to bring the health system reforms into effect on 1 July 2022, and seeks agreement for relevant decision-making to be delegated to the boards and/or chief executives of the interim Health New Zealand and interim Māori Health Authority.

Recommendations

a. **Note** the set of critical policy and system design decisions which are to be made in advance of July 2022 to give effect to the structures and functions agreed by Cabinet.

b. **Agree** that decisions relating to the design of internal structures and functions within Health New Zealand and the Māori Health Authority be delegated to the Ministerial advisory committees acting as boards of their respective interim agencies, or the chief executives of those agencies, as appropriate. **YES / NO**

c. **Agree** that this delegated authority is subject to the following conditions:

- that decisions must be consistent with the essential features of the reformed system agreed by Cabinet; **YES / NO**
- that the boards should ensure visibility to Ministers of both upcoming decisions to be taken, to support early discussions where necessary, and of decisions that have been made; **YES / NO**
- that the delegation does not apply to any specified system design decisions that you wish Ministers to retain. **YES / NO**

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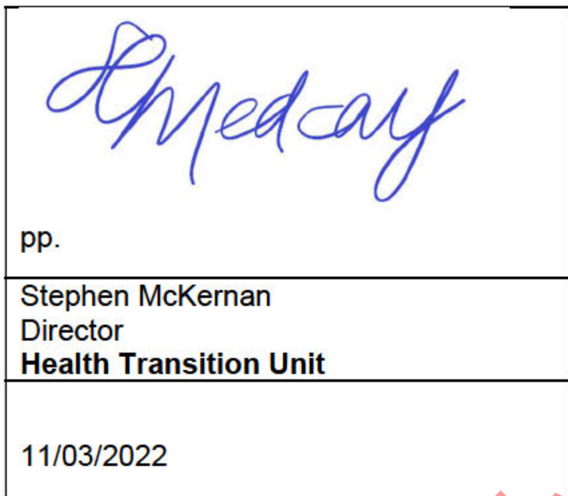
d. **Note** that you have already indicated that you wish Ministers to retain decision-making authority in relation to the funding formula for allocations to primary care.

e. **Indicate** any further policy or system design decisions for which you would wish to retain decision-making authority, whether alone or in consultation with the boards of the health entities.

f. **Agree** to set an expectation for interim entities to develop and publish establishment plans in advance of Day 1, setting out their emerging operating models and functional design. **YES / NO**



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Stephen McKernan
Director
Health Transition Unit

11/03/2022

Hon Andrew Little **Minister of Health**	Hon Peeni Henare **Associate 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

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HEALTH REFORMS: KEY DECISIONS AND DELEGATIONS

Context

1. At our meeting on 8 March, we discussed the critical path of policy, legislative and budget decisions that will deliver the health reforms on 1 July 2022 [DPMC-2022/23-1581 refers]. That briefing noting that there remains a significant number of detailed policy and design decisions to be made to support the health system to come into effect on Day 1 as intended by Cabinet.

2. This paper sets out the most crucial policy and design decisions that need to be taken in advance of Day 1, and seeks your view on who should make those decisions.

Key policy and system design decisions for Day 1

3. Cabinet has already made a large number of foundational decisions regarding the structure and functions of the reformed health system – and these are the basis on which work to implement the reforms is progressing.

4. Beneath the level of Cabinet decisions, there is a much larger set of detailed choices to be made over *how* those decisions are given effect. The majority of these relate to questions of internal system design, including for example choice as to:

   a. how structures are to be designed in the new entities (including at a national, regional, district and locality level);

   b. how functions are to be delivered (including the potential for shared functions across multiple entities); and

   c. how funding will be allocated to match the intended reform objectives.

5. An inherent part of these choices is a decision as to what the initial or interim approach should look like on Day 1, as compared with the longer-term aspiration that may be worked towards over the first two years. Many of these policy and system design decisions will be relatively straightforward for Day 1 – for instance, by taking a pragmatic choice to adopt an existing system approach at the outset rather than design something new. In some cases, moreover, a decision may be made to de-prioritise non-essential work and take this forward after July 2022. However, each of these nonetheless requires a decision of some type to be made, and for this to be communicated to the system.

6. **Annex 1** summarises the key policy and design decisions which are required to set clear expectations for system functions from Day 1. In our view, these represent the critical areas in which choices are needed to give effect to Cabinet decisions in the practical and operational settings of the reformed system. In the absence of these, it may not be clear how a function is to be discharged, with likely consequences for consistency of approach across the system. It may also risk the design of the system model deviating from Cabinet's agreed approach.

7. Work is underway on the large majority of the individual areas included in the annex. This development work spans the Transition Unit and Ministry, which are generally

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taking forward the remaining system-level design elements, and the interim entities, which are focused on the design of their internal operating models.

Decision-making authority

8. To support effective decision-making in a constrained period of time, it is important to be clear on roles and responsibilities. In this respect, there is question as to whether you wish to take some or all of the policy and design decisions, or whether you intend to delegate them, with any conditions, to the two advisory committees acting as Crown entity boards in respect of the interim agencies.

9. The large majority of the detailed decisions in the annex relate to internal system design issues, of the sort that would have been delegated to district health boards in the past. There is therefore a good argument to follow the same principle and delegate these decisions to the interim agencies (both to their boards and chief executives).

10. s9(2)(g)(i)

11. Given these considerations and the unique circumstances in which decisions on the design of the health system will be made in coming months, we recommend:

    a. in line with precedent regarding delegated decision-making to DHBs, **that you agree to delegate to the interim Health NZ and the interim Māori Health Authority decisions relating to the design of structures and functions of their relevant permanent entity**; however,

    b. this delegation **is subject to the following conditions**:

        i) that decisions must be consistent with Cabinet's agreed system operating model and the wider objectives of reform;

        ii) that the boards must update you regularly on decisions that are forthcoming, to ensure visibility and enable early discussion where necessary, including with the Transition Unit and Ministry of Health; and must communicate all decisions made to you; and

        iii) that this delegation shall not extend to any specific policy matters over which you wish to retain authority.

12. Consistency with Cabinet decisions is crucial to maintain the integrity of the system model and to avoid re-litigation of matters agreed by Ministers. The Transition Unit will be able to advise boards and chief executives of relevant advice and decisions to support a common understanding and set parameters where necessary for their design decisions.

13. In our view, there are a number of areas in which Ministers will, or may consider, retaining decision-making authority, including:

    a. system-level decisions (i.e., which affect the system as a whole, including the high-level delegation of functions across entities);

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b. the accountability framework (i.e. decisions on how entities are held to account, including how Government priorities are set and monitored);

c. matters affecting individual rights (e.g. setting minimum requirements for access to health services for the whole population); and

d. the strategic and legislative framework for the health system.

14. There are a number of policy decisions to be made which you have already indicated you do not wish to delegate – including in relation to the approach to enrolment in primary care in the future, and changes to the design of national allocative funding models, both of which align with the list in the paragraph above. These will be communicated to boards to ensure clarity on expectations for Ministerial approval.

15. For the most part, the advice above reflects the assumptions already held by the boards of the interim agencies, and the basis on which development work is progressing. However, confirming both the delegated authority and your expectations will support clarity and ensure that processes for decision-making are effective and timely.

Communicating decisions on detailed system design

16. As above, visibility as to the decisions made by the interim entities and the implications for the detailed design of their operating models from Day 1 will be essential to ensure clarity and consistency with Ministers' expectations.

17. In advance of Day 1, it will be important to communicate the starting point for the operating models of both entities, and how each expects to function and be led from July 2022. These models will flow directly from the decisions made in advance by the boards and chief executives, and in our view should be captured and published in a clear way that can be shared across the health system.

18. There is currently no required single document to capture the description of the entities' operating models. While these will be relevant to the interim NZ Health Plan, for example, the Plan will not be focused on setting out internal mechanics and functions. The requirements for entities to both produce statements of intent will have some overlap, but will not on their own cover the depth of detail needed to explain national and sub-national structures, roles and responsibilities.

19. We recommend therefore that both interim agencies be expected to produce an establishment plan prior to Day 1, which would detail their emerging operating models and functional design, and set out the choices made in response to the decisions identified in annex 1. The establishment plans may be combined or separate for the two entities, at their discretion. They would fulfil the statutory requirements for a statement of intent and be presented in due course alongside the interim Health Plan as part of the foundational documents for the reformed system.

20. We understand that interim entities are already developing proposals to this effect, and this expectation should not constitute an additional burden. However, there is merit in setting a Ministerial expectation here to support delegation of decision-making and consistency in key outputs. Should you agree, we will engage with the interim agencies and advise you accordingly on next steps.

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Next steps

21. Subject to your views, we recommend that your decisions be communicated to the chairs and chief executives of the interim agencies in your meeting with them and the Minister of Finance on 16 March. This would support messaging on your expectations for the boards and the extent of their authority.

22. We suggest that this meeting should be followed with a written confirmation of the delegations agreed, including setting out conditions. The Transition Unit will engage with the interim agencies to determine what further advice and support may be provided to ensure that Cabinet decisions are well-understood.

23. We will work with the interim agencies to support the development of a pathway for necessary decisions and a process for informing you as required. We expect this will include regular updates through the weekly reports of the interim agencies.

24. There are a number of signals that may be expected from the sector on Day 1, even if no change is happening immediately. For example, primary health organisations or national providers, such as Plunket, may expect to see a plan for progressive change, or a direction of travel for primary care and localities that articulates their future role. We will come back to you with further advice on areas of future system design that will require at a minimum a longer-term work programme and communications strategy for Day 1.

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Annex 1: Summary of key policy and design decisions for Day 1

Entity	Key Cabinet decisions	Key policy and design issues for Day 1
Māori Health Authority	• System lead for Māori health, having co-leadership role with MoH and Health NZ for everything that relates to hauora Māori. Will have critical policy and strategy function to advise Ministers on hauora Māori for the system. • Lead commissioner of kaupapa Māori health services and co-commissions other health services accessed by Māori. • Partner with Health NZ to develop and agree the NZ Health Plan and other national plans and operational frameworks. • Co-design and deliver health promotion activity with Health NZ. • Partner with Health NZ to improve population health through intersectoral action.	MHA organisation design • Structures and processes to support accountability to Māori (e.g. governance, partnership, reporting arrangements). • Governance structure (sub-boards, including shared governance with HNZ for co-commissioning etc.). • Executive leadership structure (inc. shared leadership roles with HNZ/MoH/PHA e.g. clinical roles). • Delegation framework (authorisation of decision-making at national, regional, locality level). • MHA regional tier – design of regional arrangements, relevant functions and relationship/co-location with HNZ regions. • Locality commissioning role for relevant services – scope of responsibilities and relationship with HNZ locality commissioners. • MHA sub-regional role – physical presence (if any) at district or locality level. MHA functional design • Overall operating model for MHA functions, including practical separation of commissioning/monitoring functions. • Shared functions with MoH/PHA/HNZ (including agreed MoUs or equivalent where necessary). • Design of policy function, including processes for advice/reporting to Ministers, alignment with MoH.

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Entity	Key Cabinet decisions	Key policy and design issues for Day 1
		• Hauora Māori system outcomes and monitoring approach, including relationship to whole-system approaches. • Commissioning and contracting framework for MHA direct-commissioned services (including payment approach etc.). • Performance management and quality improvement approach for MHA-commissioned services. • Process for managing complaints and disputes relating to MHA-commissioned services. IMPBs • Process for ratification of IMPBs through Bill, including process for future changes (additions, removals, mergers). • Standing support offer for IMPBs and individual development plans for boards based on assessment of needs. • Process for IMPBs to input into MHA functions (e.g. IMPB chairs forum). • Process for managing disputes between IMPBs and MHA (aligned wider broader disputes process and HNZ).
Health NZ	• Lead system operations, planning, commissioning and delivery of health services. • Commissions and co-commissions frontline health services with the Māori Health Authority. • Health NZ will not maintain a significant strategic policy function of its own, expect where it is necessary to partner with MoH and MHA on strategy and policy development, and translate this direction into operational policy and plans.	HNZ organisational design • Overall description of HNZ operating model, distribution of functions and levels. • Delegation framework for authorisation of decision-making in support of above model (including areas for joint decision-making with MHA), and escalation framework for performance or clinical risks and issues (especially for Health NZ delivered services).

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Entity	Key Cabinet decisions	Key policy and design issues for Day 1
	• Te Hiringa Hauora / Health Promotion Agency disestablished and core delivery functions transferred to PHA and Health NZ – to be a shared service for HNZ and MHA. • Lead the development of the New Zealand Health Plan, partnering with MHA. • Responsible with MHA for engaging with social sector agencies, iwi, communities, and local authorities to improve population health through intersectoral action. *National public health service* • The NPHS will be established within Health NZ and encompass the 12 PHUs towards a more centralised public health operations function, which will align operations firmly within Health NZ. • NPHS and MHA will determine and evaluate public health programmes, such as screening, immunisation programmes and Well Child Tamariki Ora, based on specifications provided by the PHA. • Director of Public Health to have key leadership role within NPHS, shared with the PHA, including professional support and oversight for the Medical Officers of Health.	*National organisational design questions:* • Executive and leadership structure (national leadership roles including those shared with MHA/MoH/PHA, sub-board governance, integration of national public health service). • Clinical governance (inc. national clinical directors, networks, senate, etc.). • Stakeholder, patient and whānau involvement in governance and national structures. *Regional organisational design questions:* • Sub-national operating model (i.e. role and functions of regions, districts and localities). • Regional governance inc. regional boards, CEs. • Regional direct commissioning (scope of services commissioned at regional level). • Regional commissioning oversight (population health and wellbeing networks, performance management of localities, sign off for locality plans). • Regional hospital networks (design and operation, including in relation to individual units and national network). • Regional complaints and dispute resolution (including escalation from local level). • Regional patient and whānau engagement in structures and governance (including roles on regional boards). *Local organisational design questions:* • Locality operating model (design of provider networks, commissioning and contracting approach, etc.). • Approach to enrolment in primary care. • Locality commissioner function (role, location, transition).

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Entity	Key Cabinet decisions	Key policy and design issues for Day 1
		• Process for determination of locality boundaries (to be completed by July 2023). • Design and expected process for developing locality plans (including engagement with social sector). • Local reporting requirements (interim and on basis of locality plans when agreed). • Local complaints and disputes procedures. <u>HNZ functional design (including across levels)</u> • Shared functions with MHA (including MoUs or equivalent where necessary). • Performance management approach (framework for monitoring service performance at all levels in line with oversight and governance arrangements, linked to MoH system monitoring). • Quality improvement approach (functions for identifying and targeting quality improvement support, including escalation process within HNZ and pathway to MoH/Ministers). • Financial framework (allocations to national/regional/local levels, payment approach, use of standard contracts, commissioner and provider incentives). • Commissioning and co-commissioning framework for health services. • Patient and whānau representation and engagement at all levels (national, regional and local mechanisms for governance, engagement and involvement in priorities and plans, including for Māori, Pacific and disabled people). • Complaints protocols and procedures (for complaints about services, including resolution and escalation pathway).

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Entity	Key Cabinet decisions	Key policy and design issues for Day 1
		• Disputes procedures (for disputes about decisions taken, including resolution mechanisms and escalation to regions and national level).
Wider health system	*Ongoing TU policy advice for Ministerial decisions, to be delivered by July (not including legislation, budget).*	• Research functions in future system. • Reform implications and options for wider health entities (including options for short and longer-term changes to roles, responsibilities, functions).

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