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: ROLE OF LOCALITIES IN THE REFORMED SYSTEM

To: Dr Liz Craig, Pae Ora Legislation Committee Cc: Hon Andrew Little, Minister of Health, Hon Peeni Henare, Associate Minister of Health			
Date	9/06/2022	**Priority**	Medium
Deadline	9/06/2022	**Briefing Number**	DPMC-2021/22-2303

Purpose

This briefing responds to your request, via the office of the Minister of Health, for additional detail on key developments related to localities in the reformed health system, the policy issues under consideration, and the next steps in the process toward wider roll-out of localities.

Recommendations

a. **Note** the contents of this briefing.

Stephen McKernan
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17/06/2022

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HEALTH REFORMS: ROLE OF LOCALITIES IN THE REFORMED SYSTEM

Overview

1. This briefing responds to your request, via the office of the Minister of Health, for additional detail on key developments related to localities in the reformed health system, the policy issues under consideration, and the next steps in the process toward wider roll-out of localities.

Background & previous decisions

2. Localities were recommended in the *Health and Disability System Review: Final Report / Pūrongo Whakamutunga* (the Final Report) as an appropriately sized unit for planning primary and community services. The Final Report defined them as "a geographically defined area with a population of between 20,000 and 100,000 people, with footprints that make sense for the community being served."

3. The rationale for incorporating service planning at a locality level, in addition to a national, regional and/or district level was that:

   "organising services around smaller populations…makes it easier to recognise what really matters to people, build relationships across professions and organisations, and work with other sectors to address the wider determinants of health."

4. There are other benefits from the localities model in addition to more locally integrated service planning. The model of localities in the future system:

   a. Requires locality plans to be in place for all localities, which act as the translation of national planning, standards and priorities into the local context.

   b. Enables local providers to work together around a common plan, with shared accountability to deliver against the plan.

   c. Enables the voice of communities to input into local planning about how services are delivered and made available to them, and the priorities that communities want to see addressed.

   d. Provides a mechanism to work in partnership with local iwi via iwi-Māori partnership boards (IMPBs) on priorities and design of local services.

   e. Enables intersectoral action on the behavioural, environmental and socio economic determinants of health.

   f. Provides a mechanism for IMPBs, the health system and other audiences to understand the performance of health services for people at a local level.

5. Cabinet agreed with the recommendation of the Final Report, noting in the *Health & Disability System Review: Proposals for Reform* Cabinet Paper that:

   "establishing networks of service providers creates a major opportunity to drive integration of care models and service delivery around local people, and to expand investment and growth in the workforce as the system realigns towards communities. The locality network also offers a platform to implement a population health approach, drive innovation and ensure that services are planned for all local people, delivered seamlessly, and that providers are incentivised to work collectively towards shared objectives."

6. Section 49 of the Pae Ora (Healthy Futures) Bill (the Bill) sets out the accountabilities for determining a locality and developing a locality plan. A locality plan must be agreed by Health NZ, the Māori Health Authority and the relevant Iwi Māori Partnership Board (IMPB). There are also mandated features of locality plans, like health needs assessments, and a process to engage local communities in the development of the plan. These provisions ensure a degree of consistency in the robustness and approach to planning across localities.

7. Budget 2021 set aside $45.98m over four years to develop prototypes across five to six localities covering in total around 5% of the New Zealand population. The prototypes will test and create exemplar models that inform national policy on how the locality approach can be applied consistently across the country. Budget 2022 funded a further $102m over three years for development and roll-out of Comprehensive Primary Care Teams, and $32.418m over two years for Service Integration for Locality Provider Networks.

What are localities?

8. The shift to a locality approach to primary care is fundamental to these reforms. The locality approach describes a new way of delivering integrated health and care services to local communities across New Zealand. This approach brings together a breadth of expertise across providers to offer people more seamless, connected care closer to home, with a better balance of nationally consistent standards and local tailoring. It emphasises a population health approach, providing for greater engagement with communities (particularly Māori and Pacific peoples), integrated health and social care for those with complex needs, and a focus on the broader determinants of health. It also focuses on collaborative community action through locality partnerships with mana whenua and local stakeholders.

9. By bringing together service providers into more responsive networks of care, and by better investing in and centring the expertise of kaupapa Māori providers, Pacific providers, and professions who sit outside the traditional models of general practice delivery (such as physiotherapists and pharmacists), the locality approach will improve continuity, quality and equity of care, particularly for Māori, Pacific peoples, disabled people and other communities traditionally underserved by our health system. Localities are also a tool to give effect to te Tiriti o Waitangi, empowering iwi, hapū and whānau Māori, alongside wider communities, to shape the care they receive close to home.

10. **Localities** are simply places defined by their communities: they are geographic areas which can be defined and bounded, and which make sense to the people who live there. From a practical perspective, they are a unit for planning and delivering health services; but they are also an important indicator of identity which will help to bind services around their communities. All of New Zealand will be covered by localities.

11. Each locality will have a **provider network**: the group of providers of health services who deliver care to people in a locality, ranging from general practice services through to health promotion and wellbeing support. All the providers who contribute to care pathways in a locality will be part of the network (over time), meaning that provider networks may run across multiple localities so that a breadth of providers can support several communities and localities (e.g. Wainuiomata, Lower Hutt and Upper Hutt might each be separate localities, with a single, shared provider network). Provider networks will be more integrated than most groups of providers are today.

12. The word *network* is one commonly used in our health system, and there will continue to be lots of kinds of networks in future, including *clinical networks* (groups of clinicians

and professionals working together on best practice) and *professional networks* of providers who serve similar communities or share disciplines. These networks will continue to be an important part of sharing capability and best practice in the future – but are not what we are talking about when we talk about provider networks.

13. Each locality will also have a **locality plan**, developed in partnership between communities (including iwi and wider Māori communities), commissioners and providers. The plan is designed to bring together the national expectations of the NZ Health Plan with the priorities, needs and aspirations of local communities. They will need to align to national pathways, best practice and minimum expectations set by the NZ Health Plan but will otherwise have flexibility to tailor the design (and in some cases, scope) of care which is provided locally.

14. Practically speaking, the way each locality will engage the local communities in the development of the locality plan is not yet determined. It will be different from locality to locality, and the locality prototypes will provide an opportunity to demonstrate the different ways community engagement could be done.

15. Within provider networks, there will be several ways in which providers group together to respond to people's health needs, building from the base of enhanced integration across the provider network. The most visible of these will be **comprehensive primary care teams (CPCTs)**, which will ensure people can access care from a range of providers seamlessly. Built around professionals who can provide care and referrals for a range of different health needs (such as general and nurse practitioners) CPCTs will bring together providers such as general practice and district nursing with other roles, like clinical pharmacists or physiotherapists, to offer wrap-around care.

16. These other roles will be drawn from a 'menu' of roles which commissioners can fund to support comprehensive primary care across different groups of providers and different communities within a locality. Different CPCT models will reflect different communities, including Māori, Pacific peoples and rural communities. CPCTs will be distinct to each locality. An initial rollout of CPCTs alongside localities has been funded through Budget 22.

17. In today's system, PHOs act as both commissioners (for GP services) and as network managers, as well as taking clinical roles in areas like population health and prevention. In future, these functions will be broken out – with a **network management** function ensuring that networks of disparate providers are integrated and work together well, and Health NZ and the Māori Health Authority acting as the commissioner in all cases. There will be flexibility in how network management functions are delivered for each locality – we expect that contracting to a third-party provider, or to a lead provider (e.g. a kaupapa Māori provider with wide capability) will be most common, but Health NZ could do this themselves in some instances.

18. This function might be delivered in a range of ways. However, unlike PHOs, network managers will not always act as an intermediate for funding or contracts through to providers – though commissioners may choose to use network managers to direct and manage subcontracts to other providers where that approach is most effective. The network manager will also work to connect the provider network to managed parts of our health system, including the national public health service, hospital and specialist services, and district nursing.

Comparison to the status quo

19. This approach differs from the status quo in a number of ways, including:

a. **Structurally**: Today, DHBs and PHOs deliver and manage primary and community care in very different ways across the motu. While localities will continue to allow for a measure of local tailoring - for example, in how best to tailor service design to whānau need - they will be managed regionally by entities with an overarching national structure and national expectations. This will both allow greater consistency in core service offerings, and better sharing of good practice, expertise and insights.

b. **In how provider networks operate**: Today, PHOs act as an intermediary between DHBs and providers for core primary medical care provided by general practice. This means they operate as a network manager, but (with some variation across PHOs), this often does not extend to other providers in the community (such as WCTO providers, pharmacists or physiotherapists). In future, all of these different kinds of primary and community providers will be part of the provider network, and will be supported to coordinate by network management functions. PHOs will not be required to carry out network management functions, though they may continue to do so in some areas.

c. **Planning**: DHBs, PHOs and the Ministry of Health are responsible for commissioning and managing various primary and community services in today's health system. The new model clarifies this with Health NZ, the MHA and IMPBs having distinct and clear roles, with co-commissioning responsibility for all primary and community care unified in Health NZ and the MHA.

d. **Community voice**: DHBs and PHOs could cover very large populations (in some instances over 500,000), meaning truly local perspectives can be lost. Localities' smaller size (around 20,000 to 100,000 people, as a broad guideline) will enhance these voices and allow for more meaningful local tailoring.

e. **In culture and emphasis**. Primary and community care today tends to be dominated by the interests and role of general practice, in large part because of their fundamental role in PHOs. Localities, with greater government accountability and wider networks of providers, are intended to centre the expertise of a wider range of providers, including Māori and Pacific providers. These wider providers both have valuable expertise to contribute to seamless whānau pathways through care, and may at times be best placed to lead the response to complex health or social needs.

Common questions on localities

20. In engaging with New Zealanders on reforms, a number of key questions about localities commonly arise. We have set out answers to those common questions below for context.

How are localities determined and plans developed?

21. A locality is not a geographic unit currently used in local government or statistical measurement. The process for developing the map of localities will be a collaborative one that involves the input of local communities, mana whenua, and the IMPBs. This process was followed in the development of the locality prototypes, which yielded 13 proposals, 9 of which were progressed to prototyping.

22. Eventually all of New Zealand will be covered by localities, with boundaries being developed in consultation with communities. The criteria for finalising them has not been finalised, but will involve the following considerations:

a. Most importantly, localities must make sense to the people who live in them.

b. Where possible, locality boundaries should reflect existing boundaries, including geographic, suburb, local authority or rohe boundaries.

c. The Health and Disability System Review suggested a population of between 20,000 and 100,000 for localities to provide the right scale for meaningful engagement. This guidance still describes the approximate scale of localities, but is not a requirement for localities - recognising that some larger and smaller areas may still make sense to people and be administratively workable.

d. Localities should reflect existing patterns of community life – for example ensuring as much as possible that where people live, shop, engage in community activities and work are within the same locality.

23. Locality plans will be drafted by staff from HNZ and MHA as appropriate following input from community and providers. The Bill details the content and process for developing and agreeing locality plans:

> **49 Locality plans**
>
> (1) Health New Zealand must develop a locality plan for each locality.
>
> (2) A locality plan must—
>
> (a) set out the priority outcomes and services for the locality; and
>
> (b) state the plan's duration, which must, as a minimum, be 3 consecutive financial years; and
>
> (c) give effect to the relevant requirements of the New Zealand Health Plan; and
>
> (d) include a statement of progress against the priority outcomes set out in the previous locality plan, unless it is the first locality plan for that locality.
>
> (3) In developing a locality plan for a locality, Health New Zealand must—
>
> (a) consult consumers and communities within the locality; and
>
> (aa) consult local authorities affected by the locality plan; and
>
> (b) consult social sector agencies and other entities that contribute to relevant population outcomes within the locality; and
>
> (c) engage with—
>
> (i) the Māori Health Authority; and
>
> (ii) iwi-Māori partnership boards for the area covered by the plan; and
>
> (d) consult any other individual or group that Health New Zealand considers appropriate.

24. Locality plans are agreed by Health NZ (likely at the level of regional commissioner), the Māori Health Authority and the relevant IMPB. Section 29 of the Bill outlines the process if disputes occur between these parties, with the Minister of Health ultimately responsible for resolving disputes with the input of the Minister for Māori Development and the Minister for Crown-Māori Relations as necessary.

25. No other parties have a statutory role in agreeing a locality plan but, noting the degree of consultation above, community support will be important for locality plans to succeed.

26. The Government Policy Statement (GPS), which sets the overarching direction of the health system, and the NZ Health Plan, which sets out how it will be delivered, will be key documents that set the context for locality plans to work within. But, in the same way, the priorities identified in locality plans, and opportunities for innovative, community-driven service improvement will inform future NZ Health Plans about the best way to achieve the goals set by the GPS.

How are locality plans delivered?

27. Health NZ and the MHA will have dedicated personnel to deliver locality plans through their commissioning and local engagement. These personnel will likely work across a

number of locality plans in a district or region rather than being solely responsible for a single locality.

28. Health NZ will commission from a range of providers to achieve them, depending on the plan. Some aspects of a locality plan will be delivered through traditional avenues of primary and community care like general practices and pharmacies, some through public and population health, and some through direct contracting or joint ventures with a wider range of social and health service providers (e.g. iwi hauora organisations).

29. The commissioning approach will depend on the nature of the objective in the locality plan. If a locality plan were focused on improving immunisation rates, for example, then Health NZ and the Māori Health Authority may negotiate an additional payment with participating general practices and pharmacies to deliver additional services, and work with local community groups and marae to increase awareness and spread the message.

What will localities mean for whānau?

30. At present, there is limited opportunity for consumers, or groups of consumers, to participate in the planning or prioritisation of local services. The health system's use of localities as a planning and prioritisation tool, and avenue for community voice and provider networking, will be judged on their contribution to better care in the community for individuals and whānau. This includes care that is more connected, easier to access, responsive to and reflective of the community it serves and delivers equitable outcomes.

31. In addition, locality planning and commissioning provides an avenue for innovative, community-driven investment (and potentially co-investment) that yields bespoke interventions community challenges.

32. One common service to be rolled out in localities is the creation of comprehensive primary care teams. These teams bring together traditional primary care providers with the allied health workforce – including clinical pharmacists, kaiawhinia, nurses and physiotherapists for example, to provide more holistic wrap around support to patients. This will mean patients with a multiple health needs can access the right support more quickly, and meeting their needs more appropriately.

33. The roll-out of comprehensive primary care teams was funded in Budget 2022 and the contracting model is still under development. More detail about the implementation of these can be provided at a later date.

Other commonly asked questions

Are localities a physical place, with an office and address?

34. Each locality will be a physical area with physical boundaries – like an electorate, or a school zone. But localities won't have a hub or headquarters in a physical building which people can go visit; like an electorate, a locality is just a way for us to engage community representation to ensure that people can influence the care provided to them locally.

Where do the people who run the locality work from?

35. Health NZ and the Māori Health Authority will be responsible for ensuring services in each locality runs smoothly for people living in our communities – so localities will be 'run' out of Health NZ and Māori Health Authority offices. In some cases these offices might be in the locality in question, but a lot of the time they won't be; we don't expect Health NZ and the Māori Health Authority to have a physical presence in every locality in the country.

36. Many people will contribute to running services in within localities in different ways – like GPs and nurses, who work out in the community or from private practices, and other organisations which might be in charge of care coordination, or outreach to whānau. These people might work from lots of different places and for different providers, but Health NZ and the Māori Health Authority are responsible for health services at the end of the day.

Do I have a say over what locality I'm in?

37. No, you won't get to pick a locality; localities are just based on where people live. However, which locality you live in won't make a difference to where you can get care or what kinds of care you'll have access to. Anyone can still seek care in any locality – which means you can pick a GP in another locality, or a midwife in another locality. You can even contribute to locality planning and service design in any locality you want, which might be more than one locality if you move often or have a few different places you consider home.

What if a provider doesn't want to be part of a locality/ or doesn't agree with their priorities?

38. Private providers can still make their own decisions about whether they want to take on contracts to provide care into the public health system, and can negotiate contracts with Health NZ and the Māori Health Authority just as they do today. But locality plans will reflect the needs and aspirations of local communities, and will set the course for how we improve care in communities – and providers won't be able to negotiate on whether those are the 'right' priorities. Commissioners will be contracting for services on the basis of locality plans and priorities, so opportunities for providers not interested in locality priorities may be more limited.

Can a locality improve access to care in hospitals?

39. Localities are focused on population health, primary and community care – but what happens in the community has a big impact on our hospital system. Localities won't directly change the care your local hospital provides, but will help move more care into the community where it's safe to do so and improve referrals, meaning more hospital capacity when people need that kind of care.

Next steps

40. Health NZ is currently implementing 9 locality prototypes funded from Budget 2021. Additional funding from Budget 2022 will be used to expand the number of localities to cover 50% of the population by the 2023/24 financial year. This second tranche will prioritise areas of New Zealand with higher Māori, Pacific peoples and higher socio-economic deprivation populations. Health NZ is currently contracting for a learning and insights programme to capture close to real time evaluation of the prototypes as they are established.

41. This is occurring alongside the establishment of the Health NZ and Māori Health Authority commissioning functions, and while lessons from the locality prototypes are gathered.

42. Health NZ is required to establish localities across all of New Zealand by 1 July 2024. It is likely that the process to consult and develop locality plans will begin as localities are established, with the consultation and engagement process as set out in the Bill occurring soon after.

43. If you have further questions about localities, officials from the Transition Unit, Health NZ and the Māori Health Authority can be available to discuss the design of localities, locality prototypes and the locality rollout with you.