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

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

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**Key to redaction codes:**

- section 9(2)(a), to protect the privacy of individuals;
- section 9(2)(f)(iv), to maintain the confidentiality of advice tendered by or to Ministers and officials; and
- section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion.

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DEPARTMENT OF THE PRIME MINISTER AND CABINET
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# Briefing

# PAE ORA BILL: KEY POLICY DECISIONS FOR RECOMMENDATION IN THE DEPARTMENTAL REPORT

| To: Hon Andrew Little, Minister of Health | | | |
|---|---|---|---|
| **Date** | 17/01/2022 | **Priority** | Medium |
| **Deadline** | 19/0/2022 | **Briefing Number** | DPMC-2021/22-1196 |

## Purpose

This briefing seeks your decision on a number of key policy issues for recommendation in the departmental report on the Pae Ora (Healthy Futures) Bill, which if you agree to would require Cabinet approval. It also seeks your comfort on additional policy matters in the Bill that can be decided by you.

## Recommendations

Please refer to the Cabinet Paper on the DPMC website for final decisions: https //dpmc.govt.nz/publications/proactive-release-health-and-disability-system-review-policy-decisions-pae-ora-healthy

1. **Note** the attached draft Cabinet paper that seeks approvals for the key policy issues detailed in this briefing.

2. **Note** that the proposals in this paper relating to hauora Māori have been discussed with the board of the interim Māori Health Authority, who will provide you with their advice separately (a draft of this advice is attached to this briefing).

*Approach to Treaty provisions*

3. **Note** almost all significant submissions from Māori expressed concern that the approach to Treaty provisions provides insufficient recognition of specific Treaty principles and will not facilitate transformational change.

4. **Note** officials' view that operative Treaty clauses are not necessary in a social service context and that the approach taken in the Bill proactively meets Treaty obligations and will facilitate a transformational change in hauora Māori.

5. **Agree** to inform Cabinet of your proposed public communications strategy developed to address concern regarding hauora Māori settings in the Bill (**Appendix A**). YES / NO

*Iwi-Māori partnership boards*

6. **Agree** to seek Cabinet approval to provide in the Bill that the functions of iwi-Māori partnership boards replicate those noted in CAB-21-MIN-0389: YES / NO

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

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

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

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

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

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

7. **Note** that officials are likely to propose additional minor amendments to iwi-Māori partnership board provisions in the departmental report to better meet the intention of the reforms, specifically requiring that:

    a. if your proposed function for IMPBs to jointly approve locality plans with Health New Zealand and the Māori Health Authority is confirmed, the approval of locality plans would remain subject to the dispute resolution process in the Bill; and

    b. that IMPBs should be engaged (rather than consulted) in the preparation of locality plans (to ensure a genuinely collaborative process for determining local priorities and preferences).

8. **Note** the draft Cabinet paper seeks approval of the specific statutory process you agreed to in our December advice [DPMC-2021/22-1065 refers], which is focused on the Māori Health Authority assessing establishment plans for prospective IMPBs against some essential but flexible principle.

*Appointment of Hauora Māori Advisory Committee*

9. **Agree** to seek Cabinet approval to provide a mechanism for IMPBs and health specific Māori organisations to appoint the Hauora Māori Advisory Committee members (and hence providing IMPBs with an additional power/function). YES / NO

10. **Agree** to seek Cabinet approval to maximise certainty and efficiency for the Hauora Māori Advisory Committee by: YES / NO

    a. setting a maximum of eight seats on the Hauora Māori Advisory Committee, with six appointable by IMPBs and two appointable by relevant hauora Māori/pan Māori leadership organisations;

    b. specifying that members of the Hauora Māori Advisory Committee are appointed once they are notified to you in writing by all of the chairs of recognised IMPBs; and

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

11. **Agree** the Bill will provide for a transitional phase, where appointments to the Hauora Māori Advisory Committee can only be made from two years after enactment. YES / NO

12. **Note** in the interim phase, the Bill will provide the Minister with the ability to appoint an interim Hauora Māori Advisory Committee if circumstances require them to consult with the Committee or obtain its agreement.

13. **Indicate** whether you would like officials to undertake another brief round of engagement with prospective parties to IMPBs in late February and early March and advise both you and the Select Committee of the outcome of that engagement prior to the Committee reporting the Bill back to the House on 27 April. YES / NO

*Hauora Māori Advisory Committee role in appointments*

14. **Agree** that the Minister be required to obtain the agreement of the Hauora Māori Advisory Committee when appointing members to the board of the Māori Health Authority. YES / NO

*Final decision in dispute resolution process exercised by Minister*

15. **Agree** to seek Cabinet's approval for the Minister's final determination power in the dispute resolution process is exercised in consultation with the Hauora Māori Advisory Committee. YES / NO

Happy for the Ministers final determination to follow consultation with either or both Minister of Māori Development and Minister of Māori Crown relations.

*Additional policy matters for your consideration*

16. **Note** submissions expressed a view that the health system principles should apply to the Minister in exercising their powers under the Bill and there was a strong perception from Māori that by not having the principles apply to the Minister, it is the Crown exempting itself from true partnership.

17. **Note** officials' view that the Minister's exception from this provision is not an exemption from Treaty partnership for the following reasons:

    a. the Bill incorporates elements of the principles that specifically relate where the Minister exercises powers under the Bill;

    b. there appears to be no example of a Minister being required to act consistently with principles or objectives similar to the principles in the Bill, or any legislation where a Minister is excluded from the application of such provisions;

    c. in exercising powers under the Bill, the Minister must act in accordance with the Bill's purpose - namely, equity; and

    d. none of this precludes the fact that a Minister of the Crown has obligations (albeit not legally enforceable) under te Tiriti as a Treaty partner.

18. **Indicate** whether the Minister should be covered by the health system principles in the Bill. YES / NO

19. **Note** the proposed removal of the Pharmac exemption from health system principles as it is unnecessary, and this is supported by Pharmac.

20. **Note** submitters' views on the difference between Health New Zealand and Māori Health Authority functions and that officials are undertaking further thought on how to modify and align the description of functions to ensure that it reflects the intention of partnership.

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|---|---|
| pp<br>Stephen McKernan<br>Director<br>**Health Transition Unit** | Hon Andrew Little<br>**Minister of Health** |
| 17/01/2022 | 18/1/22 |

**Contact for telephone discussion if required:**

| Name | Position | Telephone | 1st contact |
|---|---|---|---|
| Stephen McKernan | Director, Transition Unit | s9(2)(a) | |
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# PAE ORA BILL: KEY POLICY DECISIONS FOR RECOMMENDATION IN THE DEPARTMENTAL REPORT

## Purpose

1. This briefing seeks your decision on a number of key policy issues for recommendation in the departmental report on the Pae Ora (Healthy Futures) Bill, which if you agree to would require Cabinet approval. It also seeks your comfort on additional policy matters in the Bill that can be decided by you.

## Context

2. The Pae Ora (Healthy Futures) Bill (the Bill) is currently at the Select Committee stage of the legislative process and is being considered by the Pae Ora Legislation Committee (the Committee). Public submissions closed on 9 December 2021, and the Committee is expected to begin hearing oral submissions on 26 January. The Committee is due to report back to Parliament on 27 April and has asked for the departmental report to be provided by 14 February.

3. As advised in December [DPMC-2021/22-1065 refers], decisions from you and Cabinet are required on a number of key policy issues to be included in the departmental report.

4. This briefing:

   a. seeks your decision on key policy issues that require your decision and Cabinet approval;

   b. seeks your comfort on additional policy matters that can be decided by you and do not require Cabinet approval;

   c. provides you with a proposed timeframe to receive policy decisions form Cabinet in order for officials to deliver the departmental report by 14 February; and

   d. attaches for your consideration a draft Cabinet paper seeking policy approvals on the issues outlined in this briefing.

5. We have discussed the proposals in this paper (and the related Cabinet paper) which relate to hauora Māori with the board of the interim Māori Health Authority (iMHA). The iMHA board is due to ratify its advice to you on the matters which it was asked to consider (relating to the role and functions of iwi-Māori partnership boards) on 19 January, and to submit this advice to you subsequently. A draft of that advice is **attached** to this briefing paper for your information. There is significant alignment between the direction in the iMHA paper and in the proposals in this briefing.

## Draft Cabinet paper

6. We have **attached** a draft Cabinet paper that seeks approval to the key policy issues outlined in this briefing. We would need Cabinet's approval in early February in order to enable us to present the departmental report to the Committee by 14 February,

7. The paper will be amended per any comments before its consideration at the Ministerial Oversight Group meeting on 25 January, directly after which we recommend commencing Ministerial and departmental consultation. Our current timeframe would then be to direct the paper to either Cabinet or the relevant committee with power to act, in early February.

## Key policy issues for consideration at Cabinet

8. The key policy issues for your decision that also require Cabinet approval relate to:

   a. the approach to Treaty provisions, including specific reference to rangatiratanga;

   b. iwi-Māori partnership boards;

      i. powers and functions (including associated amendments relating to localities);

      ii. representation; and

   c. accountability settings of the Māori Health Authority.

### Approach to Treaty provisions

9. In December, you agreed to brief Cabinet on submitters' views about the overall approach to legislating for Treaty of Waitangi obligations in the Bill [DPMC-2021/22-1065 refers].

10. As expected, almost all significant submissions from Māori (including those from the National Iwi Chairs Forum, the National Hauora Coalition, the Māori Women's Welfare League, and significant Iwi organisations) expressed concern that the approach to Treaty provisions provides insufficient recognition of specific Treaty principles, and will not facilitate transformational change. These submissions highlight a surge of opinion within the Māori community towards general operative clauses as a result of the choice to include such a clause in the exposure draft of the Natural and Built Environments Bill (many submissions put this clause forward as an alternative for the Pae Ora Bill).

11. As previously advised, adding an operative clause would mean health entities have to weigh competing sets of principles – the Treaty principles and the health system principles (which already aim to reflect desired outcomes and behaviours consistent with the Treaty principles), thereby creating significant uncertainty. If given a high legal weighting (e.g. 'give effect to'), such a clause would also give the Court the ability to substitute its own decision for that of Health New Zealand or the Māori Health Authority on specific choices about service design or delivery.

12. We remain of the view that such clauses are not appropriate in a social service context and that the approach taken in the Bill proactively meets Treaty obligations and will facilitate a transformational change in hauora Māori.

13. The draft Cabinet paper explains this issue and the reasoning above, and does not recommend a substantive change. However, it also highlights the importance of the government speaking publicly about why it has adopted this approach for the health

reforms compared with the operative approach for Resource Management Act reform, and the significant Treaty based aspects of the Health system principles.

14. The draft Cabinet paper refers to public communications points you intend to make on te Tiriti and hauora Māori settings more widely in the Bill that have been developed to raise public awareness and help to address any information gaps or misunderstanding about this aspect of the reforms. The communications points and strategy is attached at **Appendix A.**

15. One change to the Treaty provision that was put forward by the Māori Health Authority was an explicit reference to rangatiratanga. Following discussion with you, and agencies, including Te Puni Kōkiri, Te Arawhiti and the Crown Law Office, we recommended a reference to the effect that the provisions of the Bill strike a balance between rangatiratanga and kāwanatanga [DPMC-2021/22-864 refers].

16. Cabinet authorised you, in consultation with Hon David Parker. Hon Kiri Allan and the Crown Law Office to consider how to give effect to the principle of rangatiratanga. Hon Kiri Allan has agreed to the reference described above. The draft Cabinet paper has been drafted on the assumption that Hon David Parker will also agree.

**Iwi-Māori partnership boards: powers and functions**

*The proposed functions take a balanced approach*

17. You have also agreed to seek Cabinet approval for the Bill to include specific functions and powers for iwi-Māori partnership boards (IMPBs) [DPMC-2021/22-1065 refers].

18. The draft Cabinet paper highlights that the engagement conducted by the interim Māori Health Authority late last year has confirmed the importance of these functions for Māori. In some cases, prospective parties to IMPBs have even greater expectations for reform (such as IMPBs directly commissioning health services). This supports the view that the set of functions you have proposed is a balanced approach to the relationship between rangatiratanga and kāwanatanga in this context.

19. The function that IMPBs agree locality plans with Health New Zealand and the Māori Health Authority is key in fulfilling the policy intention of giving statutory recognition to IMPBs and elevating them above the role of consultative bodies.

20. You will receive separate advice from the board of the interim Māori Health Authority. A draft of this is attached to this briefing and subject to confirmation by the board. We expect that the board will recommend some additional functions to those previously proposed.

21. The draft Cabinet Paper suggests that the functions represent the 'minimum' level of local Māori participation necessary to secure a good level of support within the Māori community for the Bill, and recommends they be included in the departmental report for the Bill. We do not recommend including additional functions relating to commissioning, since this is not intended as a core function of all IMPBs, but could be delegated to nominated IMPBs by the MHA if desired in the future.

22. If you agree with our recommendation at paragraph 43 of this advice, an additional function would be added to reflect IMPBs' role in appointing HMAC members. As

discussed below, this recommendation has been set out in the draft Cabinet paper. The full set of functions is set out in paragraph 47 of the draft Cabinet paper.

*Associated amendments relating to localities*

23. As briefed in December, the draft Cabinet paper also notes that you intend to make some less significant (but still material) changes to respond to key points raised in engagement or submissions, including requirements for:

    a. Health New Zealand and the Māori Health Authority to consult IMPBs or relevant Māori organisations (who may form IMPBs) when determining localities;

    b. Health New Zealand and the Māori Health Authority to have regard to the priorities and preferences expressed in approved locality plans when drafting subsequent versions of the New Zealand Health Plan;

    c. if your proposed function for IMPBs to jointly approve locality plans with Health New Zealand and the Māori Health Authority is included, the approval of locality plans to remain subject to the dispute resolution process in the Bill; and

    d. IMPBs to be engaged (rather than consulted) in the preparation of locality plans (to ensure a genuinely collaborative process for determining local priorities and preferences);

24. In feedback on our December briefing [DPMC-2021/22-1065 refers], you asked for clarification on proposed amendments c and d.

    c: Locality plans remaining subject to the Bill's dispute resolution process

25. Currently, the Bill states that a locality plan is made when:

    a. It is agreed by Health New Zealand and the Māori Health Authority; or

    b. If they disagree, through the dispute resolution process in the Bill.[1]

26. The list of IMPB functions initially agreed in September, on which public statements have been made, included a function that IMPBs also agree locality plans.

27. Assuming this function is confirmed, the Bill will be amended to state that a locality plan is made when it is agreed by Health New Zealand, the Māori Health Authority, and the IMPB or IMPBs for the area covered by the plan. We are of the view that the dispute resolution process in the Bill should continue to apply in the event that Health New Zealand, the Māori Health Authority, and IMPBs are unable to reach an agreement on a locality plan. In this context, applying dispute resolution to approval decisions simply reflects the fact that some ultimate circuit-breaker is required to ensure locality plans are in place. It is important to remember that locality plans set priority outcomes and approaches, but are not commissioning or financial documents.

[1] The dispute resolution process in clause 28 states that parties must then comply with either the Minister's determination, or the process determined by the Minister and its outcome.

d: Requirement for IMPBs to be 'engaged' rather than 'consulted' in the preparation of locality plans

28. Currently, Health New Zealand must consult relevant IMPBs when developing a locality plan. This means Health New Zealand must tell IMPBs what is proposed, must give them a fair opportunity to express their views and must consider their views with an open mind before making the plan. Consultation does not require negotiation or agreement. In our view, this is the wrong standard for the locality plan process.

29. If the function for IMPBs to agree locality plans is confirmed, Health New Zealand will necessarily be required to do more than consult – it must agree. Agreement will only result from an engagement process that is satisfactory to the IMPBs, very likely including a process of negotiation and co-design.

30. If the function is not confirmed, the term 'engage' is still preferable to "consult". Using 'consult' risks limiting the level of engagement the Crown is required to have with Māori from the outset. A requirement to "engage" in this context, will require processes that reflect the principles of the Treaty and that are consistent with tikanga. These will likely require a significant role for IMPBs, although ultimately agreement will not be required. Our view is that 'engage' will encourage and require a more collaborative and effective process. To avoid the creating two different standards of engagement, we also propose amending the other 'consult' requirements in the clause to 'engage'.

31. These changes have been proposed in response to feedback from Iwi/Māori that they expect the locality planning process to be a genuinely collaborative process, where the objectives, parameters, approach to, and information relating to the task are shared with all relevant parties at the outset, and where decision-making strives for consensus in the first instance.[2]

32. We are available to discuss these issues further if you wish, but have drafted the Cabinet paper to note these changes without going into significant detail, as we consider them within the scope of the policy intention you articulated in September.

**Iwi-Māori partnership boards: constitution and representativeness**

33. In December you agreed to seek Cabinet approval of an approach to ensuring the representativeness of IMPBs. The draft Cabinet paper summarises the context for this issue, including the need to balance a flexible, Māori-led process for determining the constitution and governance arrangements of the IMPBs with the need for certainty, efficiency, and the Crown's obligation to actively protect the interests of all Māori wishing to be represented by IMPBs.

34. The draft Cabinet paper seeks approval of the specific statutory process we highlighted in our December advice, which is focused on the Māori Health Authority assessing establishment plans for prospective IMPBs against some essential but flexible principles, including:

    a. the representativeness of the IMPB – whether the prospective IMPB has sufficiently engaged the wider Māori community about its proposal and whether its

[2] This concept of engagement is increasingly recognised in frameworks such as Te Arawhiti's guidelines for Crown engagement with Māori and is originally derived from the International Association for Public Participation.

constitution and governance arrangements ensure it will continue to be engaged with and can represent the views of that community; and

b. whether the area proposed for coverage will best allow the IMPB to efficiently fulfil its purpose and functions - the Bill will still provide that there may only be one IMPB for any area.

35. The draft Cabinet paper highlights that the challenge of balancing certainty with a flexible, Māori-led approach is also occurring in the context of the Three Waters reform (in the governance arrangements for Water Service Entities) and for the joint committees proposed in resource management reform, and that this approach is broadly consistent with ideas being explored in those processes.

36. It also emphasises that, in some places, no representation approach will please everybody, and judicial review of the Māori Health Authority's decisions to recognise IMPBs are an inevitable part of the process, but that taking a flexible approach will allow the Māori Health Authority to mitigate this risk from the outset.

**Māori Health Authority – accountability to Māori**

37. We have previously discussed with you the view expressed in almost all significant submissions from Māori that the Māori Health Authority cannot be meaningfully accountable to Māori when:

a. a Minister of the Crown holds the determinative role in appointing the board of the Māori Health Authority; and/or

b. the Hauora Māori Advisory Committee (the HMAC) is not directly appointed or representative of Māori [DPMC-2021/22-1065 refers][3].

*Appointments to the Hauora Māori Advisory Committee*

38. Some submissions reference the model used for appointments to Te Mātāwai, where board members are appointed directly by 'selection clusters' of iwi and Māori language-related organisations.

39. s9(2)(g)(i) 

40. We consider that the fundamental concern reflected in these submissions is a desire for a more explicit partnership between the Crown and Māori at the highest level of the system (where key accountability functions are exercised by the Minister and the HMAC).

41. As such, we recommend you seek Cabinet approval of a process for Māori to directly appoint the members of the HMAC, which provides a buffer between representation

[3] The Bill currently requires the Minister to consult the HMAC when making appointments to the Māori Health Authority Board, but the HMAC itself is appointed by the Minister.

politics and merits/skill-based appointments. Whilst this could be achieved in a variety of ways, we consider there are two leading options.

Option One: A Te Mātāwai based model

42. One option is to closely replicate the 'iwi' and 'Māori organisational' clusters used for appointing board members of Te Mātāwai. While some adjustment would be needed to include relevant Māori organisations in a health context, the same seven 'regional' clusters of iwi could be used. This has the advantage of using a known and understood model, which, in the short time available to make this change, could help to build public recognition and support.

43. However, the Te Mātāwai approach has not met with universal support (several iwi have sought for the cluster boundaries to be re-aligned or broken down into smaller areas), and it was designed to broadly reflect the way the Māori community organises itself in a Te Reo Māori/radio spectrum context, which is not likely to be the same for health services.

Option two (recommended): Appointments by IMPBs & Māori organisations

44. Our recommended option is to provide a mechanism for IMPBs and health specific Māori organisations to appoint the HMAC members. This avoids the risk above and has the significant advantage of responding to concerns raised by prospective IMPB members as to how they will hold the Māori Health Authority to account and ensure that their views on local priorities and preferences for service delivery are taken into account. This is our recommended option.

45. The recommended option would require careful framing to ensure the certainty and efficiency of HMAC membership, especially given that the form and geographical coverage of IMPBs is not fixed in the Bill and there are likely to be between 15-20 total boards. However, as proposed above at paragraph 33 IMPBs and their areas will be formally recognised on the advice of the Māori Health Authority, and the recognised IMPBs provide a building block for this appointment process.

46. If you wish to progress this option, we would recommend you maximise certainty and efficiency for the HMAC by:

    a. setting a maximum of eight seats on the HMAC, with six appointable by IMPBs and two appointable by relevant hauora Māori/pan Māori leadership organisations;

    b. specifying that members of the HMAC are appointed once they are notified to you in writing by all of the chairs of recognised IMPBs; and

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

47. At this stage, we consider the organisations that could be clustered for the purpose of appointing the remaining two seats of the HMAC would include some mix of appropriate Māori organisations that still need to be discussed and worked through, and would for example be very likely to include the Māori Women's Welfare League.

48. In order to allow time for IMPBs to establish (and avoid a small number of front-running IMPBs appointing all the seats in the first six months), we would provide a

transitional phase, where appointments to the HMAC can only be made from two years after enactment. This would align with other implementation phases in the reforms and ensure the HMAC is in place for appointments to the board of the Māori Health Authority at year three.

49. In the interim phase, the Bill could provide for the ability for the Minister to appoint an interim HMAC if circumstances require them to consult with the HMAC or obtain its agreement.

50. Given the limited time to make this change, the draft Cabinet paper sets out the preferred option for your colleagues and proposes that officials recommend it in the departmental report.

51. We could also undertake another brief round of engagement with prospective parties to IMPBs in late February and early March and advise both you and the Select Committee of the outcome of that engagement prior to the Committee reporting the Bill back to the House on 27 April. The draft Cabinet paper also suggests that you will proactively communicate this change to the Bill at that time

*Hauora Māori Advisory Committee role in appointments*

52. Currently, the Bill requires the Minister to consult the HMAC on appointments to the Māori Health Authority Board. Given the considerable interest in the appointment process to submitters and the desire for increased Māori accountability here, we recommend this be amended so the Minister is required to obtain the agreement of the Hauora Māori Advisory Committee when appointing members to the board of the Māori Health Authority. This would be consistent with the greater level of accountability of the HMAC to Māori as proposed above.

*Final decision in dispute resolution process exercised by Minister in consultation with HMAC*

53. A number of submissions from Māori have raised concerns with the dispute resolution process where Health New Zealand and the Māori Health Authority cannot agree on a matter they are required to work together on. This process would also apply to IMPBs in the locality planning context as discussed in paragraph 26.

54. Current drafting provides that if Health NZ and the MHA are unable to resolve the dispute between themselves, a dispute must be referred to the Minister of Health. The Minister may determine the dispute or a process to resolve the dispute, the outcome of which the parties must comply with. Disputes relating to locality plans would be escalated to the regional level within Health NZ and the MHA in the first instance, but may ultimately reach the Minister if resolution fails at earlier stages.

55. Submitters have pointed out the unilateral nature of this determination and suggested variously that this process should include either the Minister for Māori Development, the Hauora Māori Advisory Committee, or greater powers for the Māori Health Authority Chief Executive.

56. Our view is that ultimately, a clear and final arbiter is needed to ensure the smooth operation of the system and incentivise collaboration between Health New Zealand and Māori Health Authority. However, a final determination in this context should not be a unilateral Crown prerogative. At the same time, the party representing the Māori perspective in this determination should be highly skilled in hauora Māori and

questions of health service provision. For these reasons, we propose that the Minister's final determination power is exercised in consultation with the Hauora Māori Advisory Committee.

## Additional policy matters for your consideration

57. The additional policy matters that we seek your comfort on and do not require Cabinet approval:

    a. applicability of the health system principles to the Minister;

    b. removal of the Pharmac exemption from the health system principles; and

    c. equivalence of Health New Zealand and Māori Health Authority functions.

**Applicability of the health system principles to the Minister**

58. Submitters expressed a view that the health system principles (the principles) should apply to the Minister in exercising their powers under the Bill. There was a strong perception from Māori that by not having the principles apply to the Minister, it is the Crown exempting itself from true partnership. Generally, this was exhibited by referencing legislative frameworks that had an operative Treaty clause, namely section 8 of the Resource Management Act 1991.

59. We have already outlined the reasons for not incorporating an operative Treaty clause at paragraph 10 and following and they also apply here. We also add that this exception is not an exemption from Treaty partnership.

60. In keeping with other legislative examples, we have incorporated elements of the principles that specifically relate where the Minister exercises powers under the Bill. As an example, when issuing the GPS there are specific requirements on the Minister such as consulting with the Māori Health Authority and having regard to their views. The Minister also cannot issue a GPS that does not include the government's priorities in relation to Māori – specifically, priorities for improving health outcomes for Māori and engaging with Māori.

61. Across the statute books, Ministerial decision-making tends to be bound by very specific or very high-level considerations.[4] We have found no examples of a Minister being required to act consistently with principles or objectives that are similar in nature to the health system principles contained in the Bill, or any legislation where a Minister is excluded from the application of such provisions.

62. In exercising powers under the Bill, the Minister must act in accordance with the Bill's purpose – namely, equity. Also, we note that none of this precludes the fact that a Minister of the Crown has obligations (albeit not legally enforceable) under te Tiriti as a Treaty partner.

63. Nevertheless, we do see this as a valid concern raised by submitters and this exception leaves open the risk of decisions being made that are less focused on the matters in the health principles. As discussed with you last year, we think the issue is

[4] See s 3A, Climate Change Response Act 2002; s 16, Food Act 2014; ss 4 and 5, Urban Development Act 2020; ss 6-8, Resource Management Act 1991; s 5, Oranga Tamariki Act 1989.

finely balanced, and you indicated a preference towards the exception. If you are satisfied that the settings outlined are sufficient, we would not recommend any amendments for this aspect of the Bill.

64. If the health system principles were to apply to the Minister, they would be subject to the same caveat that currently applies to health entities. The Minister would need to be guided by the principles as far as reasonably practicable, having regard to all the circumstances, including any resource constraints, and to the extent applicable to Minister and their functions. In practice this may resolve many of the potential issues that you had identified based on our earlier advice.

**Pharmac exemption from health system principles**

65. Some submitters, including Pharmac, queried its exemption from the health system principles that require engagement and finding opportunities for Māori to exercise decision-making authority on matters of importance to Māori. The exemption was inserted late in drafting to address a concern that the principle might unduly interfere with the Pharmac model.

66. We recommend the removal of this exemption as it is unnecessary. We consider it unlikely that the principle will interfere unduly with the Pharmac model. There is a caveat in the decision-making principle that entities must take into account the strength of Māori interest in the matter, and the interests of other health consumers and the Crown, and also the general caveat that entities must be guided within circumstances, as relevant to their work. The removal of the exemption is supported by Pharmac.

**Other minor policy and transitional matters officials are considering**

67. There are other minor policy and transitional matters that officials are currently working through with the Treasury and the Public Service Commission. While there may be changes to provisions of the legislation, we do not anticipate these issues will lead to policy changes that require new decisions from you, but will provide advice if appropriate. These include:

    a. transitional employment matters, including the possible transfer of interim entity chief executives to become the permanent chief executives of the new organisations. These matters are straightforward in policy terms, but complex in detail. We are working on them with the Public Service Commission, and employment law specialist advisors;

    b. the New Zealand Health Charter, which we are actively discussing with the Public Service Commission;

    c. requiring the Health Quality and Safety Commission to work with Health New Zealand;

    d. the concept of a Crown Manager as an additional intervention power which may be used by Ministers, which at present we do not see as a useful mechanism, especially for the Māori Health Authority; and

    e. modification and alignment of Health New Zealand and Māori Health Authority functions in order to ensure drafting reflects the intention of partnership. This

addresses concerns raised by submitters that the differences in functions meant Health New Zealand was the dominant party and undercut partnership.

## Next steps

68. We are available to discuss any of the matters in this advice with you and will amend the draft Cabinet paper per your feedback prior to Ministerial consultation. Next week we expect to provide your office with an initial draft of the departmental report.

69. We will continue to analyse submissions and support the Pae Ora Legislation Committee as needed. To ensure we can present the departmental report to the Committee in mid-February, we will need to obtain agreement from you and Cabinet on the key issues highlighted in this briefing.

70. To meet this timetable, we expect the next steps will be:

| | |
|---|---|
| *17 January* | Draft Cabinet paper and policy decisions briefing to Minister's office |
| *19 January* | Officials receive feedback from Minister |
| *20 January* | Submit draft Cabinet paper for Ministerial Oversight Group |
| *25 January* | Ministerial Oversight Group Meeting to discuss proposed amendments |
| *25 – 31 January* | Draft Cabinet paper Ministerial and Departmental consultation |
| *3 February* | Lodge Cabinet paper |
| *4 February* | Advice on final proposed recommendations for departmental report to Minister's office |
| *9 February* | SWC with power to act |
| *11 February* | Final departmental report to Minister for information |
| *14 February* | Send departmental report to the Committee |

**Appendix A - Public communications points and wider strategy for te Tiriti / hauora Māori provisions in the Bill**

Following our briefing note to you previously, we have developed a high-level communications approach to both raise awareness, and help address any information gaps or misunderstandings as to how the Treaty provisions in the Bill will be given effect to. The draft Cabinet paper details that such communications are likely to emphasise that:

- approaches to Treaty provisions should not be one-size-fits-all, but reflect the particular context in which they apply
- in the Pae Ora Bill, the Crown has sought to take a very practical and clear approach to Treaty obligations by providing for the Māori voice at all levels of the system;
- it is the combined effect of those specific provisions (such as the role of the Māori Health Authority) and the health system principles that provide for the Crown's Treaty obligations;
- the system principles aim to reflect the outcomes and behaviours that are required by the Treaty principles in the health context, and, like for an operative Treaty clause, all decisions made by health entities under the Act can be judicially reviewed against those principles.

We will work with your office to further develop this approach, but in principle, we propose to:

- draft a stakeholder update article on the Pae Ora Treaty obligations for our regular sector newsletter, and also publish this on the Future of Health website
- develop a comms product – such as a brochure, fact sheet, or similar (tailored for the relevant audience) – that summarises the Government's approach to Treaty provisions, which would also be available on the Future of Health website
- proactively set-up interviews with Waatea News and Māori TV that focus on Treaty provisions, with an appropriate spokesperson
- draft an opinion-editorial that is focused on Treaty provisions, and identify suitable publications that it could run in
- convene a virtual hui/kōrero on the provisions for key Māori stakeholders.

The development of the above products would be supported by:

- an agreed set of key messages (including the ones we have provided previously but expanded where necessary)
- agreed core content for comms material
- a set of Q&A – both public-facing and reactive.